

Consumer Protection

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Consumer Protection

I. The Public's Well Being

The states have promulgated, enacted and modified an array of consumer protection laws and regulations. Market, regulatory, and legal forces have combined with societal perceptions to continually transform the way in which the insurance industry is viewed. These two trends overlap, so every agent needs to be aware of the impact of consumer protection on his or her job. Whether dealing with a business owner, an employee, a dependent; whether of substantial wealth or of modest means, all of these people have rights under state law when filing an insurance claim. Consumer protection includes watching out for the public's well being, as well as seeing that all claims are settled fairly. This text will help the reader gain knowledge of consumer protection. Although designed primarily for the adjuster, it may be used by any insurance professional as a means of acquiring a perspective on the issues involved in consumer protection.

Consumer Protection Legislation

The first piece of legislation passed in the consumer protection area was the Federal Trade Commission Act of 1914. Its self-stated basic purpose is:

"Unfair methods of competition in or affecting commerce and unfair or deceptive acts or practices in or affecting commerce are declared unlawful."

A result of the consumer movement that followed is regulation and litigation. Insurers in general and adjusters in particular are thrown into the spotlight. After a loss has occurred, the consumer, often in an agitated emotional state, looks to the insurer to be made whole again. If this cannot be done under terms of the insurance contract, no amount of explanation can assuage the hurt caused by the economic gap and financial hardship. The policy becomes a red flag to the consumer's raging bull, leaving legions of lawyers and other "consumer advocates" to bridge the economic gap on the insured's behalf. Proper documentation and knowledge of legal procedure are basic for protection of the insurance professional and, ultimately, the insured public he or she serves.

One of the oldest principles of doing business was expressed during the days of the Roman Empire in the Latin phrase "*Caveat emptor*" or "Let the buyer beware." In other words, it was up to the purchaser of goods or services to make sure of getting what he or she paid for.

Government Regulation of Commerce

Governments did take some part in regulating commerce, even in early times, by controlling coinage, supervising weights and measures, and issuing charters and licenses. Businessmen cooperated in such procedures and did some regulating on their own, as in the case of the medieval guilds. But generally in pre-industrial times the relationship between buyer and seller was based on the "*caveat emptor*" principle.

With the coming of the industrial revolution in the 19th century and the development of complex urban societies, buyers became more and more removed from sellers and correspondingly less able to bargain with them. A demand arose for regulation to protect consumers from error or fraud on the part of producers, which under the industrial system had the potential for adversely affecting millions of people. Around the turn of the century in the United States, muckraking books exposed abuses in the meatpacking and other industries, and government agencies for consumer protection began to be set up. The process was expanded by the Depression, the growth of industry after World War II, and the Great Society programs of the 1960's.

The modern consumer protection movement began in the early 1960s with reference to a Consumer Bill of Rights by President Kennedy, the growth of the so-called "Great Society" program of the Johnson Administration, and the meddling of Ralph Nader and other consumer advocates to highlight the existence of unsafe products and the need for greater government regulation. The hoped-for result was that, instead of creating a nanny state, American consumers would be protected from unsafe products, fraud, deceptive advertising, and unfair business practices through a mixture of national, state, and local governmental laws and the existence of many private rights of actions. These public and private rights protect consumers equip them with the knowledge they need to protect themselves, and create a bonanza for tort lawyers

Although U.S. mechanisms for consumer protection often exist separately from each other, what the overall scheme lacks in centralization, it gains in depth and variety of protection. Its strength is the array of governmental actors, formal legal rights, and remedies protecting consumers. Its weakness lies in the unequal reality of who has access to the government and the courts.

Consumer Protection at the National Level

There are two principal consumer protection agencies at the federal level; the United States Federal Trade Commission and the more recently created Consumer Finance Protection Bureau.

Federal Trade Commission

The United States Federal Trade Commission (FTC) works alone, and in concert with other federal agencies, to administer a wide variety of consumer protection laws. The overall goal is to afford consumers a deception-free marketplace and provide the highest quality products at competitive prices. The FTC is an independent federal agency with five Presidentially-appointed, Senate-confirmed commissioners who each serve seven-year terms. No more than three commissioners may be members of the President's political party. Created in 1914, the FTC has two principal goals:

- To protect consumers by preventing fraud, deception, and unfair business practices in the marketplace
- To maintain competition by preventing anticompetitive business practices

The FTC's Bureau of Consumer Protection is charged with achieving this goal. Consumer protection authority vested in the FTC comes from Sec. 5(a) of the FTC Act, which prohibits "unfair or deceptive acts or practices in or affecting commerce."

According to the FTC, deception occurs when there is a material representation, omission, or practice that is likely to mislead a consumer who is acting reasonably under the circumstances. Unfair practices are those which cause, or are likely to cause, reasonably unavoidable and substantial injury to consumers without any offsetting countervailing benefits to consumers or competition.

The FTC uses its investigative authority to uncover deception, unfair activities, or violation of any statute under which it has authority. The Bureau of Consumer Protection may issue civil investigative demands ("CIDs") to explore possible violations. Like a subpoena, a CID can compel the production of existing documents or oral testimony, while also requiring that a recipient file written reports or responses to questions. Investigations can be triggered by Presidential or Congressional requests, court referrals, consumer complaints, or internal research.

Consumer Finance Protection Bureau

The **Consumer Financial Protection Bureau (CFPB)** is an independent federal agency that holds primary responsibility for regulating consumer protection with regard to financial products and services in the U.S. The CFPB was created in 2011.

The jurisdiction of the bureau includes banks, credit unions, securities firms, payday lenders, mortgage-servicing operations, foreclosure relief services, debt collectors and other financial companies. It was designed to consolidate employees and responsibilities from a number of other federal regulatory bodies, including the Federal Reserve, the Federal Trade Commission, the Federal Deposit Insurance Corporation, the National Credit Union Administration, and the Dept. of Housing and Urban Development. The bureau is an independent unit located inside and funded by the United States Federal Reserve, with interim affiliation with the U.S. Treasury Department. It writes and enforces rules for financial institutions, examines same, monitors and reports on markets, as well as collects and tracks consumer complaints.

The Treasury Department states that the bureau is tasked with the responsibility to "promote fairness and transparency for mortgages, credit cards, and other consumer financial products and services." According to its webpage, "The central mission of the Consumer Financial Protection Bureau is to make markets for consumer financial products and services work for Americans- whether they are applying for a mortgage, choosing among credit cards, or using any number of other consumer financial products."

As the movement now known as consumerism gained strength, in fact, so many regulations were put into effect that some critics claimed the correct term for the situation might be "*Caveat venditor*" or "Let the seller beware." Deceptive trade practices now to a large extent are not only unethical and poor business policy but also illegal, with stated penalties enforceable if an unhappy buyer calls on the proper government agency for help and is able to prove his case.

The States and Consumer Protection

Every state in this country has enacted a deceptive trade practice or consumer protection statute¹. Although these statutes vary from state to state and may be modeled after different federal acts, they all have the same basic purpose; to protect the public from unfair or deceptive acts or practices with respect to the sale of goods or services.

It has been noted that consumer protection legislation is a relatively new concept. The purpose of these statutes is "to provide a private cause of action for consumers injured by unfair or deceptive commercial practices." The Uniform Deceptive Trade Practices Act served as a model for some states; others based their statutes on the Sherman Antitrust Act' or the Federal Trade Commission Act of 1938 (15 U.S.C. § 45(a)(1) (1994)). The development of these laws has been attributed to the increasingly impersonal nature of the marketplace and consumer dissatisfaction with the traditional commercial law remedies for mistreatment by large-scale business organizations.

Insurance Consumer Protection and the States

Consumer protection laws prohibit deceptive practices in consumer transactions and, in many states, also prohibit unfair or unconscionable practices. Theirs is a critical role in ensuring marketplace justice and fairness. The effectiveness of consumer-oriented laws varies widely from state to state. Legislation or court decisions in dozens of states have narrowed the scope of consumer protection laws or granted sweeping exemptions to entire industries.

Consumer protection statutes provide the basic protections for the thousands of everyday transactions that each consumer in the United States enters into each year. Although consumer protection statutes vary widely from state to state, their basic premise is that unfair and deceptive tactics in the marketplace are inappropriate. Consumer protection statutes are the basic legal underpinning for fair treatment of consumers in the marketplace. Before the adoption of state consumer protection

¹ The corresponding state statutes are as follows: ALA. CODE § 8-19-5 (1993); ALASKA STAT. § 45.50.471 (Michie 1998); AZ REV STAT ANN. § 44-1522 (West 1994); ARK. CODE ANN. § 4-88-107 (Michie 1996); CAL. BUS. & PROF. CODE §§ 17200, 17500 (West 1997); CAL. CIV. CODE § 1770 (West 1985 & Supp. 1995); COLO. REV. STAT. ANN. § 6-1-105 (West 1996); CONN. GEN. STAT. ANN. § 42-110b (West 1992 & Supp. 1999); DEL. CODE ANN. tit. 6, § 2513 (1993 & Supp. 1999); FLA. STAT. ANN. § 501.204 (West 1997); GA. CODE ANN. § 10-1-393 (1994 & Supp. 1999); HAW. REV. STAT. ANN. § 481A 3 Michie 1999); IDAHO CODE § 48-603 (1997); ILL. COMP. STAT. 815/505-2 (West 1993 & Supp. 1995); IND. CODE ANN. § 24 5-0.5-3 (West 1998); IOWA CODE ANN. § 714.16(2) (West 1993 & Supp. 1995); KAN. STAT. ANN. § 50-626 (1994); KY. REV. STAT. ANN. § 367.170 (Michie 1998); LA. REV. STAT. ANN. § 51.1405 (West 1987); ME. REV. STAT. ANN. tit. 5, § 207 (West 1989); MD. CODE ANN., COM. LAW I § 13-303 (1990 & Supp. 1994); MASS. GEN. LAWS ANN. ch. 93A, § 2 (West 1997); MICH. COMP. LAWS ANN. § 445.903 (West 1989); MINN. STAT. ANN. § 325D.44 (West 1995); MISS. CODE ANN. § 75-24-5 (1991 & Supp. 1999); MO. ANN. STAT. § 407.020 (West 1990 & Supp. 1999); MONT. CODE ANN. § 30-14-103 (1993); NEB. REV. STAT. § 59-1602 (1998); NEV. REV. STAT. ANN. § 598.0914 (Michie 1998); N.H. REV. STAT. ANN. § 358-A:2 (1995); N.J. STAT. ANN. § 56:8-2 (West 1989); N.M. STAT. ANN. § 57-12-2 (Michie 1999); N.Y. GEN. BUS. LAW § 349 (McKinney 1999); N.C. GEN. STAT. § 75-1.1 (1994); N.D. CENT. CODE § 51-15-02 (1989); OHIO REV. CODE ANN. § 1345.02 (West 1993 & Supp. 1998); OKLA. STAT. ANN. tit. 201 § 3 (1997); OR. REV. STAT. §§ 646.607, 646.608 (1997); 73 PA. CONS. STAT. ANN. § 201-3 (1993 & Supp. 1995); R.I. GEN. LAWS § 6-13.1-2 (1992); S.C. CODE ANN. § 39-5-20 (Law. Co-op. 1985 & Supp. 1994); S.D. CODIFIED LAWS § 37-24-6 (Michie 1994); TENN. CODE ANN. § 47-18-104 (1995 & Supp. 1998); TEX. BUS. & COM. CODE ANN. § 17A6 (West 1987 & Supp. 1995); UTAH CODE ANN. § 13-5-2.5 (1999); VT. STAT. ANN. tit. 9, § 2453 (1993); VA. CODE ANN. § 59.1-200 (Michie 1998); WASH. REV. CODE ANN. § 19.86.020 (West 1999); W. VA. CODE § 46A-6-104 (Michie 1998); WIS. STAT. ANN. § 100.20 (West 1998); WYO. STAT. ANN. § 40-12-105 (1993).

statutes in the 1970's and 1980's, neither consumers nor state agencies had effective tools against fraud and abuse in the consumer marketplace. This was so even though the Federal Trade Commission Act had prohibited unfair or deceptive acts or practices since 1938. In most states, there was no state agency with a mandate to root out consumer fraud and abuse, much less tools to pursue fraud artists.

Consumers had even fewer tools at their disposal. A consumer who was defrauded often found that fine print in the contract immunized the seller or creditor. Consumers could fall back only on claims such as common law fraud, which requires rigorous and often insurmountable proof of numerous elements, including the seller's state of mind. Even if a consumer could mount a claim, and even if the consumer won, few states had any provisions for reimbursing the consumer for attorney fees. As a result, even a consumer who won a case against a fraudulent seller or creditor was rarely made whole. Without the possibility of reimbursement from the seller, consumers could not even find an attorney in many cases. Consumer protection statutes were passed in recognition of these deficiencies. States worked from several different model laws, all of which adopted at least some features of the Federal Trade Commission Act by prohibiting at least some categories of unfair or deceptive practices. But all go beyond the FTC Act by giving a state agency the authority to enforce these prohibitions, and all but one also provide remedies that consumers who have been cheated can invoke.

Laws other than consumer protection statutes rarely fill this need. For example, much consumer fraud is not a criminal offense. Even where an activity might violate a criminal law, police and prosecuting authorities usually have few resources to devote to non-violent crime. In addition, the burden of proof is extremely high in a criminal case, and the result of the case may only be punishment of the offender- not the refund that the consumer wants.

State Consumer Protection Laws

State and federal consumer protection legislation are different in several respects; the states provide a private right of action, different remedies, and relaxed common law limitations on consumer protection actions when compared to FTC policy standards. The FTC Act does not include a private enforcement mechanism. State consumer protection legislation grants consumers a private right of action, the privilege of instituting a lawsuit arising from a particular transaction or state of facts, such as a suit that is based on a contract or a tort, a civil wrong.

This difference is driven by the "balance of power" argument that in interactions between businesses and consumers, more power must be shifted towards consumers. This argument suggests that a private remedy for wronged consumers is necessary for the effective prosecution of consumer complaints. These private rights of action were envisioned as a complement to public agency administrative enforcement under the FTC Act. Although public enforcement under the FTC Act requires the Commission to consider the public interest in deciding whether to challenge a practice, only a few states include a public interest requirement for private actions.

Insurance Consumers and Deceptive Trade Practices-Consumer Protection Act

In the early twentieth century state regulation of commerce came to the fore when the Progressive movement gained stature. The states became "laboratories" of social reform, as wage and hour legislation and child labor laws, among others, were passed. Federalism, noted James Bryce in his book, *American Commonwealth*, enabled people "to try experiments in legislation and administration which could not be safely made in a large centralized country. Progressives harbored a deep ambivalence to federal regulation, and often preferred state controls (G. Mowry, *The Era of Theodore Roosevelt, 1900-1912* pp. 59-84 (1958)). Louis Brandeis, the Progressive era's most celebrated reformer, typified this attitude in the fight over the reform of industrial life insurance, one of his most important causes. Brandeis believed that the entire industry principally served to defraud working people of their life savings. His solution, however, was to impose strict state, rather than federal, regulation of the insurance industry. Brandeis believed that federal regulation would lead to capture of the national legislature by the industry, but that the insurance industry could never capture every statehouse (P. Strum, *Louis D. Brandeis, Justice for the People*, pp. 74-93 (1984)).

Basic Purpose

The basic purpose of a Deceptive Trade Practice Consumer Protection Act is stated as: "to protect consumers against false, misleading, and deceptive business practices, unconscionable actions, and breaches of warranty and to provide efficient and economical procedures to secure such protection."

A 'consumer' can be defined as a person or group of people, such as a household, who are the final users of products or services. The consumer's use is final in the sense that the product is usually not improved by the use. The term "consumer" as used in consumer protection legislation may or may not include a business consumer that has assets over some threshold value (\$25 million or more, for example) or that is owned or controlled by a corporation or entity with assets above a certain level.

Prohibited Practices Under the Act- The "false, misleading, and deceptive business practices" prohibited by the act include but are not limited to:

- ◆ Causing confusion or misunderstanding about the source, certification, sponsorship, or approval of goods or services.
- ◆ Causing confusion or misunderstanding about association, connection, or affiliation with or certification by another.
- ◆ Using deceptive representations about geographic origins of goods or services.
- ◆ Representing goods as new that are used, secondhand, reclaimed, reconditioned, or deteriorated.
- ◆ Representing goods or services as being of a particular grade, quality, or standard, or goods as being of a particular style or model, if they are of another.
- ◆ Using false or misleading representation of facts to disparage the goods, services, or business of another.
- ◆ Advertising goods or services and not intending to sell them as advertised.
- ◆ Advertising goods or services without intending to supply a public demand that reasonably could be expected, without stating a limitation of quantity in the advertising.

