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LIABILITY INSURANCE

Changes in Policies Set Limits on Risks to Insurers

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The Honorable James J. Florio
Chairman, Subcommittee on Commerce,
Transportation and Tourism
Committee on Energy and Commerce
House of Representatives

The Honorable Henry A. Waxman
Chairman, Subcommittee on Health
and the Environment
Committee on Energy and Commerce
House of Representatives

The Honorable Albert D. Gore,
Daniel K. Inouye, John D. Rockefeller, and
Paul E. Simon
United States Senate

This briefing report is submitted in response to your requests of May 27 and June 19, 1986. It provides a description of the recent major changes in policies and practices in the commercial general liability (CGL) insurance field, as well as the insurance industry's reasons for making these changes. We also present the opinions and perceptions of organizations representing industry and buyer interests concerning the possible effects of these changes on the availability, affordability, and adequacy of coverage of this type of insurance. This is one of several reports on liability insurance issues that you have requested. Other topics to be covered in later reports include profitability, insolvency, the effects of tort reforms on insurance rates, and lines of insurance with severe availability and affordability problems.

Commercial general liability insurance covers a broad range of business risks, including basic types of coverage, such as that for overall operations and product liability. During the past year, problems with CGL insurance availability, affordability, and adequacy of coverage reached crisis proportion, according to some sources. Businesses and public entities have experienced problems in both finding coverage and paying costly premiums for available coverage.

The insurance industry, citing unprecedented losses in recent years, states that substantial rate increases or withdrawals from certain lines of coverage were essential to maintain a reasonable level of profitability. The industry said that changes in commercial general liability coverage were needed to counter long-standing problems in predicting the level of financial liability for risks assumed. Prediction is difficult because of the latent nature of some damages, the long time ("long-tail") before damage becomes evident, and thus the long time before claims are received. The industry also cites judicial interpretation of insurance coverage as altering the intended scope of traditional CGL policies to a situation in which the insurers' liability is unlimited.

From our discussions between July and September of this year with spokespersons of 12 different organizations representing both the insurance industry and buyer interests, we identified three major changes in CGL policies. These are (1) the introduction of the claims-made policy as an alternative to the traditional occurrence-based policy, (2) aggregate dollar limits on all coverages, and (3) the broadened scope of the pollution coverage exclusion. All three of these changes were included in revisions made by the Insurance Services Office (ISO) to CGL policies submitted for state regulatory approval this year (see p. 9). As of September 26, 1986, 39 states, the District of Columbia, and Puerto Rico had approved ISO's occurrence-based and claims-made policies for insurance business in their jurisdictions. However, data were not available on the extent to which such policies have been written using the revisions.

All the changes (described in detail in the body of this report) are intended to set limits on insurers' liability. Claims-made policies limit the time period during which a single policy is liable for a claim. They prevent the application of a claim to more than one policy because only one policy is in effect at one time. Aggregate policy limits set an upper bound on liability for coverages. The pollution exclusion eliminates coverage for a segment of pollution liability.

As to the potential effect of these changes on the availability, affordability, and adequacy of CGL coverage, insurance organizations' and buyers' views differ. Indeed, the recency of these changes means that opinions about many of their long-term effects cannot be based on actual experience.

Some conclusions, however, can be drawn from an analysis of the changes themselves. There seems to be general agreement among industry and buyer organizations that the ISO changes enhance the insurance industry's ability to predict the level of risk

and to price premiums accordingly. It is also evident that insurance buyers will shoulder greater responsibility for risk and the management of risk. Businesses will have to become more knowledgeable about the options and combinations of coverage appropriate for their needs.

Under some circumstances, claimants may be adversely affected by the shift of responsibility for risk from insurers to buyers. If businesses reduce coverage or the policy's aggregate limits are exhausted and neither self-insurance nor excess coverage is available, a claimant may have greater difficulty recovering losses than under the previous occurrence-based policy that had no aggregate policy limits. The actual effects on claimants can be assessed only after a body of experience with these changes develops.

As agreed with your offices, unless you publicly announce its contents earlier we plan no further distribution of this report until 30 days from its issue date. At that time, we will send copies to other interested congressional committees and members and other interested parties. We will also make copies available to others upon request.

Should you need additional information on the contents of this document, please call me on 275-6193.

Sincerely yours,

Joseph F. Delfico

Joseph F. Delfico
Senior Associate Director

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ABBREVIATIONS

CGL	commercial general liability
GAO	General Accounting Office
ISO	Insurance Services Office

LIABILITY INSURANCE: CHANGES IN POLICIES SET LIMITS ON RISKS TO INSURERS

BACKGROUND

Since mid-1985, problems with the availability, affordability, and adequacy of coverage of commercial general liability (CGL)[1] insurance have been widely reported. The media, state and federal governments, and nationally based insurance industry and consumer organizations all have characterized these problems as a crisis. Businesses and public entities, large and small, have reported serious difficulties arising from insurance premium increases, policy cancellations, and refusals to insure specific risks. But, according to the insurance industry, it has experienced unprecedented losses in recent years. As a result, such actions as premium increases are needed to bring insurance prices into line with the cost of policies written today and to return the industry to a reasonable level of profitability.

This briefing report summarizes the most recent and significant modifications to CGL policies and coverage. It also presents the opinions and perceptions of nationally based organizations representing both industry and buyer interests concerning the effects of these modifications on CGL availability, affordability, and adequacy of coverage.

What is Commercial General Liability Insurance?

Commercial general liability is one form of property and casualty insurance. Property and casualty insurance is a method of transferring risk of financial loss sustained by a relative few to the many who buy such insurance. A contract is made between the insurer, who represents the insured in liability suits and indemnifies for adjudicated claims, and the insured, who pays a premium for the contract.

One form of property/casualty insurance is third-party liability, which covers claims against the insured for bodily injury or property damage suffered by a third party. CGL insurance is third-party insurance, covering a broad range of business risks, including:

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[1]CGL coverage has been known as "comprehensive" general liability insurance. According to the Insurance Services Office (ISO), such coverage is now termed "commercial" general liability insurance to reinforce the limited nature of coverage, particularly concerning exclusions. In this report, we use the latter term because it is the most current. This and other technical terms in this report are defined in the glossary.

