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update

Beech payments to captive not tax-deductible: Court

DENVER—Beech Aircraft Corp. isn't entitled to tax deductions for premiums paid to its captive insurance company because there was no transfer of risk, a federal appeals court says.

The 10th U.S. Circuit Court of Appeals earlier this month ruled that Beech could not deduct as an ordinary business expense $1.7 million in premiums it paid to Travel

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Tax reform to raise benefit costs

By JERRY GEISEL

WASHINGTON—The tax overhaul bill approved by a congressio-al conference committee will mean higher benefit costs for employ-rs and less attractive benefits for some employees.

In addition, legislators' desire to curtail tax shelters and shift more f the tax burden to business from individuals will lead to new tax iabilities for owners of some offshore insurance companies and as nuch as $7.5 billion in new taxes for prop-rty/casualty insurers.

The tax bill, approved by the conference ommittee Aug. 16, took its final shape 18 nonths after the Reagan administration first roposed a complete overhaul of the tax code o lower tax rates through the elimination of undreds of tax breaks and deductions.

Benefit and risk managers have been kept n the edge of their seats during those 18 nonths, watching as legislators considered, liscarded and refined proposals affecting orporate programs as part of their effort to craft a new tax code.

The full House and Senate are expected to approve the legislation ext month, and President Reagan has said he is satisfied with its ontents.

Benefit managers have been particularly interested in the tax lebate, as earlier proposals would have mandated drastic changes in mployee benefit plans, including taxes on employer-provided health nsurance benefits and the elimination of 401(k) salary reduction lans.

While the conference bill has not damaged benefit plans as much as nce had been feared, "Employers will have major administrative eadaches for the next several years," said Thomas Butterworth, partner in the Rowayton, Conn., office of Hewitt Associates.

"It's a whole new ball game. Virtually every pension and savings lan will have to be looked at, redesigned and amended," said rederick Rumack, director of taxes and legal service at Buck Consultants Inc. in New York.

> **'Virtually every pension and savings plan will have to be looked at, redesigned and amended,' says Buck's Mr. Rumack.**

For example, every 401(k) plan must be amended to accommodate new, more complex and restrictive non-discrimination rules and a new $7,000 annual limit—down from the current $30,000—on maximum annual deferrals.

But observers note that 401(k) plans—which had been targeted for extinction several times by the administration—will still be an attractive benefit for employees after the tax bill is enacted.

"In essence, we have cemented 401(k) as a legitimate plan. The uncertainty is wiped out. Congress has put its imprimatur on the plans," said Edward J. Davey, a vp with Johnson & Higgins in New York.

While 401(k) plans will survive, the tax legislation will deny millions of middle- and upper-income taxpayers the opportunity to make tax-deductible contributions to Individual Retirement Accounts.

Most corporate pension plans also will have to be overhauled. The popular 10-year vesting schedule offered by most defined benefit plan sponsors will be scrapped, and in its place employers will have to adopt new, more rapid vesting schedules. One new schedule would require full vesting after five years of service.

While vesting changes will raise corporate costs, "It is an advance for employees who move from job to job and never stay long enough at one company to vest," said Tom Stapleton, vp and tax director at Metropolitan Life Insurance Co. in New York.

The tax bill also will limit the amount employers can cut pension benefits by Social Security benefits received by retirees. While this change will boost pension benefits received by some retirees, it also will inflate corporate pension costs.

Companies wanting to terminate their pension plans to recapture excess assets will, unless the funds are rolled over into an Employee Stock Ownership Plan, be hit with a new 10% excise tax.

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THE NEW TAX BILL

- Limits maximum annual 401(k) deferral to $7,000.
- Bars pretax IRA contributions by middle- and upper-income pension plan participants.
- Establishes a five-year pension plan vesting schedule.
- Creates new non-discrimination rules for pension and welfare plans.
- Continues tax-free status of educational assistance and group legal benefits through 1987.
- Imposes a 10% excise tax on most pension plan reversions.
- Imposes current tax on income to shareholders of offshore captives with 25% or more U.S. ownership.
- Taxes property/casualty insurers' tax-exempt and unearned premium income. Also requires reserve discounting for tax purposes.
- Removes BC/BS plans' tax-exempt status.

Delaware may force firms to offer health coverage

By DONNA DiBLASE

DOVER, Del.—Delaware employers that do not now provide group health insurance plans would be forced to offer employees the right to purchase health insurance at their own cost under legislation pending in the Delaware Legislature.

