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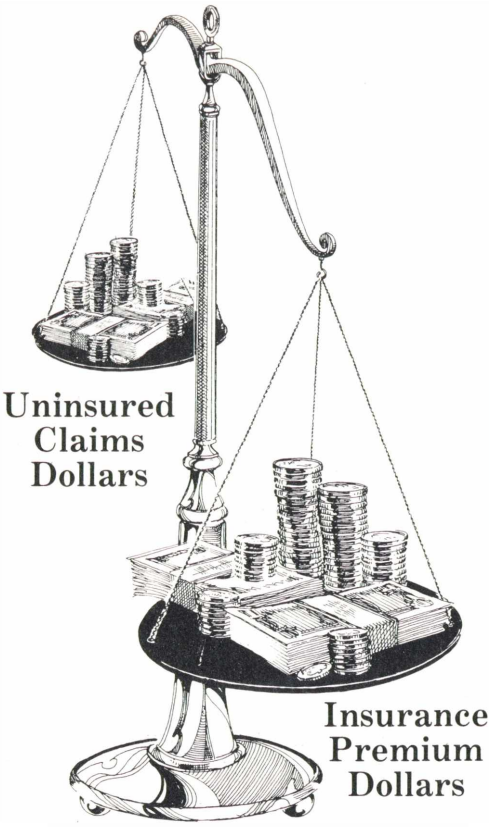

Risk Management: Balancing the Costs

Requiring Insurance Disclosure

By Frankie Gurganus and Charles L. Holley

The Accounting Standards Executive Committee (AcSEC) of the American Institute of Certified Public Accountants (AICPA) recently issued the Report of the Task Force on Disclosure of Insurance. According to the issues paper initially presented to AcSEC by the task force, disclosure of insurance coverage should be **required**; according to the final report, disclosure is "encouraged, but not required" [Task Force, p. 2, 1987]. Before examining the report of the task force and other relevant accounting pronouncements, the circumstances that led to the issue of insurance coverage disclosure will be discussed.

Liability Insurance Crisis

Liability insurance is currently at a crisis level in the United States. For many companies, availability of insurance is limited. For other companies, coverage has been reduced and/or restricted. Some insurance, such as pollution liability, is almost nonexistent. The liability coverage that is available is so expensive that many companies cannot afford it. Premium increases have ranged from 50% to 1,000% in some cases [Bader, p. 112, 1986]. For example, FMC Corporation had premium increases of 350% in 1985 for less than one-half the coverage received in 1984. This costly coverage was what was found to be the best available following FMC's search for alternatives in the worldwide insurance market [Malott, p. 10, 1986].

Companies and consumers alike find themselves involved in the liability insurance crisis. Companies pay through increased premiums and increased exposure to risks. Consumers pay through increased product costs and through reduced availability of desired products and services.

Factors Contributing to the Crisis. Insurance price wars throughout the late 1970s and early 1980s, the litigious attitude of many people, the United States tort system, the contingency fee system, escalating judgments and the general broadening of the scope and definition of liability by the courts are all factors which have contributed to the crisis in the liability insurance industry.

Many insurance companies had excess capital in the late 1970s. These excess funds often led to premium price cutting in order to increase market shares [Sinnott, p. 56, 1987]. High prevailing interest rates also contributed to decisions involving price cutting. Insurance companies expected to pay claims out of the high interest earnings, but interest rates started to decline while claims escalated. Property and casualty insurance companies lost $2.9 billion in 1984, $5.5 billion in 1985, and an estimated $22 billion in 1986 [Farrell, p. 88, 1986; Sinnott, p. 57, 1987]. The industry is projected to lose $62 billion in commercial liability in the next five years [Hackenburg, p. 3, 1987].

The litigious mindset of the American public is also partially responsible for the insurance crisis. In 1984, 16.6 million private civil suits were tried in federal courts. This represented an average of one civil lawsuit filed for every 15 Americans [Collins, p. 57, 1985].

The tort system frequently allows individuals to sue for trivial matters. Suits are brought even when the victim sometimes shares the fault. Too, the legal system awards damages not only for economic loss but for pain and suffering as well. Punitive damages may also increase the award. The tort system judgments have reached a point that Lloyd's of London has indicated that it might withdraw from the U.S. market if tort law reforms are not passed [Malott, p. 10, 1986].

Liability insurance is currently at a crisis level in the United States.