-- Premises/operations exposure--coverage for liability resulting from ownership or use of covered premises as well as business-related activities performed by an insured's employees. A claim by a customer who slipped and fell on a wet floor while visiting the insured's premises would be handled under premises and operations coverage.

-- Contractual exposure--limited liability assumed for claims arising from incidental contracts. A claim by an individual injured in an elevator accident that resulted from faulty maintenance would be handled under contractual coverage related to the elevator maintenance contract.

-- Product liability--coverage for bodily injury or property damage arising from the insured's products, but only after the product is away from insured's premises and out of the insured's possession. An individual's claim for injury and damage incurred when his kitchen stove exploded due to a defect in manufacturing would be handled under the manufacturer's product liability coverage.

-- Completed operations--coverage for accidental injury or damage due to operations performed by the insured away from the insured's premises. A claim by an individual for injury and damage when his kitchen stove exploded due to faulty installation would be handled under the installer's completed operations coverage.

Several other specific risks are included in CGL coverage, as described in appendix I.

Like other forms of liability coverage, CGL coverage can be purchased in layers. As many insurance companies have maximum limits of coverage they will write for individual risks, one company's policy may not individually meet an insured's total needs for coverage. When this happens, the insured may purchase additional coverage from other insurers. For instance, Company A may need insurance totaling $1 million, but its insurer, Insurer X, will write only $700,000 worth of coverage. Company A purchases a $700,000 policy from Insurer X as its first layer of coverage (known as primary coverage). It then purchases an additional $300,000 policy, for the same type of coverage, from Insurer Y. Insurer Y's policy--the second layer--is "excess" over Insurer X's. This means that Insurer Y will begin to cover Company A's claims only after Insurer X's policy limit is exhausted. Company A may choose to obtain another layer of coverage, further increasing the dollar limits and covering exposures not covered by X's or Y's policies. This type of coverage, which is also "excess," is known as an umbrella policy.

The Impetus for Change

In response to long-standing problems in predicting the level of financial liability for the risks insurers assumed under the old CGL policy, the Insurance Services Office[2] revised the CGL policy. The process of making the revisions began in the mid-1970's. While developed prior to the recent crisis, the revisions were introduced for comment during the crisis--in 1984--which gave them both momentum and visibility.

Part of the problem of predicting losses is inherent in the nature of some types of potential damages. These damages do not reveal themselves until years, even decades, after the incident or incidents believed to be their cause. Thus, any claims for such long-term or "long-tail" damages will be made long after the end of the policy period. For example, many claims for injuries from exposure to asbestos in the 1940's did not become evident until the 1970's or later. Similarly, problems resulting from ingestion of the drug DES (Diethylstilbestrol) by pregnant women to prevent miscarriages did not become evident until their children reached adulthood. Today, there is substantial concern that current exposure to various hazardous materials will result in bodily injury that will reveal itself some time in the future.

The insurance industry claims that it never intended to provide coverage for claims "forever after" a policy's expiration date. According to the industry, since the 1960's the courts increasingly have held insurers responsible for covering such "open-ended" risks as asbestos exposure. As a result, according to industry representatives, the premiums charged in the past have greatly underestimated insurers' future payouts, as they did not anticipate the obligation for this long-term coverage.

Also, according to the industry, the courts have expanded coverage by ruling, in some cases, that all policies in effect between initial exposure to harm and the manifestation of that harm may be subject to liability.[3] The process of applying more than one policy to a single claim is termed "stacking."

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[2]ISO is a non-profit national organization that serves over 1,300 affiliated insurers. ISO collects, stores, and disseminates data from its affiliates and uses the data to develop advisory rates and forms.

[3]The insurance industry cites as an example Keene Corp. v. Insurance Co. of North America 667 F.2d 1034 (D.C. Cir. 1981), cert denied, 445 U.S. 1007, rehearing denied, 456 U.S. 951 (1982).

For instance, a claim for a person exposed to a cancer-causing chemical for 15 years may be applied to all of the 15 policies covering those years, instead of only to the one policy in effect at the time of initial exposure.

Another "stacking" problem that could occur, the insurance industry fears, concerns the earlier occurrence-based form's lack of an aggregate policy limit on certain types of coverage (i.e., for premises and operations). Court judgments could make their liability "astronomical," insurers believe, depending on how courts interpret the term "occurrence." An insurer's liability could increase with the number of occurrences held to have produced an injury. Hypothetically, a court might count each drink of water containing a toxic substance as a separate occurrence, rather than the poisoning of the water source as a single incident or occurrence. In the latter case, that of a single occurrence, only one occurrence limit would constitute the maximum amount of settlement. In the former case, that of multiple occurrences, the maximum amount of settlement would equal the occurrence limit times the total number of occurrences. Insurers maintain that if judgments "stack" per-occurrence limits within a single policy, insurance availability and insurer solvency would be threatened.

OBJECTIVES, SCOPE, AND METHODOLOGY

At the request of Chairmen James J. Florio and Henry A. Waxman in their letter dated May 27, 1986, and Senators Paul E. Simon, John D. Rockefeller, Albert D. Gore, Jr., and Daniel K. Inouye in their letter of June 19, 1986, we undertook a review of liability insurance issues. As agreed with the requesters' offices, this report contains information on

- -- recent changes in property/casualty insurance industry policies and practices and
- -- the views of insurance industry and buyer organizations on the effects of modifications to property/casualty policies on availability, affordability, and adequacy of coverage.

To identify the most recent and significant modifications to property/casualty industry practices and procedures, we contacted 12 organizations representing the insurance industry and buyers. (See app. II for a list of the organizations contacted.) We selected these organizations based on prior GAO work in the area and suggestions from ISO and others. We selected organizations that have a national membership or otherwise would have knowledge of and a stake in the CGL issue. Using a combination of structured and unstructured questions, we made telephone and in-person contacts.

