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CONTENTS

ARTICLES

NOTES AND COMMENTARIES

BOOK REVIEW

INSURANCE PRIVATIZATION IN COSTA RICA: LESSONS FROM LATIN AMERICA WITH SPECIAL REFERENCE TO URUGUAY

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TABLE OF CONTENTS

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> *Thanks to 50 years of domestic tranquility, they call [Costa Rica] . . . the Switzerland of Central America. But with lavish government benefits and a sprawling public sector, Costa Rica is more like a Latin Sweden. It must slip these statist shackles if it hopes to grow beyond its status as a tourism and retirement Mecca.*[1]

INTRODUCTION

In recent years, many developing countries have undergone significant economic reform. This is mainly a consequence of the economic order in place for the last two decades, one that has seen a consolidation after the fall of the Berlin Wall. Central, state-run economies, slowly but surely, have been replaced by market economies, where private sector participation has been marked.[2]

In this context, the privatization of government enterprises has occurred at a remarkable rate. For Russia and the Eastern European nations, large-scale economic reform and mass privatization have been fairly commonplace.[3] The same can be said for other former Soviet republics, now part of the Commonwealth of Independent States.[4] These

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1. Deroy Murdock, Editorial, *A New Man for a New Costa Rica*, WASH. TIMES (D.C.), May 8, 1998, at A23, *available at* 1998 WL 3447344.

2. The ideal world economy is a competitive economy. But because a system cannot be competitive without an adequate number of participants, it is necessary to integrate developing countries into a single world economy in order to achieve the desired level of competition within the global economic system.

   Currently, most developing countries are not fully integrated into the world economy because most such countries lack the efficiency and productivity required for full participation in the global market. Yet, despite their relative lack of progress to date, many developing countries are currently moving away from a centralized government and toward a market economy in an effort to become more efficient and productive.

Kim Reisman, *The World Bank and the IMF: At the Forefront of World Transformation*, 60 FORDHAM L. REV. S349, S349 (1992) (footnotes omitted).

3. Yuliya Mitrofanskaya, *Privatization as an International Phenomenon: Kazakhstan*, 14 AM. U. INT'L L. REV. 1399 (1999). The author describes the market reform and privatization schemes employed in Russia, Poland, and the Czech Republic, in addition to focusing on Kazakhstan's economic reforms.

4. *Id.*

processes have continued in recent years.[5] Latin American has been no exception to such economic reform.[6] Although the reform process there began as early as the 1970s in countries such as Chile, the most significant developments have occurred in the 1990s.[7]

In terms of financial services and insurance reform, most developing countries have underdeveloped insurance sectors, mainly for regulatory and economic reasons.[8] Specifically, low levels of income and wealth and restrictive regulations inhibit the supply of insurance services.[9] Thus, many countries have begun processes to reform their insurance industries.[10]

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5. *See, e.g.*, Janet Belkin & Jerry Warshaw, *India, Costa Rica and Brazil Move Toward Privatization*, BEST'S REV. – LIFE-HEALTH INS. ED., July 1, 1996, *available at* 1996 WL 8831424 (stating that "[e]very year we see new markets and new opportunities for expanding insurance businesses. However, some economies still support a state insurance monopoly. . . . The insurance industries in India . . . and Costa Rica are examples of such monopolies. However, external pressure has begun to encourage them to move toward a more open an genuinely competitive market.").

6. *See generally* INTER-AMERICAN DEVELOPMENT BANK, PRIVATIZATION IN LATIN AMERICA (Manuel Sánchez & Rossana Corona eds., 1993) (commenting and comparing the privatization experiences of Argentina, Chile, Colombia, and Mexico); José Antonio Ocampo & Roberto Steiner, *Foreign Capital in Latin America: An Overview*, FOREIGN CAPITAL IN LATIN AMERICA 30 (José Antonio Ocampo & Roberto Steiner eds., 1994) (noting, in regard to Argentina, Chile, Colombia, and Mexico, that countries "have moved or are moving toward economic structures in which the dominant role is played by the private sector."); Miguel Urrutia, *Conclusions*, INTER-AMERICAN DEVELOPMENT BANK, LONG-TERM TRENDS IN LATIN AMERICAN ECONOMIC DEVELOPMENT 164 (Miguel Urrutia ed., 1991) (concluding, *inter alia*, that governments in Latin America "have discovered through bitter experience the ineffectiveness of many types of intervention and are therefore allowing markets to function more freely.").

7. By the early 1990s it was clear that Latin American and Caribbean economic reforms would create many opportunities for foreign investors, especially for investors from the United States. *See, e.g.*, Latin American and Caribbean Economic Reforms (Part 1), LA-C Business Bulletin U.S. Dept. of Commerce, March 1, 1992, *available* at 1992 WL 2494294; Latin American and Caribbean Economic Reforms, Latin America Opportunity Report Penny Hill Press, May 1, 1992, *available at* 1992 WL 2410096 (both stating that by then many governments in the region had initiated liberalization measures designed to generate economic growth, attract foreign investment, and reverse the economic difficulties engendered by past protectionist policies).

8. *See, e.g.*, DIMITRI VITTAS, THE WORLD BANK GROUP, SEQUENCING SOCIAL SECURITY, PENSION, AND INSURANCE REFORM 1 (1995).

9. *See, e.g.*, MARTIN F. GRACE & MICHAEL M. BARTH, THE WORLD BANK GROUP, THE REGULATION AND STRUCTURE OF NONLIFE INSURANCE IN THE UNITED STATES (1993).

10. *Id.*

This Article comments on Costa Rica as an example of one such country undergoing insurance reform. In Part I, this Article explores the issue of privatization in a general context. The first section refers to the privatization question from a conceptual approach and attempts to explore its goals and objectives. Part I also discusses privatization's prerequisites and preferred techniques, comments on the special problems posed by state-owned enterprises (SOEs) that operate a monopoly, and outlines general lessons of privatization. Emphasis is also placed the pros and cons of privatization in assessing its success. Section II of Part I discusses generally the privatization experiences of Argentina, Brazil, Chile and Mexico, and comments on selected issues from each of those countries' processes. The third and final section of Part I refers specifically to Uruguay's experience in privatizing its insurance sector in the early- and mid-1990s.

Part II of this Article focuses on the privatization of insurance in Costa Rica. The first section lays out a brief history of insurance in Costa Rica, including commentary on that country's legal framework for insurance. The second section of Part II describes the basic aspects of the insurance reforms proposed in Costa Rica, including specific reference to the proposed legislation being discussed in Costa Rica's Legislative Assembly and the problems it is meant to remedy, according to the Costa Rican government. The third and final section of Part II contains conclusions as to how the privatization experiences of Latin America generally, and Uruguay in particular, may aid Costa Rica in structuring its impending insurance reform.

I. THE PRIVATIZATION OF INSURANCE AND THE LATIN AMERICAN EXPERIENCE

A. Privatization: General Notions

In order to place the discussion of Costa Rican insurance privatization in the appropriate context, this section includes: (1) a general background on privatization, and (2) a description of the benefits and costs of privatization.

1. A General Background on Privatization

The term "privatization" is one that is used quite frequently. A truly in-depth analysis of all things that sound in privatization would consume (and, in fact, does consume) many books. In order to place the Costa Rican

dilemma of insurance privatization in the appropriate context, this subsection briefly comments on: (a) defining privatization and its goals; (b) the prerequisites and preferred techniques or methods of privatization employed; (c) the specific issue of SOEs that operate monopolies; and (d) the lessons that have been learned so far.

a. Defining Privatization and Its Goals

"Like so many concepts that elicit unquestioning adherence by the millions and equally uncritical rejection by a like number of others, 'privatization' lacks an easily rendered definition . . . ."[11] In effect, because privatization is such a broad concept, it stands for many different things in many different contexts. The most important common thread of the privatization boom is simply a change in the philosophy about the proper role of the State.[12] It is also said that, historically, countries have had a sort of pendulum oscillation between nationalization and privatization, and that this corresponds to a society's pursuit of balance between its "outward-looking" and "inward-looking" natures.[13]

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11. Maxwell O. Chibundu, *Law and the Political Economy of Privatization in Sub-Saharan Africa*, 21 MD. J. INT'L L. & TRADE 1, 5 (1997).

12. *See, e.g.*, *Latin American Financing*, 18 N.Y.L. SCH. J. INT'L & COMP. L. 41, 46 (1998); *see also* RUMU SARKAR, DEVELOPMENT LAW AND INTERNATIONAL FINANCE 145 (1999) (commenting that "[m]ost importantly, perhaps, the privatization process can be instrumental in transforming the role of the state from that of being a provider of goods and services to being a regulator of commerce and private enterprise.").

13. SARKAR, *supra* note 12, at 146, 148, 149. Sarkar points out that privatization usually follows periods of social disillusionment with ideals of collective development goals sought through nationalization, and that it leads to a "retreat to the private pursuit of material gain." *Id.* However, Sarkar emphasizes that privatization and nationalization cannot be equated, respectively, with idealism and self-interest. *Id.* (quoting Amy Chua, *The Privatization-Nationalization Cycle: The Link Between Markets and Ethnicity in Developing Countries*, 95 COLUM. L. REV. 226, 227 (1995)). Sarkar further notes that:

> [a]lthough for many Western policy-makers nationalization is inextricably intertwined with the idea of socialism, this association can be very misleading. . . . [F]or most developing countries, nationalization was not directed at bringing about a Marxist revolution, but rather was aimed at two completely different goals: to end foreign economic domination and control of economic assets and to achieve economic self-sufficiency.

Id. at 148 (footnotes omitted). Other authors indicate that "nationalization is an obvious sign of socialist development." Andrei A. Baev, *Civil Law and the Transformation of State Property in Post-Socialist Economies: Alternatives to Privatization*, 12 UCLA PAC. BASIN L.J. 131, 134 (1993).

As noted above,[14] in recent years privatization has swept across the globe.[15] Despite that trend, some commentators believe that little attention has been devoted to asking fundamental questions about privatization.[16] There are, however, clear indications of the policies that have made the pendulum oscillate once again towards privatization.

Some argue that privatization is a reaction to the failure of development models based on import substitution and state control of the productive sectors.[17] In addition, it refers to the increase in the integration of national economies in a worldwide trade setting when increased

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14. *See supra* Introduction.

15. Mitrofanskaya, *supra* note 3, at 1401 (commenting that "[t]he world is currently experiencing a 'privatization revolution' - State enterprises in Europe, Asia, Africa, and Latin America are in various stages of privatization."); Reisman, *supra* note 2, at S372-73 (explaining that the World Bank 1991 Annual Report stated "many nations initiated reforms that were markedly different from those instituted in the past. As the World Bank [had] reported, the new pattern of economic policy [in Latin America and the Caribbean] emphasizes smaller and more efficient governments, privatization of government enterprises, more open foreign-trading regimes, deregulation of financial and commodity markets, and reductions in public-sector expenditure imbalances.") (footnotes and internal quotation marks omitted.); Mark R. Yzaguirre, *Project Finance and Privatization: The Bolivian Example*, 20 HOUS. J. INT'L L. 597, 597 (1998) (stating that "[i]n recent years, many countries in the Third World and the former Eastern Bloc have moved from state ownership of various industries and natural resources to private ownership. This move towards privatization, with the encouragement of foreign investment capital, is a dominant trend in the global economy.").

16. Chibundu, *supra* note 11, at 3-4. Chibundu has termed privatization as a "self-validating orthodox creed, and while there remain some doubters, privatization looks less and less like a 'fad.'" *Id.* Chibundu stresses that:

> [a]bove all, the process has become sufficiently routine and seemingly sufficiently understood so that it is no longer arcane, and as such it can be marketed at minimal intellectual cost across the globe. In other words, we have stopped asking foundational questions about privatization, and to the extent we ask any questions at all, they focus on how particular transactions can be more efficiently accomplished.

Id.

17. Robert Pritchard & Douglas Webb, *Privatization and Private Provision of Infrastructure,* ECONOMIC DEVELOPMENT, FOREIGN INVESTMENT, AND THE LAW 67, 67 (Robert Pritchard ed., 1996); *see also* SARKAR, *supra* note 12, at 149 ("Inefficient [SOEs], mounting external debt, capital flight, the failure to develop robust export-oriented industries are but a few reasons which all account for a gradual economic decline. Corruption from within, and the failure of the state to deliver on the ideals of nationalization, has often led to wide-scale disillusionment.").

deregulation and harmonization combine with a concomitant increase in the international flow of private capital.[18] In other words, "globalization," another often-used term with uncertain definitional scope, has contributed to the surge in privatization. Moreover, the role of international financial institutions such as the World Bank and the International Monetary Fund (IMF) cannot be understated.[19]

In this context, many have set out to attempt to define "privatization," however difficult that may be. "What molds this broad idea of 'privatization' into anything approaching coherence appears to be that it relates to mechanisms and arrangements (however loosely structured) that share the goal of reducing or eliminating state or governmental ownership or control over entities whose primary raison d'être lies in the socio-economic realm."[20] In effect, "[t]he term privatization encompasses many different policies with a common objective to reduce the influence of the state in the economy and strengthen the role of market forces."[21]

With this broad definition of privatization in mind, one must turn to the question of what goals underlie privatization. Of course, before initiating any sort of privatization program, governments must define their goals as clearly as possible.[22] But what are the goals and objectives of privatization? Generally, privatization has been seen as a way to achieve

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18. *Id. See also* Alfred C. Aman, Jr., *The Globalizing State: A Future-Oriented Perspective on the Public/Private Distinction, Federalism, and Democracy*, 31 VAND. J. TRANSNAT'L L. 769, 774 (1998). Professor Aman argues that the end result of many of these processes is to place traditionally public decisions into the hands of the private sector, in effect lessening the public's direct involvement in these matters. Professor Aman further explains why he believes that the processes of globalization, of which privatization is only a component, have changed the state's structure and role fundamentally.

19. Luigi Manzetti, *Second Conference on "The Economic and Political Challenges of Market Reform in Latin America," Southern Methodist University Tower Center, Dallas, Texas, 4 October 1997*, 4-SPG NAFTA: L. & BUS. REV. AM. 5 (1998).

20. Chibundu, *supra* note 11, at 6 (footnotes omitted).

21. Werner Baer & Melissa Birch, *Privatization and the Changing Role of the State in Latin America*, 25 N.Y.U. J. INT'L L. & POL. 1, 15 (1992). *See also* Leslie Elliot Armijo, *Menem's Mania?: The Timing of Privatization in Argentina*, 1 SW. J.L. & TRADE AM. 1, 6 (1994) ("Privatization refers to opening up new arenas of economic production, of both goods and services, to private, profit-seeking entrepreneurs, managers, and investors. Usually, privatization means sales of majority ownership in historically state-owned enterprises . . . .").

22. SARKAR, *supra* note 12, at 167.

greater efficiency in economic performance.[23] Directly related to that goal is the increase in the quality of the goods and services provided by these enterprises.[24]

There are other goals and objectives of privatization, however, that do not deal with improving the actual provision of goods and services in an economy, but rather concern other, broader macro-economic issues. Generally, these include seeking budgetary relief from unprofitable SOEs, fostering competition (and thereby production) among national and foreign economic actors,[25] and breaking up public monopolies.[26]

Another government objective often sought in the privatization process is to encourage the development of capital markets.[27] As is often noted,

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23. Pritchard & Webb, *supra* note 17, at 68 ("Privatization has been seen as offering a means of increasing the efficiency with which scarce public resources are used, and of improving the delivery of services to the public. . . . [T]he state [is left] with the role of providing appropriate economic conditions, an enabling legal and regulatory framework and the core infrastructure to support the emerging private sector."); *see also* DENNIS J. GAYLE & JONATHAN N. GOODRICH, PRIVATIZATION AND DEREGULATION IN GLOBAL PERSPECTIVE 78 (1990) (stating that one of the tenets on which privatization should be based is increasing industry efficiency and competitiveness); SARKAR, *supra* note 12, at 154 (suggesting that increasing a state-owned enterprise's efficiency can be one of the political objectives of the state in privatizing); Mary M. Shirley, *The What, Why, and How of Privatization: A World Bank Perspective*, 60 FORDHAM L. REV. S23, S25-7 (1992) (stating that the three main economic reasons why a government should privatize are improving the use of public resources, improving operating efficiency, and improving dynamic efficiency); Yzaguirre, *supra* note 15, at S603 (commenting that privatization through the outright sale of state-owned industries is done, *inter alia*, "to increase efficiency by exposing the industry to market discipline").

24. Pritchard & Webb, *supra* note 17, at 68; *see also* SARKAR, *supra* note 12, at 153 (stating that "privatization should result in better quality, lower-priced goods and services with export potential which will generate foreign exchange revenues.").

25. SARKAR, *supra* note 12, at 154; Yzaguirre, *supra* note 15, at S603.

26. SARKAR, *supra* note 12, at 154.

27. *Id.* at 174-75. Specifically, Sarkar states that:

> [a]nother important government objective in the privatization process is encouraging the growth of capital markets and ensuring broad-based ownership of the equity in the productive enterprises of a developing country. . . .
>
> Moreover, the role of institutional investors . . . also adds to the depth and liquidity of capital markets. These financial intermediaries provide the retail investor with the means of diversifying his/her portfolio, and of benefiting from investment advice from experienced fund managers.

Id.

countries pursue privatization with the ultimate objective of complying with the demands of the international financial institutions,[28] who make privatization a condition of any assistance.[29] Still, other goals are the mobilization of domestic savings, the attraction of foreign investment, and the creation of jobs.[30] Finally, it is of particular interest to note that some forms of privatization allow the government simply to raise large sums of money that, in turn, enable it to reduce its own budget deficits.[31]

In effect, the goals and objectives of privatization are many and varied. Inevitably though, they tend to focus on the benefits that the market economy will purportedly generate.

b. Prerequisites and Preferred Techniques of Privatization

Before engaging in any particular privatization effort, a government must undertake several steps and exhibit certain prerequisites. First it must have in place a legal framework within which privatization is to operate. Generally, this framework involves guaranteeing the rule of law.[32] It also involves enactment of a content-specific body of business laws that support the dynamics of a market economy.[33] Further, special legislation should be in place, which authorizes and describes the entire privatization

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28. Reisman, *supra* note 2, at S373 ("[S]ome governments in Latin America seem to be implementing privatization programs in order to acquire funds from international monetary groups and participate in international reform programs.") (citing *Central American Governments Move to Privatize Inefficient Industries*, INT'L TRADE DAILY (BNA), Aug. 23, 1991).

29. *Id.* at S350 ("Of the many programs *imposed* on developing countries by the World Bank and the IMF, one of the most controversial is that of privatization.") (emphasis added). Reisman also notes that "[t]he principal goal of the [Bretton Woods] [C]onference was to promote international trade. Specifically, the World Bank was created to 'help finance the rebuilding of Europe's economies,' and the IMF was created to supervise and foster an 'open and stable monetary system' and thereby promote a more efficient allocation of resources." *Id.* at S351 (footnotes omitted).

30. *Id.* at S357.

31. *Id.* ("Privatization is also an effective way to raise considerable sums of money for a country's treasury, which, in turn, enables the government to finance expenditures, repay loans, or defer tax increases."); *see also* Pritchard & Webb, *supra* note 17, at 68; SARKAR, *supra* note 12, at 154.

32. Pritchard & Webb, *supra* note 17, at 68. The authors suggest that the rule of law will be "exemplified through a stable body of laws, readily interpretable, widely published and supported by effective administrative bodies and judicial recourse."

33. *Id.*

process.[34] Particularly in regard to this latter element, it has been suggested that a general privatization law is not indispensable, but the lack thereof has perceptible disadvantages.[35]

Countries with poorly developed capital markets must take additional steps towards privatization including corporatizing SOEs in order to allow for privatization, restructuring the enterprises by liquidating or selling certain non-performing assets, fragmenting the SOEs into smaller units that are more conducive to public sales (which is especially important in large, monopolistic concerns), or writing off or transferring bad debts to other SOEs or government-owned holding or trust companies.[36] Indeed, commercialization is also seen by some as part of the preparatory stage for an outright divestiture of an SOE.[37]

For the purpose of this Article, it is also important to stress the need for preparatory work at the regulatory level in dealing with heavily regulated industries such as insurance. Some of the more important characteristics of the regulatory scheme that must precede any successful privatization program include: making the regulator legally and organizationally separate from the government; specifying the regulatory agency's objectives as clearly as possible; limiting the scope of the regulator's personal discretion; making regulatory procedures transparent and easy to administer; requiring promptness in regulatory action;

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34. *Id.* at 68-69.

35. *Id.* at 69-70.

> [L]aws and structures can often be adapted to support privatization without the need for a special purpose-built set of laws. There is downside though. It lies in predictability: the capacity of the laws and institutions to resolve the inevitable conflict as to authority to privatize, and to provide a high degree of certainty to investors as to the principles governing privatization. Governments can and do privatize without specific privatization laws. But they often face delays and other problems as a result.

As an example, the authors point to Turkey's experience with a general, vague privatization law that did not cover all state enterprises. Thus, it sought ad-hoc, case-by-case solutions that were usually ineffective because the opponents kept challenging them successfully.

36. SARKAR, *supra* note 12, at 167.

37. Pritchard & Webb, *supra* note 17, at 75. "In preparing for privatization, it has become increasingly common for governments to experiment with private sector processes and disciplines. . . . Commercialization . . . which falls short of privatization nevertheless involves a far-reaching shift in the way a government conducts its activities." In this excerpt, the authors are referring to privatization as the equivalent of divestiture.

providing for price regulations (if necessary) that allow producers to benefit from efficiency improvements; allowing regulators to easily assess service quality and consumer satisfaction; and specifying that the regulatory system is to operate free of political intrusions.[38]

Most important, a government must have the necessary level of commitment in order to successfully undertake privatization. In effect, "high-level government commitment is crucial for public enterprise reform and privatization, given the needed changes in laws and the need to deal with powerful stakeholders, including the entrenched bureaucracy, labor unions, and opposition parties."[39]

Assuming a government has assessed whether it is prepared to undertake privatization, one would then turn to the issue of the techniques and methods available to it. Accompanying the broad definition of privatization is an equally broad range of techniques or methods that can comfortably fit into the designation of privatization. Accordingly, the most appropriate way to examine these different techniques may well be to situate them along a privatization continuum.[40] Thus, on one extreme of the continuum, one would find those government measures that simply aim at introducing market economy efficiencies into governmental functions. This may involve, for example, the outsourcing of services to the private sector, even though the outsourcing entity is still nominally a governmental body.[41] The government may also opt to enter into a management agreement with a private party to attempt to improve an enterprise's economic performance.[42] Under this broad view, deregulation is also considered to be privatization in that it allows a higher degree of private sector participation in the economic process.[43]

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38. *Id.* at 80-81.

39. The World Bank, THE WORLD BANK ANNUAL REPORT 81 (1999) <http://www.worldbank.org/html/exptb/annrep99/box2_15.htm> (visited Feb. 20, 2000) [hereinafter WORLD BANK].

40. Pritchard & Webb, *supra* note 17, at 69 ("The possible methods of privatization range through a variety of forms of sale of assets or shares, to the introduction of private sector management skills without ownership change. There is no single method of choice."); Yzaguirre, *supra* note 15, at 604 ("There are many different types of privatization, which lie on a continuum from outright sale and divestiture of nationalized industries to simple deregulation and outsourcing of certain tasks to the private sector.").

41. Pritchard & Webb, *supra* note 17, at 69.

42. SARKAR, *supra* note 12, at 167.

43. Yzaguirre, *supra* note 15, at 604.

More intermediate pursuits that could well be termed privatization involve activities such as commercialization, whereby an SOE will adopt a general policy effectuated by a series of measures that will make it operate much like a private company.[44] Of course, under a commercialization approach, the entity still remains an SOE.

On the other extreme of the privatization continuum one would find the outright sale or divestiture of government assets and SOEs.[45] For some, "[p]rivatization simply means the transfer of ownership or control of enterprises or assets from the government to private individuals or entities."[46] In effect,

> [w]here a government privatizes an SOE by sale, it can either negotiate on an exclusive basis with a candidate selected for the capital, technology and skills it can bring to the SOE or, more commonly and preferably, it can institute an open and competitive bidding process where it seeks to maximize the sale price.[47]

Overall, it must be stressed that the various techniques for privatization often overlap and become indistinguishable. Any distinctions or classifications that are drawn serve simply to note, precisely, that under the broad umbrella of privatization a government may undertake many

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44. Pritchard & Webb, *supra* note 17, at 75-76. While of the opinion that commercialization does not fit into a narrower definition of privatization, the authors define commercialization as a process that entails:

> adopting a separate legal structure for the SOE and appointing an independent board of directors; . . . making the SOE solely legally accountable for its functions without government support; withdrawing further government funding from the SOE; freeing the SOE from political and bureaucratic interference; laying down commercial objectives and performance targets for the SOE; requiring the SOE to function under conditions of competitive neutrality by paying taxes (or tax-equivalent charges) to the government; changing the SOE's management system from bureaucratic and hierarchical to a system which emphasizes delegation of authority and accountability; and retraining the SOE's managers and other employees in how to work and how to think in an environment where the incentives and accountabilities match closely those of comparable private entities.

Id.

45. Yzaguirre, *supra* note 15, at 603, 604.

46. SARKAR, *supra* note 12, at 145.

47. Pritchard & Webb, *supra* note 17, at 73.

measures that will ultimately reduce its presence in a given economic activity. Thus, for this Article's purposes, there may be privatization when there is an outright divestiture, but one may also speak of privatization where there is simply the introduction of private sector competitors in an industry formerly operated solely by an SOE.[48]

For this analysis, it will be useful to focus attention on the extreme of the privatization continuum involving divestiture of SOEs. In addition to the general preparatory steps and prerequisites already mentioned above,[49] a government that is divesting itself of an SOE must deal with the issue of valuing the company in order to determine a suitable sale price. This is, of course, a delicate issue and there are several techniques employed for such purposes.[50] The valuation of the SOE is closely related to the preparatory process of making the SOE more attractive to potential buyers.[51] Consideration should also be paid to the size of the enterprise being divested, under the obvious assumption that larger SOEs will involve transactions significantly more complex than smaller SOEs, which may be sold through public auctions or direct sales.[52]

The divestiture process includes a wide variety of alternatives from which to choose, including selling the SOE to a buyer in the private sector (either already engaged in the business being divested, or seeking to diversify its business), selling to management and/or employees of the company, or selling to the general public.[53] If a country has relatively well-developed capital markets, then an SOE may be sold by means of an initial public offering (IPO) of its stock (once the company is

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48. *Id.* at 73-74.

49. *See supra* p. 9, § I.A.2.

50. Anthony M. Vernava, *Latin American Finance: A Financial, Economic and Legal Synopsis of Debt Swaps, Privatizations, Foreign Direct Investment Law Revisions and International Securities Issues*, 15 WIS. INT'L L. J. 89, 119 (1996) ("The value of the SOE may be established by considering a variety of financial factors such as discounted projected cash flow, capitalized earnings, adjusted book value, or a combination and weighting of values achieved under alternative valuation methods.").

51. Shirley, *supra* note 23, at S30 ("To attract buyers who are willing both to pay a reasonable price for an entity and to invest in improving the efficiency of the entity, governments must make the public enterprises more attractive.") Commenting on whether restructuring should be done in order to advance a proper valuation, Reisman, *supra* note 2, at S357 points out that the valuation process may significantly delay the actual divestiture.

52. Reisman, *supra* note 2, at S357.

53. *Id.*

incorporated).[54] On the other hand, if the country has poorly developed capital markets, the sequencing of the entire process becomes a relevant concern.[55] Other countries may be in a position to seek to list the SOE's stock in the international markets, with a view toward attracting more significant amounts of capital.[56]

If one of the particular goals of the government in privatizing a given SOE is to obtain specific managerial expertise and access to technology or international capital markets, one possibility is that the divestiture of the SOE will occur through a private placement with a limited group of investors, provided that these investors effectively demonstrate the sought-after characteristics.[57] On the other hand, "[c]ompetitive bidding may take place through a government-issued tender for private bids, or through public auctions. Public auctions, of course, ensure transparency in the privatization process, and deflect criticisms that the 'family jewels' are being sold to foreign interests in secret deals."[58]

As with any business activity, the party or parties who decide to acquire a full or partial interest in the SOE that is to be divested will have to procure financing for the investment in the form of either debt or equity.[59] In these cases, governments should be particularly wary of the eventuality of default and the possibility that the purchaser of the SOE will

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54. SARKAR, *supra* note 12, at 166.

55. *Id.* Sarkar notes nonetheless that "[p]ublic flotations of stock are usually only appropriate for companies that are large, well-managed and profitable. Since IPOs -- from legal, investment banking, and accounting standpoints -- are technically complex transactions, the transaction costs and the time involved generally need to be carefully justified before initiating an IPO." *Id.* at 174. Sarkar refers to the success story of an IPO in the context of an underdeveloped capital market. In 1986, the Jamaican government offered 51% of the shares of the National Commercial Bank. This offering was oversubscribed by 170%, and the government collected $16.5 million in revenues from this IPO. Sarkar stresses that key to the success of any such IPO is the existence of accumulated domestic savings, even if a well-functioning stock market is not present. *Id.*

56. *Id.*

57. *Id.* at 168.

58. SARKAR, *supra* note 12, at 168; *see also* Vernava, *supra* note 50, at 120 ("[A]fter the non-public phase of the privatization, a public offering of stock in the Latin American privatized firm may be made. If offered internationally, the offering will usually follow one in the domestic stock market.").

59. SARKAR, *supra* note 12, at 168-69. Sarkar points out that financing through equity is particularly useful when it is determined that it is necessary to recapitalize the SOE, and that it is also possible that there be sensitive issues regarding the nationality of the party who would now hold an ownership interest.

have given its interest in the SOE as collateral for the financing.[60] The sale may also be financed through the issuing of bonds, in which case the bonds may be placed internationally. If possible, the bonds may be purchased domestically by the general public or by local institutional investors (e.g., local pension plans or mutual funds).[61]

If the SOE is burdened with heavy indebtedness, the government will, of course, make debt workouts a priority. "Debt-equity swaps permit an investor to purchase the sovereign debt at a discount and exchange it for an equity position in the newly privatized SOE. . . . Thus, a debt-equity swap enables the government to reduce its external debt overhang while privatizing an SOE."[62]

If independent buyers are not available, but a speedy privatization is desired, the government may consider management and/or employee buyouts. While such buyouts are sometimes criticized for lacking transparency (that is, "insiders" are acquiring the privatized SOE), the government may actually benefit by reducing or eliminating labor opposition to the privatization. The drawback, of course, is that such transactions generally entail preferential or discounted terms for SOE employees thereby distorting the potential sale value of the SOE.[63]

There are still other techniques that have been employed. For example, a country may implement voucher programs. These programs were used widely in the transition economies of Eastern Europe and Central Asian countries.[64] Of course, the challenges posed by privatization in the post-socialist economies of the former Soviet Union

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60. *Id.*

61. *Id.* at 169.

62. *Id.* at 170; *see also* Vernava, *supra* note 50, at 116-17.

> The equity portion of a debt swap which is correlated with a program of privatization can be structured to provide the seed money or initial investment capital for the privatized enterprise. . . . The equity investment in the privatized enterprise is long-term. Investors may be committed to several years of additional investment in capital improvements.

Id.

63. SARKAR, *supra* note 12, at 170.

64. *Id.* at 172.

and Eastern Europe cannot be understated, and they can make comparison between such countries and Latin American countries futile.[65]

c. State-Owned Enterprises that Operate a Monopoly

In dealing with privatization, certain specific issues are raised in the case of an SOE that operates a monopoly. Prior to privatization, the government that operates a monopoly is nevertheless still interested in doing so with optimal efficiency so that the SOE is not a financial drain on government funds.[66] In effect, certain government monopolies, for example, oil and gas monopolies such as Pemex in Mexico and PDVSA in Venezuela, and the National Insurance Institute in Costa Rica, actually operate without causing a drain on government resources.[67]

Even so, governments have become and are still becoming concerned with the efficiency of their state-run monopolies.[68] It has been noted that:

> the import-substitution policies adopted by many Latin American, Caribbean, African and Asian countries, began to unravel in the early 1970s. The creation of state monopolies in those countries led to many inefficient practices. The monopolistic status of [SOEs] was reinforced by establishing market entry barriers, thereby

65. Baev, *supra* note 13, at 131, 139; *see also* Georgi G. Angelov, *Legal Framework of Privatization in Russia*, 2 MINN. J. GLOBAL TRADE 207 (1993) (discussing the daunting process of Russia's privatization efforts after the 1992 adoption of the Program for Deepening the Economic Reform in the Russian Federation); Matthew J. Hagopian, *The Engines of Privatization: Investment Funds and Fund Legislation in Privatizing Economies*, 15 J. INTL. L. BUS. 75 (1994) (commenting on the legislative options available to post-socialist, privatizing economies in Eastern Europe and the former Soviet Union with regard to the establishment and operation of investment funds); Janine S. Hiller & Snjezana Puselj Drezga, *Progress and Challenges of Privatization: The Croatian Experience*, 17 U. PA. J. INT'L ECON. L. 383 (1996) (commenting on the difficulties that Croatia faced in undertaking privatization after its turbulent separation from the former Yugoslavia and its transition to a market economy).

66. Pritchard & Webb, *supra* note 17, at 76.

67. In particular, the National Insurance Institute in Costa Rica has operated for many years "at a profit" to the government. Naturally, the net income is not distributed to anyone but simply accounted for as accumulated reserves. In practice, though, the National Insurance Institute is forced to buy a significant amount of government bonds, in effect serving as a "cash cow" for the central government.

68. Pritchard & Webb, *supra* note 17, at 76.

> discouraging private sector competition for the production of the same goods and services.[69]

One particular concern that may be especially significant in the context of insurance is the issue of cross-subsidization between consumers.[70] This issue involves the contrast between insurance coverage that is priced based on community rating practices (i.e., where all policyholders are charged identical premiums without regard to the particular level of risk exposure that a particular insured represents), and coverage that is priced based on risk classifications.[71]

Another issue is whether the monopoly in question is a natural monopoly. "The existence of a natural monopoly may have the effect of preventing competition either in the upstream (production) activities or in the downstream (distribution) activities."[72] A clear example of where you may have a natural monopoly is that of a vertically-integrated state-owned electricity utility such as Costa Rica's *Instituto Costarricense de Electricidad*, where the lack of access to the transmission grid prevents or diminishes competition both in the upstream generation of power and in its downstream distribution to consumers. Evidently, in the case of an insurance monopoly, there would be no such natural monopoly questions.

Particularly in the insurance context, it should be emphasized that,

> [i]nsurance sectors in developing countries are often dominated by state-owned entities with limited participation by private or foreign companies and are characterized by inadequate capital, high operating costs, limited product innovation, low investment returns, lax control over brokers, high levels of receivables, extensive fraud, unduly large claims by some insureds but otherwise low claims and settlements for the majority of customers, protracted disputes and long delays in settlement, and generally widespread mutual mistrust between insurance companies and the insured.[73]

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69. SARKAR, *supra* note 12, at 152.

70. *Id.*

71. In the case of the National Insurance Institute, the only line of insurance that is considered to be subsidized is crop insurance, a mandatory coverage for certain groups.

72. Pritchard & Webb, *supra* note 17, at 76.

73. DIMITRI VITTAS, THE WORLD BANK GROUP, INSTITUTIONAL INVESTORS AND SECURITIES MARKETS: WHICH COMES FIRST? 5 (1998).

In light of the above, it seems that there are three general courses of action a government can pursue in order to deal with a SOE that enjoys a monopoly over a particular economic activity. First, the government can simply retain the monopoly but impose strict regulatory controls in order to address any problems such as cross-subsidization.[74] Second, the government may choose to divest itself of the monopoly. In this case, it is important that there be appropriate regulatory reform *before* the divestiture to ensure healthy competition and not selling at too much of a discount (if at all). In effect, before buying an SOE, an investor will need to know what the regulatory regime will be in order to determine the price he/she is willing to pay.[75] Third and finally, a government may choose to undertake comprehensive structural and regulatory reform and separate the natural monopoly element (if any) from any competitive activities.[76]

d. Lessons Learned from Privatization

There are many specific lessons to be learned from the vast experience in privatization. But, as has been noted, ultimately every individual country will have to determine the privatization goals in which it is most interested. These goals can be as varied as the countries themselves, and will be heavily influenced by many factors, not the least of which are the political forces within each country.[77]

With this in mind, it is nevertheless useful to point out some generally valid lessons. First, it seems to be fundamental to have the proper legislation in place in order to translate a government's privatization policy into specific action. This is to say that,

> [i]f the legal infrastructure is weak, the consequence is likely to be that potential investors will be more risk-averse. And implementation can be badly delayed by clashes between various interest groups both within and outside government which use uncertainty as a means of blocking progress. . . . Apart from providing certainty, the

74. Pritchard & Webb, *supra* note 17, at 77.

75. *Id.* at 77-78 (citing Pierre Guislain, *Divestiture of State Enterprises: An Overview of the Legal Framework*, World Bank Technical Paper Number 186 (1992)).

76. *Id.* at 78.

77. Chibundu, *supra* note 11, at 13 (noting that "it would be shortsighted to overlook the significance of political forces in shaping the form of privatization in [Latin American countries].").

other major role of law in privatization is to provide transparency.[78]

Second, it also seems evident that privatization, especially if defined as broadly as it has been here, is more than a transaction; it is a process. To succeed, it requires clear institutional authority, a stable set of rules and laws defining and protecting the rights of the private investor.[79]

Third, there must be some form of appropriate institutional authority. In effect, it seems to be useful to designate either a special-purpose agency or a department of an existing agency (such as a Ministry of Finance) to conduct and oversee the privatization process.[80] But regardless of the form used, "successful agencies have three basic characteristics: a clear goal of achieving privatization and accountability for results; power to direct enterprises to take actions needed for privatization; and responsibility for achieving a transparent process."[81]

Finally, attention should be given to specific transactional requirements for divestitures, since it is necessary that there be clear property rights, a fair allocation of liabilities, and laws dealing with the mechanics of the sale.[82]

2. The Pros and Cons of Privatization: Measuring Success

The previous section of this Article attempted to set out a general foundation upon which to assess the successes and failures of privatization. To complete this task, this Article will now address (a) some of the arguments made in favor of privatization, and (b) some of the arguments espoused against privatization.

a. Arguments in Favor of Privatization

In trying to assess whether a particular privatization program has been successful, there are many issues to consider. Of course, if one begins by recalling that the central goal of privatization is the enhancement of economic performance, one may therefore expect the arguments favoring privatization to refer to economic gains. Thus, some argue that "[i]f privatization is done properly and with due care, it will provide for

78. Pritchard & Webb, *supra* note 17, at 70-71.
79. *Id.* at 71.
80. *Id.* at 71-72.
81. *Id.*
82. *Id.* at 72.

increased market competition, accountability, and incentives, resulting in rapid economic growth."[83] Of course, efficiency is also a prime consideration in this test for success, especially where one is dealing with a monopolized industry.[84]

There are several corollaries that stem from this general economic evaluation of the success of privatization. One often-cited measure of success is whether privatization advances the development of capital markets. "[W]ith privatization, Latin American equity markets have become important sources for raising capital by the newly privatized domestic firms, and have acted as springboards for the international offering of the stock of these enterprises."[85] Another economic measure of success is whether privatization contributes to the creation of employment opportunities. "[P]rivatization may actually provide increased employment opportunities by introducing better technology, opening up new markets and creating new investment opportunities."[86] Yet another test for measuring success, in the case of privatization accomplished through divestiture of SOEs, is whether the project has

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83. Mitrofanskaya, *supra* note 3, at 1403 (footnotes omitted); *see also* Baer & Birch, *supra* note 21, at 17 ("The arguments in favor of privatization generally rely upon economic or financial reasons. The most frequently cited justification for privatization is the gain in efficiency said to result from reduced political interference, exposure to competitive input markets (particularly financial markets), and increased competitive pressure on enterprise management arising from the fear of takeover or bankruptcy.").

84. Baer & Birch, *supra* note 21, at 17 ("If the public monopoly is statutory, (i.e., not a result of economic forces), the mere threat of competition may make the enterprise more efficient and keep output prices closer to marginal cost, even if new firms do not enter the market and government ownership is maintained.").

85. Vernava, *supra* note 50, at 112; *see also* William Glade, *Second Conference on "The Economic and Political Challenges of Market Reform in Latin America," Southern Methodist University Tower Center, Dallas, Texas, October 4 1997 -- Current Trends and Problems in Foreign Investment in Latin America*, 4-SPG NAFTA: L. & BUS. REV. AM. 57, 67 (1998) ("Privatization, to put it most succinctly, provides a major impetus to the deepening and widening of capital markets in Latin America, multiplying the connections between these markets and those of the money center countries.").

86. SARKAR, *supra* note 12, at 153. This assumes that technological improvements will necessarily accompany privatization. Baer & Birch, *supra* note 21, at 18 ("Technological capability is another argument for privatization, and an important one for certain industries.").

effectively allowed the government to raise revenues with a view to improving its general finances (i.e., reducing existing budget deficits).[87]

Once privatization is implemented, there will be unavoidable hardship. Thus, it is said that international financial institutions such as the World Bank and the IMF tend to prefer "shock treatment," for example, implementation of privatization reforms as quickly as possible.[88] This, some say, will make privatization successful because it will inflict the unavoidable hardship for the least amount of time possible.[89]

In the end, the prevailing view is that an improvement in economic indicators is the best way to measure the success of privatization. Of course, along with improved economic indicators should come an improvement in standards of living for a country's population.[90]

b. Arguments Against Privatization

On the other hand, it is important to look at the main arguments that are generally made against privatization processes. As in dealing with arguments in favor of privatization in the previous subsection, one must bear in mind that because privatization's goals are fundamentally economic, so are a majority of the arguments made against it.

In effect, it is said that privatization done poorly, that is, unsuccessfully, can stifle a country's economic growth.[91] Thus, if a public monopoly is traded in for a private one, the economic goals of efficiency and increased competition may be thwarted.[92] For this reason,

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87. Baer & Birch, *supra* note 21, at 18 ("An important advantage of divestiture is the generation of capital and current income for the treasury. While this is a one-time exchange of physical assets for financial ones, it is appealing to developing countries with large external debt burdens.").

88. Reisman, *supra* note 2, at S390.

89. *Id.* ("Once a country expresses a desire to establish a market economy, it then has to decide how to achieve this goal. The World Bank and the IMF appear to favor a 'shock therapy' approach, believing that this approach will inflict 'the attendant hardships for as short a time as possible.' On the other hand, opponents to this approach favor an 'evolutionary approach,' seeing a gradual transition as necessary to maintain political stability.") (footnotes omitted).

90. *Id.* ("For most countries, privatization is a necessary step in the quest for higher living standards, even if it lowers those standards in the short term. In fact, the effects of these hardships may be lessened simply by implementing privatization on a smaller scale at first, over a longer period of time, and with plenty of forethought as to the means used.")

91. Mitrofanskaya, *supra* note 3, at 1403.

92. Yzaguirre, *supra* note 15, at 604-05.

> some Latin American liberals have expressed dissent with the reform movements in Latin America. . . . [R]eformers are confusing mercantilist private enterprise with free market capitalism, and the failures of the former will be blamed on the latter. . . . [M]any countries are merely shifting control of monopolies via privatization, and . . . when the people see the problems of these monopolies, . . . capitalism and liberalism will be blamed for the failures of a system that is neither truly capitalist nor liberal.[93]

There are several examples of unsuccessful privatizations, such as those in the telecommunications industries of Peru, Mexico, and Argentina, where the problems of replacing a public monopoly with a private one have occurred.[94] In the context of proposals to privatize the Overseas Private Investment Corporation,[95] the single most significant argument against privatization is where there is an absence of a private market substitute for the privatized entity and the goods or services it provides.[96]

> It is no small feat to structure privatization deals. Too low of a sale price can lead to complaints that the government is giving away national assets to foreigners. Also, creation of the proper post privatization regulatory regime is key for the government to achieve it goals, such as increased competition. For example, trading a public monopoly for a private one can undermine efficiency goals.

Id.; *see also* SARKAR, *supra* note 12, at 153; Baer & Birch, *supra* note 21, at 17.

> However, privatization is unlikely to generate major gains in efficiency unless it is accompanied by reforms that alter the relative prices prevailing in the economy. For example, private monopolies may prove to be somewhat more efficient than public ones, but how much more will depend largely on the effectiveness of the regulatory environment.

Id.

93. Yzaguirre, *supra* note 15, at 626-27 (citing Alvaro Vargas Llosa, *Give Latins Real Reform, Start with Property Titles*, Wall St. J. Eur., Jan 6, 1997, at 6 (footnotes omitted)); *see also* Manzetti, *supra* note 19, at 5 ("[D]espite much rhetoric to the contrary, many governments paid relatively little attention to the issue of creating competition through privatization.").

94. Yzaguirre, *supra* note 15, at 626-27 n.229.

95. OPIC is the United States self-sustaining government-backed political risk insurer. Marvin W. Tubbs, *Political Risk Insurance: The Potential Effects of Privatization on Credit Availability*, 16 ANN. REV. BANKING L. 553, 554 (1997).

96. *Id.* at 572.

Along these lines, there are also other economic arguments against privatization, such as its destruction of jobs[97] and the idea that the creation of additional public resources does not necessarily follow from the divestiture of an SOE.[98] In effect, the sale of a public enterprise will generate income in an amount equal to the discounted net present value of any future income the enterprise would have generated plus the scrap value of the enterprise. By selling, however, a government relinquishes future revenues.[99] While taxation of the private sector substitute(s) will offset this, the overall gain may be overstated. Also, the lack of developed capital markets is mentioned as something that will make privatization's goals unattainable.[100]

There are also arguments made against privatization that are specific to the methods and techniques employed. For example, in the context of debt-equity swaps, such initiatives have the disadvantage of stopping other forms of foreign direct investment that are not linked to similar concessionary programs (concessionary because such debt-equity swaps offer severely discounted debt as the instrument for the swap).[101]

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97. Reisman, *supra* note 2, at S390 ("[Privatization] inevitably leads to the destruction of jobs, which obviously leads in turn to harsher living standards for much of a developing country's population."); *see also* SARKAR, *supra* note 12, at 153 ("Since privatization inevitably raises the spectre of lay-offs of redundant employees, sacrifices may be required of more than just the ruling political elite."); Baer & Birch, *supra* note 21, at 18. Note that just the opposite is mentioned as an argument *in favor* of privatization.

98. Shirley, *supra* note 23, at 27.

99. *Id.*

100. Baer & Birch, *supra* note 21, at 19 ("However, many countries resorted to sealed-bid auctions to sell major portions of large public enterprises because the size of their stock markets proved too small for a successful public sale. Consequently, privatization resulted in the transfer of public assets to a small group of wealthy elites."); SARKAR, *supra* note 12, at 165 ("A commonly cited reason for the scarcity of privatization opportunities in many developing nations is the absence of capital markets.").

101. Vernava, *supra* note 50, at 117.

> Critics of swaps of severely discounted debt for equity in SOEs that are being privatized express the view that such programs stop other FDI not linked to concessionary programs, allow valuable national assets to be sold to foreigners, and permit these assets to be sold at significant discounts because the discounted debt becomes the vehicle for the swap.

Id.; *see also* Baer & Birch, *supra* note 21, at 20 ("[T]here are strong indications that debt-equity swaps do not increase the flow of foreign direct investment into the country, but merely alter its form and subsidize the foreign currency cost of the investment.").

Similarly, governments have been unsuccessful in privatizing if they do not adopt appropriate regulations or sell to incapable purchasers[102] who, in turn, do not necessarily increase productivity.[103] In addition, problems with appropriately valuing SOEs that are to be sold suggest that privatization may be unsuccessful if government assets are sold off "too cheaply."[104]

But in addition to essentially economic arguments that disfavor privatization as unsuccessful, there are many other political arguments. For example, notions of nationalism in terms of retaining control over the means of production are cited as arguments against privatization.[105] Thus, it would follow that a privatization is unsuccessful if SOEs are sold off to foreigners. Another criticism is that many countries have implemented privatization with relative ease due to the existence of authoritarian, anti-democratic regimes.[106] Of course, this argument still retains an economic

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102. Reisman, *supra* note 2, at S390 ("Another supposed disadvantage of privatization is that governments tend to be short-sighted in their privatization policies because of their impatience for 'high prices and quick deals,' and often will sell to new owners who are not capable operators, or will sell industries without establishing firm government regulations.") (footnotes omitted).

103. Armijo, *supra* note 21, at 18.

> Analysts agree that most of the improved profitability of newly privatized Argentine firms has come from the enhanced ability of the new owners to raise prices and fees for their outputs, in an environment of low or nonexistent competition and lax government regulation. That is, 'profits' have come from an implicit tax on consumers, not from heightened productivity, however measured.

Id.

104. Baer & Birch, *supra* note 21, at 19 ("Valuation of public enterprises is extremely difficult in economic environments characterized by weak or non-existent capital markets, concentrated private sectors, a lack of reliable operating data for the firm under consideration, and difficult macroeconomic environments.").

105. Reisman, *supra* note 2, at S390 ("[I]f the privatization occurs by selling to foreign entities, there is a hue and cry that the patrimony of the country is being given away at bargain prices."); *see also* Baer & Birch, *supra* note 21, at 18 (speaking of "eroding sovereign control" and foreign ownership).

106. Enrique R. Carrasco, *Law, Hierarchy, and Vulnerable Groups in Latin America: Towards a Communal Model of Development in a Neoliberal World*, 30 STAN. J. INT'L L. 221, 226 (1994).

> This approach to the crisis [in Latin America] included the implementation of economic adjustment measures formulated by the IMF and the World Bank that resulted in a significant neoliberal economic transition. Chile and Mexico have experienced particularly

component in that the consequence is privatization's failure to improve the economic well-being of the poor. Commenting on politicians and the "dynamic dependency model," which accords vulnerable groups first-order priority in a country's development process, some have suggested that "[p]opulism in Latin America should be criticized not for its redistributive goals per se, but rather for its propensity to view vulnerable groups paternalistically and to exploit them for political purposes."[107] This development model can be justified in Latin America because it is morally unacceptable that there be an increasingly large gap between the wealthy and the poor, because development goals will not be achieved when citizens are undereducated and apathetic, because such social inequities heighten the risk of political instability brought about by military intervention, and finally, because those same inequities distort development endeavors.[108]

In sum, it can be said that, while there is a significant amount of political rhetoric involved in assessing the success or failure of privatization, the underlying idea is that privatization will be unsuccessful if it fails in improving the economic conditions in which a country's population lives.

B. Privatization in Latin America

As noted above, Latin America has not been exempt from the sweeping effects of privatization.[109] Previously, during a good part of this

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> swift transitions because their authoritarian regimes have used extensive executive powers to implement the economic laws and regulations that facilitated adjustment. This process has resulted in increased poverty and a widening of the gap between the rich and the poor.

Id.; *see also* Manzetti, *supra* note 19, at 5 ("[L]ittle progress has been made in the political and legal realms.").

107. Carrasco, *supra* note 106, at 312.

108. *Id.* at 310-11; *see also* Baer & Birch, *supra* note 21, at 15 ("Two major limitations to the dispersion of ownership in Latin America were the highly skewed distribution of income and the absence of well-developed capital markets.").

109. Manzetti, *supra* note 19, at 5.

> In the 1980s and early 1990s, market reforms swept all the regions of the developing world, particularly in Latin America, which by itself between 1988 and 1993 accounted for 58 percent of total worldwide privatization sales. In fact, trade liberalization, privatization of state-owned enterprises (SOEs) and deregulation of a wide variety of

century, import-substitution-industrialization was the central economic development doctrine adopted by many countries in Latin America.[110] Pursuant to these policies, many countries (including Costa Rica) controlled and operated SOEs in such areas as telecommunications, banking, hotels, airlines, petrochemicals, and insurance.[111] Costa Rica, in fact, still operates SOEs in telecommunications, electricity, banks, oil refining, and insurance.

As a reaction to the bad experiences encountered with these SOEs, Latin America became one of the prime regions in terms of privatization campaigns. Focus was also placed on trade liberalization, which has become increasingly important to the development of Latin American economies. However, some argue that these economies should redirect their energies toward attracting foreign direct investment.[112] Opposition to privatization in Latin American countries has led to what has been called "setbacks,"[113] but a sort of privatization frenzy that affected most countries has even led some to consider Latin America as "the next economic powerhouse."[114] In fact, when measured in terms of dollars, 57% of all privatizations took place in Latin America in 1995.[115] This section will illustrate some of the issues that are dealt with in the privatization context, drawing from the experiences of Argentina, Brazil, Chile, and Mexico.

1. Argentina

Privatization in Argentina is largely credited to the politics of Carlos Menem, who served as President of Argentina during the 1990s and promoted the process. As in other countries in the region, from World War II through the early 1980s, the Argentine State grew significantly, especially in terms of the prominence and size of SOEs. After civilian government was restored in 1983, the economy was in generally poor

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> economic activities were the pillars upon which the Latin American market reform agenda was based.

Id.

110. Baer & Birch, *supra* note 21, at 2.

111. SARKAR, *supra* note 12, at 152.

112. Mark B. Baker, *Integration of the Americas: A Latin Renaissance or a Prescription for Disaster?*, 11 TEMP. INT'L & COMP. L. J. 309, 310 (1997).

113. Reisman, *supra* note 2, at S374.

114. *Id.*

115. SARKAR, *supra* note 12, at 145.

shape and there remained a large SOE sector.[116] Of course, there was significant opposition to any privatization program, especially from worker organizations who, it was said, profited from the previous government control and stood to lose jobs and benefits if SOEs were sold to the private sector.[117] Ironically, it was Menem himself who once enlarged the government sector he now sought to reduce.[118]

Menem was given ample authority, by a law enacted in 1989, to commence a privatization process that touched many state industries.[119] Debt-equity swaps were a crucial part of that privatization program, and soon Argentina was the most ambitious user of this technique.[120] Privatization in Argentina involved the sale of state airlines, telecommunications companies, the government steel company, the Buenos Aires electric utility company, and railway systems, among others.[121] In effect, "[l]aw 23.696 declared a state of emergency which applied to the various state enterprises, corporations, and banks. State-owned property, services, or utilities could be privatized upon a formal declaration by the executive branch with Congressional approval."[122] In September of 1991, Argentina announced another plan for privatization (including sensitive military real estate holdings) and tax reduction and simplification.[123] In addition, by 1993, Argentina's Foreign Investment Law had been changed to reflect the new government policies, and thus

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116. Armijo, *supra* note 21, at 2-6.

117. Julio C. Cueto-Rua, *Privatization in Argentina*, 1 SW. J. OF L. & TRADE AM. 63, 66 (1994) ("However, the unions and their workers profited from this bleak situation, and stood to lose jobs and benefits if the companies were turned over to more prudent management.").

118. Reisman, *supra* note 2, at S378.

119. Cueto-Rua, *supra* note 117, at 69 ("Law 23.696, officially titled 'Administrative Emergency and Reorganization of the State,' gave President Menem both the broad authority to begin the privatization process and listed the state industries, public services, and public utilities which were subject to privatization. These enterprises included . . . insurance companies.").

120. Vernava, *supra* note 50, at 116.

121. Proceedings of the Sixth Annual Seminar on Legal Aspects of Doing Business in Latin America: Free Markets in Latin America: New Games -- New Rules, *The New Latin American Economic Landscape: Emerging Market Capitalization: Country Updates Part I*, 8 FLA. J. INT'L L. 192, 192-93 (1993) [hereinafter *New Latin American Landscape*].

122. Cueto-Rua, *supra* note 117, at 70 (footnotes omitted).

123. *Id.*

provided that foreign investors would be treated in the same manner as domestic investors.[124]

Also in 1993, Argentina partially privatized its social security system.[125] The reform, while based on the Chilean example, is less far reaching because workers still retain the possibility of keeping their pension with a state-run system.[126] Thus, in terms of pensions, "[t]he case of Argentina demonstrates how, in a democratic political system as opposed to Pinochet's military junta in Chile, the legislative process works more slowly, and widespread reforms come about more gradually."[127]

From 1990 to 1995, Argentina privatized 126 SOEs.[128] In looking back at Argentina's privatization programs, it can be noted that the two main components of the Menem program were first, the structural reform to eliminate the public sector's deficit and terminate its inefficient interventions in the market and, second, the improvement in the supply of certain public goods and services indispensable to private sector growth.[129] In addition, it is noteworthy that efforts were made to avoid the establishment of private monopolies, and when possible, SOEs were divided and sold to separate buyers for this purpose.[130]

In the end, it must be noted that Menem's leadership was praised during the privatization period. The process he led has been described as a "simple and well-reasoned procedure for selling the state-owned enterprises that in turn ended the drain these enterprises placed on the Treasury and helped the government stop inflation."[131] Some have also

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124. Vernava, *supra* note 50, at 113.

125. Michael Alan Parkin, *Privatization of Old-Age Pensions in Latin America: Lessons for Social Security Reform in the United States*, 62 FORDHAM L. REV. 2199, 2210 (1994).

126. *Id.*

127. *Id.*

128. Vernava, *supra* note 50, at 152.

129. *New Latin American Landscape, supra* note 121, at 192.

130. Cueto-Rua, *supra* note 117, at 73.

131. *Id.* at 71. Cueto-Rua notes that:

> [t]he success of the privatization process can be attributed to four main sources: the government's use of both foreign and domestic advisors in developing the actual sales procedures, the speed with which the sales took place, the government's policy of making it possible for all sectors of the society to take part in investing in the privatization, and the government's delicate treatment of the labor unions and workers.

Id.

noted that it is hard to believe the breadth of the Argentine privatization process.[132] In the final analysis, the heavy hand that politics and shifting ideologies played cannot be overlooked.[133] In effect, some authors opine that, in Argentina's case, decisions to bring about economic reform and privatization had more to do with politics than with the actual intrinsic efficiency or profitability of state-owned enterprises.[134]

2. Brazil

It was not until 1990 that Brazil began reforming its economy and engaging in privatization efforts.[135] As was also the case with other countries in the region during the early 1990s, Brazil was burdened with a huge external debt that reached $121 billion. This, along with political obstacles and bureaucracy held up Brazil's privatization enterprise until more recently.[136] Again, as in other countries, by 1991 "violent demonstrations against privatization efforts [had] twice forestalled the process of reform. Indeed, as one reporter stated, Brazil [was] increasingly the odd one out in Latin America as it struggle[d] to come to terms with its awesome problems while elsewhere in the region foundations [were] being laid for stable growth."[137]

In spite of this, a broad privatization program was initiated in 1990, pursuant to a federal law.[138] Among the goals sought to be achieved by the Brazilian government through privatization was the attraction of foreign capital to abate its trade deficit and to draw much needed investment in technology infrastructure.[139] In the early 1990s, there appeared to be a government commitment to privatizing SOEs in both the steel and the

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132. *New Latin American Landscape*, *supra* note 121, at 192 ("Those reforms were really remarkable. No one who knows the history of Argentina could believe that such reforms could be achieved there. Mr. Menem restructured and privatized state-owned enterprises in literally all sectors of the economy, including the all-sacred defense sector.").

133. Armijo, *supra* note 21, at 17 ("Despite his nationalist and statist past and his recent rhetoric, Menem moved to implement strongly neoliberal policies, including slashing the public sector.").

134. *Id.* at 2.

135. Reisman, *supra* note 2, at S379.

136. *Id.*

137. *Id.* at 380 (footnotes and internal quotations omitted).

138. Christopher R. Rabley, *The Need for Liberalization of Barriers to Trade in Insurance to Promote Consumer Interests: Analysis of the Brazilian Reinsurance System as a Case Study*, 24 N.C. J. INT'L. & COM. REG. 633, 644-45 (1999).

139. *Id.*

petrochemical sectors. "Brazil's privatization of USIMINAS (one of the country's many state steel companies) initially faltered due to procedural problems and political opposition. Nevertheless, the eventual privatization of USIMINAS in November 1991, launched extensive privatization plans in Brazil."[140] There was an increase in the number of large companies operating in Brazil, and in 1995, previously untouchable government assets (such as electrical, gas, oil, and telecommunications) were privatized.[141] "Between 1991 and 1997, the government sold fifty-five companies for a total of $15 billion, with many receiving foreign capital."[142] This process also included mining, B-bandwidth cellular phone concessions, and telephone systems (through the privatization of Telebras).

As a matter of illustration, the case of the much-discussed privatization of the Brazilian government-controlled monopolistic reinsurer may be useful. For many decades, Brazil's insurance market had been off-limits to foreign investors (both to primary insurers and reinsurers).[143] Of course, Brazil has the largest insurance market in Latin America and has, thus, been an important target for trade negotiators and insurance companies.[144] It is noteworthy that foreign insurers invested over $1 billion in Brazil between 1994 and 1998.[145]

The *Instituto de Resseguros do Brasil* ("Brazilian Reinsurance Institute," or IRB) retains control of the Brazilian insurance market through a strict legal monopoly on the underwriting of reinsurance in Brazil.[146] As commentators have noted, one of the main arguments for pursuing privatization is that the existence of the SOE's monopoly runs in the face of worldwide trade liberalization under the World Trade Organization (WTO) agreements.[147] Of course, one of the problems this

140. Baer & Birch, *supra* note 21, at 2 (footnotes omitted).

141. Rabley, *supra* note 138, at 658.

142. *Id.*

143. *Id.* at 636 ("For over thirty years, Brazil's insurance market has been sealed from foreign insurance and reinsurance companies. Strict regulations prohibited any new investments by foreign insurers, and a government monopoly over reinsurance kept reinsurers away from Brazil's reinsurance market.").

144. Rabley, *supra* note 138, at 635.

145. *Id.*

146. *Id.* at 646-47.

147. *Id.* at 637-38. Rabley argues that:

process has faced is that the reinsurance monopoly was initially excluded from Brazil's National Privatization Program.[148]

Still, there appears to have been some progress in this field. "Prior to the WTO negotiations, Brazil maintained strict barriers to trade in insurance."[149] This included not allowing foreign insurance companies to transact business in Brazil (except for minority partnerships in joint ventures), and restricting the repatriation of any more than 12% of foreign concerns' profits. There was a further requirement that Brazilian government entities place their business with Brazilian wholly-owned companies.[150] The argument is, then, that significant improvements can be achieved if more private sector participation, especially from foreign players, is increased.[151]

3. Chile

Saying that Chile is regarded as the leader among Latin American privatizers is almost cliché.[152] In effect, as has been noted, Chile deregulated and privatized much of its previously government-held industry.[153] From 1990 to 1995, Chile privatized only 12 SOEs,[154] mainly because by then it was further along in the process than other Latin American nations (or, as detractors would put it, "there was nothing more

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> Brazil's strict reinsurance regulations serve as a substantial barrier to trade and create an isolated marketplace. The regulations suffocate the development of the insurance industry and stifle innovations in products, processes, and market efficiency. . . . Consumers in Brazil have been forced to purchase insurance in an uncompetitive environment where products are excessively priced and inadequate as compared to open market standards.

Id.

148. *Id.* at 652.

149. *Id.* at 643.

150. *Id.* at 643-44.

151. *Id.* at 666 ("Once allowed to do business in Brazil, foreign insurance companies will import sophisticated insurance services, underwriting practices, and modern management techniques. The benefits of this to Brazilian consumers can be many including improved quality of services and diverse products.").

152. Vernava, *supra* note 50, at 125. ("Chile preceded other Latin American nations in privatization and financial liberalization.").

153. Baer & Birch, *supra* note 21, at 1 ("In Latin America, Chile led the way. Chile deregulated many sectors and sold state enterprises to both domestic and foreign private groups.").

154. Vernava, *supra* note 50, at 153.

left to sell"). In particular, as this topic relates to insurance, it must be noted that Chile, again, started the process of insurance deregulation in the early 1980s, and now operates an open market system.[155]

By some estimates, the regime of Salvador Allende (1970-1973) in Chile operated approximately 600 SOEs that together made up about 50% of Chile's GDP.[156] In 1973, a dramatic change of events would alter the course of Chile's economy. By now it is well known that the military coup and subsequent authoritarian government that ousted Allende and put General Augusto Pinochet in power was central in Chile's privatization process. "Pinochet's authoritarian government rode roughshod over any objections voiced by interest groups, and began instituting free market economy reforms in 1980. Among his reform package was the wholesale privatization of SOEs."[157]

Given the lack of a democratic element in Chile's policies, Pinochet's government implemented radical financial and trade liberalization, which was followed by the outright transfer of previous nationalized enterprises, and enterprises that had been especially created for the government.[158] Of course, there has been criticism of this process, consisting mainly of indications that many SOEs were stripped of their debts in order to quickly

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155. Tony Santos, *Unique Opportunities and Challenges: Country Updates*, 10 FLA. J. INT'L L. 40, 55-56 (1995).

156. Reisman, *supra* note 2, at S375.

157. SARKAR, *supra* note 12, at 162; *see also* Kristen V. Campana, *Paying Our Own Way: The Privatization of the Chilean Social Security System and Its Lessons for American Reform*, 20 U. PA. J. INT'L ECON. L. 385, 393 (1999) ("Pinochet's military control is often considered responsible for the successful implementation of this effort, because it eliminated all opposition from the old Congress and political groups.").

158. Reisman, *supra* note 2, at S375-76.

> The government that succeeded the Allende regime in 1973 responded by implementing 'drastic financial and trade liberalization.' In this way, the first of Chile's four phases of privatization began, during which approximately 240 previously nationalized enterprises were either transferred outright or were returned to prior owners. In the second phase of privatization, begun in 1975, the government divested itself of enterprises that the previous government had created, or in which the previous government had bought shares. The third and fourth phases began in 1985, with the third phase involving 'the reprivatization of enterprises divested during phases one and two,' and the fourth phase involving the divestiture of the final forty large industrial companies controlled by the government.

Id.

sell them and obtain higher prices. The debt that was left over, however, burdened the Chilean Central Bank and "drained the Central Bank's resources by two percent of gross domestic product annually, according to one estimate."[159]

Among Chile's most acclaimed success stories is the privatization of its pension system. "In 1980, Chile privatized its social security system to relieve the government's administrative burden, eliminate the stratification and inequality that pervaded the pension system, and promote economic growth through saving and investment in private capital markets."[160] Indeed, some authors choose Chile's pension privatization program as an illustration of the benefits that such programs can generate in terms of capital market enhancement. "[Chile] successfully transformed [its] pay-as-you-go pension system (of a type still used in the United States), into a system of privately funded and managed individual retirement accounts. Ultimately, pension fund privatization and reform proved to be instrumental in Chile's economic recovery."[161]

In the end, several characteristics of Chile's privatization scheme are of note. First, it appears that tactics of widespread share ownership (such as special discounts, incentives, or quotas) can be employed in order to avoid concentration.[162] Second, and more importantly, the soundness of the macro-economic environment is crucial to success.[163] Third, some conclude that learning from Chile's experience suggests that privatization should not be implemented on a widespread scale.[164] Nonetheless, it seems that the use of pension funds (in Chile's case, *Administradoras de Fondos de Pensiones* or AFPs) can be a strong catalyst for capital market development, even in a small market.[165]

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159. *Id.* at S376 (citing Jerome I. Levinson, *While the Bankers Confront a New Lending Order*, WASH. POST, Oct. 13, 1991, at C3).

160. Parkin, *supra* note 125, at 2205.

161. SARKAR, *supra* note 12, at 162; *see also* Campana, *supra* note 157, at 391-421.

162. Reisman, *supra* note 2, at S376 (citing HELEN NANKANI, TECHNIQUES OF PRIVATIZATION OF STATE-OWNED ENTERPRISES 40 (1988)).

163. SARKAR, *supra* note 12, at 164.

164. Reisman, *supra* note 2, at S376 (citing NANKANI, *supra* note 162, at 40).

165. SARKAR, *supra* note 12, at 165; Vernava, *supra* note 50, at 125 ("The [privatization] process included expanding the availability of capital that could flow into the stock market. Thus, in March 1994, the Chilean Congress passed a law allowing pension funds to extend their investments to nearly 300 of Santiago's listed companies.").

4. Mexico

Again, as with other Latin American countries, Mexico has historically oscillated between cycles of nationalization and privatization. "Mexico began nationalizing its industries around 1917, privatized beginning in 1940, nationalized again beginning in 1958, and began privatizing yet again in the mid-1980s."[166] From 1990 to 1995, Mexico privatized 221 SOEs,[167] by far the highest number of SOEs privatized by a Latin American country in that period.

In Mexico, almost all large SOEs have been privatized, but privatization has slowed down otherwise.[168] In 1989, Mexico began by reforming its financial system, including liberalization of interest rates and reduction of reserve requirements and mandatory credit allocations.[169] In particular, by 1991, seven state commercial banks had been privatized,[170] and the privatization of railway systems and ports increased investment opportunities.[171] Mexico had also participated in the wave of acquisitions of Latin American insurers by foreign companies.[172] At the same time, Mexico updated and reformed its laws governing foreign direct investment in order to facilitate inflows of foreign capital.[173]

One of the cited benefits that Mexico experienced through its privatization efforts is the increase in foreign capital invested in the Mexican stock market. With privatization, "Mexico . . . has seen dramatic inflows to and outflows from the Mexico City Stock Exchange. . . . In 1989, a puny half-million dollars moved into the Bolsa. In 1993, $33.3

> AFPs demonstrate that institutional investors can be a strong catalyst for capital market development even if stock market listings are limited. By investing in government commercial paper and other government-backed securities, institutional investors add a great deal of stability to financial markets. Moreover, by privatizing AFPs and allowing them to invest in the shares of private companies, local capital markets are both broadened and deepened.

Id.

166. SARKAR, *supra* note 12, at 146 (footnote omitted).

167. Vernava, *supra* note 50, at 153.

168. *Id.* at 111.

169. Reisman, *supra* note 2, at S377.

170. *Id.*

171. Glade, *supra* note 85, at 65.

172. *Id.* at 60.

173. Vernava, *supra* note 50, at 112 (commenting that Mexico rewrote its foreign investment law effective January 1, 1994).

billion dollars in foreign investment were made in Mexico."[174] It should be noted, furthermore, that Mexico has also undergone privatization efforts as a part of an integral macro-economic reform process that has put emphasis on improving income distribution, domestic saving, and productivity.[175] Some commentators stress that other efforts should be made to continue with privatization of certain industries, such as Mexico's high-profile petrochemical SOE, Pemex.[176]

One particular feature of Mexico's privatization process is that it has been significantly centralized and streamlined. In effect, some commentators note that Mexico has successfully sold thousands of enterprises (including its larger ones) with the involvement of only a relatively small group of persons.[177] Alternatively, this has been criticized because many crucial decisions have been left by the legislature to the executive branch and its administering agencies.[178] Finally, it is noteworthy that Mexico has attempted to reform its pension system much in the same way that Chile did.[179]

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174. *Id.* at 115.

175. Reisman, *supra* note 2, at S377.

176. J. Keith Russell, *The Time Is Now for Full Privatization of PEMEX*, 20 HOUS. J. INT'L L. 173, 201-02 (1997).

> The only thing standing in the way of full privatization of Pemex is an outdated notion about national sovereignty being dependent upon the existence of a national oil company. This sentiment is further being exploited by self-serving, clever politicians at the expense of the very people Pemex was supposed to help: the working people of Mexico.

Id.

177. Shirley, *supra* note 23, at S29 ("Mexico has successfully sold thousands of enterprises, including some very large enterprises, with only seven people conducting transactions. . . . Such a centralized system might seem subject to abuse, but the check in Mexico was transparency.").

178. Chibundu, *supra* note 11, at 15-16 ("Thus, the constitutive documents in countries like Mexico . . . often have covered several disparate cases of privatization, and left many of the crucial decisions to the post hoc discretion of the executive branch and its administering agencies.").

179. Parkin, *supra* note 125, at 2214.

> In February 1992, the Mexican government enacted legislation that reformed the existing system to provide better pensions for workers. . . . The case of Mexico illustrates the interaction between private pensions and capital markets, and shows that a relatively small transfer of social security money to private fund managers can significantly affect the level of private saving and investment.

Id.

C. The Privatization of Insurance in Uruguay

This section describes the current situation of Uruguay's insurance industry, and will reflect on Uruguay's recent move from a closed insurance market, very similar to Costa Rica's, to an open market. In order to accomplish this, it will be necessary, first, to explain why Uruguay is especially helpful as a model for analyzing Costa Rican insurance reform issues and, second, to describe the relevant and fundamental features of Uruguay's insurance reform and its main effects.

1. Uruguay: A Model for Costa Rican Insurance Reform

When dealing with issues of insurance reform in Latin America, several recent examples of fundamental insurance reform are available. Nonetheless, for the purpose of this Article, the experiences of some countries are only somewhat useful. For any comparison of this nature to be of any practical relevance, it is imperative that one avoid "comparing apples with oranges."

Although the experiences of Argentina, Brazil, Chile and Mexico serve to illustrate some of the issues that Latin American countries deal with in undertaking privatization efforts, when commenting on insurance reform it is imperative that the size of the countries' economies be given due regard. Thus, for example, while Brazil has been undergoing a fundamental restructuring of its insurance market, the clear differences between a market such as Brazil's and a market like Costa Rica's should put comparisons into the appropriate perspective. With a population of over 171 million (July 1999 estimates) and a Gross Domestic Product (GDP – purchasing power parity) of $1.0352 trillion (1998 estimates),[180] Brazil's economy and markets clearly dwarf those of Costa Rica.

By contrast, Uruguay and Costa Rica share many characteristics that, arguably, make Uruguay the best reference for comparison in dealing with insurance reform issues.[181] Although the two countries are geographically

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180. *See* CENTRAL INTELLIGENCE AGENCY WORLD FACTBOOK, *available at* http://www.odci.gov/cia/publications/factbook/ index.html (visited Nov. 21, 1999).

181. *See generally* THE POLITICAL ECONOMY OF POVERTY, EQUITY, AND GROWTH, The World Bank (Simon Rottenberg ed., 1993). This study of Uruguay and Costa Rica presents the two nations as having remarkable similarities in their historic development. It explains how the two countries achieved relatively high levels of per capita income through the export of primary products, and comments on the countries' social and redistributive

far apart, upon closer examination, they share many similarities. In terms of population, Costa Rica and Uruguay are very similar. Estimates for July of 1999 show that Costa Rica has a population of 3,674,490 million,[182] while Uruguay's population is 3,308,523.[183] Further, Costa Rica and Uruguay have similar racial compositions.[184] The same can be said about the socio-economic structure of these countries' societies[185] as measured in indicators such as life expectancy,[186] literacy rate,[187] and infant mortality rate.[188]

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policies. It is said that the consequence of such policies has been a high level of justice in both countries and the benefit of a democratic system of government.

182. CENTRAL INTELLIGENCE AGENCY WORLD FACTBOOK *at* http://www.odci.gov/cia/publications/factbook/geos/cs.html (last visited Nov. 21, 1999) [hereinafter CIA DATA ON COSTA RICA]; *see also* Costa Rica, *available at* MICROSOFT ENCARTA ENCYCLOPEDIA, *at* http://encarta.msn.com/encarta/Article.asp?z=2&br=0&mod=1&pg=6&ti=05223000 (last visited Nov. 11, 1998) [hereinafter ENCARTA ENCYCLOPEDIA ON COSTA RICA].

183. *See* CENTRAL INTELLIGENCE AGENCY WORLD FACTBOOK *at* http://www.odci.gov/cia/publications/factbook/uy.html (last visited Nov. 18, 1999) [hereinafter CIA DATA ON URUGUAY].

184. Costa Rica's 96% white (including *mestizo*, i.e., mix of European and Amerindian) population almost identically matches Uruguay's 94% (88% white, 8% *mestizo*), and the minority racial groups are also similar (blacks represent 2% of Costa Rica's population and 4% of Uruguay's, while Amerindian populations are practically non-existent in Uruguay and represent only 1% of Costa Rica's population). *See* CIA DATA ON COSTA RICA, *supra* note 182; CIA DATA ON URUGUAY, *supra* note 183. *See also* U.S. Department of State, *Background Notes: Costa Rica, July 1998*, *at* http://www.state.gov/www/background_notes/costa_rica_0798_bgn.htm (last visited Nov. 18, 1999) [hereinafter U.S. STATE DEPT. DATA ON COSTA RICA]; U.S. Department of State, *Background Notes: Uruguay, March 1998*, *at* http://www.state.gov.background_notes/uruguay_0398_bgn.htm (last visited Nov. 18, 1999) [hereinafter U.S. STATE DEPT. DATA ON URUGUAY].

185. Both Costa Rica and Uruguay have a large middle class. *See* ENCARTA ENCYCLOPEDIA ON COSTA RICA, *supra* note 182; Uruguay, available in MICROSOFT ENCARTA ENCYCLOPEDIA, [hereinafter referred to as ENCARTA ENCYCLOPEDIA ON URUGUAY] *at* http://encarta.msn.com/encarta/Article.asp?z=2&br=0&mod=1&pg= 6&ti=0437C00 (last visited Nov. 18, 1998). This element is particularly important when discussing issues of insurance reform. Arguably, the existence of a large middle class will facilitate the increased development of an "insurance culture" among consumers that will generally be both more aware of the need for insurance, and in a better financial position to buy insurance.

186. The life expectancy in Costa Rica is 76.04 years, the highest in the Western Hemisphere. ENCARTA ENCYCLOPEDIA ON COSTA RICA, *supra* note 182; *see also* CIA DATA ON COSTA RICA, *supra* note 182. The life expectancy in Uruguay is 75.83 years. CIA DATA ON URUGUAY, *supra* note 183.

In purely economic terms, the countries are also similar enough to provide a basis for a meaningful comparison. Both the Costa Rican economy and the Uruguayan economy are small economies.[189] Similarly, the GDP composition by sector (industry, agriculture, and services) is also substantially the same.[190] Of course, given the comparable populations and GDPs, the per capita GDP (purchasing power parity) is consequently very similar.[191] Finally, inflation rates (consumer prices)[192] and GDP growth rates[193] are comparable.

Lastly, as will be described in the following subsection, during the twentieth century, the insurance industry evolved in a similar manner in both Costa Rica and Uruguay. In sum, it is apparent that there are many similarities that make a comparison between Uruguay and Costa Rica a meaningful one. Of course, there are also important differences between

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187. The literacy rate in Costa Rica (defined as the percentage of the population 15 years of age and over that can read and write) is 94.8%, while in Uruguay it is 97.3%. CIA DATA ON COSTA RICA, *supra* note 182; CIA DATA ON URUGUAY, *supra* note 183.

188. Infant mortality in Costa Rica reaches 12.89 deaths/1,000 live births (1999 est.), while in Uruguay the rate is 13.49 deaths/1,000 live births (1999 est.). CIA DATA ON COSTA RICA, *supra* note 182; CIA DATA ON URUGUAY, *supra* note 183.

189. GDP (purchasing power parity) for Costa Rica (1998 est.) was $24 billion, while GDP for the same period in Uruguay was $28.4 billion. CIA DATA ON COSTA RICA, *supra* note 182; CIA DATA ON URUGUAY, *supra* note 183. Compare both GDP's with those for Brazil ($1.0352 trillion, 1998 est.), Argentina ($374 billion, 1998 est.), Mexico ($815.3 billion, 1998 est.), and Chile ($184.6 billion, 1998 est.) -- all countries within Latin America -- or the United States ($8.511 trillion, 1998 est.), Germany ($1.813 trillion, 1998 est.), the United Kingdom, ($1.252 trillion, 1998 est.), Japan ($2.903 trillion, 1998 est.), Canada ($688.3 billion, 1998 est.), and France ($1.32 trillion, 1998 est.). CENTRAL INTELLIGENCE AGENCY WORLD FACTBOOK, *at* http://www.odci.gov/cia/publications/factbook/index.html (last visited Jan. 16, 2000).

190. GDP composition by sector for Costa Rica is as follows: agriculture, 15%; industry, 24%; services, 61%. GDP composition by sector for Uruguay is as follows: agriculture, 8%; industry, 26%; services, 66%. CIA DATA ON COSTA RICA, *supra* note 182; CIA DATA ON URUGUAY, *supra* note 183.

191. Costa Rican GDP (purchasing power parity) per capita is $6,700 (1998 est.); Uruguayan GDP (purchasing power parity) per capita is $8,600. CIA DATA ON COSTA RICA, *supra* note 182; CIA DATA ON URUGUAY, *supra* note 183.

192. Costa Rica has an annual inflation rate of 12% (1998 est.), while Uruguay has one of 8.6% (1998 est.). CIA DATA ON COSTA RICA, *supra* note 182; CIA DATA ON URUGUAY, *supra* note 183.

193. GDP real growth rate for Costa Rica was 5.5% according to 1998 estimates. Estimated GDP real growth rate for Uruguay for the same period was 3%. CIA DATA ON COSTA RICA, *supra* note 182; CIA DATA ON URUGUAY, *supra* note 183.

the countries,[194] but the general proposition that they are comparable seems to be well based.

2. The Uruguayan Insurance Reform: Brief Background, Fundamental Features, and Current Key Insurance Market Indicators

This subsection will first set forth a brief background on the fundamental features of Uruguay's insurance industry and the reform process undertaken during the early 1990s in this South American country, and then describe the main effects of the insurance reform in terms of certain key insurance market indicators.

a. Brief Background and Fundamental Features of Uruguay's Insurance Industry and Recent Reform Process

As in Costa Rica, in Uruguay the insurance industry was (until 1993) a government monopoly. The earliest significant development of the insurance industry in Uruguay can be traced to the second half of the nineteenth century, when Uruguay as a whole started recuperating from the *Guerra Grande* (The Great War).[195] At that time, foreign (mainly British) insurance companies established themselves in Uruguay alongside Uruguayan insurers created after 1854.[196]

By the early twentieth century, the prevailing ideology and economic tendencies of the time led to the establishment of the *Banco de Seguros del Estado* (State Insurance Bank). Established in 1911, the purpose of the State Insurance Bank was to "regulate the private sector."[197] However,

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194. For example, while Uruguay is part of MERCOSUR, Costa Rica does not share a similar situation; the Central American Common Market (MERCOMUN) has been highly unsuccessful by most accounts. *See, e.g.*, MIGUEL A. EKMEKDJIAN, INTRODUCCIÓN AL DERECHO COMUNITARIO LATINOAMERICANO: CON ESPECIAL REFERENCIA AL MERCOSUR 125 (1994). In addition, and in connection to this, Uruguay's largest trading partners are Brazil and Argentina, while Costa Rica is heavily dependent on trade with the United States, Germany, and other European countries.

195. Banco de Seguros del Estado, *Historia del Banco de Seguros del Estado* (History of the State Insurance Bank), *available at* http://www.bse.com.uy/compania/ historia.html (last visited Nov. 21, 1999).