Employers with at least 10 full-time permanent employees would have to make available to employees health insurance that provides a lifetime major medical benefit of $250,000. The insurance also would have to include wellness incentives, such as reduced premiums for non-smokers.

Delaware employers that now provide group health plans would not be forced to alter their group health benefits to include wellness incentives, but the law would encourage them and health insurers in the state to add wellness incentives to their health plans. By including such benefits, the health plans would be declared "certified" by the state.

The bill has passed the state House of Representatives and is expected to be acted on next month in a special Senate session.

If the bill is enacted, Delaware would be the first state to force employers to offer employees the right to buy health insurance.

Since it unanimously passed an earlier version of the bill that was later amended by the House, "there is no logical reason for anyone in the Senate not to vote for the bill," said David N. Levinson, Delaware's insurance commissioner and a proponent of S.B. 517, enti-

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California probes insurers in alleged illegal boycott
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California architects design peer review to trim losses

By STEVE TARAVELLA

LOS ANGELES—Some architects are learning loss prevention the hard way.

Consider the architect who approved the work of his structural engineer without checking the engineer's incorrect calculations. As a result, the walls in a six-story condominium project failed to meet the 1980 California building code and now the structure could tumble during an earthquake that measured 6.5 on the Richter scale.

Discovery of the flaws prompted lawsuits. The architect and his professional liability insurer will wind up paying at least $650,000 to settle the claims that resulted from the engineer's error, according to a source close to the case, which is pending in California. The engineer and the developer will pay the remainder of the $1.3 million settlement.

Architects in litigation-prone California are hoping that a peer review program to begin in January will help avert this kind of errors and omissions claim.

Had this architect's business practices been reviewed by colleagues, he would have been advised not to rely on the structural engineer's calculations, but to check them for himself.

The review program, akin to what physicians have used to reduce medical malpractice claims, is being organized by the California Council of the American Institute of Architects (CCAIA).

The peer review tactic—and many others—came out of a six-month, six-architect study commissioned by the CCAIA last October, after its board unanimously moved to make professional liability and loss prevention "its number-one priority," explains Jayne Madamba, the association's director of governmental relations in Sacramento.

"This is a very ambitious project, and I think it will have a direct impact on the business of an architect. Over the next 18 months, people will have some tools they haven't had previously," Ms. Madamba says.

These attempts are necessary in California, architects and their insurance specialists say, because the state's design professionals receive more E&O claims than their counterparts in most other states.

As many as 750 claims—with an ultimate claim value of at least $50 million—are filed annually against insured architects and engineers in California, one insurance company estimates.

The CCAIA has no aggregate figures on the number of claims against architects and the amount of losses incurred, but part of the loss-control effort involves collecting such data, Ms. Madamba says.

CCAIA is an organization of about 8,000 licensed California architects and architectural apprentices, working in both the public and private sectors.

Its program will enable a member to call upon a team of three or four volunteers—perhaps composed of a fellow architect, an attorney and a business manager—to review the member's business practices.

The CCAIA peer review program will enable a member architect to call upon a team of three or four volunteers—perhaps composed of a fellow architect, an attorney and a business manager—to review the member's business practices.

The peer review program is geared to addressing the architect's business procedures in general, and not his design projects in particular. Colleagues would not be called in before construction to evaluate an architect's work on a particular blueprint.

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California probes insurers in alleged illegal boycott

By ROBERT A. FINLAYSON

SAN FRANCISCO—The California attorney general's office is investigating accusations from public officials that some insurers violated antitrust and unfair business practice laws by refusing to sell municipal liability insurance.

The attorney general's office last week issued subpoenas to 125 insurance companies doing business in California as part of an investigation of complaints by policyholders that insurers engaged in an illegal boycott of the municipal liability insurance market.

The companies that are the target of the wide-ranging probe were not identified.

Additional subpoenas will be forthcoming in the next few weeks and will include other insurers, reinsurers and brokers, according to Thomas P. Dove, deputy attorney general for the antitrust division in San Francisco.

The California investigation follows similar recent probes in New York, Ohio and West Virginia, although the number of insurers investigated was smaller and different lines of insurance were involved.

Mr. Dove said the California investigation began in January after his office received a formal complaint from Mayor Richard Holmes of Lafayette, Calif., alleging an illegal boycott on the part of municipal liability insurers.