We asked each organization to identify the changes it believed most significant and to comment on the effects of these changes in terms of insurance availability, affordability, and adequacy of coverage. Although our respondents provided some data to support their positions, we did not attempt to validate the existence or probability of the effects they cited due to time and resource constraints. We also reviewed written material describing the changes and contrasting them with previous practices, as well as some organizations' position papers.

Revisions by ISO to CGL policies were the most significant changes in property/casualty insurers' practices and procedures, according to the representatives of the organizations we contacted. ISO's revisions encompass many facets of CGL insurance policies, such as standardizing the exposure bases for classifying risks, including coverages previously available only by endorsement in the standard CGL package, and introducing new coverage restrictions and limits. The 12 groups we contacted, many of which contributed to and commented on ISO's proposed changes, cited as most significant three revisions on which we focus this report:

1. Introducing claims-made policies to CGL,

2. Imposing aggregate dollar policy limits, and

3. Broadening the pollution exclusion.

Insurers may modify ISO's advisory rates and policy forms (the insurance contract), we were told, as well as develop their own with state approval. ISO mentioned that, because its CGL package took several years to be reviewed and finalized, many companies began to implement their own claims-made forms. For the purpose of our review, we emphasized ISO's version because the organizations we contacted mentioned that they expected it to be the most commonly used claims-made CGL policy. ISO, the largest advisory rating service in the country, has introduced its policy forms nationwide.

COMMERCIAL GENERAL LIABILITY POLICIES REVISED

ISO's revisions to CGL policies were available, subject to state regulatory approval, for insurers to use on January 1, 1986. The following April, ISO made further adjustments to the forms. The revisions include new policy forms, policy-writing rules, classification tables, rates, and rating rules. During our discussions with trade associations representing the various interests in the insurance community, we were told repeatedly that the major changes included

-- introducing a claims-made policy,

-- including aggregate dollar limits on all coverages, and

-- broadening the pollution coverage exclusion.

The claims-made policy represents an entirely new component to CGL. The latter two changes apply to both the occurrence policy and the new claims-made policy.

According to ISO, as of September 26, 1986, 39 states, the District of Columbia, and Puerto Rico had approved its CGL package, which includes both occurrence-based and claims-made policies for insurance business in their jurisdictions. An additional five states had accepted only the occurrence policy and five others had taken no action. One state, Hawaii, had disapproved both policy forms. As of September 1986, ISO did not have data on the extent to which policies had been written using the new forms.

Occurrence and Claims-Made Policies: Basic Concepts

ISO's new CGL package includes two different policy forms--a revised occurrence-based form (very similar in concept to the earlier occurrence form) and, for the first time, a claims-made form. Although new to CGL, the claims-made form has been used in medical malpractice and professional liability coverage since the mid-1970's and early 1980's, respectively, and is now used extensively in these two lines.

Until 1986, virtually all CGL policies were written using the occurrence-based policy form. This type of policy insures against claims for incidents occurring during the term of the policy, regardless of when (either during the policy year or in the future) the claims are made. An occurrence-based policy for the year 1986 would cover all claims, no matter when made, arising from incidents that happened in 1986. Thus, an occurrence policy, when written, can be thought of as prospective in nature because it covers claims that will be made in the future.

A claims-made policy covers claims filed during the current policy year for incidents occurring during that year. It can also cover claims filed during the term of the policy for incidents occurring prior to the policy year. Thus, when written, a claims-made policy can be thought of as retrospective in nature because it covers current claims for past occurrences and those occurring in the current policy year.

A primary difference, then, between the two policy forms is the coverage "trigger." The "triggering event" under the claims-made policy is the filing of a written claim against the

insured. Claims must be filed during the term of the policy. For an occurrence-based policy, the "triggering event" is the occurrence of an incident giving rise to a claim filed either immediately or in the future. The incident must occur during the policy year.

Claims-Made: Technical Provisions

Claims-made policies contain several unique technical provisions. These include

-- the establishment of a date from which coverage begins ("retroactive date");

-- provisions for extended reporting periods ("tail coverage") beyond the policy year; and

-- "laser" endorsements, which allow insurers to exclude coverage for specific events occurring during the prior policy period.

These provisions are discussed below.

Date from which coverage begins

The first day of a one-year claims-made policy is termed the inception date. Claims filed between this date and the expiration date can be honored under the terms of the policy. But when must the incident that gives rise to the claim occur to be covered? The earliest possible date is called the retroactive date. Typically, for an insured's first claims-made policy, the retroactive date will be the same as the inception date.

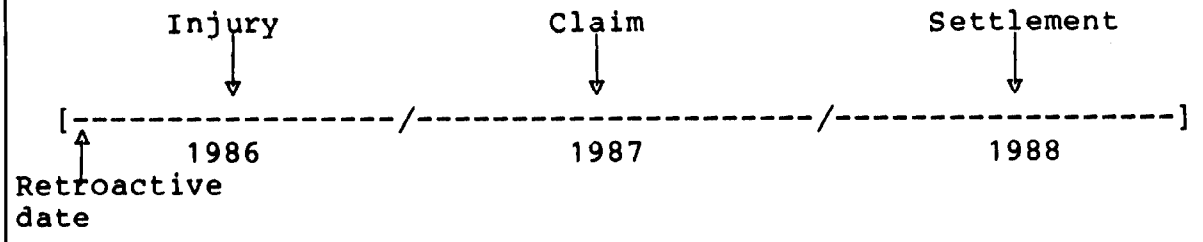
The insured's prior occurrence-based policies would cover claims prior to the inception date, so additional coverage for incidents before that date is not routinely needed. The insured could negotiate an earlier retroactive date, however, were additional coverage deemed desirable. If the insurer agrees to an earlier retroactive date, the claims-made policy would be considered excess over any occurrence-based policies in force prior to the claims-made policy's inception date.

When the insured renews the initial claims-made policy, the inception date of this second policy is the first day of the new policy term. The retroactive date, however, remains the same as on the original policy. As an example, Company A purchases a one-year claims-made policy with an inception date of January 1, 1986, and an identical retroactive date. The next year, Company A renews the policy. The inception date of this policy is January 1, 1987, but the retroactive date remains January 1, 1986. Thus, claims filed during 1987 for incidents occurring during both 1986 and 1987 will be covered by the 1987 claims-made policy.