196. *Id.*

197. *Id.* "*La corriente ideológica y las tendencias económicas predominantes en la época llevaron a que en 1911,* a efectos de regular el sector privado, *se creara una entidad estatal denominada Banco de Seguros del Estado . . .*" *Id.* (Author's translation: "The

the State Insurance Bank was granted a monopoly over a large part of the insurance industry in Uruguay.[198]

The State Insurance Bank enjoyed its monopoly status until 1993 when, following a shift in the prevailing economic conditions, particularly those in South America regarding MERCOSUR,[199] Uruguay enacted Public Law No. 16.426 (the "Demonopolization Act").[200] The Demonopolization Act, adopted by the Uruguayan legislature on October 6, 1993, and signed into law by the Executive Branch on October 14, 1993, provides for the freedom to choose insurance companies.[201] Exempted from this general lifting of the State Insurance Bank's monopoly was insurance for government entities, government procurement sureties (both those guaranteeing participation in the bidding processes, and those guaranteeing actual performance of awarded government contracts), and worker's compensation insurance.[202]

There are five main features to the Demonopolization Act.[203] First and most obviously, as already noted above, its main feature is the

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ideological movement and the predominant economic tendencies of the period, *to the effect of regulating the private sector*, led in 1911 to the creation of a state entity named State Insurance Bank.") (emphasis added).

198. *Id.*

199. MERCOSUR, or *Mercado Común del Sur* (Southern Common Market), is the regional multilateral trade treaty in force between Argentina, Brazil, Paraguay, and Uruguay. Among its objectives, MERCOSUR includes the free circulation of goods, services, and persons among the member countries, the establishment of a common external tariff, the adoption of a common commercial policy towards third countries, a commercial liberalization program, and the coordination of the macroeconomic policies of the member nations. For a general introduction to MERCOSUR, *see, e.g.* MIGUEL A. EKMEKDJIAN, *supra* note 194, at 23.

200. LEY DE DESMONOPOLIZACIÓN DEL BANCO DE SEGUROS DEL ESTADO [STATE INSURANCE BANK DEMONOPOLIZATION ACT] (Uru.), *available at* http://206.99.48.149:8585/bcu/index5 (last visited Nov. 21, 1999) [hereinafter DEMONOPOLIZATION ACT].

201. Article 1 of the Demonopolization Act states: "*Declárase libre la elección de las empresas aseguradoras para la celebración de contratos de seguros sobre todos los riesgos, en las condiciones que determine la ley.*" *Id.* (Author's translation: "The choice of insurance companies for entering into insurance contracts on all risks is declared to be free, in the conditions determined by law.").

202. *Id.*

203. Superintendencia de Seguros y Reaseguros, Banco Central del Uruguay, *Sobre las Leyes y Decretos que Regulan la Actividad Aseguradora en el País*, http://www.bcu.gub.uy/autoriza/sssrer/ssrig005.htm (last visited Nov. 21, 1999).

abrogation of the State Insurance Bank's monopoly on insurance in Uruguay,[204] with the noted exceptions. Second, the Demonopolization Act also provides that the determination of market entry and operation regulations, as well as the authorization (licensing) of insurers, is to be done by the Executive Branch with the advice of the Uruguayan Central Bank.[205] Companies are authorized to enter into reinsurance agreements regardless of their establishment as Uruguayan companies.[206]

Third, the Demonopolization Act created the *Superintendencia de Seguros y Reaseguros* (Superintendency of Insurance and Reinsurance, hereinafter referred to as "SSR," its acronym in Spanish) as a dependency of the Uruguayan Central Bank, and vested it with technical and operative autonomy.[207] The SSR is funded by the Uruguayan Central Bank, and the Superintendent is appointed by the Directors of said bank.[208] In broad terms, the SSR is charged with controlling public and private companies that carry out insurance or reinsurance activities (i.e., agents and brokers), as well as controlling those persons who conduct intermediary activities in insurance, and coordinating the activity of the public sector.[209] Specifically, the SSR is charged with providing for the establishment of insurers once they have been authorized for operation by the Executive Branch.[210] The SSR also establishes minimum capital requirements, solvency margins, and technical reserves,[211] and creates an accounting system to which insurers must adhere.[212]

Fourth, the Demonopolization Act expanded the system of penalties and sanctions applicable to financial intermediaries so that it would be applicable to insurers. Thus, several types of sanctions may be imposed for non-compliance with insurance regulations according to the

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204. Reisman, *supra* note 2; *see also* Baer & Birch, *supra* note 21.

205. DEMONOPOLIZATION ACT, *supra* note 200, arts. 2-3.

206. *Id.*

207. *Id.* art. 6.

208. *Id.*

209. *Id.* "Compete a la Superintendencia de Seguros y Reaseguros controlar a las empresas públicas y privadas que realicen actividades de seguros o reaseguros, así como las personas que ejerzan actividad de intermediación en la materia indicada y coordinar la actividad del sector público." *Id.*

210. *Id.* art. 7.A.

211. *Id.* art. 7.D.

212. *Id.* art. 7.H.

seriousness of the fault, ranging from a simple notice to a definitive revocation of the license to do business.[213]

Fifth and finally, the Demonopolization Act authorizes the Executive Branch to grant preferential tax treatment to those insurers that operate in Uruguay specifically for the purpose of insuring risks related to persons or property not located within Uruguayan territory.[214] Clearly, the establishment of favorable tax treatment for off-shore insurers was seen as a means of developing the local insurance market.

According to the Uruguayan Central Bank, "since its creation the [SSR] has devoted itself to defining the new game rules for the insurance market, to achieve an efficient and transparent operation, that may definitively guarantee the consumer an effective protection through the development of a solvent market."[215] In order to do so, the SSR and the Executive Branch, mainly through Executive Decree 354/994,[216] have defined certain key areas: market access conditions, insurer solvency, the establishment of accounting standards for insurers, reinsurance with non-domiciled reinsurers, and the determination of minimum requirements for Uruguay's collective disability, death, and retirement income insurance system.

The first of these key areas concerns market access conditions. Only Uruguayan stock corporations (*sociedades anónimas*), the share capital of which is represented by nominative shares, may operate in the Uruguayan

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213. *Id.* art. 7.K. *See also* Superintendencia de Seguros y Reaseguros, Banco Central del Uruguay, *Sobre las Leyes y Decretos que Regulan la Actividad Aseguradora en el País*, *supra* note 203.

214. DEMONOPOLIZATION ACT, *supra* note 200, art. 13.

215. "Desde su creación, la [Superintendencia de Seguros y Reaseguros] . . . se ha abocado a definir las nuevas reglas de juego del mercado asegurador, para lograr un funcionamiento eficiente y transparente, que en definitiva garantice al consumidor una efectiva protección a través del desarrollo de un mercado solvente." *See* Superintendencia de Seguros y Reaseguros, Banco Central del Uruguay, *Creación y Marco Regulatori*, http://206.99.48.149:8585/docs/SSRIG008.html (last visited Nov. 21, 1999).

216. EXECUTIVE DECREE 354/994, *available at* http://206.99.48.149:8585/docs/DEC354A.html (last visited Nov., 21, 1999) [hereinafter DECREE 354/994]. Decree 354/994 was issued on August 17, 1994 by the Uruguayan Ministry of Finance, and it constitutes a main source of administrative regulation of the Uruguayan insurance industry, alongside the normative bulletins (*circulares*) issued by the SSR itself.

market,[217] and their articles of incorporation must provide for the exclusivity of their corporate purpose as insurers.[218] These companies must be authorized by the Executive Branch in order to operate, and thus the Executive Branch evaluates the insurance plan proposed by the insurer.[219] It is possible to serve both as a property/casualty insurer and a life/health insurer.[220]

The second key area of concern relates to insurer solvency.[221] There are several mechanisms in place that aim to control insurer solvency, the first of which is the accreditation of a minimum basic capital (*capital básico*),[222] currently established at a minimum of approximately $525,000 (with increases of one-sixth this amount for each additional line of fire, automobile, theft, liability, jail bond, and/or transportation insurance written by the insurer).[223] The second mechanism relates to solvency margins; Uruguay has chosen to follow the European Union model.[224] The third mechanism regulates the establishment of technical reserves, including reserving for incurred but not reported (IBNR) losses.[225] Finally, the investment practices of insurers are regulated in terms of return rates, liquidity and safety, and regulations for valuation and diversification of investments are in place.[226]

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217. DEMONOPOLIZATION ACT, *supra* note 200, art. 2; DECREE 354/994, *supra* note 216, arts. 2, 4, 4.a.

218. DECREE 354/994, *supra* note 216, art. 11.

219. *Id.* arts. 3, 4.e.

220. *Id.* art. 4.d.

221. *See* Superintendencia de Seguros y Reaseguros, Banco Central del Uruguay, *Creación y Marco Regulatorio*, *supra* note 215.

222. *Id. See* DECREE 354/994 arts. 5, 15.1; *see also* RECOPILACIÓN DE NORMAS DE SEGUROS Y REASEGUROS arts. 9.A., 10.A. (compilation of insurance and reinsurance regulations) (Uru.) [hereinafter SSR REG.].

223. The exchange rate used for calculation purposes was US$ 1 = UYP 11.385. *See* Superintendencia de Seguros y Reaseguros, Banco Central del Uruguay, *Comunicación No. 99/25, Ajuste de Capital Básico*. (July 2, 1999). This SSR regulation is the latest minimum basic capital adjustment valid as of September 30, 1999.

224. SSR REG., *supra* note 222, arts. 9.B, 10.B.; *see also* Superintendencia de Seguros y Reaseguros, Banco Central del Uruguay, *Creación y Marco Regulatorio*, *supra* note 215.

225. SSR REG., *supra* note 222, arts. 14-25; *see also* Superintendencia de Seguros y Reaseguros, Banco Central del Uruguay, *Creación y Marco Regulatorio*, *supra* note 215.

226. SSR REG., *supra* note 222, arts. 26-37; *see also* Superintendencia de Seguros y Reaseguros, Banco Central del Uruguay, *Creación y Marco Regulatorio*, *supra* note 215.

A third key area of concern for the SSR has been the establishment of accounting standards for insurers,[227] including uniform account plans and information reporting requirements.[228]

The fourth key area of the SSR's activity relates to the definition of rules for ceding risks to reinsurers not established in Uruguay.[229] In these cases (where the ceding insurer either directly places its risk with a non-domiciled insurer or where it goes through a broker), a series of conditions and requirements are in place to ensure prior control on the part of the SSR in relation to minimum solvency requirements and the inclusion of a designated non-domiciled reinsurer register.[230]

Finally, the fifth key area of concern in the SSR's activity to date has been to define minimum requirements for Uruguay's collective disability, death, and retirement income insurance system established through Public Law No. 16,713.[231]

In addition to the Demonopolization Act, it is important to note that there are several other pieces of legislation that directly bear upon insurance issues in Uruguay, including the Commercial Code,[232] several tax laws,[233] the Aeronautical Code,[234] the condominium property law,[235] and certain worker's compensation and social security laws,[236] among others.

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227. SSR REG., *supra* note 222, arts. 40-64; *see also* Superintendencia de Seguros y Reaseguros, Banco Central del Uruguay, *Creación y Marco Regulatorio*, *supra* note 215.

228. *Id.*

229. SSR REG., *supra* note 222, arts. 65-77; *see also* Superintendencia de Seguros y Reaseguros, Banco Central del Uruguay, *Creación y Marco Regulatorio*, *supra* note 215.

230. *Id.*

231. SSR REG., *supra* note 222, arts. 78-100; *see also* Superintendencia de Seguros y Reaseguros, Banco Central del Uruguay, *Creación y Marco Regulatorio*, *supra* note 215.

232. CÓDIGO DE COMERCIO [COMMERCIAL CODE] (Uru.) [hereinafter URUGUAYAN COMMERCIAL CODE]. The Uruguayan Commercial Code provides the substantive legislation applicable to insurance contracts. This is a distinction with Costa Rica, the Commercial Code of which includes no specific provision relating to insurance contracts. Instead, the 1922 INSURANCE ACT provides the substantive rules relating to insurance.

233. *See* Superintendencia de Seguros y Reaseguros, Banco Central del Uruguay, *Sobre las Leyes y Decretos que Regulan la Actividad Aseguradora en el País*, *supra* note 203. These tax laws include insurer income tax provisions (ranging from 0.5% through 15%) and premium taxes (used to fund the National Blood Service and the National Organ and Tissue Bank). *Id.*

234. *Id.*

235. *Id.*

236. *Id.*

b. The Main Effects of the Uruguayan Insurance Reform in Terms of Certain Key Insurance Market Indicators

In general terms, it can be said that the Demonopolization Act and the reforms it brought into the Uruguayan insurance industry have had a positive impact. In 1995, the first year of the Uruguayan open insurance market after the lifting of the State Insurance Bank's monopoly, there were nine private insurers operating alongside the State Insurance Bank, which continued to participate in the Uruguayan insurance market.[237] The number of private insurers increased by four to thirteen by 1996,[238] and again by three to sixteen by 1997.[239]

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237. It is important to stress that the State Insurance Bank was not sold and was, instead, left to compete with other insurers in Uruguay's market. In this regard, *see* Banco de Seguros del Estado, *Historia del Banco de Seguros del Estado [History of the State Insurance Bank]*, *available at* http://www.bse.com.uy/compania/historia.html. On 1995 insurance industry figures, *see* Superintendencia de Seguros del Estado, *Información Técnica y Financiera del Mercado Asegurador Correspondiente al Año 1995, available at* http://www.bcu.gub.uy/autoriza/sssrer/srerco97003.pdf (Pursuant to the Demonopolization Act, art. 7, and Decree 354/994, art. 17, the SSR is required to periodically publish the financial statements and other relevant information on the public and private entities operating in insurance and reinsurance in Uruguay. Purportedly -- through the joint effort of both the SSR and the regulated insurers, detailed, uniform, and periodic information is made available in these annual reports for the benefit of insureds, insurers, foreign reinsurers, and investors. Until now, one such report has been issued for each of 1995, 1996, and 1997.) [hereinafter 1995 SSR ANNUAL REPORT].

238. Superintendencia de Segurosy Reaseguros, *Información Técnica y Financiera del Mercado Asegurador Correspondiente al Año 1996, available at* http://www.bcu.gub.uy/autoriza/sssrer/srerco97022.pdf [hereinafter 1996 SSR ANNUAL REPORT].

239. Superintendencia de Seguros y Reaseguros, *Información Técnica y Financiera del Mercado Asegurador Correspondiente al Año 1997, available at* http://www.bcu.gub.uy/autoriza/sssrer/ssrer99002.pdf. The following are the private companies selling insurance in Uruguay alongside the State Insurance Bank: AIG Uruguay Compañía de Seguros, S.A (fire, theft and similar risks, automobile, liability, transportation, and others), ALICO Compañía de Seguros de Vida, S.A. (life), Compañía Cooperativa de Seguros SURCO (fire, life, and retirement), Compañía de Seguros Aliança da Bahia Uruguay, S.A. (transportation), FAR Compañía de Seguros, S.A. (automobile), Guardian Insurance, S.A. (fire, theft and similar risks, automobile, liability, and transportation), ITT Hartford Seguros de Vida, S.A. (life and retirement), Jefferson Pilot Omega Seguros de Vida, S.A. (life), Mapfre Uruguay Compañía de Seguros, S.A. (fire, theft and similar risks, automobile, liability, and transportation), Porto Seguro – Seguros del Uruguay, S.A. (automobile), Real Uruguaya de Seguros, S.A. (life, retirement, fire, theft and similar risks, automobile, liability, transportation, and others), Royal Insurance (Uruguay), S.A. (fire,

The State Insurance Bank retains a large share of the Uruguayan insurance market. According to the latest published SSR data, in 1997 the State Insurance Bank collected 77.64% of the premiums charged in Uruguay (all lines included).[240] Still, there are several factors that point to the increasing growth and development of the open-competition market established in 1995. First, the overall production of insurance (such as the aggregate of direct written premiums, in the case of property/casualty insurers, and gross premiums, in the case of life insurers) grew at a rate of 12.6% with respect to the previous year, in excess of $375 million.[241] This compares favorably with Uruguay's modest growth rate for 1996 (5.4%).[242]

Second, although property/casualty insurance still retains 64.9% of the insurance production during 1997,[243] it is relevant that life insurance has gained a more significant presence, increasing by 10.4% with respect to the prior year.[244] Such a significant increase in the life insurance sector is possibly a sign of the establishment and increasing development of an "insurance culture" among the Uruguayan population.[245]

Third, based on official population estimates and projections,[246] Uruguay attained a direct per capita premium of $114.9 for 1997.[247] This figure places Uruguay among the Latin American countries with the highest per capita premium, only behind Argentina and Chile (both of

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theft and similar risks, automobile, liability, and transportation), Santander Seguros, S.A. (life and retirement), SUL America Surinvest Compañía de Seguros, S.A. (fire, theft and similar risks, automobile, liability, and others), and UAP Seguros Uruguay, S.A. (fire, theft and similar risks, liability, and transportation) [hereinafter 1997 SSR ANNUAL REPORT].

240. 1997 SSR ANNUAL REPORT, *supra* note 239, at 5, 7. For financial statements and business purposes, the Uruguayan insurance sector follows the calendar year, i.e., January 1 through December 31.

241. *Id.*

242. 1996 SSR ANNUAL REPORT, *supra* note 238, at 4.

243. 1997 SSR ANNUAL REPORT, *supra* note 239, at 3. Automobile insurance alone represents 59.7% of the property/casualty insurance production, or 38.7% of the total production.

244. *Id.*

245. *Id.*

246. Instituto Nacional de Estadísitica, *Estimaciones y Proyecciones de la Población 1950-2050*, *cited in* 1997 SSR ANNUAL REPORT, *supra* note 239, at 3.

247. 1997 SSR ANNUAL REPORT, *supra* note 239, at 3. Compare this figure with $100.8 for 1995 and $107.6 for 1996. 1995 ANNUAL REPORT, *supra* note 237, at 3; 1996 ANNUAL REPORT, *supra* note 238, at 4.

which have had a competitive insurance market for some time).[248] In addition, it is necessary to take into account that a significant segment of the market, specifically worker's compensation insurance, is still under monopoly status in the hands of the State Insurance Bank.[249]

Fourth, there has been a sustained increase in consumer spending on insurance of approximately 7% (both for 1997 and 1996).[250] Although this increase may be due in part to macroeconomic factors not specifically related to the insurance industry,[251] it again seems to denote the development of an "insurance culture" among the Uruguayan population. This is a necessary component of any successful insurance reform process.

Fifth and finally, total premiums as a percentage of GDP are 1.88% for 1997, an increase of 7.5% with respect to 1996.[252] This figure seems to confirm, in the view of the SSR, the progressive development of the Uruguayan insurance market.[253] In particular, gross life insurance premiums as a percentage of the GDP are 0.24% for that same period, which represents a 17% increase with respect to 1996.[254] Thus, the participation of life insurance in the economy, despite important growth, is still somewhat reduced in comparison with countries with more developed insurance markets. Meanwhile, non-life insurance represents 1.64% of the GDP in 1997, an increase of 6.2% with respect to 1996.[255]

In summary, one can conclude that several important indicators show signs of improvement in the Uruguayan insurance market: the increase in the number of insurers operating in the market; the increase in the overall production of insurance; the increase in the life insurance sector, possibly signaling a progressive development of an insurance culture among Uruguayan consumers; the increase in direct per capita premium; the increase in consumer spending in insurance; and the increase in total premium as a percentage of the GDP.

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248. *Id.*

249. DEMONOPOLIZATION ACT, *supra* note 200, art. 1; 1997 SSR ANNUAL REPORT, *supra* note 239, at 3.

250. 1997 SSR ANNUAL REPORT, *supra* note 239, at 3.

251. *Id.* The SSR itself recognizes that this increase may be due to the good performance of the Uruguayan economy as a whole. *Id.*

252. 1997 SSR ANNUAL REPORT, *supra* note 239, at 4.

253. *Id.*

254. *Id.*

255. *Id.*

II. THE PRIVATIZATION OF INSURANCE IN COSTA RICA

A. A Brief History of Insurance in Costa Rica

In order to understand the current status of the insurance sector in Costa Rica, it is necessary to consider the relevant historical background. This section will briefly refer to the following periods: (1) the general background of insurance prior to 1924; (2) the *Banco Nacional de Seguros* ("National Insurance Bank") and the advent of the State monopoly on insurance; (3) the *Instituto Nacional de Seguros* ("National Insurance Institute"); and (4) the current legal framework for insurance in Costa Rica.

1. General Background: Insurance in Costa Rica prior to 1924

Costa Rica's legal system is based on the Spanish civil law system. After Costa Rica gained its independence from Spain,[256] the Spanish Civil Code was adopted through a process of reception.[257] Some years later, the first Civil Code, formally enacted by a Costa Rican Government, was adopted.[258] Thus, beginning with Costa Rica's early history as a sovereign Republic, insurance developed within the general framework of a civil law system based primarily on the operation of laws formally enacted by the government.

Within this general context, the first two decades of the twentieth century constitute the most relevant time period to understanding the insurance industry today. During this period, insurance in Costa Rica operated in an open market system. Private insurers offered and sold insurance policies under the supervision of an Insurance Superintendent.[259] In general terms, insurers in the pre-1924 period offered common insurance products (fire, crops, life, accident-health,

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256. The official date of Costa Rica's independence from the Kingdom of Spain is September 15, 1821. CIA DATA ON COSTA RICA, *supra* note 182.

257. For a basic, general overview of the Costa Rican legal system *see generally* ROGER PETERSEN, THE LEGAL GUIDE TO COSTA RICA (1997).

258. CÓDIGO GENERAL (1841) (Costa Rica). The *Código General*, or "General Code," was the product of the efforts of President Braulio Carrillo (1835-1837, 1838-1842) to develop a uniform system of laws, and it included general sections on civil law (understood as the law the regulates transactions between private individuals), criminal law, and procedural law.

259. The office of the Insurance Superintendent was established by the 1922 Insurance Act. LEY DE SEGUROS arts. 50-63 (Costa Rica) [hereinafter 1922 INSURANCE ACT].

marine, and inland marine).[260] The laws allowed insurance coverage for any kind of insurable risk.[261] Hence, in general terms, it can be said that the Costa Rican insurance system in the first quarter of this century operated very much like a standard open market insurance system.

In the years immediately preceding 1924, two particular characteristics of the Costa Rican insurance sector were especially important. First, there was a significant number of foreign-owned or foreign-controlled insurers operating in Costa Rica.[262] Under the legal framework existing up until 1924, foreign insurers were allowed to operate in Costa Rica alongside local insurers.[263] Second, insurer solvency became a prime concern in certain government circles.[264] These two characteristics prompted the Government at the time to consider nationalization of the insurance industry as a viable solution.

2. The Banco Nacional de Seguros and the Advent of the State Monopoly on Insurance

In 1924, during President Ricardo Jiménez's second presidential term,[265] then Treasury and Commerce Minister Tomás Soley began to advocate strongly in favor of the nationalization of the insurance industry. Soley's proposal was based on two main arguments. First, the operation of foreign-owned or foreign-controlled insurers in the Costa Rican insurance industry was prejudicial to the country's interests because large amounts of

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260. *Id.* art. 1.

261. *Id.* The requirement of insurable interest was the central factor established in order for a risk to be considered insurable. *Id.* art. 3.

262. As noted below, the presence of significant foreign investment in the Costa Rican insurance industry prior to 1924 was one of the main factors considered for the nationalization of the industry, purportedly in order to avert the loss of capital to foreign markets. Instituto Nacional de Seguros, *Presentación* (visited Oct. 12, 1999) <http://www.ins.go.cr/prese/prese.htm>.

263. 1922 INSURANCE ACT, *supra* note 259, arts. 44, 45.

264. LATIN FINANCE PR 73, Jan. 1, 1993, *available at* 1993 WL 12254097 (noting that "[i]n the 1920's, after a number of important and unclear bankruptcies and other events in the insurance business took place, the local insurance industry entered a period of serious crisis.").

265. Ricardo Jiménez served as President of Costa Rica on three occasions: 1910-1914; 1924-1928; and 1932-1936. Aside from creating the National Insurance Institute, Jiménez has been credited with rebuilding the city of Cartago after the great earthquake of 1910, promoting the development of the port of Puntarenas, and completing the electrification of the railway to the Pacific.

capital were being diverted from the economy and into the hands of foreign investors.[266] Second, the recent wave of insurer insolvencies had to be dealt with in an appropriate manner; by nationalizing the insurance industry, Soley argued, the people could eliminate the problems of private insurer insolvencies.[267]

In this context, Soley successfully convinced the Costa Rican legislature to enact a comprehensive law that expressly and effectively nationalized the insurance industry.[268] Under this law, enacted on October 30, 1924, writing insurance for risks of any nature was declared to be a monopoly of the State.[269] The legislation also created the *Banco Nacional de Seguros* ("National Insurance Bank") and charged this Government institution with the administration of the monopoly on insurance.[270]

One of the distinguishing and obvious features of the monopoly created by the Nationalization Act of 1924 was that the National Insurance Bank's insurance operations were guaranteed by the State.[271] In other words, the solvency of this government insurer was not truly relevant. In the event that the institution were to become technically insolvent, the operations and liabilities would be backed up by the government and by adjusting the national budget accordingly.

3. The Instituto Nacional de Seguros

The National Insurance Bank operated under this name until 1937, when its name and structure were modified by the Costa Rican legislature.[272] The National Insurance Bank was then transformed into the *Instituto Nacional de Seguros* ("National Insurance Institute"), and its

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266. 1922 INSURANCE ACT, *supra* note 259, arts. 44, 45.

267. *See supra* note 264.

268. LEY DE MONOPOLIOS Y DEL BANCO NACIONAL DE SEGUROS (Costa Rica) [hereinafter NATIONALIZATION ACT].

269. Article 1 of the Nationalization Act states: "*El contrato de seguros sobre riesgos de cualquier género será en lo sucesivo monopolio del Estado. Exceptúanse de este monopolio las sociedades nacionales de seguros de vida, cooperativo o mutuo, existentes en la actualidad.*" *Id.* art. 1 (Author's translation: "The contract of insurance for risks of any nature shall heretofore be a monopoly of the State. Exempted from this monopoly are national [government] companies of life insurance, cooperatives, or mutuals, currently existing.").

270. *Id.* art. 5.

271. *Id.* art. 7.

272. LEY DE REORGANIZACIÓN DEL INSTITUTO NACIONAL DE SEGUROS art. 1 (Costa Rica) [hereinafter INS ACT].

operations were placed under the management of a six-member Board of Directors appointed directly by the *Consejo de Gobierno* ("Council of Government").[273] Subsequent legislation, though, effectively transferred the legal representation of the National Insurance Institute to its Executive President.[274] The National Insurance Institute was subjected to the supervision, regulation, and reporting requirements of the Banking Superintendent.[275] This provision remains on the books today, but is not applied in practice.

The subsequent development of the National Insurance Institute and its operations were directly influenced by Costa Rica's most significant historic event of the century: the Revolution of 1948 and the Constitution of 1949.[276] Under the Constitution of 1949, the *institución autónoma* ("autonomous institution") was created as a new form of government entity.[277] In general terms, these government institutions would be charged with specific functions or activities that required both a certain degree of political independence vis-à-vis the Executive Branch and a substantial level of technical competence.[278] Specifically, the Constitution

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273. *Id.* art. 2. Under current Costa Rican law, the Council of Government is comprised of the President and the cabinet (i.e., the Ministers of Government) acting jointly. *See* LEY GENERAL DE LA ADMINISTRACIÓN PÚBLICA arts. 21-22 (Costa Rica) [hereinafter PUBLIC ADMINISTRATION ACT].

274. REGLAMENTO A LA LEY DE PRESIDENTES EJECUTIVOS art. 10. (Costa Rica) [hereinafter REGULATIONS TO THE EXECUTIVE PRESIDENTS ACT].

275. INS ACT, *supra* note 272, art. 8.

276. Although an in-depth analysis of the events of 1948-1949 is beyond the scope of this historic perspective of insurance in Costa Rica, a brief comment is important to understanding the current situation. In 1948, an allegation of fraud in the presidential elections led to an armed "revolution" that lasted eight weeks and cost the lives of approximately 2,000 people. This uprising is termed "revolution" by most Costa Ricans, improperly so because it did not carry with it a truly fundamental change in the structure of Costa Rican society and institutions, but rather a more modest though significant reform of certain aspects of the legal and electoral system. The immediate result of the uprising was the assumption of government by an interim Government Board, the calling for a Constitutional Assembly, and the adoption of the Constitution of 1949. Although this Constitution is substantially based on the previous Constitution of 1871, it created the legal framework and laid down the principles of democratic government, the common good, and social justice which define much of what Costa Rica is today.

277. CONSTITUCIÓN POLÍTICA DE LA REPÚBLICA DE COSTA RICA art. 188 (Costa Rica) [hereinafter CONST. COSTA RICA].

278. In this sense, autonomous institutions are similar to administrative agencies in the United States' legal system. Each autonomous institution is created by an enactment of the

of 1949 established that Government insurers (the National Insurance Institute) would assume the form of an autonomous institution.[279] Thus, the National Insurance Institute has been, since 1949, an autonomous institution, as defined under Costa Rican constitutional and administrative law.

4. The Current Legal Framework for Insurance in Costa Rica

The current legal framework, pursuant to which the insurance industry operates in Costa Rica, is complex. From a substantive law perspective, insurance transactions are governed primarily by the Costa Rican Civil Code[280] and the 1922 Insurance Act.[281] The Civil Code also governs the general contract law issues affecting insurance policies at large.[282] At the same time, the 1922 Insurance Act refers to insurance issues in more specific terms than does the Civil Code. In general terms, the 1922 Insurance Act provides for the types of insurance coverage available to insureds,[283] the requirement of insurable risk, insurable interest, and the definition of an insured,[284] policy provisions,[285] representations and warranties,[286] notice requirements,[287] and other general substantive law provisions. The 1922 Insurance Act has been amended, in part, on only three occasions: once in 1926, once in 1940, and a third time in 1973.

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legislature, and the institution enjoys a certain degree of administrative and technical independence as regards issues within its authority. For a general discussion on administrative agencies in the United States, *see generally* NEW YORK UNIVERSITY SCHOOL OF LAW, FUNDAMENTALS OF AMERICAN LAW 129-36 (Alan B. Morrison ed.) (1996).

279. CONST. COSTA RICA, *supra* note 277, art. 189. The only other entities specifically targeted by the Constitution of 1949 for autonomous institution status were Government banks. Subsequent to 1949, many other autonomous institutions have been created for a variety of purposes (e.g., to assist to local municipalities, to combat alcoholism and drug addiction, to provide technical job training, to operate oil refineries, etc.).

280. CÓDIGO CIVIL (Costa Rica) [hereinafter C. CIV.].

281. 1922 INSURANCE ACT, *supra* note 259.

282. C. CIV., *supra* note 280, arts. 1107-1033, 1410 (Costa Rica).

283. 1922 INSURANCE ACT, *supra* note 259, arts. 1-2 (Costa Rica).

284. *Id.* art. 3.

285. *Id.* arts. 4, 18.

286. *Id.* art. 6.

287. *Id.* art. 19.

In addition to the 1922 Insurance Act, administrative regulations are also issued by the Executive Branch,[288] but usually administered and applied directly by the National Insurance Institute.[289] In some cases, the legislature has specifically delegated "legislative" authority to the National Insurance Institute in order for it to adopt regulations on certain lines of coverage.[290] Still in other cases, the National Insurance Institute has, on its own, adopted regulations that would typically pertain to the authority of an insurance regulatory agency.[291]

From a purely administrative law perspective, as an autonomous institution, the National Insurance Institute has the authority to issue administrative regulations relative to its own internal operations.[292] In other cases, the Executive Branch determines the regulation of the National Insurance Institute's everyday operations.[293] Finally, as a Government institution, the National Insurance Institute is subject to the

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288. An administrative regulation assumes the form of an Executive Decree that must be issued jointly by the President and the Ministry or Ministries related to the particular activity being regulated. *See* PUBLIC ADMINISTRATION ACT arts. 6.1.d., 21.2., 25. Thus, for example, mandatory vehicle insurance is governed by an executive decree issued by the President and the Ministry of Public Transportation, the Ministry of Justice, and the Ministry of the Presidency. *See* REGLAMENTO SOBRE EL SEGURO OBLIGATORIO PARA VEHÍCULOS AUTOMOTORES (Costa Rica) [hereinafter MANDATORY VEHICLE INS. REG.].

289. MANDATORY VEHICLE INS. REG., *supra* note 288, art. 1.1.

290. *See, e.g.*, PUBLIC LAW NO. 7107 art. 29 (Costa Rica). This law delegates legislative authority upon the National Insurance Institute for the establishment and regulation of insurance on Costa Rican exports.

291. *See* REGLAMENTO PARA LA OPERACIÓN DE ENTIDADES COMERCIALIZADORAS DE SEGUROS [REGULATIONS FOR THE OPERATION OF PRIVATE INSURANCE INTERMEDIARIES] (Costa Rica) [hereinafter INSURANCE INTERMEDIARIES REGULATIONS]. The Board of Directors of the National Insurance Institute adopted these regulations in 1998 in order to authorize and regulate the sale of its insurance products through licensed, privately owned insurance intermediary companies. As will be discussed below, the lack of a regulatory authority has led the National Insurance Institute to assume the mutually exclusive roles of being both the regulated entity and the regulator. This applies to the field of supervision.

292. *See* INS ACT, *supra* note 272; REGLAMENTO GENERAL DEL INSTITUTO NACIONAL DE SEGUROS [GENERAL REGULATIONS OF THE NATIONAL INSURANCE INSTITUTE] (Costa Rica).

293. *See* DECRETO SOBRE RESERVAS TÉCNICAS [TECHNICAL RESERVES DECREE] (Costa Rica). This decree is issued jointly by the President and the Ministry of Treasury. *See supra* note 43, at 9.

limitations and restrictions of administrative law relative to government procurement and appropriate use of government funds.[294]

In sum, it can be said that the legal framework within which insurance is provided in Costa Rica is, at least, diverse, dating back over 75 years in some cases. Moreover, the National Insurance Institute is the only entity that may legally sell insurance coverage in Costa Rica.[295] These are the main aspects to consider regarding the current laws applicable to insurance transactions in Costa Rica.

B. The Current Situation and the Proposed Insurance Reform Bill

The previous section attempted to introduce the reader to the general background and history behind today's Costa Rican insurance industry. This Article will now discuss that industry, identifying current problems in the Costa Rican insurance "market," and will describe the scope and content of the legislation that has been proposed with a view towards undertaking significant insurance reform.

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294. *See, e.g.*, LEY DE ADMINISTRACIÓN FINANCIERA DE LA REPÚBLICA [FINANCIAL ADMINISTRATION ACT] (Costa Rica); LEY DE LA CONTRATACIÓN ADMINISTRATIVA [GOVERNMENT PROCUREMENT ACT] (Costa Rica).

295. NATIONALIZATION ACT, *supra* note 268, art. 1.

1. Current Problems of the Insurance "Market"[296]

The current problems of the insurance "market" in Costa Rica, which insurance reform seeks to solve, can be subdivided into two general categories: (1) those that affect the insured directly; and (2) those that have only an indirect effect on insureds, but affect the economy as a whole.

a. Problems that Affect the Insured Directly

The first main problem that affects the insured directly under the present situation is the cost of insurance. A monopoly, by definition, excludes competition. By excluding competition, innovation and consumer-oriented practices are not stimulated. An additional consequence is that the cost of the service is established unilaterally, and it may respond to considerations other than the actual risks assumed by the National Insurance Institute.

As an example of this problem, the Government points to certain comparative analyses prepared by the World Bank. These analyses tend to show that comparable coverage in countries with closed, monopolized

296. *See* Presidency of the Republic of Costa Rica, *Documento para la concertación sobre el futuro del Mercado de Seguros en Costa Rica* (visited Sept. 26, 1999) http://www.nacion.co.cr/concertacion/ins.html [hereinafter NATIONAL CONSENSUS PROPOSAL]. Except where otherwise specifically noted, the information used to prepare this subsection regarding problems of the current insurance market in Costa Rica has been obtained from this source. The National Consensus Proposal was prepared under the authority of the President of the Republic of Costa Rica in connection with a Government project officially called *Proceso de Concertación Nacional* ("National Consensus Process"). Pursuant to this National Consensus Process, the government proposed that certain fundamental and current issues (e.g., insurance, energy, and telecommunications reform and/or privatization, pensions reform, environmental issues) be openly discussed by all interested and formally organized parties in a structured, government-sponsored debate lasting several months. In preparation for this endeavor, the Government prepared a report on each of the issues to be submitted for discussion in the National Consensus Process. After the actual debates and discussions were concluded, the working committees of the National Consensus Process, composed of representatives from all sectors of Costa Rican society (*e.g.*, labor unions, employers, public interest organizations, the Roman Catholic Church, trade associations, etc.), prepared final reports that would serve as the basis for bills to be proposed by the Executive Branch, and discussed and debated finally by the Legislative Assembly.

insurance industries is more expensive than in countries with open competition insurance markets.[297]

A second problem identified by the Government that affects consumers directly refers to the diversity and variety of insurance coverage available in the market. Specifically, the Government questions the National Insurance Institute's (and thus its own) ability to provide an adequate variety (supply) of health insurance coverage. The basic reasoning is that an insurer in a closed market cannot offer the same array of coverage available in open markets with many specialized insurers.

b. Problems that Affect the Economy as a Whole

The first problem identified as affecting the economy as a whole relates to the illegal sale of insurance coverage in Costa Rica. Pursuant to the applicable insurance laws, it is illegal for entities other than the National Insurance Institute to sell insurance coverage in Costa Rica when such coverage is to apply in Costa Rica.[298]

In spite of this, and due to the lack of enforcement mechanisms, it is common knowledge that Costa Ricans purchase insurance from foreign insurers on a regular basis.[299] It has been estimated that at least twenty companies are selling insurance coverage in Costa Rica in breach of the insurance monopoly legislation. Much of the coverage being purchased under these conditions is life and/or health insurance.[300]

Because of the insurance monopoly, Costa Rican consumers do not have access to the necessary information to make an informed decision as to purchasing coverage. When the lack of insurance policy enforcement mechanisms under Costa Rican law is added -- policies purchased in violation of the monopoly are unenforceable under Costa Rican law[301] -- the problem becomes self-evident.

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297. *Id.* (The example provided by the government compares net single premium for comparable earthquake coverage in Mexico (0.001% in an open market system) and Peru (0.004% in a monopoly system)).

298. NATIONALIZATION ACT, *supra* note 268, art. 1, 4.

299. Carolina Carazo, *Pólizas Extranjeras Encontraron Nicho en el País [Foreign [Insurance] Policies Found Niche in our Country]*, EL FINANCIERO (San José, Costa Rica), June 1-7, 1998, at 12.

300. *Id.*

301. Article 4 of the Naturalization Act states:

Desde la fecha en que el Ejecutivo declare asumir el monopolio de toda clase de seguros, quedará prohibido . . . el tramitar operaciones de

The second main problem relates to the development of Costa Rica's capital markets. It is clear that well-developed capital markets contribute to the financing of productive activities through long-term investments in equity or debt. In so doing, well-developed capital markets contribute to a country's economy on a larger scale.

The existence of institutional investors, who create and maintain demand for long-term investment securities, is crucial to the success of any capital market. Typically, the insurance industry is comprised of leading institutional investors who contribute to this economic process alongside pension funds and mutual funds. This occurs because insurers are generally interested in investing a significant portion of their reserves in long-term, higher return investments.

Today in Costa Rica insurance contributes little to capital market development. The National Insurance Institute is a government entity and, as such, it is subject to different standards in terms of the types of investments it can make. Because it is a Government entity, and because, despite any formal legal requirements of institutional autonomy[302] the Government ultimately controls it, the central government's financing needs also ultimately control the investment of the National Insurance Institute's reserves.

This introduces distortions into the economic system in terms of a high concentration of investment in government bonds and a relatively low participation in private sector equity or debt. Furthermore, where a possibly higher return on investments is sacrificed in order to comply with the central government's financing needs, the National Insurance Institute must then make up the difference in returns by either increasing premiums or reducing benefits.

In sum, two categories of problems exist in Costa Rica's current insurance market. The first category encompasses two problems that

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> *seguro de la clase indicada en el respectivo decreto, y se reputarán como inexistentes y sin valor, las pólizas expedidas en contravención de esta ley y que deban tener su realización en el país.*

NATIONALIZATION ACT, *supra* note 268, art. 4 (Author's translation: "As of the date on which the Executive Branch shall declare to assume the monopoly on all kinds of insurance, it shall be prohibited ... to transact in insurance operations of the kind indicated in the corresponding decree, and those policies issued in contravention of this law and that are to have their realization in the country shall be deemed non-existing and without value.").

302. *Id.* art. 21 (requiring the National Insurance Institute to invest its reserves in the best conditions of return and liquidity).

affect the consumer directly (higher cost of insurance and reduced variety of coverage offered), while the second category refers to two issues that affect the economy as a whole ("black market" insurance, and the negative impact of the monopoly on the development of capital markets).

2. The Insurance Reform Bill

Since the early 1990s, the Government has worked to lift the monopoly on insurance.[303] This occurred despite setbacks resulting from the opposition to privatization by President José María Figueres's administration.[304] Some movement has occurred towards privatization,

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303. *See, e.g.*, *Costa Rica: A Corporate Finance Update*, LATIN FINANCE S84, Dec. 1, 1993, *available at* 1993 WL 12254424 (reporting that several bills had been discussed at the Legislative Assembly to break up the National Insurance Institute to make it more efficient); *Privatization*, CARIBBEAN UPDATE, INC., Dec. 1, 1992, *available at* 1992 WL 2399575 (reporting in 1992 that the government wanted to sell the National Insurance Institute).

304. Although the intricacies of Costa Rican politics are beyond the scope of this Article, suffice it to say that former president José María Figueres' *Partido Liberación Nacional* ("National Liberation Party," Costa Rica's left-of-center party), in power from 1994 to 1998, has generally tended to oppose privatization. *See* Privatization, *supra* note 303 (reporting that leaders of the National Liberation Party in principle tend to oppose privatization); *Costa Rica*, CARIBBEAN UPDATE, Mar. 1, 1994, *available at* 1994 WL 2238630 (stating that then President-elect Figueres would back Costa Rica away from privatizing the state owned insurance company); *Special Focus on Costa Rica*, CARIBBEAN UPDATE, June 1, 1994, *available at* 1994 WL 2238447 (reporting that by June 1994 Figueres viewed privatization of the insurance institution as "out of the question until such time as [its] productivity . . . is raised").

This contrasts with President Rafael Calderón's (1990-1994) and current President Rodriguez's (both of the right-of-center *Partido Unidad Social Cristiana*, or Social Christian Unity Party) policy of promoting open markets and privatization. *See* Costa Rica (Privatization Programs), *available at* 1993 WL 12254097 (noting President Calderón's commitment to privatization of state-owned enterprises as a means for increasing revenue collection and easing the strain on the government's cash flow by eliminating the need to finance new investment and on-going deficits); Murdock, *supra* note 1, at 1 (commenting that President Rodríguez "represents the return to a path of free-market reforms, less governmental influence in the private lives of citizens, and a speedier opening of the economy" (quoting Juan Fernando Bandfeldt of National Economic Studies Center)).

It is important to note, however, that President Figueres's administration is credited with a successful emphasis on the development of the high-tech and information industries, and especially with securing the largest single foreign investment ever made in Costa Rica, the establishment of Intel Corporation's microprocessor assembly plant. *See Costa Rican Colon Depreciation Steady as Investment Flows Rise*, FX MANAGER, Mar. 6, 1998, *available at* 1998 WL 31002447.

such as the authorization issued for private companies to commercialize policies sold by the National Insurance Institute.[305] Costa Rica must end the state monopoly on insurance if it hopes to gain access to the World Trade Organization, or membership in NAFTA, or if it hopes to obtain credit from the World Bank. The current Government of President Miguel A. Rodríguez (1998-2002) has declared that it wants to transform the Costa Rican insurance industry into an open market system.[306] Towards that end, in December of 1998, the government submitted to the Costa Rican Legislative Assembly[307] a comprehensive bill that would fundamentally reform the insurance industry in Costa Rica.[308]

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305. INSURANCE INTERMEDIARIES REGULATIONS art. 1. It is interesting to note that in January of 1997, private companies commercializing National Insurance Institute insurance represented 30% of all sales. In February of 1998, private companies already represented 80% of the market. *See also* Mensaje (visited Nov. 21, 1999) <http://www.ins.go.cr/esp/Mensaje> (where National Insurance Institute Executive President, Cristóbal Zawadzki, states that the "National Insurance Institute initiated several years ago a process of restructuring and modernization of its operations; this is not an effort that ends with one administration, but it is the work of several of them, united by a common thread." Author's translation: "*El INS inició hace varios años un proceso de reestructuración y modernización de sus operaciones; no obstante, éste no es un esfuerzo que termina con una administración, sino que es la obra de varias de ellas, unidas por un hilo común.*"). Belkin & Warshaw, *supra* note 5, at 2 (stating that Costa Rica is redesigning the INS for it to be competitive when new companies are allowed to enter the market).

306. *See, e.g., Central America, A Glimpse Up the Deal Pipeline*, EUROMONEY, June 10, 1999, *available at* 1999 WL 10187797 (reporting that the current Costa Rican government's first target for privatization is the National Insurance Institute); *Costa Rican Colon Depreciation Steady as Investment Flows Rise*, *supra* note 304, ¶ 3 at 15 (reporting that Rodríguez pledged to address Costa Rica's domestic debt by boosting currency inflows through privatization, including that of the National Insurance Institute); *Costa Rican President Keen to Privatize*, XINHUA ENGLISH NEWSWIRE, Feb. 4, 1998, *available at* WL 2787689 (reporting that then newly elected President Rodríguez would give priority to promoting privatization of state institutions and referring to the debate surrounding the privatization of the National Insurance Institute); Paul J. Deveney, *World Watch - Costa Rica to Sell State-Owned Firms*, WALL ST. J., Apr. 28, 1998, at A11, Apr. 28, 1998, *available at* 1998 WL-WSJ 3491783 (reporting that then President Elect Rodríguez said his government plans to privatize state-owned monopolies such as the insurance industry, among others); Murdock, *supra* note 1 (reporting that President Rodríguez aims to privatize the state insurance company).

307. CONST. COSTA RICA, *supra* note 277, arts. 116, 118. Under the Constitution of 1949, the President has the authority to propose legislation to the Legislative Assembly during a limited period of each year called the "extraordinary sessions" period.

308. PROYECTO DE "LEY DE SEGUROS" [INSURANCE REFORM BILL] (Costa Rica), 236 Official Gazette 11, App. 89.

In this context, the insurance reform proposed would involve possibly up to four successive phases, all of which were included in the Insurance Reform Bill originally submitted for discussion to the Legislative Assembly. Under the proposed scheme, these phases are ordered chronologically so that each subsequent phase necessarily requires (at least) the (simultaneous) adoption of any phase that precedes it. Nonetheless, it has not been determined whether *all* the phases will be adopted, nor their timing, because not all phases would be strictly necessary in order to undertake some reform. These phases are:

Phase I (substantive law issues): this phase mandates the creation of a new body of substantive law. As indicated above, the current insurance legislation is both outdated (the main pieces of legislation, the Civil Code and the 1922 Insurance Act, dating back to 1888 and 1922, respectively) and diverse (there are many other specific laws and administrative regulations on a variety of insurance-related topics, issued by a multiplicity of entities).

Phase II (regulatory and supervisory issues): this phase mandates the creation of a regulatory and supervisory agency (most likely an insurance superintendent). The superintendent system already operates in the banking (*Superintendencia General de Entidades Financieras*),[309] securities (*Superintendencia General de Valores*),[310] and pensions (*Superintendencia de Pensiones*)[311] industries, all of which are currently under the umbrella of the National Council for Supervision of the Financial System ("*Consejo Nacional de Supervisión del Sistema Financiero*").[312] This Superintendency will most likely be a technically independent agency with full authority to oversee the industry, issue administrative regulations and guidelines, and conduct administrative proceedings.

Phase III (opening the market): opening the insurance market. This is, quite simply, the elimination of the monopoly currently existing in favor of the National Insurance Institute.

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309. *See* LEY ORGÁNICA DEL BANCO CENTRAL [CENTRAL BANK ACT] art. 115 (Costa Rica).

310. *See* LEY REGULADORA DEL MERCADO DE VALORES [SECURITIES MARKET REGULATION ACT] art. 3 (Costa Rica) [hereinafter SEC. REG. ACT].

311. *See* LEY DEL RÉGIMEN PRIVADO DE PENSIONES [PRIVATE PENSIONS RÉGIME ACT] art. 33 (Costa Rica).

312. *See* SEC. REG. ACT, *supra* note 310, art. 169.

Phase IV (privatization): privatization of the National Insurance Institute. This has been proposed under several forms, including its transfer to the state-owned banks, the selling of its commercial (private) insurance lines, and the modification of its structure into a corporation (the shares of which would be sold either to a single strategic partner or through a stock exchange, or both).

Thus, for example, the government may wish to "overhaul" the substantive law applicable to insurance (Phase I) and create a regulatory agency (Phase II), but may ultimately choose not to open (or be forced not to open) the market to competition and not to divest itself of the National Insurance Institute.[313]

From this general outline of the purposes of an insurance reform in Costa Rica, the more important aspects of the Insurance Reform Bill can be summarized as follows.

The Bill creates the obligation to insure with Costa Rican insurance companies or foreign insurance companies authorized to operate in Costa Rica all real property, ships, aircraft and automobiles of Costa Rican registration, as well as business activities undertaken by natural or legal persons in Costa Rica. It reserves the use of certain terms and names ("insurance company," "insurance commercializing company," "insurance agents," "insurance," etc.) to be used only by companies authorized to operate within the insurance industry. It also establishes the general requirements for participating in the Costa Rican insurance market, and it establishes the general prohibition of conducting certain non-related activities by insurance industry participants. Finally, there is a special

313. In this context, it is important to note that on Oct. 13, 1999, the Permanent Committee on Economic Affairs of the Costa Rican Legislative Assembly unanimously agreed that Chapter X of the Insurance Reform Bill would be for the time being stricken from the full text of the bill. Thus, as the Insurance Reform Bill stands now, Phase IV of the reform process (privatization of the National Insurance Institute) has been left for a later time. According to legislators from all the political parties represented on the committee, the idea of excluding Chapter X of the Insurance Reform Bill is based on hopes that this will make approval of Phases I through III more politically viable. *See* José D. Guevara, *Descartan vender INS*, LA NACIÓN, October 13, 1999, at 4A. It is, precisely, the question whether Chapter X, or some variation thereof, *should* remain a part of the Insurance Reform Bill that we are attempting to answer. Subsequently, in December of 1999, the government proposed the formation of a "committee of experts" that would advise the Legislative Assembly on the Insurance Reform Bill, in an effort to streamline the entire process. *See* Ismael Venegas Campos, *Agilizan Ley de Seguros*, LA NACIÓN (San José, Costa Rica), Dec. 10, 1999. So far, little else has been done.

provision ensuring free market competition in the insurance industry. In particular, Article 8 would be the legal provision lifting the insurance monopoly.[314]

It also creates an Insurance Superintendent along the same lines as those existing for the banking, securities, and pensions industries.[315] It includes several antitrust provisions specifically aimed at the insurance industry and subjects the industry to the provisions of Costa Rican antitrust and consumer protection laws.[316] The Insurance Superintendent would be the industry regulatory and supervisory agency.[317]

The Insurance Reform Bill outlines the applicable law for the operation of insurance and reinsurance companies, and it includes regulations concerning capital reserves and investment management, minimum share capital requirements, mergers and acquisitions, and divestitures.[318] It sets down a comprehensive regulation for insurance contracts, establishing provisions on insurable risk, insurable interest, voiding of insurance policies, conditions, exclusions, representations and warranties, and reinsurance.[319] Moreover, it provides the general legal provisions applicable to property and casualty insurance,[320] as well as life insurance.[321] It also provides for the statute of limitations applicable to insurance coverage cases.[322] The Insurance Reform Bill also regulates the commercialization of insurance policies, and provides for commercialization through brokers, agents, direct commercialization by insurance companies, and insurance commercializing companies.[323] In addition, the Bill regulates the activity of claims adjusters.[324]

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314. INSURANCE REFORM BILL, *supra* note 308, arts. 1-9.

315. *See supra* notes 312-14.

316. INSURANCE REFORM BILL, *supra* note 308, arts. 10-39. Article 14 of the Bill provides that the general antitrust laws will operate as fall-back provisions to the Bill's specific antitrust provisions. *See also* LEY DE PROMOCIÓN DE LA COMPETENCIA Y DEFENSA EFECTIVA DEL CONSUMIDOR [ANTITRUST AND CONSUMER PROTECTION ACT] (Costa Rica).

317. INSURANCE REFORM BILL, *supra* note 308, arts. 10-39.

318. *Id.* arts. 40-76.

319. *Id.* arts. 77-130.

320. *Id.* arts. 131-200.

321. *Id.* arts. 201-32.

322. *Id.* arts. 233-37.

323. *Id.* arts. 238-57.

324. *Id.* arts. 258-71.

One of the more important chapters of the Insurance Reform Bill provides for the transformation of the National Insurance Institute into a stock company (*Seguros de Costa Rica, Sociedad Anónima*) the shares of which would be sold as follows: 60% of the share capital would be made up of common shares (vesting voting and dividend rights) while the remaining 40% would be composed of preferred shares (vesting only dividend rights). Two-thirds of the common shares (or 40% of the entire share capital) would be sold through an international bidding process to a single strategic (foreign) investor that would therefore control *Seguros de Costa Rica, S.A.* The remaining third of the common shares (or 20% of the entire share capital) would be sold through the local stock market. Of the 40% preferred shares, one-half (or 20% of the entire share capital) would be set aside in a trust fund the earnings of which would be assigned to the mandatory social security pensions system, and the remaining one-half (or 20% of the entire share capital) would be transferred to the capitalization regime managed by the Teachers' National Pensions Board.[325]

The Bill's final provisions would repeal certain existing laws and regulations and establish provisions that would regulate the transition from the current system to the newly adopted and reformed system.[326]

It is from within this general background that we will now attempt to outline lessons for Costa Rica, drawing on both the experience of Uruguay (particularly insofar as it has undertaken significant insurance reform in recent history) and the other Latin American countries already discussed.

C. Lessons for Costa Rica

This section will attempt to draw lessons from the Latin American experiences commented on above. Specifically, this section will deal first with the lessons to be learned from Uruguay's specific insurance privatization experience, and then the fundamental question of whether Costa Rica should in fact privatize its National Insurance Institute.

325. *Id.* arts. 272-320.

326. *Id.* arts. 321-38 and transition provisions I-X.

1. Lessons from Uruguay

This subsection section seeks to analyze and compare the Uruguayan insurance reform experience with the insurance reform that is being proposed for Costa Rica under the Insurance Reform Bill described above. The main premise on which such a comparison is founded is that Costa Rica and Uruguay are generally comparable countries and economies, and that the insurance sector specifically has followed a very similar path in both countries during the twentieth century. The Insurance Reform Bill would incorporate into the Costa Rican market changes almost identical to those adopted in Uruguay under the Demonopolization Act and related laws and regulations.

From the description of the main features of the proposed Costa Rican insurance reform process (embodied in the Insurance Reform Bill)[327] and those of the Uruguayan Demonopolization Act and related regulations,[328] one finds several important points of comparison. First, the Insurance Reform Bill, in what, for purposes of this Article, has been termed Phase I of the insurance reform process, creates and establishes a new body of substantive insurance law.[329] This is a main difference compared to the Uruguayan process, under which the substantive laws applicable to insurance were not affected by the reform process.[330] In any event, it is apparent that this difference in the reform process does not affect the general lines that are relevant to our comparison. In essence, both countries would have modern substantive insurance statutory law, an element of key concern in these two civil law jurisdictions.

Second, in terms of Phase II of the proposed Costa Rican insurance reform, there is an important similarity in that Costa Rica is proposing to establish an insurance superintendency along the same lines as it has been established in Uruguay.[331] The similarities in their general authority[332]

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327. *See supra* Part II.B.2.

328. *See supra* Part I.C.2.a.

329. INSURANCE REFORM BILL, *supra* notes 308, arts. 77-271.

330. *See* DEMONOPOLIZATION ACT, *supra* note 200. The Demonopolization Act does not contain substantive rules of insurance law, because these provisions already existed in other statutory law in Uruguay (e.g., the Commercial Code). *See* URUGUAYAN COMMERCIAL CODE, *supra* note 232.

331. INSURANCE REFORM BILL, *supra* note 308, arts. 10-39; DEMONOPOLIZATION ACT, *supra* note 200, art. 6.

and in their specific competencies[333] are noticeable from an examination of the relevant provisions. Thus, the regulatory and supervisory structures are very similar. This is a product of increasingly similar issues faced by Latin American insurance regulators.[334]

Third, regarding Phase III of the proposed Costa Rican reform (the opening of the insurance market to competition), the fundamental similarity with Uruguay's reform is also clear. The Insurance Reform Bill

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332. INSURANCE REFORM BILL, *supra* note 308, art. 16; DEMONOPOLIZATION ACT, *supra* note 200, art. 6, ¶ 3 (both providing in almost identical terms that each superintendency is charged with control of all insurers, reinsurers, and insurance producers operating in the respective markets).

333. INSURANCE REFORM BILL, *supra* note 308, art. 19; DEMONOPOLIZATION ACT, *supra* note 200, art. 7. Each of these provisions sets forth the specific competencies of the insurance superintendencies in language that can almost identically be made to correspond section by section. *See, e.g.*, INSURANCE REFORM BILL, *supra* note 308, art. 19.1 and DEMONOPOLIZATION ACT, *supra* note 200, art. 7.C (on the superintendencies' authority to issue general regulations); INSURANCE REFORM BILL, *supra* note 308, art. 19.3 and DEMONOPOLIZATION ACT, *supra* note 200, art. 7.J (on the superintendencies' authority to inspect and examine insurers on a permanent basis in order to verify insurers' economic and financial situation); INSURANCE REFORM BILL, *supra* note 308, art. 19.5 and DEMONOPOLIZATION ACT, *supra* note 200, art. 7.D (on the superintendencies' authority to fix and modify regulations relating to minimum capital requirements, solvency margins, and reserves); INSURANCE REFORM BILL, *supra* note 308, art. 19.8 and DEMONOPOLIZATION ACT, *supra* note 200, arts. 7.E, 7.F (on the superintendencies' authority to approve insurer mergers and acquisitions).

334. *Conference Report: A Conference for Latin American Regulators on International Financial Services Regulation*, 6 CONN. INS. L.J. 149, 149 (1999). During this conference -- which brought together high-level insurance and financial services regulators from Argentina, Bolivia, Brazil, Chile, Costa Rica, El Salvador, Guatemala, Mexico, Panama, Peru, the United States (both at the official state level and at the National Association of Insurance Commissioners level), Uruguay, and Venezuela, it was clear that there are many common challenges with which Latin American insurance regulators are faced: e.g., regulation of reinsurance and financial reinsurance transactions, consumer protection, rehabilitation and liquidation of companies, and early warning systems for solvency problems. Indeed, in an increasingly more interdependent global economy, insurance regulators are making significant efforts to develop cooperation among them and set international standards with a view "to ensure improved supervision of the insurance industry on the domestic as well as the international level in order to maintain efficient, fair, safe and stable insurance markets for the benefit and protection of policyholders." International Association of Insurance Supervisors, *About IAIS* (visited Nov. 21, 1999) <http://iaisweb.org/1/about.html>. The International Association of Insurance Supervisors (IAIS) was established in 1994 for such purposes, and currently comprises insurance supervisors from over 100 jurisdictions.

lifts the government's monopoly on insurance as did the Demonopolization Act in Uruguay.[335] In so doing, both countries allow or would allow private insurers to operate in the local marketplace, a feature that may be of particular interest to foreign investors and foreign insurance and financial services groups.[336] This is a key element of the reform process that will promote competition and allow for much needed capital investments and transfers of technology.

Finally, in terms of Phase IV of the Costa Rican reform process, while Chapter X of the Insurance Reform Bill would provide for the privatization of the National Insurance Institute (despite what may ultimately come out of the political and legislative process),[337] in Uruguay the reform process did not go as far. Thus, as explained above, the State Insurance Bank in Uruguay was left a competitor in a newly opened market[338] and currently still retains a clearly dominant position in terms of market share.[339] Notwithstanding that, the opening of the market has caused more competitive pricing and reduced premiums for consumers and, significantly, caused an improvement in the quality of service provided by insurers.[340] These improvements reflect well on all players in the Uruguayan insurance market, including the State Insurance Bank.[341]

In sum, while there are some points of variation, the general lines of the insurance reform process being proposed in Costa Rica are practically

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335. INSURANCE REFORM BILL, *supra* note 308, art. 8; DEMONOPOLIZATION ACT, *supra* note 200 art. 1.

336. INSURANCE REFORM BILL, *supra* note 308, art. 1 (risks located or otherwise linked to Costa Rica e.g., ships or aircraft of Costa Rican flag -- must be insured by either Costa Rican insurers or foreign insurers established in Costa Rica and authorized by the superintendent); DEMONOPOLIZATION ACT, *supra* note 200, art. 2 (public or private companies must establish themselves in Uruguay in order to insure Uruguayan risks).

337. *See* INSURANCE REFORM BILL, *supra* note 308, at arts. 10-39; *See also* LEY DE PROMOCIÓN DE LA COMPETENCIA Y DEFENSA EFECTIVA DEL CONSUMIDOR, *supra* note 316 .

338. *See supra* note 238.

339. *See supra* note 240 and corresponding text.

340. Interview with Jorge Sánchez, Head, Department of Analysis and Control, Superintendency of Insurance and Reinsurance, Uruguay, in Hartford, CT. (Oct. 19, 1999). *See also Banco de Seguros Analiza Ampliar el Servicio Móvil, y Enviar Abogados a los Siniestros*, EL PAÍS (Montevideo, Uruguay), (July 7, 1998), *available at* http://buscador.elpais.com.uy/1998/07julio/ 980711/socil.html (reporting, e.g., that as a consequence of the demonopolization automobile insurance rates fell on average nearly 50%, from $1,000 to $600.).

341. *Id.*

identical to those followed in Uruguay. The establishment of a regulatory and supervisory authority and the opening of the insurance market to competition (local and foreign) have been structured (and done, in Uruguay's case) in two very similar ways.

2. Should Costa Rica Privatize its National Insurance Institute?

Part I of this Article highlighted the issues that underlie a government's success or failure in privatization by commenting on examples from Latin America. Ultimately, the question becomes one of achieving better living standards through economic reform. In that context, this Article will now examine whether the Costa Rican insurance industry should be privatized.

As has been noted above, privatization is a very broad concept encompassing many different policies and techniques located on a continuum that ranges from simple changes in organizational structure to outright divestiture of SOEs. Accordingly, it can well be said that the National Insurance Institute has already begun a process of privatization. In effect, the policies of commercialization which have been adopted by the management of the National Insurance Institute in recent years can themselves be thought of as a form of privatization (a change in policy and structure that aims to integrate further participation by the private sector in a given economic enterprise).[342]

Furthermore, while the proposed Insurance Reform Bill[343] is not considering outright divestiture of the National Insurance Institute (for reasons of political expediency), the opening of the market and the introduction of industry competition is under consideration. This too, would be a form of privatization under our broad concept as outlined above.

Central American countries such as Costa Rica have not been isolated from the process of economic reform that has engulfed Latin America. Indeed, "[e]very Central American country has implemented neo-liberal economic reforms: privatizing public enterprises, liberalizing foreign trade, reforming the tax system, freeing interest and exchange rates, increasing fiscal austerity, and enacting laws to attract and facilitate

342. *See supra* note 307 and accompanying text.

343. *See* LEY DEL REGIMEN PRIVADO DE PENSIONES, *supra* note 311, art. 33.

foreign investment."[344] In the past, the same policies of nationalization and import-substitution industrialization that prevailed in other regions also created a large public sector in Costa Rica, of which the National Insurance Institute is only a component part.

If one assumes that the goal of privatization is to achieve enhanced economic performance that will in turn increase living standards for the majority of the population, it would seem impossible to disagree with the need to privatize. Obstacles to achieving well distributed wealth, such as a long tradition of anti-democratic government or already existing high levels of poverty, are not as prevalent in Costa Rica as they are in other countries.[345] Indeed, it has been recognized that Costa Rica's tradition of democracy and promoting social equity have given it a greater degree of economic development, where poverty, though clearly existent, is not as extreme nor extended as in other regions.[346]

As has been noted already, however, "[r]edrawing the line between the public and private sectors requires clear and well-thought out government policy determinations on which industries should be privatized, and which should remain in the public sector, and why."[347] A clear, consistent, well-articulated government policy towards privatization has been somewhat lacking in Costa Rica. Although, as noted above, the current government of President Rodriguez campaigned on a platform of "neoliberal" economic reform, the fact remains that forceful political action has not materialized.[348] Thus, the main challenge facing the Rodríguez

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344. Alejandro Ferrate, *Foreign Direct Investment in Costa Rica After the "Death" of CBI*, 2 J. INT'L LEGAL STUD. 119, 119 (1996).

345. REISMAN, *supra* note 2, at 392-3 ("The 'Social Question' becomes very important in countries where great majorities live in conditions of dehumanizing misery, and forceful minorities control the wealth-producing assets of the lands, for example, in the countries of Latin America.").

346. *See* ROTTENBERG, *supra* note 181.

347. SARKAR, *supra* note 12, at 154.

348. Of course, this is in large part due to the fact that Costa Rica's Legislative Assembly is controlled by the opposition *Partido Liberación Nacional*. *See supra* note 306 (discussing that this opposition party has traditionally opposed privatization, and the fact remains that Rodríguez has made little progress). One recent example is the Rodríguez administration's setback in attempting to pass legislation aimed at opening up the electricity and telecommunications monopoly administered by the *Instituto Costarricense de Electricidad* (Costa Rican Electricity Institute). Although Rodríguez eventually mustered up support from a majority of legislators, even from the opposition, National Liberation Party, a series of abnormally violent protests led by unions, university students, and an

administration in regard to these issues is the need to construct a real consensus on a somewhat scattered and diverse privatization initiative, aimed at expediting the sale of state assets including the National Insurance Institute and promoting deregulation in areas such as banking, telecommunications, and electricity.

For example, Costa Rica does not have a general privatization law. As discussed above,[349] the privatization process requires that there be a clearly defined legal framework within which privatization will take place. In contrast, Costa Rica has only attempted something remotely similar through what was called the "National Consensus Process." Seen from the outside, this National Consensus Process which was implemented through an executive decree might seem an appropriate framework. However, the mere fact that it was based on a decree makes evident that no real authority for the government to pursue reform can be derived therefrom. In effect, the government even requires that constitutional amendments be passed in order to implement certain reforms. (In the case of the National Insurance Institute, however, this is not the case, since the monopoly is statutorily not constitutionally mandated.)

The need for the Costa Rican economy to diversify is clear. A traditionally agricultural economy based on coffee and banana exports, Costa Rica has achieved certain success in recent years by allowing tourism to grow to become the country's main industry. In effect, "[f]oreign investment in Costa Rica will, or should, probably shift from export enterprises dependent on CBI [Caribbean Basin Initiative] to enterprises which service the domestic market."[350] But the lack of progress in opening state-owned monopolies will stall the attraction of foreign investment.[351]

From this standpoint, there seems to be nothing more than political rhetoric in arguing against the government's divestiture of the National

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emerging left-wing political party that holds only three of 57 seats in the legislature, (*Partido Fuerza Democrática*) has forced the government to postpone discussion of the bill for some time. *See* Ismael Venegas Campos, *Gobierno Posterga Plan del ICE*, LA NACIÓN (San José, Costa Rica), (April 3, 2000) *available at* http://www.nacion.co.cr/ln_ee/2000/abril/03/pais1.html (last visited April 16, 2000).

349. Pritchard & Webb, *supra* note 17 and accompanying text.

350. Ferrate, *supra* note 344, at 147.

351. *Id.* at 138. Commenting on former President Figueres's opposition to opening up the insurance and telecommunications sectors, Ferrate grimly states that "[t]here probably will be no further investment opportunities in sectors reserved for the government."

Insurance Institute. Even Russia, after the collapse of the Soviet Union, moved on and privatized its insurance industry. Today, the Russian insurance industry is substantially improved from even ten years ago. "Instead of two companies providing limited forms of insurance . . . thousands of insurers exist providing a much wider range of services."[352]

Financial sector adjustment and reform, in the form of removal of excess reserve requirements for central and commercial banks, elimination of interest rate ceilings, and the creation of a functional regulatory and supervisory framework, form part of an integral government macro-economic policy approach to successful privatization.[353] These steps, however slowly, have already been taken or begun in Costa Rica. This (and the proposition that insurance reform should be adopted in and of itself)[354] suggests that Costa Rica is ready for the privatization of the National Insurance Institute.

Ultimately, the question of whether the Costa Rican government should divest itself of the National Insurance Institute should also be answered. For our purposes, while recognizing that such a measure would be very difficult to adopt today in light of the opposition by certain sectors of Costa Rican civil society (labor unions and certain political opponents), the issue will be examined with a view to analyzing this more extreme facet of the privatization continuum.

It would seem apparent that such a measure would be in the best interests of consumers. In the case of Uruguay, it has been shown how some degree of privatization has allowed for an improvement in several insurance market indicators.[355] Nevertheless, it seems that the existence of the State Insurance Bank in Uruguay and the distortions it creates as "just one more competitor" in an open market, take away from the full benefits of a truly competitive environment.[356] And while socially

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352. Christopher A. Thompson, *Insuring a Brighter Future: The Emerging System of Russian Insurance Law*, 19 HOUS. J. INT'L L. 863, 871-2 (1997).

353. SARKAR, *supra* note 12 at 165-6.

354. VITTAS, *supra* note 73, at 5 ("Insurance reform is primarily sought for its own sake, as insurance business is underdeveloped in most low and middle income countries. In addition to achieving macroeconomic stability, reforming the insurance sector implies the removal of repressive regulations that impede competition, innovation and efficiency.").

355. WORLD BANK, *supra* note 39.

356. Juan E. de los Santos, *BSE Continúa con el 80% del Mercado de Seguros*, EL PAÍS (Montevideo, Uruguay), (Jan. 1, 1998), *available at* <http://buscador.elpais.com.uy/1998/01enero/980107/noti3.html>. As an example of the

desirable objectives such as mandatory vehicle liability insurance or worker's compensation schemes must be preserved and strengthened, it is not necessary for the services to actually be provided by the government itself, only that they be statutorily required and appropriately regulated.[357] Of course, the challenges posed in terms of achieving effective regulation are by no means small, but preserving a government owned bureaucracy simply because of the difficulty of the task of adequately regulating is not a sound argument.

To some, privatization is yet another step in man's endless pursuit towards an ideal economic and political system.[358] However, like it or not, it is a current reality. If Costa Rica persists on its track of lukewarm positions on privatization issues, it will fall behind even if this is only a temporary solution in the never-ending cycle. Costa Rica, thus, should be wary only of avoiding the so-called "race to the bottom" in competing for the attraction of investors.[359]

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distortions introduced into an otherwise competitive insurance market, this Article points out that the State Insurance Bank retains such a large market share in great measure because its operations are still backed by the Uruguayan Government's guarantee. Thus, to the average consumer, *ceteris paribus*, the State Insurance Bank is more attractive than a private insurer.

357. Thus, for example, in the United States most individual states require vehicle liability insurance. Pursuant to legal or regulatory provisions, this form of socially desirable insurance is offered by private companies that must provide the statutorily prescribed minimum coverage. Companies compete for market share based on their ability to operate at lower costs and with optimum resource utilization. *See, e.g.*, ROBERT E. KEETON & ALAN I. WIDISS, INSURANCE LAW, 385. (1988); KENNETH S. ABRAHAM, INSURANCE LAW & REGULATION 647 (1995).

358. Chibundu, *supra* note 11, at 44.

359. FERRATE, *supra* note 344, at 128 (citing RICHARD J. SWEENEY, THE INTERNATIONAL COMPETITION FOR INVESTMENT IN THE GLOBAL RACE FOR FOREIGN INVESTMENT: PROSPECTS FOR THE FUTURE 76 (Lars Oxelheim, ed. 1993) ("Instead of depending on a foreign government's investment incentive to draw foreign investors, Costa Rica is now forced to further revamp its municipal laws to attract investments. As the country hones its municipal laws to compete in the marketplace for foreign direct investment, it will become an attractive place to invest in the long run. This may be a proverbial 'race to the bottom', in which a country competes for foreign investment dollars by cutting its taxes, social expenditures, and regulatory supervision of different sectors of the economy.")).

CONCLUSION

Immersed as it is in the global economy, Costa Rica is faced today with the possibility of undertaking substantial insurance reform. This reform is part of an ongoing modernization process that aims to reduce the State's role as provider of goods and services. If approved, it would lead to the modernization of the substantive insurance laws in Costa Rica, the establishment of an insurance regulatory and supervisory authority (the insurance superintendency), the opening of the insurance market to competition, and, possibly, to the eventual privatization of the National Insurance Institute.

Uruguay, a country that has remarkable similarities with Costa Rica in economic, social, political, and historical conditions, adopted insurance reforms in 1993. These reforms were fundamentally similar to those being proposed in Costa Rica, and they have resulted in significant and promising improvements in several fundamental insurance market indicators. One can therefore suggest that the reforms are on their way to succeeding in their goal of improving the quality and availability of insurance coverage, allowing for better pricing mechanisms through open competition, providing adequate safeguards for consumers (through the operation of an insurance superintendency with regulatory and supervisory powers), and contributing to the development of the Uruguayan economy as a whole by developing insurers as key institutional investors. While surely one would not argue that Costa Rica should undertake such substantial reforms just for the sake of not being "the odd one out," it has the benefit of having had an unlikely laboratory in Uruguay. Costa Rica should not allow Uruguay's lessons to go unlearned.

In the broader sense, Costa Rica may also learn from the experiences of other Latin American countries. It is clear that for privatization of any sort to be successful it must result in increased living standards for the population. As with anything, privatization can be done poorly. But privatization is not somehow intrinsically sinister. Indeed, if one looks at the broader experience of some Latin American countries, many of the problems associated with privatization's failures existed well before the countries undertook reform in the last few decades. Problems of social justice, unequal distribution of wealth, a weak or non-existent rule of law, deeply rooted corruption, and poor democratic tradition have all contributed to such failures. But Costa Rica, though certainly not immune from such problems, is not as severely affected by them. Thus, one may

expect that a well thought-out, properly assessed program of privatization, including the insurance sector, may well contribute to achieving the desired goals.

MUSINGS ON THE SEEMING INEVITABILITY OF GLOBAL CONVERGENCE IN BANKING LAW

*Patricia A. McCoy**

TABLE OF CONTENTS

INTRODUCTION

In the past decade, there has been heated debate over the extent to which global convergence in corporate governance is attainable and desirable. One thing is clear, however; international convergence in corporate governance law has not been achieved.[1] Many would ascribe that fact, among other

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1. *See, e.g.*, DOUGLAS M. BRANSON, THE VERY UNCERTAIN PROSPECT OF 'GLOBAL' CONVERGENCE IN CORPORATE GOVERNANCE 5 (Working Paper 2000), *available at* http://papers.ssrn.com/sol3/papers.cfm?...992&cftoken=52818259&abstract_id=244742; William W. Bratton & Joseph A. McCahery, *Comparative Corporate Governance and the Theory of the Firm: The Case Against Global Cross Reference*, 38 COLUM. J. TRANSNAT'L L. 213 (1999); John C. Coffee Jr., *The Future As History: The Prospects for Global Convergence*

things, to incompatible differences between *market* systems of corporate governance, which have widely dispersed stock ownership and deep, liquid stock markets, and *block-holding* systems, in which stocks are thinly traded and control is held by insiders or banks. Market systems of corporate governance typify the United States and Britain, while block-holding systems are found in continental Europe, East Asia and most other capitalist economies.[2]

The nature of a system often shapes the legal relationships between corporations and banks as financiers. Thus, in the United States, the most prominent market system, banks are generally prohibited from owning equity stakes in the corporations to which they lend, partly to avoid connected lending to corporate affiliates of banks and partly to avoid aggregation of financial power.[3] In contrast, in Germany and Japan (both of which are block-holding systems), connected lending and equity ownership by banks are mainstays of corporate finance. In both of those countries, banks traditionally have been the largest equity-holders in major corporate borrowers and have used their equity stakes to monitor loans. The same pattern exists in many transition economies, albeit often without the safeguards that exist in Germany.

Other important implications flow from differences in the relative importance of capital markets and bank finance in market and block-holding systems. Market systems put a premium on transparency and disclosure because shareholders are typically dispersed and cannot monitor their

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in Corporate Governance and Its Implications, 93 NW. U. L. REV. 641, 641-47 (1999); Mark J. Roe, *A Political Theory of American Corporate Finance*, 91 COLUM. L. REV. 10 (1991).

In referring to "corporate governance law," I consciously exclude national schemes of securities regulation, which have undergone greater movement toward international convergence due to systemic risk concerns that are comparable to similar concerns in the banking industry. *E.g.*, Stephen J. Choi & Andrew T. Guzman, *National Laws, International Money: Regulation in a Global Capital Market*, 65 FORDHAM L. REV. 1855 (1997); Coffee, *supra*, at 650-53. Quite recently, with the growing fungibility of commercial banking and securities, securities regulators and banking regulators have cooperated, through the Basel Committee and the International Organization of Securities Commissions ("IOSCO"), in developing joint global standards. Joseph J. Norton, *"International Financial Law," An Increasingly Important Component of "International Economic Law": A Tribute to Professor John H. Jackson*, 20 MICH. J. INT'L L. 133, 139-41 (1999).

2. *E.g.*, Bratton & McCahery, *supra* note 1, at 218; Coffee, *supra* note 1, at 641-42, 647-48.

3. PATRICIA A. MCCOY, BANKING LAW MANUAL: FEDERAL REGULATION OF FINANCIAL HOLDING COMPANIES, BANKS AND THRIFTS § 7.03[1][b] (2d ed. 2000 & 2001 Supp.).

investments through day-to-day involvement. In contrast, block-holding systems normally favor opacity over disclosure. In part, that is because dispersed ownership is uncommon; in part, it is because lack of transparency deters other competitors from doing business with corporate borrowers, thereby enabling the banks that lend to them to obtain captive returns on their investments. As a result, finance in block-holding systems tends to rely on relationships of trust more than on impersonal markets and judicially enforceable contracts.[4]

Market and block-holding systems also differ in the level of protections that are accorded to minority shareholders. In block-holding systems, protections for minority investors are generally weaker than in market systems. As a result, shareholders demand control stakes in block-holding systems in order to protect their investments.

Given these differences between market systems and block-holding systems, one might surmise that the same structural impediments to international convergence in the corporate governance area would crop up in cross-border banking regulation. In fact, however, convergence has made greater headway in banking law than in corporate governance law. Furthermore, the trend toward global convergence in banking cuts across market and block-holding systems alike.

Given the close relationship between banks and corporate governance, why has global convergence in banking made greater strides than in corporate governance law? At first blush, one might suppose that the movement toward international convergence in banking is propelled by Darwinian notions of efficiency, *i.e.*, the idea that one set of regulatory principles will result in optimal banking operations around the world and that systems that fail to evolve toward those principles are doomed to failure. If that were the case, however, why would banking regulation be any more conducive to uniform oversight based on efficiency notions than corporate governance?

This article sets out to examine these questions. I begin by describing the forces behind global convergence in banking regulation and how those forces differ from the constellation of forces affecting convergence in corporate governance. In that regard, I suggest that global convergence in banking has been reactive in nature and has responded more to perceived threats than to idealized notions of efficiency. Nevertheless, the *outcome* of that

4. *See, e.g.*, Raghuram G. Rajan & Luigi Zingales, *Which Capitalism? Lessons from the East Asian Crisis*, 11 J. APPLIED CORP. FIN. 40, 41 (1999).

international project has been to produce unitary standards that emulate specific efficiency paradigms.

Accordingly, it is necessary to consider whether those efficiency notions represent an inevitable development or whether global convergence in banking is a transient phenomenon that contains the seeds of instability. I conclude that the efficiency paradigm that is implicit in the Basel Committee's pronouncements is an impoverished model that fails to account for broader systemic tradeoffs and varying stages of economic development.

I. GLOBAL CONVERGENCE IN BANKING REGULATION AND ITS UNDERLYING FORCES

Why has global convergence in banking advanced farther than in corporate governance? After all, the efficiency norms that are imbedded in international banking standards arguably apply to corporations of all types. As I will explain, however, the greater speed with which international standards emerged in banking was a function of concerns that are unique to the financial services industry and that are otherwise absent in corporate governance, i.e., worldwide financial contagion and fears about ensuing political unrest. Due to the often-urgent nature of those concerns, the Basel Committee has been able to achieve at least surface agreement on international banking standards, despite major differences between market and block-holding systems.

A. The MOVEMENT TOWARD GLOBAL STANDARDS IN BANKING

The movement toward uniform global banking standards[5] began in the mid-1970s, triggered by the failure of the Bankhaus Herstatt in West

5. Global convergence can come in a variety of forms, including binding treaties, voluntary compliance with multilateral standards, standardization of industry practices or conscious parallelism in the enactment of national laws. In banking regulation, the movement toward uniform standards has been accomplished, not through treaties, but through "soft law" in the form of model principles and guidelines, developed by the Basel Committee on Banking Supervision, for adoption on a voluntary basis by signatory countries. *E.g.*, Lawrence L.C. Lee, *The Basle Accords as Soft Law: Strengthening International Banking Supervision*, 39 VA. J. INT'L L. 1, 3-6 (1998). Consequently, I will use "convergence" as it applies to banking regulation to denote non-binding multilateral standards that individual sovereign nations adopt as law.

The Basel Committee's accomplishments are not the only evidence of convergence. Further movement in that direction can be seen in the General Agreement on Trade in Services and the European Union's Second Banking Directive. *See, e.g.*, Mary E. Footer, *GATT and*

Germany in 1974.[6] Under the auspices of the Bank of International Settlements (BIS) in Basel, Switzerland, the Group of 10 (the G-10) linked arms with Luxembourg and Switzerland to form what is known today as the Basel Committee on Banking Supervision.[7] The Basel Committee's stated purpose is to encourage progress toward convergence in the banking regulations of its members by promulgating model standards and serving as an information exchange. While the Basel Committee's standards are non-binding, they are endorsed by the governors of the G-10 central banks and are formulated with the expectation of adoption by G-10 members.[8]

The earliest pronouncements of the Basel Committee addressed the anomaly that banks were increasingly multinational, but regulation was national in scope. Growth in international trade had spurred growth in international banking. Advances in computerization and the management of risk through derivatives had also fueled growth. The progressive dismantling of restrictions on capital movements in many countries caused foreign currency trading to surge, especially on the financial derivatives markets.[9] Indeed, ultimately in recognition of that growth, the Uruguay Round's General Agreement on Trade in Services (G.A.T.S.)[10] was hammered out to liberalize cross-border trade in financial services.