The investigation is now specifically focused on the municipal liability insurance market but may be expanded to other areas of liability coverage, Mr. Dove said.

"We're looking into allegations that we've received from certain governmental agencies that the unavailability (of municipal liability insurance) may be the result of illegal activity in violation of state or federal law," Mr. Dove said.

"If you have a concerted effort within the insurance industry to basically coerce or intimidate—in this case by the act of boycott—consumers into having them, in turn, apply pressure for reform of the law, then we may well have an unreasonable restraint in the business of insurance in violation of the law," he said.

Mr. Dove said many people who became leading proponents of Proposition 51 did so "because they were informed by Lloyd's (of London) representatives, and by their brokers, and in some cases by insurance companies—or so we've been told—that until tort reform measures were passed, there wouldn't be any coverage," Mr. Dove said. "If that in fact occurred, you have a case for violation of a state law."

Proposition 51, which was approved overwhelmingly by California voters in June, eliminates the application of joint and several liability to non-economic damage awards in third-party lawsuits (*BI*, June 9).

Mr. Dove said his office has been told that all but one municipal liability insurer—Planet Insurance Co.—stopped writing municipal liability insurance early this year at about the time the debate over Proposition 51 began to heat up.

"If all of this business disappeared for strictly legitimate business reasons, then my office will be satisfied," Mr. Dove says. "But if there are reasons that are illegal, then this office will take all the necessary steps to correct that situation, both to penalize those who have acted that way in the past and to keep it from ever happening again."

The insurers that were subpoenaed have the option of sending senior level executives to the attorney general's office in San Francisco to testify in person or have those executives send in written responses.

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Accountants form captive in Bermuda

By JUDY GREENWALD

NEW YORK—Accountants Liability Assurance Co., formed by 27 medium-sized accounting firms, is providing its investor-owners with $5 million in primary or excess professional liability insurance limits.

The Hamilton, Bermuda-based insurer is now issuing policies retroactive to July 1, according to Howard Stone, the captive's chairman and managing partner of Chicago-based Altschuler, Melvoin & Glasser, the 18th-largest U.S. accounting firm.

The captive, which was created with the help of Montreal-based Minet International Professional Liability Ltd., ultimately hopes to attract a total of 40 to 45 investors and to offer up to $10 million in coverage, Mr. Stone said.

So far, response to the program has been enthusiastic, he said. "My phone has been ringing off the hook" with calls from accounting firms that are "desperately seeking coverage," Mr. Stone said.

The captive was formed because accounting firms have been confronted

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Insurer restores cover to settle town's lawsuit

By MEG FLETCHER

NORWOOD, Ohio—A Cincinnati suburb, which sued its liability insurer rather than pay an explosive premium increase for half the coverage limits, is now paying the same premium as last year for the full policy limits under a settlement of the lawsuit.

Early this year, the city of Norwood received a $203,755 bill from The Home Insurance Co. for $250,000 in per-occurrence general liability limits for the year ending Dec. 14, the third year of a three-year policy period.

The proposed premium represented a 737% increase from the $24,353 premium for the previous year's coverage, even though the policy limits had been cut to $250,000 from $500,000, according to figures supplied by the office of Robert G. Kelly, Norwood's city attorney.

The general liability policy, which contained no aggregate limit, did not include coverage for police, paramedics, public officials or auto liability, Mr. Kelly said.

"Home Insurance selectively and discriminatorily targeted Norwood as a political entity for a drastic increase in its general liability insurance premium," according to the complaint filed on behalf of Norwood this spring in Hamilton County State Court.

In addition, the city complained to the Ohio Insurance Department, which helped launch an investigation into The Home's pricing of municipal liability insurance. The first formal hearing stemming from this study is scheduled for Sept. 15.

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update

Beech can't deduct premiums

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Air Insurance Co. Ltd., for the fiscal year ending Sept. 30, 1973.

The decision follows several others in which federal courts have held that payments to wholly owned insurance company subsidiaries are not insurance premiums and thus are not deductible.

In only one case, *Crawford Fitting Co. vs. U.S.A.*, did a court hold for the taxpayer fighting an Internal Revenue Service finding that payments to a captive insurer were not deductible as premiums. However, in that case, the taxpayer did not directly own the captive to which it paid premiums—a deciding factor (*BI*, April 14).