As the example illustrates, once the retroactive date has been set, annual claims-made renewals using the original retroactive date provide continuous coverage as would annual occurrence-based policies. One important difference, however, is which policy responds to a claim. Continuing the example above, an incident occurring in 1986 that resulted in the filing of a claim in 1987 would be covered under Company A's 1987 claims-made policy. Had Company A purchased successive occurrence-based policies instead, the claim for an incident occurring in 1986 would be covered by the 1986 occurrence policy regardless of when it was reported. (See fig. 1 for a comparison of the two types of CGL policies.)

Figure 1:

Claims-Made Versus Occurrence-Based Insurance Policies: Example of a Covered Occurrence



Assumption: Both the 1986 occurrence policy and the 1986 claims-made policy are renewed in 1987 and 1988 with the same insurer.

Examples:

Occurrence-based policy: The 1986 occurrence policy is triggered because the injury occurred during its policy period. The dates of claims and settlement have no bearing on which policy applies.

Claims-made policy (using the same retroactive date): The 1987 claims-made policy is triggered because the claim was first made against the insured during its policy period. The dates of injury and settlement have no bearing on which policy applies.

Source: Jack P. Gibson, The New CGL Policies: A Guide for Public Agencies (Public Risk and Insurance Management Association, 1985) p. 6.

For claims-made policies, then, only the current year's policy is active and responds to claims. Prior years' claims-made policies are no longer in force. In contrast, an occurrence-based policy remains in force beyond the policy year to handle claims related to that year. Over the course of many years, the number of active, or potentially active, occurrence-based policies would increase. In general, the number of active claims-made policies would always remain at one. The exceptions to this occur when there is a change in the retroactive date, as described below.

Changing the retroactive date

Continuity of coverage is maintained by keeping the retroactive date the same throughout successive policies. Under some circumstances, however, the insurer may move the retroactive date forward in time, creating the potential for a break in continuous coverage. This can happen if the insured

-- changes insurance companies and the new insurer does not agree to maintain the original retroactive date,

-- substantially changes operations, resulting in an increased exposure to loss or damage,

-- fails to provide information requested by the insurer or does not provide known information about the risk that would have been material to the insurer's accepting it, or

-- requests the insurer to advance the retroactive date.

ISO's revisions provide that the insurer may move the retroactive date forward only if the insured consents in writing and acknowledges having been advised of the right to buy extended reporting-period coverage. This coverage is discussed in the next section.

Extended reporting-period coverage

Extended reporting-period coverage (also known as "tail coverage") provides a continuation of coverage for a specific time after an interruption in a claims-made policy. This interruption can be the result of policy cancellation, a change in the retroactive date for one of the reasons discussed above, or a "laser endorsement," discussed in the next section.

There are two types of tail coverage, "basic" and "supplemental." Both apply to claims for only injuries or damages that occur during a policy period. They will, however, cover claims for injuries and damages which occur--but are not reported before the end of the period.

Basic tail coverage is automatic, free of additional charge to the insured, and begins at the end of the policy period when there is an interruption in claims-made coverage. Basic tail coverage has two components:

-- A 5-year tail covers occurrences that took place before the end of the policy period and for which the insured has given the insurer a notice of occurrence no later than 60 days after the end of the policy period. The claim must be filed within 5 years after the end of the policy period.

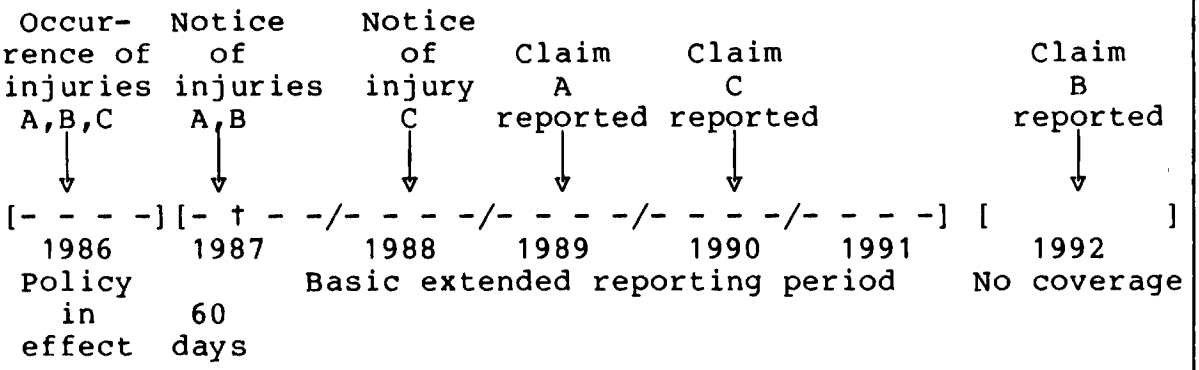
-- A 60-day tail covers claims first known and reported during the 60-day tail period for occurrences that took place before the end of the policy period.

The first component, then, allows 5 years for the filing of claims related to occurrences reported either during the term of the policy or within 60 days of the expiration of the policy. The second component extends to 60 days the time limit for reporting occurrences that could result in a claim. (See fig. 2 for examples of extended reporting-period coverage.)

Figure 2:

Extended Reporting-Period Coverage:
Examples of Covered and Uncovered Occurrences

Assumptions: The insured's first claims-made policy has an inception date of January 1, 1986, with an identical retroactive date. The insurer does not renew it. From another insurer, a subsequent claims-made policy is obtained for 1987 with a new retroactive date. The insured elects not to purchase supplemental reporting-period coverage, so the first insurer must provide only the basic reporting-period coverage. During 1986, three different injuries occur (A, B, and C). The insured provides the insurer with a notice of injuries A and B during the first 60 days of 1987. The notice of injury C is given in 1988. The claim of the third party who suffered injury A is reported by the insured in 1989, claim C is reported in 1990, and claim B in 1992.