Most states have adopted some type of tort reforms, such as limiting the damages awarded and/or making liability several but not joint. Also, Congress is giving consideration to at least ten tort reform bills. The purpose of many of these bills is to provide uniform product liability among the States. Placing limits on economic and noneconomic loss awards, reducing lawyer contingency fees, making liability several but not joint, setting statutes of limitation, and providing guidelines for settlement are some of the ways the

various bills address tort reform. These changes will reduce the right and/or incentive to sue but will not totally solve the insurance problem.

The contingency fee system for determining lawyers' fees is also an important factor in the insurance crisis. This practice lessens plaintiffs' financial risks and possibly encourages even more suits since awards often reach a million dollars or more and attorney fees are based on percentages of the judgments.

Escalating judgments by juries are also partly to blame for the insurance crisis. According to the Jury Verdict Research Institute, multimillion dollar claims increased from 25 in 1975 to 450 in 1985 [Gahin, p. 48, 1987]. For example, Ford Motor Company had projected death benefits to be $200,000 per accident in lawsuits related to the Pinto automobile. Awards were so much higher (one as high as $12 million — later reduced to $6.7 million) that Ford was forced to recall the Pinto [Farrell, p. 89, 1986]. An article published in *Business Week* reported similar costly judgments: "A. H. Robins Co. filed for Chapter 11 protection after paying out $530 million to settle 9,500 claims against its Dalkon Shield intrauterine device, with 6,000 claims still pending. Union Carbide Corporation faces billions of dollars in suits for the toxic-gas leaks at its plant in Bhopal, India" [Farrell, p. 89, 1986].

The broadening definition and scope of liability as interpreted by the courts is another reason for the insurance crisis. The application of joint and several liability, as well as strict liability for products, has expanded the scope of liability. Also, the courts often have provided liberal interpretations of policy terms that favor the policyholder.

These factors have made it difficult for insurers to estimate losses and set premiums. As a result, rates have been increased, liability limits have been lowered, coverage has been reduced, claims-made policies are replacing occurrence policies, and in some cases, insurance companies are going out of business.

Current Practices

Businesses today are absorbing and financing more risks than ever before because of the lack of affordable and/or available liability insurance. Companies that cannot afford the high premiums are being forced to turn to claims-made policies, some form of self-insurance and risk management, or captive insurance companies.

Claims-Made Policies. Traditionally, insurance policies have been "occurrence" policies. An occurrence policy covers liability for any claims that take place during the time that the policy is in effect, regardless of when the claim is made. The insurer's obligation is indefinite.

The litigious mindset of the American public is also partially responsible for the insurance crisis.

By contrast, "claims-made" policies cover only liabilities for claims that occur and **are filed** during a policy year. There is no coverage for a claim filed after the policy period. Because of the typical delay in making claims, a company could find itself without coverage if it changes insurers or if insurance is canceled from year to year. For protection against claims that might be brought in the future, a company must buy additional "tail coverage" insurance which costs about three times as much as a claims-made policy [Brown, p. 60, 1986]. Included in a claims-made policy is a general aggregate limitation on claims under the policy.

A liability policy usually has two limits: (1) a maximum amount that the insurer will pay for a single occurrence and (2) a total amount that the insurer will pay for all occurrences in one year. A claims-made policy has an aggregate limit on claims for all coverage under the policy. Under this kind of policy, one accident claim brought under a section of the policy could be large enough to exhaust the aggregate limit, leaving the company uninsured for the rest of the year. Drug, chemical, and heavy manufacturing firms — firms with long tail exposure for settling claims and large settlements — are targets for the new claims-made policies.

Self-Insurance. As an alternative to purchasing claims-made policies, many companies are becoming self-insured. Some companies retain all of the risks; others self-insure for frequent, predictable losses and purchase insurance for catastrophic losses.

Basically, a self-insured company views the payment of claims as the same as paying insurance premiums. Richard M. Page, chairman and chief executive officer of insurance broker Fred S. James & Co., projects that "by 1989 at least a third — and maybe as much as a half — of the commercial insurance market could be covered by self-insurance and captives" [*Business Week*, p. 112, 1986].

The problem with self-insurance is that the company may underestimate the frequency and severity of losses, thus assuming more risk than anticipated. Also, excess and umbrella coverage may not always be available because underwriters may be reluctant to provide excess coverage to self-insured companies.

Captive Insurance Companies. Congress passed the Product Liability Risk Retention Act of 1981 in response to the decrease in available product liability coverage that occurred during the late 1970s. The act allowed product manufacturers to form risk retention groups. Risk retention groups, or captive insurance companies, are entities that provide liability coverage for companies in a given business or with similar risks. The act allowed the groups to form offshore entities (for example, in Bermuda) and sell product liability coverage onshore if they met one state's capitalization requirement. The captive insurance company was to be regulated by the state in which it was chartered [Riley, p. 62, 1986].