In affirming a decision by a U.S. District Court in the Beech case, the court relied on *Stearns-Roger Corp. vs. United States* in which the 10th Circuit came to a similar conclusion.

"We agree that Beech and Travel Air are separate corporate entities and that Beech formed Travel Air for a legitimate business reason," the court said. "But that does not establish risk-shifting and risk-distributing, nor does it foreclose a finding or conclusion that there was neither."

Grace seeks defense costs

NEW YORK—W.R. Grace & Co. is seeking to recover approximately $2.5 million in defense costs from its insurers stemming from toxic chemical litigation in Woburn, Mass.

The New York-based company filed a summons in the New York County Supreme Court on July 29 against three of its liability insurers: Maryland Casualty Co., Continental Casualty Co. and Hartford Accident & Indemnity Co.

A summons gives notice to the defendants that a suit is being initiated. Filing of a complaint is expected to follow.

Grace seeks a declaratory judgment and damages resulting from the insurers failure to defend.

In the first phase of the toxic chemical litigation, Grace last month was found to have contributed to the contamination of two municipal wells in Woburn that allegedly caused numerous diseases, including leukemia, in city residents. The next phase of the litigation will decide whether the chemicals caused the illnesses.

Beatrice Foods Co. also was a defendant but was found not to have contributed to the contamination. It also is litigating with its insurers over defense costs in federal court in Chicago (*BI*, July 28).

Corroon to sell National Excess

NEW YORK—Corroon & Black Corp. will sell its National Excess Insurance Co. subsidiary to a newly formed subsidiary of Premier Hospitals Alliance Inc.

Corroon & Black discontinued operations at NATEX in 1984 and has been attempting to sell the subsidiary since 1985.

The Premier subsidiary, Premier Hospitals Alliance Holdings Inc., will purchase the insurer for approximately $11 million in cash. NATEX, domiciled in California, is licensed to write property/casualty coverage in 38 states and the District of Columbia.

The insurer will operate under the new name of Premier Insurance Co. of America. It will initially underwrite professional liability insurance for Premier hospitals and their medical staff members and eventually expand into other property/casualty lines.

Premier Hospitals Alliance, a service corporation based in Westchester, Ill., is owned by 33 metropolitan hospitals nationwide.

AIG unit settles bad-faith suit

LOS ANGELES—National Union Fire Insurance Co. of Pittsburgh, Pa., has settled a bad-faith lawsuit filed by the Worldwide Church of God in Pasadena, Calif., for failure to pay defense costs under a directors and officers liability insurance policy.

Terms and conditions of the settlement are confidential, but the church is satisfied with the outcome, according to Earl Reese, assistant to the church's general counsel. National Union, a unit of New York-based American International Group Inc., could not be reached for comment.

The settlement, which was approved in March by the U.S. District Court in Los Angeles, ended about five years of litigation begun in August 1981 when the church sued National Union, charging the insurer refused to pay defense costs under a $10 million D&O policy.

The church incurred the costs fighting charges by the state attorney general's office, which assumed control of part of the church in 1979 while investigating activities of certain church leaders.

The case was dismissed before going to trial when a new state law took away the attorney general's authority to prosecute civil fraud cases against religious corporations, said Carole Kornblum, an assistant attorney general in San Francisco.

When the church asked National Union to reimburse it for defense costs, the insurer took a "wait-and-see" attitude, responding that it would review any defense bills submitted once the case concluded, Mr. Reese said. The insurer did not provide representation and later countersued the church, alleging, among other things, that its leaders exhibited fraud in buying the policy.

The church has obtained D&O coverage from another insurer.

Briefly noted

Litton Industries Inc. is suing Shearson Lehman Brothers Inc. and former Shearson employee Dennis Levine for more than $30 million, charging Mr. Levine's insider trading almost doubled the price Litton paid in 1983 for Itek Corp. "We're insured for it," a spokeswoman for the investment banker said. . . .The Senate Commerce Committee filed its official report accompanying **federal product liability reform legislation**, S. 2760, that it passed in June, clearing the measure for possible Senate floor action next month (*BI*, June 30). A stiff floor battle is expected if the bill comes up for a vote.

inside

- A risk manager who has finally selected a risk management information system may be tempted to relax, but the work is not over yet, according to risk management consultant David A. Tweedy. **PAGE 23**