Synopsis: Under an occurrence policy, the 1986 policy would cover all three claims. However, as the insured had a 1986 claims-made policy that was not renewed and decided to carry only the "basic" extended reporting-period coverage, only one claim would be covered as follows:

Example 1: Claim A is covered because: (1) notice was given of the injury within 60 days after policy termination, and (2) the claim was filed within 5 years of policy termination.

Example 2: Claim B is not covered, although notice of injury was given within 60 days after policy termination, because the claim was filed more than 5 years after termination.

Example 3: Claim C is not covered, although it was filed within 5 years after policy termination, because the incident was not reported within 60 days after policy termination.

Note: Purchasing supplemental extended-reporting period coverage would allow all three claims to be covered.

Some insureds, of course, may expect to receive claims beyond the time afforded by the basic tails. In these cases, claims-made procedures allow them to purchase supplemental tail coverage, i.e., supplemental extended reporting-period coverage, which provides an unlimited reporting period for claims. ISO's revisions direct insurers to make this coverage available for claims-made customers who experience an interruption in coverage as discussed above. The aggregate dollar limit for such coverage is equal to that of the most recent claims-made policy, and its cost to the insured is capped at 200 percent of the insured's most recent claims-made policy. Essentially, purchase of this supplemental tail converts the claims-made policy to an occurrence policy with aggregate limits. Claims may be made at any time in the future, just as under the terms of an occurrence-based policy, and will be honored up to the amount of the aggregate limit.

Laser endorsements

An insurer may modify a claims-made policy by issuing an "endorsement," which adds to or excludes from a policy a specific provision of the basic CGL forms. For example, an insurer may exclude from coverage specific accidents, products, types of work, or locations. Such an exclusion is known as a "laser endorsement," the name coming from the ability of a laser to excise targeted material without disturbing the rest.

If a laser endorsement is attached to a policy, ISO revisions direct the insurer to provide the basic tail coverage discussed above in relation to the type of incidents that no longer will be covered. The insurer also must make supplemental tail coverage available to the insured. Although the insurer will no longer cover new incidents of the kind that have been deleted from coverage, it has obligations, as discussed in the previous section, for incidents that occurred prior to the endorsement. It should be noted that the upper limit of indemnification for these earlier incidents is the aggregate dollar limit of the most recent claims-made policy. Therefore, coverage for these prior incidents is not unlimited.

A laser endorsement gives the insurer a mechanism to drop portions of coverage when the insurer finds a risk unacceptable because of the potential magnitude of future claims. For instance, during 1986 the employees of Company A are exposed to a cancer-causing agent. Aware of the exposure, the insurer agrees to renew the policy but attaches a laser endorsement to the company's 1987 policy excluding claims related to this type of exposure. While the insurer is obligated to provide the basic tail coverage and offer the supplemental tail coverage, the endorsement affords the insurer the opportunity to limit its liability for future incidents (in this example, involving this cancer-causing agent from 1987 on). The upper limit of this

liability is the aggregate limit of the supplemental tail coverage.

Aggregate policy limits

Aggregate policy limits place a cap on the total amount of award damages an insurer is obligated to pay under a policy. Once the applicable aggregate limit has been paid (whether it takes only one claim or a number of claims to reach that limit), the insurer's liability ends. The insured can cover amounts exceeding the limit through either excess coverage or self-insurance. A related concept, per-occurrence limits, caps the amount of dollar damages an insurer is liable to pay for each occurrence.

While the previous CGL occurrence-based form included limits per individual occurrence for CGL risks, it applied aggregate policy limits of liability only to risks involving bodily injury and property damage arising from products and completed operations. It did not place aggregate limits on the other types of risks (i.e., those falling within the premises/operations category).

Under the previous form, for example, Company A may have had an occurrence-based policy with a per-occurrence limit of $250,000 for all claims other than those for products and completed operations, but no limit on the number of occurrences. Conceivably, the insurer might have had to pay several claims, each up to the $250,000 per-occurrence limit, because there was no aggregate dollar limit.

The new CGL applies aggregate dollar limits to all risks, including those to which it did not apply in the past. It does not change the existing limits (i.e., it maintains the per-occurrence limits), but adds a separate aggregate limit for other risks previously exempt from these limits. Consequently, the aggregate dollar limits cap insurers' liability for claims involving multiple occurrences.

Pollution exclusion broadened

In the past, most CGL policies restricted coverage for pollution to incidents that were both "sudden and accidental." This was intended, according to insurers, to cover instances such as a breach in a hazardous waste impoundment wall that suddenly and accidentally spills waste on neighboring property. Insurers would contend sudden and accidental pollution coverage would not apply to gradual leakage of hazardous waste into a neighboring community's ground water.

As we reported in May 1986,[4] insurers believe the courts have extended liability for pollution incidents that were not sudden and accidental. Because of this unanticipated expansion of liability, insurers have dropped most pollution coverage, according to several insurance groups. The broad pollution exclusion in the new CGL revisions reflects this current industry practice. The new policies do, however, include endorsements that allow insureds to buy back some specific levels of pollution coverage, if they can find an insurer willing to sell them a policy containing the endorsements. For example, an endorsement to the claims-made form could provide some coverage for clean-up costs mandated by a governmental body.

EFFECTS OF REVISED CGL POLICY: INDUSTRY, BUYER VIEWS

Given the recency of the ISO changes, we also asked representatives of insurance organizations and buyer associations to describe possible effects, if any, on insurance affordability, availability, and adequacy of coverage as a result of the changes. As discussed in the previous section, all the organizations we contacted agreed that the most significant changes center around ISO's revised CGL policy forms, especially the introduction of a claims-made policy, the imposition of aggregate dollar policy limits, and the broadened pollution exclusion. As described below, the groups agreed that the changes could help alleviate some of the insurance industry's longstanding problems in predicting potential financial liability for their underwriting risks. They differed, however, in their perceptions of the revised form's possible effects on the insurance buyer in terms of affordability, availability, and adequacy of coverage.