- ◆ Making false or misleading statements about the amount, existence of, or reasons for price reductions.
- ◆ Representing that obligations, rights, or remedies are conferred by or involved in an agreement which it does not have or which are illegal.
- ◆ Making false or misleading statements of fact knowingly about the need for repair service, parts, or replacement.
- ◆ Misrepresenting authority of an agent, salesman, or representative to negotiate final terms of a consumer transaction.
- ◆ Basing repair charges for an item in whole or part on a guaranty or warranty instead of on the value of the actual repairs made or work to be performed without separating the charges for the work and the charge for the warranty or guaranty.
- ◆ Resetting, disconnecting, or turning back the odometer of a motor vehicle to reduce the number of miles shown on the odometer gauge.
- ◆ Fraudulently advertising a sale by representation that a person is going out of business.
- ◆ Using a chain referral plan in the sale or offer to sell goods or anything of value, promising future consideration to the buyer for furnishing the seller with the names of other prospective buyers.
- ◆ Misrepresenting the rights or remedies provided by a warranty or guarantee.
- ◆ Selling or offering to sell a right of participation in a multi-level distributorship, either directly or in association with the sale of goods or services, promising a rebate or payment to individuals conditioned on their recommending or securing additional individuals for positions in the sales operation and not exclusively in relation to proceeds from the retail sale of goods.
- ◆ Representing that work or services were performed on or parts replaced in goods when they were not.
- ◆ Filing suit for payment of money on a contract signed by a defendant for goods, services, loans, or extensions of credit for personal, family, household, or agricultural use in any county but the one in which the defendant is living at the time of the suit or the one in which he signed the contract.
- ◆ Inducing a consumer into a transaction by failure to disclose information, which would have caused the consumer not to enter the transaction.
- ◆ Using the term "corporation" or "incorporated" or using an abbreviation for such terms in the name of an unincorporated business entity.

Consumer Protection and the Insurance Profession

Consumer protection statutes vary from state to state, but they all have the same basic purpose; protection of the public from unfair or deceptive acts or practices with respect to the sale of goods or *services*. It is within the context of those who supply services, rather than goods, that the actions of insurance professionals engender debate among the various states and their judicial tribunals.

In 1944, the United States Supreme Court held in *United States v. South-Eastern Underwriters Association* that insurance companies operating across state lines were engaged in interstate commerce and thus subject to the federal antitrust laws. The decision sent shock waves through the insurance community. To state insurance officials the decision made comprehensive federal taxation and trade regulation of insurance inevitable, draining state coffers of revenue and terminating the need for their services. The ruling caused the insurance industry to re-think its position, as overall it preferred the localized regulation of the state authorities. The specter of

federal antitrust actions aimed at its cooperative rate setting and policy-writing activities caused the insurance industry to rally around legislation proposed by the National Association of Insurance Commissioners. The legislation, known as the McCarran-Ferguson Act, passed in 1945.

State Regulation

The McCarran-Ferguson Act, while forbidding any construction of federal law that would invalidate, supersede or impair state insurance regulations, expressly subjected the business of insurance to the Sherman and Clayton antitrust acts and the Federal Trade Commission Act “to the extent that such business is not regulated by State law.” Thus the act created a “reverse preemption,” displacing federal law only if the state in which the conduct occurred regulated anti-competitive, unfair and deceptive trade practices in the insurance business.

The states were regulating insurance, but none had laws aimed at anti-competitive, unfair and deceptive conduct anywhere approaching the strength and scope of the Sherman, Clayton, and Federal Trade Commission acts. To give the states time to fill the regulatory gap, Congress exempted the business of insurance from these federal statutes for three years.

Realizing, as did Congress, that state regulatory schemes were deficient, the National Association of Insurance Commissioners began work almost immediately on a model unfair competition and deceptive practices act for adoption by the states. This effort culminated in 1947 with the NAIC’s adoption of “An Act Relating to Unfair Methods of Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance.” Lifting language directly from Section 5 of the Federal Trade Commission Act, the NAIC model law prohibited any “unfair method of competition” and any “unfair or deceptive act or practice” in the business of insurance. The model law listed certain activities that it “hereby defined” to be such methods, acts or practices and provided for regulatory oversight by the state insurance commission.

Several states were slow in adopting the language of the model legislation. Why is unclear, though it seems safe to conclude that the insurance industry did not particularly like the model act’s broad condemnation of unfair and deceptive practices and the strengthened hand it gave state regulators. And despite Congressional opinion that existing state laws were inadequate and that the three-year moratorium was to be used to beef them up, the insurance industry and state officials were apparently unconvinced that incorporating the model act into state law was needed to avoid federal regulation. Legislative foot-dragging continued for several years.

Investigation Impetus

What finally moved states to pass the NAIC model law was an extensive Federal Trade Commission investigation of the advertising practices of the health and accident insurance industry in 1953 and 1954 culminating in two major enforcement actions decided in 1956. In April of that year, the Commission issued a cease and desist order against The American Hospital and Life Insurance Company located in San Antonio, Texas and a month later issued another against a Michigan insurer, National Casualty Company. In each case, the Commission found that brochures the companies had mailed to out-of-state agents for delivery to prospective policyholders

were false, misleading and deceptive in violation of Section 5 of the Federal Trade Commission Act. More importantly, the Commission ruled in both cases that the McCarran-Ferguson Act did not bar federal action, even in those states with statutes regulating the insurance industry. Suddenly, federal regulation of insurance trade practices had gone from theoretical threat to cold, hard fact. Though the Commission would later be reversed by the appeals courts in 1957, by that time the state legislatures, prodded by an insurance industry and state insurance departments desperate to ward off federal regulation, had passed the model act.

At first, it seemed that the insurance industry and state regulators might fare well before the Commission. The hearing examiners in both *American Hospital* and *National Casualty* ruled that, under the McCarran-Ferguson Act, the Commission had no jurisdiction in those states that regulated insurance by statute. Ironically, though *American Hospital* involved a Texas insurer, the adequacy of Texas' regulatory scheme was not at issue in that case because the jurisdiction of the Commission, in its words, "has not been asserted over respondent's business transacted wholly within that State." Texas law, as well as that of every other state, was at issue in *National Casualty*, however, because the Michigan insurer in that case was licensed to do business everywhere in the country. The hearing examiner found that the Commission's jurisdiction over National Casualty Company was limited to Mississippi, Rhode Island, Missouri, Montana and the District of Columbia, which had no state statute, and that "each of the states other than those named fully regulates the business of insurance by legislative enactment, with the result that as to transactions within such states the Commission's jurisdiction is withdrawn."

Whether the *National Casualty* hearing examiner analyzed the laws of the other states as inadequately as he did those of Texas is not known. Examiners' decisions are unpublished and in neither its *National Casualty* nor *American Hospital* opinions did the Commission pay any attention to the adequacy of the state statutes themselves or to the criteria the hearing examiners had used in reviewing them. Instead, the Commission concluded that it had jurisdiction regardless of state regulation because, in its view, the McCarran-Ferguson Act preserved the Commission's power where there were "interstate aspects" of the insurance business at issue such as the distribution of deceptive sales materials across state lines.

Consumers and Professional Services

Some states maintain that professional services are beyond the reach of consumer protection statutes. The rationales vary from state to state, but the crux is that true professional services are not commercial in nature. Rather, they fall outside the scope of "trade and commerce." Typically, clients of the insurance profession are protected by enforcement of regulations by various state insurance departments. Complaints are made either separately or in conjunction with negligence, breach of contract, or breach of fiduciary obligation-based malpractice claims. The potential application of state consumer protection statutes to insurance transactions therefore opens the door for the possibility of inconsistent results and inconsistent applications of rules and regulations.

Regardless of its domicile in a state's legal structure, what is important to remember is that states have enacted legislation regarding deceptive practices of insurance companies, including those practices related to the sale of policies and the payment

of claims. A deceptive trade practices statute may also provide a remedy in insurance cases where state insurance laws do not apply.

Relief Provided Under State Law

A consumer may claim damages from any of specifically enumerated acts, or from breach of an express or implied warranty, any unconscionable action by any person, or acts in violation of the state insurance code. An "unconscionable action" means an act or practice which takes advantage of the lack of knowledge, experience, ability, or capacity of a person to a grossly unfair degree, or results in a gross disparity between the value received and consideration paid, in a transaction involving transfer of consideration. There follows a recital of mechanics of application and a list of remedies under a typical state law. Precise language may vary from state to state

Notice Required Under the Act- The consumer before filing a suit seeking damages must give written notice at least 60 days ahead of time to the person he contemplates suing, advising him in reasonable detail of the specific complaint and the amount of actual damages and expenses expected to be incurred in the suit.

Period of Limitation Under the Act- A limit of two years is set for actions to be brought under the Deceptive Trade Practices- Consumer Protection Act, running from the date on which the act or practice complained of occurred or from the time the consumer discovered or reasonably should have discovered the occurrence. If the plaintiff proves that failure to commence the action in time was caused by deliberate conduct on the part of the defendant solely for the purpose of delaying the action, the period of limitation may be extended for 180 days.

Injunction Process Under the Act- The Consumer Protection Division of the Attorney General's office can bring an action in the name of the state to secure a temporary restraining order, temporary injunction, or permanent injunction when there is reason to believe that any person is engaging in, has engaged in, or is about to engage in an act or practice prohibited by the Deceptive Trade Practices-Consumer Protection Act, in order to prevent such an action.

Locations for Filing Under the Act- Actions for restraining orders by the Consumer Protection Division may be brought in the district court of the county in which the defendant lives, has his principal place of business, or has done business, or in the county where the transaction occurred, or on consent of the parties in a district court in Travis County.

Notification to Defendant Under the Act- The Consumer Protection Division is not required to notify a person that an investigation under the act is being considered. Seven days before a court action is instituted, however, the division is required to inform the person of the alleged unlawful conduct, unless there is good cause to believe that if such notification were made the person would evade service of process or destroy relevant records, or if an emergency exists such that delay in obtaining a temporary restraining order would result in irreparable injury, loss, or damage.

Receivership Provisions Under the Act- When judgment awarding money has been entered in a case under the Deceptive Trade Practices- Consumer Protection Act, the defendant has 30 days to make payment. After that time, if the plaintiff has

made a good faith attempt to collect the money, the legal presumptions are the following:

Assurance of Voluntary Compliance Under the Act- The Deceptive Trade Practices- Consumer Protection Act provides for acceptance by the Consumer Protection Division of written assurance that an alleged violator will comply voluntarily with the provisions of the act. The assurance is to be filed with and subject to approval of the district court in the county of residence of the alleged violator or in the district court of Travis County. It may be conditioned on the restoration of any money or property acquired by means of practices in violation of the act. The act provides that an assurance of voluntary compliance is not to be considered an admission of a prior violation. Failure to comply with terms of the assurance, however, unless it has been rescinded by agreement of the parties or voided by the court, is to be considered prima facie evidence of violation.

Investigative Demand Under the Act- An authorized member of the Consumer Protection Division having reason to believe that a person is violating, has violated, or is about to violate any provision of the Deceptive Trade Practices- Consumer Protection Act may require the person to fill out on prescribed forms a report in writing as to all the facts and circumstances concerning the alleged violation.

Criminal Penalties Under the Act- Concealing or withholding documentary evidence or merchandise under the statute is a misdemeanor subject to a fine or a jail term, or both. Final orders in these cases are generally subject to appeal through the state's judicial system. Failure to comply with a final order is punishable by contempt.

Lawsuits brought under the Act- Many of the lawsuits brought against insurance professionals include a cause of action under the state Deceptive Trade Practices Act. Any consumer can maintain a deceptive trade practices action for one of the violations designated by statute if it is a producing cause of damages:

- a.) The use or employment by any person of a false, misleading, or deceptive act or practice that is specifically enumerated. Specific points of these provisions will be reviewed subsequently.
- b.) Breach of an express or implied warranty.
- c.) Any unconscionable action or course of action by any person.
- d.) The use or employment by any person of an act or practice in violation of applicable sections of the state insurance code.

"Economic damages" means compensatory damages for pecuniary loss, including costs of repair and replacement. The term does not include exemplary damages or damages for physical pain and mental anguish, loss of consortium, disfigurement, physical impairment, or loss of companionship and society. "Knowingly" means actual awareness of a falsity, deception, or unfairness of an act or practice giving rise to the consumer's claim or, in an action brought under a breach of an express or implied warranty. Actual awareness of the act or practice constituting the breach of warranty, but actual awareness may be inferred where objective manifestations indicate the person acted with actual awareness.

Definitions Common to the DTPA

Agents should be familiar with certain definitions common to the Deceptive Trade Practices Act of the various states;

Goods- These are defined as tangible chattels or real property purchased for lease or use.

Services- Refers to work, labor or services purchased or leased for purchase including services furnished in connection with the sale or repair of goods.

Consumer- This means an individual, partnership, corporation, or governmental entity that seeks or acquires by purchase or lease any goods or services.

Unconscionable action or course of action- This is an act or practice which, to a person's detriment, does one or both of the following. 1.) It takes advantage of the lack of knowledge, ability, experience, or capacity of a person to a grossly unfair degree 2.) It results in a gross disparity between the value received and consideration paid in a transaction involving transfer of consideration.

Liberal Construction

Many state legislatures by statute direct that the DTPA shall be liberally construed and applied to promote its underlying purposes, which are to protect consumers against false, misleading, and deceptive business practices, unconscionable action, and breaches of warranty and to provide effective and economical procedures to secure such protection. Some states have amended DTPA legislation to prohibit a claim for damages based on the rendering of a professional service, the essence of which is the providing of advice, judgment, opinion, or similar professional skill. This exemption may apply to insurance agents (or other types of state license holders), if the courts consider the task or tasks of insurance agents to be a "professional service." This new exemption does not apply to any of the following;

- An express misrepresentation of material fact
- An unconscionable action or course of action, the failure to disclose information
- A breach of an express warranty that cannot be characterized as advice, judgment or opinion

Consumer Lack of Knowledge-This portion of the statute has been interpreted as meaning "taking advantage of the consumer's lack of knowledge to a grossly unfair degree." A statement such as this should be a warning to insurance professionals. They have superior knowledge of the terms, conditions and settlement procedures involved in the insurance contract. They are acting in their capacities as principal when dealing with a consumer who is held to a much lower duty of care. Under the Deceptive Trade Practices Act, the consumer has been held to have a duty of care of being ignorant, unthinking, and credulous.

II. Adjusting and the Consumer

After a loss has occurred, the insured must notify the insurance company. This notice represents a claim for payment. Before making a payment for the claim, the insurer will want a claims investigation made. The person performing the claims investigation, as well as performing other tasks needed before a claim will be paid, is known as a loss adjuster, a claims agent, or a claims auditor. Loss adjusting is most

important in property insurance, where many losses are partial losses and where the extent of property damage is not always clear. Loss adjusting is generally not a problem in life insurance, since no payment is made for "partial" losses, and the face of the policy is paid whenever death occurs.

In some cases, claims for accidental death benefits, disability income benefits, and health insurance benefits do create a need for loss adjusting of claims made on life insurance policies. Adjusters generally work with fire, liability, property, and marine insurance contracts. Health and life insurance coverages are normally reviewed by claims examiners since they seldom involve adjustment of unliquidated amounts, as do settlements in the property and casualty field.

The Claim

When an insured has a loss, the insurance company assigns an adjuster to assess the claim. As the title "adjuster" implies, the person is there to adjust the claim, not accept it without question. Hence, "adjust" means "negotiate." Who does the negotiating and what is the point of this exercise?

Although the role of insurance claims adjusters is crucial after a car crash, conflagration, or major catastrophe, licensing and training requirements for adjusters vary considerably among states. Some states have no requirements for insurance claims adjusters, while others have licensing and training requirements for most types of adjusters operating in the state. Many states have licensing and training requirements for some types of adjusters, but not for other claims adjusters that may also be called upon after a catastrophe. Further, licensing and training requirements may be temporarily relaxed after a catastrophe, meaning that adjusters entering a state may not have met the normal requirements needed to work there. As a result, the qualifications and training of adjusters who assess damages following a catastrophic event may vary significantly. State insurance regulators generally rely on the insurance companies to ensure the quality of their adjusters and adjustment processes, though states may also choose to conduct reviews of claims already processed through market conduct examinations.