- How do you bring senior management into insurance policy renewal discussions? Share a neighboring corporation's experience is one suggestion offered in this month's "Ask a Risk Manager" column by Amfac Inc. risk manager Ralph F. Perry Jr. **PAGE 24**

- Everybody likes to be told they are doing a good job, especially when the job is extremely difficult. This week's editorial suggests nominating risk managers for the *BI* Risk Manager of the Year award. **PAGE 6**

- Second-quarter results for the property/casualty insurance industry confirm the underwriting recovery that began in the first quarter, and virtually all segments of the industry appear to be participating, according to analyst Myron M. Picoult. **PAGE 31**

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Risk manager award enters 10th year

It's time to nominate candidates for the 1987 *Business Insurance* Risk Manager of the Year Award, as the annual competition enters its 10th year.

The award was created in 1977—on the 10th anniversary of the magazine's publication—to increase recognition of the risk management profession and to recognize outstanding performance in the practice of risk management.

The winner of the 1987 competition will be selected by a panel of 10 independent judges who score the nominations based on 10 specific criteria (see box, page 18).

The judges include former winners of the competition, top executives of insurance companies and insurance brokerage firms, a consultant and a risk management academician.

The names of the judges who will select the 1987 winners will be announced next month.

While only one candidate will be named the 1987 Risk Manager of the Year, as many as four candidates can be named to the Risk Management Honor Roll, which was inaugurated in 1980 to recognize risk management achievements in different types of employment settings.

Starting with the 1981 competition, all the candidates were segregated by employment categories: corporations with sales exceeding $300 million; corporations with sales less than $300 million; government entities; and tax-exempt or not-for-profit institutions.

A fifth category was added in 1985 to recognize achievements by risk management professionals employed by financial institutions.

According to the rules of the competition, the employment category represented by the candidate with the highest cumulative score—who is named Risk Manager of the Year—is eliminated.

Then, in each of the four categories not represented by the Risk Manager of the Year, the highest-scoring candidate is named to the Risk Management Honor Roll. However, in some years there may not be a winner in every category.

Winners of the 1987 competition will be announced in the March 30, 1987, issue of *Business Insurance*, which will coincide with the annual Risk & Insurance Management Society conference.

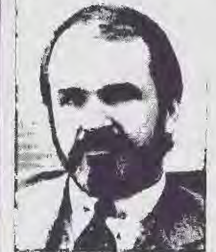
Anyone who is in charge of the risk management function for any corporation, government entity, financial or not-for-profit institution is eligible for nomination.

The candidate need not spend full time handling risk management, but must be a full-time employee of the organization for which he or she directs the risk management program.

Past winners

Mr. Weber-1978

Mr. Erickson-1979


Mr. Hallett-1980

Mr. Allen-1981

Mr. Russell-1982

Mr.O'Connell-1983

Mr. Inserra-1984

Mr. Lang-1985

Mr. Nelson-1986

A candidate may be nominated by anyone familiar with the risk management professional's work. Any employee or group of employees can nominate the organization's risk manager; a broker, consultant or other service supplier can nominate a client; and a risk manager can nominate a colleague.

Nominations must be submitted according to the detailed instructions contained in a special nominating form available from the *Business Insurance* editorial office in Chicago. The deadline for submitting nominations is Nov. 23, 1986.

The nine previous winners of the Risk Manager of the Year Award are:

- Donald Nelson, director of risk management at ARA Services Inc. in Philadelphia, in 1986.
- Harold C. Lang, director of insurance and risk management at Leaseway Transportation Corp. in Cleveland, in 1985.
- Richard M. Inserra, director of insurance and risk management at American Can Co. in Greenwich, Conn., in 1984.
- John A. O'Connell, executive director/risk manager at Holy Cross Shared Services Inc. in Notre Dame, Ind., in 1983.

Mr. O'Connell was the first risk manager of a not-for-profit institution to receive the top award. Holy Cross is the management arm of the 950-member Congregation of the Sisters of the Holy Cross, which sponsors primarily health care and educational activities.

- Eckart Russell, then risk and insurance manager at Alcan Aluminium Ltd. in Montreal, in 1982.

Mr. Russell is now vp-client services for broker Johnson & Higgins in Montreal.

- Duane E. Allen, assistant treasurer at Hanna Mining Co. in Cleveland, in 1981.