Insurance Affordability

Representatives of insurance buyers and the industry differed in their perceptions as to how insurance affordability would be affected by the CGL changes. Actual claims-made

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[4]Motor Carriers: The Availability of Environmental Restoration Insurance (GAO/RCED-86-150BR), May 1986. An example of this extension provided by insurers is Jackson Township Municipal Utilities Authority v. Hartford Accident and Indemnity Co. 451 A.2d 990 (1982). We note, however, that in this case the court did not extend liability to pollution incidents that were not sudden and accidental. Rather, the court broadly interpreted the sudden and accidental clause to permit coverage when an action was intentional but the resulting injury was unexpected or unintended. See id. at 994.

premiums will vary, due to differences in insurers, customers, and desired packages. Insurer representatives said they believed that the price of claims-made policies would be lower generally than occurrence-based policies. In addition, because insurers' liability has been limited via aggregate dollar policy limits and laser endorsements, insurers may raise premiums less often. Buyer groups, however, believed that claims-made coverage might prove more expensive, given both inflation and the necessity of buying supplemental tail coverage if coverage is interrupted.

ISO representatives told us that the initial claims-made policies will be less expensive than occurrence policies with identical coverage and limits. They said since very few liability occurrences immediately result in claims, the early years of a claims-made program will yield a lower premium than would be incurred through an occurrence program with identical coverage and limits. ISO representatives told us that even considering the premium increases in the later years of a claims-made policy, they anticipated that the premium will always be slightly less than that for an occurrence policy.

Several buyer organizations believe that claims-made insurance is a more expensive form of coverage. Any premium savings to insureds are temporary and somewhat illusory, according to the New York State Insurance Department, because the initial savings are paid for in future higher premiums. Also, costs are likely to escalate if an insured decides to switch insurers. Additionally, insureds believe that, if the new insurer refuses to pick up the original policy's retroactive date (a likely situation), the insured would pay for one year of primary insurance with the new carrier, and, to maintain coverage for the old policy period, supplemental tail coverage--at up to 200 percent of the last policy's premium.

The Professional Insurance Agents and the National Insurance Consumer Organization expressed concerns that the changes will foster anticompetitiveness, leaving the insurance buyer worse off in the long run. According to these groups, insureds may feel "locked in" to renewing policies with their original claims-made insurer because, as discussed above, they may face additional costs for tail coverage if they change carriers.

Price competition among insurers may be reduced considerably, the agents and brokers pointed out. If, as insurers believe, major premium increases slow down, insureds will have little incentive to shop around for another carrier with a better rate.

Insurance Availability

According to ISO and others, insurers will be more willing to offer insurance coverage because of the changes. This is because the industry can better assess a risk's loss potential, enabling it to price premiums more accurately and maintain reserves to reflect those losses. Aggregate dollar limits, which essentially "cap" the maximum potential payout associated with a policy, allow insurers to set premiums in accordance with their maximum potential liability. In addition, because claims-made policies will cover claims filed during the current policy period, the premiums and aggregate limits will more accurately reflect expected claim patterns and changes in the cost of living, ISO and others believe.

As a result of increased ability to predict their financial liability for risks they underwrite, insurers may be inclined to provide coverage for risks previously considered uninsurable, according to several groups. For example, insurers no longer will need to cancel entire policies because of a single incident or operations component. A laser endorsement attached to the policy will exclude from future policies all claims from that single component, thus enabling the insurer to continue to cover the rest of the insured's operations.

Both industry and consumer groups believe that the claims-made policy could increase insurance availability for long-tail risks. In recent years, occurrence policies have been unavailable for some of these risks. A claims-made policy's retroactive nature--covering claims filed within a specific time period for incidents occurring in a specific time period--may induce insurers to offer claims-made coverage for risks, these groups said. This is because they can predict potential exposure and resulting financial liability better in a limited time frame.

At the same time, however, buyer groups were concerned that claims-made coverage, which they view as more limited than occurrence policies, may be the only coverage available. These groups advocated the restriction of claims-made insurance to long-tail or other hard-to-predict risks, while making it optional for other CGL risks. The marketplace will determine the extent to which each of the two new policy forms will be offered and accepted, ISO representatives told us.

Adequacy of Coverage

Representatives of consumer and buyer groups expressed concerns, as did some industry organizations, that insureds, while possibly benefiting in terms of coverage affordability and availability, will find available coverage inadequate for their needs. These concerns ranged from potential gaps in coverage

due to confusion about the new policies to lack of indemnification possibilities for third-party claimants. Most of the groups' representatives focused on the introduction of the claims-made policy to CGL insurance.

The new CGL is confusing, some buyer group representatives believed, and some insureds may experience coverage gaps because they misunderstand the changes. Fears were expressed that insureds would not receive adequate information to assess clearly which of the two forms--occurrence or claims-made--would work best for them. Insureds purchasing a claims-made policy might also be confused as to when and why they might need extended reporting-period coverage. Insureds should be aware, some groups asserted, that the new CGL will require them to either accept more of the risk (through self-insurance, for example) or transfer additional risk to another insurer (such as an excess insurance carrier) to meet their insurance needs.

Some groups have called for industry-sponsored education for both buyers and sellers concerning claims-made coverage, regarding, for instance, the reporting and filing of a claim. They believe insureds are faced with either (1) reporting all normal business activities, because a claim could arise from any business activity, or (2) reporting only specific incidents for which the insured is certain that claims will be filed. The insured could jeopardize future coverage because of (in the first case) an appearance of operations provoking large numbers of claims or (in the second case) under-reporting potential claim-causing occurrences. Adequate clarification of issues such as reporting incidents would allow the buyer to obtain the full coverage value of his policy, these groups' representatives believed.

Excess insurance underwriters will face a huge administrative burden as they implement ISO's changes, according to representatives of the National Association of Professional Surplus Lines Offices, which represents them. Until now, they indicate, excess underwriters have had to track payouts on only limited lines, such as product liability, that carry aggregate limits. Now, however, excess insurers will have to track the primary insurers' payouts for every line of CGL coverage. The group believes this will have two effects: (1) excess insurers will require verifiable loss information on every policy with any propensity towards claims, and (2) the pressure on primary underwriters and the excess market to provide higher underlying limits--regardless of their capacity to do so--will increase dramatically.