The cross-border expansion of banking in the past thirty years, however, came at the expense of worldwide financial contagion. Repeatedly, banking regulators have been saddled with crises after foreign activities by local banks

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the Multilateral Regulation of Banking Services, 27 INT'L LAW. 343 (1993); Christos Hadjiemmanuil, *European Monetary Union, the European System of Central Banks, and Banking Supervision: A Neglected Aspect of the Maastricht Treaty*, 5 TUL. J. INT'L & COMP. L. 105 (1997). With respect to *prudential regulation* of commercial banking practices, however, the Basel Committee is the foremost purveyor of international standards.

Many, including sometimes the Basel Committee itself, use the alternative spelling "Basle." For the sake of consistency, I will use the German spelling "Basel" except where citations or quotations otherwise require.

6. *See* Joseph J. Norton, *The Work of the Basle Supervisors Committee on Bank Capital Adequacy and the July 1988 Report on "International Convergence of Capital Measurement and Capital Standards,"* 23 INT'L LAW. 245, 247-48 (1989).

7. *Id.* The G-10 consists of Belgium, Canada, France, Germany, Italy, Japan, the Netherlands, Sweden, the United Kingdom and the United States. *Id.* at 248 n.16.

8. *Id.* at 262.

9. *E.g.*, Stephen Zamora, *Regulating the Global Banking Network - What Role (If Any) for the IMF?*, 62 FORDHAM L. REV. 1953, 1957 (1994).

10. *See* Footer, *supra* note 5, at 345-51.

evaded regulation and resulted in bank failures, inflicting losses at home. Comparable harm occurred when poorly supervised foreign banks expanded overseas and wreaked damage on their host countries. In response, the Basel Committee's first major initiative, the Basel Concordat of 1975, formulated guidelines for consolidated supervision by home countries and host countries of the foreign activities of banks.[11] Later sovereign debt crises prompted the Basel Committee to revise the Concordat in 1983[12] and to supplement the Revised Concordat in 1990.[13] A year later, in 1991, the notorious failure of the Bank of Credit and Commerce International (BCCI) sent shock-waves around the world and caused the Basel Committee, in 1992, to issue new minimum standards for the supervision of international banking groups.[14]

As this chronology suggests, the Basel Committee's earliest concerns were with cross-border supervision. Only later did the Basel Committee turn to the substantive content of banking regulation. In 1988, the Basel Committee issued the Basel Accord, which called for minimum capital standards for commercial banks pegged at eight percent of risk-weighted assets.[15] Capital adequacy is a mainstay of banking regulation: it seeks to ensure that banks have an adequate cushion against losses for the protection of depositors. The Basel Committee's contribution was to require higher-risk

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11. BASEL COMMITTEE ON BANKING SUPERVISION, *History of the Basle Committee and its Membership*, Compendium of documents produced by the Basel Committee on Banking Supervision, *available at* http://www.bis.org/publ/index.htm (Feb. 2000).

12. BASEL COMMITTEE ON BANKING SUPERVISION, *Principles for the Supervision of Banks' Foreign Establishments* ('*the Concordat*'), Compendium of documents produced by the Basel Committee on Banking Supervision, *available at* http://www.bis.org/publ/index.htm (May 1983).

13. BASEL COMMITTEE ON BANKING SUPERVISION, *Information Flows Between Banking Supervisory Authorities, (Supplement of the 'Concordat')*, Compendium of documents produced by the Basel Committee on Banking Supervision, *available at* http://www.bis.org/publ/index.htm (April 1990).

14. BASEL COMMITTEE ON BANKING SUPERVISION, *Minimum Standards for the Supervision of International Banking Groups and Their Cross-border Establishments*, Compendium of documents produced by the Basel Committee on Banking Supervision, *available at* http://www.bis.org/publ/index.htm (July 1992). *See generally* RAJ K. BHALA, FOREIGN BANK REGULATION AFTER BCCI (1994).

15. BASEL COMMITTEE ON BANKING SUPERVISION, *International Convergence of Capital Measurement and Capital Standards*, Publications, *available at* http://www.bis.org/publ/index.htm (July 1988).

banks to maintain commensurately higher capital.[16] Since its appearance twelve years ago, the Basel Accord has had astonishingly wide acceptance, with adoption by approximately one hundred countries.[17] If anything epitomizes the movement toward global convergence in financial services regulation, it is unquestionably the Basel Accord.

The Basel Committee's moorings in fixed notions of economic efficiency are most evident from its substantive banking standards. The Basel Accord proceeded on the premise that a single capital structure, based on a minimum capital ratio of eight percent, was universally optimal for banks, both in terms of return on equity and adequate protection for depositors or their insurers. As such, it embraced a determinist notion of economic efficiency that assumed, as Professor John Coffee has put it in a somewhat different context, that "large-scale firms [would] adopt a common set of structural characteristics" and would not subsequently depart from that predetermined equilibrium.

The same lockstep notions of efficiency appeared in the Basel Committee's more ambitious attempt a decade later to formulate a comprehensive regime for the prudential regulation of commercial banks. In 1997, the Basel Committee issued the *Core Principles for Effective Banking Supervision*, its most comprehensive set of banking standards to date.[19] In a set of twenty-five core principles, the Basel Committee formulated substantive standards on everything from the preconditions for effective banking supervision and chartering standards to risk management, examinations, disclosure and enforcement.

In considering the efficiency rationale behind those standards, it is worth examining the example of Principle 10 of the Core Principles on "connected lending." Principle 10 states:

> In order to prevent abuses arising from connected lending, banking supervisors must have in place requirements that banks lend to related companies and individuals on an arm's-

16. PATRICIA JACKSON ET AL., *Capital requirements and bank behaviour: the impact of the Basle Accord 1, in* BASEL COMMITTEE ON BANKING SUPERVISION, Working Papers No. 1, *available at* http://www.bis.org/publ.htm (April 1999) [hereinafter BASEL ACCORD STUDY].

17. *Id.*

19. BASEL COMMITTEE ON BANKING SUPERVISION, *Core Principles for Effective Banking Supervision*, Compendium of documents produced by the Basel Committee on Banking Supervision, *available at* http://www.bis.org/publ/index.htm (Sept. 1997) [hereinafter *Core Principles*].

> length basis, that such extensions of credit are effectively monitored, and that other appropriate steps are taken to control or mitigate the risks. [20]

Thus, the embedded notion is that efficiency is to be measured, in isolation, by terms that would be extended to previously unfamiliar borrowers, without regard for the feasibility of setting those terms or other social benefits that might accrue from connected lending to related borrowers.

This formulation of efficiency is inextricably bound up with the Basel Committee's moorings in the Western industrialized world and particularly in market systems, primarily the United Kingdom and the United States. The Basel Committee, as Stephen Zamora has described it, is "an exclusive club representing the central banks of the most highly (Group of Ten) industrialized countries" and consists of the major powers of Western Europe, the United States and Japan.[21] Until recently, the Basel Committee assiduously resisted expanding the Committee's membership to Third World countries.[22] Furthermore, it is generally agreed that the 1988 Basel Accord was the product of behind-the-scenes maneuvering by the two most important market systems, the United Kingdom and the United States.[23]

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20. *Id.* at 27.

21. Stephen Zamora, *Regulating the Global Banking Network - What Role (If Any) for the IMF?*, 62 FORDHAM L. REV. 1953, 1970 (1994).

This is not to say that the G-10 regularly achieves full consensus. There are many topics about which the bank supervisors of the different G-10 nations have failed to agree. Examples include the debate over activities restrictions and universal banking, the optimal degree of concentration within the banking industry, state subsidies to local banks and bank secrecy. *E.g.*, Heidi Mandanis Schooner & Michael Taylor, *Convergence and Competition: The Case of Bank Regulation in Britain and the United States*, 20 MICH. J. INT'L L. 595 (1999); *German Banks Under Fire*, THE ECONOMIST, May 22, 1999; *Bank Rules in Disarray*, THE ECONOMIST, Nov. 27, 1999, at 75.

22. JOSEPH JUDE NORTON, DEVISING INTERNATIONAL BANK SUPERVISORY STANDARDS 229 (1995) [hereinafter STANDARDS].

23. The Basel Accord was hammered out in haste after the United States, the United Kingdom and Japan proposed their own trilateral agreement on capital standards, the effect of which would have been to raise the bar to entry by most of the world's other major banks. The following protest by one observer captured that dynamic and the tension that ensued:

> The two countries [the United States and the United Kingdom] -- the homes of the two largest financial centres in the world -- have agreed to a joint approach in defining the capital of banks, laying down a system for valuing banks' assets including off-balance-sheet operations and allocating them to specific categories or risk. As a next step, they are trying to reach agreement with Japan. This would cover the three most important

In more recent years, stung by allegations of hegemony on the part of Western capital-exporting powers, the Basel Committee decided to include banking supervisors from offshore countries and emerging economies in its deliberations in order to enlist their enforcement on a voluntary basis and confer greater legitimacy on the Committee's efforts.[24] The Basel Committee's standards have also been enforced in emerging economies through considerably more coercive means. The most potent means of such enforcement in recent years has been International Monetary Fund (IMF) conditionality, whereby the IMF has insisted on compliance with the Basel Accord and the Core Principles as a condition of aid.[25]

B. THE DRIVING FORCES BEHIND INTERNATIONALIZATION OF BANK REGULATORY STANDARDS

In corporate governance, as opposed to banking, there is no pretense of a consensus among the G-10 nations on an optimal set of standards. Commentators have advanced a number of explanations for this state of affairs, including political rent seeking and path dependency, the role of legal

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> financial centres in the world. Countries not prepared to join an agreement among this group of three countries could easily be put under pressure. It would be sufficient to bar their banks from using the three financial centres or to subject them to special treatment. If they wish to remain competitive internationally, the large banks that operate worldwide can no longer be absent from these centres today. They would quickly try to encourage their governments to co-operate internationally. . . .
>
> However, should the example set a precedent and the strategy of the two powers be extended to other fields of harmonising banking supervision -- as a substitute, so to speak, for internationally negotiated compromises -- then the willingness to co-operate internationally could suffer damage in the long run. In view of the problems that need to be solved, this would be a harmful development.

Dr. Lusser assesses various aspects of international co-operation in the field of monetary policy, 64 BIS REV., Apr. 1, 1987, at 6. *Cf.* BASLE ACCORD STUDY, *supra* note 16, at 38 (discussing joint statement of January 8, 1987 by the Federal Reserve Board and the Bank of England announcing their intent to establish bilateral minimum risk-based capital requirements).

24. Cynthia C. Lichtenstein, *Dealing with Sovereign Liquidity Crises: New International Initiatives for the New World of Volatile Capital Flows To and From Emerging Markets*, 29 MCGEORGE L. REV. 807, 819 (1998); Lee, *supra* note 5, at 6 n.20; Norton, *supra* note 6, at 251-52.

25. Lee, *supra* note 5, at 38-39.

institutions in shaping the preconditions for efficiency, and varying liquidity preferences.[26]

So why has consensus in the banking area been easier to achieve? After all, the banking regimes in the G-10 countries grow out of the same political milieus as corporate governance regimes. Furthermore, one could argue that the determinist notions of economic efficiency that undergird the Basel Committee's substantive pronouncements apply equally to corporate governance.

Nonetheless, global convergence has made greater headway in banking than in corporate governance. That can be explained, in large part, by many of the same reasons that cause governments to regulate banks in the first place. The preeminent reason, systemic risk, is reactive in nature and flows from common concerns by national bank supervisors about the domestic repercussions of cross-border banking crises that they cannot individually control. As in corporate governance, it has not been enough to subscribe to the view that international corporations are evolving toward a common ideal of efficiency. Rather, in banking, the main impetus towards harmonization consisted of international banking crises of catastrophic proportions that could not be quelled without international cooperation.

The roots of systemic risk lie in the capital structure and mutual interdependence of banks.[27] Banks obtain the bulk of their funds from debt in the form of demand deposits, rather than from shareholders' equity. Because banks borrow short and lend long, they suffer from a fundamental mismatch in the maturities of their assets (which are usually illiquid) and their liabilities (which are liquid). When depositors demand more funds than the bank has on hand, the result can be a devastating bank run.

Ordinarily, under the law of fractional reserves, banks can estimate how much money to have on hand each day to satisfy depositors' needs. If rumors or reports of bank distress circulate, however, causing depositors to fear an imminent bank run, that fear can become a self-fulfilling prophecy. Absent a lender of last resort, a bank that experiences a run will not be able to pay off its depositors because it will not be able to liquidate its assets immediately at full value. Depositors unlucky enough to stand at the back of the line will lose their money and the bank will close its doors.

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26. *E.g.*, Coffee, *supra* note 1, at 642-48.

27. For fuller discussion of these dynamics, *e.g.*, MCCOY, *supra* note 3, at 1-1 through 1-24.

As this suggests, solicitude for depositors is part of the motivation behind government regulation of banks, both out of concern for political instability and to encourage households to channel their savings into the economy. Thus, a fundamental purpose of banking regulation is to solve the information asymmetry that exists between banks and their depositors by interposing the government as a monitor. Monitoring by demand depositors is normally not cost-effective due to depositors' lack of information about their banks and the small size of their deposits. Even if monitoring were possible, depositors usually find it more cost-effective to exercise their rights of immediate exit through withdrawal than to engage in continuous monitoring.

Depositors are not the only subject of concern for government regulators. Governments also monitor banks out of concern for systemic risk. Banks are inextricably linked to one another through the payments system, as well as through an intricate web of inter-bank lending and derivatives swaps. As a result of those linkages, if a major bank fails and defaults on its obligations, other banks may fail, causing a ripple effect throughout the banking system. Insofar as banks are levers of monetary policy, the ensuing bank panic can have profound negative macroeconomic consequences, including contraction of the money supply and a resulting economic downturn. As such, systemic risk constitutes a negative externality of banks, because failed banks and their shareholders do not have to pay for systemic harms they inflict on other banks and other economies. As the largest banks grow larger, moreover, the danger of contagion grows. While the likelihood of contagion is subject to debate, governments are loath to risk it because the consequences can be devastating.[28]

In the global context, contagion is of even greater concern, not only because of the vast size and scope of international banking operations, but because jurisdictional boundaries hamper the ability of bank regulators, both de jure and de facto, to supervise banking operations abroad. Losses from speculative overseas banking activities can easily spread to a bank's home country, inflicting losses which regulators are helpless to prevent.

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28. *E.g.*, RANDALL S. KROSZNER, BANK REGULATION: WILL REGULATORS CATCH UP WITH THE MARKET? 9-12 (Cato Inst. Briefing Paper No. 45, 1999), *available at* http://www.cato.org/pubs/briefs/bp-045es.html; Jonathan R. Macey & Geoffrey P. Miller, *Bank Failures, Risk Monitoring, and the Market for Bank Control*, 88 COLUM. L. REV. 1153, 1157 (1988); David G. Oedel, *Puzzling Banking Law: Its Effects and Purposes*, 67 U. COLO. L. REV. 477, 524-26 (1996).

For these reasons, systemic risk has been the most powerful driving force behind the Basel Committee's pronouncements. As the Basel Committee noted with respect to the Basel Accord, the Committee "believed that the [capital adequacy] framework would help to strengthen the soundness and stability of the international banking system by encouraging international banking organizations to boost their capital positions."[29] Indeed, the bulk of the Basel Committee's initiatives have been undertaken in response to global banking crises. Whenever major international banking scandals have roiled the financial world in recent years -- witness Franklin National Bank, Bankhaus Herstatt, Banco Ambrosiano in Italy, Continental Illinois, BCCI and Baring Bank -- the Basel Committee has regularly responded with a regulatory pronouncement.[30] The thrust of those pronouncements has been to assure uniformly high prudential safeguards throughout major banking markets and cross-border enforcement. The collapse of the Thai bhat in 1997 and the Russian ruble in 1998, with their worldwide repercussions, underscored the frailties of interdependent markets and the need for global coordination and oversight.[31]

In contrast, outside of the financial services industry, contagion almost never is a concern in corporate governance. The reason why is that other types of corporations do not have to resort to the highly unstable device of demand deposits in order to finance their operations. Established corporations get outside financing through equity and through loans; other corporations that lack access to outside financing achieve growth through retained earnings. While the assets of most corporations are illiquid, so are their liabilities, which normally cannot be withdrawn immediately upon demand.[32] Consequently, in industrial corporations, rapid contagion is not a concern as it is in banking. To be sure, one corporation's death may lead to the eventual failure of other corporations that are its suppliers, but the illiquid nature of their liabilities means that failure will be slow rather than precipitous, allowing time for countermeasures and intervention. Thus, discussions of corporate governance are almost never animated by concerns over the larger macroeconomic consequences of corporate failures.

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29. BASEL ACCORD STUDY, *supra* note 16, at 1.

30. *E.g.*, Norton, *supra* note 6, at 245-46.

31. *See generally* Lichtenstein, *supra* note 24, at 807.

32. Notes that are subject to call upon default are an exception.

Similarly, systemic risk is closely related to the other motivating factors behind the Basel Committee's standards, i.e., competitive parity and market entry. In major Western countries, governments reserve discretion to deny entry to the banking industry through charter denials. While entry controls in banking have obvious anti-competitive implications, normally they are justified as necessary to ensuring the solvency of banks. Concerns about lax oversight are often stronger for overseas banks than for their domestic counterparts, which is one reason why entry controls are often imposed on foreign banks. Given those supervisory concerns, uniform regulatory standards can help open markets by providing host countries with some assurance that the identical regulatory standards are being enforced in the home country of a foreign competitor. Similarly, for foreign banks that have already achieved market entry abroad, "a standard approach applied to internationally active banks in different countries" helps reduce competitive inequalities.[33]

Obviously, in corporate governance generally, market entry is of concern as well. In trade for goods as opposed to financial services, however, usually the concern is with market entry in a narrower sense. Corporations that are in the business of selling goods almost never are subject to barriers against entering foreign markets due to reservations by the host country about their form of corporate governance. In other words, in manufacturing, whatever market barriers exist operate against the entry of particular *goods* rather than against particular *companies* or particular forms of *corporate governance*. In contrast, in the area of bank regulation, market controls are elevated to the level of outright prohibitions against *firms*, based at least in part on solvency concerns. Thus, the stakes associated with market entry in banking are usually considerably higher than for firms that are not financial services providers.

Lastly, it is necessary to observe that international convergence in banking, in contrast with corporate governance, has occurred in less visible fora where change may be easier to accomplish. In civil law jurisdictions and increasingly in common law jurisdictions, corporate governance law is formulated by the legislature, often in the harsh glare of publicity. In contrast, the bulk of international banking standards are initiated by the Basel Committee, which attempts whenever possible to operate informally and behind closed doors.[34] Once a particular set of principles has been

33. BASEL ACCORD STUDY, *supra* note 16, at 1.

34. Norton, *supra* note 6, at 249.

formulated and endorsed by the G-10, adoption of those principles may be accomplished by executive decree or agency order in many countries, without the need for statutory enactment. The obscure nature of capital adequacy rules and other forms of banking regulation aid the Basel Committee's attempts to preserve a low profile. As a result, political impediments to convergence in banking regulation, at least initially, may be lower than in corporate governance. At the same time, the behind-the-scenes nature of that process raises very real questions of political legitimacy.

To summarize, concerns about systemic risk, market entry and competitive parity coalesced in global harmonization in banking to a degree not yet seen in corporate governance law. Despite that rather remarkable accomplishment, the Basel Accord, in implementation, has developed fissures that cannot be ignored.

II. CENTRIFUGAL FORCES IN GLOBAL CONVERGENCE

I have argued that the result of the Basel Committee's initiatives has been to promote a uniform conception of economic efficiency.[35] Nevertheless, it would be a grave mistake, based on a single snapshot, to conclude that convergence toward a unitary norm of economic efficiency is inevitable. It is a common failing to treat harmonization as a unidirectional movement, rather than as a series of reactions and counter-reactions that may trigger movements toward and away from shifting equilibria. Accordingly, it is important to ask whether the Basel Committee and its member states are

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35. As recent moves toward deregulation in the United States have shown, efficiency norms do not necessarily result in *stricter* regulation. Regulators face a mixed array of considerations and pressures when attempting to formulate optimal levels of regulation. Nevertheless, among the major capital-exporting countries, fears about systemic risk from international contagion have been sufficiently insistent that the Basel Committee's products have generally resulted in stricter standards to date.

Due to the newness of the Core Principles, most of the available data bears on the Basel Accord's effect on capital adequacy levels. The Basel Committee recently concluded "that at least initially, the introduction of formal minimum capital requirements across the G-10 appears to have induced relatively weakly capitalized institutions to maintain higher capital ratios." BASEL ACCORD STUDY, *supra* note 16, at 2. Moreover, "those countries which were close to, or below, the Basle minimum capital adequacy ratio of 8% in 1988 evidenced a much higher overall increase than those which had historically high capital ratios." *Id.* at 6-15. In the study, the Basel Committee was unable to conclude definitively, however, that the Basel capital adequacy ratios were responsible for the increase, as opposed to increased bank supervision or market discipline. *Id.* at 15.

subject to pressures that could cause banks or member states to depart from the Committee's supposedly efficient norms.

The seemingly rosy progress of the Basel Committee to date might suggest that centrifugal forces are not at work. In the short run, the confluence of forces has favored stricter uniform standards. Regulators are not the sole impetus for uniformity in banking, moreover; the impetus also comes from major international banks. Uniformity helps international banks by leveling the playing field so that regulated banks in one country do not suffer a cost disadvantage vis-à-vis their peers abroad due to stiffer regulatory requirements at home. Precisely for that reason, competitive equality was one of the stated rationales for the 1988 Basel capital adequacy accord.[36]

In the international arena, the strongest large banks have furthermore favored *stricter* uniform standards in order to hurt weaker competitors. If uniform standards are set sufficiently high, weaker banks will not be able to meet them and will either be acquired by stronger banks or close their doors. The Basel Accord, which raised minimum capital levels above the then-prevailing average in the United States, is just one example. In the United States, numerous weakened banks were acquired in mergers after the United States adopted risk-based capital standards under the 1988 Basel Accord.[37] Similarly, higher uniform standards can eliminate potential future competition by setting a higher (and sometimes insuperable) bar to new entrants to the industry. This phenomenon has been the source of endless controversy in emerging economies, where fledgling domestic banks complain that major Western international banks have exerted pressure for adherence to global prudential standards in order to corner the market for banking services.[38]

Other private benefits inure to major international banks from uniform regulation. From the standpoint of cost savings and efficiency, international banks would prefer to operate on a consolidated basis, with one set of capital rules, accounting standards, internal controls, regulatory reports and books.[39]

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36. *E.g.*, Zamora, *supra* note 21, at 1958.

37. *See generally* John P. O'Keefe, *Banking Industry Consolidation: Financial Attributes of Merging Banks*, 9 FDIC BANKING REV. (1996), *available at* http://www.fdic.gov/bank/analytical/banking/1996fall/merger.html.

38. *E.g.*, Roman Terrill, *The Promises and Perils of Globalization: The Asian Financial Crisis*, 9 TRANSNAT'L L. & CONTEMP. PROBS. 275, 280 (1999).

39. Michael E. Patterson, *Convergence of Global Financial Services*, 21 FORDHAM INT'L L.J. 377, 381-82 (1997).

Since a single international regulatory system is nowhere close to a reality, international banks must settle for a second-best solution, in the form of substantial uniformity across the various national banking regulation regimes. Thus, a subsidiary goal of cross-border uniformity is a lower cost structure and greater economies of scope and scale for international banks.

Notwithstanding the competitive motives of large international banks, emerging economies may have reasons of their own to sign on to the Basel Committee standards. Domestic banks in emerging economies that want to attract major Western firms as clients and establish correspondent relationships find it easier to establish customer trust by observing the Basel Committee standards. Foreign investors are unwilling to use local banks for their banking and payments needs unless the safety of their deposits can be assured.[40] Absent a credible system of deposit insurance guarantees, compliance with rigorous international standards sends a signal that a bank can be trusted with one's deposits. As banks in emerging economies mature, moreover, and extend their own operations abroad, they will need to comply with Basel Committee standards in order to gain entry to the major Western banking centers. Finally, in times of domestic monetary crisis, compliance with the Basel Committee's standards is a standard condition of IMF aid.

Nevertheless, the championing of a single, lockstep model of economic efficiency will inevitably be followed by antithesis in the form of economic and political destabilization. One source of instability inheres in the law of cartels. Another source of instability grows out of the fact that market systems and block-holding systems have deep-seated differences in their constructs of economic efficiency. These latter differences are especially apparent in norms concerning connected lending.

A. Cartel Dynamics

First, with respect to the law of cartels: one way to view the Basel Committee's actions is as the actions of a cartel (one that is governmentally sanctioned). Under the auspices of that cartel, the members of the G-10, through the Basel Committee, have agreed on a pricing structure for a regulatory tax on the business of banking. In keeping with the Basel Committee's pronouncements, that regulatory tax is supposed to be uniform throughout signatory countries through adherence to common standards. The

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40. Susan M. Phillips & Alan N. Rechtschaffen, *International Banking Activities: The Role of the Federal Reserve Bank in Domestic Capital Markets*, 21 FORDHAM INT'L L.J. 1754, 1757 (1998).

signatory countries include most, if not all, of the major financial centers of the world and control the majority of bank financing worldwide. Thus, by imposing higher standards, the Basel Committee can control the supply of financial services to a significant extent and maintain prices.

The devil, however, lies in enforcement. As with any cartel, the Basel Committee is susceptible to cheating by individual banks and member states.[41] Member states have an incentive to relax their enforcement of the Core Principles and the Basel Accord whenever they can derive net benefits without getting caught.

In many cases, it is relatively easy for a country to cheat on the Core Principles and the Basel Accord and evade detection, at least in the short to medium term. Banking regulation is notoriously opaque around the world, with respect to disclosures by regulators and by banks themselves. Unlike securities regulation, which is premised on transparency and disclosure, banking regulation regimes around the world are highly secretive, even in societies that are otherwise open, in part due to fears about bank runs. Compounding this problem, because the Basel Committee operates through consensual standards, it lacks formal enforcement mechanisms.[42] Unlike the regulatory system of a single sovereign nation, there is no international super-regulator with binding authority to keep national regulators in line. Accordingly, whether a country's banking regulators enforce the Basel Committee's principles once those principles become law may be difficult to ascertain, except from anecdotal evidence.

Another inducement to cheating consists of the fact that accounting treatments can give a false appearance of compliance.[43] Although international accounting systems have moved towards common norms, significant national differences in accounting treatments remain. The effectiveness of risk-weighted capital, for instance, has a lot to do with whether assets are represented at cost (in which case the sting may be less

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41. While this point has been briefly mentioned in passing, it has not been developed in the literature. *E.g.*, Eric J. Gouvin, *Banking in North America: The Triumph of Public Choice over Public Policy*, 32 CORNELL INT'L L.J. 1, 26 (1998).

42. *E.g.*, Cynthia C. Lichtenstein, *Bank for International Settlements: Committee on Banking Regulations and Supervisory Practices:* Consultative Paper on International Convergence of Capital Measures and Capital Standards, 30 I.L.M. 967 (1991).

43. *E.g.*, BASEL COMMITTEE ON BANKING SUPERVISION, *A New Capital Adequacy Framework* 10-11, *available at* http://www.bis.org/publ/index.htm (last modified Feb. 12, 2001).

harsh) or fair market value. These differences make it harder to detect the extent of any cheating.

Other cheating is easier to detect, but difficult to counteract absent an overarching regulator. Thus, in recent years, German regulators have been accused of manipulating the risk-weight categories in two respects. They have given unduly low weights to bonds issued by German mortgage banks. In addition, they have permitted German banks to meet core capital requirements through a form of subordinated debt that other G-10 regulators had agreed to prohibit.[44]

Finally, banks and nations can evade higher standards through regulatory arbitrage, which is not strictly cheating but lawful exploitation of intentional or unintentional regulatory loopholes in a manner that violates the spirit of the standards. Under the 1988 Basel capital adequacy accord (the substantive Basel pronouncement with the longest track record), four prominent examples of regulatory arbitrage can be discerned.

1. Securitization

The most important example of regulatory arbitrage under the Basel Accord has been the use of securitization by United States and European banks to sell off loans to avoid higher capital requirements that otherwise would apply if those loans remained on the books. In securitizations, banks bundle their loans or other assets and sell interests in those bundles to the public in the form of securities that are backed by the assets. A window for regulatory arbitrage occurs because banks sign recourse clauses in which they

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44. *German Banks Under Fire*, *supra* note 21, at 20; *Germany's Protective Wings*, THE ECONOMIST, May 22, 1999, at 83; *Bank Rules in Disarray*, *supra* note 21, at 75-76.

In the negotiations leading up to the 1999 proposed revisions to the Basel Accord, Germany continued to press for special treatment. The negotiations over the revisions became deadlocked when Germany insisted on a special German exception to the one hundred percent weight for commercial-property lending, on grounds that such lending has been low-risk historically in Germany when compared with other countries. *Germany's Protective Wings*, *supra* note 21, at 82-83; *see also Bank Rules in Disarray*, *supra* note 21, at 76. In the proposal, the Committee broke the logjam by stating that "mortgages on commercial real estate do not, *in principle*, justify other than a 100% weighting for loans secured." BASEL COMMITTEE ON BANKING SUPERVISION, *A New Capital Adequacy Framework* 31 (June 1999), *available at* http://www.bis.org/publ/index.htm (emphasis added). *The Economist* later jibed that the "two weasel words . . . 'in principle'" were designed to "allow Germans (but, with luck, nobody else) to give their mortgage banks generous treatment." *Growing Basle*, THE ECONOMIST, June 5, 1999, at 70. *See also* Daniel Pruzin, *Capital Requirements: Basle Committee's Capital Proposals Aim to Measure True Risks of Banks' Assest*, BNA BANKING DAILY, June 4, 1999.

agree to indemnify the buyers of the securities if any of the underlying loans go into default. Such clauses, otherwise known as "credit enhancements," make it easier to market securitizations to the investing public.

The problem with recourse clauses is that current regulations do not necessarily require banks to maintain capital that is commensurate to the risks retained. Under U.S. banking regulations, banks must reserve eight cents on the dollar in capital for any commercial loans on their books. If a bank instead takes those loans off its books by securitizing the loans with recourse, it currently must reserve the *lesser* of eight cents on the dollar or the amount of the bank's maximum contractual exposure under the recourse clause. That is true even if the residual interest that the bank retains under the recourse clause exceeds eight cents on the dollar. If the securitized loans are highly risky (a recent hallmark of bank securitizations of subprime loans in the United States), or if the bank has forfeited servicing rights that would otherwise enable the bank to monitor the loans closely to facilitate prompt repayment, the bank may eventually sustain losses that exceed the capital reserved.[45] Thus, U.S. banks have incentives to engage in securitization with risky recourse provisions because they could boost their capital ratios under federal banking regulations as long as two conditions are met: (1) the banks retain the risk of default through recourse clauses; and (2) the recourse interests exceed eight percent of the value of the securitized pool.[46] The same phenomenon has occurred in Western Europe.

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45. An example from regulations proposed by federal banking regulators in the fall of 2000 illustrates the point. Assume that a bank securitizes subprime credit card loans valued at $100 million. In order to market the securities, the bank agrees to accept recourse for up to $15 million of the loans (fifteen percent) in the case any of the loans go into default. Under current federal regulations, the bank only needs to reserve capital against the recourse interest of eight percent, instead of fifteen percent. Capital: Leverage and Risk-Based Capital Guidelines; Capital Adequacy Guidelines; Capital Maintenance; Residual Interests in Asset Securitizations of Other Transfers of Financial Assets, 65 Fed. Reg. 57993, 57996 (Sept. 27, 2000) (to be codified at 12 C.F.R. pts. 3, 208, 225, 325, 567).

46. *E.g.*, Capital; Leverage and Risk-Based Capital Guidelines; Capital Adequacy Guidelines; Capital Maintenance; Residual Interests in Asset Securitizations of Other Transfers of Financial Assets, 65 Fed. Reg. at 57995-97; BASEL ACCORD STUDY, *supra* note 16, at 21-26, 45-52; Susan M. Phillips, *Symposium: Derivatives & Risk Management: Keynote Address*, 66 FORDHAM L. REV. 767, 774 (1997); Daniel Pruzin, *Basle Committee Details Proposal to Use Market Discipline with Bank Capital Rules*, BNA BANKING DAILY, Jan. 19, 2000.

In September 2000, federal banking regulators proposed amendments to U.S. capital standards to require insured depository institutions to hold dollar-for-dollar capital for retained recourse interests, even if that capital exceeds the capital an institution otherwise would have

This technique grew so quickly in the United States and Western Europe that "[f]or certain banks," the Basel Committee concluded that securitization was "undoubtedly starting to undermine the comparability and even the meaningfulness of the capital ratios maintained."[47] Because of disparities in the growth of securitization internationally, banks in the United States and Western Europe have been able to avoid maintaining capital commensurate with their risks while gaining an unfair advantage in the application of the Basel capital adequacy standards.[48]

2. Manipulation Of The Risk Weight Categories

The second example of regulatory arbitrage consists of exploitation by banks of the Basel Accord's relatively crude system of weighting risk.[49] Under the 1988 risk-weighted capital system, assets are divided into four broad categories, referred to as "buckets." Each bucket has a different weight, according to its supposed level of risk. The bucket that is deemed the highest risk (consisting of unsecured loans, commercial loans, real estate owned, and loans to non-OECD foreign borrowers and governments) is weighted one hundred percent, while the bucket deemed free of credit risk (consisting of cash, U.S. government obligations, Federal Reserve Bank stock and obligations, and gold bullion) is weighted zero. In between falls the bucket for low-risk assets (such as loans backed by cash deposits, certain government guarantees and government securities), which is weighted twenty percent, joined by the bucket for medium-risk assets (such as loans secured by residential real estate and certain revenue bonds), which is weighted fifty

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to reserve to retain the entire asset on its books. In addition, the regulators proposed capping residual interests at twenty-five percent of Tier 1 capital in order to prevent over-concentration in the holdings of recourse interests. Capital; Leverage and Risk-Based Capital Guidelines; Capital Adequacy Guidelines; Capital Maintenance; Residual Interests in Asset Securitizations of Other Transfers of Financial Assets, 65 Fed. Reg at 57995-97; *see also* Risk-Based Capital Standards; Recourse and Direct Credit Substitutes, 65 Fed. Reg. 12320 (Mar. 8, 2000) (to be codified at 12 C.F.R. pts. 3, 208, 225, 325, 567).

47. BASEL ACCORD STUDY, *supra* note 16, at 4; *see also id.* at 3-4, 21-27, 45-52; *German Banks Under Fire*, *supra* note 21, at 19-20.

48. *E.g.*, BASEL COMMITTEE ON BANKING SUPERVISION, *A New Capital Adequacy Framework* 9, 36 (June 1999), *available at* http://www.bis.org/publ/index.htm; Capital; Leverage and Risk-Based Capital Guidelines; Capital Adequacy Guidelines; Capital Maintenance; Residual Interests in Asset Securitizations of Other Transfers of Financial Assets, 65 Fed. Reg. at 57994-96.

49. *See generally* Heath Price Tarbert, *Are International Capital Adequacy Rules Adequate? The Basle Accord and Beyond*, 148 U. PA. L. REV. 1771, 1800-01 (2000).

percent.[50] To determine how much capital must be held against a particular asset, regulators multiply the weight of the applicable bucket by eight percent. Thus, a loan weighted twenty percent requires the bank to hold capital in the amount of 20 percent times 8 percent, or 1.6 percent of the value of the asset.

The four-bucket system assumes, however, that assets within each bucket have equal risk, when often that is not the case. Commercial loans, for example, are lumped into a single bucket, whether a corporate borrower has a sterling AAA credit rating or is in danger of default. Thus, the system gives banks incentives to shed lower-risk assets for higher-risk assets within each bucket. It is relatively easy to engage in those tactics, moreover, without detection. Due to methodological difficulties, studies attempting to detect that activity have been inconclusive. Nevertheless, there is widespread agreement that the problem exists.[51]

Similarly, the four-bucket system assumes that assets with higher weights have higher risks than lower-weighted assets. That is not always the case. Relatively risky loans to South Korean banks, for instance, require four-fifths less capital than loans to United States companies with AAA credit, simply because South Korea is a member of the OECD.[52] Under the circumstances, the rational choice would be to lend to South Korean banks.

3. Off-balance-sheet Items

The Basel Accord's treatment of off-balance-sheet items provides a third opportunity for regulatory arbitrage. Under the current Accord, off-balance-sheet items in the form of commitments with an original maturity of one year or less do not require capital, while commitments with a longer maturity are

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50. MCCOY, *supra* note 3, § 6.03.

51. *E.g.*, VIRAL V. ACHARYA, IS THE INTERNATIONAL CONVERGENCE OF CAPITAL ADEQUACY REGULATION DESIRABLE? 22 (May 3, 2000), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=223768 (last visited Feb. 16, 2001); BASEL COMMITTEE ON BANKING SUPERVISION, *A New Capital Adequacy Framework* 9, 30, *available at* http://www.bis.org/publ/index.htm (last modified Feb. 12, 2001); BASEL ACCORD STUDY, *supra* note 16, at 20-21, 23.

52. *E.g.*, *Basle Brush*, THE ECONOMIST, May 1, 1999, at 69; BASEL COMMITTEE ON BANKING SUPERVISION, *A New Capital Adequacy Framework* 26-28, 30, *available at* http://www.bis.org/publ/index.htm (last modified Feb. 12, 2001) (loans to banks in OECD nations are weighted twenty percent, while loans to corporate borrowers are weighted one hundred percent).

weighted fifty percent.[53] Banks have neatly circumvented this rule by devising "evergreen" commitments with an initial maturity of less than one year that the banks roll over on an annual basis.[54]

4. Divergent Bank Rescue Policies

Finally, opportunities for regulatory arbitrage occur where nations have identical capital adequacy policies but radically different rescue policies for failed banks.[55] Around the world, the bank rescue policies of different nations range from strict market discipline (denying recovery to shareholders of failed banks) to full bailouts for bank shareholders (found in many emerging economies). Those rescue policies have feedback effects that alter the future risk propensity of banks. If a country bails out the shareholders of its banks, the bailout sends signals to shareholders of other banks that they can increase risk-taking with impunity.[56] When capital adequacy rules are uniform from country to country, international banks will have incentives to charter in countries with lax bank rescue policies, because they will not have to reserve additional capital to offset the heightened incentives for risk created by lax bank rescue policies. Moreover, international banks in lax countries that operate abroad through branches rather than through separately incorporated subsidiaries have higher incentives to increase their risk-taking abroad and at home. This is because if the bank becomes insolvent, the generous rescue policies of the lax country will apply to the entire bank corporation, including its overseas branches.[57] Thus, as Viral Acharya recently concluded, "when the rescue policy of one regime becomes more forbearing, the change not only destabilizes the banking sector with the lax

53. BASEL COMMITTEE ON BANKING SUPERVISION, *A New Capital Adequacy Framework* 32, *available at* http://www.bis.org/publ/index.htm (last modified Feb. 12, 2001). In addition, commitments of any maturity do not require capital where those commitments can be unconditionally cancelled at any time. *Id.*

54. *Id.*

55. In the United States, for example, almost three quarters of failed banks are resolved through assisted mergers with other banks (also known as purchase and assumption agreements), while Finland, Sweden, Norway and Japan rely principally or exclusively on open bank assistance (government bailouts). ACHARYA, *supra* note 51, at 23-24.

56. *Id.* at 24-26.

57. *Id.* at 32, 36-38.

regime but through a systemic effect also destabilizes the banking sector of the stringent regime."[58]

In sum, while the Basel Committee has moved rapidly toward international prudential standards, the inevitable centrifugal forces that are characteristic of cartels have already reared their head. Cognizant of the Basel Accord's many flaws, the Basel Committee responded in June 1999 by issuing a consultative paper seeking comment on amendments to the Basel Accord. In response to comments, the Committee revised the proposal and issued a massive second consultative paper on January 16, 2001, a complex proposal that together with its supporting documents exceeded 500 pages.[59] The draft revisions attempt to discourage regulatory arbitrage in loan decisions by proposing two alternative ways in which banks may satisfy their minimum capital requirements as to credit risk. Far from papering over the cracks, however, the Committee's proposal exposed a deep rift in the economic philosophies of the G-10 members.

The Committee's first proposed alternative is called the "standardised approach" and consists of a variation on the four traditional risk-weight buckets. Under the standardised approach, the Basel Committee would expand the number of buckets to six or more. More importantly, the Committee would refine the risk-weight bucket system by tying risk weights to external credit ratings by agencies such as Standard & Poor's instead of to asset type, for loans to commercial banks and corporate borrowers (as well as for securitizations). Risk weights for loans to sovereigns would be tied to published credit scores of export credit agencies.[60]

The purpose of this new approach is to enlist market discipline by assigning risk weights according to a borrower's actual credit risk as

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58. *Id.* at 38.

59. BASEL COMMITTEE ON BANKING SUPERVISION, *A New Capital Adequacy Framework, available at* http://www.bis.org/publ/index.htm (last modified Feb. 12, 2001); BASEL COMMITTEE ON BANKING SUPERVISION, *The New Basel Capital Accord, available at* http://www.bis.org/publ/bcbsca.htm (last visited April 22, 2001); BASEL COMMITTEE ON BANKING SUPERVISION, *Overview of The New Basel Capital Accord* 13, *available at* http://www.bis.org/publ.bcbsca.htm (last visited April 22, 2001).

60. *The New Basel Capital Accord, supra* note 59, at 7, 9-10; *A New Capital Adequacy Framework, supra* note 59, at 5,13,26-27. In a related vein, the Basel Committee proposed increasing the risk weights of assets and commitments that have proven over time to pose higher risk. Certain higher risk assets would be weighted 150 percent or more. *The New Basel Capital Accord, supra* note 59, at 11. Similarly, short-term off-balance-sheet commitments would be weighted twenty percent to stem the use of evergreen commitments. *Id.* at 12.

determined by the market, thereby reducing opportunities for arbitrage.[61] Under the new system, for example, the risk weight assigned to a corporate loan could vary from twenty percent to over one hundred percent, depending on the borrower's external credit rating.[62] Similarly, capital charges for asset securitizations would be based on external credit ratings for the underlying issue of securities.[63]

Under the Committee's second alternative, called the "internal ratings based" or "IRB" approach, sophisticated international banks would be permitted to calculate their capital according to their own internal assessments of credit risk instead of the standard risk-weight buckets. As proposed, the IRB approach would have two tracks: the foundation approach and the advanced approach. Under the foundation approach, strong banks that met certain prerequisites could use their own estimates of probabilities of default for individual borrowers. Regulators would then estimate the likely losses upon default, exposure at default and effective maturities to come up with risk weights. Under the advanced approach, banks meeting the strictest safety and soundness standards would be allowed to use their own estimates of loss upon default, exposure at default and effective maturities (in addition to probabilities of default), instead of those furnished by regulators.

The Committee gave three purposes for the IRB approach. First, the Committee sought to capitalize on the fact that banks are usually better informed about their borrowers than credit rating agencies or regulators (because, among other things, banks can monitor borrowers' financial

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61. As one commentator has noted, however, if the Committee does not expand the number of rating buckets beyond six, serious arbitrage incentives will remain. *See* JOÃO A.C. SANTOS, BANK CAPITAL REGULATION IN CONTEMPORARY BANKING THEORY: A REVIEW OF THE LITERATURE 19 (Bank for International Settlements, BIS Working Paper No. 90, Sept. 2000), *available at* http://www.bis.org/publ/work.htm (last visited April 21, 2001).

62. *The New Basel Capital Accord, supra* note 59, at 10; *A New Capital Adequacy Framework, supra* note 59, at 30-32.

63. *The New Basel Capital Accord, supra* note 59, at 89; *A New Capital Adequacy Framework, supra* note 59, at 36-37. U.S. regulators have proposed a similar approach. *Risk-Based Capital Standards; Recourse and Direct Credit Substitutes*, 65 Fed. Reg. 12320 (Mar. 8, 2000) (to be codified at 12 C.F.R. pts. 3, 208, 225, 325, 567). In addition, U.S. regulators have proposed superimposing a dollar-for-dollar capital charge for all retained recourse interests. *See supra* note 46; *Capital; Leverage and Risk-Based Capital Guidelines; Capital Adequacy Guidelines; Capital Maintenance; Residual Interests in Asset Securitizations of Other Transfers of Financial Assets*, 65 Fed. Reg. 57993, 57997-98 (Sept. 27, 2000). It is not yet clear how the two approaches would be harmonized. *Id.* at 57998-99.

movements through their checking accounts). In addition, the proposal seeks to harness the natural incentives of most large banks to avoid undue losses. Finally, the Committee was responding to criticisms, particularly by banks, about the drawbacks of the "one size fits all" approach that was implicit in the original 1988 Basel Accord.[64]

Despite the surface appeal of both proposals, they have been embroiled in controversy from the outset. In response to the proposed revisions, the same cartel forces surfaced that undermined the original 1988 accord. The fault lines, moreover, fall along the traditional divide between *market* systems and *block-holding* systems. As this history suggests, the problems of enforcement that are inherent in any cartel may be even more intractable in the case of the Basel Accord because the disagreements reflect incompatible differences in economic structures and norms.

The first example involves the proposal to link risk-weight categories to external credit ratings. External credit rating agencies are primarily an incident of the U.S. market system and specifically of capital markets, which require transparency and disclosure in order to work. In the rest of the world, which is mostly characterized by block-holding systems, external credit rating services are scant or simply not in place.[65] Rating services have not taken root in block-holding systems because capital markets in those countries are weak (reducing the need for external ratings) and the control stakes by banks that are typical of those systems have traditionally been the substitute for the data that credit agencies provide. Thus, it comes as no surprise that the three

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64. *A New Capital Adequacy Framework, supra* note 59, at 5-6, 13-14, 37-41. For a description of the committee's two approaches see *The New Basel Capital Accord, supra* note 59, at 32-86.

65. *See* RANGE OF PRACTICE IN BANKS' INTERNAL RATINGS SYSTEMS 22 (Basel Comm. on Banking Supervision, discussion paper, Jan. 2000), *available at* http://www.bis.org/publ/index.htm; *Basle Brush, supra* note 52, at 69; BNA BANKING DAILY, June 9, 1999; Rafael D. Frankel, *Singapore Official Announces Guidelines to Coincide With Basel Accord*, BNA BANKING REP., Apr. 2, 2001, at 595. Britain's market system falls in the middle, having more corporate ratings than Germany but fewer than the United States. *See Basle Brush, supra* note 52, at 69.

Even in market systems such as the United States, external credit rating systems are not a panacea because corporate borrowers are not always externally rated. (As this suggests, to some extent credit rating agencies and banks serve different segments of borrowers). *See* BNA BANKING DAILY, June 9, 1999; *A New Capital Adequacy Framework, supra* note 59, at 27. For a survey of credit rating systems generally, see CREDIT RATINGS AND COMPLEMENTARY SOURCES OF CREDIT QUALITY INFORMATION (Basel Comm. on Banking Supervision, Working Paper No. 3, Aug. 2000), *available at* http://www.bis.org/publ/index.htm.

main credit rating systems that the Basel Committee looks to as models are Standard & Poor's, Moody's Investor Service, Fitch IBCA and Duff & Phelps, all of which are based in the United States.[66]

The effect of using external credit rating systems, as conceived by the Basel Committee, moreover, would often be to favor rated borrowers over unrated borrowers. Thus, corporate borrowers with ratings of "the very highest quality" would receive favorable risk weights of twenty or fifty percent,[67] while most other corporate loans (including unrated loans) would continue to receive the one hundred percent weight that is customary under the current system.[68] Since external credit ratings are most prevalent in the United States, U.S. banks would thus be positioned to obtain preferential capital treatment over their overseas competitors.

Under the circumstances, the backlash that ensued[69] was understandable. On the surface, the external credit rating proposal was viewed in Western Europe and elsewhere as an attempt by U.S. regulators and banks to use their unique informational advantages to win lower capital ratios for the United States. Furthermore, those advantages are not necessarily transitory. To the contrary, those advantages are likely to persist so long as capital markets for corporate debt offerings remain weaker in block-holding countries than in the United States and Britain. Alternatively, block-holding countries could subvert the system, either by encouraging the formation of new competitors

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66. *See A New Capital Adequacy Framework, supra* note 59, at 27 n.16, 35 table 2; *The New Basel Capital Accord, supra* note 59, at 7 n.7; CREDIT RATINGS AND COMPLEMENTARY SOURCES OF CREDIT QUALITY INFORMATION 2 & n.1, 9 (Basel Comm. on Banking Supervision, Working Paper No. 3, Aug. 2000), *available at* http://www.bis.org/publ/index.htm; *Bank Rules in Disarray*, *supra* note 21, at 75. *See also* http://www.standardandpoors.com/ratings/aboutus/index.htm; http://www.moodys.com (with links to "About Moody's" and "Moody's History"); http://www.dcrco.com (with links to "About DCR, A Corporate Profile" and "Fitch IBCA/DCR Merger Information"); *New interests, new conflicts*, THE ECONOMIST, Apr. 14, 2001.

67. *A New Basel Capital Accord, supra* note 59, at 10.

68. *Id.* This is not to say that rated borrowers would invariably receive preferential treatment. At a minimum, borrowers with lower ratings would continue to receive risk weights of 100 percent. Indeed, under the Basel Committee's proposed scenario, it is possible that a rated borrower with a poor rating would be weighted 150 percent and thus be treated more harshly than unrated borrowers, who would be weighted 100 percent. *See id.*; *Growing Basle*, *supra* note 44, at 69-70; *Bank Rules in Disarray*, *supra* note 21, at 75. To that extent, banks that lend to unrated borrowers would have the same opportunity as previously to exploit the risk-weight buckets to their advantage.

69. *See, e.g.*, *Bank Rules in Disarray, supra* note 21, at 75; *Basle Brush*, *supra* note 52, at 69.

to Standard & Poor's, Moody's and Fitch IBCA, with the attendant danger of grade inflation, or by permitting weaker banks to switch to the IRB system.[70] Either way, the overriding goals of capital adequacy–i.e., competitive parity and safeguards against systemic risk -- would be disserved.

Market and block-holding systems also split over the Committee's alternative proposal to permit sophisticated banks to use their own internal credit risk assessments in lieu of external ratings. Once again, the United States and specifically American banks were the major proponents of the IRB approach. Major banks in block-holding systems (most visibly Germany) had barely any experience with internal credit rating systems.[71] Until the Basel Accord revisions were proposed, those banks did not need to resort to well-developed internal systems, because they used their equity stakes in corporate borrowers to monitor credit risks. Once again, as with the case of external credit ratings, the IRB standard largely favors U.S. banks, to the detriment of their overseas competitors.[72]

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70. *See, e.g., Sweeter Basle*, THE ECONOMIST, Jan. 20, 2001. The Basel Committee would require all external credit rating agencies (known as "external credit assessment institutions") to be recognized by national supervisory authorities under criteria formulated by the Basel Committee. *See A New Basel Capital Accord, supra* note 59, at 12-13. Banking supervisors in many countries would face political pressure to grant recognition to lax credit rating agencies, particularly from domestic concerns.

71. *Bank Rules in Disarray*, *supra* note 21, at 75.

72. *Basle Brush*, *supra* note 52, at 69 ("Regulators in continental Europe have been far cooler [to the internal credit ratings proposal]. Edgar Meister, the Bundesbank's representative on the committee, has been consistently skeptical.").

There are other serious problems with relying on internal ratings systems for capital adequacy. For one thing, it is questionable how well those systems measure risk. *See* RANGE OF PRACTICE IN BANKS' INTERNAL RATINGS SYSTEMS 5 (Basel Comm. on Banking Supervision, discussion paper, Jan. 2000), *available at* http://www.bis.org/publ/index.htm ("it is less clear in some cases whether the information emerging from these measurement systems is genuinely integral to the risk management of the bank at this time"); *Statement of the Shadow Financial Regulatory Committee on The Basel Committee's Revised Capital Accord Proposal* 1 (Statement No. 169, Feb. 26, 2001), *available at* http://www.aei.org/shdw/shdw169.htm (hereinafter "*Statement of the Shadow Financial Regulatory Committee*"). Furthermore, there are immense conflicts of interest inherent in using internal rating systems, a problem that the Basel Committee has barely mentioned. Banks would have powerful incentives to rig their internal rating systems in order to downplay the amount of capital they would have to reserve. Banks that engaged in such deception would be aided, moreover, by the proliferation of individual internal rating systems, each with its own standards and idiosyncrasies, hampering oversight and making comparison virtually impossible across banks and nations. *See* RANGE OF PRACTICE IN BANKS' INTERNAL RATINGS SYSTEMS, *supra*, at 39; *Statement of the Shadow*

B. DIVERGENT EFFICIENCY NORMS IN MARKET AND BLOCK-HOLDING SYSTEMS

As the problems enforcing the Basel Accord indicate, there is an even more fundamental source of instability in the Basel Committee's edicts, arising from the inherent problems in forcing a single, culturally dependent template of efficiency over banking systems at different stages of development and with fundamentally different needs and norms.[73] The sit-ins and the riots at the 1999 negotiations of the World Trade Organization in Seattle[74] were testament to the growing backlash against the muscle of Western multinational corporations, Western governments and international financial institutions. Increasingly, the Basel Committee's initiatives may be vulnerable to similar opposition.

In the final portion of this article, I would like to explore this problem as it applies to varying efficiency norms in patterns of bank lending. Previously I spoke about the information asymmetry between depositors and banks. Banks suffer from information asymmetries of their own with respect to borrowers. When banks extend credit, they do not know with perfect assurance that the loan will be repaid in a timely manner and in full. Every economy has methods for attempting to redress that asymmetry. Those methods, however, can vary depending on a variety of factors, including the economy's stage of development and business norms. Mature capitalist economies have the greatest latitude in that regard, because of the richness and stability of their monitoring mechanisms. Thus, banks in mature economies can depend on courts to enforce collateral and notes, may have access to credit rating services, can analyze the borrower's likelihood of repayment through desktop underwriting models that have been actuarially

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Financial Regulatory Committee, supra, at 1, 4; BNA BANKING DAILY, June 9, 1999; SANTOS, *supra* note 61, at 19 n.46. Today, major banks use a variety of internal rating systems, ranging from those "focussed on the judgement of expert personnel" to "those based solely on statistical models." RANGE OF PRACTICE IN BANKS' INTERNAL RATINGS SYSTEMS, *supra*, at 4, 17. A Basel Committee report recently found potentially significant inconsistencies in the data sources reviewed by banks, the definitions and tools used to measure that data, and the conclusions as to risk that were drawn. *See id.* at 4, 10, 14, 16, 42.

73. *See, e.g., Financial Standards– Indian Understanding*, FINANCIAL TIMES INFORMATION, March 22, 2001. Professor Douglas M. Branson has recently discussed this problem as it pertains to global convergence in corporate governance. *See* BRANSON, *supra* note 1.

74. Sam H. Verhovek & Steven Greenhouse, *National Guard Is Called Out to Quell Trade-Talk Protests*, N.Y. TIMES, Dec. 1, 1999, at A-1, cols. 3-6.

tested and can monitor the borrower's financial status through computerized loan reports.

In block-holding systems such as Germany's, banks also monitor borrowers through equity stakes and direct representation on the borrower's board (something that is banned in the United States).[75] This form of lending, which I will call "connected lending," is one of the hallmarks that distinguishes block-holding systems from their market system counterparts. In block-holding systems, connected lending of one form or another is considered integral to both banking and corporate governance and, as such, is legally sanctioned. Conversely, in market systems such as the United States, connected lending is heavily regulated and strongly discouraged.[76] Instead, in the United States, arms' length terms are an overriding norm in lending.[77] Connected lending is frowned upon, in part because of concerns that cozy relationships might impair underwriting judgments and also because financing might dry up for new entrepreneurial ventures. In contrast, the German system views preferential treatment of connected borrowers as beneficial on balance, because of the informational advantages of ongoing membership on the borrower's board, the bank's pivotal role in monitoring corporate governance and the long-term horizon of investment. Weak protections for minority shareholders in block-holding systems such as Germany's, moreover, mean that if the interest rate or the prospects for return are suboptimal, banks may seek to augment low returns through other means, such as interested transactions, insider trading or higher interest charges over the long term.[78]

These differences become even starker in emerging economies. Unlike their wealthier neighbors, many emerging economies have little choice except to embrace connected lending to a greater or lesser degree. In those nations, little of the infrastructure is in place that would allow banks to bridge the natural information gaps with unfamiliar loan applicants. In economies where the rule of law is weak and force is the rule, where credit reporting systems have not taken root, where social trust is frayed and inflation is

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75. *See, e.g.*, David Charny, *Special Symposium Issue: The German Corporate Governance System*, 1998 COLUM. BUS. L. REV. 145, 151-158 (1998); Roe, *supra* note 1, at 11.

76. *See* MCCOY, *supra* note 3, § 6.04[2].

77. *See, e.g.*, 12 U.S.C. §§ 371c, 371c-1.

78. *See, e.g.*, Bratton & McCahery, *supra* note 1, at 267-68; Rajan & Zingales, *supra* note 4, at 40, 42-43.

rampant, banks will generally restrict their lending to individuals and businesses whom they know and trust.[79]

In the abstract, connected lending of this sort may not be optimally efficient. Price signals are weaker in block-holding systems than in systems favoring arms' length lending.[80] In addition, connected lending often diverts capital from more efficient uses and is conducive to kickbacks at its worst. Obviously, the grosser forms of connected lending are signs of underlying pathology. Examples include extensions of credit where repayment is known to be unlikely or where the borrower's management in effect controls the lending decisions of the bank. But where blatant misconduct such as looting of the bank is not involved and the bank is acting in good faith, connected lending may be the best that banks can do in a bad situation, until some later date when the legal and information infrastructures are in place. In more mature economies such as Germany or Japan, where connected lending is not strictly a function of an economy's stage of development, it nevertheless may be integral due to other tradeoffs, such as the importance of banks as corporate monitors.

Nevertheless, when we examine Principle 10 of the Basel Committee's Core Principles, we see the admonition, characteristic of market systems, that "[c]onnected lending . . . can lead to preferential treatment in lending and thus greater risk of loan losses."[81] Trying to force block-holding systems to abandon connected lending altogether and apply an arms' length model patterned after loans to strangers may ultimately cause more harm than good. Banks may simply steer clear of the well and withhold private extensions of credit altogether, instead shifting their investments to government securities. In transition economies, if banks do lend to strangers, they well might lose their shirt, increasing the risks of bank runs and losses to small depositors. That, in turn, can retard the growth of domestic banks by leading to domination by foreign banks.[82] Finally, in countries such as Germany where banks are important monitors of corporations, proscriptions against connected lending to related borrowers could have serious adverse consequences for imbedded norms of corporate governance.

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79. *See, e.g.*, Bratton & McCahery, *supra* note 1, at 227 nn.41-42; Rajan & Zingales, *supra* note 4, at 41.

80. *See* Rajan & Zingales, *supra* note 4, at 43-44.

81. *Core Principles*, *supra* note 19, at 20.

82. *See, e.g.*, Terrill, *supra* note 38, at 280.

CONCLUSION

In conclusion, the Basel Committee needs to tread cautiously if these deep-seated sources of incompatibility are not to undermine consensus. At a minimum, the juggernaut toward global harmonization in banking could well engender experiences such as Russia's, where the Basel Committee's standards have been honored in the breach as often as not. At the worst, its pronouncements could lead to calls to storm the barricades, similar to what occurred in Seattle, and most recently in Genoa, if the Committee's lack of political accountability and legitimacy came to a head. If the Basel Committee continues to ignore these concerns, it will do so at its peril.

PRE-APPEARANCE SECURITY REQUIREMENTS FOR UNLICENSED REINSURERS IN THE UNITED STATES

*Kirill P. Strounnikov**

TABLE OF CONTENTS

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INTRODUCTION

Lex non intendit aliquid impossibile –
The law does not intend anything impossible.

The study of pre-appearance security requirements reveals issues related to different areas of law and requires a multi-faceted approach. Moreover, the application of these requirements raises many questions, which makes the topic especially attractive for theoretical study. Finally, a practical analysis is particularly timely given the growing amount of insurance and reinsurance litigation and arbitration.[1] This Article analyzes the pre-appearance security requirements of various states and their application by American courts, primarily to non-admitted and foreign alien reinsurers. Further, this Article will focus on the arguments advanced by non-admitted foreign and alien reinsurers to avoid security-posting obligations.

Part I discusses various state security-posting statutes with a particular focus on those states most influential in the field of insurance, e.g., New York, Connecticut, California and Illinois.[2] Part II analyzes the application of security-posting provisions to arbitration proceedings, first as a court-mandated requirement and, second, as an equitable remedy. Part II also addresses the applicability of security requirements to reinsurers.

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1. Although the issue is acute, there is not much written on the topic. For an example of what has been published in legal periodicals see Joseph A. Kilbourn, *Pre-Answer Security Posting Requirements for Unauthorised Insurers and Reinsurers in the United States*, 1996 INT'L J. OF INS. L. 266-75 (1996), and Christopher Hitchcock & Peter J. Biging, *Tactical Use of State Laws Requiring Unauthorized Insurers to Post Preanswer Security*, 31 TORT & INS. L.J. 767 (1996).

2. Approximately forty states have adopted security-posting provisions. Of those, this paper will analyze statutes from New York, California, Connecticut and Illinois. First, these are the most important states for American business of insurance. Connecticut is historically the center of insurance business in the United States, for major insurers and reinsurers have their principal place of business in this state. In later years, however, the business of insurance concentrated more in such financially and economically important states as New York, California and Illinois, among which New York comes in first place. Additionally, the laws of these four states differ, and it will be helpful for the purposes of this paper to highlight certain distinctions. Below is an overview of the security-posting provisions of these states, with a particular focus on New York law.

Parts III and IV of this Article examine unlicensed foreign (and especially alien) reinsurers' defenses to security-posting provisions, the recognition and enforcement of arbitral awards, and the judgments rendered pursuant to such provisions. Analysis of the relevant case law shows how reinsurers' defenses, although mostly dismissed by United States courts, nevertheless reveal deficiencies in the security-posting legislation and its application. For the reasons given below, these deficiencies can result in problems regarding the recognition and enforcement of a default award or judgment in a foreign forum, the country of domicile of an unlicensed reinsurer. This Article concludes that the purpose of security-posting statutes—ensuring the availability of funds and freeing domestic insureds and reinsureds of the need to resort to distant fora to assert their rights—can be frustrated when a domestic plaintiff, having obtained a default judgment, nevertheless has to seek relief in a foreign jurisdiction without much hope for success.

I. STATE LEGISLATION

A. The Nature and Purpose of Security-Posting Provisions

Pursuant to the Uniform Unauthorized Insurers Process Act,[3] most states have adopted statutes requiring that an unlicensed foreign or alien insurer,[4] before it can defend any action initiated against it, deposit with the court in which the proceeding is pending, security for the amount of any judgment that may be rendered against it.[5] United States courts tend to

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3. National Association of Insurance Commissioners, 4 MODEL INSURANCE LAWS, REGULATIONS AND GUIDELINES 860-2 (1948).

4. "Foreign" referring to that from another state within the United States; "alien" referring to that from another country.

5. 45 states have adopted similar legislation: Alabama (ALA. CODE § 27-10-53 (1994)), Alaska (ALASKA STAT. § 21.33.031 (Michie 1994)), Arkansas (ARK. CODE ANN. § 23-65-205 (Michie 1994)), California (CAL. INS. CODE § 1616 (West 1995)), Colorado (COLO. REV. STAT. ANN. § 10-3-1004 (West 1995)), Connecticut (CONN. GEN. STAT. ANN. § 38a-27 (West 1995)), Delaware (DEL. CODE ANN. tit. 18, § 2107 (1994)), Florida (FLA. STAT. ANN. § 626.908 (West 1995)), Georgia (GA. CODE ANN. § 33-5-57 (1994)), Hawaii (HAW. REV. STAT. ANN. § 431:8-208 (Michie 1994)), Idaho (IDAHO CODE § 41-1208 (Michie 1994)), Illinois (215 ILL. COMP. STAT. ANN. § 5/123 (West 1994)), Indiana (IND. CODE ANN. § 27-4-4-4 (West 1995)), Iowa (IOWA CODE ANN. § 507A.7 (West 1996)), Kansas (KAN. STAT. ANN. § 40-2003 (1993)), Kentucky (KY. REV. STAT. ANN. § 304.11-040 (Banks-Baldwin 1995)), Louisiana (LA. REV. STAT. ANN. § 1255 (West 1994)), Maine (ME. REV. STAT. ANN. tit. 24-A, § 2107 (West 1999)), Massachusetts (MASS. GEN. LAWS ANN. ch. 175B, § 3 (West 1998)), Minnesota (MINN. STAT. ANN. § 60A.21 (West 1995)), Mississippi (MISS. CODE ANN. § 83-21-45 (1993)), Missouri (MO. ANN. STAT. § 375.281 (West 1994)),

apply these statutes broadly, extending their application to reinsurers, retrocessionaires and to arbitration proceedings. Such practices raise concerns among foreign and alien reinsurers.

Contemporary reinsurance claims, especially those arising out of asbestos and environmental pollution, subject reinsurers to millions of dollars in potential liability. At the same time, a court requested to order a security posting does not consider whether the claimed amount is actually covered by the contract in dispute. Given the length of time often required to resolve those claims, huge sums of money may remain pledged for years. On the other hand, failure to meet the posting requirement results in the striking of the respondent's answer and the rendering of a default judgment against the respondent without considering the merits of the case.

Courts often cite to public policy in upholding the constitutionality of security posting provisions: funds must be available to pay insurance and reinsurance obligations.[6] Similarly, state legislatures express concern over where state residents can pursue litigation, especially where many of those residents hold insurance policies issued or delivered by insurers not authorized to do business within that state. As the New York Insurance Code states, unauthorized, out-of-state insurance policies present "to [...] residents the often insuperable obstacle of resorting to distant forums for the purpose of asserting legal rights under such policies."[7]

In many aspects, basic security-posting provisions are uniform among the states. There are, however, important differences. For example, Arizona provides that an unauthorized insurer must post security "sufficient

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Montana (MONT. CODE ANN. § 33-1-615 (1993)), Nebraska (NEB. REV. STAT. ANN. § 44-2005 (Michie 1999)), Nevada (NEV. REV. STAT. ANN. § 685B.060 (Michie 1998)), New Hampshire (N.H. REV. STAT. ANN. § 406-B:6 (1998)), New Jersey (N.J. STAT. ANN. § 17:51-2 (West 1996)), New Mexico (N.M. STAT. ANN. § 59A-15-8 (Michie 2000)), New York (N.Y. INS. LAW § 1213 (McKinney 2000)), North Carolina (N.C. GEN. STAT. § 58-16-35 (1999)), North Dakota (N.D. CENT. CODE § 26.1-02-12 (1995)), Ohio (OHIO REV. STAT. ANN. § 3901.18 (Anderson 1996)), Oregon (OR. REV. STAT. § 746.340 (1999)), Pennsylvania (PA. STAT. ANN. tit. 40, § 46 (West 1999)), Rhode Island (R.I. GEN. LAWS § 27-16-10 (1998)), South Carolina (S.C. CODE ANN. § 38-25-550 (Law. Co-op. 1993)), South Dakota (S.D. CODIFIED LAWS § 58-8-13 (Michie 2000)), Tennessee (TENN. CODE ANN. § 56-2-607 (1994)), Texas (TEXAS INS. CODE ANN. art. 1.36 (Vernon 1993)), Utah (UTAH CODE ANN. § 31A-15-107(1) (1999)), Vermont (VT. STAT. ANN. tit. 8, § 3387 (1998)), Virginia (VA. CODE ANN. § 38.2-806 (Michie 1999)), West Virginia (W.VA. CODE § 33-4-13 (2000)), Wisconsin (WIS. STAT. ANN. § 618.47 (West 1999)), and Wyoming (WY. STAT. ANN. § 26-12-205 (Michie 1999)). There is a similar statute also in Puerto Rico (26 P.R. LAWS ANN. § 1006 (1994). Hitchcock & Biging, *supra* note 1, at 767.

6. *See, e.g.*, Curiale v. Ardra Ins. Co., 667 N.E.2d 313, 318-19 (N.Y. 1996).

7. N.Y. INS. LAW § 1213(a) (McKinney 2000).

to secure the payment of any *costs and attorney's fees* which may be assessed against the unauthorized insurer in the action."[8] Accordingly, the amount posted pursuant to that provision, in most instances, would be considerably smaller than the amount required in other states. Thus, only relatively small sums remain pledged for an extended period of time.[9]

B. Legislation of Most Important Insurance States

1. New York

New York courts, which hear more cases with an international element than courts in other states, generate the majority of case law pertaining to security-posting provisions.[10] As in many other states, New York's pre-appearance security requirement is included in the New York "Unauthorized Insurers Service of Process Act,"[11] codified at section 1213 of the New York Insurance Code. Subsection (a) states that the purpose of section 1213 is "to subject certain insurers to the jurisdiction of the courts of this state in suits by or on behalf of insureds or beneficiaries under certain insurance contracts."[12] To this end, the statute provides a substituted service of process upon unauthorized insurers. Essentially, the statute appoints the Superintendent of Insurance as the attorney for unauthorized insurers in New York for certain acts, such as the issuance and delivery of an insurance contract or soliciting applications.[13] This service of process, though, does not limit the right to serve process upon an insurer in any other lawful manner.[14]

By its terms, this law applies not only where a foreign insurer has issued a policy to a New York resident, but also where it has issued a policy to an entity that, although incorporated in another state, is licensed to conduct business in New York.[15] However, the courts' treatment of the statute allows for an even broader application. For example, in *American*

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8. ARIZ. REV. STAT. ANN. § 20-403, 405 (1994) (emphasis added).

9. Interestingly, prior to its amendment in 1972, the Arizona provision had required an amount "sufficient to secure the payment of a final judgment which may be rendered in the action," text common in most similar state provisions. 1954 Ariz. Sess. Laws Ch. 64, Art. 7, § 5; ARIZ. ADMIN. CODE § 61-1905 (1939, Supp. 1954).

10. Moreover, security-posting provisions are mostly applied to alien non-admitted reinsurers.

11. 11 N.Y. INS. LAW § 1213 (McKinney 2000).

12. *Id.* § 1213(a).

13. *Id.* § 1213(b)(1).

14. *Id.* § 1213(b)(5).

15. *Id.*

Centennial Insurance Co. v. Seguros La Republica,[16] where a default was rendered against the defendant insurer because of its failure to produce the requisite security, the plaintiff, a corporation licensed to do business in New York, was substituted with the real party-in-interest, a non-licensed corporation.[17] The defendant then moved to vacate the default on the grounds that the basis for granting the default no longer existed.[18] While denying the motion on the grounds of untimeliness and willfulness of the default, the court, nevertheless, examined the substance of defendant's argument and found it without merit.[19]

Subsection (c) of section 1213 stipulates that an unauthorized foreign insurer, before filing its pleadings, shall either deposit a security or procure a license to conduct insurance business in the state.[20] The court, however, has discretion to dispense with a deposit if the Superintendent certifies that the insurer maintains, within the State of New York, funds sufficient and available to satisfy any final judgment.[21]

If an insurer fails to file the specified security with the court, a default judgment is entered, as if the party did not appear before the court or did not defend the suit. In *Curiale v. Ardra Insurance Co., Ltd.*,[22] the New York Court of Appeals upheld the striking of the answer because the defendant was unable to post the security required, ruling that "when an answer is stricken and a default entered, the defendant 'admits all traversable allegations in the complaint, including the basic allegation of liability.'"[23]

Court orders requiring a foreign insurer to deposit a security are interlocutory and, therefore, cannot be appealed under federal law.[24] New York, however, allows immediate appeals from interlocutory orders. Thus,

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16. No. 90 Civ. 2370, 1998 U.S. Dist. LEXIS 21965 (S.D.N.Y. Oct. 30, 1998).

17. *Id.*

18. *Id.* at *2.

19. *Id.* at *3-4. In *Allstate Insurance Co. v. Administratia Asigurarilor De Stat*, where a non-licensed party was substituted with a licensed party, the same U.S. District Court for the Southern District of New York ruled differently. The court held that the new party-in-interest, the assignee, could not invoke the security-posting provision, because it would violate the rule that an assignee can never stand in a better position than an assignor. 875 F.Supp. 1022, 1026 (S.D.N.Y. 1995).

20. N.Y. INS. LAW § 1213 (c)(1).

21. *Id.*

22. 667 N.E.2d 313 (N.Y. 1996).

23. *Id.* at 320 (quoting Rokina Optical Co. v. Camera King, 469 N.E.2d 518, 519 (N.Y. 1984)).

24. 28 U.S.C. § 1291 (2001) (citing BARRY R. OSTRAGER & MARY KAY VYSKOCIL, MODERN REINSURANCE LAW AND PRACTICE 13-16 (1996)).

in New York an order requiring the posting of pre-appearance security would be appealable. On appeal, the foreign insurer might contest its involvement in any activities that would subject it to the pre-answer security requirements, e.g. soliciting insurance in this state, either directly or otherwise.

2. Connecticut

Connecticut's security-posting provision is contained in section 38a-27 of the Connecticut Code entitled "Procedure Where Substituted Service Made Against Unauthorized Insurer."[25] The Connecticut statute, unlike its more conservative counterparts, provides certain guarantees for unauthorized insurers. First, the statute allows the court or the commissioner in administrative proceedings to dispense with the deposit if the insurer shows that it maintains sufficient funds in the state. Second, the court or the commissioner (in administrative proceedings) may postpone the posting of security to afford the defendant an opportunity to raise the necessary funds. Thus, Connecticut has codified what has developed as practice by courts in other states.[26]

Finally, section 38a-27 enables the unauthorized insurer to move to vacate the order to post security on the grounds that it was not engaged in activities subject to the security-posting provisions.[27] Particularly, the insurer may argue that it was engaged in the lawful transaction of reinsurance and, therefore, is exempt from any obligation to post security.[28] For example, in *Certain Underwriters at Lloyd's v. Travelers Indemnity Co.*,[29] the court granted Lloyd's motion to avoid posting security under the Connecticut security provisions.[30]

3. California

The relevant provision of the California Insurance Code is contained in section 1616, entitled "Prerequisites to Filing of Pleading." It reads as follows:

> Before any nonadmitted foreign or alien insurer shall file or cause to be filed any pleading in any action, suit or proceeding instituted against it, the insurer shall either: (1)

25. CONN. GEN. STAT. ANN. § 38a-27 (West 1995).
26. *Id.* § 38a-27(b).
27. *Id.* § 38a-27(c).
28. *Id.* § 38a-271.
29. No. 395CV02420 (TFGD) (D. Conn. Jan. 2, 1996).
30. *Id.*

> procure a certificate of authority to transact insurance in this state; or (2) give a bond in the action, suit or proceeding in an amount to be fixed by the court sufficient to secure the payment of any final judgment which may be rendered in the action, suit or proceeding.[31]

On its face, the California law is not much different from that of most other states. There are, however, some important distinctions. First, the text of the provision does not refer to court actions, but rather broadly refers to "any action, suit or proceeding."[32] This wording suggests a broader interpretation of the provision. Implications of this distinction are analyzed in the next section.[33]

The California law does not, however, include an asset exception found in the New York and Connecticut security-posting provisions. That is, it does not allow a court dealing with the matter to dispense with security obligations if the defendant shows (in New York - the Superintendent certifies) that it maintains sufficient funds within the state to satisfy any judgment.

4. Illinois

The security-posting provisions of the Illinois Insurance Code are contained in Title 123.[34] Unlike other states, Illinois provides certain security posting rules that avoid the confusion found in other statutes. For example, Title 123 expressly states that reinsurers are subject to security-posting provisions, unlike the New York law that addresses reinsurers in a different section, and thereby giving rise to disputes over the applicability of the statute to reinsurers.[35]

Illinois courts possess discretion to order postponement of security posting to afford the unlicensed insurer an opportunity to comply with the provisions.[36] It is not, however, in the court's discretion to dispense with the deposit where the defendant maintains, in the state, funds sufficient to

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31. CAL. INS. CODE § 1616 (West 1995).

32. Compare the California rule codified at section 1616 with the corresponding Connecticut rule analyzed below, which applies to "any court action or proceeding or ... any administrative proceeding before the commissioner . . ." CONN. GEN. STAT. ANN. § 38a-27.

33. *See infra* notes 41-45 and accompanying text.

34. 215 ILL. COMP. STAT. ANN. § 5/123 (5) (West 1998).

35. Nevertheless, courts have uniformly ruled that reinsurers are included within the scope of New York security-posting provisions.

36. ILL. COMP. ANN. STAT. ch. 215, § 5/123 (5) (West 1998).

satisfy any possible judgment. The right to file a motion to quash substitute process is, as in Connecticut, guaranteed.[37]

II. APPLICABILITY OF SECURITY-POSTING PROVISIONS

A. Applicability to Reinsurers and Retrocessionaires

As the previous section illustrates, the laws concerning pre-appearance requirements vary from state to state. Some states explicitly include reinsurers in the definition of an "insurer" for the purposes of the security-posting requirement.[38] In these jurisdictions, reinsurers and retrocessionaires are unable to answer a complaint before posting a security in the amount specified by the court. As we already have seen, the reference to reinsurers can be contained in the very security-posting provision, as in Illinois, or in some other title, as in New York.

Other jurisdictions do not contain specific provisions related to reinsurers. However, courts tend to construe "insurers" to include reinsurers and retrocessionaires within the purview of the security-posting provisions.[39] Yet, there are states that specifically exclude foreign reinsurers from the reach of pre-appearance security statutes.[40]

B. Applicability to Arbitration Proceedings

The texts of most security-posting statutes usually do not lend themselves to explicit answers regarding the applicability of security requirements to arbitration proceedings. Yet, comparing the statutes of different states can provide some guidance. For example, the title of the corresponding Arizona provision reads: "Prerequisites for Participating in Court Action,"[41] thus, suggesting that the requirement is not applicable to arbitration.[42] California law simply requires that "before any nonadmitted foreign or alien insurer shall file or cause to be filed any pleading in any action [...] instituted against it, the insurer shall [...] give a bond in the action [...] in an amount to be fixed by the court."[43] Some commentators

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37. *Id.*

38. *See, e.g.*, N.Y. INS. LAW §1101(b)(2)(G) (McKinney 2000).

39. Int'l Surplus Lines Ins. Co. v. Certain Underwriters & Underwriting Syndicates at Lloyd's of London, 868 F.Supp. 923, 926 (S.D. Ohio 1994).

40. These are: Arkansas, Connecticut, Delaware, Florida, Georgia, Idaho, Indiana, Iowa, Maine, Missouri, Montana, Ohio, Oregon, Pennsylvania, Rhode Island, and Wyoming.

41. ARIZ. REV. STAT. ANN. §§ 20-403, 405 (West 1994).

42. Hitchcock & Biging, *supra* note 1, at 767.

43. CAL. INS. CODE § 1616 (West 1995).

have noted that, where the security provisions require that the security be deposited with the clerk of the court in which a proceeding is pending, the wording probably suggests that the drafters did not intend that preanswer security provisions be applied in arbitrations.[44]

Recent decisions, however, reflect a tendency of the courts to apply pre-appearance statutes to require security in arbitration proceedings, even when the language of a statute suggests otherwise.[45] This is also the case for pre-arbitration court hearings and arbitration proceedings where the arbitration panel is requested to order a posted-security.

1. Authority of an Arbitration Panel to Require Posting of Security

Case law supports an arbitration panel's authority to require posting of pre-answer security as part of its equitable powers regardless of any specific statutory provisions.[46] In *Insco Ltd. v. Meadows Indemnity Co.*,[47] the United States District Court for the Central District of California confirmed the interim arbitral award requiring the respondent to post security pending final arbitration.[48] Respondent's claims of insolvency and the panel's lack of authority to order security were rejected. The court relied on the Ninth Circuit's decision in *Pacific Reinsurance Management Corp. v. Ohio Reinsurance Corp.*[49] In this case the Ninth Circuit held that where an arbitrator is even arguably construing the contract between the parties to the effect that he has authority to require security, the court cannot overturn the arbitrator's decision even if it is convinced that the arbitrator committed serious error.[50]

Likewise, in *Konkar Maritime Enterprises, S.A. v. Compagnie Belge D'Affretement*,[51] the United States District Court for the Southern District of New York upheld arbitrators' "broad discretion in fashioning remedies

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44. Hitchcock & Biging, *supra* note 1, at 767.

45. Am. Centennial Ins. Co. v. Seguros La Republica, 1992 WL 162770 (S.D.N.Y. 1992).

46. *See* Blue Sympathy Shipping Co. v. Serviocean Int'l, S.A., No. 94 Civ. 2323, 1994 WL 597144 (S.D.N.Y. July 6, 1994); Konkar Mar. Enters., S.A. v. Compagnie Belge D'Affretement, 668 F.Supp. 267, 271 (S.D.N.Y. 1987).

47. No. CV 90 2935 SVW (TX), 1993 WL 328376 (C.D. Cal. 1993).

48. *Id.*

49. 935 F.2d 1019 (9th Cir. 1991).

50. *Id.* at 1024. To support its conclusion the court relied, *inter alia*, on the United States Supreme Court's decision in *United Paperworkers International Union v. Misco, Inc.*, 484 U.S. 29, 38 (1987).

51. 668 F.Supp. 267 (S.D.N.Y. 1987).

and [granting] 'equitable relief that a Court could not.'"[52] In this case, respondent argued that the arbitration panel had exceeded its authority under the arbitration clause in the insurance contract by ordering it to deposit a disputed amount in a jointly held escrow account.[53] Although such authority had not been agreed upon by the parties to the contract, the court found it to be "implicit in the submission of the main dispute to the Panel."[54]

In another case, *Blue Sympathy Shipping Co. v. Serviocean International,*[55] the arbitration panel issued an award ordering the parties to post a specified amount of security for one another. Serviocean failed to comply with the award, and Blue Sympathy petitioned the court to confirm it. The court was confronted with two issues. First, whether the award ordering the parties to post security qualified as a "final award" within the meaning of 9 U.S.C. § 10(a)(4). This provision allows a United States District Court to vacate an arbitral award "where the arbitrators exceeded their powers, or so imperfectly executed them that a mutual, final and definite award upon the subject matter submitted was not made."[56] The court found that the relevant case law traditionally viewed arbitral relief (such as the posting of security pending final resolution of the parties' claims) as an equitable and not a provisional remedy, squarely within the arbitrators' broad discretion to award.[57] Accordingly, the award in question was found to be a "final and definite equitable remedy, fully within the arbitrators' power to impose."[58]

The second issue was whether the court should have ordered the respondent to comply with the award in contempt. The court denied petitioner's request to issue a contempt order, but noted in *dictum* that it would issue such an order should the respondent fail to comply with the award. In such a case "the mere plea of financial inability will not shelter [respondent] from contempt."[59] The court went on, however, to say that

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52. *Id.* at 271 (citing Compania Chilena de Navegacion Interoceanica v. Norton, Lilly & Co., 652 F.Supp. 1512, 1516 (S.D.N.Y. 1987) (citing Sperry Int'l Trade, Inc. v. Gov't of Israel, 532 F.Supp. 901, 905 (S.D.N.Y. 1982), *aff'd*, 689 F.2d 301 (2d Cir. 1982)).