States Requiring No Adjuster License	
Colorado	New Jersey
Illinois	North Dakota
Iowa	Ohio
Kansas	South Dakota
Maryland	Tennessee
Massachusetts	Virginia
Missouri	Wisconsin
Nebraska	Pennsylvania (Auto Adjuster License Required)

In order to adjust flood insurance claims, adjusters are certified by the National Flood Insurance Program (NFIP), in addition to the state requirements. Following Hurricane Katrina, some states that lacked licensing requirements for adjusters passed laws to raise the level of oversight for adjusters. Several states affected by recent hurricanes have also initiated market conduct examinations to evaluate insurers' claims adjustment processes, in part because of consumer complaints about the handling of hurricane-related claims.

Consumer Protection and Adjuster Responsibility

There are three major points of view regarding the insurance adjuster and his or her responsibility to the consumer;

- 1.) What the lawyers say; Insurance adjusters, acting as agents of the companies employing them, offer the insured suffering a loss an unrealistically low figure in compensation for the claim. People have to accept the offer. They do not have the means to deal with the economic consequences of the loss, fight to have the settlement increased, and deal with day-to-day living issues simultaneously.
- 2.) What the public adjusters say; these are adjusters for hire. They are akin to the independent property appraisers, with a fee or commission based approach to arriving at an appropriate value for the loss in question. Like the adjuster assigned by the insurer, the public adjuster is there to negotiate. Public adjusters maintain that they are there to negotiate for the consumer, not against the consumer. Public Adjusters are licensed by the states' insurance departments to advise and assist policyholders with insurance claims. Most insureds do not feel the need to hire an adjuster. But, in the case of complicated losses, either commercial or personal, the insured may feel a fairer settlement will be forthcoming if an adjuster is representing its interests. Public adjusters, in their promotional material, on the Internet, and among their various trade groups, like to stress the these points;
 - a.) The insurance company (who the company adjuster represents) wrote the policy.
 - b.) After a loss is suffered, the insurance company sends an adjuster to adjust the loss and pay what they think is right. It is easy to see where the independent adjusters can create a modicum of angst with this juxtaposition of players

The public adjusters naturally want the consumers to come to them. These adjusters also want the public to end-run the lawyers, who only have their own best interests at heart. The public adjusters say attorneys take too big of a slice out of the settlement, generally end up negotiating a settlement anyway (not trying it in court), and drag the process out even further.

- 3.) What the insurance company adjusters say; these adjusters work for the insurer. There is no question as to where their loyalties lie. But wait a minute. Every day, these people are faced with inflated or downright fraudulent claims under policy. They are there to protect the insurance company's interest. This can be seen, in a roundabout way, as protecting the policyholders as a group. The adjuster is not the candy man. He or she is not there to hand out blank checks. As claim payouts go up, premiums inevitably follow. Across the country people complain about auto insurance rates going up. This is not because of a bleeding heart mindset on the part of the adjuster. It is because of policyholder schemes, fraud, inflated claims and sock-it-to-'em mentalities on the part of juries. Insurance company adjusters work for the people also. By managing claims, they manage to hold down premiums. A first line of defense in the battle to keep a private system of insurance, locally controlled and operated, going in an economically efficient manner.

Many insurance companies use loss adjusters who are not their own employees. Instead, when they need a loss adjusted, they hire the services of an independent adjustment bureau. It would not be practical for every automobile insurance company to keep an adjuster near the scene of every possible automobile accident in the

country or to send its adjusters all over the country to investigate claims. When a Texas insurance company must pay a claim for an accident in Illinois, it will hire an adjuster from the nearest independent adjustment bureau to complete the investigation. While independent adjusters are not employees of the insurance company, they are acting in the capacity of an agent for these insurers. In addition to handling claims for insurance companies, the independent adjusters work for companies with self-insurance programs as well as with government entities. Insurance claims adjusters generally meet the duties requirements for classification as administrative or professional-level employees, whether they work for an insurance company or other type of company, if their duties include activities such as interviewing insureds, witnesses, and physicians; inspecting property damage; reviewing factual information to prepare damage estimates; evaluating and making recommendations regarding coverage of claims; determining liability and total value of a claim; negotiating settlements; and making recommendations regarding litigation.

Legal Issues Facing Adjusters

Even with the case of a loss adjuster is employed directly by an adjustment bureau, when adjusting a loss for a particular insurance company, it is important to note that the adjuster is an agent of the insurer. As an agent, the adjuster's acts or omissions may result in a company's paying an unsubstantiated claim. Therefore, the competent adjuster will take every legal precaution to do only those things that promote fairness and impartiality and will carefully avoid any acts that may result in litigation for claims payment where such litigation is a result of poor adjusting.

When reviewing existing policies, an adjuster can obtain insights into the policyholder's character by reviewing the policyholder's claim information. Claim adjusters typically accumulate a significant amount of underwriting information during their investigations. For example, an adjuster investigating a small fire loss at a machine shop might uncover evidence of poor housekeeping and the policyholder's disregard for loss control. Some insurers have a formal system for claim adjusters to notify underwriters about pertinent information on hazards.

For personal insurance policies, a claim file review can identify insureds that are making many small claims that most people attribute to normal wear and tear. With a workers' compensation policy for example, a claim file review might help the underwriter identify dangerous conditions requiring loss control attention. The claim adjuster is one of the few insurer employees who get a firsthand view of the insured locations. The adjuster's observations are valuable, and every effort should be made to gain them.

When a loss is reported, a file on the claim is set up in the insurer's data base. This serves as an active repository until reimbursement, at which time all information is archived. The agent is normally the recipient of tidings concerning loss. The agent notifies claims personnel and an adjuster is sent to investigate or 'adjust' the claim. For the adjuster to operate efficiently and fairly, information concerning the insurance contract (policy limits, coverages, deductibles) must be readily available. Other facts needed to insure rapid claim turnaround include time, date, and location of loss, amount of damage, and other parties involved.

Adjuster Training and Claims

Determining the cause and extent of damages is primarily the job of insurance adjusters, who are either employed or contracted by insurance companies and generally licensed by the states. Adjusters assess damage; estimate losses; and submit required reports, work sheets, and photographs to the insurance company, which reviews the claims and approves them for payment. In general, insurance adjusters are paid on a percentage basis or fee schedule tied to the amount of damages. These adjusters can fall into several categories:

- Staff (or company) adjusters are employees of insurance companies who determine the amount of damages payable on claims under a contract of insurance.
- Independent adjusters and adjuster firms are contractors that insurance companies hire to assess damages and determine claims losses.
- Emergency adjusters are sometimes allowed by states to operate on a temporary basis to further augment the force of adjusters following a catastrophe.
- Public adjusters are hired by and work on behalf of property owners to assess damages and help prepare claims.

Storm Adjusting

Insurance adjusters are regulated by the states, which have been granted authority by Congress to oversee insurance activities. The federal government retains the authority to regulate insurance, giving primary responsibility for insurance regulation to the states in accordance with the McCarran-Ferguson Act of 1945. State insurance regulators' oversight includes requirements pertaining to the licensing and training of insurance adjusters. In addition, adjusters that have been licensed or allowed to operate by a state can also be certified as flood adjusters by NFIP to assess flood damages on properties. A property owner who has experienced hurricane damages can initiate a flood insurance claim by contacting the insurance agent of the WYO insurer that sold the NFIP flood policy. The agent relays the claim information to the WYO insurer, which assigns a flood claims adjuster to the case. The adjuster will then inspect the property to determine the damage caused by flooding and the extent to which that damage is covered under the flood policy. To help carry out this work, insurance adjusters commonly use software that organizes the damage information and estimates the repair or replacement costs for such damages. Factors utilized in determining loss estimates include the square footage of the building; the type of building materials; and the cost of materials and repairs at the market rate, which is subject to change. Once the assessment of a damaged property is complete, the adjuster files a report with the WYO insurance company, which reviews the claim and approves or denies it for payment to the policyholder.

Property owners do not know in advance whether their insurance policies will cover all damages from a hurricane, because the payments ultimately will depend on the extent to which each policy will cover the damages—that is, whether the damages are determined to be the result of hurricane winds, flooding, or some combination of both. Even property owners that purchase the maximum amount of flood insurance available through NFIP, along with other private insurance for wind-related risks, do not know whether they are completely covered until the insurers' claims adjusters determine what caused the damage. Given the differences between the coverage offered under flood insurance and the coverage offered by private property-casualty

insurance, the damage determinations can be crucial. For example, a homeowner whose house is worth \$450,000 may have both a flood insurance policy and wind coverage, but flood insurance covers only up to \$250,000 in damages. If damages to the policyholder's house are severe, and all of it is determined to be from flooding, the property owner may not receive enough compensation to fully rebuild and pay for temporary housing under the terms of the NFIP flood policy. But if all of the damages are determined to have been caused by wind, the homeowner may be able to fully recoup their losses and additional living expenses. Hence, insurance coverage uncertainties can arise when hurricane damages occur.

Adjustment Uncertainties

Claims adjustment uncertainties include challenges that can arise in assessing and adjusting damages due to wind and flooding when the evidence of damage at the damage scene is limited or compromised. As a result of the magnitude and severity of damage from Hurricanes Katrina and Rita, evidence of the damaged structures was often limited or compromised. In some cases, buildings were completely destroyed, leaving little except the foundations. Insurance claims adjusters and industry participants acknowledged that assessing the cause and extent of damages was more problematic when little evidence of the structure was left. Exacerbating such difficulties was the fact that adjusters commonly arrived on the damage site several weeks after Hurricane Katrina occurred, given the scope of damage. During the time between Hurricane Katrina and the arrival of the adjusters, the remaining evidence at damage scenes may have been further compromised by subsequent natural and man-made events (such as the clearing of debris from streets and roadways).

Finally, there is an inherent conflict of interest when the same insurer is responsible for assessing damages for its own property-casualty policy, as well as for the NFIP policy, each covering different perils on the same property. As part of the WYO arrangement, private property-casualty insurers are responsible for selling and servicing NFIP policies, including performing the claims adjustment activities to assess the cause and extent of damages. When the WYO insurer writes and services its own policy, along with the NFIP policy for the same property, the insurer is responsible for determining the cause of damages and, in turn, how much of the damages it will pay for and how much NFIP will cover. In certain damage scenarios, the WYO insurer that covers a policyholder for wind losses can have a vested economic interest in the outcome of the damage determination that it performs when the property is subjected to a combination of high winds and flooding. In such cases, a conflict of interest exists with the WYO insurer as it determines which damages were caused by wind, to be paid by itself, and which damages were caused by flooding, to be paid by NFIP. Moreover, the amount WYO insurers are compensated for servicing a flood claim also increases as the amount of flood damage on a claim increases—an allowance of 3.3 percent of each claim settlement amount.

Legal Disputes Involving Coverage Arise

In the aftermath of every hurricane season that produces significant damage, legal disputes emerge between policyholders and insurers that center largely on the extent to which damages would be covered under a homeowner's policy, as distinct from an NFIP policy, when both high winds and flooding occurred. Such disputes have been

and continue to be argued and resolved through state and federal courts, as well as through mediation programs.

Many of these cases centered on the interpretation and/or enforceability of certain property-casualty policy language in the context of challenging which factors were the cause of the damages or losses. For example, some disputes raised the question of whether a policy's flood exclusion language clearly excluded the water-related event, such as storm surge, that caused the damages at issue. Other cases challenged the enforceability of a property-casualty policy's anti-concurrent causation clause. Such a clause generally provides that coverage is precluded for damage caused directly or indirectly by an excluded cause of loss (for example, flood), regardless of any other cause (for example, wind) that contributes concurrently to or in any sequence with the loss. These cases were very slow in working their way through the judicial trial and appeals processes and will eventually be resolved based on the particular language of the policy, the evidence presented by both the policyholders and the insurers, and the governing state law.

State mediation efforts helped address the backlog of unresolved claims between policyholders and insurance companies on private homeowners policies. These programs, particularly in Louisiana and Mississippi, played a major role in facilitating many settlements of residential property insurance claims arising out of Hurricanes Katrina and Rita. Established after the 2005 hurricane season, these programs offer policyholders and insurers a nonbinding, alternative dispute resolution procedure to resolve claims and avoid the delays, expenses, and uncertainties of resolving the disputes through the courts. On the whole, state insurance regulators in Mississippi and Louisiana report that the majority of cases brought to mediation were resolved.

Licensing and Training

In spite of the importance of the insurance claims adjuster to policyholders after a national catastrophe, licensing and training requirements for adjusters vary considerably by state. Some states have no requirements for insurance claims adjusters, others have them for most types of adjusters, and many states have them for some types of adjusters but not for others. This lack of uniformity results in uncertainties over the qualifications and training of claims adjusters. Further, states may temporarily relax these requirements after a catastrophe. Claims adjusters who adjust flood insurance claims, however, must be trained and certified by NFIP. Following Hurricane Katrina, some states that lacked licensing requirements for adjusters passed laws to raise the level of oversight for adjusters.

Adjuster licensing and training requirements vary considerably among states, including those along the Gulf Coast. Of the eight coastal-region states, most had varying degrees of licensing and training requirements for different types of adjusters. Some of the coastal states had also instituted some common licensing requirements for staff adjusters, independent adjusters, and public adjusters, while others had varying requirements for different types of adjusters. Similarly, information gathered from industry representatives showed that licensing and training requirements varied substantially among the states nationwide. Figure 2 summarizes the varying level of requirements for claims adjusters among several coastal states, as well as recent legislation enacted in some of the coastal states impacted by Hurricane Katrina to strengthen their requirements.

Figure 2: Licensing and Training Requirements for Adjusters in Selected Coastal States as of 2017

		Adjuster			
		Staff/company	Independent	Emergency	Public
Louisiana ^a	State licensing exam	○ ^c	○ ^c		○ ^c
	Continuing education	○ ^c	○ ^c		○ ^c
	Payment scheme	Flat fee	Flat fee	Undefined	Flat fee
Mississippi ^b	State licensing exam		○		○
	Continuing education		○		○ ^c
	Payment scheme	Salary	Undefined	Undefined	% of claim/settlement
Florida	State licensing exam	○	○		○
	Continuing education	○	○		○
	Payment scheme	Salary	Undefined	Undefined	% of claim/settlement
Texas	State licensing exam	○	○		○
	Continuing education	○	○		
	Payment scheme	Fee schedule	Fee schedule	Fee schedule	% of claim/settlement
South Carolina	State licensing exam	○	○		○
	Continuing education				
	Payment scheme	Salary	Undefined	Undefined	Undefined
North Carolina	State licensing exam	○	○		○
	Continuing education				
	Payment scheme	Salary	Salary	Undefined	% of claim/settlement
Georgia	State licensing exam		○		○
	Continuing education		○		○
	Payment scheme	Undefined	Undefined	Undefined	Undefined
Alabama	State licensing exam				Not allowed ^d
	Continuing education				Not allowed ^d
	Payment scheme	Salary	Hourly	Hourly	Not allowed ^d

Source: GAO summary of information from state insurance regulators and legislation enacted after Hurricane Katrina.

^a In 2006, Louisiana enacted both The Louisiana Claims Adjuster Act (Acts 2006, No. 783) and The Louisiana Public Adjuster Act (Acts 2006, No. 806). Beginning June 30, 2007, these Acts generally require licensure, along with a licensing examination, for staff/company adjusters, independent adjusters, and public adjusters, respectively. The latter Act prohibits public adjusters from being paid a fee contingent on or a percentage of a claim amount.

^b In 2007, Mississippi enacted House Bill No. 1524, which provided, among other things, for the licensure and regulation of public adjusters.

^c Requirements were established after the 2005 hurricane season.

^d Alabama law prohibits public adjusters from operating independently and considers such activities as the unauthorized practice of law.

For coastal states with licensing and training requirements for claims adjusters, a state licensing examination has been the principal oversight tool used to regulate the entry of adjusters into the marketplace.

Coming to an Agreement

If a policyholder and adjuster cannot on a settlement amount, the insured should contact his or her agent or insurance company’s claim department manager. Policyholders should make sure to have figures to back up the claim for more money.

If the insured and insurer still disagree, the insurance policy provides a roadmap for an independent appraisal of the loss. The insured can hire an independent appraiser and the insurance company also hires an independent appraiser. Together the appraisers choose a mediator. The decision of any two of these people is binding. The parties in disagreement each pay for their own appraiser and share the other costs. Hopefully, disputes rarely get to this stage. Some insurance companies may offer a slightly different way of settling a dispute. After the claim has been settled and the repair work is underway is a good time for homeowners to evaluate their insurance coverage. Coverage evaluation should also be reviewed by homeowners each year when the policy is renewed. Making sure the home is adequately insured with sufficient replacement cost coverage for personal property; this is an important job for the insurance professional to ensure that the policyholder does not come up short in coverage when time comes to use it.

III. Agent Action or Inaction

The actions (or failure to act) of an agent or adjuster can have undesirable consequences for the insurer. To understand the adjuster's problems in this area, the legal doctrines of waiver and estoppel must be outlined.