Mr. Allen is now a principal of American Risk Funding Services in Laguna Hills, Calif., a consulting, management and administration firm specializing in captive insurance company funding programs.

He also is director of Corporate Insurance & Reinsurance Co. Ltd., a group-owned captive insurer in Bermuda.

- Thomas V. Hallett, then risk manager at General Motors Corp. in Detroit in 1980.

Mr. Hallett is now senior vp of broker Frank B. Hall & Co. Inc. in Briarcliff Manor, N.Y. He also is chairman of Risk Sciences International and chairman and chief executive officer of Adjustco Inc.

- Edward L. Erickson, director of insurance at American Broadcasting Cos. Inc. in New York, in 1979.
- Howard T. Weber, director of insurance at Minnesota Mining & Manufacturing Co. in St. Paul, Minn., in 1978.

The Risk Management Honor Roll in 1981 included: Robert Bieber, then risk manager of Westchester County,

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Tort reform model?

Work comp system is a starting point: Experts

By CAROL CAIN

ORONO, Maine—The workers compensation system is not a perfect model for tort reform, but it's a starting point, according to a panel of experts.

Most discussions of reform appear to be "headed in the direction of some form of analogue to workers compensation," says Kenneth R. Feinberg, a Washington attorney.

> 'There tends to be a mystique about workers compensation from outsiders. . .a naive view,' says Cornell University Professor John F. Burton Jr.

The type of compensation system tort reformers are considering—one that "makes it easier for victims to recover, while limiting the scope and amount of that recovery"—resembles the workers compensation system, Mr. Feinberg said.

The workers compensation system, he pointed out, involves trade-offs—known as the exclusive remedy doctrine. Under workers comp, employers enjoy tort immunity in exchange for accepting absolute liability for all work-related injuries.

How the workers compensation system can serve as a model for tort reform was discussed by a panel during the 10th Annual National Symposium on Workers' Compensation held on the University of Maine campus July 13-18.

While suggesting that 75 years of experience with the workers compensation system offers lessons for tort reforms, panelists warned that too many people may misunderstand the workers compensation system and that there are problems with it.

"There tends to be a mystique about workers compensation from outsiders. . .a naive view," said John F. Burton Jr., a professor of labor relations at Cornell University in Ithaca, N.Y., who moderated the panel.

While on the surface the "no-fault, administrative, streamlined" workers compensation seems ideal, Mr. Feinberg points out that the system has flaws, "particularly when you talk about occupational disease."

The workers compensation system is still struggling to cope with compensating victims of occupational disease because controversy still exists over the definition of causation. As a result, causation "remains one of the most serious obstacles to come up with alternatives to tort," Mr. Feinberg said.

Further, the workers compensation system is tackling some of the same problems that tort reformers are facing, he said, including:

- The latency period between exposure to a harmful substance or situation and the manifestation of an illness or injury.

Statutes of limitations, for example, preclude some workers from recovering benefits for latent illnesses.

- The definition of a compensable injury.

Disputes arise over whether a worker's illness or injury is related to work or to other factors such as age or environment.

"A true paradigm (for reform) is a series of alternatives," and not just one model, suggested Mr. Feinberg, of the law firm Kaye, Scholer, Fierman, Hays & Handler.

Two panel members, however, more strongly endorsed the workers compensation system as a model for tort reform.

The predictability and certainty of the workers compensation system make it a model for tort reform, said John Crosby, senior vp and general counsel for the National Assn. of Independent Insurers in Des Plaines, Ill.

"The underlying reason why the tort system is so horrendous for commercial insurance is the fact that we lost certainty. We cannot write these risks given what the

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Arizona high court restricts recovery of punitive damages

By STEPHEN TARNOFF

PHOENIX, Ariz.—A recent Arizona Supreme Court decision makes it much more difficult to recover punitive damages in the state, attorneys say.

The high court ruled last month that a defendant's conduct not only must be aggravated or malicious for punitive damages to be warranted, but that the defendant also must have an "evil mind," evidenced by an intent to injure the plaintiff or a conscious disregard of a substantial risk of significant harm.

In addition, the court said that the more stringent standard of "clear and convincing" evidence, rather than only a "preponderance" of evidence, is required to prove punitive damages are warranted.

"It's a victory for anybody sued in a punitive damage case," said Guy O. Kornblum, an attorney for Nationwide Life Insurance Co., one of the defendants in the case.