53. *Id.* Escrow accounts are widely used in arbitration proceedings for the purpose of security posting. The contents of an escrow account, like security in the court proceedings, is released according to the award.

54. *Id.*

55. No. 94 Civ. 2323, 1994 WL 597144 (S.D.N.Y. July 6, 1994).

56. *Id.* at *1 n.1.

57. *Id.* at *1.

58. *Id.* at *2.

59. *Id.*

respondent could defend against contempt by proving "that its compliance with the order is 'factually impossible.'"[60]

The cases cited above show that the authority of an arbitration panel to order pre-answer security is generally recognized. Unless there is a statutory provision to the contrary, the courts will uphold interim arbitral awards requiring the posting of security. It appears that all a reinsurer can do to circumvent the posting of security, is to include a provision into the arbitration agreement depriving the arbitration panel of such an authority.

2. International Arbitrations

Court orders requiring security while considering a petition to confirm an arbitral award are permitted by Article 6 of the 1958 United Nations Convention on the Recognition and Enforcement of Foreign Arbitral Awards.[61] Yet, the pre-appearance security requirement has also been applied before the commencement of the arbitration proceedings. In *Northwestern National Insurance Co. v. Kansa General Insurance Co.*,[62] petitioner, an American corporation, sought an order designating and appointing an umpire in the arbitration proceeding, compelling arbitration, and requiring respondent, a Finnish corporation, to post security. The federal district court ordered Kansa to post a security bond in an amount to be agreed upon by the parties.[63] Decisions like *Kansa* reveal the "tension between the internationalist outlook of the Convention [...] and the more local concerns of state legislatures and insurance regulators, which are rooted in the McCarran-Ferguson Act."[64]

Indeed, as certain authors have pointed out, "the compatibility of pre-answer security with the Convention poses far more delicate questions than the [court in *Kansa*] thought to consider. Chief among these is whether the Convention permits the courts to order provisional remedies, such as pre-answer security, in arbitrations subject to the Convention."[65] The question

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60. *Id.*

61. United Nations Convention on the Recognition and Enforcement of Foreign Arbitral Awards, June 10, 1959, 330 U.N.T.S 38.

62. No. 92 Civ. 7433, 1992 WL 367085 (S.D.N.Y. Nov. 25, 1992).

63. *Id.* In *Travelers Insurance Co. v. Keeling*, a New York trial court reached substantially the same conclusion. Travelers Ins. Co. v. Keeling, No. 24376/91, slip op. (N.Y. Sup. Ct. Jan. 5, 1994).

64. David J. Grais & Michael C. Zeller, *Arbitrability of International Reinsurance Disputes Under New York Law: Claims by Receivers and Pre-Answer Security*, Reinsurance Litig. and Arbitration 235 (1995).

65. *Id.* at 234.

of whether pre-answer security[66] has the effect of a provisional remedy, such as pre-judgment attachment, was addressed by a federal court in *Moore v. National Distillers & Chemical Corp.*[67] Relying on extensive judicial precedent,[68] the court found that "the pre-answer security requirement has the effect of an 'attachment prior to judgment.'"[69]

Courts disagree as to whether the Convention permits them to order provisional remedies. In *Cooper v. Ateliers de la Motobecane, S.A.*,[70] the Court of Appeals of New York, by a 4 to 3 vote, held that the UN Convention does not provide for preaward attachment. The court found that "[t]he purpose and policy of the UN Convention will be best carried out by restricting prearbitration judicial action to determining whether arbitration should be compelled."[71] On the other hand, the Second Circuit, in *Borden, Inc. v. Meiji Milk Products Co.*,[72] determined otherwise. According to the *Meiji* court, a provisional remedy "is not precluded by the Convention but rather is consistent with its provisions and its spirit."[73]

Controversial as it is, application of security posting is being resisted by foreign and alien non-admitted reinsurers on various grounds. The next section describes the most frequently used defenses against posting of security.

III. DEFENSES TO POSTING OF SECURITY

A. Constitutional Challenges

Constitutional challenges to pre-answer security statutes have historically been unsuccessful. In *Curiale v. Ardra Insurance Co., Ltd.*, the New York Court of Appeals held that applying the New York security-

66. Pre-answer security is required under New York State law. N.Y. INS. LAW § 1213(c)(1) (McKinney 2000).

67. 143 F.R.D. 526 (S.D.N.Y. 1992).

68. *E.g.*, Arnold Chait, Ltd. v. La Metropolitana, Compania Nacional de Seguros, S.A., 207 N.Y.S.2d 22 (N.Y. Sup. Ct. 1960) (explaining the court's refusal to require the posting of pre-answer security because the plaintiff had already obtained adequate security by attachment).

69. *Nat'l Distillers & Chem. Corp.*, 143 F.R.D. at 535. The same approach was taken in cases where foreign insurers have been held exempt from the security requirement as qualifying as "foreign states" within the meaning of FSIA, which exempts "foreign states" from pre-judgment attachments. Moore v. Aegon Reinsurance Co. of Am., 608 N.Y.S.2d 166, 174 (N.Y. App. Div. 1994).

70. 442 N.E.2d 1239 (N.Y. 1982).

71. *Id.* at 1243.

72. 919 F.2d 822 (2d Cir. 1990), *cert. denied*, 500 U.S. 953 (1991).

73. *Id.* at 826.

posting provision to an unlicensed Bermuda reinsurer does not violate the right to procedural due process guaranteed by the United States Constitution.[74] This case is a good example of not only how courts deal with the constitutional challenges to the security requirement provisions, but also of how these provisions work and the dangers they contain for foreign reinsurers.

Ardra, a Bermudian company, provided reinsurance to Nassau Insurance Company, a New York corporation. After Nassau became insolvent, the New York Superintendent of Insurance, acting as its liquidator, initiated an action before the New York Supreme Court to recover reinsurance proceeds allegedly payable under three reinsurance treaties concluded between Nassau and Ardra.[75] When Ardra served an answer to the Superintendent's complaint, the Superintendent moved to strike Ardra's answer and render a default judgment in its favor on the grounds that Ardra, an unlicensed alien reinsurer, had failed to provide sufficient security under New York Insurance Law section 1213.[76]

The trial court ordered Ardra to post security in an amount to be negotiated by the parties before it could file its answer.[77] Ardra later informed the court that it was financially unable to post a security in an amount of more than one million dollars, but that it would not seek a license to do business of insurance in New York. The court having found that one million-dollar security was inadequate, ordered Ardra to post security in an amount of more than ten million dollars, otherwise Ardra's answer would be struck.[78]

Ardra filed an interlocutory appeal with the Appellate Division contesting the order requiring it to post security. It argued that section 1213 of the New York Insurance Law as applied to it was unconstitutional. Particularly Ardra argued that it was denied procedural due process because its financial inability to post security resulted in a default judgment. In other words, Ardra was allegedly deprived of property without a hearing.[79] The Appellate Division affirmed the order of the trial court, holding that by choosing to provide reinsurance in New York as an

74. 667 N.E.2d 313 (N.Y. 1996).
75. *Id.* at 315.
76. *Id.*
77. *Id.* at 315-16.
78. *Id.* at 316.
79. *Id.*

unlicensed reinsurer, Ardra agreed to comply with the security posting provisions of New York Insurance Law.[80]

As a result, Ardra's answer was stricken and the trial court entered a default judgment against the unlicensed reinsurer.[81] The judgment, however, was entered on liability, and referred to a Special Referee to determine the exact amount of damages payable under the reinsurance contracts.[82] Before the Referee, Ardra conceded liability under the reinsurance agreements. Nevertheless, it asserted that certain reinsurance claims contained in the Superintendent's complaint were actually covered by reinsurance treaties that were not the subject of the complaint.[83] Ardra reasoned that, as the same claim cannot be covered by different reinsurance agreements, certain claims should be excluded as damages.[84] The Referee, however, concluded that the reinsurance agreements outside of the complaint were irrelevant absent a showing that the Superintendent's claims did not fall under the reinsurance agreements under which Ardra had been held liable.[85] The report of the Special Referee was confirmed by the trial court and Ardra was held liable for more than 16 million dollars.[86]

Ardra appealed to the Appellate Division again; arguing that the evidence concerning the reinsurance treaties outside of the complaint had been erroneously excluded from consideration.[87] The Appellate Division rejected Ardra's argument and concluded that the evidence had been properly excluded from the proceedings.[88]

Ardra finally appealed to the Court of Appeals.[89] Ardra asserted, *inter alia*, that "the entry of a default judgment against a litigant who is financially unable to post the pre-answer security in the amount set by a trial court unconstitutionally deprives that litigant of due process of law."[90] Moreover, it argued that "its private interest and the risk of an erroneous deprivation of its property outweigh the State interest here," and therefore

80. Curiale v. Ardra Ins. Co., 189 A.D.2d 217 (N.Y. App. Div. 1993).
81. Curiale v. Ardra Ins. Co., 667 N.E.2d 313, 316 (N.Y. 1996).
82. *Id.*
83. *Id.*
84. *Id.*
85. *Id.*
86. *Id.*
87. *Id.*
88. *Id.*
89. *Id.*
90. *Id.* at 316.

its answer should not have been stricken and the merits of the case should have been litigated despite Ardra's failure to post the pre-answer security.[91]

The Court of Appeals unanimously rejected Ardra's arguments as disingenuous."[92] In particular, it cited *Matthews v. Eldridge*,[93] where the United States Supreme Court noted that "due process is a flexible concept which tailors procedural protections to particular facts."[94] Following *Matthews*, the Court of Appeals considered three factors in determining the appropriate level of procedural protection. These factors are:

> 1) the private interest that will be affected by the official action;
>
> 2) the risk of an erroneous deprivation of such interest due to the procedures that are used, and the probable value, if any, of additional or substitute procedural safeguards;
>
> 3) the Government's interests, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.[95]

The court further found that "the regulation of the insurance industry is closely related to the public interest and a legitimate exercise of a State's police powers."[96] Therefore, the State of New York "may require that an insurer maintain adequate funds to satisfy a judgment against the policies it has issued in New York State," and that was the purpose of the section 1213 of the New York Insurance Law.[97] The court also noted that section 1101 (b)(2) of the Insurance Law specifically provides that alien insurers are "a group which need not obtain a license to conduct the business of insurance in New York State," but section 1213 "shall nevertheless be applicable to such insurers."[98] Thus, according to the court, the Insurance Law provides sufficient notice to an alien insurer that security will be required if that insurer chooses to operate in New York without obtaining a license.[99]

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91. *Id.* at 317.
92. *Id.* at 318.
93. 424 U.S. 319 (1976).
94. *Curiale*, 667 N.E.2d at 317 (quoting *Matthews*, 424 U.S. at 335).
95. *Id.*
96. *Id.* at 318.
97. *Id.*
98. *Id.*
99. *Id.*

According to the court, the amount of security is "tied directly to the volume of business conducted by the alien unlicensed insurer."[100] Thus, abolition of this requirement would let alien insurers with little or no assets in New York conduct extensive insurance operations in the State at the expense of licensed insurers subject to certain requirements, such as limiting their risk, maintaining certain reserves, etc.[101] To adopt Ardra's position would contravene the legislature's policy of ensuring the availability of funds to pay insurance and reinsurance proceeds. Moreover, the ability to conduct insurance business free from government regulation (being unlicensed) is not a constitutionally protected property or liberty interest.[102]

The court analyzed the nature of the security-posting provision by comparing it with other forms of prejudgment attachment. It had to distinguish the United States Supreme Court's holding in *Fuentes v. Shavin*,[103] which struck down some prejudgment replevin[104] statutes as violative of procedural due process.[105] The statutes at issue in *Fuentes* authorized the state to seize property prior to a determination of lawful possession and without notice and opportunity to contest the procedure. According to the New York Court of Appeals, the crucial distinction was that "all the insurers subject to section 1213(c) are provided with notice and an opportunity to be heard before being subjected to the preanswer security requirement."[106]

In summary, the *Ardra* court concluded that state interests outweighed a reinsurer's interests in filing an answer and in litigating the case without posting the security in an amount sufficient to satisfy any possible judgment. The state maintains an interest in ensuring the availability of funds to satisfy a judgment as opposed to requiring resident claimants to resort to distant forums. Nothing suggests, however, that either the drafters of the security-posting provisions, or the courts applying them, considered the issue of enforcing the default judgments in those distant forums. It is not entirely clear how these provisions serve the interests of resident claimants in cases where defendants are financially unable to post security

100. *Id.*
101. *Id.*
102. *Id.* at 318-19.
103. 407 U.S. 67 (1972).
104. Replevin is the repossession by the owner of his personal property wrongfully taken or detained. BLACK'S LAW DICTIONARY 1305 (7th ed. 1999).
105. *Curiale*, 667 N.E.2d at 319.
106. *Id.*

and claimants get nothing more than default judgments. Claimants will inevitably resort to distant forums to satisfy judgments when local jurisdictions fail to ensure the availability of judgment funds.

As discussed below,[107] the Supreme Court of Bermuda refused to enforce the *Ardra* judgment, holding that the proceedings in this case were contrary to "natural justice" as understood in England and Bermuda. This decision supports the notion that American courts' zealous application of security-posting statutes against alien reinsurers harms domestic entities, leaving them with unenforceable judgments.

B. Applicability to Foreign State Agencies

Pre-appearance security requirements have been held inapplicable to entities identified as "foreign states" following the provisions of the Foreign Sovereign Immunities Act.[108]

In *Moore v. Aegon Reinsurance Co. of America*,[109] Instituto de Resseguros Do Brasil (IRB) appealed from an order of the court which, *inter alia*, granted plaintiff's motion to strike IRB's answer on the grounds that it failed to post pre-answer security. IRB argued that it was immune from the requirement pursuant to the Foreign Sovereign Immunities Act (28 U.S.C. § 1609). The plaintiff (New York Superintendent of Insurance) contended that: 1) IRB was not an instrumentality of a foreign state; and 2) if IRB was such an instrumentality, it was still not entitled to the FSIA protection because of the McCarran-Ferguson Act,[110] which provides that the business of insurance shall be regulated by the states.[111] The court found "sufficient evidence of ownership and control by the Brazilian government to conclude that IRB [was] entitled to protection afforded by the FSIA."[112] While the fact that the Brazilian government owned 50% of IRB did not reveal "a clear majority interest", the following factors were decisive: 1) IRB was created by statute; 2) IRB was given certain regulatory powers over other insurance companies; 3) the Brazilian government had the authority to appoint IRB's officials; and 4) the Brazilian Minister of Finance supervised IRB's operations.[113] Additionally,

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107. *See infra* Part IV.B.
108. 28 U.S.C. §§ 1602-1611 (1992 & Supp. I 1993).
109. 608 N.Y.S.2d 166, 174 (N.Y. App. Div. 1994) [hereinafter *Aegon*].
110. 15 U.S.C. § 1011 (2001).
111. *Id.*
112. *Aegon*, 608 N.Y.S.2d at 174.
113. *Id.*

the court relied on *Metropolitan Life Insurance Co. v. Ward*[114] to determine that the preemptive effect of the McCarran-Ferguson Act only "'exempts the insurance industry from Commerce Clause restrictions.'"[115] The court referred to a number of other opinions to conclude that the Act "does not preempt the application of the Constitution and other Federal Laws,"[116] and that "it is settled that [i]n enacting the FSIA, 'Congress expressly exercised its power to regulate foreign commerce, along with other specified Article I powers.'"[117]

It should be noted, however, that Instituto De Resseguros Do Brasil was involved in two other actions in Ohio and New York and was found not to have satisfied the requirements of the FSIA.[118] In the 1994 Ohio case, the United States District Court relied on the 1992 New York Supreme Court ruling that IRB was not immune from the reach of a bond-posting statute. For some reason, the District Court did not consider the more recent Supreme Court of New York Appellate Division opinion in *Moore v. Aegon Reinsurance Co. of America*.[119]

C. Availability of Assets in the United States

Another argument raised by foreign insurers and generally rejected by the courts is that the availability of assets in the United States abrogates the need for security posting. It is well known that Lloyd's of London maintains trust funds in the United States specifically for the purpose of payment of insurance and reinsurance proceeds.[120] Nevertheless, the Federal District Court for the Southern District of Ohio in *International Surplus Lines Insurance. Co. v. Certain Underwriters at Lloyd's* held that

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114. 470 U.S. 869, 880 (1985).

115. *Aegon*, 608 N.Y.S.2d at 173. The court here agrees with the Southern District of New York magistrate judge's ruling in *Moore v. National Distillers & Chem. Corp.*, 143 F.R.D. 526 (S.D.N.Y. 1992), the case involving the same parties and the same issue. The Court's ruling in *Aegon* follows that of the federal court. In this part of the opinion, the Court is citing *National Distillers & Chem. Corp.*, which in turn is citing *Metro. Life* and other cases.

116. State Bd. of Ins. v. Todd Shipyards, 370 U.S. 451 (1962).

117. Verlinden B.V. v. Cent. Bank, 461 U.S. 480, 496 (1983).

118. Write v. Aegon Reinsurance Co. of Am., No. 22313/91-001, slip op. at 10 (N.Y. Sup. Ct. June 22, 1992); Int'l Surplus Lines Ins. Co. v. Certain Underwriters & Underwriting Syndicates at Lloyd's of London, 868 F.Supp. 923, 927 (S.D. Ohio 1994).

119. *Aegon*, 608 N.Y.S.2d at 166. This opinion had been entered a month before the Ohio opinion.

120. In 1994 Lloyd's trust funds in the United States exceeded $8 billion. Hitchcock & Biging, *supra* note 1, at 779 n.48.

"the existence of the Lloyd's trust does not excuse the Lloyd's defendants from posting a bond."[121]

In this case the London Market reinsurers argued that the Lloyd's American Trust Funds are held specifically for the purpose of ensuring the availability of funds to satisfy any potential liability of Lloyd's Underwriters to policyholders in the United States.[122] The court, however, strictly construed the Ohio statute, which provides in relevant part that an unauthorized foreign insurer must "deposit with the clerk of the court [...] cash or securities or file [...] a bond."[123] The court held that there are no exceptions in the statute for any entity, including Lloyd's, and that the statute aims "to place in *the Court's* custody assets sufficient to satisfy any judgment rendered in order to facilitate a plaintiff's ability to enforce a judgment."[124]

D. Other Defenses to Posting of Security

The previous section discussed the basic arguments against posting a security. The courts have concluded that these arguments are without merit, except for the contention that the foreign insurer/reinsurer qualifies as a "foreign state agency" under the Foreign Sovereign Immunities Act. As noted above, notwithstanding the fact that the regulation of the business of insurance is the domain of the states, Congress still has the power to regulate foreign commerce.

Constitutional objections have also failed. Yet, these opinions fail to distinguish situations where the defendant is financially unable to post security. The drafters of security-posting provisions, and the courts interpreting them, seem to have concluded that the risk of becoming insolvent or simply unable to pledge a certain amount of money is a risk inherent in the business of insurance or reinsurance itself.

It is clear that a technically insolvent foreign reinsurer will usually be unable to post security in million dollar amounts, nor will it be able to obtain an insurance license, which in turn requires maintaining certain funds, reserves, deposits, etc. Here the due process argument acquires new strength, because the courts in cases involving insolvent reinsurers, like Ardra, issue orders that they know are impossible to comply with.[125] Construing the security-posting provisions narrowly and always in favor of

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121. 868 F.Supp. at 927.
122. *Id.* at 926.
123. OHIO REV. CODE. ANN. § 3901.18(A)(1) (Anderson 1996).
124. *Int'l Surplus Lines Ins. Co.*, 868 F.Supp. at 927 (emphasis added).
125. See p. 132 for discussion about the enforcement of *Ardra* judgment in Bermuda.

the party requesting a security, the courts refuse to take into consideration the financial situation of the unlicensed reinsurers. And this is despite the fact that, while the statutes do not mandate it, they equally do not prohibit it. In *Stephens v. American Risk Management,* the reinsurer claimed that it could not post security in the required amount because of technical insolvency, and the court ruled that financial considerations are "simply not a factor in determining the proper level of security to be posted."[126] Thus, insurers unable to post security have had their answers stricken and default judgments rendered against them.[127]

A judgment against an alien defendant, however, itself does not guarantee final relief for the plaintiff. In order to seize defendant's assets located on the territory of another country, the judgment has to be recognized and enforced in that country. On this stage alien reinsurer may oppose recognition and enforcement on the grounds described in the following section.

IV. DEFENSES TO RECOGNITION AND ENFORCEMENT OF DEFAULT ARBITRAL AWARDS AND JUDGMENTS ENTERED PURSUANT TO THE SECURITY-POSTING PROVISIONS

A. Arbitral Awards

Logically, the party in whose favor an arbitral award has been rendered would seek to enforce the award in the country where the debtor's assets are located. In most cases, an American party seeking such enforcement will rely on the 1958 New York Convention referred to above.[128] Today this international treaty can be considered virtually universal, as some 90 nations have ratified it.[129] In some cases, however, the 1975 Inter-American

126. Stephens v. Am. Risk Mgmt., Inc., No. 89 Civ. 2999, slip op. at 3 (S.D.N.Y. Mar. 11, 1993). The argument that pledging assets to comply with the order to post a security is forbidden by the laws of the country in which the insurer is domiciled has also proven unsuccessful. One court has concluded that "the laws of the reinsurer's place of domicile 'have no relevance to the obligation of a foreign insurer under the security provision.'" *See* Report and Recommendation of Leonard Bernikow, U.S. Magistrate Judge (Mar. 23, 1992) (*adopted by* the court in *Am. Centennial Ins. Co. v. Seguros La Republica*, No. 90 Civ. 2370, and *Am. Centennial Ins. Co. v. Seguros La Republica*, No. 91 Civ. 1235, at 11). Hitchcock & Biging, *supra* note 1, at 767.

127. *E.g.* John Hancock Prop. & Cas. Ins. Co. v. Universale Reins. Co., No. 91 Civ. 3644, 1993 WL 267345 (S.D.N.Y. July 12, 1993), Curiale v. Ardra Ins. Co., 595 N.Y.S.2d 186 (N.Y. App. Div. 1993).

128. *See supra* note 61 and accompanying text.

129. 9 U.S.C. § 201 (1970). The United States acceded to the Convention in 1970.

Convention on International Commercial Arbitration (Panama Convention)[130] or bilateral treaties are also important.[131] Article VII (1) of the 1958 Convention provides that the Convention "shall not affect the validity of multilateral or bilateral agreements concerning the recognition and enforcement of arbitral awards [and] has been interpreted by U.S. courts [...] to permit agreements and awards to be enforced under *either* the Convention or another treaty . . . ."[132] It can be reasonably anticipated that the enforcement abroad of an arbitral award, rendered by default upon respondent's failure to post the security required, can encounter at least two defenses provided for in Article V of the New York Convention.

1. Public Policy Defense

> [T]he New York Convention of 10 June 1958 [...] provides that arbitration proceedings must conform to the law of the country in which arbitration takes place, but makes in Article V (2) (b) a condition for recognizing and enforcing an arbitral award that the award should conform to the public policy of the country in which recognition and enforcement are sought.[133]

Article V(2)(b) provides that "[r]ecognition and enforcement of an arbitral award may also be refused if the competent authority in the country where recognition and enforcement is sought finds that. . . [t]he recognition and enforcement of the award would be contrary to the public policy of that country."134

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130. Inter-American Convention on International Commercial Arbitration was signed in Panama on January 30, 1975. In addition to the United States, which ratified the Convention in 1990, the other contracting nations are Chile, Columbia, Costa Rica, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Panama, Paraguay, Uruguay and Venezuela. Its provisions are similar to those contained in the New York Convention.

131. Provisions on reciprocal recognition of arbitral awards are usually included in Friendship, Commerce and Navigation treaties. The United States has concluded such treaties with a number of countries including Belgium, Denmark, France, Germany, Greece, Ireland, Israel, Italy, Japan, Korea, Luxembourg, Netherlands, Nicaragua, Pakistan, Thailand and Togo. GARY B. BORN, INTERNATIONAL COMMERCIAL ARBITRATION IN THE UNITED STATES: COMMENTARY & MATERIALS 23 (1994).

132. *Id.* at 19-20.

133. Cour D'Appel De Reims– 23 July 1981– Firme Denis Coakley v. Reverdy. International Commercial Arbitration. New York Convention. Giorgio Gaja. National Judicial Decisions. V.112. Original text in Revue de l'arbitrage, p.304 (1982).

134. United Nations Convention on the Recognition and Enforcement of Foreign Arbitral Awards, *supra* note 61.

Authorities are split over the question of whether the proceedings that led to the award can be scrutinized on the grounds that it contradicts the public policy of a state where recognition or enforcement is sought. It is generally agreed that it is mainly the substance of the award that must contradict public policy to prevent recognition or enforcement of the award. Theoretically, it is the effect of the recognition or enforcement of the *award* in the requested state that should not contradict the public policy. Thus, the requested authority should be primarily concerned with the contents of the award.[135] The procedural aspects of arbitration, however, can also conflict with public policy. This view was articulated by the Geneva *Cour de Justice Civile* in its decision of 17 September 1976.[136] The court confirmed that "public policy may be invoked not only with regard to the contents of the foreign arbitral award the enforcement of which is requested in Switzerland, but also with reference to the proceedings that led to the award."[137] Nevertheless, the court reversed the lower court's decision rejecting leave to enforce the award, *inter alia*, on the grounds that the limit of Swiss public policy is broader with regard to the recognition and enforcement of awards than, for example, with regard to the application of foreign law by Swiss courts.[138] Accordingly, the opponents of this approach argue that arbitral procedure aspects should not be reviewed under Article V(2)(b) of the New York Convention,[139] or that Article V(2)(b) should be applied to procedural aspects only under exceptional circumstances.[140]

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135. Ironically, the contents of many reinsurance arbitration awards is limited to the sum awarded with no reasons given. In American reinsurance arbitration practice, such is almost always the case. This fact, however, itself is able to raise a question of compliance with the public policy of a requested foreign state. Courts of different jurisdictions to date have generally expressed the view that the absence of a reasoned opinion as such does not violate public policy. *See* Firme Denis Coakley v. Reverdy, *supra* note 133, S.A. Tradax Export v. S.p.a. Carapelli, 3 Y.B. Com. Arb., 279 (1978). Moreover, under Article VIII of the 1961 Geneva Convention on International Commercial Arbitration, raising a public policy question in this respect by a requested court is impermissible if the parties agreed that an award would be given without reasons.

136. Leopold Lazarus Ltd. v. Chrome Ressources, S.A. International Commercial Arbitration. New York Convention. Giorgio Gaja. National Judicial Decisions. V.98. Original text in 98 La Semaine judiciaire, p. 506 (1976).

137. *Id.*

138. *Id.*

139. FOUCHARD, L'ARBITRAGE COMMERCIAL INTERNATIONAL 346 (1965).

140. Bulow, *La convention des perties relative a la procedure d'arbitrage visee a l'Art. V, par. 1, litt. d) de la Convention de New York*, Commercial Arbitration. Essays in memoriam Eugenio Minoli (1974), at 92.

If an authority requested to recognize or enforce an award decides to review the security issue under Article V(2)(b) of the New York Convention, then the public policy question can give rise to serious concerns. These concerns are likely to be especially serious in civil law jurisdictions where judges have powers of inquiry and do not render default judgments without considering the merits of the case, unlike judges in common law jurisdictions. But at least one common law court to date has refused to enforce a default judgment rendered pursuant to the security posting provisions, holding that the proceedings that led to the judgment were contrary to public policy and natural justice as understood in the country where the enforcement was sought.[141]

The general view, however, is that such judgments should nevertheless be recognized and enforced, notwithstanding considerable differences in the procedural laws of any two given countries. As early as 1895 the United States Supreme Court, in *Hilton v. Guyot*,[142] considered similar issues and adopted an internationalist approach. In this case, the enforcement of a French judgment was objected to on the grounds that French procedure permitted testimony not under oath and not subject to cross-examination, thus depriving the defendant of essential procedural safeguards guaranteed by the laws of the United States.[143] The Court held that "the practice followed and the method of examining witnesses were according to the laws of France, we are not prepared to hold that the fact that the procedure in these respects differed from that of our own courts is, of itself a sufficient ground for impeaching the foreign judgment."[144]

Commentators suggest that there is substantial international agreement on this issue.[145] However, enforcement of a default award or judgment entered under the security-posting provisions can reveal more fundamental differences than those discussed in *Hilton*. That is – deprivation of a party of an opportunity to defend its case, as opposed to application of a different method of examining witnesses, as in *Hilton*.[146]

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141. *Muhl, Superintendent of Insurance in the State of New York, as Liquidator of Nassau Ins. Co. v. Ardra Ins. Co. Ltd.*, Supreme Court of Bermuda, 16 May 1997 [hereinafter *Muhl*]. For the case note, *see* Jan Woloniecki, *Muhl, Superintendent of Insurance in the State of New York, as Liquidator of Nassau Insurance Company v. Ardra Insurance Company Ltd.*, 1997 IJIL 318.

142. 159 U.S. 113, 170-71 (1895).

143. *Id.* at 204.

144. *Id.* at 205.

145. ANDREAS F. LOWENFELD, INTERNATIONAL LITIGATION AND THE QUEST FOR REASONABLENESS 112 (1996).

146. *Hilton*, 159 U.S. at 204.

2. Due Process Defense

In addition to Article V(2)(b), which has a general application, the New York Convention contains Article V(1)(b), applicable to procedural aspects of an arbitral award:

> Recognition and enforcement of the award may be refused, at the request of the party against whom it is invoked, only if that party furnishes to the competent authority where the recognition and enforcement is sought, proof that:
>
> The party against whom the award is invoked was not given proper notice of the appointment of the arbitrator or of the arbitration proceedings or was otherwise unable to present his case.147

Article V(1)(b) specifically facilitates due process protection for the respondent in an arbitration proceeding to counterbalance "[t]he possible absence of adequate protection from the rules selected by the parties, or otherwise applicable."[148] It is worth noting that the provision considers only notice and opportunity to be heard rather than incorporating "wholesale the law of procedural due process."[149] This suggests that the drafters considered these two elements of due process to be of paramount importance.[150]

There is dispute concerning the applicability of this exception. The major question is which standard is appropriate to determine whether the due process requirement fixed by the Convention has been complied with. Should the courts look to municipal rules or to an international standard?[151] Authorities can be found to support both. In *Parsons & Whittemore*,[152] the

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147. United Nations Convention on the Recognition and Enforcement of Foreign Arbitral Awards, *supra* note 61.

148 International Commercial Arbitration. New York Convention. Giorgio Gaja. I.C.3.

149. JACK J. COE, JR., INTERNATIONAL COMMERCIAL ARBITRATION: AMERICAN PRINCIPLES AND PRACTICE IN A GLOBAL CONTEXT 337 (1997).

150. "The primary elements of due process are notice of the proceedings and the opportunity to be heard thereon." Biotronik Mess-Und Therapiegeraete GmbH & Co. v. Medford Med. Instrument Co., 415 F.Supp. 133, 140 (D.C.N.J. 1976). *See also* Fuentes v. Shevin, 407 U.S. 67, 80 (1972); Goldberg v. Kelly, 397 U.S. 254, 267-68 (1970).

151. Commentators have expressed different views on the subject. *See generally* FOUCHARD, *supra* note 139, at 343 (describing the "international standard" approach); Leonard V. Quigley, *Accession by the United States to the United Nations Convention on the Recognition and Enforcement of Foreign Arbitral Awards*, 70 YALE L.J. 1049, 1067 n.81 (1961).

152. Parsons & Whittemore Overseas Co. v. Societe Generale de L'Industrie du Papier (RAKTA), 508 F.2d 969 (2d Cir. 1974).

Second Circuit took the view that Article V(1)(b) "essentially sanctions the application of the forum state's standards of due process."[153] Authors suggest that this approach "arguably follows from the provision's failure to indicate otherwise."[154] The same approach was taken by Hamburg *Oberlandesgericht* in its decision of 14 October 1964. The court held that the Article V(1)(b) objection to the enforcement of the award given by the Arbitral Tribunal of the Czechoslovak Chamber of Commerce in a dispute between a Czechoslovak firm and a German company must have been ascertained under German law.[155] On the other hand, Cologne *Oberlandesgericht*, in its decision of 10 June 1976,[156] reasoned that the Convention, while not containing a reference to the law of the forum state, "rather intends to fix an international standard."[157]

Notwithstanding the fact that courts, observing international reciprocity, tend to construe public policy issues narrowly, enforcement of a default award can encounter considerable problems. For example, in cases similar to those referred to above, where the foreign reinsurer is financially unable to post the security[158] or is forbidden to pledge assets under the law of its domicile,[159] enforcement of an award in the country of reinsurer's domicile might be unsuccessful.

B. Judgments

Foreign judgment recognition and enforcement rules are less uniform than the rules on recognition and enforcement of foreign arbitral awards. With few exceptions, each country has its own rules. There are a number of multilateral conventions unifying the rules upon which a foreign judgment is subject to recognition and enforcement. These conventions, however, are mostly regional.[160] Nevertheless, it is common to regulate

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153. *Id.* at 975.

154. COE, *supra* note 149, at 337 n.61.

155. International Commercial Arbitration. New York Convention. Giorgio Gaja. National Judicial Decisions. V.45. Original text in Die deutsche Rechtsprechung auf dem Gebiete des internationalen Privatrechts in den Jahren 1964 und 1965, p.794.

156. *Id.* at V.104.

157. International Commercial Arbitration. New York Convention. Giorgio Gaja. I.C.3.

158. *See supra* notes 125, 126. *See* also *infra* Part IV.B for the discussion of *Ardra* judgment enforcement in Bermuda.

159. *See supra* note 126.

160. For example, most Western European countries are members of the 1968 EEC Convention on Jurisdiction and Commercial Matters (Brussels Convention) or 1988 Lugano Convention. Likewise, the CIS (Commonwealth of Independent States) countries concluded

issues related to reciprocal recognition and enforcement of judgments on a bilateral basis. Therefore, it is hard to derive a general idea of how foreign courts will approach cases concerning recognition and enforcement of judgments, absent a uniform rule such as the New York Convention. In each case it will depend upon the procedural law of the country where recognition and enforcement is sought, and provisions of a particular treaty concluded with this foreign country.

Moreover, absent a treaty with a state where recognition and enforcement is sought, such procedures may be impossible. In fact, "that is the law in as generally enlightened and internationalist countries as the Netherlands, Norway, and Austria."[161] At the same time, the United States has not concluded any treaties with any foreign state on recognition and enforcement of judgments. In most cases an U.S. judgment is going to be enforced, if at all, on the basis of reciprocity.

It is not necessary for the purposes of this paper to explore the laws and practices of foreign states related to the recognition and enforcement of foreign judgments. It is understood, however, that the public policy defense, as well as the due process defense, can be available under the laws of virtually every foreign state.

A Bermuda Supreme Court decision illustrates the due process and policy concerns with respect to default judgments rendered pursuant to security-posting provisions. Here, the New York Superintendent attempted to enforce the *Ardra* judgment[162] in Bermuda. The court found that enforcement of the *Ardra* judgment could be resisted on two of the four grounds available under English law.[163] First, it was contrary to public policy to enforce the judgment because the plaintiff ignored the *ex parte* injunction obtained by Ardra from the Bermuda court restraining the plaintiff from bringing the court action with respect to the contract, which

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a 1993 Convention on Legal Assistance, according to which the states' parties undertook to recognize and enforce each other's judgments in civil, family and criminal cases (came into force 10 December 1994), SOBRANIE ZAKONODATELSTVA ROSSIISKOY FEDERACII, No 17., 1995.

161. LOWENFELD, *supra* note 145, at 109.

162. *See supra* Part III.

163. Woloniecki, *supra* note 141, at 318. The four grounds for denial of enforcement of a foreign judgment under English law are: contradiction with public policy, contradiction with natural or substantive justice, the cause of action is unknown to English law, the judgment was obtained through fraud. M. WOLFF, PRIVATE INTERNATIONAL LAW, OXFORD UNIVERSITY PRESS, 1945, at 291-293.

provided for arbitration in Bermuda. The court held that it "would, therefore, on this ground alone have refused to enforce the judgment."[164]

Although the first ground was enough to deny the enforcement, the court went on to explore the merits of Ardra's claim and determined that the proceedings that led to the judgment were contrary to natural justice as understood in England and Bermuda.[165] The court concluded that it was "contrary to substantial or natural justice to require a defendant to put up a security as a condition of defending which it cannot meet."[166] If the New York court, upon considering relevant evidence had determined that Ardra was actually able to pay, the outcome could have been different, yet the circumstances of the case were such that Ardra, being unable to post the required security, had been unfairly deprived of due process.[167] While the Bermuda Court did not go further in concluding that the security-posting provisions were contrary to natural justice, the court recognized that under certain circumstances application of such provisions may lead to unfair results.[168]

The significance of this case is enormous. Suffice it to say that the Judge was interpreting English and Bermuda law, under which most international reinsurers of the world are organized. If the reasoning of *Muhl* is followed in Bermuda and the U.K., "American plaintiffs may well find that a default judgment against a reinsurer with no assets in the United States is effectively worthless."[169]

CONCLUSION

Security posting is an unusual procedural device designed to afford procedural protection for resident insureds and reinsureds in litigating their claims against unlicensed insurers and reinsurers. This Article has addressed the basic justifications for the application of such provisions, including ensuring immediate availability of funds necessary to satisfy a judgment against an unlicensed insurer, and limiting the volume of business conducted by such insurer to its actual financial capabilities. At the same time, this Article argue that the broad application of such

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164. *Muhl, supra* note 141.

165. This ground for denial of enforcement is mainly construed to mean contradiction with the principle *"audiatur et altera pars"* (or *"audi alteram partem"*) – Hear the other side. M. WOLFF, *supra* note 163, at 292.

166. *Muhl, supra* note 141.

167. *Id.*

168. *Id.*

169. Woloniecki, *supra* note 141, at 321.

provisions is not always reasonable and can actually work against the state's interests, including possibly reducing alien reinsurers' activities within the American insurance market. It also becomes evident that domestic insureds and reinsureds, having obtained a default judgment under a security-posting statute, might not be able to enforce it. Thus, protectionist policy can actually do a disservice to those whom it is supposed to protect. This is evidenced by the Bermuda Supreme Court decision in *Muhl*. If the refusal to enforce American default judgments becomes common practice, American courts will have to reconsider their approach and become more flexible with respect to imposing security, or the amount of business carried by foreign reinsurers in the United States will be greatly reduced.[170]

There are ongoing disputes over other issues related to the application of security-posting provisions. Sometimes judicial practice is inconsistent, particularly, with respect to the interpretation of certain New York Convention provisions that govern the mandating of prejudgment attachments. The security-posting problem became acute not long ago with the rapid growth of larger and more complex insurance and reinsurance claims. As more of these cases are tried, case law in this area will further develop, casting new light upon disputed issues.

170. The New York Superintendent of Insurance already considered an amendment to the New York Insurance Law to the effect of denying to any company ceding to an unlicensed Bermuda reinsurer the benefit of such reinsurance for accounting purposes. *Id.*

THE EUROPEAN INSURANCE MARKET, HARMONIZATION OF INSURANCE CONTRACT LAW, AND CONSUMER POLICY

*Juergen Basedow**

TABLE OF CONTENTS

INTRODUCTION

The internal market, which the European Community (EC) established at the end of 1992, is defined by the realization of some basic freedoms. Under Article 14, paragraph 2 of the EC Treaty, "[t]he internal market shall comprise an area without internal frontiers in which the free movement of goods, persons, services and capital is ensured in accordance with the provisions of this Treaty."[1] This target clearly includes insurance markets, and the Community has made great efforts to achieve that goal. The Community finally succeeded following the adoption and transformation of numerous directives during the mid-1990s. The first section of this Article describes that process in detail. From an economic perspective, the existence of a Single Market is perhaps indicated by the guarantee of some basic freedoms, such as the freedom of establishment or the freedom to provide services, but more clearly by the effective existence of

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1. Treaty Establishing the European Economic Community art. 7a, Mar. 25, 1957, 298 U.N.T.S. 11 (as in effect 1986) (now article 14) [hereinafter EC Treaty] *most recently amended by* Treaty of Amsterdam amending the Treaty on European Union, the Treaties Establishing the European Communities and Certain Related Acts, Oct. 2, 1997, O.J. (C 340) 1 (1997) [hereinafter Treaty of Amsterdam]. The present version of article 14 was inserted by the Single European Act. Single European Act, Feb. 17 and 28, 1986, 1987 O.J. (L 169) 1 [hereinafter Single European Act].

transnational business. The second part of this Article will therefore explore the internal insurance market from that point of view, explaining the existence of a deficit of market integration by analyzing the subsisting differences between national insurance contract laws within the EC. These differences are increasing and being reinforced as increasing numbers of Member States enact new legislation on insurance contract law (Part II).[2] This observation raises concerns and requires an inquiry into the goals and perspectives of European policy in this field (Part III). A plea for renewed harmonization efforts may appear untimely since former attempts in that direction have proven unsuccessful. The final part of this Article will therefore indicate reasons why the prospects for an approximation of insurance contract law in the European Union (EU) are much better today than they were twenty years ago (Part IV).

I. THE SINGLE INSURANCE MARKET: A SURVEY

The move towards an internal market for the insurance industry has been marked by three generations of EC directives. First, in the 1970s, we witnessed the implementation of the freedom of establishment, which became effective when the restrictions on the creation of agencies and branches were abolished.[3]

However, due to the strong and common interests of all participants, all efforts to effectuate the freedom to provide services (i.e., the provision of insurance coverage by insurers established in one Member State for clients domiciled in another) were doomed to failure. First, insurance companies feared foreign competitors, because under the country-of-origin rule these foreign competitors might have been able to offer their services at much

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2. Within the European Economic Area comprehensive acts were recently adopted by several Member States. *E.g.* Loi sur le contract d'assurance terrestre (1992) (Belg.); Moniteur belge (1992) (Belg); Lag om försäkringsavtal Nr. 543 (1994) (Fin.); Finlands författningssamling 1994, 1450 (Fin.); Law no. 2496 (1997) (English translation by *Manessiotou/Murray* from the law firm of *Rokas & Partners* is on file with the author) (Greece); Lov om forsikringsavtaler, Nr. 69 (1989) (Nor.); Norsk lovtidend 1989 I, 494. Further drafts are under preparation in various countries. *See e.g.* BT-Drucksache 13/8163 (1997) (a draft Act reforming the insurance contract law) (F.R.G.); Reimer Schmidt, *Gedanken zur Arbeit an einem neuen Versicherungsvertragsgesetz [Thoughts for work on a new law of insurance]*, 1998 ZVERSWISS 55.

3. Council Directive 73/239 of 24 July 1973 on the coordination of laws, regulations and administrative provisions relating to the taking-up and pursuit of business of direct insurance other than life insurance, 1973 O.J. (L 228) 3; First Council Directive 79/267 of 5 March 1979 on the coordination of laws, regulations and administrative provisions relating to the taking-up and pursuit of the business of direct life insurance, 1979 O.J. (L 63) 1.

lower rates. Second, customers worried about the transparency of the market and feared that the domestic standard of protection would decline if foreign companies were allowed to enter the market without any form of control effected by an insurance authority of the host state. Third, the governments of the Member States wanted to preserve the national insurance industries as prime borrowers, who had always been reliable partners when new state loans were issued, but who might be less willing to lend their support once under attack from foreign competition. It was not until 1986, that the European Court of Justice, in a courageous decision, declared the direct applicability of the freedom to provide services in the field of insurance.[4] Finally, the coalition advocating the preservation of the status quo was weakened. Starting with the second generation of directives in 1988/1990, the conditions for the exercise of the freedom to provide services were created.[5]

The third generation of directives went further by promoting the harmonization of certain areas of market control regulation, the effect of which is that today, the country-of-origin principle is implemented. This means that the state of origin of an insurance company is exclusively responsible for its admission, supervision and control. Tying the Member States to a common European standard of market supervision ensures acceptance by the host Member States.[6]

What was the role of insurance contract law in this development? The Commission's formula was twofold. First, for insurance involving transportation and large risks, the Commission focused on a conflict of laws solution dispensing with the harmonization of substantive law. In its 1979 draft directive, the Commission suggested guaranteeing the freedom

4. Case 205/84, Commission v. Federal Republic of Germany, 1986 E.C.R. 3755, ¶ 25, ¶ 52.

5. Second Council Directive 88/357 of 22 June 1988 on the coordination of laws, regulations and administrative provisions relating to direct insurance other than life insurance and laying down provisions to facilitate the effective exercise of freedom to provide services and amending Directive 73/239, 1988 O.J. (L 172) 1; Second Council Directive 90/619 of 8 November 1990 on the coordination of laws, regulations and administrative provisions relating to direct life assurance, laying down provisions to facilitate the effective exercise of freedom to provide services and amending Directive 79/267, 1990 O.J. (L 330) 50.

6. Council Directive 92/49 of 18 June 1992 on the coordination of laws, regulations and administrative provisions relating to direct insurance other than life assurance and amending Directive 73/239 and 88/357, 1992 O.J. (L 228) 1 (third directive on non-life insurance); Council Directive 92/96 of 10 November 1992 on the coordination of laws, regulations and administrative provisions relating to direct life insurance and amending Directive 79/267 and 90/619, 1992 O.J. (L 360) 1 (third directive on life insurance).

to contract for the choice of law, in the first place, and to apply the law of the company's state of origin where no choice was agreed to by the parties.[7] Second, as to other risks, especially in relation to consumer insurance, a different solution was advocated. According to the Commission, contractual choice of law would be excluded and the applicable law would be the law of the company's state of origin. At the same time, the harmonization of insurance contract law should guarantee that basic rights of the insured are protected once the insured agrees upon a policy governed by foreign law.[8] Nevertheless, after a long debate, the Commission eventually concluded that, for reasons of consumer protection, the future conflict of laws rule could not refer to the law of the company's state of origin. Instead, the applicable contract law should be the law of the state in which the risk is situated,[9] which in most cases, is the law of the consumer's habitual residence. However, the harmonization of the substantive law of insurance contracts might help to win acceptance for a gradual extension of the free choice of law, which still was regarded as a necessary prerequisite for the effective exercise of the freedom to provide services.[10]

This proposition too has come under attack.[11] According to the critics, the freedom of choice of law in the field of consumer insurance is not a prerequisite, but rather an obstacle to the effective implementation of the freedom to provide services since consumers would not buy policies subject to foreign law through a choice of law clause. Therefore, the target of allowing the free choice of the applicable law could hardly be regarded as a sufficient justification for the harmonization of the substantive law of insurance contracts.[12] The failure of the substantive harmonization approach had other reasons as well. It turned out to be utterly difficult due to its entanglement with the general law of obligations. These difficulties were particularly emphasized by those who lobbied for a continuous policy of protection of national markets. Since the Commission was not

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7. Commission Proposal for a Council Directive on the coordination of laws, regulations and administrative provisions relating to insurance contracts 1979 O.J. (C 190) 2, consideration 2. *See* Schwartz, *Errichtung des Gemeinsamen Marktes für Schadensversicherungen* [*Building a Common Market for Insurance*], 1972 ZVERSWISS 101, 109, 111. *Compare supra* notes 5-6.

8. *Cf.* Schwartz, *supra* note 7, at 112.

9. *Cf.* Commission Proposal, *supra* note 7, ¶ 3, consideration 3.

10. *Id.*, ¶ 4, consideration 4.

11. Steindorff, *Rechtsangleichung in der EG und Versicherungsvertrag*, 114 ZHR 447-83 (1980).

12. *See id.* at 455.

sufficiently prepared with comparative research, it could not give a serious reply to these arguments.[13] Moreover, the harmonization of insurance contract law has lost importance over the course of time, in particular, after the ruling of the European Court of Justice in 1986, which exerted considerable pressure to implement the single insurance market within a couple of years before the end of 1992. Other areas of harmonization such as the admission and supervision of companies, and the control of solvability, investment policy, and technical reserves, acquired primary importance in that period of time constraints.

Eventually, a solution was adopted which was entirely based on the conflict of laws. That conflicts regime is limited to risks located in the European Economic Area, while risks in other countries are subject to the general rules of private international law as set forth in the Rome Convention of 1980.[14] Moreover, the regime of the directives not only deals with intra-community relations but has been extended, by some Member States, to insurance contracts conducted with insurance companies outside the EU. While this allows for a choice of applicable law with regard to transportation and large risks, all other risks, particularly those in the field of consumer insurance, are governed by the law of the policyholder; the choice of another law will usually be without effect.[15] This solution can hardly be characterized as a harmonization of private international law. The Court of Justice had permitted the Member States in 1985, for reasons pertaining to the public good, to avoid the country-of-origin rule which is inherent in the free movement of services, and to provide for the application, to the insurance contract, of the law of the host state.[16] The latter conflicts rule was clearly meant, by the Court of Justice, to be an exception from the country-of-origin principle and to permit a kind of national reservation commanded by the public interest of the host state. However, the second generation of insurance directives has turned this

13. The study of *Berr*, Le contrat d'assurance dans la C.E.E. (1974) did not cover the required parts of the topic and was outdated very quickly.

14. Rome Convention (of the EC Member States) of 19 June 1980 on the law applicable to contractual obligations, 1980 O.J. (L266) 1.

15. *Cf.* Second Council Directive of 88/357, art.7, *supra* note 5; Second Council Directive 90/619, art. 4, *supra* note 5; *see also* INTERNATIONAL INSURANCE CONTRACT LAW IN THE EC, Proceedings of a comparative conference held at the European University Institute, Florence, May 23 to 24, 1991 (Reichert-Facilides, et al. eds., 1993); ASPEKTE DES INTERNATIONALEN VERSICHERUNGSVERTRAGSRECHTS IM EUROPÄISCHEN WIRTSCHAFTSRAUM (Reichert-Facilides ed., 1994). *Cf. Basedow & Drasch*, Das neue Internationale Versicherungsvertragsrecht, NJW 1991, 785 ff.

16. *See* case 205/84, *supra* note 4, at ¶ 40.

exception into the general rule, purporting that it would serve the implementation of the free movement of services. It should, however, be clear that this has nothing in common with the initial concept of the Commission since the target of an approximation of the substantive law of insurance contracts was no longer pursued. The Commission withdrew the draft directive relating to this matter in 1993.[17]

II. THE SINGLE INSURANCE MARKET: AN APPRECIATION

Whoever tries to assess the practical importance of the European Insurance Market at a distance of some years from its establishment will be disillusioned. According to EUROSTAT, the European Union's agency responsible for statistics, most of the European insurance companies prefer to organize their activities in other Member States by means of subsidiaries or branches, instead of directly acquiring transborder business from their headquarters. Such cross-border transactions contribute only 0.13 percent of the total turnover of German non-life insurance companies. It is only for smaller Member States, such as Luxembourg, Belgium and Ireland, that the percentage of such transactions plays an important role.[18]

The statistical data confirms the assessment of the internal market for insurance made by the European Commission and by the Economic and Social Committee of the European Union. At the end of 1997, the Commission issued a draft communication in which it addressed concerns relating to the interpretation of some basic terms such as the free movement of services and the public interest. These were said to be responsible for barring insurance companies from making effective use of the basic freedoms granted by the treaty although the third generation of insurance directives purported to foster the use of such freedoms.[19] In a carefully prepared opinion of early 1998, the Economic and Social Committee revealed a series of obstacles and problems, which hamper the realization of the internal market in this area.[20] The opinion points out that all attempts have failed so far, which were meant to guarantee the consumers the right of equal access to insurance coverage in every Member State outside their

17. *Cf.* Withdrawal of Draft Directive, 1993 O.J. (L 228) 4, 14.

18. *Cf. Grenzüberschreitendes Versicherungsgeschäft noch bescheiden*: FRANKFURTER ALLGEMEINE ZEITUNG, Aug. 14, 1998, at 26.

19. Draft Commission Interpretative Communication on Freedom to Provide Services and the General Good in the Insurance Sector, 1997 O.J. (C 365) 7.

20. Opinion of the Economic and Social Committee on "Consumers in the Insurance Market," 1998 O.J. (L 95) 72, ¶ 77, § 2.1.9.

countries of domicile or origin.[21] Those seeking insurance coverage were refused by foreign insurance companies.

This assessment is supported by facts and can by no means be regarded as surprising. With regard to cross-border contracts, an insurer usually has to face two categories of special risks. First, the overall damages in a given sector may differ from domestic experience due to particular economic, social, and cultural conditions of the foreign environment. To obtain information on these differences requires time and depends on the volume of business contracted abroad. Second, the insurer has to deal with the foreign contract law of the policyholder's country, which is applicable under the relevant conflict of law rules, and, which determines the interpretation and the effects of the policy. In the case of insurance, which rightfully has been characterized as a "legal product,"[22] the contract and the law by which it is governed are more than the legal framework of a transaction, more than the mere "selling arrangements" as described by the European Court of Justice in the *Keck* decision.[23] Under the test advocated in that case, the contract law is more related to the product itself since it defines the extent of coverage, which is the product offered by the insurer. Having to cope with fifteen different insurance contract laws within the EU might be as important for an insurance company as the accommodation of fifteen different national foodstuff acts for a producer of chocolate bars, tinned chicken soup or fruit yogurt.

The producer of foodstuff must either adjust his products to the changing requirements of the different foreign markets and their respective legal frameworks or must dispense with exportation of his products to these countries. In the same way, insurance companies operating from their home bases must either invest into the costly adaptation of their policies to the foreign insurance contract laws, or if they are unwilling to incur such costs, they must abandon the idea of expanding their activities into the foreign markets. It appears that the costs of adaptation would not be much higher if the insurance company decides to set up a branch or subsidiary in the foreign market thus making use of its freedom of establishment. On the other hand, the profit to be expected from a permanent establishment in the foreign market would be higher than the profit which possibly can be made from a limited number of cross-border transactions. For practical and

21. *Id.* at ¶ 73, § 1.7.

22. DREHER, DIE VERSICHERUNG ALS RECHTSPRODUKT (1991).

23. Case C-267/91, Keck, 1993 E.C.R. 6097; Case C-268/91 Mithouard, 1993 E.C.R. 6131 (considerations 15 and 16).

commercial reasons the insurance companies therefore will either continue their activities in national confinement, or they will establish a branch or subsidiary in a foreign market, which conducts business within that state on an equally national basis. Due to the applicability of different national insurance contract laws it would appear highly unlikely that an insurer would assemble policies from different countries into one pool of risks subject to a uniform coverage. The creation of such multistate risk pools would, however, be a major incentive for cross-border underwriting activities, thereby effectively exercising the freedom to provide insurance services. Such multistate risk pools are commercially feasible, although the insurer gains little business from each Member State. Under the present conditions, no insurance company will be willing to pay for costly legal advice on the insurance contract laws of fourteen foreign Member States in order to obtain a few new customers from each nation. Practically speaking, the insurance companies, therefore, have only the choice between continuing a purely national business activity and the establishment of a branch or subsidiary abroad. Although cross-border transactions are particularly favored by the intangible character of financial services, they remain exceptional in that field.

After all, the internal market for consumer insurance exists on paper only since the conflict of laws approach taken by the second generation of directives failed.[24] While this is also true for the insurance of smaller commercial risks, the implementation of the free choice of law in the field of high volume and transportation risks allows the insurance companies to assemble those multistate risk pools. These are governed by a single law, usually that of the insurer, which are therefore subject to a uniform coverage.

III. GOALS AND PERSPECTIVES

In light of the above discussion, it is difficult to understand why the European Commission takes the view that the conflict of law solution adopted by the second generation of directives is an efficient approach. Efficiency in this assessment apparently is not measured by reference to the goal of the Single Market. In this respect, it should be clear that the mandate of Article 14 (ex. 7a) of the EC Treaty to accomplish an internal market is still unfulfilled in the area of small commercial insurance and consumer insurance and, therefore, is still on the agenda of the EU. Future

24. Reichert-Facilides, *Europäisches Versicherungsvertragsrecht*, FESTSCHRIFT FÜR DROBNIG 119, 131 (1998).

action should focus on the following goals. First, insurance companies must have an effective opportunity to form risk pools consisting of participants from different Member States. The pooling of a great number of risks, which is the basis of all insurance activities, must not be hampered by national borders. The policies of an all-European, multistate risk pool must essentially be determined by the same product related rules, the same contract law.

Second, the consumer should have the opportunity to choose between competing offers from different Member States which should be comparable among each other. In order to allow for the comparison, an expenditure for information and consultation may be necessary and which should not be disproportionate to the significance of the policies. Thus, the consultation of an experienced insurance agent could be justified in the case of industrial fire insurance while it might be regarded as an unreasonable expenditure if it is required to make private liability or household equipment policies comparable.

Third, the special interest in promoting continuity for all the parties involved has to be taken into account. For example, if a "euromobile" policyholder has his domicile in different Member States throughout his lifetime, he should be able to renew or supplement his policy with the same insurance company. Whereas the present legal situation requires a change of the applicable law for every contract made after a cross-border change of domicile, the interest of both parties to maintain contractual continuity within the European internal market should be safeguarded.[25]

What options are open to European legal policy to achieve these goals? A first approach would follow the example given by the conflict of law rules relating to transportation and large risks, which are based on the principle of free choice of law. Consequently, insurance companies would likely insert choice of law clauses into their policies declaring their own national law applicable. Therefore, transnational risk pools would in fact be governed by one single law of contract, the law of the insurer. Although this approach would help to attain the first goal, the second goal, the consumer's choice between several comparable offers, would not be achieved. The consumer would not be in a position to compare the private liability insurance policy offered by a German company and governed by German law, and a competing offer made by a English company under the

25. *Cf.* Jürgen Basedow, *Das österreichische Bundesgesetz über internationales Versicherungsvertragsrecht – Eine rechtspolitische Würdigung*, *in* Reichert-Facilides, *supra* note 15, at 89, 91, 99.

laws of England; such a comparison would probably surpass even the talents of an expert in the field of comparative law. Establishing comparability would require an unreasonable expenditure in terms of time and money. While the risk of ignorance of the applicable law is allocated with the insurance company under the present conflict of law rules, this approach would shift that risk to the policyholder. Therefore, the second goal can hardly be said to be furthered. As knowledge of this fact would spread, consumers would rather refrain from buying policies from foreign insurance companies, and we could not expect an increase in the number of cross-border transactions.

Moreover, that transfer of risk to the consumer would work at cross purposes with the goal of a high level of consumer protection mandated by Article 95 (ex. 100a) of the EC Treaty. Quite to the contrary, the level of consumer protection would be reduced particularly because litigation arising from the insurance contract would cause a split of jurisdiction and applicable law: whereas the courts in the country of the insured have a concurrent jurisdiction (Article 8) or even the exclusive international jurisdiction (Article 11) under the Brussels or Lugano Conventions,[26] they would probably have to apply foreign law, the law of the insurer stipulated in the policy in most cases. The lawyers of the forum state would undoubtedly lack the specific knowledge required for giving advice on the applicable law. Moreover, the costs of applying foreign law would be unjustifiably high for the court system, too.[27] The free choice of law, therefore, cannot be regarded as an appropriate solution for insurance contracts concerning smaller business risks and consumer risks.

A second option would be the harmonization of the substantive law of insurance contracts. The Economic and Social Committee supports this solution. According to its opinion, the deficits of the Single Market are due to the lack of Community provisions on contracts of insurance, in particular a minimum of harmonization of the substantive law.[28] In fact, the harmonization of essential points of insurance contract law would help consumers trust the comparability of policies offered by insurance companies in different Member States. Whether they actually compare the details is of secondary importance, for there is reason to believe that the trust in the comparability of policies will enable consumers to focus on

26. Lugano Convention on Jurisdiction and the Enforcement of Judgements in Civil and Commercial Matters, Sept. 16, 1988, 1994 II Bundesgesetzblatt 2660.

27. *Cf.* Steindorff, *supra* note 11, at 450.

28. Opinion, *supra* note 20, at ¶ 77, § 2.1.9.

essential issues, such as the definition of risk and the premium, and to make their choice on this basis. On the other side of the market, the harmonization of the substantive law of insurance contracts will reduce the risk, which insurance companies face under the present conflict of laws rules when they assemble risks from various Member States into all European risk pools. Take the extreme case of a complete harmonization or even unification by an EC regulation - the practical result would be the same as if the free choice of law, the application of one single contract law to all policies, which are part of the all-European risk pool, were accepted.

Even if that goal were out of reach, it can be said that every single step in this direction could help to reduce the uncertainties and distortions, which at present exist due to divergent interpretations, and effects given to the same insurance policy in different Member States. Finally, a harmonization would support the continuity interests of the above mentioned "euromobile" policyholders. It is true that the harmonization of substantive law would not change the conflict of law rules. There would still be a change in the applicable law with regard to renewed or supplementary policies when such persons move from one Member State to the other. Such changes would be more readily accepted if the policyholder were confident that the essential substantive rights and obligations arising from the contract would continue under the new law.

It would appear that the second option, a renewed attempt at the harmonization of the law of insurance contracts, is to be preferred. Neither considerations of subsidiarity, nor those of proportionality, (Article 5 paragraphs 2 and 3, ex 3b EC Treaty) can be accepted as valid objections to this proposal. With regard to subsidiarity, it should be recalled that the mandate to establish an internal market has yet to be fulfilled in the insurance sector and that the Member States are not able to create that internal market by themselves. Moreover, experience from other areas of uniform law tells us that we should not rely on the instrument of an international convention in a Community of fifteen or even more Member States if we want to achieve harmonization. Bearing all of this in mind, it is difficult to maintain that the principle of subsidiarity could bar harmonization measures adopted by the Community.[29]

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29. Taschner, *Richtlinie oder Internationale Übereinkommen? Rechtsinstrumente zur Erreichung der Ziele der Europäischen Union*, *in* RHEINISCHE FRIEDRICH-WILHELMS-UNIVERSITÄT ZENTRUM FÜR EUROPÄISCHES WIRTSCHAFTSRECHT, 66 VORTRÄGE UND BERICHTE (1996) (a disillusioning report about the harmonization process promoted by means of agreements within the Council of Europe).

The principle of proportionality requires a more careful review of the situation. As pointed out earlier, the internal market is already established in the fields of large risks and transportation risks where the free choice of law is admitted by the conflict of laws rules of the second generation of directives. Therefore, harmonization measures cannot be regarded in these areas as "necessary" within the meaning of Article 5 para. 3 (ex 3b) of the EC Treaty. For reasons of proportionality, the Community would have to focus on insurance contracts covering consumer risks and small commercial risks. The perspective outlined here is not attractive. Next to the existing national insurance contract laws which would continue applying to transportation and large risks, the Community would introduce its own legislation on the insurance of small commercial risks and consumer risks. The Member States are, of course, not precluded from extending the Community legislation to the area of large risks and transportation insurance. It might equally be worthwhile to consider the possibility of a common understanding of the proportionality principle, which would allow the Community to enact comprehensive legislation not limited to certain types of risk.

IV. OUTLOOK ON IMPLEMENTATION

After the failure of former harmonization efforts in the 1980s, the proposition made in this Article will certainly raise the question as to whether and why the chances of success of a renewed attempt at harmonization are better today. If we compare the present situation with that of 1980, we can, in fact, discover some differences in the political and economic environment which allow for an optimistic outlook toward success.

First, it should be recalled that the establishment of the Single Market has to be viewed, not as an accomplished fact, but rather as a process that is still under way. In the course of this process, political interest is of course focused, at a first stage, on the greatest and most conspicuous obstacles for the realization of the basic freedoms. These are national market regulations of a public law character, such as the former German statute, requiring foreign insurance companies to maintain a separate domestic establishment for doing business in Germany. As such regulations are being abolished, the market actors, both insurers and policyholders, are becoming more sensitive for other national regulations which equally impede the access to foreign markets, although perhaps in a less intense and less visible way. In the 1980s, the differences in contract law may not have mattered as compared with differences relating to the regulation of premiums,

investment policy or technical reserves. After the harmonization in those areas, they are felt to be an important barrier to the implementation of the single insurance market today.

A second change concerns the attitude of the insurance industry towards the single insurance market. At the end of the 1980s, the official positions taken by the industry associations were characterized by the fear of foreign competition and a strong reluctance to the implementation of the freedom to provide services and the deregulation necessary for this purpose. This defensive attitude has given way in the last few years to the rising conviction that deregulation and European integration offer new business opportunities to domestic companies in foreign markets. As this more offensive approach is gaining support, the industry is losing its interest in the maintenance of legal differences between Member States, which formerly were welcomed as tools of protectionism. Quite to the contrary, the industry itself will lobby for the harmonization of the legal framework.

The introduction of the EURO is a third change of fundamental importance. It will most likely accelerate the process of harmonization. The indication of insurance amounts and premiums in national currency gives clear evidence of the separation of national markets, which exists even for intangible goods such as insurance. Many consumers feel a psychological barrier, which is often underestimated, to insure their risks with a foreign insurance company. Once this barrier is eliminated by the introduction of the European currency, the direct comparison between domestic and foreign policies will suggest itself to many people. Their demand for comparable policies will increase and can be satisfied by a harmonization of the substantive contract law.

A fourth change has emerged in the general environment relating to the law of contracts. It cannot be denied that the interaction between the law of insurance contracts and the general law of obligations renders harmonization of the former a particularly difficult task. On the other hand, there are some signs, which announce a forthcoming eurofication of the general law of obligations, in particular the adoption of the principles of European contract law by the so-called Lando Commission[30] and of the Principles of International Commercial Contracts by the Institute for the

30. *The Principles of European Contract Law I*, 1996 ZEuP 864 (German translation); Zimmermann, *Konturen eines Europäischen Vertragsrechts*, 1995 J.Z. 477.

Unification of Private Law (UNIDROIT) in Rome.[31] These developments were entirely unexpected in 1980, when the first speculations on a common private law for Europe had not even been published.[32] Today, the national civil codes and common law no longer seem to be as untouchable as they were at that time.[33] It would appear doubtful whether these traditional fortresses of legal nationalism can still be used against the europeanization of the law of insurance contracts. When doubts arise in the application of Community measures on the law of insurance contracts, the proper approach today would no longer appear to assess the meaning of the Community acts in the light of a national system of contract law. Rather, the interpretation should be guided by the principles of European contract law of the Lando Commission.[34]

As compared with the early 1980s, things have finally changed. The Community has already taken some initial steps towards an integration of European law of insurance contracts. They address some specific rules of contract law contained in several insurance directives, such as the required minimum information and the right of cancellation in life insurance, minimum coverage and the scope of liability in the compulsory liability insurance of car owners, as well as some aspects of the insurance of litigation expenses.[35] Second, the directive on unfair terms in consumer contracts of 1993[36] will apply to insurance contracts as a matter of principle, as can be concluded from preliminary consideration no. 19.[37] In its opinion, the Economic and Social Committee recently referred to the abundant case law of national courts in the area of unfair terms in general

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31. *UNIDROIT Principles of International Commercial Contracts*, 1997 ZEuP 890 (German translation); *cf.* MICHAEL JOACHIM BONELL, AN INTERNATIONAL RESTATEMENT OF CONTRACT LAW (2nd ed. 1997).

32. Hein Kötz, *Gemeineuropäisches Zivilrecht*, *in* FESTSCHRIFT FÜR ZWEIGERT 481 (1981).

33. *Cf.* TOWARDS A EUROPEAN CIVIL CODE (A.S. Hartkamp ed., 1998) (articles within); Ulrich Drobnig, *Private Law in the European Union* 22 FORUM INTERNATIONALE (1996).

34. Jürgen Basedow, *The Renaisscance of Uniform Law: European Contract Law and Its Components*, 18 LEGAL STUDIES 121, 133, 139 (1998).

35. Reichert-Facilides, *supra* note 24, at 128, n.56.

36. Council Directive of 5 April 1993 on unfair terms in consumer contracts; Council Directive 93/13, 1993 O.J. (L 95) 29.

37. *Cf.* Brandner, *Auswirkungen der EU-Richtlinie über mißbräuchliche Vertragsklauseln auf Versicherungsverträge*, *in* VERSICHERUNGSWISSENSCHAFTLICHE STUDIEN 2 67 (Basedow et al. eds., 1995); Kieninger, *Die Kontrolle von leistungsbeschreibenden Versicherungsbedingungen nach der AGB-Richtlinie – Fortschritt oder Rückschritt?*, 1994 ZEuP 277.

conditions of insurance.[38] It is safe to assume that the European Court of Justice sooner or later will have to interpret the directive in its application to standard terms of insurance, and there is no need to explain the obvious interaction between the review of standard insurance terms and the law of insurance contracts. Third, guidance for a future harmonization of European law on insurance contracts is given by the block exemption regulation for the insurance industry of 1992.[39] Article 5 seq. of this regulation specifies the conditions which model insurance terms must fulfill in order to be exempted from the prohibition of cartels and concerted practices in Article 81 (ex 85) of the EC Treaty. Since the contract terms set forth in the regulation are mainly inspired by considerations of competition, it is not possible to draw final conclusions on the contractual fairness of such terms. However, it can be stated that the massive use of blacklisted terms runs counter to a competitive orientation of the European insurance market. There are authors who in fact take the view that the black list of Article 7 of the Regulation equally serves the protection of individual rights of the insured.[40]

This short outline of changes which have occurred in the political, economic, and legal environment leads to the conclusion that the renewed efforts for a harmonization of the substantive law of insurance contracts may be more successful than previous attempts. Since the Community is still under an obligation to establish an internal market in the insurance sector, such efforts should be made.

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38. Opinion, *supra* note 20, at 83, § 3.7.3.2 - 3.

39. Commission Regulation 3932/92 of 21 December 1992 on the application of art. 85 (3) of the Treaty to certain categories of agreements, decisions and concerted practices in the insurance sector, 1992 O.J. (L 398) 7.

40. *WINDHAGEN*, DIE VERSICHERUNGSWIRTSCHAFT IM EUROPÄISCHEN KARTELLRECHT 169 (1996); *VEELKEN*, EG-WETTBEWERBSRECHT I 664, para. 44 (Immenga et al. eds., 1997).

A FEDERAL BILL, WITH COMMENTARY, TO ALLOW CHOICE IN AUTO INSURANCE

Jeffrey O'Connell, Peter Kinzler** and Hunter Bates****

TABLE OF CONTENTS

INTRODUCTION

> The generally prevailing system of providing damages for motor vehicle accidents is inadequate to meet existing conditions. It is based on the principle of liability for fault which is difficult to apply and often socially undesirable in its application; its administration through the courts is costly

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* The Samuel H. McCoy II Professor of Law, University of Virginia; B.A., Dartmouth College; J.D., Harvard Law School.

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> and slow, and it makes no provision to ensure the financial responsibility of those who are found to be liable.

Report by the Committee to Study Compensation for Automobile Accidents
Columbia University Council for Research in the Social Sciences (1932), 216-217.

> [T]he existing system ill serves the accident victim, the insuring public and society. It is inefficient, overly costly, incomplete and slow. It allocates benefits poorly, discourages rehabilitation and overburdens the courts and the legal system. Both on the record of its performance and the logic of its operation, it does little if anything to minimize crash losses.

Motor Vehicle Crash Losses and Their Compensation in the United States
A Report to the Congress and the President
United States Department of Transportation (March 1971), 100.

For years, commentators and—more importantly—motorists have complained about the inadequacies of the tort and liability insurance system, both in terms of slow and inadequate compensation and in terms of excessive costs. Reform efforts over the years—including adoption of no-fault insurance laws and modifications of the tort and liability insurance system, such as the near universal replacement of contributory negligence with comparative negligence, higher liability insurance limits and underinsured motorist coverage—have focused primarily on improved compensation. All of these efforts have improved compensation somewhat but often at the cost of higher premiums. The tort and liability insurance system changes have predictably increased premiums because they have not been accompanied by any cost saving measures. Many of the no-fault laws have also resulted in higher costs, in substantial part because the trial bar has weakened the restrictions on lawsuits that were intended to keep costs down. In sum, if you pay more people more dollars without sufficiently limiting other costs, then the system will be more expensive.

This federal legislation—the Auto Choice Reform Act of 2001—is intended to break out of this box by giving people the opportunity to both

increase compensation of economic losses and reduce costs. In essence, under the bill here presented, motorists would have two choices. Those who want to exit the personal injury tort liability system, based on fault with payment for pain and suffering, could do so by buying personal injury protection insurance (PIP). Instead of suing other motorists for economic damages and pain and suffering based on who was at fault in the accident, motorists who elect PIP would be compensated automatically without regard to fault for all economic losses up to their policy limits by their own insurance company, with nothing available for pain and suffering. PIP motorists would retain the right to claim in tort for economic losses above policy limits against an at-fault driver. In turn, other motorists could claim in tort against PIP motorists only for economic losses above policy limits. In sum, PIP motorists could neither sue or be sued for non-economic losses, except for injuries inflicted intentionally or as the result of abuse of alcohol or drugs. The creation of a primarily first-party system of compensation for economic loss with the elimination of most pain and suffering lawsuits would generate huge savings in attorneys' fees, pain and suffering damages and reduction of fraud associated with running up economic loss for the pain and suffering multiplier. The result would be that more dollars would be available for *both* better compensation of serious injuries and significantly lower costs.

In the alternative, motorists could essentially retain the rights they currently have by buying tort maintenance coverage (TMC). For accidents involving two or more TMC motorists, remedies would be unaffected. But for accidents involving PIP and TMC motorists, TMC motorists would claim for both economic and non-economic losses against their own insurer much as they do under existing uninsured motorists coverage. If losses exceed TMC policy limits, TMC motorists could claim against negligent PIP motorists for the excess of such economic loss. As will be discussed in the commentary accompanying section 2(b), "Purposes," the combination of TMC benefits and recoveries through claims against negligent drivers for excess economic loss would mean that TMC motorists would by no means be penalized in serious injury cases, as contrasted to their recoveries under the tort system. They would receive similar or somewhat higher benefits for serious injuries than they receive under today's tort system because the tort system fails, on average, to compensate even the economic losses of seriously injured people, not to speak of their non-economic losses.

COMMENTARY

The legislation (H.R. 1704 and a companion Senate bill)[1] is divided into 10 sections. These sections set forth the title; explain the need for the legislation and its benefits and savings through findings and purposes; define the terms used generally in the bill; explain the two auto insurance options; include provisions to guard against insurance fraud; describe the sources of compensation for different accident scenarios; contain specific provisions preserving State and private rights and State regulation of insurance; and set forth the authority of each State to opt out of the Auto Choice system. The legislation is accompanied by a detailed section-by-section commentary.

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1. H.R. 1704, 107th Cong. (1st Sess. 2001), was introduced by Representatives Armey (R-TX), Moran (D-VA) and Cox (R-CA), on May 3, 2001. Representatives Dooley (D-CA), Northup (R-KY) and Weldon (R-FL) were added as cosponsors later. At publication time, several senators were preparing a nearly identical bill for introduction in the Senate. In the 106th Congress, Senators McConnell (R-KY), Moynihan (D-NY), Lieberman (D-CT) and McCain (R-AZ) introduced S. 837, 106th Cong. (1st Sess. 1999), which was nearly identical to H.R. 1704. An earlier model version of the bill allowed choice between no-fault and tort coverage, drawing also on the Uniform Motor Vehicle Accident Reparations Act, promulgated by the National Conference of Commissioners on Uniform State Laws and its extensive commentary. *See* Jeffrey O'Connell, *A Model Bill Allowing Choice Between Auto Insurance Payable With and Without Regard to Fault*, 51 OHIO ST.L.J. 948 (1990).

107th Congress

1st Session

H.R. 1704

To enable drivers to choose a more affordable form of auto insurance that also provides for more adequate and timely compensation for accident victims, and for other purposes.

IN THE HOUSES OF REPRESENTATIVES

MAY 3, 2001

Mr. ARMEY (for himself, Mr. MORAN of Virginia, and Mr. COX) introduced the following bill; which was referred to the Committee on Financial Services

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A BILL

To enable drivers to choose a more affordable form of auto insurance that also provides for more adequate and timely compensation for accident victims, and for other purposes.

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

SEC. 1. SHORT TITLE; TABLE OF CONTENTS

(a) SHORT TITLE.—This Act may be cited as the "Auto Choice Reform Act of 2001".

Section 1(a) gives the legislation its title, the "Auto Choice Reform Act of 2001."

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

(a) Rights of States
(b) Preservation of State Regulatory Authority
(c) Rights of Private Parties

SEC. 10. APPLICABILITY TO STATES
(a) Election of Nonapplicability by States
(b) Nonapplicability Based on State Finding
(c) Implementation Period
(d) Accelerated Applicability
(e) Election of Nonapplicability by a State After This Act Becomes Applicable With Respect to the State

SEC. 2. FINDINGS AND PURPOSES

(a) FINDINGS.—The Congress finds the following:
(1) Auto insurance premiums are too high, largely because the current auto liability insurance system (referred to in this section as the "present system")—
(A) encourages costly fraudulent claims and unnecessarily contentious behavior by both claimants and defendants; and
(B) often requires expensive lawyers on both sides of a dispute to settle claims.

Section 2(a) outlines the rationale for the legislation. Paragraph (1) states the conclusion that the current auto liability insurance system costs too much. The present system consists, primarily, of two types of auto insurance: (1) tort liability insurance,[2] which is the only option in 35 states,[3] and (2) no-fault

2. All terms in this article, which are defined within the context of the legislation, are intended as they are defined in the legislation. Two frequently used abbreviations—PIP for personal injury protection and TMC for tort maintenance coverage—are also marked with asterisks, as are "no-fault insurance" and "no-fault auto insurance," which are short for the defined term "no-fault motor vehicle law."

3. Some commentators contend there are 27 "tort" states and 10 "add-on" no-fault states (Arkansas, Delaware, Maryland, New Hampshire, Oregon, South Dakota, Texas, Virginia, Washington and Wisconsin). *See, e.g.*, ROBERT H. JOOST, AUTOMOBILE INSURANCE AND NO-FAULT LAW 2D (Clark Boardman Callaghan 2d ed. 1992) [hereinafter JOOST]. Add-on no-fault was an idea developed by the trial bar, whereby some states mandate or permit people to purchase no-fault benefits coverage to fill in the compensation gaps of the tort system. This coverage differs from the Medical Payments (MedPay) coverage carried by about 86 percent of drivers in tort states (1992 National Association of Independent Insurers, *Automobile Experience*) in that it also covers work loss. However, it seems more appropriate to call eight

insurance, which is offered in 13 states.[4] The fact that the RAND Institute for Civil Justice (RAND) estimates that the new insurance option available under the Auto Choice system would reduce bodily injury premiums by an average of 57 percent in the 50 states is an indication that the auto liability system is too expensive.[5]

Paragraph (1)(A) explains one major reason for excessive costs—the fact that the tort system encourages fraudulent claims. It does so by routinely awarding three times the amount of economic loss (medical bills and lost wages) for noneconomic damages, or pain and suffering. As Senator Mitch McConnell stated in his floor statement when introducing S. 837, the Auto Choice Reform Act of 1999, on April 20, 1999:

> Why would an injured party inflate their medical claims, you might ask. It's simple arithmetic. For every $1 of economic loss, a party stands to recover up to $3 in pain and suffering

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of these states "tort" states because: (1) the mean benefit level in these state is only $7,616, JOOST, *supra* § 5:18, at 35, not much higher the typical MedPay policy limits of $1,000 to $5,000, STEPHEN CARROLL ET. AL., NO-FAULT APPROACHES TO COMPENSATING PEOPLE INJURED IN AUTOMOBILE ACCIDENTS 80 (RAND INST. FOR CIVIL JUSTICE, 1991) [hereinafter NO-FAULT APPROACHES]; (2) the coverage is optional, JOOST, *supra* , at 35; and (3) there are no restrictions on lawsuits in "add-on" states. Oregon and Delaware are different because they require motorists to purchase no-fault benefits and at reasonably high levels. The trial bar's rationale for add-on no-fault was that if people were properly treated by their insurers, they would not sue. Not surprisingly, in most of these states, the people just took the no-fault benefits and then sued, because the incentive to sue—the pain and suffering multiplier, *see* discussion in the commentary about section 2(1)(A)—was still there. In some respects, the no-fault benefits helped finance lawsuits for some who otherwise would have settled because they could not have afforded to wait long enough to sue. As a result of these inherent defects, cost experience in the add-on states has generally been poor.

4. Ten states mandate no-fault insurance, while three others—Kentucky, Pennsylvania and New Jersey—are actually choice states, in that they offer a choice between a no-fault system and a tort option with no restrictions on lawsuits. The District of Columbia also has a choice system under which, after an accident, a motorist can decide whether to use tort coverage or no-fault coverage. Unlike H.R. 1704, however, none of these state laws offers drivers a choice to forgo pain and suffering coverage entirely.

5. STEPHEN J. CARROLL & ALLAN F. ABRAHAMSE, THE EFFECTS OF A CHOICE AUTOMOBILE INSURANCE PLAN ON INSURANCE COSTS AND COMPENSATION: AN ANALYSIS BASED ON 1997 DATA 20 (RAND INST. FOR CIVIL JUSTICE, 1999) [hereinafter CARROLL & ABRAHAMSE]. This estimate is based on the assumption that half the drivers switch to the new insurance option. Were all drivers to switch, RAND estimates the savings at 55 percent. The RAND estimate is based on the provisions of S. 837 and H.R. 1475, identical bills entitled the Auto Choice Reform Act of 1999, 106th Cong. (1st Sess. 1999). H.R. 1704 is identical to these two bills in all parts relevant to the RAND estimate.

> awards. In short, the more you go to the chiropractor, the more you get from the jury. And, the more you get from the jury, the more money your attorney puts in his own pocket.[6]

The pain and suffering multiplier encourages people to file claims for nonexistent injuries or to run up unnecessary bills to increase their recovery—and that of their doctor and lawyer. Both RAND and the Insurance Research Council (IRC) have estimated that more than one-third of all claims fit into these categories of "excess" medical claims.[7] Some of these excess claims are even caused by staged accidents, but the vast majority are merely the everyday padding of claims to increase recoveries.

Paragraph (1)(B) states the other reason for excessive costs—recovery is contingent on establishing "legal fault" so the system often requires expensive lawyers, for both the plaintiff and the defendant, to settle claims. The latest IRC data show that 52 percent of tort claimants retain attorneys and those claimants receive 82 percent of all the dollars paid to injured persons.[8] Using attorneys is a very expensive way to settle these routine claims for, what Senator Moynihan calls, not accidents but "statistically predictable collisions—[actuarially inevitable] foreseeable events—in a complex transportation system . . . ."[9]

> **(2) The adversarial tort system that is in effect in 35 States poorly compensates the most needy individuals, in that the system—**
>
> **(A) pays no liability benefits to more than 30 percent of all accident victims;**
>
> **(B) takes too long to pay victims when it does pay them;**
>
> **(C)(i) pays victims with minor injuries an average of 2 to 3 times the cost of their medical bills and lost wages; but**

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6. 145 Cong. Rec. S. 3920 (daily ed. Apr. 20, 1999) (statement of Sen. McConnell accompanying introduction of S. 837, the Auto Choice Reform Act of 1999).