Waiver and Estoppel

As a means of counterbalancing the excessive advantages believed by many courts to have been taken by insurance companies through their control over the drafting of complex policy language and their severe use of the device of warranties, courts have employed two powerful counter-defense mechanisms for the benefit of the insured. They are waiver and estoppel.

Waiver- The doctrine of waiver applies to those situations in which the insurer is aware that it has valid grounds for rescission of the policy or defense to any claim on the policy, and through the acts of its agents, conveys to the insured its intentional and voluntary surrender of a known right. The doctrine will apply only in cases in which the insurer is considered to have actual knowledge of the grounds for rescission or defense, or in which the insurer has knowledge of facts that would put a reasonable person on inquiry and a reasonable inquiry would disclose the pertinent grounds for rescission or defense. There are two manners in which waiver can be made known;

- a.) Express Waiver- The express statement of an agent of the insurer that a particular circumstance contrary to the terms of the policy (like mortgaging the property or leaving the property vacant for an extended period of time) will not be relied upon by the insurer to avoid its obligations under the policy. It can also be expressed in the policy itself, such as with an incontestably clause, or a written endorsement added to the policy varying the terms or conditions of the policy.
- b.) Implied Waiver- The courts have found that the voluntary surrender of a known right can be implied in any of the following circumstances;
 - i. Acceptance of a premium for future coverage with knowledge of an existing breach of condition or warranty.
 - ii. Exercise of a right under the policy, such as to demand an appraiser or arbitrator or to take possession of the damaged property.

- iii. Demand for proof of loss from the insured without a prior non-waiver agreement with the insured.
- iv. Acceptance and retention of proof of loss without objection.
- v. Exercise of any right or making of any demand under the policy which would be inconsistent with intent to rescind the policy or deny liability under it.
- vi. Failure to specifically plead a defense in an action on the policy by the insured.

Estoppel- This is generally held to apply to an insurance policy in the circumstance in which an insurer is, or ought to be, aware of its right to defend or rescind on the basis of a misrepresentation or breach of warranty or condition, and expressly or impliedly represents to the insured, who is unaware of the grounds for defense or rescission, that the policy is enforceable, and the insured relies upon the representation of the insurer to his detriment. Courts differ on the question of whether or not an insured is permitted to claim an innocent lack of knowledge of the grounds for rescission of defense if it is a result of his failure to read the policy. Many courts accept the reality that insureds are generally disinclined and frequently incapable of reading and understanding the complex policy language, and therefore impose no such obligation on the insured. As in the case of waiver, the courts are in agreement that while the doctrine of estoppel may be used to render a defense based on misrepresentation or breach of condition or warranty ineffective, it will not be used to extend coverage to losses not included or expressly excluded from coverage under the policy.

Estoppel generally applies to an insurance contract when an insurer is or should be aware of its right to rescission on the basis of a misrepresentation by the insured. With this condition extant, the insurer expressly or impliedly represents to the insured that the policy is enforceable. The insured is thus unaware of the grounds for policy rescission and relies on the representation of the insurer to his or her detriment. It is a restraint or a bar which arises where a person has done some act that the policy of the law will not permit him or her to deny. Under the doctrine of equitable estoppel, A makes a representation to B. This person B, having a right to do so, relies on the representation to their detriment. A is now estopped from denying the truth of the representation, or from taking a position inconsistent with the representation.

Thus a waiver is the intentional abandonment of a known right while estoppel is the result of conduct that is inconsistent with asserting a known right. When either of these doctrines is asserted in a particular case, an insurer may find that it must pay claims it otherwise might not have to pay. For example, an insurance policy might contain a right for the insurer to receive a full and complete inventory from the insured claimant within 60 days after a loss. Such a right could be waived by an insurer. If such a right is waived, the insurer can no longer deny the claim because of a failure by the insured to deliver the inventory when specified in the contract. In another scenario, an adjuster could have knowledge that an insured's acts before the loss resulted in a breach of the contract. Assume that, in spite of this knowledge, the adjuster continues with the investigation and claims adjustment. Then, at some time after the adjustment has been agreed to, the insurer denies the claim. It is possible in such a situation that a court would estop the insurer from denying payment. Since it knew of the breach of contract before agreeing to the adjustment and went ahead with the adjustment anyway, it would not be fair for the insurer at a later date to deny the claim because of the insured's known breach of contract

When an Insurance Company Breaches Its Contract

Insurance contracts are written by experienced attorneys who carefully reword the agreements as appellate courts hand down new decisions. Coverage attorneys incorporate new case law into policies and regularly re-write their contracts. Terms that may appear to a consumer to be simple English may have their origin in a legal opinion and may have been given a special interpretation. Companies make it their business to know the standard terms judges have defined. Insurance companies have years of legal experience litigating the terms of their contracts. As a result, carriers have the upper hand in drafting policies and selecting the language they find most advantageous for making a profit.

Provisions of Insurance Law

Insurance law routinely provides that should there be an ambiguity or uncertainty in a policy, any uncertainty in choice of wording or ambiguity in meaning would be resolved in favor of the policyholder and against the insurer. In the absence of a misrepresentation regarding coverage or exclusions, if the language of the policy is clear and explicit, the clear meaning will be enforced.

Insurance contracts are interpreted by judges and courts to effectuate only the objectively reasonable expectations of the insured. Any personal, or subjective, expectation of a policyholder that cannot be reasonably supported by the language of the contract is unenforceable. It does not matter what the insured truly and honestly believes in his or her own mind. That subjective opinion is never in issue in a court of law. The real contest is to decide what the words of the policy mean to an objective person or a disinterested, common reader.

The guiding public policy routinely followed by courts is that judges will seek to find and enforce coverage in case of a loss rather than defeat coverage. In other words, if there is a fair and honest interpretation that will result in the policyholder enjoying the benefit of the bargain, then so be it. Courts do not lean over backwards to interpret a contract to create losses for policyholders. So, when reading an insurance policy, the words selected by the insurance company are to be interpreted by judges according to their plain meaning. A plain meaning is one that an ordinary person would attach to such words, not the meaning that might be utilized by an insurance company executive or an attorney.

Exclusions and limitations in a policy, because they often result in denying coverage when there is a loss, must be in clear and unmistakable language. It is for this reason that exclusions and limitations are always narrowly, or strictly, construed. If there is more than one meaning to be given to an exclusion or a limitation, the narrowest interpretation will be adopted by the court. Any exclusionary clause that is not clear and conspicuous will be interpreted in the interests of the insured. In cases where a policyholder's lack of knowledge could result in the loss of benefits or the forfeiture of rights under a policy, an insurer is required to bring such fact to the insured's attention and to provide relevant information to enable the insured to take action to secure rights provided by the policy. Unfortunately, an insurance agent is not obligated to advise a policyholder on the adequacy of the limits of coverage

selected by the policyholder. The term "limits" refers to the amount of insurance coverage.

Refusal to Enforce-When an insurance policy contains provisions that are stacked in favor of the company, courts will find that the contract, or any portion of the agreement, was unconscionable at the time it was made and the court may refuse to enforce that provision. The basic test followed in most states is to ask, in light of the general background and the needs of the particular case, whether the causes involved are so one-sided as to be unconscionable under the circumstances existing at the time the contract was made.

Unfair/Deceptive Advertising-When an insurance company has used advertising and solicitation materials that are unfair or deceptive, some states provide legal protection to the policyholders and others do not. A policyholder may only have a cause of action for negligent or intentional misrepresentation against the agent selling such a policy as opposed to a cause of action against the carrier who often times is more likely to be able to pay a judgment rendered by a court in favor of the policyholder. Only the words in the actual policy are actionable and falsely written advertisements do not give rise to a cause of action against the carrier. Policyholders must realize that they are buying the contract, not the advertising.

Agent Responsibility

What an agent says in terms of "puffing" or exclaiming the virtue of a policy is often not actionable, except in certain circumstances. If an agent assumes additional duties, has a special relationship of trust with the buyer, or holds himself/herself out as having special expertise, then a special duty arises. But when an insurance agent gives assurance of proper coverage and it turns out to be false, that agent will be held liable for negligent misrepresentation. That is not to say that an insured can remain intentionally ignorant of the terms of a policy. An insured is not required to independently verify the accuracy of representations made by the agent regarding the policy and an agent can be held liable for intentional or negligent misrepresentation.

Contract Covenants

A covenant is a formal agreement to do or not to do a particular thing. Every insurance contract contains an unwritten, invisible, or implied term referred to as the covenant or promise of good faith and fair dealing. This is a promise imposed by law upon an insurance company to always act fairly towards its insureds in handling their claims. Whether or not such a clause is included in the policy, judges will read the policy as if it were there. Carriers must meet the reasonable expectations of the policyholder and an insurer must always give as much consideration to the financial interests of its insureds as it does to its own financial interests.

In bad faith cases a jury is always asked whether under the facts the carrier acted reasonably. Denying benefits, delaying payments and paying less than that which is owed are examples of bad faith. An insurance company is obligated to thoroughly and promptly investigate all claims and must inquire into all the possible issues that might support an insured's claim. This obligation is not terminated simply because

the insured files a lawsuit against the company. Where an insurer makes a belated offer of settlement, a cause of action for bad faith does not correct or set aside the previous wrongful conduct. Any payments to the insured only reduce the amount of the insurance company's final liability as it may be determined by a jury.

In a bad faith action an insurance company's business practices or common course of conduct is routinely admissible to show motive, knowledge or the absence of a mistake or an accident in the manner in which it dealt with its insured. It is not necessary to show that the insurer intended to cause harm in a breach of the covenant of good faith and fair dealing. The policyholder need only show that the insurer failed to honor the agreement and had no cause not to pay what was due under the contract. When a person buys an insurance policy, the very risks that are insured against make it clear that if a claim is not satisfied the policyholder will suffer financial pressure and emotional distress. Policyholders obviously will be vulnerable to oppressive tactics by a carrier and insurance companies are presumed to know that a denial of benefits will very well result in emotional distress to their insureds.

Available Recoveries- Where a policyholder successfully shows that an insurer breached the covenant of good faith and fair dealing, the insured can recover all damages caused by the breach. This includes all consequential losses, loss of use of the insurance proceeds, general damages, attorneys' fees and in cases of egregious and outrageous misconduct, punitive damages. To recover for emotional distress it must be shown to have been caused directly as a result of the insurer's conduct. Normally, once actual economic loss is established, the policyholder is entitled to recover damages for emotional distress as well, as long as that injury was caused by the insurer's breach of the covenant of good faith and fair dealing. The statute of limitations in a bad faith case varies from state to state. A statute of limitations is the legal deadline after which a lawsuit cannot be filed. In most states, the two-year statute for personal injuries and emotional distress governs a lawsuit for bad faith. California, on the other hand, has a one-year statute. Many insurance policies impose a contractual obligation on the insured to bring any lawsuit within one year after breach of the contract, no matter what the rule is under state law concerning when a lawsuit can be lawfully filed. Calculating this statutory period, though, is not simple. Most states hold the time limit in the contract is enforceable but suspend the running of the statute between the period of time the policyholder gives notice of the loss and the date on which the claim is denied.

Licensing and Consumer Protection

All states require agents and brokers to be licensed. In most states, the applicant must pass a written examination or complete a specific course of study. The examinations are usually given under the direction of the state insurance department. The purpose of the examination is to ensure that the applicant possesses some knowledge of insurance law and of the contracts that he or she intends to sell. If the agent is incompetent or dishonest, the state insurance commissioner has the authority to suspend or revoke the agent's license; this provides a powerful control over the agent's behavior. Most states have legislation requiring the continuing education of agents. The continuing education requirements are designed to upgrade an agent's knowledge and skills. Other prohibitions or features designed to protect consumers include:

Twisting- All states forbid twisting. Twisting is the inducement of a policyholder to drop an existing policy in another company due to misrepresentation or incomplete information. Twisting laws apply largely to life insurance policies; the objective here is to prevent policyowners from being financially harmed by replacing one life insurance policy with another. Most states have replacement regulations that are designed to provide policyowners with enough information to make an informed decision concerning the replacement of an existing policy. These laws are based on the premise that replacement of an existing life insurance policy generally is not in the insured's best interest. For example, a new front-end load for commissions and expenses must be paid; a new incontestable clause and suicide clause must be satisfied; and higher premiums based on the policyholder's higher attained age may have to be paid. Some researchers are challenging the basic premise that replacement of an existing life insurance policy is undesirable. In some cases, researchers maintain that switching policies can be financially justified.

Rebating- Most state insurance codes also forbid rebating. Rebating is giving to an individual a premium reduction or some other financial advantage not stated in the policy as an inducement to purchase the policy. One obvious example is a partial refund of the agent's commission to the insured. The basic purpose of anti-rebate laws is to ensure fair and equitable treatment of all policyowners by preventing one insured from obtaining an unfair price advantage over another.

Unfair Trade Practices- Insurance laws prohibit a wide variety of unfair trade practices, including misrepresentation, twisting, rebating, deceptive or false advertising, inequitable claim settlement, and unfair discrimination. The state insurance commissioner has the legal authority to stop insurers from engaging in unfair trade practices and deceptive advertising. Insurers can be fined, an injunction can be obtained, or, in serious cases, the insurer's license can be suspended or revoked.

Complaint Division- State insurance departments typically have a department for handling consumer complaints. The department or individual will investigate the complaint and try to obtain a response from the offending insurer or agency. Most consumer complaints involve claims. An insurer may refuse to pay a claim, or may dispute the amount payable. Although state insurance departments are highly responsive to individual complaints, they generally lack direct authority to order insurers to pay disputed claims where factual questions are an issue. In a study of complaint handling, the General Accounting Office found that most consumer complaints are viewed as valid, and that the majority of them are resolved in favor of consumers.

Readable Policies- Greater protection of the consumer is also evidenced by the trend toward more readable policies. In order to make insurance contracts more understandable, the states have approved policies in which the language is less technical and is therefore simpler and easier to understand. The development of more readable policies will undoubtedly benefit most consumers.

Shopper's Guides- Several states publish shoppers' guides for insurance consumers. These guides provide useful information about the types of insurance contracts to buy, saving money on insurance, selecting an insurer and agent, filing a claim, resolving disputes, and other practical tips. The guides often furnish valuable

information concerning premiums charged by different insurers for similar policies, so that consumers can make meaningful cost comparisons among insurers. Cost information on automobile insurance, homeowners insurance, and life insurance can help consumers purchase policies from low-cost insurers.

Claim Settlement

Every insurance company has a claims division or department for settling claims.

There are three basic objectives in settling claims:

- 1.) Verification of a covered loss
- 2.) Fair and prompt payment of claims
- 3.) Personal assistance to the insured

The first objective in settling claims is to verify that a covered loss has occurred. This involves determining whether a specific person or property is covered under the policy, and the extent of this coverage.

The second objective is the fair and prompt payment of claims. If a valid claim is denied, the fundamental social and contractual purpose of protecting the insured is defeated. Also, the insurer's reputation may be harmed, and the sales of new policies may be adversely affected. Fair payment means that the insurer should avoid excessive claim settlements and should also resist the payment of fraudulent claims since they will ultimately result in higher premiums. If the insurer follows a liberal claims policy, all policyowners will suffer because a rate increase will become necessary.

A third objective is to provide personal assistance to the insured after a covered loss occurs. Aside from any contractual obligations, the insurer should also provide personal assistance after a loss occurs. For example, the claims adjuster could assist the agent in helping a family find temporary housing after a fire occurs.

Most states have passed laws that prohibit unfair claim practices. These laws are patterned after the National Association of Insurance Commissioners' Model act.

Some unfair claim practices prohibited by these laws include the following:

- Refusing to pay claims without conducting a reasonable investigation based on all available information
- Not attempting in good faith to effect prompt, fair, and equitable settlements of claims in which liability has become reasonably clear
- Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds.

IV. The Role of Advertising in Insurance

Attention is now given to the role of advertising and its effects on consumers and the industry. The free enterprise system that exists in most western democracies is one in which individuals own the means of production and market decisions are made largely by individual businesses and consumers, all acting in their own self interest. This free market form of economic organization has convincingly demonstrated its

superiority in satisfying consumer needs over alternative forms of economic organization. The most important of the competing systems is socialism, under which the government both owns the means of production and makes all definitive resource allocation decisions. A key element in the relative success of the free market system is its superior ability to generate and process the immense quantities of information that characterize the modern economy. Without central intelligence or computation, the market solves a problem that the largest supercomputer could not solve today, involving millions of unknown variables and relations. Nobody designed the market; yet it functions remarkably well.