Businesses today are absorbing and financing more risks than ever before because of the lack of affordable and/or available liability insurance.

The Risk Retention Act of 1986 expanded the 1981 act to include commercial liability coverage. Companies in the same business or with similar risks can form an insurance company to provide themselves with commercial liability coverage. The insurance company must be licensed under the laws of at least one state and provide coverage for its members only. Risk retention groups are not subject to certain Securities and Exchange Commission requirements and other regulations in solicitation of funds for capital and surplus. Groups operating out of state are not subject to guaranty fund assessments or assigned risk pools. Therefore, they are not eligible for state insurance insolvency funds which pay claims if an insurer folds [Hackavy, 1987].

Risk Management. Because of the retention of more risk than ever before, many companies are placing an emphasis on risk management. In the past, risk management consisted of buying insurance to cover the risk of loss and implementing an employee safety program to reduce internal claims. Today, a risk management program must involve much more than that. It must identify the risks throughout the organization, recommend ways to eliminate or reduce the risks, and determine ways to finance the losses from risks that cannot be eliminated. In these times of high cost and limited or unavailable coverage, many companies are making risk management a major concern. According to an article in *Risk Management*, "the design of an insurance/self-insurance program has important cost implications in risk, cash flow, taxation, cost stability, and profits, to name but a few areas" [Best-Devereux, p. 32, 1985].

Relevant Pronouncements

Concepts relevant to the disclosure of self-insurance are found in current accounting pronouncements and other references, even though none of these sources explicitly requires disclosure. FASB Statement of Financial Accounting Standards (FASB) No. 5 requires disclosure of a loss contingency that is reasonably possible or a loss that is probable but for which no estimate can be determined. It does not require disclosure of uninsured risks "[b]ecause of the problems involved in developing operational criteria for disclosure" [AICPA, p. 4, 1986]. Those problems still exist, but today's insurance environment has increased the risks for uninsured or underinsured companies.

The objective of financial reporting, according to FASB Concept Statement No. 1, is to provide users with information that will help them to assess the amounts, timing and uncertainties of a firm's future cash inflows. Information about factors affecting a firm's liquidity or solvency, as well as disclosure of significant uncertainties, should be provided [Task Force, p. 14, 1986].

The Securities and Exhange Commission (SEC) requires that uncertainties that materially affect a firm's liquidity, capital resources and/or results of operations, "or that are reasonably expected to materially affect income from continuing operations" be disclosed [Hackavy, p. 9, 1987]. Firms registering for initial public offerings are required to provide information about the high-risk factors of the current or proposed business. These requirements exceed the requirements of generally accepted accounting principles applicable to the usual financial statements [AICPA, pp. 15-16, 1986].

AcSEC recently issued a Statement of Position, *Accounting for Asserted and Unasserted Medical Malpractice Claims of Health Care Providers and Related Issues*. AcSEC's position is that a health care provider's malpractice coverage is significant to an understanding of its financial statements. Thus, the statement requires that uninsured asserted and unasserted medical malpractice claims that cannot be estimated be disclosed as a contingency as required by FASB Statement No. 5 [AICPA, SOP, pp. 8-9, 1983; Holley, p. 58, 1985].

Due to the concern about insurance coverage, early in 1986 AcSEC established a Task Force on Disclosure of Insurance. In the issues paper presented at the October 2, 1986, meeting of the AcSEC, the Task Force concluded that "if a reporting entity is exposed to risks of loss relating to torts; theft of, damage to, expropriation of, or destruction of assets; business interruption; errors or omissions; injuries to employees; or acts of God, but has not transferred such risks to which it is exposed to unrelated third parties through insurance, disclosure of such circumstances should be required" [AICPA, p. 19, 1986].

The Task Force also considered the issue of whether to require disclosure "only when it is at least reasonably possible that (a) the risk could result in an event that is **material** as defined in FASB Concepts Statement No. 2, or (b) the risk could result in an event that could have a **severe impact** on an entity's future cash flows or results of operation."

> **Severe Impact** is defined as one that is disruptive to a business enterprise. Disruptions include, for example, substantial disposition of assets, restructuring of debt, forced revisions or curtailment of operations, or major changes in the reporting entity's revenue or cost structure. A severe impact does not necessarily threaten an enterprise's continued existence, but it may. The concept of **severe impact** differs from the concept of **materiality** in that matters that may be important enough to influence a user's decision (and are therefore material), may not be so significant as to disrupt an enterprise. For example, some items are material to an investor because they might affect the price of the enterprise's stock (such as a modest decline in net income), but they would

Companies in the same business or with similar risks can form an insurance company to provide themselves with commercial liability coverage.

not necessarily have a severe impact on the enterprise itself [AICPA, p. 23, 1986].