7. STEPHEN CARROLL ET AL., THE COSTS OF EXCESS MEDICAL CLAIMS FOR AUTOMOBILE PASSENGER INJURIES 23 (RAND INST. FOR CIVIL JUSTICE 1995) [hereinafter EXCESS MEDICAL CLAIMS]; INSURANCE RESEARCH COUNCIL, FRAUD AND BUILDUP IN AUTO INJURY CLAIMS: PUSHING THE LIMITS OF THE AUTO INSURANCE SYSTEM 1 (1996).

8. INSURANCE RESEARCH COUNCIL, INJURIES IN AUTO ACCIDENTS: AN ANALYSIS OF AUTO INSURANCE CLAIMS 59 (1999) [hereinafter IRC 1].

9. 145 CONG. REC. S. 3924 (daily ed. Apr. 20, 1999) (statement of Sen. Moynihan accompanying introduction of S. 837).

(ii) pays victims with serious injuries an average of less than 50 percent of those bills and lost wages; and

(D) pays twice as much for plaintiff and defense lawyers combined as it pays for victims' medical bills and lost wages.

Paragraph (2) outlines the compensation deficiencies of the tort system in that it not only costs too much, it pays out too little to those who are most in need of compensation. Paragraph (2)(A) cites the fact that the tort system pays no benefits to more than 30 percent of all accident victims.[10] The largest category of such victims are people injured in single car crashes.[11]

The reason for these large compensation gaps is simple—by its terms, there is no recovery under the tort system unless the accident is caused by the wrongdoing of another, a "tortfeasor." By definition, there is no tortfeasor in single car accidents, nor can there be recovery if the injured person is entirely legally at fault. Many of these cases involve little or no fault and yet can cause lifelong injuries for which liability insurance pays nothing. For example, a person who skids on the ice and hits a tree cannot recover, nor can the parent who is injured when his car crosses a double yellow line while trying to retrieve a wayward pacifier for a baby properly buckled in the backseat.[12]

Paragraph (2)(B) cites the deficiency that even those who recover must wait long periods of time for their money. A 26-volume study by the U. S. Department of Transportation (DOT) in 1971 found that it takes 16-18 months on average to receive payment.[13] In larger cities it can take more than four years to receive payment if the case goes to trial.[14] Not only can

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10. CARROLL & ABRAHAMSE, *supra* note 5, at 10 n.9.

11. U.S. DEP'T OF TRANSP., NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., TRAFFIC SAFETY FACTS 1997 90 (1998).

12. In order to address the concern about the lack of compensation in these cases, insurers sell—and the trial bar supports the sale of—MedPay coverage, which pays benefits regardless of fault. However, the typical MedPay policy is low, between $1,000 and $5,000 on average. NO-FAULT APPROACHES, *supra* note 3, at 80; INS. RESEARCH COUNCIL, INJURIES IN AUTO ACCIDENTS: AN ANALYSIS OF AUTO INSURANCE CLAIMS 105 (June 1999). MedPay does not protect against wage loss. As a result, it provides grossly inadequate benefits for anyone seriously injured in this large category of cases for which the tort system offers no recovery.

13. U.S. DEP'T OF TRANSP., MOTOR VEHICLE CRASH LOSSES AND THEIR COMPENSATION IN THE UNITED STATES, A REPORT TO THE CONGRESS AND THE PRESIDENT 43 (1971).

14. U.S. DEP'T OF JUSTICE, CIVIL JURY CASES AND VERDICTS IN LARGE COUNTIES, 1996 13 (1999). This study of the 75 largest counties in the United States found that 26.2 percent of

this long wait present an economic hardship for injured people, it can also result in no or less than full rehabilitation. Many studies show that rehabilitation must begin promptly to be effective. Inevitable delays from protracted litigation mean either no rehabilitation or a longer, less effective rehabilitation.[15]

Paragraph (2)(C)'s findings that people with minor injuries receive far more than their economic losses, on average, while those with more severe injuries recover less than 50%, are both drawn from RAND studies. Specifically, RAND found that people with economic losses of $500-$1,000 recover on average 250% of those losses; those with losses of $25,000-$100,000 recover on average 56% of those economic losses (and nothing for pain and suffering); and those with losses over $100,000 recover on average only 9% of economic losses (and nothing for pain and suffering).[16]

Financial consumer writer Andy Tobias says that this system is "like homeowner's insurance that pays triple if your stereo's stolen (or you say it was) but only 9 percent if the house burns down."[17] The RAND findings are consistent with those from the 1971 DOT study[18] and largely reflect the fact that the average bodily injury liability coverage is about $60,000.[19] After subtracting one-third for lawyer payments, that leaves only $40,000. This amount may be sufficient to pay for a minor injury, but it is woefully inadequate to cover the economic losses of a serious injury, let alone any pain and suffering.

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auto tort cases took two to four years to resolve and 6.9 percent took more than four years to resolve.

15. JEFFREY O'CONNELL, THE LAWSUIT LOTTERY 19-22 (1979).

16. NO-FAULT APPROACHES, *supra* note 3, at 21-22. These figures are gross recovery figures, i.e., what injured people were paid before they pay their attorneys' fees.

17. *Auto Choice Reform Act: Hearing Before the Senate Comm. on Commerce, Science and Transportation*, 104th Cong. 104, 116 (1996) (testimony of Andrew Tobias).

18. The DOT study found that people with injuries over $25,000 recovered, on average, only 30 percent of their economic loss. U.S. DEP'T OF TRANSP., ECONOMIC CONSEQUENCES OF AUTOMOBILE ACCIDENT INJURIES 47 (1970).

19. This figure was derived from the book of business of a large insurer. The conclusion is supported by the findings of a recent IRC study. The study found that 52 percent of all policyholders carry $50,000 or less of liability insurance (with most of such policyholders carrying $25,000 or less). Most of the rest of the drivers carry $100,000 of coverage. IRC 1, *supra* note 8, at 104. When one factors in either the RAND estimate that 15 percent of all drivers are uninsured, CARROLL & ABRAHAMSE, *supra* note 5, at 20, or the IRC estimate that 14 percent of drivers are uninsured, Press Release, Insurance Research Council, Uninsured Motorists (Aug. 12, 1999), nearly 60 percent of all drivers carry $50,000 or less of insurance.

(3) The chance of winning the lawsuit lottery in the present system—

(A) results in the filing of billions of dollars of fraudulent or otherwise unnecessary auto insurance claims annually;

(B) generates billions of dollars in unnecessary health care costs for private, Federal, and State health care programs;

(C) raises auto insurance premiums for all drivers, including drivers operating business vehicles; and

(D) makes auto insurance premiums unaffordable for many low-income individuals.

Paragraph (3) cites the adverse societal effects of maintaining a "lawsuit lottery" system for auto accidents, where recovery is left up to the vagaries of how an accident occurs, the unpredictable decisions from trials and the insurance choices of strangers. Paragraph (3)(A) cites the billions of dollars wasted on fraudulent claims encouraged by the tort system. Using 1993 data, RAND estimated that "excess consumption of health care in the auto arena in response to tort incentives accounted for about $4 billion."[20] The total premium cost is even greater when the pain and suffering multiplier and insurance overhead costs are added to the false medical claims. When RAND added these additional costs, it estimated the total cost of these claims at $13-18 billion annually.[21]

Paragraph (3)(B) cites the impact of the incentives to inflate medical bills on public and private health care systems—billions of dollars in unnecessary health care costs. These collateral sources of payment for auto accident costs, including Medicare and Medicaid, often pay the medical costs of victims while their auto insurance claims wind their way through lengthy lawsuit proceedings. Even when victims are fortunate enough to obtain compensation from the other driver's auto insurance, collateral sources frequently fail to recoup what they have paid to their insureds (who have been paid twice for the same loss—once by the health insurer and once by the other driver's auto insurance—as a result of a successful lawsuit) because the collateral sources are often unable to readily track the outcome of the lawsuits. Thus, NHTSA has found that the federal government picks up almost 15% of the total medical care cost of auto accidents through the

20. EXCESS MEDICAL CLAIMS, *supra* note 7, at 23.

21. *Id.*

Medicare and Medicaid programs, while the states pick up an additional 10%.[22]

Some of these costs for health insurance also occur in three other situations: (1) where the injured person is involved in one of the 30% of auto accidents that do not produce any recovery under the tort system; (2) where the other driver's coverage is insufficient to pay the injured person's loss; and (3) where the driver is partly at fault and thus also has residual medical costs.

Paragraph (3)(C) states that the tort system raises auto insurance premiums for all drivers. This finding is based on the fact that RAND estimates that the PIP (personal injury protection) option of Auto Choice could save people who select it about 57% on their bodily injury premiums.[23] The waste in the tort system is so great that, had Auto Choice been in effect in 1998 and had every driver elected the new personal injury protection (PIP) option, the Joint Economic Committee (hereinafter "JEC") estimated the annual savings would total $35 billion ($27 billion for private passenger drivers and $8 billion for businesses).[24]

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22. U.S. DEP'T OF TRANSP., NATIONAL HIGHWAY TRAFFIC SAFETY ADMINISTRATION, THE ECONOMIC COST OF MOTOR VEHICLE CRASHES, 1994 46 (1996).

23. CARROLL & ABRAHAMSE, *supra* note 5, at 20. In a tort state, the bodily injury portion of an auto insurance premium consists of bodily injury liability, uninsured and underinsured motorist coverage and medical payments coverage. In a no-fault state, it substitutes no-fault benefits coverage for medical payments coverage. The bodily injury portion of the premium averages slightly less than 50% of the total premium. *Id.* at 20. The other components are collision, property damage liability and comprehensive (which covers fire and theft losses). Collision and comprehensive are first party "no-fault" coverages whereby the insurer pays its own insured without inquiring into the question of fault. Property damage liability is a third party fault-based coverage whereby an insurer pays for damage to the other car when its own insured was at fault. Auto Choice only affects the bodily injury portion of this system; all the property damage coverages mentioned above (collision, property damage liability and comprehensive) would be unaffected. As a result, RAND finds that the 57 percent savings on the bodily injury portion of the premium would translate into a 24 percent savings in the total premium nationwide. *Id.* at 20.

24. JOINT ECONOMIC COMMITTEE, AUTO CHOICE: IMPACT ON CITIES AND THE POOR 34 (1998) [hereinafter JEC]. The JEC estimate for private passenger vehicles was based on RAND Institute for Civil Justice estimates that were made in 1998 using 1992 Insurance Research Council data. STEVEN J. CARROLL & ALLAN F. ABRAHAMSE, THE EFFECTS OF A CHOICE AUTOMOBILE INSURANCE PLAN ON INSURANCE COSTS AND COMPENSATION: AN UPDATED ANALYSIS (RAND INST. FOR CIVIL JUSTICE, 1998). The new 1999 RAND estimate is based on 1997 IRC data. CARROLL & ABRAHAMSE, *supra* note 5, at iii. The new data show an average private passenger vehicle savings of 57 percent, compared to 45 percent using 1992 data. As a result, the new aggregate annual savings potential for both private passenger vehicles and

Paragraph (3)(C) also states that the tort system raises costs for businesses. Nearly every business operates one or more vehicles and thus has to pay for the cost of operating those vehicles through insurance or self-insurance (whereby a business forgoes insurance but is still obligated to pay for the cost of any accidents its drivers cause). All businesses—whether they operate one delivery truck or thousands of vehicles, such as UPS—must protect against the costs of fraud and lawsuits associated with auto accidents. The JEC estimated that Auto Choice could have enabled businesses to save $8 billion in 1998.[25]

Paragraph (3)(D) cites the fact that auto insurance premiums are unaffordable for many low-income drivers. Oklahoma State University Professor Robert Lee Maril's study of people living at half the poverty level in Maricopa County, Arizona, confirms this finding. Professor Maril found that "the poorest household paid . . . the greatest percentage of their annual incomes to mandatory car insurance. The poorest households paid almost one-third of their total annual income for mandatory car insurance."[26] The problem can be even worse for the many low-income people who reside in major cities, where premiums are far higher. Further, the JEC has found that low-income drivers pay more in auto insurance in two years than the value of their car, and that people in the bottom income quintile pay seven times the percentage of their household income on auto insurance than families in the top quintile.[27] Michael Dukakis put it succinctly in describing the burdens imposed by high premiums in Boston: "How can we expect mothers to get off of welfare and go to work when it costs them over $2000 to put a car on the road?"[28] The JEC estimates that low-income drivers who elect the PIP option of Auto Choice would see a 36% reduction in total premium, far higher than the 23% reduction average drivers would see. Low-income drivers in Massachusetts would see a 48% reduction in total premium.[29]

(4) The present system harms cities by—

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commercial vehicles should be significantly higher than the previous JEC estimate of $35 billion

25. *Id.*

26. *Auto Choice Reform Act of 1999: Hearing on S. 837 Before the Senate Comm. on Commerce, Science, and Transportation*, 106th Cong. 41 (1999).

27. JEC, *supra* note 24, at 30-31.

28. *Auto Choice Reform Act of 1999: Hearing on S. 837 Before the Senate Comm. on Commerce, Science, and Transportation*, 106th Cong. 35 (1999) (testimony of the Hon. Michael S. Dukakis).

29. JEC, *supra* note 24, at 35.

(A) encouraging the filing of frivolous and inflated claims that cities pay at the expense of all taxpayers; and
(B) contributing to the abandonment of cities by taxpayers who can achieve substantial reductions in their auto insurance premiums by moving to the suburbs.

Paragraph (4) cites the harm that the tort system inflicts on cities. The JEC has found that an increasing number of auto accident claims are filed against cities themselves. In New York City, for example, the cost of settling personal injury lawsuits against the city increased from $28 million in 1979 to $275 million in 1995. Over $40 million of that amount, and between 60 and 75 percent of those payments, went for pain and suffering claims.[30] Since the payment of auto accident claims is not discretionary, the rise in claims costs means that cities must pay these claims in lieu of spending the money on other necessities such as schools, libraries and law enforcement.[31] In addition, the JEC has found that city residents can often cut their auto insurance premiums by about one-third by simply moving across a jurisdictional line to a suburb.[32] The price differential creates a strong incentive for people with limited discretionary funds to move out of cities.

(5) The present system provides individuals little incentive to purchase safer automobiles.

Paragraph (5) cites the finding that the present system provides individuals with little incentive to purchase safer vehicles. This finding

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30. *Auto Choice Reform Act: Hearing on S. 1860 Before the Senate Committee on Commerce, Science and Transportation*, 104th Cong., S. Hrg. 104-613, 210 (1995) (submitted statement of Rudolph W. Giuliani, Mayor of New York City).

31. Paul Crotty, when he was Corporation Counsel for the City of New York, spoke pointedly about the implications of the increasing costs of tort litigation, including auto accident litigation, for New York City: "If half the money we spent last year on our tort settlements and claims were spent on delivery of services: The city could have added almost 3,000 policemen. We could have added almost 3,500 teachers. We could have enhanced and refurbished our parks. We could have extended library hours. We could have reduced our debt. We could have added to our capital plant. So the fact that the city pays out money and pays out money in this size and dimension has a real cost to the taxpayers of the City of New York and the citizens of the City of New York." Comments before a Conference entitled "Auto Insurance Reform at the Federal Level: An Opportunity for Better Compensation for Insured Persons and Lower Premiums for All," cosponsored by the Auto Accident Compensation Project, a program of the Center for Consumer Affairs within the University of Wisconsin-Milwaukee and the Committee for Comprehensive Automobile Accident Restitution and Rate Reductions 143-144 (January 30, 1997).

32. JEC, *supra* note 24, at 38.

draws on academic work noting that insurers cannot give discounts in the tort system to people who drive safer vehicles because their insurance merely protects them when found at fault in an accident with an unknown third person.[33] In such a system, it is irrelevant for auto insurance purposes if a person drives a car that is safer than other cars because the insurer is not liable for the injuries suffered by its own insured.

(6) All of the no-fault insurance reform laws that exist in 13 States provide more timely and equitable compensation for medical bills and lost wages to more accident victims.

Paragraph (6) cites the fact that there are 13 State no-fault insurance reform laws—laws that combine the payment of benefits without regard to fault with restrictions on lawsuits for pain and suffering damages. As noted by DOT in a 1985 study, in contrast to the tort system, the no-fault components of these laws all provide more timely and equitable compensation for the medical bills and lost wages of accident victims: "Significantly more motor vehicle accident victims receive auto insurance compensation in no-fault States than in other States; . . . compensation payments under no-fault insurance are made far more swiftly than under traditional auto insurance; [and] . . . no-fault insurance systems pay a greater percentage of premium income to injured claimants than do traditional liability systems."[34]

(7) Some of those no-fault insurance reform laws, however, have not been successful in controlling insurance premiums, in large part because opponents of such reform have weakened the laws by creating loopholes for unnecessary and costly lawsuits.

Paragraph (7) cites the converse proposition, that some of the no-fault states have failed to deliver on their promise of lower premiums. However, the paragraph places the blame where it belongs—on the trial lawyer opponents who weakened the restrictions on pain and suffering lawsuits, thereby driving up the costs. The primary way the trial bar has done this is by opposing or undermining "verbal thresholds" (which permit suits for pain and suffering for certain verbally defined categories of cases, such as serious or permanent injuries) and, instead, encouraging the adoption of "dollar thresholds" (which permit suits for pain and suffering when a person incurs

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33. Jeffrey O'Connell et al., *Consumer Choice in the Auto Insurance Market*, 52 MD. L. RV. 1016, 1040-41 (1993).

34. U.S. DEP'T OF TRANSP., COMPENSATING AUTO ACCIDENT VICTIMS 3-4 (1985).

a specific amount of medical bills, typically about $2,000). Instead of assuring the necessary inhibitions on lawsuits to finance the no-fault benefits, most dollar thresholds have become targets, encouraging people to run up their medical bills so they can sue.[35] This raises the overall cost of the system. Should those who engineered this unworkable system be able to benefit from it by turning around and using the higher costs they worked to bring about as a reason to oppose legislation that includes an unbreachable threshold?[36] Surely, this should not be allowed.

The paragraph properly cites the fact that only some—not all—states have had less than satisfactory cost experience. According to the latest data, in 1997, the trial bar has not been able to undermine all state no-fault laws. For example, North Dakota, with $30,000 in no-fault benefits and a dollar threshold, has the lowest insurance premiums in the country (largely because there are relatively few cars and accidents). Michigan also has one of the least expensive liability premiums, despite the fact that it is a high vehicle-density state with major metropolitan areas and its no-fault law provides for unlimited medical benefits. Its tight verbal threshold is largely responsible for the fact that it ranks 38th in the country for the total liability portion of its premium (including liability for property damage but still a good proxy for

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35. Although, in general, verbal thresholds produce better results than dollar thresholds, the trial bar has found ways to weaken and erode verbal thresholds as well. As a result, for example, a study showed that New York no-fault drivers still paid two-thirds of the bodily injury premium for lawsuits that meet the verbal threshold. In Michigan, with a more effective verbal threshold, motorists still paid about 33% of their bodily injury premium for lawsuits that cross the threshold. Jeffrey O'Connell, *No-Fault Insurance: Back by Popular (Market) Demand?*, 26 SAN DIEGO L. REV. 993, 998 tbl. 15 (1989). H.R. 1704, by contrast, eliminates all such suits and permits motorists to lower their premiums instead. Section 9(a)(5) would permit states to require PIP insurers to offer first party insurance in specific amounts for those who wish to retain coverage for pain and suffering in death and serious injury cases. Of course, insurers themselves could offer such coverage. The protection would be more valuable because it would cover cases not covered under the tort system, such as single car crashes and, according to a reliable insurance industry source, would still be cheaper than a verbal threshold. By making such coverage permissible rather than mandatory, H.R. 1704 would have the added benefit of letting low-income individuals decide not to purchase such coverage and instead lower their premiums. As discussed later, this option would still give them more compensation in serious injury cases than the tort system but would cost far less. *See infra* note 72 and accompanying text.

36. A threshold is unbreachable when, with few exceptions, people who choose the PIP system cannot sue nor be sued for pain and suffering. This restriction is designed to eliminate the incentives for padding claims—the pain and suffering multiplier. O'Connell, *supra* note 33, at 993-94.

bodily injury costs alone). The total liability premium includes the costs of both no-fault benefits and residual bodily injury liability coverage.[37]

> **(8) The alternative form of insurance, personal injury protection, that may be offered to drivers by reason of this Act, gives drivers the ability to—**
>
> **(A)(i) insure themselves in all accidents for their own medical bills and lost wages; and**
>
> **(ii) sue other drivers on the basis of fault for any economic losses that are not covered by their insurance; and**
>
> **(B) forgo lawsuits against other drivers for noneconomic damages on the basis of fault in return for being free from suit for noneconomic damages by other drivers.**

Paragraph (8) describes the new alternative—insuring oneself for personal injuries in all motor vehicle accidents, as is done with a health insurance policy; retaining the right to sue other drivers only for the cost of any medical bills, work loss and other economic loss not covered by one's own benefits; and forgoing suits against other drivers for pain and suffering in return for being protected from such suits by other drivers.

> **(9) Personal injury protection, by reducing the need for auto liability lawsuits and the incentives for fraudulent and otherwise questionable claims, could—**
>
> **(A) save drivers billions of dollars annually; and**
>
> **(B) enable them to receive more adequate and timely compensation when they are seriously injured.**

Paragraph (9) sets forth the principal benefits of Auto Choice. Paragraph (9)(A) explains that consumers could save billions of dollars in lower premiums (the JEC estimates that Auto Choice could have saved drivers as much as $35 billion in 1998).[38] Most of the savings come from the reduction in both the need for attorneys and in payment for losses in excess of actual economic loss.[39] Paragraph (9)(B) notes that the other primary benefit for consumers would be more adequate and timely compensation for serious

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37. NAT'L ASS'N INS. COMM'N, STATE AVERAGE EXPENDITURES & PREMIUMS FOR PERSONAL AUTOMOBILE INSURANCE IN 1997, table 1 (1999).

38. JEC, *supra* note 24, at 34. The JEC estimate is a maximum savings number, assuming all drivers elected the personal injury protection (PIP) option. The JEC estimated the potential savings for five years, 1998-2002, at $193 billion. *Id.*

39. *Id.* at 5, 12-17.

injuries, as a result of guaranteed recovery of economic loss up to one's policy limits, with fewer lawsuits and less lawyer involvement.

The coverage is more timely because insurers are obligated to pay claims within 30 days, based on the relative ease of paying without reference to fault only for economic loss. It provides more coverage for serious injuries in two ways. First, because the insurance pays without regard to fault, all insured drivers—including the 30 percent of injured persons who have no recovery under the tort system—would be assured of coverage up to the amount of PIP benefits they select.[40] Second, a seriously injured person whose loss was caused by the negligence of another driver would now have two sources of money to recover from instead of one: (1) one's own PIP benefits and (2) a lawsuit against that driver for any economic loss not covered by one's own PIP coverage. The recovery under the lawsuit would, on average, be somewhat higher than what a person recovers under the tort system today (56 percent for economic loss between $25,000 and $100,000 and 9 percent for economic loss over $100,000).[41] A PIP insured is not disadvantaged by the prohibition on the right to seek pain and suffering because average existing recoveries in serious injury cases do not cover nearly all one's economic loss never mind anything for pain and suffering. Thus, a PIP insured's overall compensation in a serious injury case would be significantly greater than it is today when one couples one's PIP recovery with one's recovery for uncompensated economic loss. Moreover, PIP drivers could purchase far more insurance coverage for less money. In fact, according to a respected actuary for a large auto insurer, PIP insureds who choose to forgo the entire cost savings could afford to buy $300,000 of PIP benefits for the same cost they now pay for bodily injury insurance. Since today's insurance is so costly, the average driver carries only about $60,000 of liability coverage[42] (which produces a net recovery of only $40,000 because of the standard one-

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40. The median amount of MedPay coverage (existing first party, non-fault-based insurance), for those who purchase it, is $5,000. IRC 1, *supra* note 8, at 105. That protection would be less beneficial than PIP coverage because (1) not all insureds carry it, (2) unlike PIP benefits, it does not provide coverage for wage loss, and (3) most importantly, it is far less than the $20,000 - $25,000 that would be the minimum required PIP coverage in most states.

41. The PIP insured's net tort recovery would, on average, be *higher* than that of a tort liability system driver today because the definition of uncompensated economic loss in section 4(31) provides for the payment of a reasonable attorney's fee on top of the insurance settlement, instead of from it. For a discussion of the application of underinsured motorist coverage, which would apply in some circumstances, see the discussion *infra* note 69.

42. *See* discussion *supra* note 19.

third payment for the plaintiff's attorney), far too little to compensate one for a serious injury and, of course, coverage that leaves no money left for pain and suffering in serious injury cases.

(10) Personal injury protection would benefit society by—

(A) increasing respect for the law by eliminating the incentives of the adversarial present system for fraudulent claims and unnecessarily contentious behavior by both claimants and defendants;

(B) saving precious health care resources;

(C) making it more affordable for low-income individuals to operate an automobile to get to better paying jobs;

(D) reducing the incentives for individuals to abandon cities, by providing greater savings for drivers who reside in cities;

(E) freeing city taxpayers' dollars for reductions in taxes or expanded city programs by reducing the amount of frivolous and unnecessary lawsuits against cities;

(F) encouraging drivers to own safer automobiles by giving insurers the opportunity to reduce premiums for the owners of safe automobiles; and

(G) helping to free up court dockets that are currently overburdened with personal injury lawsuits fueled by the incentives for lawsuits under the present system.

Paragraph (10) lists the societal benefits expected from the PIP system. Paragraph (10)(A) is self-explanatory. Paragraph (10)(B) cites the savings in health care resources that would occur because people would not have the present incentive to run up their medical bills. According to RAND, those savings would have amounted to about $4 billion in 1993.[43]

Paragraph (10)(C) cites the implication of lower premiums for the poor—estimated by the JEC at 36% of the total premium[44]—in terms of being better able to afford to own a car to get to the jobs which have often moved to the suburbs. Transportation to better paying jobs is a key to helping people move from welfare to work.[45] As Denver Mayor Wellington Webb testified before

43. EXCESS MEDICAL CLAIMS, *supra* note 7, at 23.

44. JEC, *supra* note 24, at 35.

45. *See, e.g.*, JEC, *supra* note 24, at 41; *see also* PROGRESSIVE POLICY INST. AND PUBLIC/PRIVATE VENTURES, WORKING FAR FROM HOME: TRANSPORTATION AND WELFARE REFORM IN THE TEN BIG STATES (1999).

the U.S. Senate Commerce Committee, Auto Choice "means lower costs and more success for our small businesses, creating jobs and opportunity. And it means that the unemployed men and women in our communities will have an easier time transition[ing] from welfare to work because of these jobs and because their transportation costs will go down."[46]

Paragraph (10)(D) cites the fact that lower premiums for those who reside in cities would encourage people to stay there. If the PIP option dramatically reduces the differential in the cost of auto insurance—a major part of the budget for city residents—between cities and adjacent suburbs, more people might better be able to afford to live in the cities and cities in turn would benefit from the increased tax base.

Paragraph (10)(E) cites the direct benefits to the cities themselves—less money spent paying off auto liability judgments and settlements with more money available for tax cuts and expanded city programs.

Paragraph (10)(F) cites the corollary to incentives for auto safety—the PIP system can *create* incentives for auto safety in the form of air bags and other injury-preventing devices. If an insurer knows in advance who it has to pay in the event of an accident (which it cannot under tort liability but can under PIP), then it can adjust that person's premiums for operating a safer car because a safer car means the insurer's own insured is less likely to be injured in the event of an accident.[47]

Paragraph (10)(G) cites the benefit of less congested court dockets. A 1999 study of civil cases in the 75 most populous counties in the country found that 32% of the civil cases involving tort, contract and real property claims disposed of by the courts in those jurisdictions during 1996 were auto accident cases. Auto accident cases were 49% of the tort cases.[48] Elimination of the vast majority of these cases would reduce the burden on overloaded court dockets.

(11) A new auto insurance system that allows drivers to select the form of auto insurance that best meets their needs, by choosing between—

(A) a modified version of the present system, or

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46. *The Auto Choice Reform Act of 1998: Hearing on S. 625 Before the Senate Committee on Commerce, Science and Transportation*, 105th Cong. (1998).

47. JERRY L. MASHAW & DAVID L. HARFST, THE STRUGGLE FOR AUTO SAFETY, 242, 501 (1990).

48. U.S. DEP'T OF JUSTICE, CIVIL JURY CASES AND VERDICTS IN LARGE COUNTIES, 2, tbl. 1 (1999).

(B) the personal injury protection system described in paragraph (9),

would enable drivers to reduce the cost of auto insurance, increase the amount of average compensation in the event of a serious accident, and enhance individual freedom.

Paragraph (11) cites the benefits of adoption of the Auto Choice Reform Act—the ability of drivers to reduce insurance costs,[49] increase compensation in serious injury cases[50] and enhance individual freedom.

(12) The Federal Government should encourage consumer choice, but not exercise regulatory authority over the business of auto insurance, including rates and insurer solvency, as that authority is appropriately exercised by the States.

Paragraph (12) states the judgment behind the legislation that the federal role should be to encourage consumer choice, but that the regulation of insurance should remain with the states.[51]

(13) During the period beginning January 1, 1957 and ending December 31, 1996–

(A) the Federal Government spent more than $400,000,000,000 to facilitate highway construction in the United States; and

(B) hundreds of thousands of individuals have been killed in motor vehicle accidents on highways constructed with those funds.

Paragraph (13) cites the major role the federal government has played in highway construction. Hundreds of thousands of people have been killed in motor vehicle accidents on these highways. Paragraphs 13 through 16 spell out additional federal interests in passing this legislation. This paragraph buttresses the interstate connection for constitutional purposes. The data are drawn from work done by the Congressional Research Service.[52]

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49. CARROLL & ABRAHAMSE, *supra* note 5, at 20; *see also* JEC, *supra* note 24, at 34-36.

50. *See, e.g.*, discussion, section 2(b) and accompanying text.

51. *See* sections 2(b)(2), 9(b) and accompanying text.

52. John W. Fischer & William A. Lipford, *General Fund Spending for Highways* (Economics Division, Congressional Research Service, The Library of Congress, March 13, 1997) [Memorandum in response to request for information by Representative Armey] On the constitutionality of federal no-fault auto insurance, *see Hearing on S. 354 Before the Senate Commerce Comm.*, 93rd Cong., 743-894 (1974) (testimony of Erwin N. Griswold).

(14) The auto insurers who operate in interstate commerce pay greater than 70 percent of the compensation paid to accident victims.

Paragraph (14) cites IRC data to the effect that more than 70% of the costs of auto accidents are paid for by auto insurers that operate in interstate commerce.[53] This paragraph, too, buttresses the rationale for congressional involvement in this area.

(15) Through programs such as Medicare, Medicaid, and Social Security, the Federal Government pays a significant amount of the costs for compensating motor vehicle accident victims.

Paragraph (15) cites the major cost to federal programs from auto accident cases. Medicaid and Medicare pay nearly 15% of the total costs of compensating auto accident victims.[54] Social Security would also bear a significant additional amount of the costs, particularly for people with brain injuries, through its disability program.[55]

(16) It is necessary and proper for Congress, in the exercise of its authority to establish post roads and regulate commerce under section 8 of article I of the United States Constitution, to provide drivers throughout the United States with an alternative to address the problems of the adversarial present system and the inadequate no-fault insurance reforms.

Paragraph (16) cites the Necessary and Proper Clause and the right to establish post roads and regulate commerce as constitutional bases for the legislation.

(b) PURPOSES. The purposes of this Act are as follows:

(1) To enable consumers of auto insurance to choose between two insurance systems, which are—

(A) a tort maintenance system based on applicable State law that provides for substantially similar insurance premiums and compensation for injuries as compared to

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53. INS. RESEARCH COUNCIL, PAYING FOR AUTO INJURIES: A CONSUMER PANEL SURVEY OF AUTO ACCIDENT VICTIMS, 15 (1994) [hereinafter IRC II].

54. *See* EXCESS MEDICAL CLAIMS, *supra* note 7.

55. For data through the years on the comparative payouts from such social insurance and automobile personal injury coverages, *see generally* Jeffrey O'Connell, *Blending Reform of Tort Liability and Health Insurance*, 79 CORNELL L. REV. 1303 (1994) (see in particular tables at 1327-37).

the auto insurance system in existence in that State on the date of enactment of this Act; and

(B) a personal injury protection system that compensates accident victims directly for their medical bills and lost wages with substantially less need to pursue lawsuits and provides the opportunity for—

(i) substantial reductions in auto insurance premiums;

(ii) more comprehensive recovery of medical bills and lost wages in a shorter period of time; and

(iii) the right to sue negligent drivers for any uncompensated medical bills or lost wages.

(2) To preserve the rights of States to regulate the business of auto insurance.

The purposes of this bill are: (1) to enable consumers of auto insurance to choose between two insurance systems; and (2) to preserve the rights of States to regulate the business of auto insurance. Today, drivers in 47 states have only one insurance option (three states and Washington, D.C. have some form of a choice system).[56]

The two insurance systems which one can choose under the bill are: (1) a tort maintenance (TMC) system and (2) a personal injury protection (PIP) system,[57] as outlined below:

Section 2(b)(1)(A) describes the TMC system. According to RAND analyses, the TMC system will provide for average premiums and injury compensation levels comparable to those in existence in a State on the date of enactment of this bill.[58] The TMC system builds on the existing liability system in a tort state.[59] A TMC insured would continue to purchase third party bodily injury liability coverage, which is the same as today's coverage

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56. *See supra* note 4.

57. For the sake of simplicity, the commentary refers to the two systems as the PIP and TMC systems and to those who elect one or the other as PIP or TMC drivers. Technically, a PIP driver carries PIP (first party, non-fault-based benefits coverage), as well as state-required third party liability coverage for residual bodily injury liability and property damage. A TMC driver carries TMC (first party, fault-based benefits coverage), as well as state-required third party liability coverage for residual bodily injury liability and property damage.

58. CARROLL AND ABRAHAMSE, *supra* note 5, at 6, 19.

59. The TMC system would also apply in a no-fault state, with TMC coverage paying for any economic loss not covered by one's no-fault benefits and for pain and suffering in cases that cross the threshold into tort. *See infra*, section 6(a).

in that it protects the assets of the insured against claims by others that the insured was at fault in an accident. In addition, the TMC insured would purchase a new supplemental coverage called tort maintenance coverage or TMC, which works like uninsured motorist coverage today. When a TMC insured is involved in an accident with a PIP driver, the TMC insured can recover both economic and noneconomic loss from one's own insurer if one can establish the requisite liability of the other driver under standard fault-based criteria. The TMC insured can sue the PIP driver on the same basis for any uncompensated economic loss.[60]

While there is an added charge for TMC, the TMC insured's premiums stay the same because of an offset: This offset is the byproduct of the fact that a TMC driver has to pay less to a PIP driver in an accident where the TMC driver is liable under the fault criterion. The TMC driver does not have to pay any economic loss covered by the PIP insured's policy and only has to pay for the PIP insured's uncompensated economic loss, not for noneconomic loss. In short, although TMC insureds will have to insure for their own economic and noneconomic loss in some cases, their insurance costs will remain the same because they will no longer have to cover most of the PIP insured's losses when the TMC driver is at fault.[61]

Compared to today's insurance system, the injured TMC insured would actually be *better off* in the average serious injury case where the PIP driver is at fault because one now has three pots of money to recover from: (1) first one's own TMC coverage, (2) the at-fault PIP driver's coverage for uncompensated economic loss and (3) the TMC insured's uninsured motorist coverage or underinsured motorist coverage, if one's economic or noneconomic loss exceed the amount of the first two coverages.[62] By contrast, today one would have only one or two coverages (the other driver's bodily injury liability coverage and, if applicable, one's uninsured motorist coverage or underinsured motorist coverage).

Today, in a serious injury case, the average driver does not get any noneconomic damages because the average recovery in a serious injury case is less than 50% of economic loss, and so one's "right to sue" for noneconomic loss is illusory. In almost all cases, the accident victim would

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60. Here and elsewhere in this commentary, when we speak of "fault-based criteria" or "recovery based on fault" or equivalent language, we include, where appropriate, consideration of contributory or comparative negligence.

61. CARROLL AND ABRAHAMSE, *supra* note 5 at 23.

62. The third coverage would apply under section 6(b) of the legislation.

be better off with the new TMC coverage because the three pots of money would provide more compensation than is available from the one or two sources of recovery under the tort system. One would only be worse off in the rare instance when the other driver is completely at fault and happens to be Bill Gates or some such other wealthy defendant or is driving a U.S. government vehicle.

Take the following example. Today, bodily injury liability coverage averages about $60,000 (when all uninsured and underinsured drivers are added to the few Bill Gateses).[63] Assume Jack incurs $100,000 of medical expenses and lost wages in an accident with Jill, in which Jill is completely at fault. Jack sues Jill and recovers $60,000.[64] Jack then pays his attorney $20,000, the customary one-third contingency fee. Thus, Jack's net recovery is $40,000, an amount that is equal to only 40% of his full economic loss.[65] And, by definition, there is no money left to pay for Jack's pain and suffering.

Now assume that Jack suffers the same loss ($100,000) under the same circumstances but he has TMC and Jill has PIP. First, Jack collects $60,000 from his own insurer under TMC.[66] If Jack uses an attorney to collect his TMC benefits, he will pay him approximately $20,000. Thus, Jack nets $40,000 from his TMC. Now, however, he can sue Jill for his remaining $40,000 of uncompensated economic loss.[67] Jill's $60,000 bodily injury liability policy is enough to pay the remaining $40,000 and, under H.R. 1704's definition of uncompensated economic loss, also pays a reasonable attorney's fee to Jack's attorney.[68] So Jack nets $80,000 from these two

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63. *See supra* note 19 and accompanying text.

64. Jack has a theoretical right to sue Jill for her personal assets, but RAND data show that individuals almost never pay for auto accident losses out of their own pockets. The data show that individuals pay less than 2% of all the losses incurred by individuals in auto accidents. In reality, people settle for "policy limits." IRC II, *supra* note 53, t. 3-10 at 46.

65. This amount is close to RAND's average *gross* recovery of 56% for losses between $25,000 and $100,000. In fact, RAND's 56% is an average for this category, one that starts at close to 100% at $25,000 and declines rapidly as it approaches $100,000. *See* CARROLL ET AL., *supra* note 3, at 21.

66. RAND assumes in its costing of tort maintenance insurance that the TMC driver will buy the same amount of coverage for TMC as for bodily injury liability. CARROLL AND ABRAHAMSE, *supra* note 5, at 14-15.

67. In this case, uncompensated economic loss is only $40,000, because the injured person has received $60,000 for economic loss from one's own TMC coverage. The fact that one chooses to retain an attorney and pay the attorney a fee does not affect the fact that one has received compensation for $60,000 of economic loss.

68. *See* definition (31), uncompensated economic loss.

sources—$40,000 from his own TMC coverage and $40,000 from Jill's coverage. In addition, he can utilize his uninsured motorist coverage or his underinsured motorist coverage to pay for the shortfall. As a result, his total recovery will exceed 100% of his economic loss. In sum, his recovery is more than twice as large as it would have been had he been injured by the average driver under the present tort system.[69] Furthermore, his premium has not changed.

Section 2(b)(1)(B) describes the PIP system, the alternative to the TMC system. Under this system, accident victims are compensated by their own insurers for their medical bills and lost wages up to the limits of their policies, regardless of fault. The collection of benefits from one's own insurer (called first party benefits) is the way most insurance works, such as health insurance or homeowners insurance. Once PIP insureds have exhausted their first party benefits, they can sue other drivers for any economic loss not covered by their policies and they, too, may only be sued by other drivers for uncompensated economic loss. PIP does not pay benefits for noneconomic loss,[70] nor can one sue or be sued for noneconomic loss. The resulting elimination of most lawsuits, along with the attendant attorneys' fees on both sides, pain and suffering damages (which are paid largely for minor injuries) and the fraud generated by the incentives of pain and suffering damages, enables PIP insureds to have substantial reductions in premiums, recover benefits more

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69. The TMC system would provide better compensation even in the twenty-one states that permit uninsured and underinsured motorist coverage to make up the difference between the person's loss and the recovery from the other driver. First, the injured individual would recover more for one's uncompensated economic loss against the PIP driver's bodily injury liability policy than one would recover against another driver in today's tort system because the definition of uncompensated economic loss calls for the payment of such losses *plus* a reasonable attorney's fee; i.e., there is no offset from the damages recovered under this system for attorneys' fees. Second, the bill permits uninsured and underinsured motorist coverage to be a third source of payment when a TMC insured exhausts TMC and the other driver's liability coverage.

70. While the basic system does not provide for first party benefits for noneconomic loss, an insured could choose to purchase such coverage for an additional premium. Under one view, first party coverage for noneconomic loss would be more valuable because it would cover all such injuries, not just those caused by another's negligence. And, according to an informal estimate by an actuary of a large insurer, PIP plus a schedule of benefits for noneconomic loss in serious injury cases would be less expensive than traditional tort liability insurance, in part because there would be no (or low) legal costs associated with the payment of noneconomic loss.

quickly, and even receive better compensation for serious injuries, as demonstrated below.

PIP insureds will receive better benefits in serious injury cases on average even if they choose the minimum permissible level of benefits because they will have two pots of money to recover against: (1) their own PIP benefits, which would cover them even when they would not be eligible to recover under the tort system, and (2) the other driver's coverage for any uncompensated economic loss, when the other driver is at fault.

To demonstrate this fact, one need only reverse the above example and assume that Jack is at fault and Jill is free from fault in the accident. In today's tort system, when Jill suffers $100,000 in medical bills, she sues Jack. Average driver Jack has $60,000 of coverage and pays Jill the full $60,000 of his policy limits. Jill then pays her attorney $20,000 for a contingency fee. So Jill nets $40,000, or 40% of her economic loss.

Now let's examine what would happen to Jill if she elects the new PIP option. Furthermore, let's assume that Jill elects the minimum amount of required PIP benefits (about $25,000)[71] and Jack elects TMC. When Jack causes her injury, Jill first collects $25,000 in PIP benefits from her own insurer. Then she sues Jack for the remaining $75,000 of economic loss. Jack's insurance pays her his full policy limits of $60,000. Thus, Jill nets $85,000, or about twice as much as she would have received under the tort system.[72] Furthermore, her insurance costs about half the amount her tort liability insurance used to cost.[73]

Furthermore, as noted above, if the average driver chose to purchase PIP but forgo the cost savings and, instead, spend the same amount of money on PIP benefits that one is spending on bodily injury premiums under the tort

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71. As of 1996, twenty-four states had long-standing 25/50 financial responsibility limits. The next largest number—ten—require 20/40. *See* Jeffrey O'Connell, et al., *The Comparative Costs of Allowing Consumer Choice for Auto Insurance in All Fifty States*, 55 MD. L. REV. 160, 214-222, app. C, tbl. XX (1996).

72. Jill's recovery would be the same if Jack were a PIP driver because PIP drivers may sue each other for uncompensated economic loss on a fault basis. If Jill's injury had occurred prior to enactment of Auto Choice in a tort state in which uninsured motorist coverage and underinsured motorist coverage paid the difference between the other driver's coverage and her loss, then the recovery would have been about the same—$80,000 ($40,000 from Jack and $40,000 from her uninsured or underinsured motorist coverage) if Jill did not have MedPay or $85,000 if she carried the median amount of MedPay—but Jill would have paid only half as much for PIP as she would have paid for bodily injury liability and MedPay insurance under the tort system.

73. CARROLL & ABRAHAMSE, *supra* note 5, at 20.

system today, one could afford to buy approximately $300,000 of PIP benefits, according to one informal estimate by the chief actuary of a large auto insurer. In the accident scenario described above, the PIP insured would then be entitled to up to $300,000 in benefits to cover a serious injury, as contrasted with only $40,000 if one were hit by the average tort driver today. That is seven and one half times the amount of protection for the same price. Moreover, such coverage would be far more valuable because it would compensate the seriously injured person no matter how the injury occurred, and the PIP insured's recovery would not be dependent upon the other driver's choice of coverage limits.

Of course, seriously injured persons would be better off in the 30 percent of accidents in which there is no tort recovery either because there was no tortfeasor or because the injured person was legally at fault. Depending on the choice of coverage, one would receive between $25,000 and $300,000 of guaranteed first party benefits. The case of Robert DeMichelis, Jr. is illustrative. As his father, Robert DeMichelis, testified at a Senate hearing:

> Robert, at age 23, 18 years ago, was in the prime of his life, had just graduated from college, had accepted a job with a Big 8 accounting firm in Chicago. The car that he was driving careened off a metal guard railing and veered into a concrete abutment dividing the east-west lanes of a four-lane major highway. Robert had a serious head injury. It was diagnosed subsequently as a closed-head injury, with frontal and parietal lobe damage.
>
> He was in the hospital for 5 weeks. The first 2 weeks he was in a coma. Doctors were able to stem the brain swelling without surgery. From that point, we transferred him to the George Washington University Hospital here in Washington, and he underwent 3 more weeks of rehabilitation. He spent a month at the Psychiatric Institute, exhausting all of his psychiatric benefits under his health insurance policy. He ended up exhausting all of his other benefits under his health insurance policy, and still has not achieved 100 percent recovery.
>
> And yet, while his employer's health insurance paid for the majority of his health insurance expenses until the policy capped, he had no benefit from his automobile insurance policy. If he had a first party protection insurance policy, such as that offered to consumers in this bill, it would have

been a much different story and a much more rapid recovery.[74]

In section 2(b)(2), the Congress also finds that it is the purpose of this bill to preserve the rights of States to regulate the business of auto insurance.[75] The bill is designed to expand the options of insurance consumers, not to get the federal government into the business of insurance regulation.

SEC. 3. DEFINITIONS

Section 3 of H.R. 1704 sets forth the definitions of the terms that are key to understanding this bill. Most of the definitions are also discussed in the substantive sections where the terms are used most frequently and most of them are self-explanatory. The commentary for this section discusses some frequently used terms that are not self-explanatory and therefore might need explanation.

In this Act:

(1) ACCIDENT.—The term "accident" means an unforeseen or unplanned event that—

(A) causes injury; and

(B) arises from the operation, maintenance, or use of a motor vehicle.

"Accident" means an unforeseen or unplanned event from the point of view of the injured person that causes injury and arises from the use of a motor vehicle.

(2) ADD-ON LAW.—The term "add-on law" means a State law that provides that persons injured in motor vehicle accidents—

(A) are compensated without regard to fault for economic loss; and

(B) have the right to claim without any limitation for noneconomic loss based on fault.

"Add-on law" is a term some use to apply to the ten states that require or encourage insurers to offer no-fault benefits but do not restrict the right to sue. The term is used in section 10 (b)(2)(B), when the cost of premiums in those states is compared to the projected cost of PIP premiums.

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74. *The Auto Choice Reform Act: Hearing on S. 625 Before the Senate Comm. on Commerce, Science, and Transportation*, 105th Cong. 57-58 (1998) (testimony of Robert J. DeMichelis).

75. *See infra* section 9(b).

(3) COLLATERAL SOURCE.—The term "collateral source" means a person, other than a tortfeasor or a motor vehicle insurer, that has a legal obligation to pay compensation for economic loss to a person who is injured in an accident.

(4) COMMON CARRIER.—The term "common carrier" means a motorized vehicle of any kind, licensed for highway use, that is—

(A) required to be registered under the provisions of applicable State law relating to motor vehicles; and

(B) used in the business of transporting persons.

(5) ECONOMIC LOSS.—The term "economic loss" means objectively verifiable pecuniary loss caused by an accident for—

(A) reasonable and necessary medical and rehabilitation expenses;

(B) loss of earnings;

(C) funeral costs; and

(D) replacement services loss.

"Economic loss" means objectively verifiable pecuniary loss, as opposed to noneconomic loss, which is for subjective, nonmonetary losses. The pecuniary elements are defined and are recoverable under a PIP policy.

(6) ELECTRONIC SIGNATURE.—The term "electronic signature" means any letters, characters, or symbols executed or adopted by a party with an intent to authenticate a writing that are—

(A) manifested by—

(i) electronic means; or

(ii) any other similar means; and

(B) logically associated with that writing.

(7) FINANCIAL RESPONSIBILITY LAW.—The term "financial responsibility law" means a law (including a law requiring compulsory coverage) penalizing motorists for failing to carry defined limits of tort liability insurance covering motor vehicle accidents.

"Financial responsibility law" means a State law that penalizes certain motorists for failing to carry specified limits of tort liability insurance with respect to an accident. It includes both compulsory insurance laws, which forty-six states have, and financial responsibility laws under which a person

is not required to carry insurance but can be severely penalized if the uninsured injures someone in an accident.[76]

(8) FIRST PARTY BENEFITS.—The term "first party benefits" means benefits paid or payable by an insurer to an insured of that insurer under a personal injury protection policy or a tort maintenance coverage policy applicable to that insured.

"First party benefits" refer to insurance benefits that one's own insurer is obligated to pay in the event of an auto accident. They can be either PIP benefits, which are first party, non-fault-based benefits, or TMC benefits, which, like uninsured motorists' coverage, are paid by one's own insurer but only on the basis of another's fault.[77]

(9) INJURY.—The term "injury" means bodily injury, sickness, disease, or death.

(10) INSURER.—The term "insurer" means any person who is engaged in the business of issuing or delivering motor vehicle insurance policies (including an insurance agent, if appropriate) under applicable State law.

(11) MOTOR CARRIER..—The term "motor carrier" means—

(A) a person who—

(i) transports by motor vehicle goods for another person or entity for compensation; and

(ii) is liable for the operation of the vehicle under part 387 of title 49, Code of Federal; or

(B) a person who transports such person's goods by a motor vehicle that such person owns or leases.

(12) MOTOR VEHICLE.—The term "motor vehicle" means a vehicle with 4 or more wheels licensed for highway use that is required to be registered under the provisions of the applicable State financial responsibility law relating to motor vehicles.

(13) NAMED INSURED.—The term "named insured" means a person designated by name in a personal injury protection policy or tort maintenance coverage policy as the insured.

(14) NO-FAULT MOTOR VEHICLE LAW.—The term "no-fault motor vehicle law" means a State law that provides that—

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76. O'Connell et. al., *supra* note 71, at 221-22.

77. First party benefits are in contrast to third party benefits wherein benefits are paid by a third party's insurer, as in tort liability insurance.

(A) persons injured in motor vehicle accidents are paid compensation without regard to fault for their economic loss that results from injury; and

(B) in return for the payment referred to in subparagraph (A), claims based on fault, including claims for noneconomic loss, are limited to a defined extent.

(15) NONECONOMIC LOSS.—The term "noneconomic loss" means subjective, nonmonetary losses recognized under applicable State tort law.

"Noneconomic loss" means subjective, nonmonetary losses recognized under applicable State tort law (principally pain and suffering).

(16) OCCUPY.—The term "occupy" means, with respect to the operation, maintenance, or use of a motor vehicle, to be in or on a motor vehicle or to be engaged in the immediate act of entering into or alighting from a motor vehicle.

(17) OPERATION, MAINTENANCE, OR USE OF A MOTOR VEHICLE.—

(A) The term "operation, maintenance, or use of a motor vehicle" means any activity involving or related to the transportation by a motor vehicle; and

(B) Such term includes occupying or being engaged in the immediate act of entering into or alighting from a motor vehicle before or after its use for transportation.

(C) Such term does not include —

(i) conduct within the course of a business of manufacturing, sale, repairing, servicing, or otherwise maintaining motor vehicles, unless the conduct occurs outside the scope of the business activity; or

(ii) conduct within the course of loading or unloading a motor vehicle, unless the conduct occurs while occupying or being engaged in the immediate act of entering into or alighting from a motor vehicle before or after its use for transportation.

(18) PERSON.—The term "person" means any individual, corporation, company, association, firm, partnership, society, joint stock company, or any other entity, including any governmental entity.

(19) PERSONAL INJURY PROTECTION.—The term "personal injury protection" means insurance that provides for—

(A) benefits to a personal injury protection insured for economic loss without regard to fault for injury resulting from a motor vehicle accident in accordance with this Act;

(B) a waiver of tort claims against other drivers, other than—

(i) claims for uncompensated economic loss based on fault; and

(ii) other tort claims exempted from such a waiver under this Act;

(C) coverage against claims for uncompensated economic losses based on fault by another party that is entitled to recover those losses under this Act; and

(D) coverage against claims for economic or noneconomic losses of a third party with respect to which the recovery of those losses is not covered under this Act.

(21) PERSONAL INJURY PROTECTION INSURER.—The term "personal injury protection insurer" means an insurer who is engaged in the business of providing personal injury protection.

(22) PERSONAL INJURY PROTECTION SYSTEM.—The term "personal injury protection system" means the insurance system described in section 6.

(23) REPLACEMENT SERVICES LOSS.—The term "replacement services loss" means expenses reasonably incurred in obtaining ordinary and necessary services from other persons who are not members of the injured person's household, in lieu of the services the injured person would have performed for the benefit of the household.

(24) RESIDENT RELATIVE OR DEPENDENT.—

(A) The term "resident relative or dependent" means a person—

(i) who is related to the named insured by blood, marriage, adoption, or otherwise (including a dependent receiving financial services or support from such insured); and

(ii) who—

(I) resides in the same household as the named insured at the time of the accident; or

(II) usually makes a home in the same family unit as the named insured, even though that person may temporarily live elsewhere.

(B) Such term does not include any person who maintains or is required to maintain insurance for a motor vehicle that such person owns.

(25) STATE.—The term "State" means any State of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the United States Virgin Islands, American Samoa, the Commonwealth of the Northern Mariana Islands, the Trust Territories of the Pacific Islands, and any other territory or possession of the United States.

(26) TORT LIABILITY.—The term "tort liability" means the legal obligation to pay damages for an injury in an accident adjudged to have been caused by a tortfeasor, under applicable State law.

(27) TORT LIABILITY INSURANCE.—The term "tort liability insurance" means a contract of insurance under which an insurer agrees to pay, on behalf of an insured, damages that the insured is obligated to pay to a third person because of the liability of the insured to that person.

(28) TORT MAINTENANCE COVERAGE.—The term "tort maintenance coverage" means insurance coverage under which a tort maintenance insured, if involved in an accident with a personal injury protection insured, may recover first party benefits for economic losses from the insurer of that insured, based on fault under applicable State law.

(29) TORT MAINTENANCE INSURED.—The term "tort maintenance insured" means a person covered by the form of insurance described in section 6.

(30) TORT MAINTENANCE SYSTEM.—The term "tort maintenance system" means an insurance system described in section 7.

(31) UNCOMPENSATED ECONOMIC LOSS.—

(A) The term "uncompensated economic loss" means any objectively verifiable pecuniary loss payable based on fault under applicable State tort law, except for any such

loss that is determined by a court of competent jurisdiction to be, in whole or in part, a product of fraudulent activity by the person making the claim.

(B) Such term includes a reasonable attorney's fee calculated on the basis of the time actually expended and the value of the attorney's efforts as reflected in payment to the attorney's client, other than any attorney's fees when the uncompensated economic loss is attributable only to a deductible for coverage specified in subparagraph (C)(i).

(C) Subject to section 8(j)(2), the term does not include amounts paid or payable under—

(i) personal injury protection;

(ii) tort maintenance coverage;

(iii) no-fault or add-on motor vehicle insurance;

(iv) Federal, State, or private disability or sickness programs;

(v) Federal, State, or private health insurance programs;

(vi) employer wage continuation programs; or

(vii) workers' compensation or similar occupational compensation laws.

"Uncompensated economic loss" means economic loss that is not compensated by any source, either one's own auto insurance or other insurance obligated to pay for the loss, such as health insurance or workers' compensation. To reduce the incentives to run up false medical bills in order to recover for them — and a reasonable attorney's fee — the definition excludes does not include any such loss that a court determines is the product of fraudulent activity by the person making the claim. The term is augmented by a reasonable attorney's fee to the extent necessary to recover uncompensated economic loss. The attorney's fee provision assures that an injured person will not have to pay the attorney out of monies that would otherwise compensate one for economic loss. The fee should be related to the time and effort actually expended and the value thereof in terms of the client's payment. No attorney's fee is payable by an insurer when the sole amount of uncompensated economic loss is within the amount of a person's choice of a deductible—a choice a person makes to reduce the cost of insurance premiums. That is a decision that the person makes voluntarily and

it is not the purpose of this bill to create a cottage industry for attorneys to seek fees to recover deductibles.

In the bill, the term is commonly used to identify the amounts either a PIP or TMC insured may claim for when one's own benefits are inadequate to cover the loss. While such a person may not sue for any damages already paid by one's health insurer, section 8(j)(2) authorizes a health insurer to seek subrogation for those benefits directly from the insurer of an at-fault driver. In this way, the auto insurance system internalizes the losses caused by auto crashes but does so in a way that discourages the inflating of claims and the filing of lawsuits, as would happen if the accident victim could collect twice.

> **(32) UNINSURED MOTORIST.—The term "uninsured motorist" means the owner of a motor vehicle, including the resident relatives or dependents of the owner, who is uninsured under either the personal injury protection system described in section 6 or the tort maintenance system described in section 7—**
>
> **(A) at the limits prescribed by the applicable State financial responsibility law; or**
>
> **(B) an amount prescribed under section 6(a)(1).**

SEC. 4. AUTO CHOICE INSURANCE SYSTEM

Section 4 sets forth the basic elements of the Auto Choice system.

> **(a) OPERATION OF THE RIGHT TO CHOOSE.—**
>
> **(1) IN GENERAL.—Under this Act, an insurer may offer a choice between—**
>
> **(A) the personal injury protection system described in section 5; and**
>
> **(B) the tort maintenance system described in section 6.**
>
> **(2) ELECTION BY SELF-INSURED PERSONS.—A self-insured person, as determined under an applicable State law, may elect coverage under paragraph (1) by filing a notice with the appropriate State or Federal agency.**
>
> **(3) EFFECT OF ELECTION BY ELECTRONIC MEANS.—For purposes of making an election of an insurance system under this subsection, unless prohibited by applicable State law, an electronic signature shall have the same force and effect as a handwritten signature.**

Section 4(a)(1) specifically provides that an insurer may offer a choice between a PIP system and a TMC system. No insurer is obligated to offer

PIP coverage although it is anticipated that competition will result in most if not all insurers offering it. Section 4(a)(2) authorizes a self-insured person, such as a large business, to elect either system by filing an appropriate notice. For most self-insureds, that notice would be filed with the State insurance commissioner. For interstate trucking operations that are currently regulated by the Federal Highway Administration (FHA), the notice would be filed with the FHA.

Section 4(a)(3) provides that, unless a State law prohibits it, an electronic signature shall have the same force as a handwritten signature. This provision is designed to facilitate business in the world of electronic commerce.

(b) EFFECT OF CHOICE ON RESIDENT RELATIVES OR DEPENDENTS.—

(1) IN GENERAL.—Except as provided in paragraph (2), a person who chooses either the personal injury protection system or the tort maintenance system also binds the resident relatives or dependents of that person.

(2) EXCEPTION.—An adult resident relative or dependent of a person described in paragraph (1) may select the form of insurance that such person does not select if the adult resident relative or dependent makes that selection expressly in writing to the insurer.

(3) TERMS AND CONDITIONS.—Insurers may specify reasonable terms and conditions governing the commencement, duration, and application of the chosen coverage depending on the number of motor vehicles and owners of such vehicles in a household.

Section 4(b) establishes a general rule that the choice of the insured also binds the resident relatives or dependents of the person who makes the election. In this way, all members of a family will be covered by the same policy as the insured, just as they are today. However, an adult resident relative or dependent who wishes to make a different election may do so, so long as it is done expressly in writing before one suffers an injury in an accident.

(c) UNIFORMITY RULES.—

(1) IN GENERAL.—Notwithstanding subsection (b)(2), and in order to minimize conflict between the insurance options, an insurer may maintain and apply underwriting rules that encourage uniformity in the provision of insurance benefits within a household.

(2) UNIFORMITY IN INSURANCE IN EMPLOYMENT.—Except as provided in paragraph (6), an employer that elects an insurance option described in subparagraph (A) or (B) of subsection (a)(1) binds the employees of that employer for purposes of coverage of that employee in the course of employment by that employer.

(3) UNIFORMITY IN INSURANCE FOR MOTOR CARRIERS.—Except as provided in paragraph (6), a motor carrier that elects an insurance option described in subparagraph (A) or (B) of subsection(a)(1) binds any owner, operator, or occupant of a motor vehicle operated by that motor carrier.

(4) UNIFORMITY IN INSURANCE FOR COMMON CARRIERS.—Except as provided in paragraph (6), an owner of a common carrier that elects an insurance option described in subparagraph (A) or (B) of subsection (a)(1) binds the owner and any operator or occupant of that common carrier.

(5) UNIFORMITY IN INSURANCE FOR MOTOR VEHICLE RENTALS.—

(A) IN GENERAL.—Except as provided in subparagraph (B), a person who is engaged in the business of renting motor vehicles and who elects an insurance option described in subparagraph (A) or (B) of subsection (A)(1) binds any operator or occupant of the rented motor vehicle with respect to the operation of that vehicle.

(B) EXCEPTION.—Subparagraph (A) shall not apply if a customer who rents a motor vehicle—

(i) specifically elects to obtain coverage within the rental agreement other than the coverage elected by the person engaged in the business of renting the motor vehicle; and

(ii) pays a separate charge for that optional coverage.

(6) RIGHT OF EMPLOYEES, OPERATORS, AND CERTAIN OCCUPANTS TO PURCHASE ADDITIONAL COVERAGE—

(A) EMPLOYEES.—An employee under paragraph (2) may elect to purchase separate personal injury protection or tort maintenance coverage in excess of the insurance provided by the employer in the scope of the employment of that employee.

(B) OPERATORS AND OCCUPANTS OF MOTOR CARRIERS.—An operator or occupant of a motor carrier under paragraph (3) may elect to purchase separate personal injury protection or tort maintenance coverage in excess of the insurance provided to that operator or occupant by the motor carrier as an operator or occupant of that motor carrier.

(C) OPERATORS AND OCCUPANTS OF COMMON CARRIERS.—An operator or occupant of a common carrier under paragraph (4) may elect to purchase separate personal injury protection or tort maintenance coverage in excess of the insurance provided to that operator or occupant by the owner of the common carrier as an operator or occupant of the common carrier.

(D) EFFECT OF ELECTION.—The election by an employee, operator, or occupant to purchase insurance coverage under this paragraph shall not affect the liability of an employer, motor carrier, or common carrier.

Section 4(c) authorizes insurers to apply underwriting rules that minimize conflicts between the two insurance options. For example, an insurer could offer a discount to a family where all its members have the same type of insurance, whether the PIP or TMC system. Such a discount would reflect the insurer's lower claims costs.

Sections 4(c)(2), (3), (4) and (5) provide that the election of an insurance option by an employer, motor carrier, common carrier or rental car company binds those who use or occupy those vehicles. For private passenger vehicles, the insurance "follows the person" in that if Jack is a passenger in Jill's car, she collects from her own PIP or TMC insurance. In the case of the motor vehicles referred to in sections 4(c)(2), (3)), (4) and (5), the insurance "follows the vehicle" in that if Jack is in Jill's truck, bus or taxi, he collects from Jill's insurer based on Jill's choice of PIP or TMC.[78] It seems rational for the owner of such vehicle to be the source and determinant of the applicable coverage. Note that in employment situations, employees will have the benefit of both workers' compensation and the new PIP or TMC insurance carried by the employer.

78. This rule is memorialized in section 8(i). *See infra* section 8(i).

Section 4(c)(5) addresses motor vehicle rentals. It provides that the person engaged in the business of renting motor vehicles selects the insurance option for any coverage it is required to maintain on the vehicle under State law.[79] The provision does not change existing law with respect to whether the rental car company's coverage is primary or secondary, i.e., whether its coverage pays first or only after the driver's own coverage when it, too, is liable for the loss. State law will continue to cover this matter. This section also would not change the nature of the driver's coverage on one's personal vehicle, to the extent that such coverage would apply when the driver was driving the rental car. It simply binds all operators and occupants of the vehicle with respect to any losses incurred under coverage provided by the rental car company. Customers may purchase a different coverage than that chosen by the rental company, but they must do so in the rental agreement and pay a separate charge for it.

Section 4(c)(6) authorizes employees and operators and occupants of motor carriers and common carriers to purchase coverage in addition to that provided by the owner of the vehicle. In addition, section (8)(i)(2)(B) of the bill provides that employees and operators and occupants of motor carriers or common carriers may claim PIP or TMC benefits from their own insurance, to the extent that their coverage exceeds that of the employer, motor carrier or common carrier.

(d) FAILURE TO ELECT TYPE OF INSURANCE.—

(1) IN GENERAL.—Except as provided in subsection (b)(1), any person who fails to elect a type of insurance under subsection (a)(1) shall be deemed to have elected insurance under the tort maintenance system in effect in the State of that person's residence.

(2) RULE OF CONSTRUCTION.—This subsection shall not be construed to prevent a State from enacting a law that deems a person who fails to elect a type of insurance under this section to have elected insurance under the personal injury protection system.

Section 4(d) provides that any person who fails to elect either the PIP or TMC system "shall be deemed to have elected the tort maintenance system in effect in the State of that person's residence." A "default" provision is needed because some people will fail to choose a particular form of coverage

79. This section would not require a rental car company to provide insurance where there is no such requirement under State law.

when Auto Choice becomes law in their State. This provision will default such people into the TMC system, the type of insurance which most closely resembles the system in their State prior to the time this law goes into effect in their State. In other words, in order to be covered by PIP, an insured will have to make an affirmative election of same. In contrast, two of today's three choice states—Kentucky and New Jersey—make the no-fault option the default position. Pennsylvania, the third choice state, makes the tort option the default position. Accordingly, section 4(d)(2) specifically authorizes a State to reverse that presumption and make the PIP system the default position for persons who fail to elect a particular type of insurance.

(e) CONSUMER INFORMATION PROGRAM.—

(1) STATE PROGRAM.—The State official charged with jurisdiction over insurance rates for motor vehicles may establish and maintain a program designed to ensure that consumers are adequately informed concerning—

(A) the comparative cost of insurance under the personal injury protection system and the tort maintenance system; and

(B) the benefits, rights, and obligations of insurers and insureds under each such system.

(2) INSURER PROGRAM.—An insurer that offers a choice of insurance systems under subsection (a)(1) shall provide to each consumer, before that consumer chooses motor vehicle insurance, written consumer information to ensure that consumers are adequately informed about—

(A) the comparative cost of insurance under the personal injury protection system and the tort maintenance system; and

(B) the benefits, rights, and obligations of insurers and insureds under each system.

(3) ADEQUATE NOTICE.—If an insurer files consumer information forms under paragraph (2) with the State official charged with jurisdiction over insurance rates for motor vehicles, and such forms are not disapproved within a reasonable period of time after that filing, such filing and use of the information in accordance with paragraph (2) shall be presumed to be adequate notice.

In order that consumers may have the proper information to make an informed choice, section 4(e) authorizes—but does not require—the State

insurance commissioner to establish a program to ensure that consumers are adequately informed of the comparative costs and benefits of the PIP and TMC systems. In addition, section 4(e)(2) requires insurers that offer a choice of systems to provide consumers with written information about the costs and benefits of the two systems before the consumer makes a choice. If an insurer files such consumer information forms with the State insurance commissioner, such filing is presumed to be adequate notice if the commissioner does not disapprove the forms within a reasonable period of time after filing. This provision is intended to encourage the provision of information to consumers so they can make informed decisions.

> **(f) SUPERSEDING PROVISION.—Subject to section 10, this Act supersedes a State law to the extent that the State law is otherwise inconsistent with the requirements of this Act.**

Section 4(f) provides generally that Auto Choice supersedes State law only to the extent that the State law is otherwise inconsistent with the provisions of the Auto Choice Reform Act. Moreover, section 10 provides states with a number of options for opting out of Auto Choice entirely.

SEC. 5. PERSONAL INJURY PROTECTION SYSTEM

Section 5 sets forth the basic elements of the new PIP system, one of the two choices authorized by this bill.

> **(a) MINIMUM POLICY REQUIREMENTS.—In order to constitute a personal injury protection policy covered by this Act, a motor vehicle insurance policy issued by an insurer shall, at a minimum—**
>
> **(1) for each accident, provide personal injury protection benefits to each personal injury protection insured in amounts equal to—**
>
> **(A) the minimum per person limits of liability insurance for personal injury under the relevant State financial responsibility law applicable to private passenger vehicles; or**
>
> **(B) in a State covered by a no-fault motor vehicle law, the minimum level of insurance required for no-fault benefits;**
>
> **(2) contain provisions for a waiver of tort claims against drivers other than the insured, except—**
>
> **(A) claims for uncompensated economic loss based on fault; or**

(B) other tort claims exempted from such a waiver under this Act;

(3) contain provisions for third party liability coverage in amounts equal to the minimum limits required under applicable Federal or State financial responsibility law for—

(A) property damage; and

(B) bodily injury to cover—

(i) uncompensated economic losses for parties who are entitled to recover such losses under this Act; and

(ii) economic and noneconomic losses of third parties whose recovery is not affected by this Act.

Section 5(a) establishes the minimum requirements whereby an auto insurance policy qualifies as a PIP policy. The policy must meet specific requirements for PIP benefits, contain limits on the right to sue and be sued and meet State bodily injury and property damage liability requirements. Section 5 (a)(1)(A) provides that in a tort state the minimum PIP benefits must equal the minimum amount of benefits for liability insurance for personal injury under the State's financial responsibility law. Tort states typically require drivers to purchase bodily injury liability insurance of either "25/50" or "20/40." "25/50" means coverage of $25,000 per person payable to another person if the policyholder is responsible for that person's injuries in a given accident, or $50,000 per accident for the injuries of two or more persons in the same accident. A qualifying PIP policy in a 25/50 state would provide $25,000 of PIP benefits, payable without regard to fault, for each member of an insured's family for each accident that a PIP insured might be involved in during the life of the insurance policy.[80] Under PIP, unlike traditional tort liability insurance, there is no per-accident limit, in that the applicable limit is available to any and all eligible claimants.

Section 5(a)(1)(B) provides that in a no-fault state the minimum PIP benefits must be the PIP limits required by State law. For example, in New York the minimum PIP benefit would remain at $50,000.[81]

Section 5(a)(2) contains the PIP requirements for waivers of tort claims against other drivers. Paragraphs (A) and (B) state the situations in which the waiver would not be honored, that is, where a PIP insured may maintain a lawsuit. Paragraph (A) permits a PIP insured to sue any other driver, PIP or TMC, for uncompensated economic loss. Paragraph (B) permits a PIP

80. *See* O'Connell et. al., *supra* note 71.

81. *Id.* at 218; *see also id.* at 173 n.h.

insured to sue other persons for tort claims that are exempted from the general waiver. The latter category would include drivers who are intoxicated or under the influence of illegal drugs, those who inflict intentional injury, uninsured motorists, lawfully uninsured persons such as many pedestrians and motorcyclists who do not elect the PIP option. In those cases, a PIP insured may sue for all tort damages, both economic and noneconomic.

Section 5(a)(3) contains the requirement that a PIP policy cover third party liability for property damage and residual bodily injury liability claims in amounts equal to the minimum limits required under applicable Federal or State financial responsibility law. The majority of states require people to carry $10,000 of property damage liability coverage.[82] However, Federal law establishes much higher minimum financial responsibility limits applicable to "for hire carriers." For example, the financial responsibility requirement for carriers of non-hazardous property is $750,000, while it is $5 million for transporters of hazardous substances.[83] Under this section, these liability requirements remain in place.

The residual bodily injury liability coverage covers most of the same situations identified in the waiver of tort claims section above. Thus, a PIP driver may be sued for uncompensated economic loss on a fault basis by either another PIP driver or a TMC driver. Also, a PIP driver who is driving under the influence of alcohol or illegal drugs may be sued for both economic and noneconomic loss. In addition, a lawfully uninsured person, such as a pedestrian who is not a member of a car-owning family, may sue an at-fault PIP driver for both economic and noneconomic loss.

(b) PRIMACY OF PAYMENT.—

(1) IN GENERAL.—

(A) PERSONAL INJURY PROTECTION BENEFITS.—

(i) IN GENERAL.—Except as provided in subparagraph (B), in any case in which a personal injury protection insurer and a collateral source are obligated to pay benefits for the same economic loss under this Act, the personal injury protection insurer shall be liable for the primary payment of benefits to cover that economic loss.

(ii) LIABILITY OF COLLATERAL SOURCES.—A collateral source shall be liable for economic loss only

82. *Id.* at 214-22.

83. 49 C.F.R. § 387.9 (2000).

to the extent that that loss exceeds benefits paid or payable by an insurer under an applicable personal injury protection insurance policy.

(B) EXCEPTION.—Personal injury protection benefits shall be reduced by an amount equal to any benefits provided or required to be provided under—

(i) an applicable Federal or State law for workers' compensation;

(ii) any State-required nonoccupational disability insurance; or

(iii) any occupational disability insurance covering professional drivers of motor vehicles who are independent contractors.

(2) REIMBURSEMENT OF PAYORS.—

(A) IN GENERAL.—A personal injury protection insurer may take appropriate measures to ensure that any person otherwise eligible for personal injury protection benefits who has been paid or is being paid for losses payable by personal injury protection from a source other than the applicable personal injury protection insurer shall not receive multiple payment for those losses.

(B) ACCRUAL OF RIGHTS.—Any right to payment for loses referred to in subparagraph (A) from a personal injury protection insurer accrues only to that payor. Payments by a payor referred to in subparagraph (A) shall not be counted against personal injury limits for personal injury protection until such time as the payor is reimbursed under this subparagraph.

(3) PROTECTION AGAINST DUPLICATION.—Upon receipt of reasonable notice, a personal injury protection insurer shall reimburse a collateral source for payments made by that collateral source for economic loss for injury resulting from a motor vehicle accident, to the extent that the personal injury protection insurer is obligated to pay for that economic loss.

Section 5(b) establishes rules for the primacy of payment, i.e., which insurer is obligated to pay first when more than one insurer is legally liable to pay for injuries in an accident. A typical example is one whereby a PIP insurer and a health care insurer (a collateral source) are both obligated to pay

the same benefits. In such a situation, section 6(b)(1)(A) establishes the general rule that the PIP insurer shall be primarily liable. A PIP insurer is obligated to pay for economic loss up to the limits of the insured's policy and then the health insurer is obligated to pay any additional amounts. For example, if a person suffers $30,000 of injuries in an auto accident and has a PIP policy that covers $25,000, the PIP insurer is legally liable to pay $25,000. Thereafter, the health insurer picks up the additional $5,000. If the PIP insured's losses are only $10,000, then the PIP insurer meets the full obligation and the health insurer would have no responsibility for payment.

Section 5(b)(1)(B) provides an exception for workers' compensation and other similar disability insurance. These forms of insurance, which are collateral sources, would be primary to one's own PIP coverage. This exception addresses the fact that these programs have long been established to cover employee-related auto accidents.

Section 5(b)(2) addresses the situation when an injured person files a claim with a collateral source for benefits the PIP insurer is already obligated to pay. This section is designed to discourage duplicate payments for the same losses. For example, the PIP insurer can refuse to pay its insured when it is aware that the insured has already recovered its losses from a collateral source.

Section 5(b)(3) addresses the right of a collateral source that has paid benefits a PIP insurer is obligated to pay to get reimbursed by the PIP insurer. Under this section, a PIP insurer must reimburse a collateral source once it receives reasonable notice that the collateral source has paid these benefits.

(c) PROMPT AND PERIODIC PAYMENT.—

(1) IN GENERAL.— personal injury protection insurer may pay personal injury protection benefits periodically as losses accrue.

(2) LATE PAYMENT.— Except as provided in section 7, a personal injury protection insurer that does not pay a claim for personal injury protection benefits during the 30-day period beginning on the date on which that insurer received a submission of reasonable proof of the loss for which those benefits are payable, shall pay—

(A) the loss compounded at a rate of 24 percent per annum as liquidated damages; and

(B) a reasonable attorney's fee calculated on the basis of the time actually expended or the value of the attorney's efforts as reflected in payment to the attorney's client.

(3) ADMINISTRATION OF PERSONAL INJURY PROTECTION BENEFITS.—To the extent consistent with this Act, any applicable provision of a State no-fault motor vehicle law or add-on law governing the administration of payment of benefits without reference to fault shall apply to the payment of benefits under personal injury protection under this subsection.

Section 5(c) assures the prompt payment of economic loss by providing that PIP insurers must pay claims within 30 days of submission of reasonable proof of loss. If the insurer fails to pay, insureds may go to court. They would be entitled to payment of the benefits, a penalty for delay of 24% of the loss per year as liquidated damages, and a reasonable attorney's fee. The penalties for late payment do not apply to claims that a court determines are the product of fraudulent activity by the insured.

(d) AUTHORIZATIONS FOR DEDUCTIONS AND EXCLUSIONS.—

(1) IN GENERAL.—A personal injury protection insurer may write personal injury protection—

(A)(i) without any deductible; or

(ii) subject to a reasonable deductible; and

(B) with an exclusion of coverage for first party benefits to cover the losses of the personal injury protection insured caused by that insured's—

(i) driving under the influence of alcohol or illegal drugs; or

(ii) driving while seeking to intentionally injure another person.

(2) APPLICABILITY OF DEDUCTIBLES.—The deductibles and exclusions described in paragraph (1) shall apply only to—

(A) the person named in the applicable insurance policy; and

(B) the resident relatives or dependents of the person described in subparagraph (A).

Section 5(d) authorizes PIP insurers to provide for deductions and exclusions in a PIP policy. A PIP insurer may offer a reasonable deductible—a common way of enabling an insured to lower his insurance premium. However, the deductible would not affect the recovery of a third party injured by such conduct by a PIP insured because the exclusion applies

only to the payment of first party PIP benefits and not to third party liability coverage.[84] In addition, a PIP insurer may write a policy to exclude first party coverage for accidents caused by alcohol, illegal drugs, or intentional injury, thus penalizing the PIP insured for such behavior. Here, too, because this section does not change state law with respect to third party liability claims, it would not, for example, penalize a third person injured by the drunk driving of a PIP insured. The third party could still sue for all damages pursuant to section 8(e).

SEC. 6. TORT MAINTENANCE SYSTEM

Section 6 sets forth the basic elements of the TMC system, the other choice authorized by this bill. The TMC system is based on the type of auto insurance required by law in the State immediately prior to the enactment of this bill. Depending on the particular state, that law is characterized today as tort liability insurance, no-fault motor vehicle law or add-on law.

(a) MINIMUM POLICY REQUIREMENTS.—

(1) IN GENERAL.—The coverage for a person who chooses insurance under section 5(a)(1)(B) shall include—

(A) the type of motor vehicle insurance that is otherwise required under applicable State law; and

(B) tort maintenance coverage at a level that is at least equivalent to the level of insurance required under the applicable State financial responsibility law for bodily injury liability.

(2) RESPONSIBILITY FOR PAYMENT UNDER TORT MAINTENANCE COVERAGE.—The responsibility for payment for any claim under tort maintenance coverage is assumed by the insurer of the tort maintenance insured to the extent of such coverage.

Section 6(a) defines the minimum policy requirements for a driver who selects the TMC system: (1) the type of auto insurance coverage presently required in a given state and (2) TMC coverage.

Section 6(a)(1)(B) states that the coverage for a person who elects this choice includes TMC coverage. TMC is a first-party, fault-based coverage that pays for the insured's economic and noneconomic loss if one can establish the other driver's tort liability. The injured person's own insurer

84. Note, however, that section 3(31)(B) provides that a plaintiff is not entitled to a reasonable attorney's fee when the only uncompensated economic loss is a person's deductible.

pays these benefits to the insured, just as it would today under uninsured motorist coverage. As with the minimum requirement for PIP benefits, the minimum level of TMC coverage is at least equal to the level of insurance required under the applicable State financial responsibility law for bodily injury.

> **(b) ADDITIONAL PAYMENTS FROM UNINSURED MOTORIST COVERAGE AND UNDERINSURED MOTORIST COVERAGE.—A tort maintenance insured who also purchases an insurance policy that provides uninsured motorist coverage or underinsured motorist coverage may recover under the terms of that policy for any economic or noneconomic loss arising from an accident involving a personal injury protection insured, in any case in which the amount of those economic or noneconomic losses exceed the aggregate amount recovered or recoverable from the—**
>
> **(1) the tort maintenance coverage of the tort maintenance insured; and**
>
> **(2) personal injury protection insured.**

Section 6(b) authorizes additional payments to a TMC insured under one's uninsured or underinsured motorist coverage. It states that a person who has such coverage can utilize it for any economic or noneconomic loss that is not paid by one's TMC coverage or by another at-fault driver. Thus, a TMC insured would have three potential sources of recovery in an accident when the PIP driver was at fault—(1) first one's own TMC coverage, (2) then the right to sue a PIP driver for uncompensated economic loss and (3) finally one's own uninsured or underinsured motorist coverage. This situation is likely to give a TMC insured far more protection than one has today, at a cost RAND estimates at no higher than one is now paying under the present system[85] (see the examples set forth above in the commentary to section 3, "Purposes").

SEC. 7. PROTECTION AGAINST INSURANCE FRAUD.

After 25-30 years of successful experience with the payment of first party benefits under state no-fault insurance laws, recently a problem has emerged: "Investigations by insurers and law enforcement agencies show that organized crime rings along with a small number of unscrupulous medical providers and attorneys are manipulating the personal injury protection (PIP) part of the New York state no-fault auto insurance plan at the expense of the

85. CARROLL & ABRAHAMSE, *supra* note 5, at 23.

state's policyholders."[86] Florida and New Jersey have reported similar fraudulent activity.[87] The dimensions of the problem are substantial. For example, in 2000, PIP claims costs in New York rose by 32.1%, as contrasted with an 11.1% increase in 1999 and only 4.5% in 1998.[88] The legislation includes several provisions designed to discourage such fraud in the new federally created PIP alternative. These provisions would not apply to the TMC system in no-fault states; the states would maintain the responsibility for addressing those problems.