The ability of a market economy to make use of information results from decentralized decision making and from incentives stemming from private property rights. In contrast, so-called "command" or "managed" economies have proved far less capable of handling the huge information demands of a modern economic system. It is especially difficult for economies based on centralized decision making to alter course in response to changing conditions of demand and supply. In particular, after the government in a command system has developed a plan to manage the economy based on certain assumptions about current market conditions, it often finds it difficult to respond to changed conditions that may arise from shifts in consumer preferences, or from improved production technologies, that may invalidate its initial assumptions. The result is a degree of rigidity in the planning process in which the constant and inevitable flow of new information is either ignored or processed incorrectly. As Janos Kornai has written: "Assembly and processing of that huge mass of information, and coordination based on this information, is too enormous and difficult a task to be undertaken efficiently through centralized planning and management." (*The Socialist System*, 1992)

Regulation of Information Flow

Advertising is a great way to reach any market. However, advertising that distorts the market by disseminating false or deceptive claims is problem advertising. These claims may induce consumers to purchase goods or services that, had the consumers not been misled by the deceptive advertising, they would not have chosen to buy. When this happens, the government may need to step in to restore the integrity of the market. It may take various steps, including case-by-case law enforcement to prevent false and deceptive advertising and issuance of regulations to address particular practices that mislead consumers about material attributes of goods and services in the market.

The Insurance Department has responsibility (along with the Attorney General's Office) for enforcing the state's laws concerning fair trade as it relates to the insurance profession. On the national level, the Federal Trade Commission, or FTC, is the primary federal consumer protection agency. It administers the nation's most comprehensive federal statute designed to protect consumers from unfair or deceptive practices, the Federal Trade Commission Act. At both state and national levels the agencies work to ensure that advertisers do not disseminate false, unsubstantiated or otherwise deceptive advertising claims. When such unlawful claims are identified, the agencies, after a formal proceeding, may impose orders, enforceable through the courts, requiring the advertisers to halt their false or deceptive advertising. In some instances, the cease and desist orders also may require the respondents to make affirmative disclosures in future advertisements to

prevent further harm to consumers, or to make corrective statements about their earlier claims to eliminate lingering false impressions they may have caused. An advertiser who violates such an order may be required to pay monetary civil penalties, which can be substantial.

Regulations Requiring Disclosure of Information

As a practical matter, markets may not always produce the optimal amount of consumer information to ensure that consumers will be fully informed before making their purchasing choices. For the most part, however, the Insurance Departments try to ensure that information provided by sellers to consumers is accurate, not that it is complete. As a general rule, regulators do not require that sellers provide particular information, or that information be provided in a particular way. Nevertheless, with respect to the insurance industry, it has been concluded that because of a lack of accessible information, or an inability on the part of consumers to evaluate information that is available, it is appropriate to issue rules that require insurers to provide particular information in particular ways. From life insurance premiums schedules to homeowner's insurance, insurers are required to disclose fully the terms of contracts offered for this purpose to ensure that the consumer knows precisely what obligations he or she is incurring by purchasing the insurance contract.

In the same vein, the FTC also has used its rulemaking authority to require disclosures of information in other markets in which consumers traditionally received relatively little information, and where the cost of providing the additional information is thought to be offset by the additional benefits flowing from the increased information. These markets include, for example, those for funeral goods and services and for used cars. At times, private markets may not provide enough useful information on product performance. Consumers may need some common standard or benchmark for comparing the claims of insurers, particularly if the claims involve technical or highly complex subjects or products and if those products tend to be costly.

Market Failure and Advertising Regulation

There are three ways in which market forces can fail with regards to advertising. The market, in fact, has no mechanisms for dealing with these deviations from the norm. So the regulators enter the picture. The three forms of market failure that require advertising regulation are deception, unfairness, and fraud.

Deception

Advertising claims offer to provide to the consumer a product that will perform as advertised. The FTC Act requires not only that advertising claims be truthful, but also, that they not mislead reasonable consumers about material and objective aspects of the product or service to which they relate. Although, in principle, the FTC may challenge any deceptive advertising claim, it is the Commission's long established practice not to challenge claims that are purely subjective ("best", "brightest", "great taste", "feels and looks great"). This type of claim generally is considered "puffery." Instead, the FTC concentrates on challenging false or misleading claims about objective facts (e.g., "fat-free," "proven effective by scientific tests"), especially if in

particular instances, those claims are expensive for consumers to verify, or are beyond the competence or expertise of ordinary consumers to verify. For most inexpensive products that consumers can evaluate themselves without unusual expertise, market forces will correct for consumer dissatisfaction. Once dissatisfied with an inexpensive product, the consumer need only choose not to buy it again and will suffer only the relatively insignificant cost of a single purchase. Because sellers of such products usually depend heavily on repeat purchase of their goods, serious misrepresentations about the attributes of those goods are unlikely to occur, and if they do occur, they likely will be short lived.

Other goods and services may be more difficult for consumers to evaluate. These are known as "credence" goods and services. Insurance certainly fits into this category. Because of their lack of susceptibility to consumer assessment, they are subject to more intense scrutiny by the FTC, state attorneys general, and insurance departments. Examples of such products include such varied goods as fire safety warning systems and over-the-counter (nonprescription) drugs and medical devices. Ordinary consumers are unable to evaluate efficacy claims for such products, and nationwide, agencies have adopted a policy that efficacy claims must be supported by what is termed a "reasonable basis."

Briefly, if a seller claims that 50% of doctors surveyed agree that a particular drug product will eliminate the pain of arthritis for 12 hours, or that in 90% of all household fires, a particular fire-detection and warning system will sound early enough to provide at least 15 minutes for occupants of a building to escape safely, the seller must be able to produce survey or test data showing that those specific claims are true. If, on the other hand, an advertisement specifies no precise level of substantiation, for example, "Fat Master -- Eliminates unsightly fat from the body without exercise or starvation diets," the FTC will assume that the claim promises what experts in the particular field would consider appropriate. In such an instance, therefore, the seller must produce medical or scientific research of a caliber recognized as authoritative by the relevant scientific or medical community demonstrating that the product works as promised.

A standard has been developed for identifying deception that relies on the perceptions of reasonable consumers "in the [relevant] circumstances." In cases where advertising is targeted to specific groups (such as insurance), the regulating authority will consider characteristics of the target audience that make that audience more or less likely to be deceived by advertisements. On the one hand, for example, the FTC is likely to examine with special care advertising that appears to have particular appeal to children because children might be more susceptible than adults to being deceived by certain kinds of claims. Conversely, the FTC would be less likely to scrutinize nonprescription drug advertising aimed at doctors and published in medical journals, than advertising aimed at children or sick or elderly individuals, because the physicians are presumed to have the knowledge and ability necessary to evaluate such claims.

Unfairness

Unfair competition is defined as unfair, untrue or misleading advertising that it is likely to cause the public to be misled about particular goods or services. The concept of unfairness potentially is so expansive that it could include virtually any practice that

the regulatory authority does not like for one reason or another. The FTC has come to realize that, because of the potential breadth of unfairness, it is important that the Commission have a well-articulated standard for delineating this authority. Otherwise, the law could result in having the government make choices it thinks are good for consumers, instead of allowing consumers to make decisions for themselves.

The FTC's definition of unfairness has evolved over its history. Since its early days, the United States Supreme Court has upheld the authority of the FTC to challenge conduct that was not specifically deceptive or violative of the antitrust laws (FTC v. Keppel Bros. Inc., 1924). The Commission's first formal articulation of its unfairness standard was set forth in 1964 as one of the justifications for a rule that would have required cigarette manufacturers to include a warning of health risks in all cigarette advertising and on each cigarette pack. Congress subsequently preempted the Cigarette Rule by enacting its own cigarette warning scheme.

By 1972, the FTC had identified three elements of unfairness:

- 1.) Whether the practice offends public policy;
- 2.) Whether it is immoral, unethical, oppressive, or unscrupulous;
- 3.) Whether it causes substantial injury to consumers (or competitors or other businesses).

The first step of an unfairness analysis is to determine whether an apparently unfair practice causes substantial consumer injury: that is, causes distortion of consumer choice. Most often the FTC finds substantial injury in the form of monetary harm. Sales practices that impose health or safety risks, however, also can support a finding of unfairness. Injury may be "substantial" if the practice causes large injury to a small number of people, or a small injury to a great number of people. This does not include trivial or merely speculative harms.

The second step of unfairness analysis is to see if the practice provides benefits that offset the harm to consumers or to competition that offset the harm. It is recognized that most business practices provide a mixture of costs and benefits for consumers. In considering whether a practice causes net injury, the FTC considers not only costs to the parties directly before the agency, but also the procompetitive aspects of a particular practice, which is a benefit that would be lost if the government takes regulatory action.

The third step in the unfairness analysis is to consider whether consumers reasonably could avoid the injury. This step acts as a check on regulatory action. For example, if a consumer is able to switch to another product without incurring substantial cost, there might be no need for government intervention.

In another sense, this third step recognizes that ensuring informed consumer choice is a primary goal of regulation. One can look at whether a challenged practice unreasonably inhibits consumers from making independent and informed purchasing decisions, regardless of whether someone else might think that a so-called "better" choice might be available. In a very real sense, the best choice for a consumer is that consumer's informed and independent choice. The term "better" choice, in this sense, simply refers to the choice that someone else would make.

Fraud

The ultimate in market failure attributable to imperfect information flow is that resulting from fraud. Fraud by the producer or seller violates an implicit or explicit offer to provide for a price, goods or services with particular attributes that have been advertised to attract consumer interest. When a seller induces the purchase of products or services that, notwithstanding his or her claims to the contrary, he or she knows, or should know, are unlikely to perform as claimed or to meet the consumer's needs as promised, the seller perverts the system and causes consumer injury.

Regulators try to rectify fraud by moving quickly to seek court injunctions against the fraudulent operator and by seeking to recover the seller's ill gotten gains for return to consumers. Firms that have little or no reputation to protect and few fixed assets that are at risk should they be caught conduct most frauds. Returning to the theme of the usefulness of information, one effective way to combat fraud is to inform consumers about the ways in which fraud can be practiced and about particular fraudulent schemes that have been identified. Armed with this information, consumers can protect themselves. To this end, the insurance department has a consumer and business education office that produces publications designed to provide information in an easily understandable format.

V. Trade Practices and Insurance

Unfair trade practice acts applying to insurance have been implemented by the states. There are laws prohibiting certain unfair trade practices in the businesses of insurance, such as false advertising or discrimination, and all states had laws prohibiting rebating of part of the insurance premium. A study of these laws by an NAIC committee raised serious doubt whether any or all of them were adequate to make the FTC Act inapplicable under the provisions of the McCarren-Ferguson Act.

The drafters of the Insurance Fair Trade Practice Act were aware of the FTC Act and that what constituted an unfair trade practice was evolving on a case-by-case basis. The prospect of the same process in each of fifty states, with the distinct possibility of conflict between the states on whether a given action was unfair, and the consequent impact on a multi-state company, was enough to convince the drafters to try another approach, a so-called definitive form of unfair trade practice act. The act prohibits anyone engaged in the business of insurance, including agents, brokers, and adjusters, from engaging in any unfair methods of competition or unfair and deceptive acts or practices which are defined as:

- False information and advertising generally,
- Misrepresentation and false advertising of policy contracts,
- Boycott, coercion, and intimidation,
- False financial statements,
- Defamation of competitors,
- Stock operations and advisory board contracts,
- Unfair discrimination (usually applicable only to life, and accident and health insurance), and
- Rebates.

Although the drafters specified certain acts as unfair, they recognized that these forbidden acts might not be coextensive with the prohibitions of the FTC Act, and

therefore the FTC might not completely be deprived of jurisdiction. For that reason they included a catchall provision in the Model Act whereby if the commissioner believes that a person is engaging in a method of competition or any act or practice *not defined in the act* that is unfair or deceptive, and a proceeding would be in the public interest, he or she can call a hearing. If after the hearing it is determined that it constitutes a violation of the act then the person may be ordered to cease. If the person does not voluntarily cease, the commissioner may then proceed, usually through the Attorney General, to request a restraining order from a court. If upon review the court agrees with the commissioner, the restraining order will issue. This in effect becomes an enumerated unfair act or practice.

Business Practices

There is a traditional view that parties involved in business negotiations are entitled to keep their cards close to their chest. Such a view holds that, in the absence of any fiduciary relationship or obligations of utmost good faith, parties are entitled to operate on the basis of advancing their own interests. Such asymmetries do not apply in the insurance business.

Uniform Claims Settlements Practice Act

In the past there was widespread public dissatisfaction with the way claims were being handled, particularly by certain companies. In response to this the NAIC developed a so-called Uniform Claims Settlement Practice Act, designed to become part of the Fair Trade Practice Act. The Claims Act makes certain claim practices unfair if they are done with a frequency that indicates a general course of business. The acts covered by the law are:

- ◆ making payments without stating the coverage under which the payment is made,
- ◆ failing to acknowledge and act promptly on communications with respect to a claim,
- ◆ failing to adopt reasonable standards for investigation of claims,
- ◆ failing to affirm or deny coverage within a reasonable time after proof of loss is rendered,
- ◆ failure to attempt to settle promptly and fairly where liability is reasonably clear,
- ◆ misrepresenting policy provisions relating to the coverage at issue,
- ◆ compelling insureds to litigate by offering substantially less than is ultimately recovered,
- ◆ attempting to settle for less than a reasonable person would expect from reading advertising material accompanying the application,
- ◆ refusing to pay claims without conducting a reasonable investigation,
- ◆ attempting to settle on the basis of an application that was altered without the consent of the insured,
- ◆ coercing the insured to accept less than the arbitration amount by a policy of always appealing arbitration awards,
- ◆ delaying the investigation by requiring a preliminary and also a final proof of loss,
- ◆ failing to settle under one coverage where liability is clear in order to influence settlement under another coverage, and

- ♦ failing to promptly provide a reasonable explanation of facts or policy provisions relied upon to deny liability.

This is a most comprehensive exposition of specific acts and practices that can be deemed unfair if done with some frequency. This addition to the Fair Trade Practice Act has been adopted by a large number of states.

Unfair Claim Settlement Practice Acts

In 1972, the National Association of Insurance Commissioners recommended this approach as an amendment to the Unfair Trade Practices Act. These Acts have now been adopted in a majority of states. The Act provides that certain practices "committed or performed with such frequency as to indicate a general business practice" constitute an unfair trade practice and are subject to certain penalties. There are fourteen practices set forth including misrepresentation of policy terms and failing to promptly settle claims when liability is reasonably clear. The Act requires evidence of a general business practice, but multiple violations in connection with the same claim are sufficient. Frequently an insured will attempt to show a violation of the standards of the Act as evidence of bad faith. Most courts appear to hold that it is not. The Act represents two major procedural questions. First, does it preempt and replace the common law punitive damage action? While there is no predominant trend, more than half the courts that have considered the matter hold that it does not. Next, does it create a new cause of action for the individual insured in addition to the punitive damage action? The majority holds that it does. A strong minority takes the position that it does not create an independent private cause of action but is only a regulatory tool. There is another by-product of the Act. It has been held, in a landmark case, that a third-party claimant who is seeking to avail himself of the coverage of a liability policy can bring a direct action against a liability insurer for breach of the Act. (Royal Globe Ins. Co. v. Super. Court. 592 P.2d 329 - Cal. 1979)

E Signatures

The insurance industry was among the first to recognize the potential of electronic signatures. Equipped with a hand held device or laptop computer, insurance agents in the field can now populate complex application forms and capture the customer's signature electronically, saving hours and even days over traditional paperbound processing. By digitally originating new home, life, auto, and health insurance policies, along with pension plans, e-documentation shortens the application process, greatly reduces costly clerical errors, and provides a verifiable, legally binding contract that cannot be altered, misfiled, or stolen. Policy information can be easily retrieved and amended in the field when processing insurance claims or when a customer requests additions or changes to their coverage.

Electronic signature capture is helping the insurance industry reduce its paperbound record keeping costs. Automated documentation not only greatly reduces the cost to input, store, and retrieve policy information; it also supports the high levels of security and confidentiality required under new, stiffer consumer protection laws. It has been estimated that the insurance industry saves seven-fold on every policy that originates as an electronically-signed document.

To comply with electronic commerce regulations, an e-signature must be capable of authentication. With all handwritten signatures, document analysts examine the sample and make determinations based on a number of forensic parameters. However, most electronic signature systems only offer a fax-quality signature record with no data about the signature's biometric characteristics and lack the means to authenticate their signatures.

An electronic signature, or e-signature, is any electronic means that indicates either that a person adopts the contents of an electronic message, or more broadly that the person who claims to have written a message is the one who wrote it (and that the message received is the one that was sent). By comparison, a signature is a stylized script associated with a person. In commerce and the law, a signature on a document is an indication that the person adopts the intentions recorded in the document.