Six of the Task Force members believed that disclosure should be required "only when it is at least reasonably possible that the risk could result in an event that could have a **severe impact** on an entity's future cash flows or results of operations" [AICPA, p. 25, 1986]. They did not consider it necessary to disclose risks "only when it is at least reasonably possible that the risk could result in an event that is **material** as defined in FASB Concepts Statement No. 2" [AICPA, p. 26, 1986].

The final Task Force report approved by the AcSEC in July 1987 concluded:

> Publicly held entities and entities with public accountability, such as governments, are encouraged, but not required, to disclose circumstances in which
>
> a. They are exposed to risks of future material loss related to
>
> i. Torts,
>
> ii. Theft of, damage to, expropriation of, or destruction of assets,
>
> iii. Business interruption,
>
> iv. Errors or omissions,
>
> v. Injuries to employees, or
>
> vi. Acts of God, and
>
> b. Those risks have not been transferred to unrelated third parties through insurance [AICPA, pp. 2-3, 1987].

In essence, AcSEC did not fully support the conclusions of the task force for required disclosures; AcSEC believed such disclosures would be too complex and voluminous to be meaningful to users of financial statements. Moreover, AcSEC expressed concern that "required disclosures of the kind recommended by the task force would involve consideration of a multiplicity of factors, none of which provides an objective way to evaluate risks" [AICPA, p. 5, 1987].

Recommendations

In today's business environment, disclosure of risk management via insurance should be required for publicly held firms, not just encouraged. High premiums, unavailability of insurance, and reduced or restricted coverage have forced many companies to accept more risks than ever before. Increased litigation, the expanding scope of liability, and escalating judgments have increased the risk that many companies will encounter large losses. Moreover, punitive damages may not be covered by insurance. Both uninsured or underinsured companies may face losses that have a severe impact on their operations. One of the principal objectives of accounting, as stated in FASB Concepts Statement No. 1, is to enable financial statement users to assess future cash flows and results of operations. If insurance coverage is disclosed, users of financial statements could make an assessment of the exposure to noninsured risks. Risks of loss are important to various financial statement users such as investors, creditors, regulators, managers and auditors.

The problem with self-insurance is that the company may underestimate the frequency and severity of losses, thus assuming more risk than anticipated.

The following disclosures should be required of public companies. The suggested disclosures are objectively determinable and are not more complex or voluminous than many other currently required disclosures. Consistent with existing reporting requirements, these insurance disclosures should be required as supplemental information for periods covered in the financial statements:

- Insurance premiums paid
- Amount of insurance coverage by major risk categories
- Description of coverage, e.g., claims-made or occurrence-based policies
- Amount of claims settled and payments made under deductible provisions
- Amount of recoveries from insurance companies or other parties

Summary

Insurance can no longer be viewed simply as an expense; it has become an integral part of corporate financial strategy. SEC rules require disclosure about uncertainties that affect a firm's liquidity, capital resources and/or results of operation. FASB Statement of Concepts No. 1 supports the disclosure of significant uncertainties and information about factors affecting a firm's liquidity or solvency. FASB Statement No. 5 requires disclosure of a loss contingency that is reasonably possible or a loss that is probable but for which an estimate cannot be determined. For uninsured or underinsured companies in today's business environment, loss contingencies due to commercial liability are reasonably possible and such losses affect liquidity and/or results of operations.

The SOP-Medical Malpractice Claims issued by the AcSEC of the AICPA requires health care providers to disclose malpractice coverage. The need for disclosure of insurance for other industries, especially toxic-waste, chemical, oil, and pharmaceutical companies, is just as great as it is for health care providers.

For many companies, self-insurance is no longer a matter of choice.

Consequently, it is desirable to require specific disclosures in order to provide investors with information necessary to assess the prospective cash flows of a company, as recommended by FASB Statement of Financial Accounting Concepts No. 1, and to meet the general intent and specific requirements of FASB Statement No. 5.

AcSEC revised the approach so that certain disclosures would be "encouraged" or recommended but not required.

The AICPA Task Force on Disclosure of Insurance recommended that certain financial statement disclosures regarding insurance be required. However, the AcSEC revised the approach so that certain disclosures would be "encouraged" or recommended but not required. This paper suggests that the AcSEC approach does not go far enough and proposes that certain insurance disclosures be required of all public companies. These disclosures are objectively determinable and should not prove unreasonably burdensome since they are not more voluminous or complex than many currently required disclosures. Ω

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