> **(a) TIMELY SUBMISSION OF CLAIMS FOR FIRST PARTY BENEFITS.—**
>
> **(1) No insurer shall be obligated to pay first party benefits to a personal injury protection insured for any economic loss that occurred more than 60 days prior to the submission of a claim for such loss.**
>
> **(2) The time for submission of a claim shall be tolled during any period during which the insured can show that—**
>
> **(A) the insured was physically unable—**
>
> **(i) to submit proof of the claim; or**
>
> **(ii) to supply the identity of the insurer to the provider of services; or**
>
> **(B) the insured was unable to identify the insurer despite good faith efforts to do so.**

Section 7(a) addresses the situation where fraud rings have taken advantage of state laws that permit claimants up to six months to file claims.[89] The rings have manipulated this provision by submitting nearly six months of bills just prior to the filing deadline, leaving insurers with only 30 days to investigate the claim or risk paying severe penalties for late payment. Section 7(a) requires claimants to file PIP claims within 60 days. This time period should be sufficient to file a claim yet avoid the abuses associated with longer filing times.

> **(b) LOSS OF FIRST PARTY BENEFITS.—No insurer shall be obligated to pay any first party benefits to a personal injury**

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86. Insurance Information Institute, "No-Fault Medical Fraud in New York State: Problems and Solutions" (April 2, 2001), 1 [hereinafter Problems and Solutions].

87. *See, e.g.*, National Underwriter, "Florida Passes Auto Fraud Bill, But Other Initiative Fall Short" (May 14, 2001).

88. Problems and Solutions, *supra* note 86, at 1.

89. *Id.* at 6-7.

protection insured for any economic loss that a court of competent jurisdiction determines is, in whole or in part, the product of fraudulent activity by the insured with respect to an accident.

Section 7(b) assures that people who file dishonest claims will not benefit from their fraudulent activity by eliminating the insurer's obligation to pay for any loss that a court determines is the product of fraudulent activity.

(c) LOSS OF ENTITLEMENT TO PURCHASE INSURANCE.—An insurer may cancel, decline to renew, or refuse to issue a personal injury protection policy to any person who a court of competent jurisdiction has determined has engaged in fraudulent activity with respect to an accident during the previous three years.

Section 7(c) contains a further strong disincentive for engaging in fraudulent activity — it permits insurers to cancel, decline to renew or refuse to issue a PIP policy to any person that a court determines has engaged in fraudulent activity during the previous three years.

SEC. 8. SOURCE OF COMPENSATION IN CASES OF ACCIDENTAL INJURY

Section 8 identifies the sources of compensation for people who are injured under the new Auto Choice system. It helps clarify exactly what compensation PIP and TMC insureds or persons who are uninsured (whether lawfully or not) are entitled to and from what source.

(a) ACCIDENTS INVOLVING PERSONS CHOOSING THE TORT MAINTENANCE SYSTEM.—

(1) IN GENERAL.—A tort maintenance insured who is involved in an accident with another person shall be subject to applicable State law for injury except that, based on fault, that person may, upon submission of proof of insurance—

(A) recover from any personal injury protection insured for uncompensated economic loss (and not for noneconomic loss); and

(B) be liable to a personal injury protection insured for uncompensated economic loss (and not for noneconomic loss).

(2) ALLOCATION OF TORT MAINTENANCE PAYMENTS.—In determining the extent of recovery of a tort maintenance insured from a personal injury protection insured under subsection (b), the payments made to the tort maintenance

insured from tort maintenance coverage shall first be allocable to economic loss, and any remainder may be allocable to noneconomic loss.

Section 8(a)(1) deals with sources of compensation for accidents involving persons who choose the TMC system. There are two basic situations. The first is where a TMC insured is involved in an accident with another TMC insured, an uninsured motorist or a lawfully uninsured person. In these three situations, there would be no change whatsoever in the rules for recovery under existing State law. The TMC insured could sue (and recover or fail to recover) or be sued (and be liable or not liable) just as is the case today.[90]

Section 8(a)(1) also addresses the situation where a TMC insured is involved in an accident with a PIP insured. In that circumstance, if the TMC driver can prove that the PIP driver was at fault, the TMC driver would first recover economic and noneconomic loss from one's own TMC policy. The TMC insured could then sue the at-fault PIP driver for any uncompensated economic loss (but not for pain and suffering). A TMC insured, having chosen to be in a fault-based system, who is at-fault in a crash would, of course, not be entitled to TMC benefits.[91] In addition, the TMC insured could be sued by the PIP insured, but only for uncompensated economic loss.

Section 8(a)(2) addresses the question of the allocation of TMC payments between economic and noneconomic loss. In most cases, this is not an issue because most accidents involve injuries below the level of the minimum required TMC so TMC covers all the damages. However, in serious injury cases, where the injuries of the TMC insured exceed the limits of the TMC coverage, it is necessary to identify when the TMC insured is entitled to sue an at-fault PIP driver. This section states that in such a situation TMC shall first be allocated to cover economic loss. Of course, in a serious injury case, as described earlier, under this approach a TMC insured is likely to recover far more than if hit by another TMC insured because one could recover economic loss from both TMC and from the PIP driver's residual bodily

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90. Another situation that would remain the same for a TMC insured involves single car accidents. For example, if a TMC driver slides on ice and runs into a tree, since there is no person to sue, the driver would not recover from the system. The TMC driver would be in the same predicament if at fault in an accident. In contrast, a PIP chooser would recover in all situations since recovery is not dependent on fault—just on injury arising from a motor vehicle accident.

91. In a comparative fault state, TMC insureds who are partially at fault would be entitled to recovery of TMC benefits to the extent permitted by State law.

injury liability coverage (in both situations, one could also use one's uninsured motorist coverage or underinsured motorist coverage for any additional economic or noneconomic loss).

(b) ACCIDENTS INVOLVING PERSONS CHOOSING THE PERSONAL INJURY PROTECTION SYSTEM.—

(1) RIGHT TO RECOVER ECONOMIC LOSS.—A personal injury protection insured who is injured in an accident may recover under the policy of that insured only for economic loss, without regard to fault.

(2) RIGHT TO SUE FOR UNCOMPENSATED ECONOMIC LOSS BASED ON FAULT.—A personal injury protection insured who is involved in an accident with a tort maintenance insured, or another personal injury protection insured, may recover based on fault from that other insured for uncompensated economic loss (and not for noneconomic loss).

Section 8(b) deals with sources of compensation for accidents involving persons who choose the PIP system. As a general rule, they recover economic loss from their own insurer and can sue the other driver—whether PIP or TMC—for any uncompensated economic loss only.

(c) ALLOCATION OF COMPARATIVE FAULT.—In any case in which a claim is made under this Act for uncompensated economic loss on the basis of comparative fault under applicable State law, the recovery of damages shall be based on the percentage of fault with respect to the amount of uncompensated economic loss.

Section 8(c) describes how a PIP insured's uncompensated economic loss would be treated in a comparative fault state. It provides that a PIP insured may recover under applicable State law based on the percentage of fault with respect to the amount of uncompensated economic loss. For example, if one has $200,000 of economic loss and only $50,000 of PIP coverage, one can sue for the remaining uncompensated economic loss of $150,000. If one is adjudged to be 40% at fault, then one can recover 60% of $150,000, or $90,000.

(d) ACCIDENTS INVOLVING PERSONS CHOOSING THE PERSONAL INJURY PROTECTION SYSTEM AND PERSONS WHO ARE UNLAWFULLY UNINSURED.—

(1) RIGHTS OF PERSONAL INJURY PROTECTION INSUREDS.—A personal injury protection insured who is involved in an accident with an uninsured motorist—

(A) shall be compensated under the insured person's policy for economic loss without regard to fault; and

(B) may recover from the uninsured motorist (other than under uninsured or underinsured motorist coverage) for economic loss and for noneconomic loss based on fault.

(2) LIMITATIONS ON LAWSUITS BY UNINSURED MOTORISTS.—An uninsured motorist may not recover from a personal injury protection insured for noneconomic loss.

Section 8(d) addresses accidents between PIP insureds and persons who are unlawfully uninsured. An unlawfully uninsured motorist is one who is legally obligated to purchase auto insurance because one owns or operates a car but fails to maintain the required insurance (the term as used here also includes one's resident relatives and dependents). The section penalizes an unlawfully uninsured motorist by not permitting a claim against a PIP insured for noneconomic loss. The motorist may, however, sue the PIP driver for economic loss on a fault basis.[92] The provision further penalizes the lawfully uninsured motorist by permitting a PIP driver to sue such a person for both economic and noneconomic loss on a fault basis. Understandably, an unlawfully uninsured person does not receive the benefits of limited immunity from suit one would receive if one had purchased the required insurance.

(e) ACCIDENTS INVOLVING MOTORISTS UNDER THE INFLUENCE OF ALCOHOL OR ILLEGAL DRUGS OR INFLICTING INTENTIONAL INJURY.—Notwithstanding any other provision of this Act, a personal injury protection insured who is in an accident may—

(1) recover all damages based on fault under applicable State law from a person who—

(A) at the time of the accident, was driving under the influence of alcohol or illegal drugs (as those terms are defined under applicable State law); or

(B) caused an injury while seeking to intentionally injure another person; and

(2) be liable for all damages based on fault under applicable State law, if such insured—

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92. The legislation was changed from the 105th Congress (S. 625 and H.R. 2021) to permit the unlawfully uninsured person to sue for economic loss in response to a concern raised by public hospitals, which presently care for many poor people, that restrictions on the right to sue for economic loss would create a hardship for them.

(A) at the time of the accident, was driving under the influence of alcohol or illegal drugs (as those terms are defined under applicable State law); or
(B) caused an injury while seeking to intentionally injure another person.

Section 8(e) deals with accidents involving motorists driving under the influence of alcohol or illegal drugs or those who inflict intentional injury. If a PIP insured is involved in an accident with such a person, that person is penalized by being subject to suit by the PIP insured for all loss, both economic and noneconomic. In turn, a PIP insured who drives in such a condition or inflicts an intentional injury loses immunity from suit for noneconomic loss and may also be sued for all economic loss without any offset for payments from the other driver's insurance. Thus the bill severely penalizes people who fit into these categories of very dangerous drivers.

The bill makes no changes with respect to accidents between TMC insureds and motorists driving under the influence or inflicting intentional injury. Present law would continue to govern such accidents.

(f) RIGHTS OF LAWFULLY UNINSURED PERSONS.—Nothing in this Act shall be construed to affect the tort rights or obligations of any person lawfully uninsured under the terms of an applicable State law for insurance under either the personal injury protection system or tort maintenance system under section 5(a)(1).

Section 8(f) deals with accidents between PIP insureds or TMC insureds and lawfully uninsured persons. Inasmuch as a lawfully uninsured person, such as a pedestrian who does not own a car or whose family does not own a car, has, by definition, not made an election of an insurance system (either PIP or TMC), the bill leaves whatever tort rights that person has today in place.

(g) RIGHTS OF PERSONS OCCUPYING MOTOR VEHICLES WITH FEWER THAN 4 LOAD-BEARING WHEELS.—Nothing in this Act shall be construed to affect the tort rights or obligations of a person who occupies a motor vehicle with fewer than 4 load-bearing wheels or an attachment thereto, unless an applicable contract for personal injury protection under which that person is insured specifies otherwise. The preceding sentence applies without regard to whether the person is otherwise legally insured for personal injury protection or tort maintenance coverage.

Section 8(g) addresses primarily the tort rights of motorcyclists. The section preserves the complete tort rights and obligations of motorcyclists unless they elect a PIP policy specifically applicable to the motorcycle. Absent such an election, they can sue or be sued for all damages on a fault basis. Because their vehicles provide little or no protection in the event of an accident, motorcyclists are highly vulnerable to physical injury. Therefore, motorcyclists may well prefer to be outside the PIP system because PIP, a first party insurance system where the insurer pays for the motorcyclist's own loss, probably would be too costly for them. Similarly, state no-fault laws typically allow motorcyclists to remain outside the first party insurance system.[93]

> **(h) FORFEITURE OF FRAUDULENT CLAIMS.—An owner, operator, or occupant of a motor vehicle involved in an accident forfeits the right to make a claim against an insured motorist for economic or noneconomic loss resulting from injury incurred by that owner, operator, or occupant if that owner, operator, or occupant knowingly participated in a scheme to obtain insurance payments for any accident that was staged with the intent to commit insurance fraud.**

Section 8(h) provides that persons who are involved in a fraudulent scheme to obtain insurance payments from a staged accident forfeit their rights to make a claim for loss against an insured motorist. While the new PIP system will eliminate the pain and suffering incentives for staged accidents, this section is designed as a further deterrent to such costly and dangerous behavior. FBI Director Louis Freeh has estimated that every American household is burdened by an additional $200 in unnecessary insurance premiums to cover the cost of staged accidents and the attendant massive fraud in the health care system.[94] Moreover, some staged accidents have even resulted in serious injuries and death.[95] The prohibition on lawsuits by participants in such schemes would apply in all accident cases, regardless of the insured's form of coverage.

> **(i) PRIORITY OF BENEFITS.—**
>
> **(1) IN GENERAL.—Except as provided in paragraph (2), a personal injury protection insured or a tort maintenance**

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93. *See, e.g.*, the New York Comprehensive Motor Vehicle Insurance Reparations Act, N.Y. COMP. CODES R. & REGS. tit. 11, §65 (2000).

94. Press Release, Fed. Bureau of Investigation, U.S. Dep't of Justice (May 24, 1995).

95. KEN DORNSTEIN, ACCIDENTALLY ON PURPOSE (1996).

insured may recover first party benefits only under the coverage of that insured in effect at the time of the accident.
(2) EXCEPTIONS.—
(A) IN GENERAL.—Except as provided in subparagraph (B), with respect to an accident that occurred while an injured individual was occupying a motor vehicle—
(i) furnished by an employer, the primary coverage shall be the coverage applicable to the motor vehicle; or
(ii) that was being used in the business of transporting individuals or property, the primary coverage shall be the coverage applicable to that motor vehicle.
(B) CERTAIN CLAIMANTS.—A claimant may claim first party benefits in an amount greater than the amounts determined under the limits under the primary insurance coverage described in clause (i) or (ii) of subparagraph (A), if that claimant would otherwise be able to receive those increased benefits by reason of insurance coverage of that claimant that would otherwise apply, but for the operation of subparagraph (A).

Section 8(i) establishes the general rule that a PIP or TMC insured recovers first party auto insurance benefits from one's own policy. A PIP or TMC insured recovers benefits from one's own insurer, regardless of whether one is injured (1) while driving one's own vehicle, (2) as a passenger in another car or (3) as a pedestrian. In insurance terminology, the insurance "follows the person," and not "the car."[96] In this way, insureds are able to deal with their own insurer, which has far more incentive to treat them well, as opposed to the other driver's insurer.

Section 8(i)(2)(A) provides for two exceptions. First, when the person is injured in an accident while on the job, the employer's insurance coverage applies. Second, when the person is injured as an operator or occupant of a motor carrier or a common carrier, the primary coverage is that of the carrier. In the employer and motor carrier situations, the business should pay for the loss because the accident occurs on the job. In the common carrier situation, the responsibility for payment is placed on the carrier because it seems

96. For a description of the exceptions to this rule for injuries that occur while one is occupying a commercial vehicle, see the discussion of sections 4(c)(2), (3), (4) and (5) *supra*.

suitable to have the carrier pay instead of the passengers. On the related question of who selects the type of coverage, see the discussion of sections 5(c)(2), (3), (4) and (5) *infra*.

Section 8(i)(2)(B) addresses the unusual situation where the injured person's coverage on one's private passenger vehicle exceeds that of the businesses described above. In those situations, if the injured person's loss exceeds that of the other coverage, one may utilize one's own auto insurance coverage to make up the difference.

(j) REIMBURSEMENT RIGHTS OR PERSONAL INJURY PROTECTION INSURERS AND COLLATERAL SOURCES.—

(1) REIMBURSEMENT RIGHTS OF PERSONAL INJURY PROTECTION INSURERS.—

(A) IN GENERAL.—A personal injury protection insurer may seek reimbursement under subparagraph (B), from—

(i) an uninsured motorist who is liable for damages caused by the accident;

(ii) a motorist who was under the influence of alcohol or illegal drugs at the time of the accident and whose conduct was the proximate cause of the accident;

(iii) a person who caused an injury while seeking to intentionally injure another person; or

(iv) any other person who is not affected by the limitations on tort rights and liabilities under this Act and whose conduct was the proximate cause of the accident.

(B) REIMBURSEMENT.—A personal injury protection insurer may seek reimbursement under this subparagraph to the extent of the obligations of that insurer, with respect to payments for a personal injury protection insured of that insurer with respect to an accident caused in whole or in part, as determined in accordance with applicable State law, from a person referred to in subparagraph (A), for the losses that insurer–

(i) has paid or reimbursed; or

(ii) under applicable law, is obligated to pay.

(2) REIMBURSEMENT RIGHTS OF COLLATERAL SOURCES.—With respect to an accident, a collateral source may seek

reimbursement from an insurer in a civil action based on fault.

(3) PROHIBITION ON MULTIPLE RECOVERY.—In any action to recover losses arising out of an accident, a person may not recover or introduce into evidence in a civil action against another person any amount of a loss that a collateral source or personal injury protection insurer—

(A) has paid or reimbursed; or

(B) is obligated to pay.

Section 8(j) addresses the reimbursement rights of PIP insurers and collateral sources. It also contains provisions to discourage duplicate recovery. Section 8(j)(1) authorizes PIP insurers to seek reimbursement from uninsured motorists, motorists under the influence of alcohol or illegal drugs whose conduct caused the accident, a person who intentionally injured another and others who are not subject to the bill's tort limitations[97] whose conduct caused the accident for all PIP benefits the insurer has paid or is obligated to pay.

Section 8(j)(2) authorizes collateral sources, such as health insurers, to seek reimbursement from an auto insurer in a civil action based on fault. This provision assures that, in economic terms, the cost of auto accidents is internalized. Giving collateral sources, rather than the injured person, the right of reimbursement from the auto insurer, has three major benefits:(1) consistent with the entire thrust of the bill, it reduces the incentives of people to inflate their losses (to get double recovery, if the collateral source is unable to monitor the lawsuit and exercise its right of subrogation); (2) it increases the chances that collateral sources will actually get the money back from the auto insurers because they— rather than the injured person—will control and monitor the litigation for reimbursement; and (3) it discourages unnecessary litigation, in that the reimbursement action is likely to take place between two insurers, with little or no court involvement, unlike an action by an individual to recover damages.

Section 8(j)(3) prohibits multiple recovery for the same injury. This section dovetails with the prior section. Because PIP insureds have already been reimbursed for their losses by the PIP insurer and, where relevant, by collateral sources, they have already received the benefits contracted with these two sources to pay. Thus, the bill prevents one from introducing

97. For example, lawfully uninsured persons and motorcyclists who do not elect PIP.

evidence of such loss in any cause of action arising from the accident. One can, of course, sue an at-fault driver for any economic loss not covered by his PIP insurance and any collateral sources. The previous section increases the chances that costs of the accident will properly be internalized within the auto insurance system without creating incentives to run up unnecessary costs.

> **(k) CHOICE OF LAW.—**
>
> **(1) APPLICABLE LAW.—With respect to a claim relating to a motor vehicle accident involving persons from different States, the choice-of-law principles applicable under the law of the State of competent jurisdiction shall apply.**
>
> **(2) APPLICABLE COVERAGE IN AN AUTO CHOICE STATE.—With respect to an accident that involved a person from a State in which this Act does not apply and a person from a State in which this Act applies, in any case in which the accident occurs in a State in which this Act applies, the coverage of the person from the State in which this Act does not apply shall be deemed to be the form of insurance (whether personal injury protection or tort maintenance coverage) that most closely reflects the form of insurance that that person maintains in the State of residence of that person.**

Section 8(k) sets forth choice of law principles. Section 8(k)(1) establishes the general principle that the choice-of-law principles applicable under the law of the State of appropriate jurisdiction shall apply. This rule of construction is no different than the rules that apply today when a driver is injured in a state other than one's home state. Not only do tort states have different rules, but there are 13 states with different rules providing for no-fault insurance. [98]

Section 8(k)(2) addresses the question of which insurance coverage applies when a person from a State that has opted out of Auto Choice is injured in a State that has Auto Choice. Today, when a person is injured in an accident outside one's own State, one's insurance coverage can automatically convert to the type of coverage in the State in which one is driving. For example, a person from the no-fault State of Michigan, when in the tort State of Illinois, is deemed to have liability insurance that meets the requirements of Illinois law. Thus, if the Michigan driver is at-fault, that

98. O'Connell et al., *supra* note 71, at app. C.

driver's coverage assures payments of tort damages, up to policy limits, in addition to providing no-fault benefits for the Michigan driver.

However, drivers in an Auto Choice state have two choices—PIP or TMC coverage. It is necessary in such a state to establish a rule as to which insurance coverage the out-of-state driver's policy should convert to when an out-of-state driver from a state that has opted out of Auto Choice is injured in an Auto Choice state. This section gives drivers from the opt-out state the form of insurance that most closely resembles the insurance system in their home state. Thus, if an opt-out state driver comes from a tort state, for choice of law purposes, one would be assumed to be a TMC insured when injured in an Auto Choice state. If an opt-out state driver comes from a no-fault state, then one would be assumed to be a PIP insured.

> **(l) JURISDICTION.—This Act shall not confer jurisdiction on the district courts of the United States under section 1331 or 1337 of title 28, United States Code.**

Section 8(l) provides that this Act does not confer original jurisdiction or federal question jurisdiction over auto accident cases in the United States District Courts. Auto accident litigation thus would normally remain in state courts, as is true today (other than cases that meet the normal diversity and jurisdictional amount rules).

> **(m) STATUTES OF LIMITATIONS.—**
>
> **(1) IN GENERAL.—Subject to paragraph (2), nothing in this Act shall supersede an applicable State law that imposes a statute of limitations for claims related to an injury caused by an accident, except that such statute shall be tolled during the period during which any personal injury protection or tort maintenance coverage benefits are paid.**
>
> **(2) CLAIMS.—Unless otherwise provided by State law, a claim for personal injury protection benefits under this Act shall be filed not later than 2 years after the economic loss that is the subject of the claim is incurred.**

Section 8(m)(1) establishes the general rule that state statutes of limitations shall continue to apply, except that such statutes would be tolled while a person was receiving PIP or TMC benefits. It is necessary to toll the statute of limitations to avoid having a state's statute expire while injured persons are still receiving benefits, but before they would be eligible to file a suit for uncompensated economic loss.

Section 8(m)(2) establishes a two-year statute of limitations for filing claims for PIP benefits for economic loss. In a state that already has no-fault benefits, the existing state statute of limitations would control.

> **(n) LIMITATIONS ON NONRENEWAL, CANCELLATION, AND PREMIUM INCREASES.—An insurer shall not cancel, fail to renew, or increase the premium of a person insured by the insurer solely because that insured person or any other injured person made a claim for—**
>
> **(1) personal injury protection benefits; or**
>
> **(2) tort maintenance coverage benefits in any case in which there is no basis for ascribing fault to the insured or one for whom the insured is vicariously liable.**

Section 8(n) prohibits an insurer from canceling, failing to renew or increasing the premium of a person solely because that person made a claim for PIP or TMC benefits. This provision is included to allay a common fear of drivers that their insurance premiums will increase solely because they file a claim, even if they have not been at fault. Similar provisions exist in state no-fault laws today.

> **(o) NEGLIGENT DRIVER RATINGS.—Nothing in this Act shall be construed to limit insurers from canceling, failing to renew, or increasing premiums for an insured person if there is a basis for ascribing moving traffic violations or fault for an accident caused by that insured or any resident relative or dependent, or employee of that insured.**

Section 8(o) addresses the converse situation of section 8(n). It provides that insurers may, consistent with state law, penalize drivers when there is a basis for ascribing a moving traffic violation or fault for an accident. This section rebuts arguments that bad drivers would not be punished under Auto Choice.

> **(p) IMMUNITY.—**
>
> **(1) IN GENERAL.—Except as provided in paragraph (2), no insurer, insurance agent or broker, insurance producer representing a motor vehicle insurer, automobile residual market plan, or attorney licensed to practice law within a State, or any employee of any such person or entity, shall be liable in an action for damages on account of—**
>
> **(A) an election of—**
>
> **(i) the tort maintenance system under section 5(a)(1)(B); or**

(ii) the personal injury protection system under section 5(a)(1)(A); or

(B) a failure to make a required election.

(2) EXCEPTION.—Paragraph (1) shall not apply in any case in which—

(A) a person described in that paragraph—

(i) willfully and intentionally misrepresents the insurance choices available to a customer or client of that person; or

(ii) willfully and with the intent to defraud, induces the election of 1 motor vehicle insurance system described in paragraph (1)(A) over the other motor vehicle insurance system described in that paragraph; and

(B) the misrepresentation or inducement under subparagraph (A) was the proximate cause of that customer or client's electing or failing to make an election of an insurance system under subparagraph (A) or (B) of section 5(a)(1).

Section 8(p) allows for claims against insurers and insurance agents for a driver's election of either the PIP system or the TMC system when the insurer or the agent willfully or intentionally misrepresents the insurance choices available or willfully and with the intent to defraud induces the election of one insurance system over the other. This section punishes bad behavior without encouraging the creation of a new cottage industry of lawsuits after an accident whenever injured persons could argue that they would have been better off under one particular insurance system or the other. Making the present system the default option ensures that people will not enter the PIP system except by an affirmative election. Moreover, neither companies nor agents have an economic incentive to move people into the PIP system in that their fees and commissions are often based on the size of the premium, and bodily injury premiums in the TMC system will be almost twice as expensive. Finally, inasmuch as the vast majority of motorists would fare better in serious injury cases if they elect the PIP option,[99] there is little reason to encourage lawsuits in the few cases when the injured person might have been better off in the tort system.

99. *See* discussion of compensation, *supra* section 2.

SEC. 9. PRESERVATION OF STATE AND PRIVATE RIGHTS

Section 9 identifies: (1) matters that are specifically reserved to the states, (2) areas where states are specifically authorized to act, and (3) some of the activities that private parties can contract for under this Act. Section 9(a) sets forth limitations on this legislation. These limitations are designed to preserve State authority to implement this Act. Further, they spell out specific items that are not clearly inconsistent with the Act.

(a) RIGHTS OF STATES.—Nothing in this Act shall be construed—

(1) to waive or affect any defense of sovereign immunity asserted by any State under any law or by the United States;

(2) to preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation;

(3) to affect the right of any court to transfer venue, to apply the law of a foreign nation, or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum;

(4) to preclude a State from establishing a schedule of payments for medical protocols for treatment of an injury that arises from an accident.

Section 9(a)(4) preserves a State's right to establish payments for medical protocols, a devise that is being used in the State of New Jersey to control costs.

(5) to preclude a State from requiring personal injury protection insurers to offer first party insurance that establishes a dollar value for noneconomic loss in objectively verifiable defined classes of cases involving death or serious and permanent bodily injury;

Section 9(a)(5) directly authorizes a State to require PIP insurers to offer first party benefits for noneconomic loss for death and serious and permanent bodily injury. This first party pain and suffering coverage would have two advantages over today's pain and suffering coverage: (1) it would cover such losses in all circumstances, including single car accidents, where the pain and suffering is every bit as great as when another driver is at fault but where the tort system provides no recovery; and (2) it would be less expensive than tort system coverage for similar injuries. This would be the case because the increase in claim frequency would be offset by the reduced overhead costs for litigation, which would in turn reduce the average claim cost. According to Dale Nelson, retired former chief actuary for State Farm Mutual Automobile

Insurance Company, a person who purchased this coverage along with the required PIP benefits would still pay less than one would for average bodily injury coverage under the tort system.

> **(6) to preclude a State from enacting a law applicable to all motor vehicle accident cases, including cases covered by this Act, to establish a minimum dollar value for economic losses for defined classes of cases involving death or serious bodily injury;**
>
> **(7) to preclude a State from providing that forms of insurance other than those listed in section 6(b) shall be subtracted from personal injury protection insurance benefits otherwise payable for injury; or**

Section 9(a)(7) authorizes a State to make other forms of health insurance primary[100] to auto insurance. The bill reflects the view that it is best to have auto insurance pay for losses from auto accidents but permits a State to make the opposite judgment if it wishes.[101] In Michigan, for example, drivers can make individual elections as to which insurance system is primary. It is worth noting that the trial bar has argued vigorously for making auto coverage primary, as this bill does, so that the costs of auto accidents are not borne by other systems. In fact, a NHTSA report concludes that, "[a]n analysis of state auto insurance laws indicates that there is a strong correlation between no-fault laws and low public (or high private) payments for motor vehicle injuries."[102] A JEC analysis of the NHTSA data on four no-fault states and eight tort states found that in no-fault states, private insurance (including auto insurance coverages, most prominently that for bodily injury liability and no-fault benefits, and health insurance, such as Blue Cross-Blue Shield) picked up 70% of the medical losses while public insurance (Medicare and Medicaid) picked up 13%.[103] In fault states, private insurance picked up only 51% of the medical costs while public insurance picked up 32%.[104] Arizona, a fault-based state, was even worse, with private insurance picking up only

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100. Were a State to elect to make health insurance "primary," in an accident where both the auto insurer and the health insurer are obligated to pay, the health insurer would pay first. The auto insurer would pay only if the injured person first exhausted applicable health benefits.

101. Section 5(b) establishes auto insurance as primary, with minimal delineated exceptions.

102. Analysis of NHTSA data by Daniel E. Miller, economist, JEC (1999).

103. *Id.*

104. *Id.*

46% of medical losses and public insurance picking up 40%.[105] Similarly, under Auto Choice, one would expect to see the auto insurance system pick up more of the costs of auto accidents, thereby relieving the public insurance systems of much of this burden. Injured persons, as discussed above with respect to section 3(1)(B), would also benefit through higher compensation for serious injuries.

(8) to preclude a State from enacting a law that—

(A) allows litigation by insureds under the tort maintenance system against personal injury protection insureds for economic and noneconomic loss; and

(B) assures through a reallocation device that the advantage of tort claim waivers by personal injury protection insureds against insureds under the tort maintenance system is reflected in the premiums of personal injury protection insureds.

Section 9(a)(8) permits a State to allow TMC insureds to sue PIP insureds for both economic and noneconomic loss, and utilize a risk exchange mechanism to allocate costs between drivers from the different systems. Such a mechanism is used in New Jersey.[106]

(b) PRESERVATION OF STATE REGULATORY AUTHORITY.— Nothing in this Act may be construed—

(1) to preclude a State or State official charged with regulatory authority over the business of insurance from fully exercising that regulatory authority, including adopting regulations and procedures regarding—

(A) rates;

(B) policy forms;

(C) company solvency;

(D) consumer protection;

(E) underwriting and marketing practices; and

(F) carrying out the requirements of this Act; or

(2) to allow or provide for Federal regulation of motor vehicle insurance.

Section 9(b) provides that nothing in this Act precludes states from regulating the business of insurance, nor does it allow or provide for Federal

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105. *Id.*

106. Jeffrey O'Connell, *A Model Bill Allowing Choice*, 51 OHIO ST. L.J. 947, 949-50 (1990).

regulation of insurance. In fact, the bill creates no new federal bureaucracy nor does it authorize any money for federal oversight. The Act is simply enforceable through the judicial system.[107]

(c) RIGHTS OF PRIVATE PARTIES.—Nothing in this Act may be construed—

Section 9(c) outlines a number of activities that private parties can contract for under this Act.

(1) to require a personal injury protection insurer to offer, or a personal injury protection insured to purchase, any coverage for bodily injury in addition to the coverage required under this Act, including uninsured motorist coverage, underinsured motorist coverage, or coverage for medical payments;

(2) to prevent insurers and insureds from contracting to limit recovery for the loss of earnings under personal injury protection by—

(A) limiting such recovery to only 60 percent or more of lost wages or income;

(B) limiting the amount of such recovery payable per week; or

(C) limiting the period of time after an accident during which the benefits referred to in this paragraph are payable to a period of not less than 1 year;

Section 9(c)(2) permits insurers and insureds to contract to limit the amount of recovery for loss of earnings to a percentage of such loss, on a weekly basis and/or for a maximum time period, so long as it is not less than one year. Each of the 13 state no-fault laws contains similar provisions. The limit to a percentage of not less than 60% of lost income addresses the concern that PIP benefits are not taxable and people should not be able to net more income by not working than by working. (Of course, insurers are free to offer, and insureds to purchase, coverage for loss of earnings in whatever amounts they wish as long as payment is not higher than 100%). This provision responds to concerns about the need for internal limits to control costs to, in turn, lessen the "moral hazard" involved especially in paying people off the job for wage loss.

(3) to prevent insurers and insureds from contracting—

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107. See the discussion of section 8(l) *supra*.

(A) to limit recovery for economic loss for medical and rehabilitation expenses t o the average amount actually paid for a particular course of treatment; or
(B) to provide medical or rehabilitation services through designated health care providers;

This provision permits insurers and insureds to contract to control medical costs in the same fashion as most employers and insurers are doing today. Insurers may utilize such systems to discourage a significant cause of fraud and reward their policyholders with lower premiums.

(4) to prevent an insurer from contracting with insureds, as permitted by applicable State law, to have submitted to arbitration any dispute with respect to payment of personal injury protection or tort maintenance coverage;

Section 9(c)(4) permits insurers and insureds to contract to have disputes about PIP and TMC coverage submitted to arbitration, another cost control method.

(5) to affect the worker classification of a person, either as an employee or an independent contractor, on the basis of the election of an employer or motor carrier of an insurance system under section 5(a); or

Section 9(c)(5) states that the election of an insurance option under this Act does not affect the worker classification of a person as an employee or an independent contractor. There is much state and federal law on the matter of worker classification, which is based on common law principles of agency,[108] and it is not the intention of the bill to alter such existing law. The mere purchase of auto insurance under this Act is not intended to have any bearing on the issue.

(6) to affect the awarding of punitive damages, or damages for bad faith refusal to pay a claim, under any applicable State law.

Section 9(c)(6) clarifies that this legislation is not meant to deal with the controversial issue of punitive damages which in any event are less applicable to auto accident claims.[109] Also, it clarifies that the legislation does not

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108. *See, e.g.* Nationwide Mut. Ins. Co. v. Darden, 503 U.S. 318, 326 (1992); RESTATEMENT (SECOND) OF AGENCY § 220(2) (1958).

109. A recent study of punitive damage awards in civil cases in the Nation's 75 most populous counties found that punitive damages were awarded in only 0.7 percent of auto accident cases and that those awards were only .36 percent of the total amount of punitive

affect lawsuits for bad faith refusal to pay claims in states that authorize such suits.

SEC. 10. APPLICABILITY TO STATES

Section 10 sets forth ways in which a State may act so that Auto Choice insurance does not apply in that State and further sets forth a time period to assure orderly implementation of Auto Choice in a State which does not act to prevent the law from going into effect in that State.

> **(a) ELECTION OF NONAPPLICABILITY BY STATES.—Subject to subsections (c) through (e), this Act shall apply with respect to a State, unless—**
>
> **(1) by not later than the earlier of the date that is 1 year after the date of enactment of this Act or the expiration of the first regular legislative session of the State beginning after the date of enactment of this Act, the State enacts a statute that—**
>
> **(A) cites the authority of this subsection;**
>
> **(B) declares the election of that State that this Act shall not apply with respect to that State; and**
>
> **(C) contains no other provision; or**
>
> **(2)(A) the State official charged with jurisdiction over insurance rates for motor vehicles makes a finding that this Act does not apply by reasons of the applicability of the conditions described in subsection(b)(1)(A); and**
>
> **(B) that finding is made and any review described in subsection (b)(1)(B) is completed not later than the date specified in subsection (b)(1)(C).**

Section 10(a) gives each State two options to prevent Auto Choice from going into effect in that State. Section 10(a)(1) provides that the Act will not go into effect in any State that passes a statute so declaring. The States may take this action within one year of the date of enactment or before the expiration of the first regularly scheduled legislative session that begins after the date of enactment, whichever occurs first. Thus, if a State begins a new legislative session two weeks after the date of enactment and that session expires three months later, the time for initial State action expires with it. The State statute must declare that this bill shall not apply to that State, and must

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damages awarded in all the cases examined. BUREAU OF JUSTICE STATISTICS, CIVIL TRIAL CASES AND VERDICTS IN LARGE COUNTIES, 1996 tbl. 8 (1999).

contain no other provisions. The purpose of this provision is to assure that the merits of Auto Choice are addressed on their own, unconnected to any other subject matter.

Section 10(a)(2) provides that the bill will not apply to a particular State if the State insurance commissioner, or its equivalent officer, makes a finding that the statewide average motor vehicle premiums for bodily injury in effect immediately prior to the effective date of this bill will not be reduced by at least 30% for persons choosing the PIP option. That finding must be supported by evidence and subject to review under applicable State administrative procedure law within 120 days after the date of enactment of this legislation.

(b) NONAPPLICABILITY BASED ON STATE FINDING.—

(1) IN GENERAL.—This Act shall not apply with respect to a State, if—

(A) the State official charged with jurisdiction over insurance rates for motor vehicles makes a finding that the statewide average motor vehicle premiums for bodily injury insurance in effect immediately before the date of enactment of this Act will not be reduced by an average of at least 30 percent for persons choosing the personal injury protection system, in the amounts required under section 6 (without including in the calculation for personal injury protection insureds any costs for uninsured, underinsured, or medical payments coverage)";

(B) the finding described under subparagraph (A) is supported by evidence adduced in a public hearing and reviewable under the applicable State administrative procedure law; and

(C) the finding described under subparagraph (A) is made, and any review of such finding under subparagraph (B) is completed, not later than 120 days after the date of enactment of this Act.

(2) COMPARISON OF BODILY INJURY PREMIUMS.—For purposes of making a comparison under paragraph (1)(A) of premiums for personal injury protection with preexisting premiums for bodily injury insurance (in effect immediately before the date of enactment of this Act), the preexisting

bodily injury insurance premiums shall include premiums for—

(A) bodily injury liability, uninsured and underinsured motorists' liability, and medical payments coverage; and

(B) if applicable, no-fault benefits under a no-fault motor vehicle law or add-on law.

Section 10(b) sets forth the equation for comparing premiums under PIP with preexisting premiums for bodily injury coverage in effect in a State immediately before the date of enactment of this Act. Paragraph (1)(A) provides that the PIP premium shall consist of the charge for the amount of coverage required under section 6. This coverage consists of two elements: (1) the amount of PIP benefits the Act requires an individual to carry (which is equivalent to the State financial responsibility limits (see section 6(a)), and (2) the amount of residual bodily injury liability coverage (which is also equivalent to the State financial responsibility limits). It does not include the cost of any coverage for uninsured, underinsured or medical payments coverage. These latter coverages are specifically excluded because they are not required under the bill and arguably are not needed in a primarily first party system like PIP where one buys protection for one's own losses, no matter who caused the accident. PIP benefits include medical payments benefits and cover economic loss caused by uninsured or underinsured motorists (though admittedly not noneconomic loss caused thereby).

Paragraph (2) identifies the coverages of the preexisting bodily injury insurance system to which the costs of the PIP system are to be compared. They include the basic coverages of the bodily injury portion of the premium—bodily injury liability, uninsured and underinsured motorists' liability and medical payments coverage. If the State is a no-fault or add-on State, the premium covers the cost of providing no-fault benefits as well. All these coverages are arguably replaced by PIP benefits.

(c) IMPLEMENTATION PERIOD.—Except as provided in subsection (d), if a State fails to enact a law by the applicable date specified in paragraph (1) of subsection (a) or if a finding described in paragraph (2) of that subsection is not made and reviewed by the date specified in subsection (b)(1)(C), this Act shall apply to that State beginning on the date that is 270 days after the later of those dates.

Section 10(c) provides for a 270 day implementation period in a State that does not opt out of the law under section 10(a). The time period begins from the earlier of: (1) the expiration of the first regularly scheduled

legislative session that occurs after the date of enactment, or (2) one year. It also attempts to ensure adequate time for the development of new forms, education of the sales force and rate filings, where appropriate. In short, if a State does not opt out during the period set forth in section 10(a), then there must be time for the orderly implementation of this Act.

> **(d) ACCELERATED APPLICABILITY.—**
>
> **(1) IN GENERAL.—Subject to paragraph (2), a State may enact a law that provides for the implementation of the provisions of this Act in that State before an otherwise applicable date determined under subsection (a).**
>
> **(2) APPLICABILITY.—If a State makes an election under paragraph (1), this Act shall apply to that State beginning on the date that is 270 days after the date of such election.**

Section 10(d) provides for accelerated applicability for a State that wishes to have the law apply sooner than the period set forth in section 10(a).

> **(e) ELECTION OF NONAPPLICABILITY BY A STATE AFTER THIS ACT BECOMES APPLICABLE WITH RESPECT TO THE STATE.—After this Act becomes applicable with respect to a State under subsection (c) or (d), this Act shall cease to apply with respect to that State if the State enacts a statute that meets the requirements of subparagraphs (A) through (C) of subsection (a)(1).**

Section 10(e) permits a State that has not opted out of this Act under section 10(a), after the expiration of the period for implementation under section 10(c), at any time to pass a law that provides that Auto Choice no longer applies in that State. Thus, as former New Jersey Governor Christine Todd Whitman has said, Auto Choice is "a model of federalism in that federal law would represent the first word, rather than the last word, on the subject."[110]

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110. *Automobile Insurance Reform, Hearing before the Joint Economic Committee, Congress of the United States, 105th Congress, First Session* 57 (S. Hrg. 105-204, March 19, 1997) (Testimony of Governor Christine Todd Whitman). For an excellent discussion of federalism, see Michael S. Greve, *A Federalism Worth Fighting For: Conservatives should stop getting bogged down in "states' rights."* (The Weekly Standard, January 29, 2001): "Empowered state governments, on top of an effectively omnipotent federal government, are the last thing we need. Rather, the virtues that commend federalism are, first, the virtues of markets -- diversity, citizen choice, and state competition; and, second, political transparency, discipline and responsibility."

LOST IN OZ: THERE IS NO YELLOW BRICK ROAD FOR STATE LAWMAKERS TO FOLLOW IN DRAFTING PRIVACY LEGISLATION FOR INSURERS

William M. Fay, Jr. *

TABLE OF CONTENTS

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INTRODUCTION

On November 12, 1999, President Clinton signed into law the Gramm-Leach-Bliley Financial Modernization Act ("Modernization Act"),[1] crowning thirty years of efforts to erode the barriers which prevented banks from acquiring security and insurance companies.[2] Specifically, the legislation allows the formation of financial holding companies, which can own banks, security firms, and insurers, provide banking services, and underwrite and sell insurance and securities.[3] The Modernization Act also includes protections for consumer privacy, requiring banks and insurers to provide privacy notices and obtain consumer permission before sharing their nonpublic personal information with nonaffiliates.[4] While this privacy protection is beneficial to consumers, a twister is mounting on the horizon: the possibility of insurers having to comply with different privacy policies from each of the fifty states and the District of Columbia.

With the passage of the Modernization Act, federal agencies were charged with issuing regulations to enforce the mandates of the legislation. While federal rules have been passed for banks and security firms,[5] the regulation of insurance companies is still under development due to the traditional role of regulating the insurance industry at the state level.

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1. Pub. L. No. 106-102, 113 Stat. 1338 (1999) (codified in scattered sections of 12 and 15 U.S.C.).

2. The Modernization Act reduces barriers between banking and securities industries, established during the Depression by the Banking Act of 1933 ("Glass-Steagall Act"), and the banking and insurance industries, established by the 1982 amendments to the Bank Holding Company Act of 1956. Paul J. Polking & Scott A. Cammarn, *Overview of the Gramm-Leach-Bliley Act*, 4 N.C. BANKING INST. 1 (2000).

3. 12 U.S.C. § 1843(k)(1) (2000).

4. 15 U.S.C. § 6802 (2000).

5. A number of agencies have issued rules governing the privacy of consumer financial information. The National Credit Union Administration issued its rules on May 18, 2000. *See* Privacy of Consumer Financial Information, Requirements for Insurance, 65 Fed. Reg. 31,722 (May 18, 2000) (to be codified at 12 C.F.R. pts. 716, 741), *amended by* Privacy of Consumer Financial Information, 65 Fed. Reg. 36,782 (proposed June 12, 2000) (to be codified at 12 C.F.R. pt. 716). The Federal Trade Commission issued its rules on May 24, 2000. *See* Privacy of Consumer Financial Information, 65 Fed. Reg. 33, 646 (proposed May 24, 2000) (to be codified at 16 C.F.R. pt. 313). The Federal Reserve Board, the Federal Deposit Insurance Corporation, the Office of the Comptroller, and the Office of Thrift Supervision issued their rules on June 1, 2000. *See* Privacy of Consumer Financial Information, 65 Fed. Reg. 35,162 (proposed June 1, 2000) (to be codified at 12 C.F.R. pts. 40, 216, 332, 573). The Securities and Federal Exchange Commission issued its final rule on June 29, 2000. *See* Privacy of Consumer Financial Information (Regulation S-P), 65 Fed. Reg. 40,334 (proposed June 29, 2000) (to be codified at 17 C.F.R. pt. 248).

Furthermore, the Modernization Act simply provides a minimum privacy standard; states which already have laws affording greater consumer privacy protection, or which pass legislation providing greater protections, supercede the Modernization Act.[6] Already, many states have some type of privacy legislation on the books, and some have more stringent protections than the Modernization Act provides.[7] The result is that insurers, along with banks and security firms selling insurance, might face a scenario in which they have to follow provisions that differ vastly from state to state.

Leaders in the insurance industry are warning about the implications for insurers and consumers. According to Debra Ballen, The American Insurance Association Executive Vice-President of Public Policy Management, "[t]hese varying approaches impose difficult and costly compliance burdens on companies."[8] Moreover, "[l]ack of uniformity will [also] be confusing for consumers because of the multiple privacy notices they will receive from the various financial institutions with which they do business.... In fact, they will probably be confused by the differences between the privacy notices they get from their bank and from their insurance company."[9]

In an effort to curtail these problems, The National Association of Insurance Commissioners ("NAIC"),[10] an organization of insurance regulators, issued model guidelines to provide a uniform privacy standard for states to adopt. However, their model met opposition, and another association, The National Conference of Insurance Legislators ("NCOIL"),[11] published their own guidelines. Thus, with two national models to choose from, in addition to previously adopted legislation, state

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6. 15 U.S.C. § 6807 (2000).

7. Part III of this Comment discusses individual state laws.

8. Dennis Kelly, *Insurance Associations Disagree over NAIC Privacy Model Regulation*, BESTWIRE, Nov. 3, 2000.

9. *Id.*

10. Created in 1871, the NAIC is an organization of insurance regulators from the 50 states, the District of Columbia and the four United States territories. Nat'l Ass'n of Ins. Comm'rs, *at* http://www.naic.org (last visited April 21, 2001). The NAIC provides a forum to coordinate regulation and uniformity of multi-state insurers. *Id.*

11. NCOIL is an organization of state legislators whose main area of public policy concern is insurance legislation and regulation. Nat'l Conference of Ins. Legislators, *at* http://www.ncoil.org (last visited April 21, 2001). Many legislators active in NCOIL either chair or are members of the committees responsible for insurance legislation in their respective state houses across the country. *Id.*

lawmakers are left without a uniform path, or a scarecrow to point them to the Emerald City.

The result of this dilemma is that states may chose to amend prior privacy legislation, adopt either model, or incorporate aspects from each plan. The disparities could lead to higher costs and confusion among insurers and consumers trying to figure out what the requirements are in each state. The question is, will state lawmakers find some harmony and adopt similar rules, or will they, along with insurers and consumers, become lost in the haunted forest and attacked by winged monkeys?

This Comment concerns the privacy aspects of the Modernization Act and the problems state lawmakers face as they try to draft legislation to comply with the Modernization Act. Part I of the comment is an overview of the Modernization Act's privacy provisions. Part II explores the similarities and differences between the NAIC's model and the NCOIL's model. Part III is an analysis of individual state efforts in drafting legislation. Part IV proposes an adoption of a uniform standard based on the NAIC's model. Finally, in Part V, the Comment concludes with a synopsis on the lawmaker's options.

I. PRIVACY PROTECTIONS OF THE FINANCIAL MODERNIZATION ACT

A. Overview

The Modernization Act requires financial institutions to protect the security and confidentiality of their customers', and in some cases consumers', nonpublic personal information.[12] Congress stated the purpose of the privacy requirements was "that each financial institution has an affirmative and continuing obligation to respect the privacy of its customers and to protect the security and confidentiality of those

12. "Nonpublic personal information" is defined as personally identifiable financial information that is provided by a customer to a financial institution, which results from any transaction with the customer or any service performed for the customer, or otherwise obtained by the financial institution. 15 U.S.C. § 6809(4)(A) (2000). Examples include Social Security numbers, birth dates, annual income, marital status, and net worth. Amber Veverka, *Banks Take Privacy Policy Public*, CHARLOTTE OBSERVER, Mar. 7, 2001, *available at* 2001 WL 15016019. It also includes any lists, descriptions, or other grouping of customers derived from nonpublic personal information. 15 U.S.C. § 6802(a) (2000), 15 U.S.C. § 6809. This is distinguishable from "public personal information," which albeit not defined by the Modernization Act, *see* 15 U.S.C. § 6809(4)(B), is any information that is publicly available without using any nonpublic information. NAIC 2000 Model, *infra* note 79, § 4(W) at 672-12 - 672-13. Examples include common government records such as real estate records and security interest filings. *Id.*

customers' nonpublic personal information."[13] Thus, the goals of the privacy provisions are to insure the security and confidentiality of customer records and information, to protect against any anticipated threats or hazards to the security or integrity of such records, and to protect against unauthorized access to or use of such records, which could result in substantial harm or inconvenience to any customer.[14]

There are three important things to keep in mind concerning the Modernization Act's privacy requirements. First, the number of organizations affected is significant because the Act impacts almost any business that provides financial services. A financial institution is broadly defined as any institution engaging in financial activities such as lending, exchanging, transferring, insuring, and underwriting money or securities.[15] Thus, a wide gamut of businesses, from finance companies and mortgage brokers to travel agents and data processors, fall under the Modernization Act's protections.[16]

Second, the privacy provisions of the Modernization Act do not apply to financial products or services obtained for business, commercial, or agricultural purposes. The Modernization Act protects the privacy of personal, family, or household information.[17] Therefore, a financial institution is not required to provide privacy notices or obtain consent when dealing with a consumer acting on behalf of a business or commercial operation.

Third, the Modernization Act only provides protection for the exchange of information between nonaffiliated third parties, which are defined as entities that are not affiliated with the financial institution, or where there is no common ownership or corporate control.[18] Thus, the privacy provisions do not protect the sharing of information between affiliates.[19] Therefore, financial companies may share information with their affiliates, such as an

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13. 15 U.S.C. § 6801(a) (2000).

14. 15 U.S.C. § 6801(b).

15. 12 U.S.C. § 1843(k)(4) (2000).

16. Polking & Cammarn, *supra* note 2, at 27-28. *See generally*, 12 U.S.C. § 1843(k)(4).

17. 15 U.S.C. § 6809(9).

18. 15 U.S.C. § 6802(a).

19. This has caused some controversy. Sen. Paul Sarbanes (D-MD) has introduced The Financial Information Privacy Protection Act of 2001. Financial Information Privacy Protection Act of 2001, S. 30, 107th Cong. (2001) (introduced on Jan. 22, 2001). This bill amends the Modernization Act to provide an opt-out for the sharing of nonpublic personal information between affiliates. *Id.*

insurer sharing information with an affiliated bank to profile customers who might want to purchase life insurance.[20]

B. Framework

At its core, the Modernization Act provides four basic privacy protections: consent, notice, reuse limitations, and prohibitions against sharing information for marketing purposes. Each protection is detailed below.

1. Notice

A financial institution must provide its customers with initial notification, in a clear and conspicuous manner, concerning the financial institution's policies and practices regarding the disclosure of nonpublic personal information to affiliates and nonaffiliated third parities.[21] The institution must also inform customers and consumers of their privacy policies if they plan to share their information with nonaffiliated third parties.[22] The notice must include: the policy and practices of the institution, the categories of nonpublic personal information the institution obtains, security measures to protect the information, and any disclosures required by the fair credit reporting act.[23] The notification must come at the start of the customer relationship, and must be relayed to the customer at least once per year.[24]

Central to the issue of notice are the differences between customers and consumers. Customers, individuals who have an ongoing relationship with a financial institution, must always receive initial notification and an opt-

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20. Joe Gardyasz, *Privacy Battles Goes Public; Personal Information Used by Financial Entities Would Be Limited by Bill*, BISMARK TRIB., Feb. 14, 2001, at 1A. While the Modernization Act did not place any restrictions on the sharing of public and nonpublic personal information with affiliates, customers may have opt-out rights under existing state laws or the Fair Credit Reporting Act. *See generally* 15 U.S.C. §§ 1681-1681t (2000). Moreover, agency agreements generally prohibit insurers from sharing policyholder information with other affiliates for sales purposes via "ownership of expiration" clauses. Jeffery M. Yates, *Privacy Debate Hits Home with Agents*, NAT'L UNDERWRITER/PROP. & CAS./RISK & BENEFITS MGMT. ED., Aug. 14, 2000, at 17. These clauses provide exclusive ownership to the use and control of expirations belonging to the agent, whereby the company agrees not to use expiration or records of the agent's work product to market, sell, or service any form of insurance, or to communicate the information to any other person or entity for marketing purposes. *Id.*

21. 15 U.S.C. § 6802(a), 15 U.S.C. 6803 (2000).

22. 15 U.S.C. § 6802(a).

23. 15 U.S.C. § 6803(b).

24. 15 U.S.C. § 6803(a).

out notice when the financial institution plans to share their nonpublic personal information.[25] On the other hand, consumers, people who have short term or isolated affiliations with a financial institution, must receive notification only if the financial institution plans to share their nonpublic personal information with nonaffiliated third parties.[26]

2. Consent

With limited exceptions, a financial institution must obtain consent to disclose nonpublic personal information to a nonaffiliated third party.[27] Significantly, however, the Modernization Act adopted the much less onerous opt-out approach to consent. An opt-out procedure requires a consumer or a customer to take affirmative steps, such as calling a toll free phone number or completing a form, if they wish to prevent the sharing of their nonpublic personal information with nonaffiliated third parties. This is distinguishable from an opt-in procedure, where it is automatically assumed the consumer does not wish to share their information, and the burden is on the financial institution to contact the consumer and obtain permission to share their information. If a consumer does not opt-out, the financial institution has the legal right to share or sell the information to nonaffiliated third parties.[28]

The consent must come prior to the dissemination of the information to third parties.[29] In addition, both notification of the option to opt-out, as well as an explanation of the opt-out procedure, are required.[30] Exceptions where the opt-out rule does not prohibit the disclosure of nonpublic personal information include: affiliates, third parties which perform

25. *Id.*

26. *See* 15 U.S.C. § 6802(a).

27. 15 U.S.C. § 6802(b). Notably, when a nonaffiliated third party is performing services or functions for the financial institution—including marketing—the consent requirement is waived, so long as notice is given to the consumer. *Id.*

28. *Id.*

29. 15 U.S.C. § 6802(b)(1)(B).

30. 15 U.S.C. § 6802(b)(1)(A), 15 U.S.C. § 6802(b)(1)(C).

services on behalf of the financial institution,[31] or where it is necessary to effect, administer, or enforce a transaction.[32]

3. Reuse Limitations

The nonaffiliated third party recipient of the customer's or consumer's nonpublic personal information can use it only in a way the original holder could use the information. Thus, the nonaffiliated third party may not disclose such information to any person or other nonaffiliated third party provided the financial institution could not legally do so itself.[33]

4. Prohibitions on the Sharing of Account Information

Finally, a financial institution may not disclose an account number or similar access number for a credit card or deposit account of a consumer to a nonaffiliated third party for use in telemarketing, direct mail marketing, or other marketing through electronic mail.[34] This is an absolute prohibition, even if a financial institution obtains opt-out permission from the customer or consumer.[35] The only exception is for consumer reporting agencies.[36]

In sum, the Modernization Act requires financial institutions, when dealing with the sharing of nonpublic information between nonaffiliates, to provide notice to consumers and customers about the information disclosed, the parties to whom the information is disclosed, provide the consumer or customer with an opportunity to opt-out, determine if the nonaffiliated third party has similar privacy protections, and keep sensitive information, such as account numbers, from nonaffiliated third party use in marketing.

C. Preemption, State Privacy Laws, and HIPAA

Congress recognized that some states have privacy laws that are more protective of consumers than the Modernization Act. Thus, the

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31. 15 U.S.C. § 6802(b)(2). A financial institution may provide nonpublic personal information to a nonaffiliated third party to perform services or functions for the financial institution—including marketing the financial institution's products or services—if the financial institution fully discloses that it is providing such information. *Id.* Further, the financial institution must enter into a contractual agreement with the third party requiring that party to maintain the confidentiality of such information. *Id.*

32. 15 U.S.C. § 6802(e)(1).

33. 15 U.S.C. § 6802(c).

34. 15 U.S.C. § 6802(d).

35. *Id.*

36. *Id.*

Modernization Act does not override state law where the state affords greater protection;[37] however, if the state does not provide adequate privacy protection, or its laws are inconsistent with the provisions of the Modernization Act, preemption will occur, but only to the extent of the inconsistency.[38]

A number of states have enacted privacy protection laws for insurers. For example, the NAIC Model Insurance Information and Privacy Protection Act, [39] drafted in 1980, ("NAIC 1980 Model") has been fully adopted by fifteen states.[40] It protects personal information obtained by insurance companies and requires insurance institutions and agents to provide notice of fair information practices to all applicants and policyholders.[41] Furthermore, it specifies the content of disclosure authorization forms[42] and grants individuals access to their recorded personal information for maintenance.[43] The act authorizes disclosures of personal information when the individual authorizes its use (i.e., opts-in),[44] to perform insurance functions,[45] to cooperate with law enforcement,[46] and in research studies.[47] Personal information may also be used for marketing purposes provided no medical record information, privileged information, or personal information pertaining to an individual's character, personal habits, mode of living, or general reputation is employed,[48] the individual has an opportunity to indicate he or she does not want the information

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37. 15 U.S.C. § 6807(a) (2000). The state must seek approval from the Federal Trade Commission to determine if the state law is more stringent and thereby have the state law supersede the federal act. 15 U.S.C. § 6807(b).

38. 15 U.S.C. § 6807(a).

39. MODEL INSURANCE INFORMATION AND PRIVACY MODEL ACT (Nat'l Ass'n of Ins. Comm'rs 1992) (originally adopted in 1980), reprinted in 4 Nat'l Ass'n of Ins. Comm'rs, Model Laws, Regulations, and Guidelines 670-1 - 670-22 (update no. 55, April 2001) (hereinafter NAIC 1980 Model).

40. The states are: Arizona, California, Connecticut, Georgia, Illinois, Kansas, Maine, Minnesota, Montana, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia. *See* discussion *infra* Part III (listing specific state statutes).

41. NAIC 1980 Model, *supra* note 39, § 4 at 670-8 - 670-9.

42. *Id.* § 6 at 670-9 - 670-10.

43. *Id.* §§ 8-9 at 670-11 - 670-13.

44. *Id.* § 13(A) at 670-15.

45. *Id.* § 13(B)(1) at 670-15 - 670-16.

46. *Id.* § 13(F) at 670-16.

47. *Id.* § 13(I) at 670-17. Such disclosure is authorized when no individual is identified in the actuarial and research report, the materials identifying the individual are returned or destroyed, and the organization agrees not to disclose the personal information unless permitted by the model regulation. *Id.*

48. *Id.* § 13(K)(1) at 670-17.

disclosed, and the person who receives the information agrees to use it only for marketing purposes.[49]

Federal privacy statutes such as The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"),[50] which provides privacy protection for medical information, may also affect insurers. Under HIPAA, Congress was required to develop standards to protect personally-identifiable health information by August 21, 1999.[51] In the event Congress missed the deadline, HIPAA required the Secretary of the Department of Health and Human Services ("DHHS") to issue regulations.[52] When Congress did not act within the thirty-six month period after the passage of HIPAA, DHHS acted and issued final regulations. Entitled "Standards for Privacy of Individually Identifiable Health Information," the Secretary of DHHS announced the regulation on December 20, 2000, and it was subsequently published in the Federal Register on December 28, 2000.[53]

"The Standards for Privacy of Individually Identifiable Health Information" applies to all health plans, health care providers, and health care clearinghouses that electronically maintain or transmit health information pertaining to an individual.[54] The standards call for a set of information practices to inform patients how their information is used and disclosed,[55] provide access to check and maintain records,[56] and install adequate safeguards to protect the confidentiality of the information from unauthorized access.[57] The health care providers are prevented from using or disclosing protected health information except in limited circumstances, such as where an individual gives authorization,[58] for emergency treatment,[59] and when dealing with a mentally incapacitated individual.[60] In addition, authorizations are required for use in research,[61] law

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49. *Id.* §§ 13(K)(2)-(3) at 670-17.
50. Pub. L. No. 104-191, 110 Stat. 1936 (codified in scattered sections of 42 U.S.C.).
51. Pub. L. No. 104-191, § 264 (c)(1).
52. *Id.*
53. Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. 82,461, 82,510 (Dec. 28, 2000) (to be codified at 45 C.F.R. pts. 160, 164).
54. *Id.* at 82,802-03 (to be codified at 45 C.F.R. pt. 164.500).
55. *Id.* at 82,820-22 (to be codified at 45 C.F.R. pt. 164.520).
56. *Id.* at 82,823-24 (to be codified at 45 C.F.R. pt. 164.524).
57. *Id.* at 82,827-29 (to be codified at 45 C.F.R. pt. 164.530).
58. *Id.* at 82,810-11 (to be codified at 45 C.F.R. pt. 164.506).
59. *Id.* at 82,810 (to be codified at 45 C.F.R. pt. 164.506(a)(3)(i)(A)).
60. *Id.* at 82,810 (to be codified at 45 C.F.R. pt. 164.506(a)(3)(i)(C)).
61. *Id.* at 82,816 (to be codified at 45 C.F.R. pt. 164.512(i)).

enforcement,[62] public health,[63] and oversight;[64] however, limitations exist in these circumstances, and the amount of information used is restricted to the amount needed for the particular purpose.[65] In all other circumstances, written authorization for use and disclosure of health information is required.[66]

The regulation's effective date was moved from February 26, 2001,[67] to April 14, 2001,[68] due to Congressional delays.[69] Compliance is required for all covered entities other than small health plans by April 14, 2003;[70] small health plans have until April 14, 2004.[71]

II. MODEL REGULATIONS

To implement the Modernization Act, a number of federal agencies were assigned the task of issuing rules.[72] The Federal Trade Commission ("FTC") noted, when publishing its guidelines to carry out the Modernization Act's privacy requirements for financial institutions, [73] that the Modernization Act explicitly committed enforcement jurisdiction over "persons engaged in providing insurance" to state insurance authorities,

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62. *Id.* at 82,815 (to be codified at 45 C.F.R. pt. 164.512(f)).
63. *Id.* at 82,813 (to be codified at 45 C.F.R. pt. 164.512(b)).
64. *Id.* at 82,814 (to be codified at 45 C.F.R. pt. 164.512(d)).
65. *Id.* at 82,813-16 (to be codified at 45 C.F.R. pt. 164.512).
66. *Id.* at 82,811 (to be codified at 45 C.F.R. pt. 164.508).
67. *Id.* at 82,462 (to be codified at 45 C.F.R. pts. 160, 164).
68. *See* Standards for Privacy of Individually Identifiable Health Information, 66 Fed. Reg. 12,432 (Feb. 26, 2001) (to be codified at 45 C.F.R. pts. 160, 164).
69. Under the Congressional Review Act, Congress has 60 days to review agency final rules and reject them. The General Accounting Office never received the rule until February 13, 2001; thus, the effective date was moved back to April 14, 2001. Steven Brostoff, *DHHS Privacy Rule Put on Hold; Government Activity; Brief Article*, NAT'L UNDERWRITER/LIFE & HEALTH/FIN. SERVS. ED., Feb. 26, 2001, at 42.
70. *See* 66 Fed. Reg. 12,434 (Apr. 14, 2001) (to be codified at 45 C.F.R. pt. 164.534(a)).
71. *Id.* (to be codified at 45 C.F.R. pt. 164.534(b)(2)).
72. 15 U.S.C. § 6804(a)(1) (2000) provides:

> The Federal banking agencies, the National Credit Union Administration, the Secretary of the Treasury, the Securities and Exchange Commission, and the Federal Trade Commission shall each prescribe, after consultation as appropriate with representatives of State Insurance Authorities designated by the National Association of Insurance Commissioners, such regulations as may be necessary to carry out the purposes of this subchapter.

73. *See supra* note 5.

thus excluding them from the FTC's authority.[74] Thus, the NAIC was charged with issuing guidelines for insurance institutions.

The NAIC finalized its rules on September 26, 2000.[75] Both the FTC and the NAIC chose to extend the deadline for full compliance from November 13, 2000 to July 1, 2001,[76] primarily due to the large number of financial institutions involved, the scope of the system-wide changes necessary for compliance, and to allay customer confusion.[77] Thus, compliance remained voluntary from November 13, 2000 to July 1, 2001.[78]

A. NAIC Guidelines

The NAIC Privacy of Consumer Financial and Health Information Regulation ("NAIC 2000 Model"),[79] which conforms to the Title V provisions of the Modernization Act, is a guide for state lawmakers in their efforts to draft privacy legislation. The NAIC 2000 Model differs from the Modernization Act in three significant ways: authorization is required for the disclosure of nonpublic personal health information, the definition of consumer has been expanded to include individuals obtaining financial products and services not used primarily for personal, family, or household purposes, and there are special exemptions for employees, agents, and representatives who do not share nonpublic information with anyone other than their principal.

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74. 65 Fed. Reg. 33,646, 33, 648 (May 24, 2000).

75. Scott Olson, *Insurers Take Privacy Steps; National Group Adopts Standards to Protect Consumers*, INDIANAPOLIS BUS. J., Oct. 16, 2000, at 21.

76. 65 Fed. Reg. 35,162, 35,184-85 (June 1, 2000).

77. *Privacy Protections for Consumers: Hearings Before the House Comm. on Telecommunications, Trade, and Consumer Protection*, 106th Cong. 53-69 (Oct. 11, 2000) (statement of Robert Pitofsky, Chairman of the Federal Trade Commission).

78. To comply with the NAIC Model regulations, an insurer needs to have completed the following steps by July 1, 2001: an audit of information practices; notice sent to all customers of the insurer's information practices and privacy policies; a reasonable amount of time for customers to opt-out; a tracking system to collect and monitor the opt-outs; and a disclosure system that recognizes all such opt-outs. Kirk J. Nahra, *What Every Insurer Needs to Know About Privacy*, EMERGING INS. DISP., Nov. 8, 2000. Financial institutions that fail to meet the July 1, 2001 deadline, including providing insufficient time for customers to opt-out, risks enforcement penalties such as potential litigation. *Id.*

79. INSURANCE INFORMATION AND PRIVACY PROTECTION MODEL ACT (National Ass'n of Ins. Comm'rs 2000), reprinted in 4 Nat'l Ass'n of Ins. Comm'rs, Model Laws, Regulations, and Guidelines 672-1 - 672-38 (update no. 55, April 2001) (hereinafter NAIC 2000 Model).

1. NAIC Distinction One: Inclusion of Nonpublic Health Information

First, the NAIC 2000 Model requires written authorization to disclose nonpublic personal health information,[80] which is subject to an opt-in procedure, rather than its financial brethren's opt-out procedure, thereby requiring financial institutions to take greater steps before disclosure is allowed. Moreover, the protection applies to affiliates as well as non-affiliates, and for both marketing and non-marketing purposes.[81] However, a number of exceptions exist to allow insurers to conduct their day-to-day business, and authorizations are not required for claims administration, policyholder service functions, disease management, auditing, and fraud investigations.[82] Thus, the degree of protection afforded nonpublic health information is significantly higher than financial information.

Drafters sought higher protections for health information for two reasons. One, federal banking agencies claimed health information could be protected by their regulations, thereby allowing health information to pass among affiliates without consent; and two, insurers store more personal data than banks.[83] The NAIC 2000 Model's protection for health

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80. "Nonpublic personal health information" is defined as health information "that identifies the individual who is the subject of the information," or health information "to which there is a reasonable basis to believe that the information could be used to identify an individual." *Id.* § 4(U) at 672-11. Insurers in these states that have already adopted the NAIC 1980 Model are already in compliance with the NAIC 2000 Model's health information provisions. *Insurance Regulation: Hearing on Gramm-Leach-Bliley Act: Hearings Before the House Committee on Energy and Power*, 106th Cong. 6-17 (Sept. 19, 2000) (statement by J. Lee Covington, Chairman, Director, Ohio Dep't of Ins.).

81. NAIC 2000 Model, *supra* note 79, § 17 at 672-32 - 672-33.

82. *Id.* § 17(B) at 672-32 - 672-33.

83. On September 28, 2000, Kathleen Sebelius, Chair of the NAIC Privacy Issues Working Group, stated in testimony before the National Conference of Insurance Legislators Regarding Consumer Privacy Legislation and Regulation:

> [w]e included health information protections in the model regulation for two reasons: the federal banking agencies included health information in their examples of the types of information that could be protected by their regulations, thus subjecting such information to the opt out standard for nonaffiliated third parties, and permitting the sharing of such information freely among affiliates; and insurance providers collect much greater amounts of health information than other financial services providers. In the new world created by [the Modernization Act], banks, securities firms and insurers can affiliate with each other, and the insurance entities will be bringing a great deal of consumer health information to those relationships.

information also mirrors prior legislation, such as state legislation drafted on the NAIC 1980 Model,[84] which generally requires an opt-in provision for insurance companies to disclose personal health information.[85]

The NAIC 2000 Model's nonpublic health information authorization procedure generally begins with an insurance company sending notification in written or electronic form to the consumer or customer.[86] The notification must identify the party, state the general description of the types of non-personal health information disclosed, the parties to whom the information is disclosed, and the purpose and use of the disclosure.[87] The notification must also identify the length of time the authorization remains valid, which cannot extend beyond a twenty-four month time period, and a consumer or customer may revoke it at any time.[88] The consumer or customer must sign and date the authorization, return it to the insurer, and the insurer must keep a record on file.[89]

The opt-in consent for nonpublic health information also raises an issue with HIPAA. Realizing HIPAA might conflict with or duplicate the provisions expounded in the NAIC 2000 Model, the NAIC drafted the model to provide that if insurers are in compliance with the HIPAA regulations as of July 1, 2001, they are not required to comply with the NAIC 2000 Model's section for health information.[90] The main reason is HIPAA provides broader privacy requirements than the NAIC 2000 Model. However, if insurers plan to comply with HIPAA at a later date, they will need to comply with the NAIC 2000 Model until their adoption of the HIPAA regulations.[91]

2. NAIC Distinction Two: Broad Definition of Consumer

Second, the definition of consumer includes claimants, beneficiaries, and persons entitled to coverage under group plans, employee benefit plans, and workers' compensation plans, all of whom do not have a direct relationship with an insurer, nor fall under a strict reading of the

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Nat'l Ass'n. of Ins. Comm'rs, *at* http://www.naic.org/1news/testimonies (last visited April 21, 2001).

84. *See supra* note 39.
85. *See supra* notes 39-49 and accompanying text (discussing the NAIC 1980 Model).
86. NAIC 2000 Model, *supra* note 79, § 18 at 672-33 - 672-34.
87. *Id.*
88. *Id.*
89. *Id.* §§ 18(A)(4)-(5) at 672-33.
90. *Id.* § 20 at 672-34.
91. *Id.*

Modernization Act's definition of consumer.[92] The direct relationship is lacking because the policy is held by a commercial enterprise (such as an employer) or a person who does not receive the benefits of such a policy. Moreover, the definition of consumer is broader than the Modernization Act, for it relates to the purchase of financial products and services for commercial purposes, and not household use.[93]

The reasoning behind the changes was put forth by Kathleen Sebelius, Chair of the NAIC's Privacy Issues Working Group, in her testimony to NCOIL regarding Consumer Privacy Legislation and Regulation.[94]

> Our members believe the definition of "consumer" under the federal regulations is too narrow to apply to all the types of individuals whose personal information needs protection in the insurance context.
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> . . . .
>
> We determined that all individuals who use insurance products or services primarily for personal, family or household purposes—including claimants and beneficiaries—should receive the same privacy protections as traditional consumers who have direct relationships with licensees. They should not be treated differently simply because they receive their insurance benefit through a policy held by another person or a commercial enterprise.[95]

Thus, the NAIC chose an expansive definition of consumer.

3. NAIC Distinction Three: Special Exemptions

Third, employees, agents, and representatives, if they do not disclose any nonpublic personal information to anyone other than their principal, appear to be excluded from the NAIC 2000 Model. Under the NAIC 2000 Model, licensees who are employees, agents, or other representatives of

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92. *Id.* § 4(F)(2)(a) at 672-4 provides, "[a]n individual who provides nonpublic personal information to a licensee in connection with obtaining or seeking to obtain financial, investment or economic advisory services relation to an insurance product or service is a consumer *regardless* of whether the licensee establishes an ongoing advisory relationship." (emphasis added). These claimants, beneficiaries, and group participants are considered consumers provided notice is given to the group policyholder and there is not a disclosure of nonpublic personal information, absent an exception. *Id.* § 4(F)(2)(e) at 672-5.

93. Remember the Modernization Act's definition of consumer only provides for financial services and products used primarily for personal, family, or household purposes. 15 U.S.C. § 6809(9) (2000).

94. *Available at* http://www.naic.org/1news/testimonies (last visited April 21, 2001).

95. *Id.*

another licensee are not included in the definition of "licensee" if: (a) the principal complies with all the requirements of the regulation, and (b) the employee, agent, and representative does not disclose any nonpublic personal information to anyone other than his or her principal or its affiliates.[96] Therefore, each group must adhere to the privacy requirements individually if they disclose to anyone other than their principal.

4. NAIC Clarification

Finally, the NAIC 2000 Model elaborated on what "publicly available" information is and what constitutes a reasonable opt-out. The NAIC 2000 Model defines publicly available information as any information that a licensee has a reasonable basis to believe is lawfully made available to the general public from governmental records, the media, or disclosures mandated by law.[97] Examples include government real estate records, security interest filings, and information from widely distributed media sources such as television and radio broadcasts.[98] The NAIC 2000 Model also elaborated on what constitutes reasonable opt-out for the release of financial information.[99] Examples include a check-off box in a prominent position on the relevant forms with an opt-out notice,[100] a reply form coupled with an opt-out notice, a toll-free telephone number for consumers to call,[101] and—with consumer permission—electronic consent via e-mail or a process at the institution's web site.[102] An example of an unreasonable method is if the institution's only method of allowing the consumer to opt-out is for the consumer to write his or her own letter.[103]

In sum, the NAIC 2000 Model requires authorization for the disclosure of nonpublic personal health information, presents an expanded definition of consumer—which includes claimants, beneficiaries, and persons entitled to coverage under group plans—and elaborates on the term publicly available information and what constitutes reasonable opt-out.

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96. NAIC 2000 Model, *supra* note 79, § 4(Q)(2) at 672-9.

97. *Id.* § 4(W)(1) at 672-12.

98. *Id.* § 4(W)(3) at 672-12 - 672-13.

99. Note here that the Modernization Act did not provide examples. *See* 15 U.S.C. § 6809(9) (2000).

100. NAIC 2000 Model, *supra* note 79, § 8(A) at 672-20.

101. *Id.* § 8(A)(2)(b)(iv) at 672-21.

102. *Id.* § 8(A)(2)(b)(iii) at 672-20.

103. *Id.* § 8(A)(2)(c)(i) at 672-21.

B. NCOIL Guidelines

Many insurers and some insurance commissioners objected to the NAIC 2000 Model because it did not mirror the FTC's rules for financial information and because it mandated privacy protections for health information that will either conflict with or copy existing state laws and the DHHS's regulations for HIPAA.[104] For example, the National Association of Independent Insurers ("NAII"), an organization representing more than 675 member companies, objected to the health provisions in the NAIC 2000 Model because the Modernization Act (1) does not include privacy provisions for health information, (2) the NAIC 2000 Model has the potential to result in dual compliance standards for property and casualty insurers, and (3) the definition of "consumer" is excessively broad and includes third-party claimants.[105]

On November 17, 2000, The National Conference of Insurance Legislators (NCOIL), recognizing the complaints by the NAII and other members of the insurance community, adopted its Financial Information Privacy Protection Model Act ("NCOIL Model").[106] NCOIL recognized that, while it was important to protect against the disclosure of nonpublic personal information, there were a variety of legitimate business purposes served by the disclosure of the information, especially within the insurance business. NCOIL claimed the Modernization Act was not designed to establish higher standards for insurance activities such as underwriting, claims adjusting and communications with agents, and that insurers need to share information, regardless of consent, to carry out insurance business activities.[107] Therefore, while the NCOIL Model is in many aspects similar to the NAIC 2000 Model (it is almost identical concerning financial information privacy), it differs in two significant ways.

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104. Briget Polichene, *Fed Up with the States on Privacy, Insurers Warm Up to U.S. Charter*, AM. BANKER, Nov. 17, 2000, at 13.

105. *Insurance Associations Disagree Over NAIC Privacy Model Regulation*, BESTWIRE, Nov. 03, 2000.

106. *Available at* http://www.ncoil.org/other/model.html (last visited Apr. 4, 2001).

107. *Id.* (NCOIL FINANCIAL INFORMATION PRIVACY PROTECTION MODEL ACT, Introduction (Nat'l Conference of Ins. Legislators 2001) (current version lacks relevant material, original information on file with author)).

1. NCOIL Distinction One: Limited Inclusion of Nonpublic Health Information

First, the NCOIL Model treats personal health information privacy in a limited way. Unlike the NAIC 2000 Model, the NCOIL Model provides opt-out consent for the disclosure of personal health information for all business needs other than marketing purposes.[108] Therefore, an insurer is required to get opt-in consent from the customer or consumer only if it wishes to use personally identifiable medical information for the sole purpose of marketing.[109] According to Susan Nolan, Deputy Executive Director of NCOIL, her organization chose a less restrictive approach than the NAIC regarding medical privacy because NCOIL was waiting for DHHS to publish its guidelines and to "give insurers a level playing field with other financial institutions [while] at the same time preserve the regulation of insurance at the state level and protect consumers."[110]

2. NCOIL Distinction Two: Narrow Definition of Consumer

Second, the NCOIL Model's definition of consumer does not include beneficiaries and claimants.[111] The NCOIL Model excluded beneficiaries and claimants to reduce the number of notices that must be mailed to employers, and to avoid problems insurers might encounter with the NAIC 2000 Model.[112] For example, when insurers need to disclose third-party claimant information to a staff agency to help determine rates, consent is required under the NAIC 2000 Model, but not the NCOIL Model.[113] Thus,

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108. NCOIL FINANCIAL INFORMATION PRIVACY PROTECTION MODEL ACT, § 501 (Nat'l Conference of Ins. Legislators 2001), *available at* http://www.ncoil.org/other/financial_information_privacy_pr.htm (last visited Apr. 11, 2001) (hereinafter NCOIL Model).

109. *Id.*

110. Meg Fletcher, *Key Differences with NAIC Model; NCOIL Drafts Own Privacy Rule*, BUS. INS., Nov. 27, 2000, at 2.

111. "Consumer" is defined as "any individual who seeks to obtain, obtains, or has obtained an insurance product or service in this state from a licensee, or that individual's legal representative, that is to be used primarily for personal, family, or household purposes, and about whom the licensee has nonpublic personal information." NCOIL Model, *supra* note 108, § 104(F), *available at* http://www.ncoil.org/other/financial_information_privacy_pr.htm (last visited Apr. 11, 2001).

112. *See* Catherine Tapia, *States Strive for Consistency in Complying with New Privacy Provisions*, INS. J., Mar. 6, 2001, *available at* http://www.insurancejournal.com/html/ijweb/publications/ijwest/w022601/statesstrive.htm.

113. *Id.*

this allowance facilitates important informational exchanges between principals and agents.

The NCOIL Model is also more aligned with the Modernization Act's definition of consumer because it does not cover commercial lines coverage such as workers' compensation. In doing so, it avoids potential conflicts with property/casualty insurers. According to Keith T. Bateman, the Alliance of American Insurers' Vice-President for Workers' Compensation and Health,[114] the inclusion of claimants and beneficiaries with commercial lines extends privacy protections to third-party claimants and beneficiaries, whose interests may not match those of the policyholder and their insurers. [115] Therefore, the NCOIL Model avoids this conflict by not providing protections.

In sum, the NCOIL Model differs from the NAIC 2000 Model by providing a less restrictive approach to personal health information and omitting beneficiaries and claimants from the definition of consumer, including workers' compensation claimants and any sort of commercial lines.

III. INDIVIDUAL STATES[116]

Today, state legislatures across the country are diligently drafting privacy regulations. Almost all have issued bulletins extending the compliance deadline from November 13, 2000 to July 1, 2001. Many have proposed bills to establish new privacy laws or strengthen existing laws. Some states, which have adopted legislation based on the NAIC 1980 Model, have decided to amend these laws rather than adopt the newer NAIC 2000 Model. Their reasoning is that the older model actually provides greater protections than the newer model, but it does not comply with all the minimum requirements of the Modernization Act. Below is a survey of each state's standing.

ALABAMA: The state extended the compliance deadline to July 1, 2001.[117] The state is currently reviewing both the NAIC and NOCIL

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114. AIA, a trade group representing 326 property and casualty insurance companies, supports the NCOIL Model. Scott Olson, *Insurers Take Privacy Steps; National Group Adopts Standards to Protect Consumers*, INDIANAPOLIS BUS. J., Oct. 16, 2000, at 21.

115. Len Famigietti, *Insurers Still Fret Over NAIC's Blending of Financial, Medical Privacy*, BESTWIRE, Aug. 24, 2000.

116. This list is current through April 4, 2001.

117. Department Regulation. No. 122, Alabama Dep't of Ins. (2000), *available at* http://www.aldoi.org/ClientDoc/122_2000.doc.

Models and whether health information will be covered.[118] Regulation No. 122, which complies with the Modernization Act's privacy requirements, has been in effect since October 15, 2000.[119]

ALASKA: The state extended the compliance deadline to July 1, 2001.[120]

ARIZONA: The state extended the compliance deadline to July 1, 2001,[121] and it has a law based on the NAIC 1980 Model.[122] Senate Bill 1288 amends the NAIC 1980 Model so that it complies with the Modernization Act.[123]

ARKANSAS: The state extended the compliance deadline to July 1, 2001.[124] House Bill 1377 has been introduced in the legislature authorizing the insurance commissioner to promote a privacy rule consistent with the NAIC 2000 Model.[125]

CALIFORNIA: The state has a law based on the NAIC 1980 Model.[126] California Civil Code § 56.265, effective Jan 1, 2001, prohibits certain persons or entities from disclosing personal health information of a customer for use concerning the granting of credit.[127] Assembly Bill 203

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118. Jim Connolly, *Work on Privacy Guidelines in Full Throttle*, NAT'L UNDERWRITER /PROP. & CAS./RISK & BENEFITS MGMT. ED., Mar. 5, 2001, at 14.