Enforceability in Law

Since well before the Civil War began in 1861, Morse code was used to send messages electrically by telegraph. Some of these messages were agreements to terms that were intended as enforceable contracts. An early acceptance of the enforceability of telegraphic messages as electronic signatures came from the New Hampshire Supreme Court in 1869. In the 1980s, many transactions involved the use of fax machines for high-priority or time-sensitive delivery of documents. Although the original signature on the original document was on paper, the image of the signature and its transmission was electronic.

Courts in various jurisdictions have decided that enforceable electronic signatures can include agreements made by email, entering a personal identification number (PIN) into a bank ATM, signing a credit or debit slip with a digital pen pad device (an application of graphics tablet technology) at a point of sale, and signing electronic documents online.

The definition of what qualifies as an electronic signature is wide and is set out in the Uniform Electronic Transactions Act (UETA) released by the National Conference of Commissioners on Uniform State Laws.

Some insurance professionals hold on to the tradition of a pen on paper possibly out of fear stemming from a lack of deep case law on the issue of electronic signature. The insurance industry as a whole frequently stays rooted in archaic practices and procedures because of the comfort of case law. The notion of having to spend unknown sums of money to defend a case that has not been previously adjudicated frequently proves to be overwhelming and suppresses action.

Secure documents do not necessarily all require a signature. This point of clarification is important because carriers want the documents they distribute electronically to be secure, and many have applied software to ensure that they are. A secure document initiative has one level of complexity, and an e-signature initiative has a whole other level. Securing documents does not necessarily require all the encryption and authorization that an e-signature systems does. It can be done through access rights management. Carriers should not be dissuaded from implementing security for electronic documents simply because they are not yet ready to adopt e-signature capabilities.

There is a difference between an "electronic signature" and a "digital signature"

Legal Term: Electronic Signature

The term "electronic signature" means "an electronic sound, symbol, or process, attached to or logically associated with a contract or other record and executed or adopted by a person with the intent to sign the record." The laws across the United States recognize that an electronic signature may be made in a variety of ways, including:

- clicking "I agree";
- typing one's name into a signature block;
- selecting certain numbers on a telephone touch pad;
- proceeding through to the next page of a website;
- saying "I agree";
- using a cursor or other pointing device to manually scroll one's name on a device that captures the image (and possibly other aspects) of the image created;
- inserting a digital representation of an individual's signature, which may or may not be cryptographic, such as a digital image of the signature or a public key infrastructure generated signature

To be effective, the sound, symbol, or process must evidence the signer's intent to be bound to the particular terms and conditions associated with that action, and must be attributable to the specific person against whom those terms and conditions are intended to be enforced. It is the surrounding context that evidences the signer's intent to be so bound. For example, typically, there would be text above an "I agree" selection that clearly indicates that by selecting the "I agree" button, the person agrees to be bound to specified terms and conditions. The term "electronic signature" refers to the legally significant act of a person signing a document or record to reflect the person's intent to be bound, where the signature is created and recorded electronically, rather than in wet ink and paper. In contrast, the term "digital signature," described below, refers to a particular technology of associating an entity (who could be a person or could be a device) to a given electronic record, and the securing of that record.

Tech Term: Digital Signature

The term "digital signature" refers only to a particular type of technology or method, which may or may not result in a legally effective electronic signature. In contrast to an electronic signature, a digital signature involves an arrangement that includes:

- An entity (person or device) who has been issued a digital certificate that includes private and public "keys" (essentially long strings of unique numerical codes), that are obtained from a trusted third party called a Certificate Authority or "CA";
- Once affixed to a record, the digital signature renders that record nearly impossible to alter without detection and provides a way for the parties to verify that the document containing the digital signature remains valid after signature
- The digital signature may, if used correctly, provide a reliable method of attributing that signature to an entity agreeing to the terms and conditions expressed in the document.

Digital signatures use a technology called public-key infrastructure ("PKI"), which requires the use of two "keys," one private to the person signing in this fashion and

one public (or at least available to the counterparty to the transaction using the digital signature). The public key and the private key are mathematically related, but it is infeasible to derive or guess the private key from the public key.

Legal Support

In a March 2011 opinion, the Supreme Court of Arkansas affirmed a lower court's granting of a summary judgment in favor of Geico, upholding the applicability of the Uniform Electronic Transactions Act (UETA) to a waiver of minimum medical coverage.

In the case of *Barwick v. GEICO*, using a click-to-sign e-signature, an insurance client had waived the minimum medical coverage on her insurance plan. Later, after suffering an accident that resulted in medical expenses, the insured claimed that the electronic signature was not binding because it was not in 'writing.'

The insured's wife completed the online application for auto insurance coverage and as part of that online application waived the minimum medical coverage. After a car wreck requiring the insured to incur medical expenses, the insured claimed that the electronic signature on the online waiver of medical coverage was not binding on him because the waiver was not "in writing" as required by the Arkansas Insurance Code. The insured later sought medical benefits under the auto insurance policy. The insured claimed that pressing a computer button did not constitute a "writing" required by the Arkansas Insurance Code, which requires certain minimum benefits to be included in an auto liability insurance policy unless the insured rejects such benefits "in writing."

The insured argued that a general statute like UETA, which provides that an electronic record satisfies the requirement for a record to be in writing, does not apply when a specific statute, i.e., the insurance statute with the "in writing" requirement, governs. The Arkansas Supreme Court, siding with Geico and upholding the summary judgment of the lower court in Geico's favor, held that the electronic record memorializing an insurance applicant's rejection of coverage qualifies as a written rejection, as required by the insurance statute.

The court saw no conflict between UETA and the auto insurance statute, and noted that UETA could not be more straightforward in allowing for an electronic record to satisfy the law that requires a record to be in writing. Geico noted the irony of an insured challenging the validity of an electronic rejection of coverage while seeking the benefit of an insurance policy obtained online, but the court chose not to address that argument due to its decision to uphold the applicability of UETA in this case. That this case was concluded on a motion for summary judgment in favor of an insurance company involving a consumer and medical claims makes this a particularly important case for insurers, of any line of business, to read. More broadly, however, this case is particularly relevant to support the proposition that if adequately explained to the online consumer, a waiver of statutory rights or opt-out election can be effective and enforceable, when signed online using an electronic signature.

Notable in this opinion is the lack of any discussion on any challenges to the admissibility of the electronic records establishing the insured's execution of the waiver of the statutory rights, in this case minimum medical benefits as an option with

the auto insurance. The opinion states that the insured acknowledged that she waived the medical benefits online. Thus, it may have been difficult for the insured to have at the same time challenged the admissibility of the very records she acknowledged signing online using an electronic signature.

Insurer and Producer Best Practices

Based on available information, here are a number of Best Practices for an insurer or producer to consider in designing and implementing effective, compliant electronic signature, delivery and archival processes.

- Start with a single business process and product line and create a process map for the ideal Electronic Signature, delivery and/or archival steps for that one business process and product.
- If documents must be delivered electronically, determine how that will occur. For any e-delivery process, Electronic Records containing sensitive personal information should not be sent via email, whether in the email text or as an attachment. Instead, emails should be sent with links to a secure site, which invite the consumer(s) to access the secure website to retrieve such Electronic Records, which the Audit Trail captures. In addition:
 - Consider requesting the consumer's consent to accept all materials that may be provided via electronic delivery, to reduce the need to later ask for additional consent as the e-delivery capabilities expand, (or for each specific electronic delivery, determine how consent will be achieved), and
 - Determine how to handle bounce-back or undelivered email. Consult the applicable insurance code on how to respond to notices of undelivered mail before determining whether to re-send via email or to initiate delivery via the USPS.
- For the chosen process and product:
 - identify each form to be signed and/or delivered and categorize each form as:
 - a document to be provided that does not need to be signed and is not a Special Consumer Disclosure,
 - a Special Consumer Disclosure not required to be signed by the consumer,
 - a Special Consumer Disclosure that is required to be signed by the consumer,
 - a document that is not a Special Consumer Disclosure but is required to be signed, and for each of the four categories, identify how the Legal Requirements summarized above will be met,
 - determine whether any forms in the process must be re-filed with any department of insurance (or for Producers, ask each appropriate insurer this question),
 - select an appropriate method to obtain the consumer's consent to sign electronically and Authenticate the identity of each person signing or receiving each Electronic Record, taking into account the motivation for a person to forge signatures in this area, as well as the harm caused by a forgery,
 - identify each document presented during the process and consider which other aspects of the process (such as IP address of the person signing, the

time and date each step is completed) should be collected and recorded in the Audit Trail,

- select the method for Tamper Sealing each Electronic Record immediately upon that record being signed by each person signing and for Tamper Sealing the Audit Trail, all which will support the Records Custodian's testimony on admissibility as well as on enforceability of the Electronic Records signed, as well as where and how each Electronic Record will be archived,
- determine how to receive the consumers' perspective on the process, in particular to assure that the legal significance of each step is adequately and clearly explained in a way consumers will understand that they are signing legally significant documents,
- for those Special Consumer Disclosures identified in step 3(a) above, how will the E-SIGN Consent be provided in accordance with the applicable insurance code Legal Requirements. If the selected process will involve the use of voice signatures, consult with legal counsel familiar with E-SIGN and UETA and the special considerations for voice signatures.
- For each process:
 - before launching on a wide-scale basis, launch at least one pilot program to determine actual adoption of the process to solicit feedback on how to make the process more user friendly, without sacrificing quality, security, compliance, admissibility or enforceability, and
 - compare the risks of the proposed electronic process with the risks in the current traditional paper process, and adjust where appropriate.
- Consider how the relevant records for a given policy owner or insured will be retrieved efficiently using a method where such records can withstand a Repudiation challenge, in response to actual or threatened litigation or regulatory examinations.
- Before purchasing an electronic signature solution from a third party or developing the solution internally, be sure the proposed solution will be implemented in a way that meets all the Legal Requirements.

Applicable to Insurers

- Publish a set of requirements for those Producers who have or want to have their own Electronic Signature or electronic delivery process so they can perform due diligence in choosing and implementing a product and process that meets company requirements.
- Develop an efficient method to review and verify Producers' requests for approval of their Electronic Signature or electronic delivery processes, such as requiring Producers to have an independent third party verify compliance.
- Create a multi-disciplinary work group for the design of the processes, including representatives from IT, operations, new business, policyholder services, claims, legal, compliance, privacy and security areas, whether the process will be supported by an internally developed solution or one acquired from a vendor.
- The work group should develop a common set of terms so all are clear on the meanings.
- Seek active input from representative samples of Producers.

- Consider the need to amend the company's current agreements or policies applicable to Producers, so that the Producers are properly informed of and bound to follow the company's e-contracting processes.

Applicable to Producers

- Request from insurers the requirements for an Electronic Signature or electronic delivery process and choose a vendor which meets those requirements as well as the company's preferred methods.

Contracts That Must Be on Paper

To protect consumers from potential abuses, electronic versions of the following documents are invalid and unenforceable:

- wills, codicils, and testamentary trusts
- documents relating to adoption, divorce, and other family law matters
- court orders, notices, and other court documents such as pleadings or motions
- notices of cancellation or termination of utility services
- notices of default, repossession, foreclosure, or eviction
- notices of cancellation or termination of health or life insurance benefits
- product recall notices affecting health or safety, and
- documents required by law to accompany the transportation of hazardous materials.

These documents must be provided in traditional paper and ink format.

VI. Market Conduct

Market regulation attempts to ensure fair and reasonable insurance prices, products and trade practices in order to protect consumers. With improved cooperation among states and uniform market conduct examinations, regulators hope to ensure continued consumer protections at the state level. Market conduct examinations occur on a routine basis, but also can be triggered by complaints against an insurer. These exams review agent-licensing issues, complaints, types of products sold by the company and agents, agent sales practices, proper rating, claims handling and other market-related aspects of an insurer's operation. When violations are found, the insurance department makes recommendations to improve the company's operations and to bring the company into compliance with state law. In addition, a company may be subject to civil penalties or license suspension or revocation.

Market conduct refers to sales and claims practices. The focus of much insurance regulation has been financial regulation. Market conduct usually is understood to encompass insurers' and agents' market practices that involve interactions with consumers or insureds. The following activities might fall within this area:

- Marketing, advertising and product representations
- Sales
- Underwriting and pricing
- Issuance of insurance policies
- Collection of premiums

- Policy renewals, terminations and refunds
- Policyholder dividends
- Policy changes
- Claims settlement and payment

Consumer Services

The states' single most significant challenge is to be vigilant in the protection of consumers, especially in light of the changes taking place in the financial services marketplace. States have established toll-free hotlines, Internet Web sites and special consumer services units to receive and handle complaints against insurers and agents. The states also have launched an interactive tool to allow consumers to research company complaint and financial data using the NAIC Web site. During 2000, state insurance departments handled 4.5 million consumer inquiries and complaints. As needed, state insurance departments worked together with policyholders and insurers to resolve disputes. In addition, many states sponsor educational seminars and provide consumer brochures on a variety of insurance topics. Some states publish rate comparison guides to help consumers get the best value when they purchase insurance.

Two Elements

Competition policy essentially has two elements. First, it entails applying various policy measures to ensure there is inter-firm rivalry and thus enhance the efficiency of markets. This involves setting market conduct rules and preventing the abuse of market power. Second, competition policy aims to ensure that regulation made in pursuit of other policy goals does not unnecessarily impede the efficient operation of markets and that, where feasible, regulation that improves market efficiency is adopted. Successful competition policy requires clear policy underpinned by strong, flexible and enforceable laws, a strong and independent competition regulator, and skilled staff and related capacities (Canadian International Development Research Centre 2007).

Regulators are most concerned about industry practices or actions that have adverse and unfair effects on consumers, policyholders and claimants/beneficiaries. The types of practices that regulators view negatively and/or in violation of state laws and regulations would include:

- Misrepresentation of insurance products
- Excessive sales pressure
- Fraud
- Sale of unsuitable products
- Replacement of policies that are not in the best interest of the consumer
- Inappropriate risk classification
- Rejection of insurance applications not based on "acceptable" underwriting criteria
- Sale of policies not approved by regulators' and/or in violation of state laws and regulations
- Premium calculations inconsistent with filed rates
- Prices that are excessive or unfairly discriminatory
- Improper terminations; failure to provide adequate notice of terminations

- Failure to refund premiums or dividends due to insureds
- Failure to pay legitimate claims, underpayment of claims and unreasonable delays in paying claims

Of course, regulator and insurer views may differ as to legality or fairness of a particular practice or action. Market conduct regulation is the broadest term that characterizes regulators' authorities and activities with respect to insurer market practices. Hence, it encompasses;

- Laws and regulations that pertain to insurers' market practices
- Regulators' monitoring of insurers' market practices and identification of violations and problems
- Regulatory enforcement actions. Some regulators also might argue that market conduct encompasses the regulation of rates and policy forms.

Market conduct surveillance primarily refers to regulatory monitoring. Market conduct examinations are an important component of market conduct surveillance, which also includes: complaint monitoring, analysis and response; market conduct "desk exams"; "testing"; and other methods of gathering information about insurers' market practices. While market conduct examinations are the primary focus of this report, they must be evaluated in the context of market conduct regulation, surveillance and enforcement actions, which influence or result from examinations.

There is a difference between routine or periodic, comprehensive market conduct examinations and targeted examinations. Like routine financial examinations, routine market conduct examinations occur on a pre-arranged schedule (e.g., every three or five years) and are typically used to detect violations and problems and well as investigate specific practices. Targeted examinations, on the other hand, are triggered by some indication of potential market conduct violations or problems and are most likely to be confined to certain areas of concern or question.

Market conduct examiners

The Market Conduct Examinations section performs unique examinations that review how insurers operate with respect to customers. The purpose of market conduct regulation is to assess how well the market is doing as a whole, and how well individual companies within the market are meeting consumers' needs.

Regulators' market conduct oversight involves protecting consumers by monitoring and examining the conduct of insurance producers. To fulfill this role, state regulators analyze information that they periodically collect on the marketing and sales behavior of insurers in order to identify any problems. Regulators also conduct periodic market conduct examinations to investigate insurers' market behaviors in greater depth. Regulators may issue findings and work with insurers on corrective actions identified as a result of market analysis and market conduct examinations. Regulation of the market conduct of insurers through regularly scheduled and targeted examinations verifies insurers are operating in accordance with applicable laws and regulations. Prompt and effective rehabilitation of troubled companies protects the public from financial harm, the industry from unnecessary guaranty fund assessments, and the revenue stream of the state from undue interruption.