Aggregate limits within a claims-made policy provide additional protection to the insurer, according to ISO and others. Because only one claims-made policy is in effect at any one time to cover claims, however, the possibility of exhausting the

aggregate dollar policy limit increases with each policy renewal. How this occurs is illustrated in figure 3.

Figure 3:

Aggregate Dollar Limits in Claims-Made Versus Occurrence Policies: An Example

The insured had the same insurer between 1986 and 1990. Each year's insurance policy had an aggregate limit of $1 million. Between 1986 and 1989, no claims against the insured were reported to the insurer. However, injuries occurred in each year. Claims for 1986 through 1990 are filed in 1990 as follows:

For injuries occurring in	Amount of claims
1986	$1 million
1987	1 million
1988	1 million
1989	1 million
1990	1 million
Total for 1986-90	$5 million

Had occurrence policies been written for the period 1986-90, the insurer would face a $5 million obligation for claims in 1990. If a series of claims-made policies had been written for the same period, the insurer would be required to to pay $1 million--the limit of the claims-made policy in effect during the year in which claims were filed.

ISO representatives stressed that claims-made policy buyers must periodically review the adequacy of their aggregate dollar policy limits to take into account the increased likelihood of claims being filed as the policy is successively renewed.

Although supplemental tail coverage must be offered by an insurer when a policy is interrupted, insureds may have difficulty affording the premiums for both a replacement policy and the supplemental tail. According to the Risk Insurance Management Society and the brokers, insureds would want any subsequent carrier to accept the retroactive date of the first claims-made policy to preclude coverage gaps. There is no guarantee, however, that the subsequent insurer would accept the original retroactive date; some groups noted that it is unrealistic to expect a new insurer to cover "prior acts" for which it provided no risk management expertise. In addition, the New York State

Insurance Department pointed out that insureds may not have sufficient ability, incentive, or wherewithal to purchase supplemental tail coverage.

Because of the uncertainties that insureds may have regarding their coverage, some group representatives believe that the general economy could suffer as insureds may be more wary of providing potentially risky products or services. Some innovative products or services will be kept off the market, they say, if companies believe that neither a claims-made policy nor self-insurance can adequately protect them from potential liability claims.

Third-Party Claimants

Claims-made policy forms increase the possibility that claimants will be without a source of recovery for their losses, according to groups representing consumers and buyers. Under an occurrence form, a third-party claimant has access to an insured's policy for any occurrence during the policy period--regardless of when the claim is made. Under a claims-made form, should an insured leave the business or become insolvent or bankrupt, quite possibly the insured would not purchase tail coverage, thus leaving claimants without a source of recovery.

According to ISO representatives, the imposition of aggregate dollar limits may be an incentive for claimants and insureds to settle claims quickly so as to take advantage of whatever amount of insurance funds are available. The New York State Insurance Department, however, believes there is a possibility of collusion between the insured and third-party claimants to delay filing a claim until limits can be increased upon policy renewal.

CONCLUSIONS

As indicated by our discussions with representatives of various insurance interests, ISO's revised CGL represents a significant departure from traditional insurance industry practice and procedures. Intended to set limits on insurers' liability by moving greater financial risk to the buyers, the changes will affect the interrelationship between the insurer and the insured and may also affect claimants. What the actual effect of these changes will be on the availability, affordability, and adequacy of coverage, it is too early to tell, as CGL policies incorporating these change have been available for less than a year.

The changes have several effects on insurers. From the industry's perspective, the changes should enhance the predictability of both exposure and financial loss. Through aggregate policy limits, a ceiling on financial risk has been established for insurers' liability. Laser endorsements and the pollution exclusion protect them from exposure to potentially large loss situations. The claims-made policy form allows insurers to adjust premiums according to recent claims experience (the prior year's) and sets a discrete time frame around claims covered. The form also limits risk exposure to a single policy as only one such policy is in effect at any time. Enhancing the predictability of exposure and loss means that insurers can more accurately set premiums in relation to losses.

The bounding of risk exposure for insurers means that more responsibility for risks should rest with the insureds. Responsibility for any risk exposure not covered by insurers would fall to insureds, who must handle it in other ways. Businesses may choose to self-insure, purchase additional coverage from other sources, or curtail lines of business in which affordable coverage is deemed inadequate.

The decisions about insurance that businesses will have to make will be far more complex than they were prior to these changes. Insurers will need substantially more knowledge about insurance and risk management to make appropriate decisions about coverage. Businesses will have to decide between traditional occurrence-based coverage and the new claims-made form. The newness and complexity of the claims-made form means that options must be carefully assessed before an informed decision about the appropriate type and level of coverage can be made.

Aggregate policy limits will require insureds to make decisions about the upper limits of coverage they need. Excess coverage and self-insurance may be needed to augment their CGL coverage.

ISO's revisions mean that insureds should be attentive to their extent of risk exposure and careful to select CGL coverage that is adequate for their situations.

The extent to which ISO's revisions affect claimants depends on the set of decisions made by insureds about the level and scope of CGL coverage they need. If insureds maintain insurance coverage at adequate levels and of a type appropriate to cover their risks, claimants should have a source from which to recover losses. However, if they do not maintain coverage at adequate levels or fail to purchase tail coverage when there is a break in the continuity of claims-made coverage, claimants could be without a source of recovery.

The changes seem to increase the chances that some claimants may have little or no recovery. First, a company's desire to conserve resources could lead it to make decisions to purchase less coverage than needed and/or coverage inappropriate for its types of risk exposure. If, for example, an insured's aggregate limit on CGL coverage is exhausted and neither self-insurance nor excess coverage is available, a claimant may have difficulty recovering losses. Second, the claims-made policy places responsibility for purchasing coverage for claims arising in the future on the insured. If for some reason this coverage is not purchased, claimants could have little likelihood of recovering losses. For instance, recovering losses from a bankrupt firm that did not purchase supplemental tail coverage at the end of its last claims-made policy period would be highly unlikely.