119. Department Regulation No. 122, Alabama Dep't of Ins. (2000), *available at* http://www.aldoi.org/ClientDoc/122_2000.doc.

120. Bulletin B 00-11, Alaska Dep't of Cmty. & Econ. Dev., Div. of Ins. (2000), *available at* http://www.dced.state.ak.us/insurance/00-11.htm.

121. Circular Letter 2000-12 from Charles E. Cohen, Director of Insurance, State of Arizona, to Insurance Industry Representatives, Insurance Trade Associations and Other Interested Parties (Oct. 3, 2000), *available at* http://www.state.az.us/id/circular/2000-12.pdf.

122. ARIZ. REV. STAT. §§ 20-2101 to 20-2120 (1981).

123. S.B. 1288, 45th Leg., 1st Reg. Sess. (Ariz. 2001), *available at* http://www.azleg.state.az.us/legtext/45leg/1r/bills/sb1288p.htm.

124. Bulletin 2000-5, Arkansas Ins. Dep't Legal Div. (2001), *available at* http://www.state.ar.us/insurance/pdf/erreg_bulletin.pdf.

125. H.B. 1377, 83d Gen. Assem., Reg. Sess. (Ark. 2001), *available at* http://www.arkleg.state.ar.us/ftproot/bills/2001/htm/hb1377.pdf.

126. CAL. INS. CODE §§ 791.01 to 791.26 (West 1989) (originally adopted in 1981).

127. CAL CIV. CODE § 56.265 (West 2000).

prevents financial institutions from disclosing nonpublic personal information without opt-in consent.[128]

COLORADO: The state extended the compliance deadline to July 1, 2001.[129] The state is moving toward the adoption of the NAIC 2000 Model that includes both financial and health privacy protections.[130] Senate Bill 01-001 protects personal health information related to injured workers and their dependents who receive or claim workers' compensation benefits.[131]

CONNECTICUT: The state extended the compliance deadline to July 1, 2001.[132] The state has a law based on the NAIC 1980 Model[133] and is considering a model similar to the NAIC 2000 Model, absent the health provisions.[134]

DELAWARE: The state extended the compliance deadline to July 1, 2001.[135]

DISTRICT OF COLUMBIA: The district is considering a model similar to the NAIC 2000 Model, absent the health provisions.[136]

FLORIDA: The state extended the compliance deadline to July 1, 2001.[137] The state is considering a model similar to the NAIC 2000 Model, with both the financial and health provisions.[138]

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128. A.B. 203, 2001-2002 Reg. Sess. (Cal. 2001), *available at* http://www.leginfo.ca.gov/pub/bill/asm/ab_02010250/ab_203_bill_20010326_amended_asm.html.

129. COLO. ADMIN. INS. REG. 6-4-1 (2000), *available at* http://www.dora.state.co.us/Insurance/regs/6-4-1.htm.

130. Connolly, *supra* note 118, at 14.

131. S.B. 01-001, 63d Gen. Assem., 1st Reg. Sess. (Colo. 2001), *available at* http://www.leg.state.co.us/2001/inetcbill.nsf/fsbillcont/F0ACA8F6AE0D6AE7872569BC005A272F?Open&file=001_rn2.pdf.

132. Bulletin No. IC-14, State of Connecticut Ins. Dep't (Oct. 23, 2000), *available at* http://www.state.ct.us/cid/bullic14.pdf (last visited Apr. 4, 2001).

133. CONN. GEN. STAT. §§ 38a-975 to 38a-998 (1983) (originally adopted in 1981).

134. Privacy of Consumer Financial Information, Proposed Regs., *available at* http://www.state.ct.us/cid/privreg.htm (last visited Apr. 4, 2001).

135. Letter from F.L. Peter Stone, Deputy Attorney General, State of Delaware, concerning Compliance with Gramm-Leach-Bliley Act (Nov. 21, 2000), *available at* http://www.state.de.us/inscom/glba.pdf.

136. Fletcher, *supra* note 110, at 3.

GEORGIA: The state extended the compliance deadline to July 1, 2001.[139] The state has a law based on the NAIC 1980 Model Act[140] and is working to amend the law to comply with the Modernization Act.[141] The state is also considering a model similar to the NCOIL Model.[142]

HAWAII: The state has not extended the compliance deadline.[143] Senate Bill 1550 governs the treatment of an individual's nonpublic personal financial information by all insurance licensees.[144]

IDAHO: The state extended the compliance deadline to July 1, 2001.[145]

ILLINOIS: The state extended the compliance deadline to July 1, 2001.[146] The state has a law based on the NAIC 1980 Model[147] and is considering a model similar to the NAIC 2000 Model, absent the health provisions.[148]

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137. Bulletin 00-004, Florida Dep't of Ins., Bill Nelson, Insurance Commissioner (Nov. 7, 2000), *available at* http://www.doi.state.fl.us/Companies/Bulletins/00-004.htm.

138. Connolly, *supra* note 118, at 14.

139. Insurance Fax, A Newsletter from the Georgia Fire and Safety Commissioner, Vol. 6, Issue 1 (January 2001), *available at* http://www.inscomm.state.ga.us/ANNOUNCEMENTS/Jan%202001%20Ins%20Fax.pdf.

140. GA. CODE ANN. §§ 33-39-01 to 33-39-23 (1985) (originally adopted in 1980).

141. H.B. 446, 146th Gen. Assem., Reg. Sess. (Ga. 2001), *available at* http://www.ganet.org/services/newleg/legsearch.cgi?year=2001&stype=billno&sparam=hb+446.

142. H.B. 455, 146th Gen. Assem., Reg. Sess. (Ga. 2001), *available at* http://www.ganet.org/services/newleg/legsearch.cgi?year=2001&stype=billno&sparam=hb+455.

143. Fletcher, *supra* note 110, at 3.

144. S.B. 1550, 21st State Leg. (Haw. 2001), *available at* http://www.capitol.hawaii.gov/session2001/bills/sb1550_.htm.

145. Bulletin No. 00-7, To All Insurers, From Mary L. Hartung, Director, State of Idaho Department of Insurance (Oct. 18, 2000), *available at* http://www.doi.state.id.us/new/00-7.pdf.

146. ILL. ADMIN. CODE tit. 50, § 4001.50 (2000), *available at* http://state.il.us/INS/legal/part4001.pdf.

147. 215 ILL. COMP. STATS. 5/1001 to 5/1024 (1997) (originally adopted in 1981).

148. Connolly, *supra* note 118, at 14.

INDIANA: The state extended the compliance deadline to July 1, 2001.[149] The state is undertaking the adoption of the NAIC 2000 Model that includes both financial and health privacy protections.[150]

IOWA: The state's financial privacy rules go into effect on July 1, 2001,[151] and medical privacy protections are awaiting approval from the results of a task force convened by Iowa Governor Tom Vilsack.[152] House Bill 110 mandates that medical information contained in medical records belongs to the patients and prohibits use of medical information without an opt-in.[153]

KANSAS: The state extended the compliance deadline to July 1, 2001.[154] The state has a law based on the NAIC 1980 Model but did not enact provisions concerning the collection and disclosure of medical information.[155] House Bill 2480 gives the commissioner the power to draft a rule consistent with, but no more restrictive than, the NAIC 2000 Model,[156] with the health provisions effective on or after February 1, 2002.[157]

KENTUCKY: The insurance department has drafted a financial privacy regulation based on the NAIC 2000 Model, absent the health provisions.[158]

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149. Title 760, Indiana Dep't of Ins., *available at* http://www.ai.org/idoi/glb_er_ir.html (last visited Apr. 4, 2001).

150. Proposed Rule, LSA Doc # 00-232, *available at* http://www.ai.org/idoi/LSA00-232.pdf (last visited Apr. 4, 2001).

151. IOWA ADMIN CODE §§191-90.1 to 191-90.21 (2001), *available at* http://www.iid.state.ia.us/docs/finprivr.pdf.

152. Connolly, *supra* note 118, at 14.

153. H.B. 110, 79th Gen. Assem., Reg. Sess. (Iowa 2001), *available at* http://www.legis.state.ia.us/GA/79GA/Legislation/HF/00100/HF00110/Current.html.

154. Bulletin 2000-05, Kansas Ins. Dep't (Oct. 10, 2000), *available at* http://www.ksinsurance.org/industry/bulletins/2000-05/2000-5.html.

155. KAN. STAT. ANN. §§ 40-2,111 to 40-2,113 (1994) (originally adopted in 1981).

156. H.B. 2480, § 1(15), 2001 Leg. Sess. (Kan. 2001), *available at* http://www.accesskansas.org/legislative/fulltext/bills.cgi/bill/2002/2480.pdf.

157. Supplemental Note on House Bill No. 2480, *available at* http://www.accesskansas.org/legislative/fulltext/bills.cgi/supp/2002/2480.html (last visited Apr. 4, 2001).

158. Privacy of Consumer Financial Information, 860 KY. ADMIN. REGS. 3:200 (2001), *available at* http://www.doi.state.ky.us/News/Documents/drafts/Reg03-200ref.html (last visited Apr. 4, 2001).

LOUISIANA: The state extended the compliance deadline to July 1, 2001[159] and is considering a model similar to the NAIC 2000 Model, absent the health and the workers' compensation provision.[160]

MAINE: The state extended the compliance deadline to July 1, 2001,[161] and it has a law based on the NAIC 1980 Model.[162]

MARYLAND: The state extended the compliance date to July 1, 2001.[163] The state is undertaking the adoption of the NAIC 2000 Model that includes both financial and health privacy protections or laws that cover both areas.[164]

MASSACHUSETTS: The state extended the compliance deadline to July 1, 2001.[165] The state has a law based on the NAIC 1980 Model.[166] House Bill 2356 authorizes the commissioner to draft a rule not inconsistent with the Modernization Act.[167]

MICHIGAN: The state extended the compliance deadline to July 1, 2001[168] and is considering a model similar to the NAIC 2000 Model, absent the health provisions.[169]

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159. Emergency Regulation 76, Kentucky Dep't of Ins. (Oct. 13, 2000), *available at* http://www.ldi.state.la.us/legal/reg76.htm.

160. Connolly, *supra* note 118, at 14.

161. Bulletin 305, *Uniform Effective Date for Privacy Standards Under the Gramm-Leach-Bliley Act*, State of Maine Dep't of Prof. & Fin. Reg., Bureau of Ins., (Nov. 9, 2001), *available at* http://www.state.me.us/pfr/ins/bull305.htm.

162. ME. REV. STAT. ANN. tit. 24-A, §§ 2201-20 (West 1999).

163. Bulletin 00-22, Maryland Ins. Admin. (Nov. 17, 2000), *available at* http://www.mdinsurance.state.md.us/downloads/bulletins/lh/bulletin00-22.pdf.

164. H.B. 362, 2001 Gen. Assem., 415th Reg. Sess. (Md. 2001), *available at* http://mlis.state.md.us/2001rs/billfile/hb0362.htm.

165. Bulletin 2000-08, Privacy Considerations, Massachusetts Div. of Ins., *available at* http://www.state.ma.us/doi/bulletins/bulletins_00_08.html (last visited Apr. 4, 2001).

166. MASS. GEN. LAWS ch. 1751, §§ 1-22 (1992).

167. H.B 2356, 182d Gen. Ct., 1st Ann. Sess. (Mass. 2001), *available at* http://www.state.ma.us/legis/history/h02356.htm.

168. Bulletin 2000-08, Compliance with Title V of the Gramm-Leach-Bliley Act, Privacy of Consumer Financial Information, New Hampshire Off. of Fin. & Ins. Servs. (Oct. 16, 2000), *available at* http://www.cis.state.mi.us/ofis/statutes/bulletin/ins/ 00_08.asp.

169. Meg Fletcher, *States Face a Deadline for Creating Privacy Rules*, BUS. INS., Feb. 12, 2001, at 3.

MINNESOTA: The state extended the compliance deadline to July 1, 2001[170] and it has a law based on the NAIC 1980 Model.[171]

MISSISSIPPI: The state extended the compliance deadline to July 1, 2001.[172] The insurance department's proposed regulation complies with the NAIC 2000 Model.[173]

MISSOURI: The state extended the compliance deadline to July 1, 2001.[174] The state is currently considering both the NAIC 2000 Model and the NCOIL Model.[175] Senate Bill 306, as originally introduced, was based on the NCOIL Model;[176] however, it was later amended to allow the insurance department to draft rules no more restrictive than the Modernization Act.[177]

MONTANA: The state has not extended the compliance deadline.[178] The state has a law based on the NAIC 1980 Model,[179] and privacy laws were passed in 1999 amending the law to require opt-in consent for insurers to collect personal or privileged information.[180]

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170. Bulletin 2000-7, State of Minnesota, Dep't of Comm. (Oct. 6, 2000), *available at* http://www.commerce.state.mn.us/bulletin/bul0007.htm.

171. MINN. STAT. §§ 72A.49-505 (1989).

172. Emergency Reg. No. 2000-7, Mississippi Dep't of Ins., *available at* http://www.doi.state.ms.us/regulations/20007reg.pdf (last visited Apr. 4, 2001).

173. Privacy of Consumer Financial and Health Information, Mississippi Dep't of Ins. Reg. No. 2001-1, *available at* http://www.doi.state.ms.us/regulations/20011reg.pdf (last visited April 21, 2001).

174. Bulletin 00-03, Missouri Dep't of Ins., *available at* http://insurance.state.mo.us/news/bulletin/00-03.htm (last visited Apr. 4, 2001).

175. Fletcher, *supra* note 169, at 3.

176. S.B. 306, 91st Gen. Assem., Reg. Sess. (Mo. 2001), *available at* http://www.senate.state.mo.us/01info/summs/intro/SB306.htm.

177. S.B. 306, 91st Gen. Assem., Reg. Sess. (Mo. 2001), *available at* http://www.senate.state.mo.us/01info/summs/comm/SB306.htm.

178. Fletcher, *supra* note 169, at 3.

179. MONT. CODE ANN. §§ 33-19-1010 to 33-19-409 (2000) (originally adopted in 1980).

180. *Id.* §§ 33-19-104, 33-19-202, 33-19-204, 33-19-306 (summary of amended law), *available at* http://data.opi.state.mt.us/bills/billhtml/SB0103.htm (last visited Apr. 4, 2001).

NEBRASKA: The state extended the compliance deadline to July 1, 2001.[181] The state is considering the adoption of the NAIC 2000 Model that includes both financial and health privacy protections, with protections for financial information becoming effective on July 1, 2001 and health information on January 1, 2003.[182]

NEVADA: The state extended the compliance deadline to July 1, 2001[183] and it has a law based on the NAIC 1980 Model.[184]

NEW HAMPSHIRE: The state extended the compliance deadline to July 1, 2001.[185] The state is considering the adoption of the NAIC 2000 Model, including both financial and health privacy protections or laws that cover both areas.[186]

NEW JERSEY: The state extended the compliance deadline to July 1, 2001.[187] The state has a law based on the NAIC 1980 Model[188] and is working to amend the law to comply with the Modernization Act.[189] The state is also considering the NCOIL Model.[190]

NEW MEXICO: The state extended the compliance deadline to July 1, 2001[191] and is considering a model similar to the NAIC 2000 Model for

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181. Bulletin No. CB-99, Implementation of Privacy Regulations Under Gramm-Leach-Bliley, Nebraska Dep't of Ins. (Oct. 11, 2001), *available at* http://www.nol.org/home/NDOI/bulletin/cb99.htm.

182. L.B. 359, 97th Leg., 1st Reg. Sess. (Neb. 2001), *available at* http://www.unicam.state.ne.us/PDF/INTRO_LB359.pdf.

183. RCB File No. R115-00, Workshop Notice, *available at* http://www.leg.state.nv.us/register/00register/r115-00_in.html (last visited Apr. 4, 2001).

184. NEV. ADMIN. CODE ch. 679B §§ 679B.560 to 679B.750 (1997) (originally adopted in 1989).

185. Bulletin, Docket No.: Ins. No. 00-020-AB, State of New Hampshire Ins. Dep't (Nov. 6, 2000), *available at* http://www.state.nh.us/insurance/News/Bulletins/Bulletin.htm.

186. Ins. 3000, Final Proposed Regulation, State of New Hampshire Ins. Dep't, *available at* http://www.state.nh.us/insurance/Regs/ins3000fpat.pdf (last visited Apr. 4, 2001).

187. Bulletin No. 00-15, Enforcement of Gramm-Leach-Bliley Privacy Requirements (Nov. 8, 2001), *available at* http://www.naic.org/nj/blt00_15.htm.

188. N.J. REV. STAT. §§ 17:23A-1 to 17:23A-22 (1985).

189. Connolly, *supra* note 118, at 14.

190. Fletcher, *supra* note 169, at 3.

191. Bulletin No. 2000-010, Gramm-Leach-Bliley Privacy Requirements, State of New Mexico Pub. Reg. Comm'n, Ins. Div., *available at* http://www.namic.org/s/newmex.htm (last visited Apr. 4, 2001).

both financial and health information. Senate Bill 352 establishes authority with the superintendent to draft privacy protection for insurance consumer's nonpublic personal information.[192]

NEW YORK: On November 13, 2000, the New York Insurance Department approved a privacy regulation consistent with the NAIC 2000 Model.[193] Two of the regulations' more salient points are: (1) licensees are generally not allowed to share any health information,[194] and (2) insurers cannot share nonpublic personal health information with affiliates or third parties unless the consumer or customer opts-in.[195] The regulation also protects consumers against discrimination from their decision to opt-in or opt-out,[196] and offers a method of recourse if information is illegally disclosed.[197] Compliance is required for financial information by July 1, 2001, and for health information by December 31, 2001.[198]

NORTH CAROLINA: The state extended the compliance deadline to July 1, 2001[199] and it has a law based on the NAIC 1980 Model.[200] House Bill 349 amends current law to comply with the Modernization Act.[201]

NORTH DAKOTA: The state has not extended the compliance deadline.[202] According to Insurance Commissioner Jim Pullman, the state is progressing toward the adoption of the NAIC 2000 Model with an opt-out for financial information and an opt-in for health information.[203] The regulation should be in place by August 1, 2001.[204] Senate Bills 2155[205]

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192. S.B. 352, 45th Leg., First Sess. (Nev. 2001), *available at* http://legis.state.nm.us/Sessions/01%20Regular/bills/senate/SB0352.html.

193. N.Y. COMP. CODES R. & REGS. tit. 11, § 420 (2001), *available at* http://www.ins.state.ny.us/acrobat/r169etxt.pdf.

194. *Id.* § 420.17.

195. *Id.*

196. *Id.* § 420.16.

197. *Id.* § 420.23.

198. *Id.* § 420.24(a).

199. Bulletin No. 00-B-5, North Carolina Dep't of Ins. (Nov. 1, 2000), *available at* http://www.ncdoi.com/industry/lbar/bulletins/2000/00-b-5.pdf.

200. N.C. GEN. STAT. §§ 58-39-1 to 58-39-120 (1981).

201. H.R. 349, Gen. Assem. of N.C., 2001 Sess. (N.C. 2001), *available at* http://www.ncga.state.nc.us/html2001/bills/AllVersions/House/H349v1.html.

202. Fletcher, *supra* note 169, at 6.

203. Connolly, *supra* note 118, at 14.

204. *Id.* See S.B. 2127, 57th Leg. Assem., Reg. Sess. (N.D. 2001), *available at* http://ranch.state.nd.us/LR/01/bill_text/BQTG0300.pdf.

and 2156[206] require written consent from a consumer to release financial and medical information, respectively.

OHIO: The state extended the compliance deadline to July 1, 2001[207] and it has a law based on the NAIC 1980 Model.[208] Currently, Ohio law includes opt-in provisions for both financial and health information.[209]

OKLAHOMA: The state extended the compliance deadline to July 1, 2001.[210]

OREGON: The state extended the compliance deadline to July 1, 2001[211] and it has a law based on the NAIC 1980 Model.[212] Senate Bill 269 blends state and federal privacy standards so that it complies with the Modernization Act yet preserves current privacy law.[213]

PENNSYLVANIA: The state extended the compliance deadline to July 1, 2001.[214] The state is considering the adoption of the NAIC 2000 Model that includes privacy protections for both financial and health information.[215]

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205. S.B. 2155, 57th Leg. Assem., Reg. Sess. (N.D. 2001), *available at* http://ranch.state.nd.us/LR/01/bill_text/BQVA0100.pdf (.

206. S.B. 2156, 57th Leg. Assem., Reg. Sess. (N.D. 2001), *available at* http://ranch.state.nd.us/LR/01/bill_text/BQVB0100.pdf.

207. Bulletin No. 2000-1, The Nat'l Ass'n. of Mut. Ins. Cos. (Sept. 27, 2000), *available at* http://www.namic.org/s/ohiopriv.htm.

208. OHIO REV. CODE ANN. §§ 3904.1 to 3904.22 (Anderson 1994/1997).

209. *Id.*

210. Notice and Press Release, Compliance Date of Privacy Provisions of Title V of the Gramm-Leach-Bliley Act, Oklahoma Ins. Dep't (Nov. 14, 2000), *available at* http://www.namic.org/s/OK%20Bulletin.pdf.

211. OR. ADMIN. R. 836-086-0005 (2000), *available at* http://www.cbs.state.or.us/external/ins/docs/rules/recent_adopt/privco.pdf.

212. OR. REV. STAT. §§ 746.600 to 746.690 (1988) (originally adopted in 1981).

213. S.B. 269, 71st Leg. Assem., Reg. Sess. (Or. 2001), *available at* http://www.leg.state.or.us/01reg/measures/sb0200.dir/sb0269.intro.html.

214. Insurance Department Notice 2000-08, Pennsylvania Ins. Dep't, *available at* http://www.insurance.state.pa.us/abn/2000-08.html (last visited Apr. 4, 2001).

215. Connolly, *supra* note 118, at 14.

RHODE ISLAND: The state extended the compliance deadline to July 1, 2001.[216] The State of Rhode Island Department of Business Regulation has issued two proposed regulations: Regulation 99 seeks to implement financial information privacy, and Regulation 100 seeks to protect health information.[217] Senate Bill 597[218] and House Bill 6092[219] both provide financial privacy protection.

SOUTH CAROLINA: The state extended the compliance deadline to July 1, 2001.[220] South Carolina's Department of Insurance intends to develop a rule that covers both financial and health information privacy.[221]

SOUTH DAKOTA: The South Dakota Department of Insurance has issued proposed financial privacy rules consistent with the NAIC 2000 Model, absent the health provisions.[222] Senate Bill 3 grants the commissioner the power to draft legislation protecting nonpublic personal financial information with special consideration given to the NAIC 2000 Model.[223]

TENNESSEE: The state extended the compliance deadline to July 1, 2001.[224] Senate Bill 1192[225] and House Bill 1628[226] allow financial

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216. Emergency Rules, Rhode Island Dep't of Prof. Reg., Dep't of Bus. Reg., (Nov. 20, 2000), *available at* http://www.namic.org/s/privacy/Rhode%20Island%20emergency%20rule.doc.

217. Insurance Regulation 100-Privacy of Consumer Health Information, *available at* http://www.dbr.state.ri.us/pdf_forms/regs/propd100.pdf (last visited Apr. 4, 2001).

218. S.B. 597, 2001 Gen. Assem., Jan. Sess. (R.I. 2001), *available at* http://www.rilin.state.ri.us/Billtext/BillText01/SenateText01/S0597.htm.

219. H.B. 6092, 2001 Gen. Assem., Jan. Sess. (R.I. 2001), *available at* http://www.rilin.state.ri.us/Billtext/BillText01/HouseText01/H6092.htm.

220. Bulletin 2000-12, South Carolina Dep't of Ins. (Nov. 3, 2000), *available at* http://www.state.sc.us/doi/Bulletin00-12.pdf.

221. *Id.*

222. Privacy of Consumer Financial Information, Ch. 20:06:45, *available at* http://www.state.sd.us/dcr/insurance/Legal/Hearing%20Schedule/FinancialPrivacyRules.doc (last visited Apr. 4, 2001).

223. S.B. 3, 76th Leg. Sess. (S.D. 2001), *available at* http://legis.state.sd.us/sessions/2001/bills/SB3enr.htm.

224. Bulletin, Privacy Considerations in Relation to the Financial Services Modernization Act, State of Tennessee Dep't of Comm. & Ins. (Oct. 31, 2000), *available at* http://www.namic.org/s/TNbulletin.pdf.

225. S.B. 1192, 102d Gen. Assem., 1st Reg. Sess. (Tenn. 2001), *available at* http://www.legislature.state.tn.us/bills/currentga/BILL/SB1192.pdf.

institutions to furnish information or records, to the extent provided under federal law, if consumer disclosure requirements and opt-out provisions are met.

TEXAS: The state extended the compliance deadline to July 1, 2001.[227] Senate Bill 11 and House Bill 1221 are two bills which focus on medical privacy.[228]

UTAH: The state extended the compliance deadline to July 1, 2001.[229] Senate Bill 100 has been amended to provide opt-in consent before insurance information is shared.[230]

VERMONT: The state extended the compliance deadline to July 1, 2001.[231] The Vermont Department of Insurance is considering a model that is stricter than both the NAIC 2000 Model and the NCOIL Model because Vermont currently has consumer privacy protection laws that are more stringent. The proposals seek to mend the federal and state law and include for the creation of an opt-in standard for the disclosure of financial information to nonaffiliated third parties.[232]

VIRGINIA: The state extended the compliance deadline to July 1, 2001[233] and it has a law based on the NAIC 1980 Model.[234] The state is

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226. H.B. 1221, 102d Gen. Assem., 1st Reg. Sess. (Tenn. 2001), *available at* http://www.legislature.state.tn.us/bills/currentga/BILL/hb1192.pdf.

227. Commissioner's Bulletin No. B-0056-00, Texas Dep't of Ins. (Oct. 6, 2000), *available at* http://www.tdi.state.tx.us/commish/b-0056-0.html.

228. Connolly, *supra* note 118, at 14.

229. R590-205, Privacy of Consumer Information Compliance Deadline (Jan 11, 2001), *available at* http://www.insurance.state.ut.us/rules/R590-205.htm.

230. S.B. 100 Second Substitute, 2001 Gen. Sess. (Utah 2001), *available at* http://www.le.state.ut.us/~2001/bills/sbillenr/SB0100.htm.

231. Bulletin 125: Compliance Date for Gramm-Leach-Bliley Provisions, Vermont Dep't of Banking, Ins. Sec. & Health Care Admin. (Oct. 12, 2000), *available at* http://www.bishca.state.vt.us/Regulations/insbull/BUL125redo.htm.

232. Nat'l Ass'n of Independent Insurers, *VT. Privacy Plan Goes Far Beyond What's Needed*, NAII News Release, Dec. 18, 2001. *See also* Proposed Banking Regulation B-2001-01, *available at* http://www.bishca.state.vt.us/Regs&Bulls/propregs/B2001_01.PDF (last visited Apr. 4, 2001); Proposed Ins./Health Care Reg. IH-2001-01, *available at* http://www.bishca.state.vt.us/Regs&Bulls/propregs/IH2001_1.PDF (last visited Apr. 4, 2001).

233. Administrative Letter 2000-13 from Alfred W. Gross, Virginia Commissioner of Insurance (Sept. 29, 2000), *available at* http://www.namic.org/s/vapriv.htm.

234. VA. CODE ANN. §§ 38.2-600 to 38.2-620 (Michie 1986/1987).

working to amend the law so that it complies with the Modernization Act.[235]

WASHINGTON: The state has adopted a final privacy rule to cover financial and health information, which went into effect on February 9, 2001.[236]

WEST VIRGINIA: The state extended the compliance deadline to July 1, 2001.[237] The state is moving toward the adoption of the NAIC 2000 Model that includes both financial and health privacy protections or laws that cover both areas.[238]

WISCONSIN: The state currently has a statute based on the NAIC 1980 Model, but limited the provision of its law to disclosure of personal medical information only.[239] The state has proposed a rule based on the NAIC 2000 Model, but it also imposes privacy requirements in the area of workers' compensation.[240]

WYOMING: Senate File 60 grants the insurance commissioner authorization to declare a privacy rule.[241] The Senate deleted language that said the rule should be consistent with, but no less restrictive, than the NAIC 2000 Model and added an amendment creating July 1, 2007, as a sunset date for the commissioner's rule.[242]

IV. PROPOSAL

State lawmakers must pass privacy legislation within the next few months to comply with the July 1, 2001 deadline. Prior to that deadline,

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235. H.B. 2157, 2001 Gen. Assem., Reg. Sess. (Va. 2001), *available at* http://leg1.state.va.us/cgi-bin/legp504.exe?011+ful+HB2157ER.

236. Rule-Making Order (RCW 34.05.360), *available at* http://www.insurance.wa.gov/tableofcontents/newrules/2000-08103.pdf (last visited Apr. 4, 2001).

237. Informational Letter No. 125 from Hanley Clark, Insurance Commissioner, West Virginia Dep't of Ins. (Oct. 2000), *available at* http://www.namic.org/s/WV%20letter.pdf.

238. Connolly, *supra* note 118, at 14.

239. WIS. STAT. § 610.70 (2000).

240. Privacy of Personal Nonpublic Information, WIS. ADMIN. CODE §§ INS. 25.01 to INS. 25.95 (2001) *available at* http://badger.state.wi.us/agencies/oci/rules/ins25.pdf.

241. S.F. 60, 57th Leg., Gen. Sess. (Wyo. 2001), *available at* http://legisweb.state.wy.us/2001/introduced/sf0060.htm.

242. *Id.*

legislators will have a choice of either adopting the NAIC 2000 Model or the NCOIL Model. Comparing the two reveals the former, like the magic in the ruby slippers, will enable the lawmakers to "go home."

The NAIC 2000 Model is advantageous for three reasons: the consumer is protected from all disclosures of personal health information; these consumer protections are immediate; and more consumers are protected with the expanded definition of consumer—many of whom would fall under traditional industry protections, but are exempt due to the noncommercial definition of consumer in the Modernization Act.

First, the NAIC 2000 Model protects *all* health information. This provides greater protection for consumers than the NCOIL Model, which only safeguards health information in marketing situations. Two arguments raised in opposition to the NAIC 2000 Model's health component—that the Modernization Act did not include protections for health information, and that the DHHS's regulations may conflict with the NAIC 2000 Model—are unfounded. While it is true that the Modernization Act's main purpose is to protect financial information, states are allowed to introduce more stringent legislation. Furthermore, the NAIC 2000 Model acquiesces to the DHHS's regulations, thereby alleviating conflicts.

Second, the NAIC 2000 Model narrows the gap in privacy coverage, due to the DHHS's compliance date. The DHHS's regulations for HIPAA take effect on April 14, 2001, nine months after the FTC's extension of the Modernization Act. Moreover, by the time all covered entities are required to comply, thirty-six more months will pass.[243] Compounding this issue is the realization that financial industries now control greater amounts of personal information as the direct result of financial holding companies. Lack of prohibitions among these entities, with the sharing of health information, imposes a great danger of inappropriate use of this information. Thus, in this time period, without adequate privacy protections, consumers will not have the protection they need to safeguard their personal health information.

Third, more consumers are included in the NAIC 2000 Model's definition of consumer. The Modernization Act's definition of consumer does not align with the traditional definition of consumer as related to the insurance industry. For example, many insurance applicants receive their policies through their employers. By not including these applicants in the definition of consumer, the privacy notices are not sent, thereby vitiating

243. *See supra* notes 70-71 and accompanying text (discussing HIPAA).

the privacy of these consumers. Thus, insurance consumers are greatly benefited by an expansive definition of consumer.

One final point, if states decide to enact varying laws, the insurance industry may seek to implement a uniform standard by asking Congress to either amend the Modernization Act or enact new federal laws, thereby usurping the responsibility from the states. Already, Rep. John D. Dingell (D-Mich.), the ranking Democrat on the House Energy and Commerce Committee, is calling for an investigation into the state insurance department accreditation program sponsored by the NAIC,[244] and the actions taken by individual states to implement the Modernization Act's privacy requirements.[245] Lack of uniformity among the states will only intensify the call for federal regulation, thereby wrestling from the states vital control of the insurance industry.

V. CONCLUSION

In the next few months, state lawmakers face the challenge of passing legislation to help insurers meet the privacy requirements of the Modernization Act. Lawmakers will need to decide whether to adopt either the NAIC 2000 Model—with its more stringent controls on personal health information and its expanded definition of consumer to cover traditional recipients of insurance coverage—or the NCOIL Model—with its limited protection of personal health information, and exclusion of claimants, beneficiaries, and group participants from its definition of consumer. The NAIC 2000 Model is, however, the better choice. It protects more consumers and delivers the protections sooner than the alternatives. Thus, the NAIC 2000 Model will help the lawmakers get out of Oz.

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244. Editorial: *Rep. Dingell Not Off-Base with Call for New Probes*, NAT'L UNDERWRITER/PROPERTY & CASUALTY/RISK & BENEFITS MANAGEMENT ED., Mar. 12, 2001, at 26. The accreditation program requires states to meet certain minimum criteria as mandated by the NAIC and requires sufficient funding levels, adequate staff, certain levels of expertise by its insurance department, and the adoption of particular model laws. *Id.*

245. *Id.*

PEGRAM V. HERDRICH: A CASE STUDY IN "DUAL" LOYALTIES: WHY "COST-CUTTING" HEALTH MAINTENANCE ORGANIZATIONS SHOULD BE HELD LIABLE FOR CUTTING MEDICALLY NECESSARY CARE

*Marni R. Wasserman**

TABLE OF CONTENTS

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INTRODUCTION

"ERISA is an evolving law; the circle has not yet closed."[1]

When Cynthia Herdrich discovered a sharp pain in her groin, she trustingly sought the advice and care of Dr. Lori Pegram.[2] Dr. Pegram, along with other participating physicians, was one of the owners of Carle Health Insurance Management Company ("HMO"), which serviced patients "whose employers contract[ed] with Carle to provide such coverage. . . . Cynthia Herdrich, was covered by Carle through her husband's employer, State Farm Insurance Company."[3] Upon inspecting Herdrich, Dr. Pegram became aware of a swollen mass, but declined to order an ultrasound, as the nearby hospital did not take part in Carle HMO.[4] As a result of Dr. Pegram's choice to defer "medically necessary" treatment, Herdrich's appendix ruptured and she suffered peritonitis.[5] On appeal, the Supreme Court reversed the Seventh Circuit's opinion, which

1. SUSAN P. SEROTA, ERISA FIDUCIARY LAW 39 (1995) (emphasis added).
2. Pegram v. Herdrich, 530 U.S. 211, 215 (2000).
3. *Id.*
4. *Id.* In fact, Herdrich was forced to wait an additional eight days for treatment at a Carle- owned facility. *Id.*
5. *Id.* Peritonitis is an "inflammation of the peritoneum [which is defined as] the smooth transparent . . . membrane that lines the cavity of the abdomen." WEBSTER'S NINTH NEW COLLEGIATE DICTIONARY 875 (9th ed. 1983) [hereinafter WEBSTER'S].

held that Herdrich (at the lowest end of the spectrum and at the pre-trial phase) had stated a claim against her HMO for breaching its fiduciary duty under ERISA to act "solely in the interest of [plan] participants,"[6] through year-end physician bonuses that were directly related to cost-cutting procedures.[7] In handing down its decision, the Court likely "handed HMOs a victory. . . . [In effect] the Court held that treatment decisions made by an HMO, acting through its physician employees, are not fiduciary acts. As a result, patients cannot sue their HMOs in federal court for offering financial incentives to doctors who keep costs down."[8]

Unfortunately for patients, Cynthia Herdrich's story is not the exception, but rather, has become the rule for HMOs that provide an array of financial incentives to physicians, thereby limiting those physicians' determinations of what does and does *not* qualify as "medically necessary" treatment under an employee welfare plan.[9] Most problematic in terms of

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6. Herdrich v. Pegram, 154 F.3d 362, 373 (7th Cir. 1998), *overruled by* 530 U.S. 211 (2000); *see* Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1104(a)(1) (1988 & 1993 Supp.) (hereinafter ERISA); *see also* SEROTA, *supra* note 1, at 19. Serota explains:

> ERISA imposes a high standard of conduct—the "highest known to law"—on fiduciaries of employee pension plans . . . the standard of conduct is the "prudent man standard of care." There are several elements to the prudent man standard of care. ERISA generally requires that a plan fiduciary, when discharging his or her duties with respect to the plan, act "solely in the interest of the participants and beneficiaries" covered under the plan . . . under the "solely in interest" / "exclusive purpose" test, a breach of fiduciary duty results if the fiduciary places his or her own self-interest ahead of the plan or its participants.

Id. (internal citations omitted).

7. *Herdrich*, 154 F.3d at 373.

8. Jason A. Glodt, *Watch Out HMOs: The Future of Patients' Rights Will Soon Be Determined*, 45 S. D. L. REV. 640, 651 (2000). Further, the *Pegram* Court noted that "any legal principle purporting to draw a line between good and bad HMOs would embody . . . . a judgment about socially acceptable medical risk." *Pegram*, 530 U.S. at 221. However, in declining to make this distinction, Herdrich was left without a viable remedy. *See* Corcoran v. United Healthcare, Inc., 965 F.2d 1321, 1338 (5th Cir. 1992) (stating, while simultaneously finding for the HMO based on precedent, that ERISA preemption is problematic, in part, because "if the cost of compliance with the standard of care need not be factored into utilization review companies' cost of doing business, bad medical judgments will end up being cost-free to the plans. . . .").

9. Richard Sorian & Judith Feder, *Why We Need a Patients' Bill of Rights*, 24 J. HEALTH POL. POL'Y & L. 1137, 1143 (1999) (emphasis added) (stating that "[h]ealth plan contracts typically include a list of covered services *but* condition that coverage on the service being 'medically necessary.' There is, however, a growing trend among health plans to define medical necessity *arbitrarily* as a means to control costs through claim denials.")

analysis under ERISA, the vast majority of plaintiffs who assert claims against their HMOs are precluded from recovering in either state or federal court due to Congress' mandatory preemption of state law under the terms of ERISA.[10] In effect, HMO defendants have successfully avoided direct liability under a broad reading of ERISA's preemption doctrine.[11] *Even if* a plaintiff successfully prevails under ERISA in federal court, she "can only recover the cost of a disputed service [she] should have received, not compensation for 'lost wages, death or disability, pain and suffering, emotional distress, or other harm that a patient suffers as a result of the improper denial of care.'"[12] Accordingly, Congress and the courts have

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10. ERISA preempts state laws insofar as they "may now or hereafter *relate to* any employee benefit plan." 29 U.S.C. § 1144(a) (1994) (emphasis added); SEROTA, *supra* note 1, at 38; *see* Brief of Amici Curiae Healthcare For All at *10-11, Pegram v. Herdrich, 530 U.S. 211 (2000) (No. 98-1949), Amici stated the problem aptly when it noted:

> [T]o the extent that preemption is appropriate to prevent potentially disuniform regulation of employee benefit plans, it should not be read to shelter entities that administer such plans from any legal oversight . . . [f]ederal displacement of state law does not erase any and all accountability. Thus, when a state law action is preempted because the matter "relates to" an ERISA plan, the presumption must be that the matter falls within ERISA's fiduciary-based system of regulation. For if there is no ERISA jurisdiction over the matter, it is difficult to see how the state action "relates to" an ERISA plan.

Id.

11. Dawn Lauren Morris, Comment, *ERISA Preemption, HMOs, and Denial of Benefit Claims*, 59 LA. L. REV. 961, 972, 1000 (1999) (arguing that "HMOs should take into account the cost of litigation when evaluating the costs of doing business. . . .) In addition, while HMOs may be held liable under ERISA, the remedies available are so limited that HMOs probably will not be forced to factor in the costs of damages when making coverage decisions. Patricia Ochmann states:

> [p]lan participants are usually opposed to ERISA preemption because of the statute's limited remedies. Individuals whose claims have been preempted by ERISA cannot recover for all of the injuries caused by their [HMOs'] refusal of treatment or substandard medical care; rather, they may seek only injunctive or declaratory relief . . . [t]he practical effect of [this] . . . is to deny many plaintiffs a legal cure for the injuries they have suffered.

Patricia Mullen Ochmann, *Managed Care Organizations Manage to Escape Liability: Why Issues of Quantity vs. Quality Lead to ERISA's Inequitable Preemption of Claims*, 34 AKRON L. REV. 571, 588-89 (2001).

12. Glodt, *supra* note 8, at 643 (quoting Robert Pear, *Judges Deplore Law that Shields HMOs*, J. REC., July 15, 1998, at 5). On the other hand, patients may still sue their *physicians* in state court for malpractice. *Id. See also* Thomas R. Mclean, M.D. & Edward P. Richards, *Managed Care Liability for Breach of Fiduciary Duty after* Pegram v. Herdrich: *The End of ERISA Preemption for State Law Liability for Medical Care Decision*

placed patients in a zero-sum position of either complete preemption or incomplete recovery.[13] As one authority noted:

> [The HMO] is not liable under state law because his actions constitute the interpretation of an ERISA plan, not the practice of medicine, and state law is therefore preempted. The [HMO] also cannot be held liable under state law for decisions interpreting an ERISA plan, or for the manner in which it delegated responsibility for such decisions. But . . . the physician and the [HMO] [will argue that they] cannot be held liable under federal law either, because the decision whether a particular test or procedure was "medically necessary" is a medical decision, not an ERISA decision.[14]

Making, 53 FLA. L. REV. 1, 4 (2001). Mclean and Richards argue that in the context of state tort law claims the *Pegram* Court's ruling effectively disallows physicians from using the ERISA preemption defense because the Court ruled that only pure administrative decisions (versus "medical" decisions or "mixed" medical and administrative decisions) may be removed to federal court. Thus,

> [o]nly pure eligibility decisions are related to the plan and hence covered under ERISA . . . because pure eligibility decisions are the only HMO administrative decision covered by ERISA, such decisions are the only ones that are entitled to ERISA preemption protection . . . in essence, while it is true that ERISA preemption protection is available to the HMO for pure eligibility decisions, *Pegram* has so narrowed the ERISA's preemption . . . as to make it an inconsequential form of protection.

Id. at 28.

> At the same time, however, the authors acknowledge that
> [p]lans may escape this [state] regulation by limiting their role in the decisions about individual patients and the *quality* of individual patient care . . . [t]o the extent that [this] results in shifting the risk of insurance to physicians without regard to their competence and performance, it will hurt the quality of patient care.

Id. at 5 (emphasis added). And indeed, based on the current "quality" versus "quantity" standard and the oftentimes apparent overlap in the medical context, it seems likely that HMOs could continue to utilize the distinction to escape liability under state tort law. *See* Ochmann, *supra* note 11, 598.

13. Morris, *supra* note 11, at 970-72 (noting that HMOs have two chances to remove state law causes of action to federal court under either complete or conflict preemption).

14. Brief of Amici Curiae Health Law, Policy, and Ethics Scholars at *12, Pegram v. Herdrich, 530 U.S. 211 (2000) (No. 98-1949); Brief of Amici Healthcare For All, Pegram v. Herdrich, 530 U.S. 211 (2000) (No. 98-1949). *See also* Morris, *supra* note 11, at 964 (stating that "[m]anaged care organizations have taken advantage of corporate medicine laws to avoid liability by claiming that since corporations cannot practice medicine . . . then

Using the Supreme Court's decision in *Pegram v. Herdrich* as a guidepost for discussion, this Note argues that the *Pegram* Court (and courts throughout the country) place patients in an insecure position by failing to distinguish between medical and administrative decisions. Significantly, when HMOs and HMO physicians make "mixed" medical and eligibility determinations which are extensively intertwined with financial incentives to limit "medically necessary" care, they act as fiduciaries under ERISA.[15] Importantly, if an HMO successfully preempts a state law cause of action due to the provisions of ERISA, that defendant cannot escape liability by arguing that it is also not liable as a fiduciary under ERISA.[16] With the modern-day "commodification of medicine,"[17] the line between the "quality" of care received and the "quantity" of benefits provided (or denied) permits HMOs to effectively escape liability.[18] This Note also suggests that if plaintiffs cannot assert a claim for breach of fiduciary duty under ERISA, they should be afforded the opportunity to hold HMOs directly liable under state law. In order to make such a remedy available, "Congress should amend ERISA so that medical malpractice suits will be *expressly* allowed against ERISA-qualified HMOs."[19] Significantly, we must also keep in mind the initial reasoning

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they, as corporations, are not practicing medicine, and therefore cannot be held liable for medical malpractice.")

15. Pegram v. Herdrich, 530 U.S. 211,228 (2000). This Note uses the terms "mixed eligibility and medical decisions" to mean decisions by HMOs and HMO doctors regarding the type of treatment received under an employee welfare plan *as well as* administrative decisions concerning coverage and plan benefits. *See* Brief of Amici Curiae Health Law, Policy, and Ethics Scholars at *4-5, Pegram v. Hedrich, 530 U.S. 211 (2000) (No. 98-1949). (arguing that "an [HMO] or physician is an ERISA fiduciary to the extent that it or she has discretionary authority to determine the coverage of the ERISA plan itself.").

16. Glodt, *supra* note 8, at 645.

17. Dahlia Schwartz, Note, *Breathing Lessons for the ERISA Vacuum: Toward a Reconciliation of ERISA's Competing Objectives in the Health Benefits Arena*, 79 B.U.L. REV. 631, 632 (1999). *See* Brief of Amici Curiae Health Law, Policy, and Ethics Scholars at *10, *Pegram* (No. 98-1949) (arguing that "[i]n such a case, it is very important. . . to maintain the conceptual distinction between the health care decisions and the plan coverage decisions. . . Petitioner's effort to immunize the plan coverage decision from ERISA (or any other) liability is both bad law and bad medicine.")

18. Notably, the distinction between "quantity" and "quality" has been created by lower state and federal courts. *See* Ochmann, *supra* note 11, at 592-98 (persuasively utilizing two similar cases of pregnant women's suits against their HMOs to establish the difficulty courts face in distinguishing between substandard care and no care).

19. Morris, *supra* note 11, at 990 (emphasis added). This idea is not novel. In fact, the modern "trend" followed by the courts is to "abrogate the immunity enjoyed by HMOs." *Id. But see* McLean & Richards, *supra* note 12, *passim* (making the argument that the

behind ERISA's application to employee welfare plans and the interpretation that courts have given ERISA during the last thirty years.

Part II commences with a brief discussion of the origins of ERISA and the current public opposition to the Act as it applies to employee welfare plans (including, cost-containment case law). This section then examines the fiduciary duty under ERISA, reviewing recent court decisions in which HMOs have been held liable for breach of their fiduciary duty. Lastly, this Part briefly analyzes other possible causes of action against HMOs. In particular, this section focuses on courts' utilization of a distinction between the "quality" and "quantity" of care, noting that this distinction is oftentimes blurred in medical decisions, but has nonetheless created a loophole for HMOs, which argue that they do not provide medical ("quality" of care) treatment, and thus, are not liable under traditional state tort law.[20] Part III then shifts to an analysis of the principal case, *Pegram v. Herdrich*.

Part IV applies the preceding discussion to *Pegram* and argues, in part, that the Court's limited focus on financial incentives in the context of employee welfare plans skewed the issue before it. The section argues that the Court should have focused on the fiduciary duty under ERISA in conjunction with financial incentives to hold that Herdrich presented a triable issue of fact as to whether Carle HMO breached its fiduciary duty. The section then contends that the fiduciary duty remains viable even though HMOs make both medical and administrative decisions, and that courts are responsible for making this distinction clear and applying *it in terms of liability*. Part IV also argues that the Court should have analyzed other possible causes of action under a more *functional* standard than the "mixed eligibility and medical" test, simultaneously questioning whether preemption *was* appropriate on a factual basis.[21] This point is significant in that it calls into question the usefulness of ERISA as it relates to medical care, something that the Court itself implicitly pondered.[22] Finally, this Note concludes with the suggestion that ERISA be amended in the context of corporate medical care, specifically citing state laws and recent

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Pegram Court's holding already allows plaintiffs an express cause of action against their HMOs for medical malpractice).

20. Ochmann, *supra* note 11, *passim*. *See also* Morris, *supra* note 11, at 968.

21. The Court declined this analysis in its decision. Justice Souter stated in a footnote that, "Herdrich does not contest the propriety of removal . . . and we take no position on whether or not the case was properly removed." Pegram v. Herdrich, 530 U.S. 211, 216 n.2 (2000).

22. *Id.* at 24. *Pegram* 530 U.S. at 225.

congressional action, which have signaled a change toward HMO liability.[23] The Court in *Pegram* should have kept the current condition of medical care in mind as it decided the outcome of Herdrich's claims.

I. BACKGROUND: THE CONVERGENCE OF ERISA AND HMOS

A. From ERISA to Corporate Medicine and Beyond: Origins, Interpretations, and Criticism

1. Origins

In 1973, Congress passed the Health Maintenance Act ("Act") in response to the increasing costs of medical care and the belief that physicians were over-utilizing patient referrals and costly medical procedures.[24] The intent of the Act was to:

> encourage development of new programs that promoted preventive care and created incentives to keep people well. . . . [c]osts are controlled through cost-containment strategies such as: incentives to physicians to decrease the patient's initial use of services; fixed fees for identified procedures; predetermined annual payment for comprehensive care; and decreased physician involvement if over-utilization of services by the plan participants can be demonstrated.[25]

In addition to creating new financial incentives for physicians who contract with HMO providers, the Act changed the relationship that previously existed between physicians and patients. Under the modern system, which defines medical treatment and benefits today, "[t]he payor [HMO] accepts some of the financial risk from the provider (physician) in exchange for some control over the way the physician practices medicine. . . . [w]hen malpractice occurs in a traditional patient-physician relationship,

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23. *See, e.g.*, Corporate Health Ins., Inc. v. Texas Dep't of Ins., 215 F.3d 526 (5th Cir. 2000), petition for cert. filed, 69 USLW 3317 (U.S. Oct. 24, 2000); Access to Quality Care Act, H.R. 216, 106th Cong. § 302(e)(1)(A) & (B) (1999). *See also* Morris, *supra* note 11, at 962.

24. Morris, *supra* note 11, at 964.

25. *Id.* at 965. Additionally, Morris contends that "[a]ny or all of these may require the physician to act as a gatekeeper by denying or restricting health care measures requested by the patient." *Id.* at 965.

direct liability exists. . . . [i]n a patient-HMO-physician relationship, however, theories of liability have become complex."[26]

One year later, in 1974, Congress passed ERISA.[27] It is important to keep in mind congressional intent at this stage of the analysis because many medical and legal writers have pointed to courts' contradictory interpretations of ERISA.[28] In attempting to create a national, uniform standard that regulated employee healthcare, Congress "included the protection of: the interests of participants . . . and their beneficiaries, by requiring the disclosure and reporting to participants . . . of financial and other information . . . by establishing standards of conduct, responsibility, and obligation for fiduciaries . . . and by providing for appropriate remedies . . . and ready access to the federal courts."[29] Hence, while the intent of Congress was to provide a remedy for patients that intent has been subrogated in favor of larger players, namely health maintenance organizations.[30]

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26. *Id.* at 965-66. *See also* McLean & Richards, *supra* note 12, at 7. The authors state:

> [T]he downside of more "cost efficient" health care is that managed care is perceived to distort the loyalty of the physician providers. Under fee-for-service reimbursement, the traditional theory was that the interests of the doctor and patient were aligned; thus, more medical care was seen by both the patient and the physician to be good medical care. . . . [i]n contrast, under managed care, the interests of the doctor and patient are clearly disassociated. In fact, the doctors' and patients' interests have become "triangulated" such that the third corner of the triangle is occupied by an HMO. The addition of the HMO to the doctor-patient relationship inexorably produces a paradigm shift in the relation of the doctor to the patient, which undermines the relationship of trust between the doctor to the patient.

Id. at 6-7.

27. Morris, *supra* note 11, at 966.

28. For example, Schwartz states that "ERISA's preemption provisions, originally intended to provide beneficiaries with federal redress for wrongful denials of benefits, instead provide benefit plans with protection against state laws intended to promote the welfare of those same beneficiaries." Schwartz, *supra* note 17, at 637-38.

29. *Id.* at 636.

30. However, some commentators have argued that financial incentives to limit care are one of the only ways to cut costs and provide care to those who are not covered by health insurance. Additionally, one author has noted that financial incentives are probably beneficial to patients, as physicians are encouraged to implement only "medically necessary" care. *See* Robert J. Herrington, Note, Herdrich v. Pegram: *ERISA Fiduciary Liability and Physician Incentives to Deny Care*, 71 U. COLO. L. REV. 715, 731-33 (2000). Furthermore, "competition" between HMOs may allow patients to choose their heath care accordingly. *Id.* However, employees cannot choose their health care provider under an

2. A "Vague" Standard of Interpretation: The "Relates To" Doctrine

There are two types of preemption under ERISA.[31] First, "ERISA provides a civil enforcement provision which allows civil actions to be brought against ERISA plans to: (1) recover benefits due under the plan (2) enforce rights under a plan, or (3) clarify rights to future benefits."[32] If a plaintiff does not state a cause of action for benefits denied under an ERISA plan, preemption is still likely under the doctrine of conflict preemption.[33] "This is [the] second line of defense for HMOs. This provision states that ERISA 'shall supercede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan.'"[34]

The Supreme Court has twice given meaning to the "relates to" doctrine.[35] In *Shaw v. Delta Air Lines, Inc.*,[36] "ERISA conflict preemption hinged on whether the state law related to an ERISA plan – that is, did the state law have a connection with or a reference to an ERISA plan? This test was later expanded to include preemption of all state laws that indirectly affected benefit plans."[37] Under both complete preemption and the "relates to" doctrine, the majority of claims against HMOs are successfully removed to Federal court based on subject matter jurisdiction.[38] Later, in 1995, the Court again interpreted the meaning of

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employee welfare plan. Significantly as well, while traditional fee-for-service medical care may have provided an incentive for physicians to increase care, that incentive does not jeopardize the health of the patient and thus, does not present the conflict faced by health maintenance organizations today. Curtis D. Rooney, *The States, Congress, or the Courts: Who Will be First to Reform ERISA Remedies*?, 7 ANNALS HEALTH L. 73, 80 (1998).

31. Morris, *supra* note 11, at 970-72.

32. *Id.* at 970 (citing U.S.C. § 1132(a)(1)(B) (1998)). Significantly, if a plaintiff seeks to recover benefits denied (a claim that relates to the "quantity," not "quality" of the plan), that claim is completely preempted. *Id.* at 972. Morris notes that "HMOs have [also] been able to take advantage of an exception to the well-pleaded complaint rule. This exception exists where there is complete preemption of the state claim by congressional intent for federal legislation to occupy an area . . . The Supreme Court has ruled that ERISA meets the requirements of this exception." *Id.* at 970-71.

33. *Id.* at 971.

34. *Id.* (citing 29 U.S.C. § 1144(a) (1994)); Elliott B. Pollack, *Are Medical Directors Subject to State Licensing Boards?*, CONN. L. TRIB., Dec. 25, 2000, at 14 (stating that arguably, the "relates to" standard is "vague").

35. Morris, *supra* note 11, at 972.

36. 463 U.S. 85 (1983).

37. Morris, *supra* note 11, at 972 (citing Ingersoll-Rand v. McClendon, 498 U.S. 133 (1990)).

38. *Id.*

the "relates to" clause.[39] The Court, in an opinion by Justice Souter, discussed the slippery slope argument that "the text of the ERISA preemption clause could not be read to extend to the furthest stretch of its indeterminacy, or for all practical purposes, preemption would never run its course for really, universally, relations stop nowhere."[40]

3. Criticism and Cost Containment[41]

In order to contain healthcare costs, doctors and HMOs contract, utilizing a number of cost-containment procedures.[42]

> [HMOS] . . . utilize payment incentives such as risk pools, bonuses and expanded capitation to decrease a primary care physician's use of referrals, diagnostic tests and other services. These payment incentives not only attempt to encourage physicians to use fewer outside services, they can also reward the physician financially for minimizing the number of referrals, tests and medical services. Payment incentives are employed to control the over utilization of outside medical services and attempt to encourage physicians to provide cost effective case-management techniques. . . . [C]ost effective measures encourage physicians to under-utilize medical services which thereby strain the physician-patient relationship . . . [however] [w]hen cost-containment mechanisms interfere with the physician's medical treatment and result in injury to the patient, courts find it difficult to determine who should be found liable and under what theory of law.[43]

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39. *Id.* at 980 (citing New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995)).

40. *Id.* (quoting New York State Conference of Blue Cross & Blue Shield Plans, 514 U.S. at 645). Morris notes that "the two-prong test . . . remains intact – a state law relates to ERISA if it: (1) has a reference to or (2) a connection with an ERISA plan, unless the relation is 'too tenuous, remote, or peripheral.'" *Id.*

41. This Note will not explore the various types of cost-containment procedures which HMOs utilize. For a discussion and description of these procedures see Allison Faber Walsh, Comment, *The Legal Attack on Cost Containment Mechanisms: The Expansion of Liability for Physicians and Managed Care Organizations*, 31 J. MARSHALL L. REV. 207, 216-20 (1997) (describing in detail utilization review, capitation, and payment or bonus incentives). Significant to this analysis, Carle HMO, in *Pegram* utilized year-end bonus incentives. Pegram v. Herdrich, 530 U.S. 211, 216 (2000).

42. Walsh, *supra* note 41, at 216-20.

43. *Id.* at 219-22.

Under the relatively new managed care system, the patient is placed in a shaky position because "direct liability" may not be obvious.[44] Additionally, the system

> [p]uts the doctor at risk for sanctions for not working within his employer's [the HMO's] mandates.. . . [i]f the physician chooses to follow the decision made by the HMO, he could be directly liable to the patient. . . . [w]ith no duty owed to the patient [however], the HMO cannot be found [directly] at fault for any wrongdoing. . . .[45]

Based on this newly created relationship in the healthcare context and the surmounting number of people who "receive care through health plans sponsored by employers and covered by ERISA,"[46] patients across the country are calling for HMOs to be held accountable for their medical and/or administrative decisions.[47] One commentator has also argued that "[t]here is not a scintilla of evidence that Congress intended to pre-empt the state law of medical malpractice or to remove the longstanding protections afforded by state malpractice law."[48] With changes in the medical arena, it is quite plausible that "[f]ederal and state laws have not kept pace with changes in the health care industry, as huge corporations buy up hospitals, nursing homes and physician groups and gain powerful influence over the *quality of care*."[49] Arguably too, based on the current state of the law, HMOs have been able to take advantage of their burgeoning "dual" roles and the courts' general confusion in enumerating these roles in measuring liability.[50] Indeed:

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44. Morris, *supra* note 11, at 966.

45. *Id.* at 999. Importantly, this makes the fiduciary duty more important under current law. *See* Discussion Part II.B and accompanying text. *But see, e.g.*, McLean & Richards, *supra* note 12, *passim*.

46. Robert Pear, *HMO Accountability in Malpractice Sparks Controversy*, J. REC., Nov. 20, 1996, *available at* 1996 WL 11102429. The number was one hundred and twenty million or "nearly half of Americans" in 1996. *Id.*

47. *Id.*

48. *Id.* (citations omitted).

49. *Id.* (emphasis added).

50. Morris, *supra* note 11, at 978. The doctor has also taken on a dual role in an era of "corporate" medicine. Indeed,

> [t]he reason why [HMOs] create financial incentives for physicians to reduce levels and expenses of service is that they do indeed reduce costs. But they achieve this by inducing physicians to make intertwined coverage and health care decisions different from those they would make if their only concern were for the employee-patient.

> Initially, newly created ERISA-qualified health plans only acted to coordinate health services, but gradually, *dual roles were created by HMOs: as providers of healthcare and as administrators of benefit plans.* These roles developed when HMOs contracted with employers to provide health insurance to the employees, then offered to administer these plans for the employers. Traditionally, courts did not distinguish between these two roles.[51]

While the current case law is unclear regarding the nature of financial incentives as an inducement to limit care, one court has held that the "question of whether a financial incentive program caused a physician to provide inadequate care, thereby committing malpractice, is a question for the jury."[52] In *Bush v. Dake*, the Plaintiff claimed the HMO that she participated in "implemented financial incentives which led to her physician's negligent medical treatment."[53] The Plaintiff asserted that the HMO's use of financial incentives provided to participating doctors "were a substantial factor in her physician's failure to provide quality health care to her."[54] Subsequently, she sued both her HMO and the physician under theories of "negligence, gross negligence, fraud, breach of trust and tortious interference with the physician-patient relationship."[55] Among other things, the HMO in which the Plaintiff participated:

Brief of Amici Health Law, Policy, and Ethics Scholars at *19, Pegram v. Hedrich, 530 U.S. 211 (2000) (No. 98-1949). *See* Pear, *supra* note 46 (noting that "HMOs are shifting virtually all of the risk of patient care to physicians, even though HMOs can force doctors to change their clinical decisions by threatening to terminate their contracts [i.e., HMOs make medical decisions too.]")

51. Pear, *supra* note 46, at 1-2 (emphasis added). *See* Brief of Amici Health Law, Policy, and Ethics Scholars at **11-12, *Pegram* (No. 98-1949) (arguing that "[f]ailure to recognize the dual role played by gatekeeping physicians effectively immunizes an important category of plan administrative decisions from any legal review whatever. . . . [t]he decision [of coverage] is subject to state law as a medical decision and to ERISA as a plan coverage decision. . . ."). *See also* Schwartz, *supra* note 17, at 655 (contending that "if courts begin to sift through what sorts of decisions are medical and what sorts are administrative, rather than shooting blindly at the moving target of the boundaries of ERISA, courts could develop a body of jurisprudence resembling an equitable balancing of ERISA's objectives.")

52. Walsh, *supra* note 41, at 235 (citing Bush v. Dake, No. 86-25767 Nm-2, slip op. (Mich. Cir. Ct. Saginaw Cty. Apr. 27, 1989)).

53. *Id.* at 234.

54. *Id.*

55. *Id.*

> Required her to seek treatment from her primary care physician for any medical problems. A specialist would be recommended for plaintiff only if the primary care physician deemed it necessary. Further, the HMO reimbursed [plaintiff's] primary care physician under a capitated system. The HMO also implemented risk pools for referrals to specialists and patient hospitalization stays. If the primary care physician's recommendations for referrals and hospital stays were minimal throughout the year, more money was left in the risk pool at the end of the year for distribution. [Plaintiff] alleged these financial incentives caused her primary physician to delay a pap smear and referral to a specialist which thereby delayed the timely diagnosis of cervical cancer."[56]

Thereafter, the plaintiff's HMO "moved for summary judgment arguing that financial incentives were consistent with public policy."[57] While the court accepted the Defendant's argument that financial incentives do not violate public policy, it held that "a jury can determine that financial incentives effected a physician's medical judgment. The court left the door open for liability against HMOs when it can be proved

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56. *Id.* The facts of this case insofar as financial incentives are implicated are similar to those in *Pegram*. One commentator has noted that "The *Bush* court . . . appears to be alone in its holding. Without more, most courts refuse to recognize a claim against an HMO based on its use of physician incentives alone." Herrington, *supra* note 30, at 720. However, many authors have also recognized the "current trend to abrogate the immunity enjoyed by HMOs," which may signal a shift toward HMO liability in the context of medical and/or administrative decision-making. *See* Morris, *supra* note 11, at 962. *See also* Petrovich v. Share Health Plan of Illinois, Inc., 188 Ill.2d 17 (Ill. 1999). In *Petrovich*, Justice Bilandic noted:

> We disagree with Share that the cost-containment role of HMOs entitles them to special consideration. The principle that organizations are accountable for their tortious actions and those of their agents is fundamental to our justice system. There is no exception to this principle for HMOs. Moreover, HMO accountability is essential to counterbalance the HMO goal of cost-containment. To the extent that HMOs are profit-making entities, accountability is also needed to counterbalance the inherent drive to achieve a large and ever-increasing profit margin. Market forces alone are insufficient to cure the deleterious effects of managed care on the healthcare industry. Courts, therefore, should not be hesitant to apply well-settled legal theories of liability to HMOs where the facts so warrant and justice so requires.

Id. at 29-30 (internal citations and quotations omitted).

57. Walsh, supra note 41, at 235 (citing Bush, No. 86-25767 Nm-2, slip op. (Mich. Cir. Ct. Saginaw Cty. Apr. 27, 1989)).

that financial incentives caused a contracting physician to commit medical malpractice."[58]

B. The Fiduciary Duty Under ERISA and Physicians Financial Incentives to Limit Care

Under ERISA, an individual takes on fiduciary status with regard to an employee welfare plan to the extent that she:

> (1) exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets; (2) renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so; or (3) has any discretionary responsibility in the administration of such plan.[59]

Additionally, "a person designated by a Named Fiduciary to carry out fiduciary responsibilities is also a fiduciary under ERISA and is therefore subject to the standards and potential liability set forth in the statute . . . The Supreme Court has recognized [that] . . . the statute delineates . . . *functional* terms of control and authority over the plan."[60] Significantly, ERISA also "imposes a high standard of conduct—on fiduciaries of employee pension plans."[61] As concerns the plan:

> [the] fiduciary must act with the exclusive purpose of providing benefits to participants. . . . [a] fiduciary must act with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity . . . would use. . . . [a] fiduciary is required to diversify the investments of the plan so as to minimize the risk of large losses (*unless under the circumstances it is clearly prudent not to do so*).[62]

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58. *Id.* at 235-36.

59. SEROTA, *supra* note 1, at 9 (citing 29 U.S.C. § 1002(21)(A) (1994)).

60. *Id.* at 9-10 (citing Mertens v. Hewitt Assocs., 508 U.S. 248, 261 (1993) (emphasis added) (internal quotations omitted)).

61. *Id.* at 19 (internal citations omitted).

62. *Id.* (emphasis added) (internal citations and quotations omitted). This language actually supports commentators' views that "Congress never meant for tort law and ERISA to become mutually exclusive such that if a patient receives benefits under an ERISA plan . . . he gives up the protections . . . [of] tort law. . . . The judiciary must exercise its role in

Within the healthcare arena, there exists "three primary players [who may be fiduciaries] – the healthcare plan itself, the physician organization responsible for delivering care, and the individual physician who provides care."[63] While most experts agree that the administrator of the healthcare plan itself is a fiduciary because the administrator "exercise[s] discretionary control over the administration of the plan and for the payment of benefits,"[64] there is mixed agreement over whether physicians and plan owners are also fiduciaries.[65] One author has noted that because plan owners (physicians/HMO participants-owners) provide care, those owners "would rarely have discretion over the administration of a plan."[66] However, plan owners make discretionary decisions regarding referrals and procedures that may or may not come under a plan.[67] "[T]he fiduciary status of physician organizations . . . is a fact-intensive issue that must be decided on a case-by-case basis,"[68] due to the modern changes in medicine and its "corporate" nature. Under ERISA, the fiduciary must act "solely in the interest of the plan participant."[69] However, "this duty . . . is not completely unqualified. Some courts have held that a fiduciary's actions may create a benefit for the fiduciary so long as the action was in the best interests of the plan."[70]

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interpreting ERISA in light of Congress' intent to protect employees." Morris, *supra* note 11, at 999.

63. Herrington, *supra* note 30, at 725.

64. *Id.*

65. *Id.* at 726-28.

66. *Id.* at 726.

67. *Id.*

68. *Id.* at 727. The importance of the physician in her single capacity is less important for analysis under *Pegram* as Herdrich's appeal implicates Carle HMO in its corporate form. *Pegram*, 530 U.S. 211, 215 n.1 (2000) (noting Pegram's peripheral role in the case). However, as Serota explains, the Court in *Mertens* "has not foreclosed entirely the possibility that nonfiduciary service providers may be held liable under ERISA . . . ERISA's functional definition of 'fiduciary' is broader than the definition under traditional trust law." SEROTA, *supra* note 1, at 22.

69. Herrington, *supra* note 30, at 729, *citing* 29 U.S.C. §1104(a) (1994). Importantly, Herrington concedes that HMOs owe patients fiduciary duties to disclose financial incentives which may jeopardize the patient's care. Herrington, *supra* note 31, at 735.

70. Herrington, *supra* note 30, at 729. On the other hand, if an HMO is held liable for a breach of its duty, the benefit to the plan for overusing financial incentives would be much less. The benefits exist, arguably, only if the plan is held unaccountable.

In *Pegram*, the Court noted the differences between a fiduciary under ordinary trust law, and the fiduciary under ERISA in the healthcare context, describing the "analogy" as "problematic."[71] The Court explained:

> Beyond the threshold statement of responsibility . . . the analogy between ERISA fiduciary and common law trustee becomes problematic. This is so because the trustee at common law characteristically wears only his fiduciary hat when he takes action to affect a beneficiary, whereas the trustee under ERISA may wear different hats. . . . [T]he trustee is not permitted to place himself in a position where it would be for its own benefit to violate his duty to the beneficiary.[72]

It is important that we actively question (as the Court *has* done in *Pegram*) whether an analogy to trust law *is* appropriate in the context of patients' healthcare in the first instance or alternatively, whether traditional state law causes of action are better suited to the healthcare context.[73]

C. A Blurry Line: Quality vs. Quantity, Medical Care vs. Eligibility Determinations and State Law Causes of Action[74]

In order for a state law cause of action to be completely preempted under ERISA, the plaintiff must assert a claim regarding an HMOs' denial of coverage or benefits (referred to in the literature and the case law as a

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71. *Pegram*, 530 U.S. at 225.

72. *Id.* Thus, the Court may have implicitly called into question the usefulness of the fiduciary standard (and the inherent conflict of interests) in the context of healthcare where patients' medical needs are paramount. Nonetheless, the standard exists under current law.

73. *See generally* Schwartz, *supra* note 17, at 638-41 (questioning how and if Congress intended to make ERISA applicable to healthcare). For cases explicitly calling into question the fiduciary duty see, e.g., Shea v. Esensten, 107 F.3d 625, 628 (8th Cir. 1997) (finding that HMO had a duty of disclosure. The court stated "[the plaintiff] did not voluntary relinquish his rights in the . . . plan. . . . [a]ny other result [other than finding a fiduciary duty] would reward Medica for giving its preferred doctors an incentive to make more money by delivering cheaper care."); Weiss v. Cigna Healthcare, Inc., 972 F. Supp. 748, (S.D.N.Y. 1997) (holding that Cigna's "restricting the disclosure of non-covered treatment options would . . . directly undermine the [fiduciary duty]). Laurence B. Wohl, *Fiduciary Duties Under ERISA: A Tale of Multiple Loyalties*, 20 U. DAYTON L. REV 43, 47 (1994). Wohl points out that "[o]nce a position of dual loyalties is sanctioned . . . it can be very difficult to determine: (1) if a fiduciary has stepped over the line and breached his duty . . . to plan beneficiaries (an ERISA violation); or (2) if the fiduciary has merely made a mistake in judgment or simply made a reasonable investment (probably not an ERISA violation)." This difficulty in line drawing and determining multiple loyalties is especially problematic in the healthcare context where a patient's medical needs are at stake.

74. The term "eligibility determinations" is taken from the Court in *Pegram*.

"quantity" determination).[75] On the other hand, if a plaintiff asserts a claim against an HMO (or a physician) based on the "quality" of services provided under the plan, that claim may not be completely preempted under ERISA.[76] Thus, courts have distinguished between "quality" and "quantity," traditionally holding that the latter claims are completely preempted, while the former, may be a matter of state tort law.[77]

As some commentators have noted, however, the distinction between "quantity" and "quality," especially in the healthcare context, is oftentimes hard to define. Pear, for example, has stated:

> Courts have split on the issue [of whether a plaintiff can sue an HMO for malpractice], depending on the details of each case. From recent rulings, it appears that patients have a better chance of winning cases against HMOs when they maintain that there was substandard care [quality] rather than an outright denial of health benefits [quantity]. *But the distinction is sometimes obscure.*[78]

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75. Morris, *supra* note 11, at 983 (citing Dukes v. U.S. Healthcare, 57 F.3d 350 (3d Cir. 1995)). Courts have held that claims relating to "quantity" of benefits directly implicate the plan's administration and thus are completely preempted. *Id.*

76. *Id.* In *Dukes*:

> The Third Circuit recognized that HMOs play two roles: as utilization reviewers and as arrangers of medical treatment. It is only in the role as utilization reviewer that an entity is in a position to deny benefits under an ERISA plan. In these cases, the plaintiffs were attempting to hold the HMOs liable for their roles as arrangers of medical treatment, and not in the roles of utilization reviewers. Furthermore, the court stated that "[p]atients enjoy the right to be free from medical malpractice regardless of whether or not their medical care is provided through an ERISA plan."

Id. at 984 (internal citations omitted).

77. Thus, as Ochmann notes, the plaintiff asserting a claim against her HMO may well be advised to "plead only state law issues." Ochmann, *supra* note 11, at 590. Notably, however, this tactic will not work if the HMO asserts that it cannot be held directly liable under traditional state tort law because it does not "practice" medicine.

78. Pear, *supra* note 46 (emphasis added). The difficulty of drawing this line is evidenced by *Pegram*. While Herdrich sued Dr. Pegram for malpractice under a "quality" of care claim, the *Herdrich* court could have held that the suit was for a denial of benefits, as Herdrich was forced to wait eight days for treatment and the ultrasound, it turned out, was "medically necessary." Respondent's Brief at *8, Pegram v. Herdrich, 530 U.S. 211 (2000) (No. 98-1949). *See also* Ochmann, *supra* note 11, at 598 (arguing that in the healthcare context, "[w]hat one court views as a denial of some quantifiable benefit, another court deems to be substandard care or a 'quality' of care question.")

Two cases, *Dukes v. U.S. Healthcare, Inc.*,[79] and the recent decision in *Corporate Health Insurance, Inc. v. The Texas Dept. of Ins.*,[80] are significant in explicating both state law causes of actions, as well as the distinction which courts have typically drawn between "quality" and "quantity" of care in the healthcare context.[81] In *Dukes*, the Plaintiffs asserted claims under an array of theories "arising from the medical malpractice of HMO-affiliated hospitals and medical personnel."[82] In that case, Mr. Dukes's doctor noticed a problem with his ears;[83] however, the nearby hospital would not perform the blood tests that Mr. Dukes's doctor ordered based on the terms of his employment plan.[84] As a result of the hospital's decision to defer treatment, Mr. Dukes's blood sugar level became so high that he subsequently died.[85] Similar to Herdrich, Mr. Dukes participated in an HMO through his employer.[86]

Thereafter, Mrs. Dukes brought suit against the HMO under agency and direct liability theories.[87] She claimed "the HMO failed to exercise reasonable care in selecting, retaining, screening, monitoring, and evaluating the personnel who actually provided the medical services."[88] The HMO then successfully removed the action to federal court based on ERISA preemption.[89] The court reversed the decision of the trial court and remanded the claim to state court.[90] In doing so, the court performed the "quality" versus "quantity" test.

> Nothing in the complaints indicate that the plaintiffs are complaining about their ERISA welfare plans' failure to provide benefits due under the plan. Dukes does not allege, for example, that the . . . hospital refused to perform blood studies on Darryl because the ERISA plan refused to pay for those studies. . . . Instead of claiming that the

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79. 57 F.3d 350 (3d Cir. 1995).

80. 215 F.3d 526 (5th Cir. 2000).

81. For a complete discussion of various state law causes of action against HMOs see Morris, *supra* note 11, at 973-77 (describing theories of vicarious liability, corporate negligence, and denial of benefits claims).

82. *Dukes*, 57 F.3d at 351.

83. *Id.* at 352.

84. *Id.*

85. *Id.*

86. *Id.*

87. *Id.*

88. *Id.*

89. *Id.* at 352-53.

90. *Id.* at 356.

> welfare plans in any way withheld some quantum of plan benefits due, the plaintiffs . . . complain about the low quality of the medical treatment that they actually received and argue that U.S. Healthcare HMO should be held liable under agency and negligence principles.[91]

Later in its opinion the court made another, and perhaps, more significant assertion for purposes of this Note. The court stated:

> We recognize that the distinction between the quantity of benefits due under a welfare plan and the quality of those benefits will not always be clear . . . where the benefit contracted for is healthcare services rather than money to pay for such services. There well may be cases in which the quality of a patient's medical care or the skills of the personnel provided to administer that care will be so low that the treatment received simply will not qualify as healthcare. . . . We also recognize the possibility that an ERISA plan may describe a benefit in terms that can accurately be described as related to the quality of service.[92]

Thus, even while the court held against the HMO based on a "quality" interpretation, it still recognized the great difficulty of distinguishing between "quality" and "quantity" of care in the medical context, and the potential problems that this poses, especially in cases where the quality of care is "so low" that it becomes difficult for a court to define it as medical care rather than as a complete denial of benefits.[93]

Finally, in *Corporate Health Ins., Inc.*,[94] the court decided whether Texas could "regulate the quality of health services when such efforts impose a duty of care upon service providers to ERISA plans."[95] While the insurance company argued that the provisions of the Texas bill dealt with

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91. *Id.* at 356-57.

92. *Id.* at 358.

93. Ochmann, *supra* note 11, *passim*.

94. 215 F.3d 526 (5th Cir. 2000).

95. *Id.* at 531. *See also* Tex. Civ. Prac. & Remedies Code Ann. § 88.002(a) (Tex. 2000) (providing that "a health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured . . . proximately caused by its failure to exercise such ordinary care."); Sorian & Feder, *supra* note 9, at 1140 (noting that "two states—Texas and Missouri—took the [HMO] debate further by voting to allow consumers to sue their health plans in state courts for damages caused by a denial or delay in coverage of needed care.")

an ERISA plan,[96] the court noted that "the Second, Third, and Seventh Circuits have held that medical negligence claims against HMOs for vicarious and direct liability are not . . . completely preempted because they involve conduct by the HMO in its capacity as a provider and arranger of health services and not as plan administrator."[97] The court then proceeded to articulate the "quality versus quantity distinction," finding that Texas' bill dealt only with the "quality" of services provided.[98] It noted, "[w]e are not persuaded that these provisions mandate the structure . . . of plans. Our analysis again stems from our recognition that HMOs . . . perform functions *both as health care insurers and as medical care providers*."[99]

The next part of this Note examines the principal case, *Pegram v. Herdrich*, looking briefly at the Seventh Circuit's decision, and then moving to the Supreme Court's opinion. This Note then proceeds to analyze *Pegram* in terms of the foregoing discussion.

II. PEGRAM V. HERDRICH

A. Facts and Procedural Posture

In March of 1991, Herdrich's primary care physician noticed an inflamed mass in Herdrich's abdomen.[100]

> Although the mass was inflamed on March 7, the primary care physician delayed instituting immediate treatment of respondent, and forced her to wait more than one week to obtain the accepted diagnostic procedure (ultrasound) used to determine the nature, size and exact location of the mass . . . [so that Herdrich] could be tested at a Carle-owned facility.[101]

Before Herdrich could seek the aid that the ultrasound offered, her appendix ruptured and she experienced peritonitis.[102]

As a result of these events, Herdrich filed a two-count claim in state court, alleging medical malpractice against Dr. Pegram, and claiming that

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96. 215 F.3d 526, 534 (5th Cir. 2000).

97. *Id.* at 535 n.25.

98. *Id.* at 535.

99. *Id.* at 536 (emphasis added).

100. Respondent's Brief at *4, Pegram v. Herdrich, 530 U.S. 211 (2000) (No. 98-1949).

101. *Id.*

102. *Id.*; *see also* WEBSTER'S, *supra* note 5, at 875.

Carle HMO was liable under the theory of respondeat superior.[103] Herdrich then filed "an addendum to her state court complaint . . . adding counts three and four. Count three alleged that Carle Clinic failed to disclose certain material facts regarding the ownership of Health Alliance Medical Plan in violation of the Illinois Consumer Fraud Act. . . . [c]ount four charged Health Alliance breached its duty of good faith and fair dealing."[104] In response, Carle and Pegram removed the case to federal court insofar as the claims "related to" ERISA.[105] Subsequently, the defendants filed a motion for summary judgment as to counts three and four,[106] which the trial court granted in regards to count four only.[107] Simultaneously, the judge denied summary judgment as to count three, but held that count three was preempted under ERISA.[108] The judge allowed Herdrich to amend count three, which she did by claiming that "the defendants breached their *fiduciary duty* to plan beneficiaries by depriving them of proper medical care and retaining the savings resulting therefrom for themselves."[109] The Defendants then moved to dismiss the suit for failure to state a claim upon which relief could be granted.[110]

Herdrich's claim for malpractice against Dr. Pegram was tried and Herdrich was awarded $35,000 in damages.[111] However, "because respondent's ERISA count had been dismissed, the jury heard no evidence concerning the fact that respondent's physicians had a financial incentive to minimize respondent's treatment."[112] Herdrich appealed this aspect of the decision to the Seventh Circuit.[113]

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103. Respondent's Brief at *5, *Pegram* (No. 98-1949).

104. *Id.*

105. *Id.* at *6.

106. *Id.*

107. *Id.*

108. *Id.* at *7. The trial judge "relied on petitioner's representations that they were ERISA fiduciaries." *Id.*

109. Herdrich v. Pegram, 154 F.3d 362, 366 (7th Cir. 1998) (emphasis added).

110. *Id.* at 367; FED. R. CIV. P. 12(b)(6).

111. Respondent's Brief at *8, Pegram v. Herdrich, 530 U.S. 211 (2000) (No. 98-1949).

112. *Id.*

113. *Id.* Neither Dr. Pegram nor State Farm Insurance were parties to the appeal. *Id.* Herdrich's amended count three merely alleges that "Carle Clinic, through its wholly-owned subsidiaries, designed and administered the incentive scheme . . . the sole focus of attention of amended count [three] is the design and administration of an undisclosed physician incentive to withhold treatment." *Id.* at *9.

B. The Seventh Circuit

On appeal, the Seventh Circuit concluded that Carle HMO acted as a fiduciary under ERISA.[114] Keeping in mind the procedural posture of the case (a motion to dismiss), and the financial incentives at work, the court held that Herdrich had established facts necessary to call into question the issue of whether the Defendants breached their fiduciary duty.[115] The court noted:

> *The Plan dictated that the very same HMO administrators vested with the authority to determine whether health care claims would be paid, and the type, nature, and duration of care to be given, were those physicians who became eligible to receive year-end bonuses as a result of cost-savings. . . . [a]n incentive existed for them to limit treatment and, in turn, HMO costs so as to ensure large bonuses.* With a jaundiced eye focused firmly on year-end bonuses, it is not unrealistic to assume that the doctors rendering care under the Plan [the HMO owners] were swayed to be most frugal when exercising discretionary authority to the detriment of their membership.[116]

In an attempt to limit its holding, the Seventh Circuit noted that

> [o]ur decision does not stand for the proposition that the existence of incentives *automatically* gives rise to a breach of fiduciary duty. Rather, we hold that incentives can rise to the level of a breach where, as pleaded here, the fiduciary trust between plan participants and plan fiduciaries no longer exists (i.e., where physicians delay providing necessary treatment . . . for the sole purpose of increasing their bonuses).[117]

The dissent argued that because ERISA "tolerates some conflict of interest on the part of fiduciaries,"[118] incentives, by themselves, do not equal a breach of the fiduciary duty.[119] The dissent further noted that:

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114. *Herdrich*, 154 F.3d at 371.