Staff conduct on-site market conduct examinations of books, records and operations of insurance companies based on:

- consumer complaint issues
- referrals from other divisions or national issues
- known or suspected behavior that is detrimental to insureds or the insurance buying public
- complaint trends and indicators within TDI and NAIC
- findings from other jurisdictions
- amount and type of business the company writes
- prior violations noted in examination reports and throughout TDI
- specific referrals from within TDI or the Financial Program.

The market conduct exams fall into three categories: comprehensive, limited scope, and compliance. Additionally, Market Conduct staff participate in NAIC multistate market conduct examinations.

It is clear that market conduct affects an insurer's bottom line. Market conduct can thus be seen as a rating issue; recognizing that market conduct affects an insurer's financial position. Research done by the NAIC expressed the belief that market conduct regulation was essential to ensure the solvency of insurance companies (*Performance (Market Conduct) Regulation Standards and Accreditation Program of the NAIC*, June 9-13, 1991).

Market Conduct Assessment

Market conduct examinations, which are generally done on site, are a review of an insurer's marketplace practices. The examination is an opportunity to verify data provided to the department by the insurer and to confirm that companies' internal controls and operational processes result in compliance with state laws and regulations.

The fundamental objective of insurance company solvency monitoring is to ensure that companies meet regulatory standards and to alert regulators if actions need to be taken to protect policyholders. To accomplish this task, the state insurance regulators conduct financial analysis using regulatory financial reports, financial tools and other sources of information to detect problems that may jeopardize a company's long-term viability. These sources include SEC filings, corporate reports, external, independent certified public accountant (CPA) attestation reports, financial examination and market conduct reports, rate and policy form filings, consumer complaints, independent rating agency reports, correspondence from agents and insurers, and business media.

Insurers face increasingly intense market competition from other providers of financial service products both domestically and internationally. In this challenging environment, it is important that financial service providers follow high ethical standards to best protect and serve consumers and to make sure the marketplace remains strong.

Most insurers adhere to principles of ethical market conduct. The principles include requirements for the marketing, advertising, sales and customer service of insurance

products. Companies are also encouraged to promote a “needs-based” selling standard and that the insurance buying public should receive clear and honest information before they purchase any type of insurance product.

The Changing Role of Market Conduct Regulation

Insurance regulation is intended to ensure a healthy, competitive marketplace, to protect consumers, and create and to maintain public trust and confidence in the insurance industry. An integral component of insurance regulation is the appropriate oversight of the ways insurance companies distribute their products in the marketplace, namely, market conduct regulation. The history of market conduct regulation goes back to the early 1970s when the NAIC developed its first handbook for market conduct examinations and did its first market conduct investigation. The system has come a long way -- by 2002, departments reported a total of 1,333 market conduct exams and 465 combined financial/market conduct exams. Under the federal form of government, each state modifies or promulgates its own set of examination parameters. Each company writing business nationally must comply with the divergent state and federal standards regarding the replacement of policies. The logical reason for so many different standards is that moral, political, and local outlooks towards regulatory content vary from state to state.

Making Market Conduct Regulation More Efficient

The challenge for the future is to create a uniform system of market conduct oversight that creates greater efficiencies for insurance companies while maintaining appropriate consumer protections and protecting states rights.

The NAIC has explored ways that regulators and best practices organizations to work collaboratively to improve market conduct regulation and advance the interests of consumers. The NAIC studied so called “best practices” organizations. State insurance departments also encourage insurance companies to become members of such organizations in an effort to promote higher market conduct standards and to facilitate the regulatory examination process. For example, as part of the examination process carried out pursuant to Texas Insurance Code Article 1.15, the Department examiners routinely inquire as to whether companies are members of best practice organizations. Such initiatives by state insurance regulators are a step towards pursuing a new market analysis approach to regulation that will hopefully reduce inefficiencies and better allocate resources to provide more comprehensive consumer protections.

The NAIC and NCOIL (National Council of Insurance Legislators) have developed a Model Law on market surveillance that promotes market analysis and greater use of insurer self-evaluative activities such as those required under best practices standards to introduce a more uniform and efficient regulatory scheme.

Establishing a system of market analysis in cooperation with best practices organizations allows regulators to focus on whether an insurer has a sound market conduct and compliance infrastructure in place to better protect consumer interests. Today's market conduct examinations tend to focus on technical instances of noncompliance rather than exploring whether a company has a comprehensive

system of policies and procedures in place to address market conduct compliance issues.

When regulators conduct a market compliance exam, they look for specific metrics to evaluate an insurer. Here is a checklist for insurers to assess noncompliance risks;

- Failure to acknowledge, pay or deny claims within specified time frames.
- Failure to properly terminate a policy, including inadequate days' notice and omitted required language.
- Improper documentation of claim files.
- Using unapproved or unfiled rates and/or rating errors.
- Failure to provide required disclosures (such as the selection, rejection, or coverage notices in the underwriting process or notices such as statute of limitations, reasons for denials, and bill of rights in the claims process).
- Failure to provide notification of producer appointments or terminations.
- Improper documentation of underwriting and policy files.
- Failure to communicate a delay in the settlement of claims in writing.
- Using unapproved or unfiled forms.
- Failure to produce requested records for an examination.

Lost Market Capitalization

As a further example of the way market conduct can affect insurers, consider the AIG, ACE, Marsh McLennan vs. New York Attorney General Elliot Spitzer battle in 2004. The amount of market capitalization lost by the three is staggering. After Spitzer's initial press conference regarding Marsh, Ace and AIG- In less than two hours on October 14, 2004, MMC, ACE and AIG lost \$25,176,390,000 in market value. This number is larger than the GDP of over 100 countries.

Enforcement Powers

State laws present a comprehensive framework of rules for agent conduct in connection with insurance sales. All of the states forbid premium rebating, churning, and twisting. The proscription of these three forms of misconduct provides the foundation of the several states regulation of unfair and deceptive trade practices. Also prohibited are misrepresentations in the sales process, fraudulent acts and forms of coercion. Outside of sales practices, insurance departments set general rules about handling the handling of business, premiums, commissions and claims. The states have enforcement powers to back up the regulations; the ability to impose cease and desist proceeding along with the ability to levy fines. The ultimate form of leverage for insurance departments is their ability to sanction or revoke licenses.

What the Agent Says

Insurance agents, like everyone else, run the spectrum of values; there are honest, dishonest, ignorant and informed agents. Ideally, agents would combine the two positive traits in the list. The problem from a consumer's point of view is finding this agent. The industry as a whole prefers to believe that very few agents are dishonest. There does seem to be, however, varying degrees of honesty (think moral relativism). For example, an agent may be well-versed in term insurance, but not so much in

whole life; an agent may know about homeowners insurance, but not so much about auto policies. They may be honest but they are ignorant of the product at hand. If a prospective insured asks them a specific question they may give him or her an answer (usually what the boss tells them to say) but it doesn't really answer prospective purchaser's question.

Fairly and simply, a policy must do what the agent says it will do. Agents are trained by their insurance companies, but not to super-high levels of detail. They know enough to talk the policy up and make it sound like gold, but not necessarily a whole lot about the fine print. Not knowing particulars about a product is not a sin, but fabricating song-and-dance responses to a prospective purchaser's questions is certainly not right.

Investment Advice

Agent statements that are seen as 'investment advice' are a case in point. Variable annuities and equity indexed annuities fall outside of the state definition of a "security." In many states, the state regulators do not view this as an impediment to enforcing investor protection safeguards under state securities laws under certain circumstances. Specifically, a growing number of state securities regulators are taking the position that when a financial professional such as a registered insurance agent confers with a client about that client's overall financial picture, including the value of the securities in their portfolio, the state's investment adviser laws apply. The regulators argue that when an insurance agent recommends that any of the client's securities be sold in order to generate funds that are subsequently used to purchase an insurance product, the insurance agent's conduct comes within the definition of an "investment adviser," since the agent provided advice regarding securities and was ultimately compensated from the annuity sale. Therefore, the state regulators reason that investment adviser registration and the fiduciary standards of conduct for an investment adviser – including investor suitability standards – apply to the transaction.

So if an agent is not licensed to sell investments, he or she should think twice about advising a client to cash out a security in order to buy an indexed annuity or other insurance product. Recent regulatory actions are cases in point:

The Massachusetts Securities Division issued a consent order to Investors Capital Corporation for allegedly allowing its representatives to use unregistered investment advisor services to sell indexed annuities.

In recent years, various state securities divisions have taken action against financial professionals who recommended liquidating securities positions and using the proceeds to purchase indexed annuities or other products. Securities boards have warned the public to be wary of unlicensed individuals selling securities. Other states have reportedly sanctioned agents for providing investment advice without a license.

Industry observers suggest that state securities regulators aren't going after insurance products per se, but rather are concerned about the market conduct of insurance professionals who hold themselves out as investment advisors while selling annuities.

"If the [insurance-only] agents are advising people to sell mutual funds or get out of 401(k)s, they are acting as investment advisers. And in my state, being an

unregistered investment adviser is a felony." - Joseph Borg, Alabama Securities Commissioner and Past President of the North American Securities Administrators Association.

This quote is just one of many warning shots that regulators launched at insurance-only agents who sold equity indexed annuities. The insurance-only agent should make sure he or she is not acting as an unregistered investment adviser with discussing how to fund an equity-indexed annuity. The Investment Advisers Act of 1940, Section 202(a)(11) defines an investment adviser as, "any person who, for compensation, engages in the business of advising other, either directly or through publications or writings, as to the value of securities or as to the advisability of investing in, purchasing, or selling securities, or who, for compensation and as part of a regular business, issues or promulgates analyses or reports concerning securities..."

This definition can be broken down into three elements:

- 1) advice concerning securities;
- 2) in the business of providing investment advice; and
- 3) for compensation.

If an insurance-only agent meets all three of the elements, they could be deemed an unregistered investment adviser and subject to disciplinary actions by the Securities and Exchanges Commission or a State's securities department. When looking at the first element, advice concerning securities, the SEC and the courts have broadly interpreted this language. The advice can be about securities in general, such as the stock market or about specific securities. In fact, telling a client when to purchase a stock, when to sell a stock, when to switch to a different investment, how a security is valued, and whether investing in securities at all, has all been considered advice under the definition of investment adviser.

The advice must concern securities, which is broadly defined in Section 202(a)(18) the Advisers Act, and the definition of securities includes notes, bonds, stock (common and preferred), options and much more. These investments are commonly found in a client's investment portfolio. This means the insurance-only agent needs to be concerned that they are giving investment advice, as defined above, when telling a client to sell a mutual fund, stock, bond or other security to purchase an equity indexed annuity. Unless the insurance-only agent is telling a client to exchange, move or sell a fixed insurance product, they could be considered giving investment advice as defined by the Advisers Act. All insurance professionals should carefully consider and review the advice they give to clients when discussing their investments.

VII. MFN Clauses

MFN Clause

Here is an issue with pros and cons as far as benefit to consumers is concerned. In international economic relations and international politics the 'most favored nation' (MFN) appellation is a status or level of treatment accorded by one state to another in international trade. Now, this hardly seems an insurance-related topic, but the reader

will push on and see. The term means the country which is the recipient of this treatment must, nominally, receive equal trade advantages as the "most favored nation" by the country granting such treatment. A country that has been accorded MFN status may not be treated less advantageously than any other country with MFN status by the promising country.

The 'most favored nation' relationship extends *reciprocal* bilateral relationships following both World Trade Organization (WTO) and General Agreement on Tariffs and Trade (GATT) norms of reciprocity and non-discrimination. In bilateral reciprocal relationships a particular privilege granted by one party only extends to other parties who reciprocate that privilege, while in a multilateral reciprocal relationship the same privilege would be extended to the group that negotiated a particular privilege.

Most Favored Nation clause- This is a contract provision in which a seller agrees to give the buyer the best terms it makes available to any other buyer. In some contexts, the use of such clauses may become commonplace, such as when online e-book retailers contract with publishers for the supply of e-books. Use of such clauses, in some contexts, may provoke concerns about anticompetitive influences and antitrust violations, while in other contexts, the influence may be viewed as fostering competition. The salient points of an MFN are;

- A most-favored-nation clause, in a business contract, requires the seller to provide the buyer the lowest price offered to any rival purchaser.
- Such arrangements can help protect long-term investments, eliminate bargaining delays and avoid price discrimination.
- The risk is that they create a financial incentive for the seller not to offer low prices, resulting in higher overall prices in the market. They can also be used by a company that dominates its market to keep out competitors.

MFN Examples

MFN clauses guarantee the recipient the lowest prices or rates charged to any buyer. In theory that could encourage competition and lower prices for consumers. According to regulators, in practice these type agreements sometimes end up establishing a minimum price. These can be seen as ethical issues.

Automotive Repair Issue

A Minnesota trade association that represents automotive-service providers, asked the Justice Department and the Federal Trade Commission to investigate MFN clauses in their industries. The director of the Alliance of Automotive Service Providers of Minnesota said such provisions in contracts between collision-repair shops and insurers artificially depressed what the shops can charge for their labor. Insurers that command the most market share will accept only the lowest rates for repairs, and their smaller competitors, knowing this, refuse to accept higher rates, fearing they'll lose business, the official said in a letter to the two federal agencies.

MEMORANDUM

TO: Department of Justice, Federal Trade Commission

FROM: Alliance of Automotive Service Providers of Minnesota (AASP-MN)

AASP-MN is the state trade association which represents Minnesota's independently owned mechanical and collision repair shops. The existence of most-favored-nation clauses in direct repair contracts between insurers and collision repair shops has become an increasing concern for our membership.

Direct Repair Contracts establish terms whereby a collision repair shop will be deemed an approved provider of repair services for an insurance company's insureds and claimants, provided the shop agrees to comply with specific insurance company requirements.

Collision repair shops are finding it increasingly difficult to survive in the marketplace unless they strive to comply with insurance company demands to become "approved" repair businesses by entering into Direct Repair Contracts.

The marketplace is most significantly skewed in circumstances where an insurance company holds a significant market share of the automobile insurance coverage in a particular state. For example, State Farm Insurance Company insures the largest segment of Minnesota's auto insurance market – approximately 20% of the state's insureds.

Collision repair shops strive to meet the State Farm direct repair program standards in order to have a reasonable chance of securing a portion of the repair work from State Farm's insureds. One of the terms State Farm imposes in its Direct Repair Program is that participating collision repair shops must grant State Farm most-favored-nation status with respect to the rates the shop charges for repairs to vehicles of State Farm insureds or claimants.

This most-favored-nation requirement has been an impediment to any adjustment to collision repair labor rates in Minnesota for several years. State Farm will not accept anything but the lowest rates in the marketplace and all other insurers point to the fact that State Farm commands the lowest labor rates and therefore they cannot or will not allow for an upward adjustment of the labor rates they will pay.

The collision repair shops find themselves in a Catch 22 where they need to strive to be accepted on the State Farm Direct Repair Program yet, in so doing, they are limiting market opportunities for adjustment to labor rates which would more accurately reflect the increase in costs the collision repair industry is facing.

The special circumstance of having a most-favored-nation clause in market-leader State Farm's Direct Repair Contract creates asymmetry in the marketplace relationship between insurers and repair shops – in this case, solely benefiting the insurer and restricting the ability of the repair industry to adjust labor rates.

AASP-MN appreciates this opportunity to share our concerns with respect to most-favored-nation clauses and would welcome the opportunity to visit further with Department of Justice and Federal Trade Commission staff on this matter.

Sincerely,

Judell Anderson, CAE, Executive Director
Alliance of Automotive Service Providers of Minnesota, Inc.



Health Care Service Providers

The field of health insurance is a growing area of attention for the consumer protection movement. There are many issues that concern the consumer and achieving maximum benefit for the dollars spent on the protection of health through insurance.

Challenges in an Evolving Market

In recent years, market and regulatory forces have combined to radically transform the delivery of health care from the traditional doctor-patient relationship into something more closely resembling a standard business transaction. Hospitals, physicians, and other providers such as visiting nurse organizations are often now consolidated into "integrated delivery systems." Managed care and the consolidation of physician group practices are making health care in the New Millennium seem far removed from the health care delivery system with which some were raised.

Health care consumers and government regulators are now turning to traditional consumer protection principles to deal with some of these commercial aspects of health care. For example, the professional billing systems adopted by many physicians' offices and hospitals, together with the aggressive pursuit of delinquent payments mean that physicians' and hospital collection efforts are subject to the state and/or federal fair debt collection acts. Similarly, consumers' unpaid debts to health providers are being reported to credit reporting agencies and are governed by state and federal fair credit reporting acts.