Of the three changes, aggregate policy limits may well have the most pervasive effect. They will apply to all new CGL policies. At renewal, then, businesses will be confronted with a need to assess their needs for aggregate coverage to a greater degree than previously, and insurers will have established an upper bound on their liability. The impact of the claims-made policy depends on the degree to which it is adopted by insureds. During competitive market periods, occurrence-based coverage most likely will be available and affordable and claims-made coverage may not capture a large market share. During tight insurance markets, however, claims-made policies may become more prevalent.

The possibility of measuring the actual effects of the changes on claimants' ability to recover losses is years away. These impacts can be measured only after insureds have set patterns of CGL coverage and sufficient time has elapsed to allow data on both short-term and long-tail claims to be examined.

BROAD FORM ENDORSEMENT COVERAGES[1]

The Insurance Services Office's revised CGL policy now applies basic coverage to the following types of risks, labeled broad form endorsement coverages. The insured no longer need purchase a separate endorsement to be covered for these risks.

1. Additional persons insured (employees). Extends liability coverage to spouse(s) and employees of the named insured(s).

2. Automatic coverage, newly acquired organizations. Automatically extends coverage for 90 days to include newly acquired organizations.

3. Blanket contractual liability. Extends the meaning of incidental contract to include any contract unless specifically excluded.

4. Broad form property damage liability. Partially covers damage to property in the care, custody, or control of the insured and damage to work performed by or on behalf of the insured.

5. Extended bodily injury. Broadens the definition of occurrence to include any intentional act by the insured resulting in bodily injury if such injury arises solely from the use of reasonable force to protect persons and property.

6. Fire legal liability. Furnishes coverage for the named insured's liability for damage to rented or leased property caused by fire if the insured is found negligent.

7. Host liquor liability. Clarifies that insureds who occasionally sell or give away liquor at social events are covered for any resulting liability.

8. Incidental medical malpractice liability. Provides medical malpractice liability coverage for insureds not engaged in a medical, surgical, or drug-related business or occupation.

9. Limited worldwide liability. Extends the definition of policy territory to include, in addition to product liability, worldwide coverage for liability arising from bodily injury, property damage, or advertising injury.

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[1]The coverage definitions are adapted from Robert I. Mehr, Fundamentals of Insurance (Homewood, IL.: Richard D. Irwin, Inc., 1983), p. 204.

10. Nonowned watercraft liability. Furnishes liability coverage for watercraft under 26 feet long and not owned by the insured.

11. Personal injury and advertising injury liability. Adds coverage for these liability exposures.

12. Premises medical payments. Provides coverage for medical payments for injuries sustained on the covered premises.

ORGANIZATIONS CONTACTED FOR GAO STUDY

Alliance of American Insurers. A trade association representing 175 property/casualty insurance companies (primarily mutual companies).

American Insurance Association. A trade association representing over 170 property/casualty insurance companies (predominately public stock companies).

Insurance Information Institute. A nonprofit information office sponsored by the insurance industry.

Insurance Services Office. The largest advisory rating organization for property/casualty insurers in the United States. ISO develops and makes available rating, statistical, actuarial, policy forms, and related services to any insurer. There are no requirements that insurers adhere to ISO's advisory rates or policy forms.

National Association of Independent Insurers. A trade association representing more than 500 property/casualty insurance companies.

National Association of Insurance Brokers. A trade association of commercial insurance brokers.

National Insurance Consumers Organization. A nonprofit consumer organization primarily engaged in educating consumers about personal lines of insurance. It also tracks developments in the property/casualty field.

New York State Department of Insurance. The state agency that oversees the insurance industry operating within the state of New York. The department has held hearings and extensively analyzed the new CGL policy.

Professional Agents of America. A professional association representing property/casualty insurance agents.

Public Risk Insurance Management Association. A professional association representing the public sector purchasers of liability insurance, such as the risk managers for state and local government units.

Reinsurance Association of America. A trade association representing reinsurance companies (i.e., companies that insure primary property/casualty insurers).

Risk and Insurance Management Society, Inc. A professional association primarily representing the corporate sector purchasers of liability insurance, such as the risk managers for businesses.

GLOSSARY

Aggregate dollar limit. The maximum dollar limit of coverage available for payment of claims.

"Cash-flow" underwriting. The practice of generating large amounts of net cash flow for investment purposes by accepting lower premiums to encourage sales.

Claimant. The party making formal demand for payment for a loss construed to be covered under the terms of an insurance policy.

Claims-made policy. A policy under which the insurer has responsibility for only those claims filed during the policy period. The policy period is defined by a set retroactive date (the first day on which a policy is effective) and tail coverage, the amount of which varies from 5 years (under ISO's CGL revisions) to an indefinite period of time (under other policy forms).

Commercial general liability. Liability for a broad range of business risks. CGL policies cover contractual liability, products and completed operations liability, structural alterations, new construction and demolition operations, ordinary repairs or maintenance, and additional premises and operations not present when the policy was written.

Endorsement. A written form modifying a policy to meet special conditions, change policies in effect, or complete a policy.

Excess insurance. Coverage against loss in excess of coverage provided under another insurance contract.

Exposure. (1) State of being subject to the possibility of a loss or (2) extent of risk as measured by payroll, gate receipts, area, or other standard.

Insured. An individual or organization protected in case of loss of property or life under the terms of the insurance policy.

Liability. The probable cost of meeting an obligation.

Long-tail. The long period of time that may elapse after an injury occurs before a claim is filed and settled (also called "long-latency").

Occurrence-based policy. A policy under which the insurer has responsibility for covering claims filed in relation to injuries that occur during the policy period, regardless of when the claim is made.

Primary insurance. Insurance providing coverage up to a specified amount or against specific perils.

Professional liability. Liability arising either from a professional's faulty services or failure to meet the standard of service expected under the circumstances.

Risk. A person or thing insured or the uncertainty as to the outcome of an event when two or more possibilities exist.

Tail. A period of time beyond the expiration of a policy period, during which a claim may be submitted for incidents occurring during the policy period.

Tort reform. Changes in tort law that center on fault, causation, damages, and transaction (i.e., legal) costs.

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