115. *Id.* at 372-73.

116. *Id.* at 372.

117. *Id.* at 373.

118. *Id.* at 381 (Flaum, J. dissenting).

119. *Id.* In effect, the dissent "suggested that market forces should help to reduce the risk of the fiduciary making a decision that will be detrimental to the plan and the

> State Farm has an interest in ensuring that its employees are satisfied with their fringe benefits, and the defendants have an interest in ensuring that State Farm is satisfied with the defendants' performance in delivering healthcare to the beneficiaries. In this sense, the interests of the administrator align with the interest of the beneficiaries.[120]

At the same time, the dissent conceded that the plan in this case may have crossed the line between efficiency and unacceptably risky medicine.[121] According to the dissent, however, this line must be articulated by Congress, not through judicial activism.[122]

C. The Supreme Court: Pegram v. Herdrich

On appeal, the Supreme Court was asked to decide whether Carle HMO, acting through its doctor-owned subsidiaries, acted as a fiduciary

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beneficiaries." Catherine M. Hedgeman, Note, *The Rationing of Medicine:* Herdrich v. Pegram, 10 ALB. L.J. SCI. & TECH. 305, 321 (2000). Hedgeman suggests:

> [I]f a patient subscribes to an HMO, or is insured by an HMO through an employee benefits plan the patient must be informed of the physicians' incentive to cost-contain and the restraints of ERISA. Once the patient is informed and agrees to the terms of the subscription agreement, he has legally bargained for the contract (the plan). Thus, the standard of care would be the result of the balancing of the physician's medical judgment and the availability of resources.

Id. at 322. The patient, however, may not maintain an adequate bargaining position relative to the healthcare provider or her employer. Additionally, a patient may not realize, at the time she enters the contract, its legal ramifications once she becomes ill or injured.

120. *Herdrich*, 154 F.3d at 382 (Flaum, J. dissenting). However, "the decision to move from fee-for-service coverage to managed care was [usually] made by [the] employer. Such an involuntary shift was bound to breed distrust among consumers. . . . [p]ublic polls indicate a strong and abiding discontent with many of the common traits of managed care plans." Sorian & Feder, *supra* note 9, at 1138.

121. *Herdrich*, 154 F.3d at 383 (Flaum, J. dissenting). Specifically, the plan provided, "by contracting with Carle owner/physicians to provide medical services . . . those owner/physicians (1) minimize the use of diagnostic tests; (2) minimize the use of facilities not owned by Carle; and (3) minimize the use of emergency and non-emergency consultation and/or referrals to non-contracted physicians." *Pegram*, 530 U.S. at 216 n.3. The Court also noted that "the relationship between sparing medical treatment and physician reward is not a subtle one under the Carle scheme." *Id.* at 220.

122. *Herdrich*, 154 F.3d at 383 (Flaum, J. dissenting). The dissent ended by stating that a breach of fiduciary duty might be appropriate if the facts established an uneven bargaining position between the plan, the administrator and the patient or beneficiaries. *Id.* at 384. Indeed, many commentators have argued that the only way to equalize these positions is to amend ERISA "to create a better balance between HMOs' desire to control costs and patients' desire to get appropriate medical care." Sorian & Feder, *supra* note 9, at 1143. This can be accomplished through external review by panels and/or the courts. *Id.*

under ERISA and whether, through financial incentives to limit "medically necessary" care, it breached that duty.[123] While the Court held that the acts of Carle HMO physicians were not fiduciary in nature, it focused primarily on what it termed "mixed eligibility and treatment decisions."[124] There are a number of important elements at work in the Court's decision that necessitate an explanation for purposes of this analysis.

The Court began its discussion by stating that "Herdrich does not contest the propriety of removal before us, and we take no position on whether or not the case was properly removed. . . . Herdrich's amended complaint alleged ERISA violations over which the federal courts have jurisdiction."[125] The Court then noted that "[a]lthough it is true that the relationship between sparing medical treatment and physician reward is not a subtle one under the Carle scheme. . . . whatever the HMO, there must be a rationing and inducement to ration."[126] While conceding that the plan in this case blatantly presented a conflict of interest,[127] the Court was not willing to "draw a line between good and bad HMOs [which] would embody . . . a judgment about socially acceptable medical risk."[128] Indeed, in the Court's opinion,

> [a] conclusion of this sort would . . . necessarily turn on facts to which courts would probably not have ready access: correlations between malpractice rates and various HMO models, similar correlations involving fee-for-service models, and so on. . . . [s]uch complicated fact-finding . . . is not wisely required of courts unless for some reason resort cannot be had to the legislative process. . . .[129]

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123. *Pegram*, 530 U.S. at 214.

124. *Id.* at 229.

125. *Id.* at 216 n.2. Significantly, however, Herdrich originally amended count three of her complaint to include an ERISA fiduciary cause of action because there was no direct redress against Carle HMO in state court. *See Herdrich*, 154 F.3d at 366-67. Additionally, in Respondent's Brief, Herdrich argued that the action against Carle physicians implicated the "quality," and not the "quantity," of benefits provided. Respondent's Brief at *8, Pegram v. Herdrich, 530 U.S. 211 (2000) (No. 98-1949).

126. *Pegram*, 530 U.S. at 220-21.

127. *Id.* at 220.

128. *Id.* at 221.

129. *Id.* The Court may be correct that the legislature is the appropriate forum for this type of investigation, *if* Congress is willing to compromise its political agenda and take action. *See, e.g.*, Rooney, *supra* note 30, at 103-104 (stating that "a federal cause of action could be established for plan liability negligence. . . . ERISA's preemption provisions could be amended to allow state tort and contract remedies to apply . . . a federal standard could be

Justice Souter then proceeded to analyze the fiduciary duty under ERISA.[130] He stated that "Carle may be a fiduciary if it administers the plan."[131] During his analysis, he explained the problems presented by analogizing the fiduciary duty under ERISA to the common law of trusts, because "the trustee at common law characteristically wears only his fiduciary hat . . . whereas . . . under ERISA [the trustee] may wear different hats."[132]

Problematically for Justice Souter, Herdrich's claims charged Carle HMO with breaching its fiduciary duty in administering the plan, while Carle was also responsible for making medical decisions under the plan (not an ERISA function as this relates to the "quality" of the plan, not the "quantity").[133] The Court noted that "[t]he kinds of decisions mentioned in Herdrich's ERISA count and claimed to be fiduciary in character are . . . mixed eligibility and treatment decisions: physicians' conclusions about when to use diagnostic tests; about seeking consultations and making referrals . . . about proper standards of care. . . ."[134] Because Herdrich's amended complaint did not allege that Carle violated its fiduciary duty merely by making "administrative decisions," ("quantity" of care), the Court could not hold that the fiduciary duty existed or had been violated.[135]

Justice Souter ended his discussion by noting that if Herdrich's claim were permitted to proceed to trial, health maintenance organizations would not be able to survive.[136] Indeed, "[i]f Congress wishes to restrict its

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used as a floor . . . [or] Congress could decide that for benefit claims, state remedies would be exclusive and that there would be no ERISA remedies.").

130. *Pegram*, 530 U.S. at 220-21.

131. *Id.* at 223.

132. *Id.* at 225. Problematically, Herdrich did not state a claim against State Farm Insurance Company (the plan and the most obvious fiduciary actor) for breaching its fiduciary duty, so that the Court was left in a difficult position from which to decide the case. *Id.* at 229 n.9; Herrington, *supra* note 30, at 725-26.

133. *Pegram*, 530 U.S. at 227. The Court stated in a footnote, however, that Carle could be a fiduciary "insofar as it has discretionary authority to administer the plan, and so its is obligated to disclose characteristics of the plan." *Id.*

134. *Id.* at 229.

135. *Id.* at 230. The Court additionally stated that since the claim had been preempted there existed "no occasion to discuss . . . the interaction of such a claim with state law causes of action." *Id.* at 229 n.9.

136. *Id.* at 233. *But see* Morris, *supra* note 11, at 999-1000. Morris notes:

> [t]his concern can easily be addressed by new legislation . . . Congress could amend ERISA to create a federal cause of action against ERISA plans, but could place caps on medical malpractice damages to address the concern of increased cost . . . [or] Congress [could] amend ERISA to

approval of HMO practice to certain preferred forms, it may choose to do so. But the Federal Judiciary would be acting contrary to the congressional policy of allowing HMO[s] . . . if it were to entertain an ERISA fiduciary claim . . . solely because of their structure."[137]

Under the above-mentioned discussion, the Court reversed the Seventh Circuit's decision.[138] But "despite the victory [of HMOs] in the Supreme Court, the decision does not mark the end of legal challenges against HMOs."[139] The next part of this Note explicates why the Court's decision *cannot* signal the end of the conflict between patients, physicians and health maintenance organizations.

III. ANALYSIS

A. HMOs, Through Their Physician Employees, act as Fiduciaries Under ERISA When They Delegate Responsibility Under a Plan. This Remains True Even Though Physicians And HMOs May Make Both Medical and Administrative Decisions

Under ERISA, an individual takes on fiduciary status when she "has any discretionary responsibility in the administration of [an employee welfare] plan."[140] In the context of healthcare, the HMO may become a fiduciary through "its contractual relationship with the health plan. . . . [by which it may] be given discretionary authority over plan administration and payment of claims."[141] While it may be arguable that the physician is not a fiduciary because "its primary role within a health plan is to provide medical care directly to plan participants,"[142] this argument is penetrated when we consider the "dual" roles of the physician and the HMO within the context of "corporate" healthcare and health maintenance providers

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> remove preemption of medical malpractice claims . . . because most states already have damage caps in place, it would also provide HMOs with protection against unlimited damage awards.

See generally Michael Misocky, *The Patients' Bill of Rights: Managed Care Under Siege*, 15 J. CONTEMP. HEALTH L. & POL'Y 57 (1998).

137. *Pegram*, 530 U.S. at 233-34.

138. *Id.* at 237.

139. Glodt, *supra* note 8, at 652.

140. SEROTA, *supra* note 1, at 87 (citing 29 U.S.C. §1002(21)(A)).

141. Herrington, *supra* note 30, at 726-27.

142. *Id.* at 727.

(which, under a plan such as that described by Justice Souter in *Pegram*, make both medical and administrative decisions.)[143]

Justice Souter noted that the Carle plan defines the role of the physician in the context of providing medical care to plan participants.[144] While the plan calls for those physicians to make decisions which are medical in nature, it also necessitates that those same physicians make administrative decisions, determining whether, under the plan, "the use of diagnostic tests . . . the use of facilities not owned by Carle . . . [and] the use of emergency and non-emergency consultation and/or referrals to non-contracted physicians" are covered (quantity determinations and subject to federal law).[145] While the Carle physicians clearly made both medical and eligibility determinations, the Court failed to "sift through what sorts of decisions are medical and what sorts are administrative."[146] Courts must clearly delineate the distinction between medical and administrative decisions in order to hold HMOs and contracting doctors accountable in a viable manner: (1) under state law when an HMO delegates medical decision-making to its physicians to determine what is and is not "medically necessary;" *and* (2) under ERISA insofar as an HMO denies benefits due under a plan.[147]

By failing to determine which types of decisions by Carle HMO physicians were administrative under the plan (relating to plan coverage and covered by ERISA), the Court failed to find a viable fiduciary duty under ERISA, and Herdrich was left without a federal remedy, even though she was forced, at the trial court level, to amend her complaint to state a federal cause of action against Carle HMO, based on Carle's argument that it did not "practice" medicine.[148] In order to prevent this type of conclusion, the Court should have looked to *Dukes v. U.S. Healthcare*,[149] in

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143. *See, e.g.*, Schwartz, *supra* note 17 and accompanying text (describing the "dual roles" of HMOs and HMO doctors and the need to parcel out those roles in order to delineate and determine liability).

144. *Pegram*, 530 U.S. at 216 n.3.

145. *Id.*

146. Schwartz, *supra* note 17, at 655.

147. Brief of Amici Healthcare For All et al, at *11, Pegram v. Herdrich, 530 U.S. 211 (2000) (No. 98-1949) (stating that "either the federal or the state system must have jurisdiction over the matter. There is no extra-territorial immunity for plan administrators.").

148. *Herdrich*, 154 F.3d at 366.

149. 57 F.3d 350 (3d Cir. 1995). *See also* Morris, *supra* note 11, at 1002 (persuasively arguing that the Court "should adopt a test defining the scope of ERISA preemption such as the Third Circuit's 'quality v. quantity' test.")

which the plaintiff claimed, under similar facts as those presented in *Pegram*, that "the HMO failed to exercise reasonable care in selecting, retaining, screening, monitoring, and evaluating the personnel who actually provided the medical services."[150] While that case did not deal with the fiduciary duty, the Plaintiff's claim, in effect, alleged that the HMO had delegated responsibility to its physicians, who then neglected their duty to provide benefits under the plan through medical treatment based on the plan's cost-containment provisions.[151] Thus, while the *Pegram* Court recognized the dual nature of Carle HMO and its physicians throughout the opinion, it failed to note how that aspect of health maintenance organizations *affects liability*. Rather, the Court simply stated that, "[b]ased on our understanding of the matters . . . we think Congress did not intend Carle or any other HMO to be treated as a fiduciary to the extent that it makes mixed eligibility decisions acting through its physicians."[152]

Indeed, the Court misconstrued both Congress' intent and prior case law dealing with mixed eligibility and medical determinations insofar as it failed to distinguish between the two.[153] While Congress may not have intended ERISA to apply to medical determinations, courts have held that it does apply to administrative decisions.[154] Thus, at least to the extent that Carle HMO and Carle physicians made determinations regarding plan coverage, they acted as fiduciaries. The Court should have clearly defined the line separating the medical from the administrative to achieve a more equitable result.

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150. *Id.* at 352. Thus, the plaintiffs in *Dukes* were able to successfully hold their HMOs accountable under state malpractice law and theories of negligence. *Id.*

151. Notably, the issue in *Dukes* was whether the plaintiffs' claim was correctly preempted because the Plaintiffs "were attempting to hold the HMOs liable for their roles as arrangers of medical treatment." Morris, *supra* note 11, at 984. *Dukes* relates to the case at hand insofar as the court in that case sought to draw a line between providers of care and administrators of benefits under an ERISA plan. *Id.* In fact, however, the *Pegram* court should have gone one step further than the *Dukes* court by determining how (and whether) this distinction affects HMO liability in ambiguous cases under ERISA (e.g., those in which HMOs are both medical and administrative decision-makers, and where the level of care is so low it may qualify as no care or as a complete denial of benefits due.)

152. *Pegram*, 530 U.S. at 231.

153. *See* Schwartz, *supra* note 17.

154. *Dukes*, 57 F.3d at 350.

B. Under Certain Circumstances, Whether an HMOs' use of Financial Incentives Causes it to Breach its Fiduciary Duty to Plan Participants is an Issue of Fact for the Jury

1. The Law Does Not Affirmatively Prevent Courts From Finding That HMOs' Utilization of Financial Incentives Creates a Triable Issue of Fact in the Fiduciary Context

In *Pegram*, the Court noted that "the relationship between sparing medical treatment and physician reward [through year-end bonuses] is not a subtle one under the Carle scheme."[155] At the same time, however, the Court stated that "courts are not in a position to derive a sound legal principle to differentiate an HMO like Carle from other HMOs."[156] But if Congress is not willing to amend ERISA to allow claims against HMOs, courts have a duty to step in and offer a solution. As seen in *Bush v. Dake*,[157] courts may validly find that financial incentives to limit care *do* (at the least) create a triable issue of fact,[158] *especially*, where, as in *Pegram*, those incentives are expressly articulated in the employee benefit plan.

While the fiduciary duty under ERISA is "not completely unqualified [in that] some courts have held that a fiduciary's actions may create a benefit for the fiduciary so long as the action was in the best interests of the plan,"[159] those actions are subsequently qualified by ERISA and congressional intent.[160] A fiduciary "is required to diversify the investments of the plan [by, for example, creating risk pools between doctors and HMOs] so as to minimize the risk of large losses [*but* this is qualified by noting that it applies] *unless under the circumstances it is clearly prudent not to do so*."[161] Thus, the prudent standard of care, applicable to fiduciaries under ERISA,[162] makes clear that a fiduciary "wear the fiduciary hat when making fiduciary decisions,"[163] with the threat of liability lingering if she fails to do so. Failure to apply this standard

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155. *Pegram*, 530 U.S. at 220.

156. *Id.* at 222.

157. Walsh, *supra* note 41, at 235 (citing No. 86-25767 N.-2, slip op. (Mich. Civ. Ct. Saginaw Cty. Apr. 27, 1989)).

158. *Id.* at 235-36.

159. Herrington, *supra* note 30, at 729.

160. SEROTA, note 68 and accompanying text.

161. *Id.* (emphasis added) (dealing with potential and possible liability for a nonfiduciary).

162. *Id.*

163. *Pegram*, 530 U.S. at 225.

correctly, as the court noted in *Petrovich v. Share Health Plan of Illinois, Inc.*,[164] leads to unfair results.[165] Repetition of Justice Bilandic's point here is worthwhile because it articulates the fairness issue that the Court in *Pegram*, in part, overlooks. Justice Bilandic poignantly stated:

> We disagree with Share that the cost-containment role of HMOs entitles them to special consideration. The principle that organizations are accountable for their tortious actions and those of their agents is fundamental to our justice system. There is no exception to this principle for HMOs. Moreover, HMO accountability is essential to counterbalance the HMO goal of cost-containment. To the extent that HMOs are profit-making entities, accountability is also needed to counterbalance the inherent drive to achieve a large and ever-increasing profit margin. Market forces alone are insufficient to cure the deleterious effects of managed care on the healthcare industry. Courts, therefore, should not be hesitant to apply well-settled legal theories of liability to HMOs where the facts so warrant and justice so requires.[166]

Clearly, the Court's anxiety in holding HMOs liable due to cost-containment measures is valid.[167] Rather than excuse HMOs from any liability whatsoever, a more equitable solution would be for Congress to "amend ERISA to remove preemption of medical malpractice claims . . . . Because most states already have damage caps in place, it would also provide HMOs with protection against unlimited damage awards."[168] Making HMOs liable for their actions would also force HMOs to factor in the cost of damages when making decisions that determine the extent of healthcare (measured in terms of quantity and quality) for their plan participants.[169] As the court in *Corcoran* noted, "if the cost of compliance with a standard of care . . . need not be factored into utilization review companies' cost of doing business, bad medical judgments will end up

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164. 188 Ill. 2d 17, 29-30 (Ill. 1999).

165. *See id.*

166. *Id.* (internal citations and quotations omitted).

167. *Pegram*, 530 U.S. at 232-33. *See* Herrington, *supra* note 30, at 716 (arguing generally that, "the use of physician financial incentives has proven vital to . . . controlling costs.").

168. Morris, *supra* note 11, at 999-1000.

169. *See Corcoran*, 965 F.2d at 1338; *see also* Morris, *supra* note 11, at 1000.

being cost-free to the plans."[170] Thus, the HMO would not forego all profit[171] by being held liable for breaching its fiduciary duty, if it factors the cost of potential damages into its profit calculation similar to any other type of business entity.[172]

2. Courts Must Decide, In the First Instance: Whether ERISA Fiduciary Law is Correctly Analogized to the Common Law of Trusts

As the Court analyzed the fiduciary duty under ERISA, it implicitly questioned the appropriateness of the standard analogy between the fiduciary duty under ERISA and the common law of trusts.[173] What is most important for this discussion is the conflicts of interest allowed under ERISA in terms of the fiduciary duty, but disallowed to the fiduciary under trust law.[174] While the Court did not state that this analogy was problematic due to the context of healthcare,[175] this remains a valid issue under ERISA.

Laurence B. Wohl asserts that

> [o]nce a position of dual loyalties is sanctioned . . . it can be very difficult to determine: (1) if a fiduciary has stepped over the line and breached his duty . . . to plan beneficiaries (an ERISA violation); or (2) if the fiduciary has merely made a mistake in judgment or simply made a reasonable investment (probably not an ERISA violation).[176]

If the determination *merely* involves money (as in trusts), the determination is not entirely problematic, as peoples' lives are not at stake. However, if that distinction determines whether a patient has *any* cause of action against her HMO (as in Herdrich's case),

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170. *Corcoran*, 965 F.2d at 1338.

171. *Pegram*, 530 U.S. at 233-34.

172. Conversely, this could increase the dollar amount of premiums paid by plan participants. Herrington, *supra* note 30, at 731. Thus, the people must decide, through Congress, how to strike the appropriate balance between the "fundamental right to healthcare . . . [and] controlling costs." Douglas A. Hastings, *The Changing Face of Law and Medicine in the New Millennium*, 26 AM. J.L. & MED. 135, 140 (2000).

173. *Pegram*, 530 U.S. at 224-25.

174. *Id.* at 225.

175. Although the Court did not state that the analogy was "problematic" due to the context of healthcare, it did note that the analogy was "problematic" generally. *Id.* at 224-25.

176. Wohl, *supra* note 73, at 47.

that distinction becomes more important and vital to the courts' interpretation of ERISA.

C. Courts Should Question Whether Preemption is Appropriate Under ERISA Using A Standard Which is More Functional Than the "Quality Versus Quantity Test"

Although the Court did not discuss the "quality versus quantity test," or whether preemption was improper due to other, more appropriate state law causes of action, it mentioned in a footnote that:

> ERISA makes separate provision for suits to receive particular benefits. We have no occasion to discuss the standards governing such a claim by a patient, who, as in the example in text, was denied reimbursement for emergency care. Nor have we reason to discuss the interaction of such a claim with state law causes of action.[177]

Indeed, while the Court did not perform the "quantity versus quality test" because the issue of preemption was not before it,[178] Herdrich originally amended her state law cause of action against Carle HMO and Pegram to comport with ERISA.[179] Thus, the case against Carle HMO proceeded in federal court (as does most every case against a health maintenance organization), because Herdrich was forced to amend her complaint to state an ERISA claim at the threat of complete dismissal.[180]

Additionally, it is not entirely clear whether Herdrich was suing based on a denial of benefits under the plan, or alternatively, for the quality of healthcare that she received, and, if the latter, whether that claim should

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177. *Pegram*, 530 U.S. at 229 n.9 (internal citations omitted).

178. *Id.* at 216 n.2.

179. *Herdrich*, 154 F.3d at 366. In this case (as in most cases that proceed against HMOs), the defendants utilized the exception to the well-pleaded complaint rule to state that ERISA preempted the state law causes of action alleging malpractice. Morris, *supra* note 11, at 970-71.

180. Pear, *supra* note 46 (emphasis added) (noting that "HMOs like U.S. Healthcare, Kaiser . . . Prudential and Pacifare have asserted in court that malpractice claims against them are preempted by the 1974 law [ERISA]. . . . [i]f a malpractice claim is preempted, it cannot be pursued and must be dismissed. . . . [This is true even though] HMOs market themselves to the public [promising] to provide *high-quality care* by choosing the best doctors and hospitals and monitoring their work to guarantee that it meets the highest standards.").

have also applied to Carle HMO.[181] It *is* clear that Herdrich recovered against Dr. Pegram in state court under a "quality" of care reading,[182] but it is not certain why she did not seek to recover against Carle HMO under the same "quality" test, as in this case, benefits were not denied, but medical care was merely delayed.[183] Although the Court did not inquire into this issue because Herdrich's amended complaint stated an ERISA claim, its failure to do so may have resulted in unfair results at the federal level (and is another example of the difficulty and potential unfairness that this standard may create). The Court's failure to distinguish between the two theories as well as Herdrich's confusion in defining the "quality versus quantity" line, further establishes the indeterminate nature of this standard.

Based on the record below, Herdrich originally stated a claim against Carle under a theory of respondeat superior:[184]

> The theory behind vicarious liability, or respondeat superior, is that the employer is liable for the acts of his employees. . . . [i]n a healthcare setting, if the health care institution has substantial control over the physician's choice of patients or furnishes the physician with equipment, an employer-employee relationship exists [here, Carle-owned facilities and Carle physicians/HMO]. . . . [C]ourts look at the operation of the HMO and determine if it conducts itself in a fashion akin to a health care provider . . . if the answer is yes, the HMO is subject to the same liability as the hospital. . . . [i]f there is no direct control . . . the court may find that an agency relationship exists. If a plan sponsor . . . has created an expectation on the part of the patient that the plan will make available high-quality providers of care, then there may be ostensible or apparent agency. Likewise, if the plan restricts the choice of providers [as in Herdrich's case], the providers may look like agents.[185]

It is not completely understandable why Herdrich's claim was initially preempted, just as it is not entirely understandable whether a plaintiff is

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181. Indeed, as the Court states, "the allegations of Herdrich's ERISA count . . . are difficult to understand." *Pegram*, 530 U.S. at 226.

182. Respondent's Brief at *8, Pegram v. Herdrich, 530 U.S. 211 (2000) (No. 98-1949).

183. *Id.* at *4.

184. *Id.* at *5.

185. Morris, *supra* note 11, at 973.

proceeding against an HMO based on its role as a provider of healthcare or an administrator of health benefits under ERISA.[186] The Court attempted to parcel out Carle's role, but its determination that mixed eligibility and medical decisions cannot be deemed fiduciary in nature[187] seems reminiscent of the oftentimes confusing "quality versus quantity test,"[188] and ultimately left Herdrich without a federal remedy (or, in fact, any remedy against her HMO).[189]

In order to prevent such unfair results, many commentators have suggested that ERISA be amended.[190] One commentator has noted that:

> Congress could amend ERISA to create a federal cause of action against ERISA plans, but could place caps on medical malpractice damages. . . . A more favorable solution could be for Congress simply to amend ERISA to remove preemption of medical malpractice claims . . . This would be consistent with ERISA's goal of uniformity [in allowing state tort laws to apply] by eliminating the conflicting interpretations of ERISA among the federal circuit courts. Because most states already have damage caps in place, it would also provide HMOs with protection against unlimited damage awards.[191]

Additionally, a better definition of the term "medically necessary" is needed to prevent inconsistent results, as well as to place both the "quality" and "quantity" of care within some contextual framework.[192] This may be accomplished, for example, through external review boards.[193]

> "To allow consumers who are dissatisfied with the results to seek review in court [is] a means to assure that the process is honest. . . . No one is advocating that courts should be used to make medical decisions . . . rather, courts are needed to provide the entire system with *legitimacy*. By punishing the miscreants, courts are a powerful

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186. *Dukes*, 57 F.3d 350 (3d Cir. 1995); Pear, *supra* note 46, at 2.

187. *Pegram*, 530 U.S. at 229-30.

188. *Id.* at 225. *See also* Ochmann, *supra* note 11, *passim*.

189. *Pegram*, 530 U.S. at 225.

190. *See, e.g.*, Morris, *supra* note 11, at 999-1000; Glodt, *supra* note 8, at 653-54; Sorian & Feder, *supra* note 9, at 1143; Rooney, *supra* note 30, *passim*.

191. Morris, *supra* note 11, at 999-1000. Texas and Missouri already "allow consumers to sue their health plans in state courts for damages caused by a denial or delay in coverage of needed care." Sorian & Feder, *supra* note 9, at 1140.

192. Sorian & Feder, *supra* note 9, at 1143.

193. *Id.*

> deterrent for bad behavior. . . . [a]s long as health plans are shielded from liability, consumers will continue to believe that the deck is stacked against them."[194]

Clearly to many commentators, "a federal Patients' Bill of Rights is a vital step toward restoring the appropriate balance between cost and access [to the courts]."[195] This "is a crucial part of restoring public trust in a market-based health care system."[196] The Court itself noted that "if Congress wishes to restrict its approval of HMO practice . . . it may choose to do so."[197] Thus, whether through congressional or court action, it is clear that something must give to cure the current uneven state of the law.[198]

CONCLUSION

> By preempting the state common law of trusts, Congress sought to develop, through federal court decisions, a more uniform interpretation and administration of pension and welfare plans. A developing federal common law was necessary to fill the gap created by ERISA preemption. Consequently, ERISA's fiduciary duties and the federal common law interpreting them have become major factors in plan governance. Federal courts are addressing many of [these] issues . . . and some of their decisions will undoubtedly yield new issues to be resolved. ERISA is an evolving law; the circle has not yet closed.[199]

When Cynthia Herdrich sought medical treatment she expected to receive care in a timely, safe manner. This expectation was due, in part, to the generally-held belief that "Americans have a fundamental right to healthcare . . . [This] continues to be an important element in the ongoing debate over the U.S. healthcare system."[200] Because Americans assert, correctly, this fundamental right, ERISA must continue to change to meet these demands, while simultaneously seeking to preserve and control the costs of healthcare.[201] With a move toward state-regulation of HMOs, "the key policy questions of the coming years are likely to focus on the

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194. *Id.* at 1143-44 (emphasis added).
195. *Id.* at 1144.
196. *Id.*
197. *Pegram*, 530 U.S. at 233-34.
198. Rooney, *supra* note 30, at 105.
199. SEROTA, *supra* note 1, at 39.
200. Hastings, *supra* note 172, at 140 (internal quotations omitted).
201. *Id.*

limitations of decentralized federal intervention . . . [indeed] the debate over national health insurance often reflects this perceived choice between market and regulation."[202] If Congress does not choose to act, courts (following the lead of the Supreme Court) must begin to question the initial purpose of ERISA,[203] its application to the healthcare context[204] and patients' burgeoning rights in "the new millennium."[205] They must also seek a more functional and realistic standard for healthcare than the current "quality versus quantity" test provides.

The courts and Congress should seriously examine the *Dukes*' court's statement that "[p]atients enjoy the right to be free from medical malpractice regardless of whether or not their medical care is provided through an ERISA plan."[206] With some evidence that President Bush plans to approve legislation allowing patients to sue their HMOs directly,[207] both Congress and the courts have much to decide in the coming months. During the recent presidential debates of 2000, "[Now President] Bush endorsed the independent review of claims by 'an objective body' . . . and the right of patients to sue HMOs."[208] "Lobbyists, even those who represent the insurance industry, [have] said the question in Congress was no longer whether to make it easier for patients to sue HMOs, but how to define the new right: For what decisions should an HMO be liable? Should lawsuits be filed in federal or state court? Should there be any limits on damages."[209] And states such as Texas and Illinois[210] "say they are exercising the traditional power of the states to regulate insurance, and the National Association of Insurance Commissioners supports the right of states to pass such laws [making HMOs liable]."[211] The ball is now in Congress' court; the test for action is imminent.[212]

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202. *Id.* at 141 (internal quotations omitted).

203. Morris, *supra* note 11, at 1000-01.

204. *Pegram*, 530 U.S. at 225.

205. Hastings, *supra* note 172, at 134.

206. Morris, *supra* note 11, at 984 (citing Dukes v. U.S. Healthcare, 57 F.3d 350 (3d Cir. 1995)).

207. Robert Pear, *Bush Set to Back State Laws to Extend H.M.O. Patients' Rights*, N.Y. TIMES, Jan. 14, 2001, at 20.

208. *Id.*

209 *Id.*

210 *Id.*

211 *Id.*

212 *See generally* Rooney, *supra* note 30, *passim.*

CLIVE TREBILCOCK, *PHOENIX ASSURANCE AND THE DEVELOPMENT OF BRITISH INSURANCE. VOLUME I: 1782-1870. VOLUME II: THE ERA OF THE INSURANCE GIANTS, 1870-1984.*

Timothy Alborn[*]

Clive Trebilcock, *Phoenix Assurance and the Development of British Insurance. Volume I: 1782-1870. Vol. II: The Era of the Insurance Giants, 1870-1984.* Cambridge: Cambridge University Press, 1985, 1998.

It is often noted that business historians tend to adopt the same perspective as the directors of whichever company they are chronicling. Other historians, and scholars more generally, are inclined to deliver that judgment and quickly move on, with the result that business historians reach an audience which is smaller than the unquestionable importance of their subject matter would warrant. Swift verdicts regarding business historians also preclude an examination of their motives for taking the perspective of the boardroom, and of the limitations of that perspective.

The most obvious, but seldom openly discussed, motivating factor behind many business histories is that they are paid for by the company in question, often to celebrate a centenary or other milestone. In this regard, the hired chronicler faces pressures that are common to anyone who requires access to private archives, but which are as severely felt by only a handful of others, such as official biographers. Another motive for taking the view from the boardroom is more widely shared by those trained in history. Like company directors, historians like to be in charge. They like to have all the facts before them, to organize those facts and to deliver decisive opinions once these preliminary steps have been taken. On this basis, a well-preserved company archive should appeal to any historian, since much of the gathering and organizing work has been done in advance. Every account record, ledger and minute book yields fruit that is ripe for the historian's interpretive skills. These two motives for

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undertaking a company history—the paid commission and the appeal of archival work—are of course related, since submitting to the editorial supervision of a present-day board of directors is often the price of admission for complete access to their predecessors' records.

Built into these motives for doing business history is a set of limitations. The first concerns the fact that company directors do not (and probably should not) *really* think like historians. They mainly adopt the narrow perspective of their own gain or that of their shareholders; they often lose sight of the forest for the trees; and they have only a patchy sense of the past. Company historians either replicate these traits (especially in the case of free-lance commission-seekers), resulting in "bad history," or continually shift gears between restating directors' justifications for past actions and holding those actions up to the measuring rod of "history" or economic theory. Both approaches sacrifice coherence, either by validating a succession of shortsighted directors (who, almost by definition, cannot all employ the same principles), or by jarringly juxtaposing the view from the boardroom with the view from the chalkboard. A second limitation concerns the appeal of the archive. Company records contain both too much and too little information. The sheer volume of documents available in a well-preserved archive instills in the historian a misguided Baconian hope that "objective truth" will waft inexorably from a faithful and thorough transcription of the "facts." Company historians are especially prone to this particular *ignis fatuus*, too often producing swampy narratives in which any interpretive light is lost in tangled minutiae.

Clive Trebilcock's *Phoenix Assurance and the Development of British Insurance*, published in two volumes in 1985 and 1998, displays some of the limitations and many of the virtues of business history as it has traditionally been written by professionally trained historians. It is perversely profuse, even by company history standards: 1856 pages, 3850 footnotes, 225 illustrations, and 262 tables, all devoted to a firm that ceased being a first-rank fire insurance company nearly a century ago. It unapologetically adopts the directors' perspective, as filtered through their minute books. As Trebilcock claims in the preface to Volume II, "the strongest account comes from the board room" and "there would be little interest... otherwise" (xxi). His stabs at "'social' history" lean toward pedestrian descriptions of head-office accommodations, great fires Phoenix has known, and the "unusually active cricketing careers" of Phoenix directors (II: 616). He aspires to a "comparative" history of

British fire insurance, but owing to his methodology this amounts in practice to charting the firm's progress alongside the only other two British fire offices (the Sun and the Royal Exchange) with similarly detailed, archive-based histories. He moves awkwardly among echoing, in his own voice, past directors' moral judgments on government regulation, competition and personnel issues; conscientiously providing ample evidence which renders those judgments ambiguous at best; and sternly lecturing Phoenix for its occasional blindness to the ABCs of management strategy.

Yet, for the patient reader, these faults also serve as virtues. Everything but the kitchen sink is certainly a better option than the kitchen sink all by itself. A book as closely based on archival material as this becomes itself an archive, which can then be mined by others; even the relatively short shrift given to "social history" yields upwards of 200 pages of rich empirical detail. And the reader is free to choose from the conflicting interpretations that Trebilcock provides at various points in his story. Another saving grace of the book is that Trebilcock is uniquely explicit about the tensions inherent in his task, not the least because Phoenix itself has ceased to exist. The firm's absorption by Sun Alliance in 1984 (shortly before the first volume appeared) not only threatened the completion of the project, but it gave Trebilcock ample justification for gazing more steadily than he might otherwise have done at the missteps and misfortunes which led to Phoenix's demise. He also pauses to consider, in terms that are diplomatic but not uncertain, the challenge of taking a company history up to recent times. His solution to the problem of constructing "virtuous recent history" is to substitute "the composite tones" of Phoenix's postwar directors for "the single voice of the historian" (II: 877).

The Phoenix Assurance office was founded in 1782 by London sugar refiners. During its first century it ranked among the top three British fire offices, and was the leading British exporter of fire insurance for much of that period. Phoenix became a composite insurance office in 1910, when it formalized its longstanding connection with Pelican Life and purchased Law Life. Under the leadership of Gerald Ryan, who came to Phoenix from Pelican, it proceeded to acquire the Union Marine office in 1911, Norwich Union Fire in 1919 and finally London Guarantee and Accident in 1922. This last acquisition proved to be Phoenix's undoing, in Trebilcock's account: LGA's anemic American reserves—hidden from Phoenix during merger talks—created immediate cash flow problems,

which forced Phoenix to unload the recently-purchased Norwich Union Fire in 1925. A further misstep occurred after World War II, when Phoenix failed to pursue the rapidly expanding market for pensions and profit-sharing life policies. And Phoenix, with its unusually large proportion of American business, suffered disproportionately when the postwar rise of direct underwriting in the US (by such firms as State Farm and All State) seriously harmed the brokerage business on which British exporters relied.

Trebilcock tells this story by arranging his chapters thematically within broad chronological divisions, which cycle through thirty year discussions of the home fire market, the foreign fire market, and life insurance (which was provided exclusively by Pelican until it merged with Phoenix). Special chapters focus on fire fighting in the nineteenth century, insurance during the two World Wars and Phoenix's post-war advertising practices. This arrangement makes for some repetition, but also allows readers to focus on a specific topic without having to wade through the entire book. Trebilcock also holds his narrative together by returning at various points to three central questions of economic and business history: the relative strengths of "the City" versus "industry" in the British economy; the relationship between information, risk, and market share; and the timing and significance of the multidivisional corporate form in the evolution of modern business.

On the first point, Trebilcock makes much of the fact that Phoenix was the creation of industrialists as opposed to the "unwieldy plutocratic clubs" which founded London's other major financial institutions (I: 29). Later departures from Phoenix's success appear as proof that the firm owed its early fortunes to its industrial values. He attributes the company's "arthritic pangs" after 1850 to its "transition from industrial to clerkly ways" (I: 414-15); he suggests that Liverpool-based fire offices achieved lasting dominance in the 1860s precisely because they maintained the insiders' edge that came from industrial (as opposed to aristocratic) boards. Secondly, Trebilcock contributes refreshing insights into the correlation between information and market share in his analysis of the practice of reinsurance, especially as it developed in riskier foreign markets. Market leaders (like Phoenix in the 1820s and its Liverpool rivals a generation later) typically spread their risks by forming reinsurance treaties with newcomers, which in turn allowed the newcomers to learn the lay of the land without actually entering it. Trebilcock concludes that this system forced original entrants to extend "special advantages to their imitators and successors" (I: 271), and further observes

that this is an inherent problem in insurance—where a firm's initial edge (proprietary information) is inevitably eroded by its need to share that information along with its risks. Finally, regarding Phoenix's place in the "managerial revolution," he indicates that the rise of the multidivisional form in British insurance evolved organically, not by design. A factory owner with a fire policy might ask for accident coverage to handle workers' compensation claims, or a group pension scheme for his employees; composites grew in response to such demands, either by acquisition or (less successfully) by the creation of new divisions *de novo*. Here, Trebilcock measures success by Alfred Chandler's yardstick for "modern" business organization, while rightly presenting insurance as proof against Chandler's claim that British business followed the lead of American firms in all sectors of the economy.

While these general insights lend coherence to Trebilcock's wealth of detail, the "voice of the historian" is less certain in his commentary on Phoenix's relations with government regulators and with other insurers. Too often, he portrays government involvement in the insurance industry—taxation at home and protectionism abroad—simply as a "routine threat" (II: 190), with little meaningful context that would allow for a more balanced perspective. In some cases he does make a strong case that official involvement was bad for both the industry and the economy at large. The fact that half of all British fire premiums in the 1830s were handed over to the state clearly inhibited the sector's growth, at a time when the country's rapidly expanding industries would surely have gained from wider coverage. In other cases, though, the costs of state interference are not fully spelled out, nor are the possible benefits to parties other than British insurers. Most foreign protectionism, for instance, came in the form of requiring a deposit of stock in the host country's private or public assets. $50,000 in Canadian stock was the price of entry into that market after 1860—but it is not clear how much this cost Phoenix in diminished profits, or how it affected liquidity. The price was clearly too high for the many firms which left Canada rather than bow to what Trebilcock calls the country's "punitive tactics" (II: 202). But even this could be seen as good policy, since it restricted entry to only the most financially secure companies.

As Trebilcock's examples accumulate of government involvement in fire insurance, one is left with the sense that the state was a pervasive but seldom completely negative presence in the industry. Even fire duties, levied in Britain from 1782-1869, helped cash flow, since fire offices

collected the tax and could hold it for up to two years; they also provide Trebilcock with most of the industry-wide empirical data that exists for that period. In World War I, the state both gave—allowing insurers their pick of marine risks, then offering 100% coverage to the rejects (enabling unprecedented profits)—and took away, wiping out profits with heavy taxation and the forced sale of low-yielding war bonds. And workers' compensation laws, both in Britain and the US, generated much of the demand for accident insurance, which in turn was a key driver in rise of the insurance industry's multidivisional structure. With this new sector, however, came continuing pressure from the state to "prevent unreasonable returns from ... insurance which was effectively compulsory upon employers" (II: 579).

Trebilcock's perspective again steers too close to the narrow interests of Britain's elite insurers when he addresses the problem of competition. In several chapters he praises Phoenix's efforts to co-operate with other market leaders to keep rates at a profitable level and, in the process, deter price competition by new entrants. Together, these two stances—anti-government and anti-competition—are off-putting, if not indefensible. The defense would be that overly aggressive price competition threatens a catastrophe-prone industry like fire insurance with instability, which was clearly on display with the recurrent waves of bankruptcies in the US fire business during the 19th century. But this defense begs the question of who is in the best position to determine a fair rate: the companies themselves, an elite subset of those companies, or the state. Trebilcock's general tone suggests sympathy with Phoenix's response to this question, which—as an elite fire underwriter—was not surprisingly the second option. He occasionally qualifies this line, noting that domestic price competition in the 1820s expanded the overall British market for fire insurance; and sniffing at the "positively bureaucratic" rate-fixing arrangements co-ordinated by British fire offices after 1860. But in general, this is a case where the view from the boardroom could have profited from an injection of regulatory theory.

When Trebilcock discusses life insurance at Pelican, and at Phoenix after 1910, the limitations of his boardroom perspective appear in a different guise. In setting premiums and selecting lives, insurance directors relied heavily on expertise generated by their actuaries and medical advisors. But in contrast to investment matters, which they robustly debated and assiduously recorded, they tended not to think very seriously about, nor record very thoroughly, how this expertise was

generated. Consequently, company archives are not the best place to learn about these very important technical components of the business. More promising are the actuaries' and doctors' professional journals and correspondence. By staying so close to the archival record, Trebilcock hence leaves these aspects of life insurance in a black box of the directors' (and to some extent the professionals' own) making. He chastises Pelican for its "inefficient actuarial work" (I: 584) prior to 1840, for instance, without discussing what the state of the art was at the time. Such omissions are less important in the case of Phoenix, which by all accounts was no industry leader in actuarial or medical matters (in Trebilcock's words, it was never able "to build up a fully developed professional capability in the discipline of life underwriting" (I: 613-14); but it is a good illustration of a common problem in business history.

Trebilcock's most successful chapters, and those most likely to appeal to a general audience, treat Phoenix's experience in the two world wars. Since World War I did not directly affect much property in England, the main focus in that chapter is on the war's impact on marine insurance (since ocean-going vessels were very much at risk) and on the threat of air attacks that never materialized. In both cases, with the government's active assistance, British insurers did remarkably well for themselves—proving that an anticipated catastrophe that never quite happens is an insurance office's dream come true. The chapter on the more destructive Second World War yields valuable insights into the curious intersection of insurance and industrialization. If it is true, as Trebilcock suggests throughout the book, that industrialization "created the widespread distribution of wealth which made it worthwhile for much of the community to insure its property against fire," that very same force created "the means of distributing destruction so widely that the property of every member of the community was put at risk" (II: 814). In contrast to the First World War, which produced risks which companies were willing to cover (and which did not, by and large, happen), its sequel created "a market for an insurance product which could not be supplied" (II: 818). The increasing present-day interest in "insurance technologies" evinced by legal scholars, economists and general historians has, one might say, similarly created a market for well-contextualized histories of insurance. That the resources exist for supplying this market is abundantly clear from Trebilcock's monumental history; that his traditional methodology is the best approach for doing so is less certain.

FROM THE JOURNALS: INSURANCE LAW ABSTRACTS

*Edited by Jeffrey Thomas**

AUTOMOBILE INSURANCE

Johnny Parker, *The Wacky World of Collision and Comprehensive Coverages: Intentional Injury and Illegal Activity Exclusions*, 79 NEB. L. REV. 75 (2000).

This Article provides an analytical framework for interpreting the "illegal activity exclusion" appearing in some comprehensive automobile insurance polices. The plain language of the clause purports to deny coverage if a loss occurs as result of any illegal act by the insured. The author contends that this exclusion could be interpreted to invalidate coverage when the insured commits even a minor traffic violation. As few courts have addressed the application of the clause in such cases, the author evaluates the interpretation of the intentional injury exclusion in automobile liability policies and the prohibitive use exclusions in rental car agreements in order to devise a parallel framework for interpreting the illegal activity exclusion. The Article applies the "perspective of the insured view," as extracted from interpretation of intentional injury exclusions, and the doctrines of ambiguity, unconscionability, and reasonable expectations as they are applied to prohibitive use exclusions, to provide a basis for interpreting the applicability of the illegal activity exclusion.

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ENVIRONMENTAL INSURANCE

Robert A. Whitney, *Environmental Law Issue: Environmental Contamination and the Application of the Owned Property Exclusion to Insurance Coverage Claims: Can the Threat of Harm to the Property of Others Ever Get Real?*, 27 N. KY. L. REV. 505 (2000).

This Article examines the application of the owned property exclusion contained in most general liability insurance policies to claims for the cost of cleaning up hazardous waste sites under federal and state laws. The author demonstrates that judicial opinions have been inconsistent in cases involving waste located on the insured's property that has not caused actual damage to third-party property. Some courts have determined that the exclusion does not apply because any threatened damage from the hazardous waste is an injury to the public at large. Courts' decisions are similarly varied when the third-party property is threatened with harm, with one line of cases holding that the exclusion does not apply, and another holding that the exclusion bars coverage even when there is an imminent threat of harm to third party property. The author concludes that the best approach when there is no third-party damage, or only a threat thereof, would be to exclude coverage. This would limit coverage to those cases where actual third-party damage has already taken place.

HEALTH INSURANCE

Jennifer S. Geetter, Note, *The Conditional Dilemma: A New Approach to Insurance Coverage of Disabilities*, 37 HARV. J. ON LEGIS. 521 (2000).

This Note analyzes case law interpreting the application of Title III of the ADA to the insurance industry with particular focus on the Seventh Circuit's decision in *Doe v. Mutual of Omaha*. The author criticizes the *Mutual of Omaha* decision because it lacks scientific underpinnings and clear guidelines for courts to follow. Attempting to balance the interests of the insurance industry and the need of the disabled to obtain insurance the author advocates an alternative approach, "the conditional extension test" that would require insurers to justify their decision to deny coverage by relying on scientific evidence. The author stresses that by requiring insurers to justify their denial of coverage based on scientific evidence,

predictability and reliability will be preserved in the insurance coverage for the disabled.

Jason A. Glodt, *Watch Out HMOS: The Future of Patients Rights Will Soon Be Determined*, 45 S.D.L. REV. 640 (2000).

This Article discusses the Patients' Bill of Rights debate that occurred in Congress during the 1999 and 2000 sessions. It identifies the dividing issue between Democrats and Republicans as the extent to which patients should be allowed to sue their HMOs. Under ERISA's preemption clause patients cannot sue their HMOs in state court and obtain damages when an HMO denies coverage or a necessary service in bad faith, though they can sue their HMOs in federal court. However, under ERISA damages are limited to the costs of services that the patient should have received and do not permit compensation for lost wages, death, disability or pain and suffering. The author suggests that this debate will be resolved by Congress in light of the United States Supreme Court's unanimous decision in *Pegram v. Herdich*. The Court stated that any principle purporting to draw lines between good and bad HMOs would embody in effect a legislative judgment that must be resolved by Congress. The author concludes that the ERISA preemption shield could be cracking and that reform may provide patients newfound rights. The author warns that increased patient rights could increase the cost of health care that HMOs were designed to contain.

Mary Carol Joly, Comment, *Doe and Smith v. Mutual of Omaha Insurance Company: The Possible Impact of Insurance Caps on HIV-Infected Individuals*, 4 DEPAUL J. HEALTH CARE L. 193 (2000).

This Comment argues that the Seventh Circuit decision in *Doe v. Mutual of Omaha Ins Co.* was incorrect and that Title III of the ADA should apply to the terms of insurance policies. The author relies on the purpose and legislative history of the ADA. She contends that allowing insurers to place caps on AIDS treatment will stifle effective treatment. Moreover, she finds that caps on AIDS treatment not based on actuarial data relating to cost are contrary to the purpose of the ADA because they perpetuate the stigma attached to people with HIV and AIDS.

Karen A. Jordan, *Coverage Denials in ERISA Plans: Assessing the Federal Legislative Solution*, 65 MO. L. REV. 405 (2000).

This Article surveys the current state of ERISA preemption law and finds that lower courts are still holding that ERISA plan participants are barred from pursuing any suit against a managed care plan for injuries as a result of the plan's wrongful denial of benefits. The author advocates a Federal legislative solution. Although the emerging view in light of the Supreme Court's decision in *New York State Blue Cross v. Travelers* may permit state law claims challenging the medical basis for coverage decisions, state law claims that would encourage managed care plans to act more fairly would likely remain preempted under current law.

The author suggests that the Norwood-Dingell Bill would provide a positive solution to the preemption problem. The Bill would preclude preemption when coverage denials result in wrongful death, including malpractice-type claims and claims for bad faith breach of contract. At the same time, the Bill contains limitations on the right to sue and would protect employer plan sponsors from liability.

Christine Lockhart, *The Safest Care is to Deny Care: Implications of Corporate Health Insurance, Inc. v. Texas Department of Insurance on HMO Liability in Texas*, 41 S. TEX. L. REV. 621 (2000).

This Article considers the implications of the Federal District Court's decision in *Corporate Health Insurance v. Texas Department of Insurance* regarding ERISA preemption of suits against HMOs. The court held that challenges to the quality of benefits under state law are not preempted by ERISA while claims based on failure to treat where the failure to treat is based on a determination that the treatment is not covered by the plan are preempted by ERISA. While acknowledging the decision as a partial victory for patients, the author criticizes the dichotomy created by the court between denial of benefits and quality of care as potentially making more egregious acts of HMOs in denying care all together cheaper in terms of liability. The author concludes by urging Congress to amend ERISA to forbid preemption of HMO liability.

INSURANCE-GENERAL

34th Annual SMU Air Law Symposium Insurance Panel, 65 J. AIR L. & COM. 545 (2000).

This Article is a transcript of a panel discussion on the mechanics of aviation insurance handling, both general aviation and air carrier. The discussion centers on the General Aviation Revitalization Act (GARA), which was written to try to curtail products type losses for manufacturers, and which many believe allows the aircraft manufacturing industry to avoid its responsibility to innocently injured victims.

Discussing GARA, the panel debated whether it is unfair to take manufacturer liability out of the dispute. Some on the panel argued that GARA essentially changes nothing, and that it offers aviation insurance companies the opportunity to fairly compensate victims based on liability. The panel experts stressed the importance of thorough investigation, although fast resolution of cases is also desirable.

James M. Cain and John J. Fahey, *Banks and Insurance Companies—Together in the New Millennium*, 55 BUS. LAW. 1409 (2000).

The Article surveys significant aspects of the Gramm-Leach Bliley Financial Modernization Act affecting banks and thrifts engaging in insurance activities. The Article reviews significant federal and state regulatory developments that have impacted the direction of financial service reform. The authors argue that the Act created a framework for functional regulation of the issuer and the distributor of banking, securities and insurance products. The author finds that passage of the Act does not mean less regulation for banks wishing to sell insurance because banks will have to comply with the complex array of banking, insurance, and securities laws.

Russel Myles and Richard M. Gaal, *Reliance More Than a Procedural Stepping Stone in Interest-Life Insurance Class Action*, 74 TUL. L. REV. 2113 (2000).

This Practitioners' Note addresses the difficulty of proving fraud in the sale of interest-sensitive life insurance. The authors argue that courts should address this difficulty by allowing alternative forms of proof, such

as presuming reliance or relieving plaintiffs of the burden of proving reliance. The authors maintain that this would appropriately shift risk from the consumers of interest-sensitive life insurance to the insurer. The authors stress that the current substantive law is fair to insurers by requiring plaintiffs to prove each element of fraud.

Gene Rappe, *The Role of Insurance in the Battle against Terrorism*, 12 DEPAUL BUS. L. J. 351 (1999/2000).

This Article argues that the insurance industry, through assessment of risk control and disaster preparedness, can be a valuable player in the battle against international terrorism. Risk control experts work with business owners to plan means by which they can recover after sustaining a loss, and losses due to terrorist activities are considered in making such assessments. Risk control also provides advice on the best means by which an insured can take action to prevent damage before it happens. Factors considered in a risk control assessment include storage, electronic file backup, redundant production, property, suppliers, vehicles, and security of premises.

The author also discusses policy responses and exclusions, noting that insurers may attempt to find policy exclusions for damages caused by terrorist acts. However, insurers assist businesses in returning to normal operations even if all damages are not covered by a given policy. The author warns that increased terrorist activity may result in insurance companies restricting coverage. If this situation occurs, carriers will need to contemplate whether or not they wish to continue to insure these types of catastrophic damages or whether they should limit coverage through sub-limits or higher deductibles.

INSURANCE REGULATION

Eun Sup Lee, *Regulation of Insurance Contracts in Korea*, 13 TRANSNAT'L LAW. 1 (2000).

This Article provides an overview of the institutions and codes that regulate the insurance industry in Korea. The author's focus is on the bodies of law that regulate insurance; the Insurance Business Act and the Insurance Contract law, and the government entities involved in regulation. These three entities are 1) The Minister of Finance and

Economy, 2) the Financial Supervisory Commission, and 3) the Financial Supervisory Service, which is a sub-agency of the Commission that supervises matters of insurance supervision. The regulations are part of the larger Commercial Code.

Analyzing the protection of insurers and policyholders, the author finds that Korea provides far-reaching protection for policyholders, based on the weakness of the insured's bargaining power. Provisions in insurance contracts are regulated directly by the code, which assures that providers will not take advantage of weaker policyholders. As compared to U.S. law, Korean law differs in its treatment of misrepresentation, requiring bad faith on the part of an insured to justify the rescinding of a contract. Korea's laws concerning causation also favor the insured.

LIABILITY INSURANCE

John E. Core, *The Directors' and Officers' Insurance Premium: An Outside Assessment of the Quality of Corporate Governance,* 16 J.L. ECON. & ORG. 449 (2000)

This Article examines the directors' and officers' (D & O) insurance premium as a measure of a corporation's ex ante litigation risk, attempting to find an association between the D & O premiums and the quality of a firm's governance structures. Hypothesizing that a firm with weaker governance will have greater litigation risk which will be reflected in higher premiums, the author uses an econometric model to examine a sample of publicly traded Canadian firms, which are required to disclose information concerning their purchase of D & O insurance.

The author claims that the data confirms his hypothesis. He maintains that D & O premiums reflect the quality of firms' governance structures by demonstrating that measures of weak governance implied by the D & O premium have a positive relationship with excess CEO compensation.

Jennifer A. Emmaneel, Note, *Hiding Behind Policy: Confusing Compensation with Indemnification*, 30 GOLDEN GATE U.L. REV. 637 (2000).

This Article analyzes the California Supreme Court's decision in *PPG Industries v. Transamerica Ins. Co.*, which held that California public policy precludes an insurer from indemnifying its insured for punitive

damages even if the punitive damages were awarded as a result of an insurer's bad faith breach of its duty to settle. The court acknowledged that if the insurer settled there would have been no punitive damages awarded, but concluded that the insured's conduct, not the insurer's failure to settle, was the cause-in-fact of the damage award. The majority explained that public policy limitations must be imposed on causation standards. It found that the insured's liability for the punitive damages could not be offset by the insurer's conduct. Additionally, the court noted that to allow the insured to recover as a result of the insurer's bad faith would allow the insured to shift the cost of its wrongful conduct to the insurer.

The author argues that *PPG Industries* was wrongly decided and that the dissenting opinion of Justice Mosk should have been followed because the majority allows the insurer to escape responsibility for its wrong—failing to settle. Justice Mosk's dissent underscored that an insurer has a duty to settle regardless of whether the damages are compensatory or punitive in nature. The author concludes by stressing that the decision excuses insurers from liability for their tortious conduct.

Nora J. Pasman-Green and Ronald D. Richards, Jr., *Who is Winning the Collateral Source Rule War? The Battleground in the Sixth Circuit States*, 31 U. TOL. L. REV. 425 (2000).

This Article examines the state of the Sixth Circuit collateral source rule, which bars introduction of evidence that a plaintiff has received support from a source collateral to the defendant. The rule has been challenged in many jurisdictions, where legislatures and courts have attempted to avoid windfalls to plaintiffs with insurance coverage. After providing a history of the collateral source rule, the author explains how the rule has been treated in the Sixth Circuit. Wisconsin is the only state that has kept the rule intact, while Kentucky courts have retained the rule by declaring the legislature's attempt to circumvent it unconstitutional. Ohio has made several attempts to modify the rule, but all have been struck down. Tennessee has successfully modified the rule, while Michigan appears to have abandoned it altogether by statute.

The authors contend that this jurisdictional split will lead to forum shopping by both plaintiffs and defendants. Notwithstanding the trend in favor of defendants, the authors argue that the best approach is to retain the

rule as it existed under common law, finding that the rule is not necessary to prevent windfalls to insured plaintiffs.

Michael Rigby, Casenote, *The Broken Triangle-Should Insurers Be Held Vicariously Liable The Legal Malpractice of Counsel They Retain to Defend Their Insureds?*, 41 S. TEX. L. REV. 651 (2000).

This Casenote criticizes the decision of the Texas Supreme Court in *State Farm Mutual Automobile Insurance Co. v. Traver*, which held that insurance companies are not vicariously liable for the malpractice of the attorney hired by the insurer. The author contends that a rule imposing vicarious liability on insurance companies is necessary because it accounts for the agency relationship between the attorney and the insurer and addresses the conflicts of interest presented by representation of the policyholder. The author asserts imposing vicarious liability would discourage insurers from exerting pressure on the attorney to keep costs down. In conclusion, the author emphasizes that a legal rule of vicarious liability creates economic incentives to protect the interests of the insured-client.

David A. Szwak, *Enforcement of the Assault and Battery Exclusion in Louisiana: Hickery v. Centenary Oyster House*, 60 LA. L. REV. 793 (2000).

This Article explains that the assault and battery exclusion in general liability insurance policies is not trumped by Louisiana's statutory requirement that every licensed private contract security guard company have at least $500,000 in general liability coverage. The Louisiana Supreme Court in *Hickery v. Centenary Oyster House* found that the statute simply required the security guard company to obtain general liability insurance and did not require insurers to provide unrestricted coverage. The court found that the purpose of the Act was to protect the public from unqualified security guards. However, fulfilling this public policy purpose does not require insurers to provide coverage for assault and battery.

The author concludes that enforcement of the exclusion allows insurers to better access the risk of providing security guard companies with coverage. He contends that broad regulatory statutes should not become a basis for requiring insurers to expand coverage to policyholders.

RECENT CASE DEVELOPMENTS

*Jeffrey W. Stempel**

WORKERS COMPENSATION APPLIES TO EMOTIONAL INJURY CAUSED BY SUPERVISOR CRITICISM

Appeal of New Hampshire Department of Health and Human Services, 2000 N.H. LEXIS 44 (New Hampshire Supreme Court, August 23, 2000)

In a decision much criticized by some in the insurance industry, the New Hampshire Supreme Court has affirmed a state Compensation Appeals Board decision finding a worker's "major depression" to be "compensable under the workers' compensation statutes because it was caused by employment-related stress arising from her supervisor's legitimate criticism of her work performance." 2000 N.H. LEXIS 44 at *2.

Gail Sirvis-Allen began working as a "Clerk I" with the State of New Hampshire in February 1978. She left state employment because of the depression and stress in August 1995 as a Case Technician II, a position she had held for nine years. The job duties included "taking applications for food stamps, Medicare, and disability, as well as verifying information and entering it into a computer" as well as contacting "clients and following up by letter." *Id.* at *2. Her job performance was checkered.

> During her tenure. . . [she] often failed to adequately fulfill her assigned work responsibilities. In 1989, due to job performance problems including inaccuracy and a poor attitude, she was transferred to a slower-paced environment. In 1992, she was given a series of performance warnings and

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> transferred to an even less demanding position. Her tenure was also marked by frequent medical and psychological problems. . . . In March 1994, she was diagnosed with clinical depression and problems related to attention deficit disorder (ADD) and excused from work [for a short time].

In September 1995, Sirvis-Allen filed her workers' compensation claims, "claiming that she suffered a work-related stress injury resulting from disciplinary action taken against her on or about August 5, 1995." *Id.* at *4. The Department of Labor hearing officer denied the claim. After a de novo hearing, the Board reversed, finding that her "ADD constituted a pre-existing weakness which caused her work performance to suffer. It also found that her supervisor's criticism, although justified, caused her major depression. Finally, the board concluded that the respondent's work-related stress, which triggered depression, headaches, and chest pain, was greater than normal, non-employment related stress." *Id.* at *4.

The employer challenged the Board's ruling, arguing that compensation benefits should not have been available because (1) Sirvis-Allen was not injured in an "accident;" (2) her depression and disability did not "arise out of" employment; (3) there was an insufficient showing that her problems were caused by the work-related criticism rather than other factors; (4) an award of compensation benefits was inconsistent with desirable public policy because "workers' compensation should not be awarded for injuries resulting from good faith criticism of an employee's job performance." *Id.* at *5. The Court rejected all of these arguments and upheld the Board's award of benefits to Sirvis-Allen.

The Court backed the Board in part because under the applicable law of workers' compensation, like most administrative law schemes, courts are required to defer to the fact-finding of the regulatory board unless it is clearly erroneous or decisions are arbitrary and capricious. The Court affirmed the award in part because of this deference to the Board's fact-finding that Sirvis-Allen was indeed disabled and that her depression was in fact sufficiently causally related to her work (thus "arising out" of employment) even though the supervisors' criticisms were apparently necessary and not excessively harsh. *See id.* at *8-9 (quoting *New Hampshire Supply Co. v. Steinberg*, 121 N.H. 506, 509, 433 A.2d 1247, 1249 (1981)).

Under the law, the Court found legally sufficient causation because the claimant had demonstrated to the Board's satisfaction that her employment-related stress was greater than what she encountered in ordinary life outside the workplace. *See id.* at *8-*9. In addition, the Court emphasized that it was

operating under the presumption that all reasonable doubts as to construction of the statutes should be resolved in favor of the injured employee, a central principle of workers' compensation in most states.

On the issue of whether the inability to work was sufficiently "accidental," the Court read the New Hampshire workers' compensation statute as requiring only that the injury be accidental, not that the events leading to injury be accidental or unintended. *See id.* at *6 (N.H. Rev. Stat. Ann. §281-A:2 speaks of "accidental injury" rather than injury caused by accident). The criticisms and work assignments of Sirvis-Allen were of course no accident—they were part of the job—but her supervisors never expected her to go into dysfunctional depression in response. Consequently, the Court found the injury sufficiently accidental. This is consistent with the purpose of workers' compensation law, which is to provide compensation for work-related injuries that stem from the regular operations of the employer. Coverage is not limited to only the improperly operating aspects of the workplace.

Regarding public policy, the Court acknowledged that affirming the award tended to be a "troubling" extension of liability greater than normally found in a common law system because of the unusual nature of the claimant's injuries and the claimant's "thin skull" susceptibility to depression coupled with her receipt of more criticism because of her pre-existing ADD and difficulty performing her work tasks. The Court also noted that cases in other states had diverged on the issue of whether proper criticism of employee work performance could be the cause of compensable workers' compensation injury. *Compare Calovechhil v. State*, 233 Mich. App. 349, 566 N.W.2d 40 (Mich. Ct. App. 1997) (injury from stress of investigation compensable) *with Duncan v. Employers Cas. Co.*, 823 S.W.2d 722 (Tex. Ct. App. 1992) (injury from stress of reprimand and job transfer not compensable). So long as a worker's depression is real rather than feigned and results from work stress, compensation would appear to be consistent with this area of the law, just as it would be for back injuries and other more physical and typical mishaps in the workplace. Because of the division of courts and observers on this issue, additional litigation and legislation on the issue is likely. Courts and legislatures may need to expressly decide whether they would rather see workers' compensation costs increase by some amount to cover mental/emotional injuries form workplace stress or whether they believe the better social policy is to leave workers on their own for these types of injuries.

SIX-YEAR DELAY IN CLAIMING DISABILITY BENEFITS DOES NOT BAR CLAIM AS A MATTER OF LAW

Brown v. Life Insurance Co. of North America, 8 P.3d 333 (Wyoming Supreme Court, July 5, 2000)

Kent Brown, a dentist, was injured in a fireworks accident on July 4, 1987 and as a result had "virtually no vision in his left eye, except for light perception." 8 P.3d at 335. His physician told him that the maximum medical recovery would take place in six months. After that time, Brown's vision was no better. He continued to practice dentistry but with difficulty and concluded that he could not continue, taking steps to sell his practice. However, the practice was not finally sold until May 1, 1993. During Summer 1993, Brown finally submitted a claim for total disability to his insurer.

The policy provided that notice should be given to the company "within 30 days after the occurrence of any loss" or "as soon thereafter as is reasonably possible." Proof of loss under the policy was required within 90 days after the date of loss but late proof of loss would not diminish benefits so long as the proof was "furnished as soon as reasonably possible and in no even . . . later than one year" (absent capacity of the claimant to make a claim during the relevant time period). *See* 8 P.3d at 336.

Despite the six-year delay in notice, the Wyoming Supreme Court rejected the insurer's defense, ruling that the notice was not late as a matter of law and might under the unusual facts of the case be notice as soon as was "reasonably possible."

Dr. Brown took the position that notice was not reasonably possible to give until he was aware of the full extent of his disability and completely unable to practice. The insurer took the view that the disability policy was triggered at the time of the accident itself (July 4, 1987) or six months later when the policyholder's vision showed no improvement (or at least insufficient improvement to overcome the disability). The policy in question defined total disability as inability to "practice your own occupation (your special area of dental practice)." 8 P3.d at 337. Based on these facts, the Court found that

> [u]nder the terms of the policy, so long as he was practicing his profession as a dentist, he was not disabled and would not have been eligible for disability benefits. Moreover, the

> question as to what constitutes a reasonable time for filing of the claim in the context of disability insurance is ordinarily for the jury. Perhaps of greater importance, the disability from which Brown suffered was a continuous disability, and under the terms of the policy, there was nothing to prevent submission of the claim within the duration of the disability covered by the policy.

8 P.3d at 337 (citations omitted).

Clearly influenced by the equities of the situation favoring the policyholder, the Court also observed that

> based on the record before us, [the insurer] does not have a viable defense based on prejudice because of an inability to investigate the claim. The record extant demonstrates that an accident occurred, that Brown was eventually totally disabled by it, and that the policy provided for benefits once Brown was deemed disabled from practicing as a dentist.

8 P.3d at 337. In other words, even though the notice was late, this if anything advantaged the insurer, making the late notice defense stand appear excessively bellicose.

ARIZONA SUPREME COURT INVALIDATES AUTO EXCLUSION AS INCONSISTENT WITH UNDERINSURED MOTORIST LAW; UIM BENEFITS APPLY TO EXTENT INJURED POLICYHOLDER NOT MADE WHOLE BY ANY APPLICABLE LIABILITY PAYMENTS

Taylor v. Travelers Indemnity Company of America, 9 P.3d 1049 (Sept. 15, 2000)

Nellie Taylor was a passenger in a family car being driven by her husband when his negligent driving caused an accident that killed him and injured her as well as four people in the other vehicle.

> The Taylors had a $300,000 single-limit liability policy issued by Travelers, with UIM [underinsured motorist] coverage in the same amount. Mr. Taylor was the named insured and Plaintiff [Ms. Taylor] was insured as a family member. Plaintiff and the four occupants of the other

> vehicle presented claims on the liability coverage, which Travelers settled by apportioning the $300,000 liability limit among the five claimants. Plaintiff received $183,500, far less than her medical bills, let alone her total damages. Having no coverage from any other source, Plaintiff made a UIM claim on her Travelers policy.

9 P.3d at 1051.

Travelers denied coverage based on a policy exclusion that barred coverage to *any* person who had received *any* payment for bodily injury under the liability provisions of the policy. *See* 9 P.3d at 1050-51 (emphasis added). The trial judge agreed and entered judgment as a matter of law for the insurer. The Court of Appeals reversed, "finding the policy provision that prohibited paying UIM to a person who received payment under the liability coverage was void because it was not permitted" by Arizona's UIM statute. *See* 9 P.3d at 1052. The Arizona Supreme Court agreed, also finding the provision too inconsistent with the statute to be effective.

Arizona law requires that UIM coverage be made available to policyholders in an amount equal to the liability limits of the auto policy and that the UIM coverage provide coverage to a person who is injured but unable to obtain full compensation for the injury from available sources of liability insurance.

PRINCIPALS IN CORPORATION ARE NOT "INSUREDS" FOR PURPOSES OF MAKING CLAIMS UNDER POLICY OR PURSUING BAD FAITH ACTION

Jadco Management Corp. v. Federal Ins. Co., 9 P.3d 92 (Oklahoma Court of Civil Appeals; decided Feb. 4, 2000; rehearing denied, March 3, 2000; certiorari denied, May 16, 2000)

Jadco Management Corp. purchased insurance from Federal. Later, it made a claim against Federal asserting that large quantities of crude petroleum were stolen from its facility in Tussey, Oklahoma. Federal denied the claim. Jadco was predictably upset. So was its sole shareholder, director and officer, John R. Armstrong. He joined Jadco's suit against Federal alleging breach of contract and bad faith handling of the claim and alleged that he suffered damages of emotional distress. The trial court dismissed

Armstrong from the lawsuit and the court of appeals affirmed, holding that the principals of a corporate policyholder have no standing to bring a lawsuit against the insurance company. According to the Court, the duty of good faith and fair dealing in insurance runs between the policyholder and the insurer, not between the insurer and those who own the insured company or are interested in its fate.

"The option of becoming an insured under an insurance policy is presumably available if the individual owner has an adequate insurable interest matching that of the company. For corporations and shareholders, however, satisfaction of this criterion will vary. For example, if Jadco Corporation is liable in tort, Armstrong's personal wealth is presumably beyond the reach of the claim because tort liability extends only to the corporation. For first-party claims (such as the crude oil theft alleged in the instant case), however, Armstrong and other company owners would appear to have an insurable interest. If Jadco goes bankrupt because of lost crude oil and no insurance payment, Armstrong as sole shareholder would certainly suffer a real loss as well when his shares are lowered in value. Presumably, he and others can find insurance carriers who will make them part of first-party coverage if that is what they desire, provided that the pool of owners is small. It is unlikely that an insurer would agree to consider shareholders insureds in the case of the typical publicly traded corporation, which has thousands of shareholders.

SEAFOOD HAULER BEREFT OF COVERAGE UNDER BOTH MARINE CARGO AND WAR RISK POLICIES FOR LOSSES STEMMING FROM RUSSIAN SEIZURE AND CONFISCATION OF CARGO

Kimta v. Royal Insurance Company, 9 P.3d 239 (Washington Court of Appeals, Sept. 18, 2000)

In December 1996, the motor vessel ship BIKIN was transporting cargo of fish and crab from the Russian Far East to Korea when Russian authorities arrested the vessel and its cargo, citing failure of the ship's captain to comply with orders to return to port and failure to obtain a required transshipment permit. "Following judicial proceedings in Russia, the Russian authorities confiscated the cargo [valued at $3 million] and sold it at auction." *See* 9 P.3d at 240. The owners of the cargo sought coverage under their marine

cargo insurance or war risk policies, whichever might be applicable. The trial court denied war risk coverage but also declined to rule for the insurer as a matter of law on the marine cargo coverage issue. The Washington Court of Appeals affirmed that there was no war risk coverage under these circumstances and also found for the insurer that, as a matter of law, the marine cargo policy offered no coverage.

A marine cargo policy, as its name implies, provides first-party coverage to the owners of ocean-going cargo that is lost. The policy generally covers losses of all types and this policy also included a so-called "Inchmaree" clause providing coverage for losses caused by the negligence of captain or crew in the navigation or management of the vessel. *See* 9 P.3d at 240. However, the policy also contained a standard "paramount warranty" provision commonly called a "Free of Capture and Seizure Clause," which excludes coverage when the cargo is confiscated by the "capture, seizure, arrest, restraint, detainment, confiscation, preemption, requisition or nationalization, and the consequences thereof or any attempt thereat, whether in time of peace or war and whether lawful or otherwise." *See* 9 P.3d at 241.

At the outset, the Court devoted considerable discussion to the applicable law to be applied, concluding that the coverage issue was governed by federal admiralty law in view of the history of maritime insurance. *See* 9 P.3d at 241-43. The Court's determination was also buttressed by the obvious need for maximum consistency in this line of insurance, where losses frequently occur in a variety of jurisdictions, with the insured cargo's itinerary varying to considerable degree. *See* P.3d at 242-43.

The use of federal admiralty law made the decision straightforward. Established precedent in the area establishes that the negligence of the captain leading up to a government seizure of goods is not the efficient proximate cause of the loss (rather, the excluded seizure is the proximate cause of the loss) unless the negligence of captain or crew endangers the cargo in a manner "independent" of the seizure. *See* 9 P.3d at 243-44. Because the captain's negligence in not returning to port and not obtaining proper permits did not threaten the cargo as such but merely led to the seizure, the loss was excluded as one resulting from seizure, notwithstanding the captain's negligence. *See* 9 P.3d at 244.

EMPLOYEE ON LEAVE REMAINS A "FULL-TIME" EMPLOYEE FOR PURPOSES OF BENEFIT PLAN AND WAS ENTITLED TO DEATH BENEFIT COVERAGE

Tester v. Reliance Standard Life Insurance Company, 228 F.3d 372 (4th Cir. Sept. 25, 2000)(applying federal common law)

Annie Ruth Tester began working for Bibb Company as a full-time employee on June 1, 1993. In August 1993, Bibb obtained group accident coverage for its employees, with death benefit coverage of $50,000 provided through a group policy with Reliance. The policy provided that it covered full-time and part-time employees, with part-time defined as working at least 20 hours per week; temporary or seasonal workers were excluded. On January 8, 1995, Tester took an approved medical leave because of health problems. On February 15, 1995, she died from injuries sustained in an automobile accident (she was a passenger and the accident was not related to her health problems).

Reliance refused to pay the accidental death benefit to her husband, arguing that she was no longer covered under the policy because she was not actively working at the time of the accident. The U.S. Court of Appeals for the Fourth Circuit rejected the insurer's defense and found coverage for the Testers. Applying the federal common law of contract interpretation applicable to employee benefit plans under ERISA (the Employee Retirement Income Security Act), the court found that the policy was ambiguous as to whether the taking of a leave made the employee "inactive" and therefore ineligible for coverage. 228 F.3d at 376.

The Fourth Circuit's decision makes sense not only in terms of the language of the policy and the likely expectations of the Bibb Company employees but also in terms of the purpose of the eligibility requirements of the policy. To avoid adverse selection, group insurers issuing policies to employers seek to define eligibility so that persons likely to need insurance will not be signing on with the company for the insurance coverage. Rather, the insurer seeks to cover a group of persons who just happen to be working at the company in order to work, with insurance a mere fringe benefit. Requiring that employees be full-time or of significant connection to the company helps to accomplish this underwriting goal. The "engaged in continuous employment" requirement also makes it easier for the insurer to assess its risk because the number of employees covered is ascertainable and

stable in a way it is not if temporary or sporadic workers are covered. Seen in this light, coverage of Annie Ruth Tester hardly undermines the insurer's legitimate need to define the covered group. Her death did not result from any health problems that could have animated adverse selection on her part; she was simply the tragic victim of a car accident. Under these circumstances, the case for coverage was overwhelmingly persuasive and the insurer's resistance to payment difficult to understand.

FEDERAL APPEALS COURT FINDS THAT POLICYHOLDER'S REFUSAL TO UNDERGO EXAMINATION UNDER OATH DOES NOT VOID COVERAGE UNLESS INSURER IS PREJUDICED

Talley v. State Farm Fire & Casualty Company, 223 F.3d 323 (United States Court of Appeals for the Sixth Circuit, August 10, 2000) (applying Tennessee law).

George Talley had a homeowner's insurance policy with State Farm. After a fire damaged his house, he submitted a claim. In response, State Farm asked him to submit to an examination under oath, as required by the policy. It is not routinely imposed but is used where the insurer regards the claim as subject to question in either source or amount of loss. Talley refused to submit to an examination "because of an ongoing criminal investigation of the fire and its cause." *See* 223 F.3d at 325.

On the basis of Talley's refusal, State Farm denied his claim, arguing that the refusal to undergo an examination under oath was a breach of the policy. The federal district court in Tennessee granted judgment as a matter of law to State Farm when Talley sued over the claim. The U.S. Court of Appeals for the Sixth Circuit (which includes Tennessee, Kentucky, Michigan, and Ohio) vacated the judgment and remanded the case for further trial proceedings. The Appeals Court ruled that the failure to participate in the examination under oath would void coverage only if the insurer could demonstrate that it suffered prejudice because of the refusal of the policyholder to be examined.

The Sixth Circuit analogized the examination under oath provision of the policy to the "cooperation" clause and related clauses in the policy (such as notice and proof of loss requirements). *See* 223 F.3d at 325-27. The overwhelming majority rule regarding cooperation holds that an insured's

failure to cooperate with the insurer (or to give timely notice or provide a sufficiently detailed proof of loss) will vitiate coverage only if the insurer is prejudiced by the policyholder's failures of cooperation.

Tennessee state courts have long followed the majority rule regarding cooperation, late notice, and proof of loss. Although the Sixth Circuit found no on-point Tennessee case addressing examination under oath, it reasoned that the Tennessee Supreme Court, if faced with the case, would require a showing of prejudice for examination under oath deficiencies as well as for other cooperation deficiencies by the policyholder. *See* 223 F.3d at 327.

One can certainly question the Sixth Circuit's analysis. Other jurisdictions have tended to construe the examination under oath strictly in view of its origins and importance. It is by no means clear that Tennessee would take as relaxed a view of the provision as did the Sixth Circuit. The examination under oath provision is included in property policies because of the traditional difficulty insurers have faced regarding arson and other fraudulent claims. In *Talley*, there was a fire of sufficiently suspicious origin that criminal proceedings were in progress and the policyholder was sufficiently concerned about these proceedings to cite this as a reason for refusing to be examined under oath. The case was thus practically tailor-made for such an examination so that State Farm could better determine whether Talley's claim was too suspicious to be paid. Instead, the Court essentially told State Farm to start digging elsewhere for evidence of arson or fraud.

MURDER OF TENANT IS "ACCIDENT" UNDER LANDLORD'S LIABILITY POLICY

Agoado Realty Corporation v. United International Insurance Company, 95 N.Y.2d 141, 733 N.E.2d 213, 711 N.Y.S.2d 141 (New York Court of Appeals, June 20, 2000)

Agoado Realty owns apartment buildings. In 1996, a tenant in one of them was murdered by an unknown assailant. The decedent's estate sued Agoado as landlord, alleging that the tenant's wrongful death occurred because of the landlord's negligence in maintaining premises security. The landlord's liability insurer raised a number of defenses to coverage, including an argument that the death was not an "accident" within the meaning of the policy because of the murder. The Court of Appeals (the highest state court

in New York) rejected this defense as inconsistent with basic principles of insurance and a common sense reading of the policy.

The Court of Appeals reversed the trial court's determination in favor of the insurer on the "accident" issue. The trial court had also ruled in favor of the insurer's late notice defense. The Court of Appeals remanded this issue to the trial court for further fact finding on whether the policyholder had given notice to the insurer "as soon as practicable" as required under the policy. The murder took place on May 19, 1996. The wrongful death action was commenced on February 10, 1997 but Agoado Realty did not receive a copy of the summons and complaint until June 20, 1997. On June 20, 1997, the insurer received the summons and complaint and notice of the occurrence. Although this was a whopping 397 days after the murder, the Court of Appeals determined that notice may be considered timely in view of the fact that the insurer received notice two weeks after receipt of the complaint against the policyholder, although there remained issues as to whether the policyholder had sufficient information so that it should have informed the insurer prior to June 1997.

WORKERS COMPENSATION STATUTE UNCONSTITUTIONAL TO THE EXTENT IT REQUIRES LIVE TESTIMONY IN CLAIMS OF MENTAL IMPAIRMENT BUT ACCEPTS DOCUMENTARY EVIDENCE ALONE IN CASES OF PHYSICAL IMPAIRMENT

Esser v. Industrial Claim Appeals Office of the State of Colorado, 8 P.3d 1218 (Colorado Court of Appeals, Jan. 20, 2000, *Modified on Denial of Rehearing*, March 23, 2000, *Certiorari Granted*, August 21, 2000).

Colorado's workers' compensation statute provides that where a worker claims injury and mental impairment, this must be "proven by evidence supported by the ***testimony*** of a licensed physician or psychologist." Mental impairment is defined as existing where there is no evidence of physical injury to the claimant. However, for claims of physical injury, a worker may prove up the claim without use of live expert testimony through use of medical records and other documentary evidence. A claimant asserting mental impairment challenged the statute's treatment as unfairly uneven

regarding mental and physical injury claims. The Colorado Court of Appeals agreed, holding that differential evidentiary treatment of the two sorts of claims was a violation of the equal protection of laws guaranteed in both the state constitutions. The Appeals Court found that there was no rational reason to require live testimony for mental impairment claims but to deem documentary proof sufficient for physical injury claims. *See* 8 P.3d at 1221-23. The Appeals Court did, however, stress that the legislature was within its prerogatives in requiring sufficient evidence of mental impairment; the legislature erred in resolutely requiring different minimum forms of evidence for different injury claims.

> The very real purpose of requiring proper verification of the claim is met once an appropriate expert report is received. And, in all cases in which the employer chooses to examine that expert, an opportunity for such examination must be provided, even if that expert is not initially called as a witness in the claimant's case.
>
> Given these considerations, therefore, we conclude that the further requirement that a mental impairment claimant produce a live witness in the first instance achieves no legitimate purpose . . . .

8 P.3d at 1222-23.