The emergence of managed care has raised a number of new consumer protection issues for patients and subscribers. For example, many consumers and consumer advocates believe patients should be informed of any financial or contractual arrangements their doctors have with insurers if those arrangements can affect health care decisions. Some managed care plans, for instance, attempt to limit referrals for specialized care by including financial incentives or disincentives in their contracts with primary care physicians who limit such referrals. These provisions

have been challenged in some cases as posing an inherent conflict between the physician's duty to the patient and the physician's self interest. The question of whether not disclosing such provisions to patients constitutes an unfair or deceptive trade practice remains unresolved by the courts.

The integration of health care into linked delivery systems also poses new consumer protection issues for both providers and consumers. For instance, in some states, a health care provider that owns or has a financial interest in a facility to which the provider's patients are referred must disclose this information to patients referred to that facility. Examples of this include a hospital owning an ambulatory care facility; a physician with a financial interest in a pathology laboratory or high tech diagnostic devices such as a CAT Scan or MRI. In states where such disclosure is not required, the question of whether patients are entitled to such information under traditional consumer protection principles remains unanswered.

These trends, which are causing a convergence of consumer protection law with the practice of medicine, are likely to accelerate in the future. Health care delivery will become increasingly subject to consumer protection laws. How this will be accomplished- either through specialized statutes or through application of traditional consumer protection laws- is not possible to predict currently. There follows a sampling of consumer protection issues that have been addressed by legislation in several states. Two terms (goals, obsessions, holy grails, or ideals) appear constantly.

Access- Access to, and the provision of, emergency services; use of specialists as primary care physicians and access to appropriate specialty care; adequacy of provider networks, travel and waiting times standards; continuity of care following enrollment and contract termination; and access to experimental and investigational procedures;

Quality- Optimizing the essential character of health care delivery through the utilization of review/referral systems; HMO internal review and assurance plans; data reporting; and provider financial risk arrangement/incentive plans;

These are the ideas that consumer groups and politicians fire at the medical-industrial complex repeatedly. Because of the nature of payment for medical care, the insurance industry is involved in these matters.

Contract Provisions

In a 2010 antitrust lawsuit against Blue Cross Blue Shield, the dominant health insurer in Michigan, the Justice Department and state authorities took aim at contract provisions that required hospitals to offer the company the lowest non-government rate for hospital services. The lawsuit said the provisions effectively forced hospitals to raise prices for Blue Cross's competitors, making it hard for them to compete (*United States of America and the State of Michigan v. Blue Cross Blue Shield of Michigan*, 2:10-cv-15155-DPH-MKM, E.D. Mich.).

The court rejected Blue Cross' argument that Michigan's regulation of the insurance industry means that Blue Cross is entitled to immunity under the state action doctrine, and that, as the state's insurer of last resort, Blue Cross is a quasi-public entity. This

defense, if accepted by the court, would have meant that the federal government could not enforce the Sherman Act against Blue Cross due to the state's heavy participation in Blue Cross' business. In order to be protected from the application of the Sherman Act under the state action doctrine, the court stated that the MFN clauses must be clearly articulated and affirmatively expressed as state policy and actively supervised by the state itself. The court found no merit to Blue Cross' claims that its business is conducted sufficiently close to the state to be exempt from the governance of the Sherman Act. The state does not support the use of MFNs to stifle competition, nor possess the statutory right to review MFN clauses in contracts between hospitals and health insurers, according to the court's analysis. The court also determined that Blue Cross is a private — not quasi-public — entity because Blue Cross controls its own business decisions and has represented itself as a private entity in prior litigation.

For similar reasons, the court rejected Blue Cross's argument that it is exempt from liability because the Michigan Antitrust Reform Act does not apply to conduct that is specifically authorized under the laws of the state and conduct that is the subject of a legislatively mandated pervasive regulatory scheme. The court found that Blue Cross is not covered by these exemptions and, even if it was, would still be subject to the Act because the use of MFNs in particular is not protected by state or federal law. In addition to this case, a class action suit has been filed against Blue Cross Blue Shield of Michigan alleging antitrust violations similar to those argued in the present matter and the United States has issued civil subpoenas to Blue Cross in six additional states.

DOJ Confab

In the fall of 2012, the Department of Justice (DOJ) and the Federal Trade Commission (FTC) held a public workshop on the use and impact of most-favored-nation (MFN) clauses and the implications for antitrust enforcement and policies. The interested reader can access the particulars of the conference; <http://www.justice.gov/atr/public/workshops/mfn/index.html>

Confab participants presented various economic theories on the effects of MFN clauses. In one view, MFN clauses are protective, preventing one party from anticompetitive behavior by the other party. In another view, however, MFN clauses reduce competition by creating fewer incentives for sellers to discount prices and for buyers to bargain seriously.

Competitive Harm from MFNs: Economic Theories

Ways MFNs May Harm Competition:

Collusive Theories- FTC concluded that sellers using MFNs had less incentive to discount making tacit collusion more likely
Facilitating coordination- MFN discourages cheating, seller has less incentive to cut price, cannot limit discount to single customer which makes cheating more costly. The buyer has less incentive to bargain hard and less likely to get competitive advantage over its rivals

Dampening competition- A seller uses an MFN to commit to less aggressive competition, less likely to lower price to any one customer, as must then lower price to all. If rivals respond by behaving less aggressively too, prices will rise.

Exclusionary Theories- Raising rivals'/entrants' costs- DOJ story in Delta Dental of Rhode Island. Largest dental insurer in state, contracts with 90%+ of dentists. MFN: Delta pays dentists the same as the rival insurer with the best deal. Rivals could not adopt a selective contracting business model that cuts costs & lowers insurance rates. Could not pay a panel of dentists low rates in exchange for steering patients. Raising Rivals'/Entrants' Costs- Excludes rival(s)/entrant(s), MFN prevents rivals from obtaining inputs or distribution cheaply. By penalizing the supplier/distributor, thereby raising rivals'/entrants' costs; Harm to competition results as dominant firm excludes fringe & entrants, coordinating firms exclude maverick. Result: obtain/maintain high prices □ Profitable to seller

Increase Seller Bargaining Power- Durable goods monopolist; Buyers won't pay monopoly price if expect seller to discount in the future; Patient buyers will delay purchases thus leading seller to price low from the start. MFN is a commitment not to discount, makes future discounts expensive, buyers no longer expect to profit from waiting, so pay monopoly price, seller makes buyer's best alternative to a negotiated agreement worse.

Efficiencies from MFNs:

Manifestation of MFNs in a contract; Adoption, explicit contractual provision, product of bilateral negotiations, part of long term contract, two-party governs prices for the contractual buyer and seller.

Most common- buyer must get the "best" price that the seller has given to any buyer; third-party governs prices that, in theory, can be obtained from every possible seller or buyer, 3rd-party MFN are essentially equivalent to a meeting competition clause. Scope of MFN often limited by market area, platform, customer type, etc.

Potential Efficiencies from MFNs-

Possible economic efficiencies for MFNs include the following

Opportunism- Relationship-Specific Investments; Investments made to support a specific transaction, but where resulting assets cannot be readily deployed elsewhere (i.e., next-best use is a poor alternative), site specificity, physical asset specificity, dedicated assets (including capacity), human capital specificity, risk of exploitation may frustrate transactions, and contractual terms may be employed to address hold-up potential

Transactions Costs- The transaction cost argument may reverberate down the chain, platform provider's MFN with an input provider certifies the platform provider's competitiveness to an end buyer. Example: Company contracting with a Pharmacy Benefit Management does not know the prices of all drugs its employees may use, MFNs between the PBM and the pharmaceutical firms could certify PBM's competitiveness.

Other possible efficiencies; Quality commitment: Extension to a model of price as a signal of quality, seller wants to convince buyers that an experience good is high quality; consumers know that high price cannot be sustained if good develops a

reputation for low quality; MFN provides a commitment on the part of the seller that the good will not be perceived as low quality in the future.

Opportunism, hold-up on relationship-specific investments, contractual rigidity, transaction cost reduction, switching/information costs, time inconsistency, quality commitment, risk reduction/distribution. Efficiencies can manifest differently in across types of MFNs, markets, industries, etc.

MFN clauses were originally intended to help businesses compete, or at least stay competitively neutral. The anticompetitive effects of MFNs can be either collusive or exclusionary. MFNs can facilitate coordination or dampen oligopoly competition by making it impossible to offer selective discounts or prevent secret discounts. MFNs can soften price competition and thereby allow firms to charge higher prices than they otherwise would. These are harmful collusive effects. MFNs also can have exclusionary effects by raising the costs of rivals or entrants that attempt to compete by negotiating lower prices from suppliers of critical inputs, or by pioneering a different business model.

Although courts have not found MFN clauses patently illegal, such clauses have been the subject of enforcement actions on the theory that they encourage coordinated pricing or discourage price cutting to particular customers by obligating the seller to make the lower price available to one or more other customers.

MFNs and Pricing

Unless they are adopted by an agreement among competitors, MFNs normally are evaluated in antitrust under the rule of reason. This evaluation can involve direct and indirect evidence of likely harms and benefits from the MFNs. This evidence can involve the upstream market in which the inputs are sold to buyers and the downstream market in which consumers participate. By analyzing the circumstances under which the MFNs were adopted, their motivation and likely effects also might be better discerned. For example, if the MFN leads to entrants being deterred or smaller rivals shrinking or exiting from the market, competition is more likely to have been reduced and consumer harm is more likely. All this evidence can aid a fact finder in evaluating whether the precompetitive or anticompetitive theory is more plausible. It also can be used to evaluate the likely overall effects on consumers. Where reliable measurement is possible, evidence of likely effects often will focus on prices. The agency and court will evaluate whether the MFNs led to higher or lower prices being paid by consumers. If the MFNs caused consumers to pay higher prices, and the higher prices were not offset by increases in quality or innovation, then consumers likely were harmed. To make this evaluation, prices before and after the MFNs were adopted might be compared. Or, prices in similar markets may be compared, but where some of the markets have MFNs and others do not. Evidence of reduced or deterred innovation also would be relevant to a competitive evaluation.

In the upstream market, price and cost are relevant. One key type of evidence of harm is the impact of the MFNs on the prices and costs of the input purchased by buyers that do not have MFN protection. If those costs are higher than they would be absent the MFN, that suggests a greater likelihood of consumer harm. Evidence of the effect on the input prices of buyers that have MFNs also is relevant. If those input costs also rise, despite the MFN protection, there is more likely to be consumer harm.

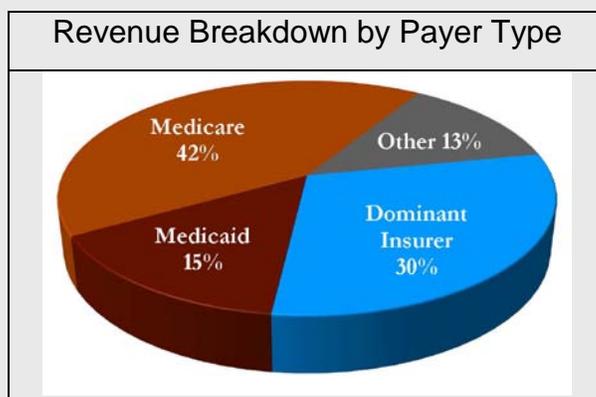
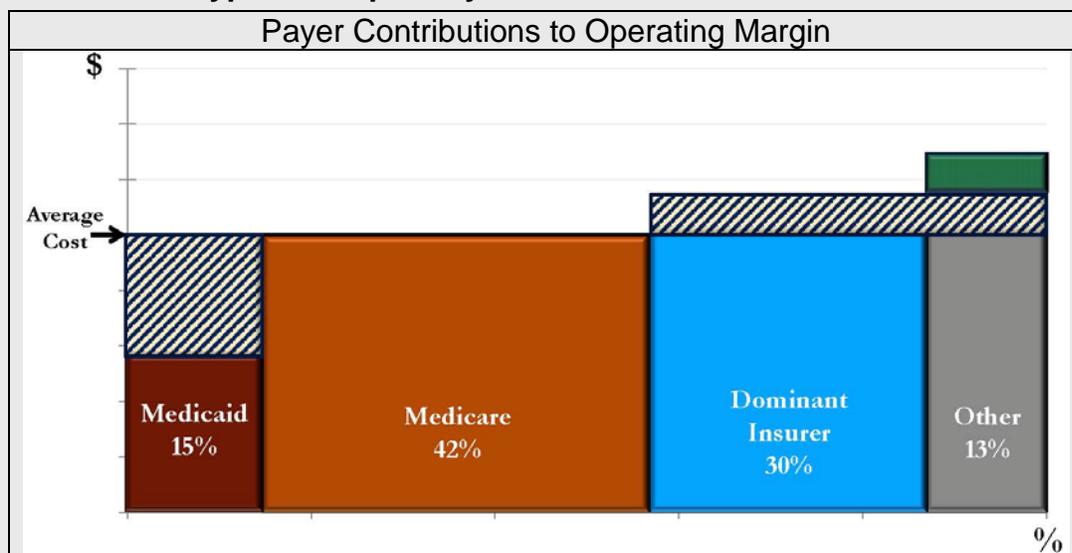
In contrast, pricing evidence can also indicate MFN benefits. This would include evidence of lower prices, either input prices or output prices. Direct evidence that the MFN led to the recipients obtaining strictly lower prices (as opposed to non-recipients paying higher prices) would be relevant to this determination. Competitive benefits are also indicated where the MFNs lead to higher output or additional products or consumer choices, where it is possible to measure these reliably. Evidence that the MFNs eliminated bargaining delays that were slowing or preventing innovation also would suggest benefits. Direct evidence of increased investment or new product innovation flowing from the adoption of the MFNs also would be relevant. Again, this evidence might involve comparisons across markets or over time;

- Theory predicts effects of MFNs depend on the facts of a particular situation
Require empirical evaluation
- Challenges for empirical evaluation of MFNs Characteristics associated with potential for anticompetitive effects also associated with efficiency motivation
- Empirical techniques capable of distinguishing competitive effects from effects of confounding factors

In general, an MFN clause guarantees a health insurer, as the purchaser, the same lowest price as obtained by any of its competitors. In the Blue Cross case the insurer purchases health care services on behalf of its subscribers from hospitals as the sellers of such services. The government assertion is that Blue Cross's use of MFNs has reduced competition in the sale of health insurance in markets throughout the state of Michigan by inhibiting hospitals from negotiating competitive contracts with its competitors. Specifically the MFNs have harmed competition by;

- reducing the ability of other health insurers to compete, or actually excluding its competitors in certain markets
- raising prices paid by competitors and by self-insured employers.

Revenue for Typical Hospital System



Boost or Suppress Competition

MFNs are generally viewed by courts and enforcers to be a boost to competition and consumer welfare-enhancing (to the extent they are scrutinized at all) because typically they promote competition and yield lower costs to purchasers, who in turn can then provide lower prices to consumers. The thrust of the government’s complaint here, however, is that as a result of Blue Cross’s market power in the sale of commercial health insurance in each of the alleged relevant geographic markets, and by intent and effect, the MFNs suppress competition in the sale of health insurance and harm consumer welfare. Through vertical agreements, in other words, Blue Cross allegedly is suppressing horizontal competition.

Market Characteristic	Efficiency Theory	Tacit Collusion
Number of buyers	MFN more likely as number of buyers increases	MFN less likely as number of buyers increases
Use of exogenous indices	MFN adoption relative to number of buyers should parallel adoption of indices	Indeterminate
Relevant region for MFN	Include the seller’s region	Include the buyer’s region

CONCLUSION

Most individual states now have consumer protection agencies. The several states have similar provisions in place to protect the consumer. On the national consumer protection scene many federal watchdog agencies have been set up to regulate activities affecting consumers. After all, every living resident of the United States is a consumer. Private groups and business associations such as Chambers of Commerce and Better Business Bureaus now also operate for the purpose of consumer protection. In addition, public schools offer courses in consumer protection, and numerous consumer guides are published.

Public interest law firms have been established to bring suits and monitor the activities of government consumer protection agencies. The Consumer Federation of America was formed in 1967 to represent local, state, and national consumer groups. Federal agencies operating in the consumer protection field include the Food and Drug Administration, the Federal Trade Commission, the Interstate Commerce Commission, the Civil Aeronautics Board, the Federal Power Commission, and many more. Regulations of the various protective agencies are enforced by the Antitrust Division of the Department of Justice.

As stated previously there is now a movement known as consumerism. It is important for the insurance professional to understand consumers' rights, and what is expected of the professional. Deceptive trade practices are not only unethical and poor business policy but are illegal, with stated penalties enforceable if an unhappy buyer can prove his/her case. As the critics are claiming, "*Caveat venditor*" or "Let the seller beware."