"It's a substantial restriction on punitive damages," says Louis Stahl, who represented the American Council of Life Insurers and the Health Insurance Assn. of America, which filed an amicus curiae brief in the case. "It will be a lot more difficult to recover punitive damages."

As a result of the decision, Nationwide and Dan R. Wagnon & Associates Inc., a third-party administrator that acted as Nationwide's Phoenix claims office, will not have to pay $2 million in punitive damages awarded by a lower court to the widow of Jerry Linthicum.

Ms. Linthicum had claimed her husband was denied coverage under a group medical policy written by Nationwide.

However, Nationwide and Wagnon remain liable for $14,951 in damages for breach of contract, $150,000 for bad-faith damages and more than $100,000 in attorneys' fees at the trial and appellate level, according to Robert D. Myers, the plaintiffs attorney.

Although the Supreme Court said Nationwide's conduct did not warrant punitive damages, Mr. Myers said last week he would ask the high court for a chance to prove to a jury that the defendants are liable for punitive damages under the newly issued standards.

The "evil mind" standard required for punitive damages was handed down in the Linthicum decision one day after the court used the same standard in another bad-faith case: *Rawlings vs. Apodaca*.

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Architects

Continued from page 1

If the architect were allowed to seek help on a particular blueprint, the underlying problem of not understanding building codes, for example, would never be identified.

Instead, under this program, peer review would uncover weaknesses in the overall skill of the architect.

"The project is to be applauded," says David Lakamp, a broker specializing in architects' E&O and president of Professional Practice Insurance Brokers Inc. in Port of Redwood City, Calif. "It's only by taking these kind of initiatives that a real impact can be made on these claims."

"Anytime you bring fellow professionals in and have them look over your shoulder, you're going to pay more attention to the details," observes Joseph Vaccaro, senior vp at architectural firm Leo A. Daly Co. in Los Angeles. Mr. Vaccaro was chairman of the CCAIA study committee.

Design Professionals Insurance Co., a leading architectural E&O insurer in Monterey, Calif., believes in peer review and might offer premium credits to its policyholders who submit their management and business practices to review by their colleagues.

The company already offers a 5% premium credit to its engineer policyholders who participate in a similar review program sponsored by the American Consulting Engineers Council in Washington, D.C., reports DPIC President Peter B. Hawes.

But the peer review program is only one of about a dozen different plans CCAIA is implementing over the 18-month period that began last June 1. Other efforts the group is undertaking to reduce the potential for professional liability lawsuits against its members include:

- Developing one uniform document for "standard of care," an industry and professional standard that architects are often accused of not meeting in E&O claims.
- Compiling a "master list" of successful seminars, speakers, documents, books and other resources designed to help architects control losses and minimize liability exposures.
- Working with collegiate schools of architecture in devising academic programs that teach skills needed to minimize unnecessary risk. Increased scholastic attention is expected to be sought on the use of documents, recordkeeping and client communications.

Good communication is particularly important in avoiding architectural claims, insurers say. About 80% of architect E&O claims are made by people who are parties to the project, such as the client, sub-contractors, material suppliers or other designers, estimates DPIC's Mr. Hawes.

- Creating greater awareness of pertinent judicial actions. The association is developing a program for tracking architectural lawsuits and for joining in the defense of architects involved in worthy precedent-setting cases.
- Improving the data base on California architects' liability exposures. This aspect of the group's loss-reduction campaign would require surveying about 2,000 firms on such issues as the types of claims filed against them, whether they are insured, and how the uninsured protect themselves against personal loss.
- Disseminating information about the architectural liability exposures unique to California. To address this, the organization plans to provide a state-level supplement to various nationally-distributed architectural papers.

For example, one California-specific supplement might address the exposures encountered in renovating public buildings laden with asbestos. Ms. Madamba notes that California generously used asbestos in a public school construction boom years ago, and is now confronted with handling it in a renovation movement.

California's geology also makes architects in the state more susceptible to E&O claims.

"The earth moves out here," notes Mr. Lakamp. California's construction community is no stranger to landslides, cracked foundations and water management problems.

Also, California's infatuation with the condominium has created a seemingly inexhaustible pool of potential plaintiffs.

Condo development on the West Coast, spurred by the buildings' highly speculative investment nature, has been "an unmitigated disaster," he says.

Even if a project is designed well, its architect frequently loses control to developers who, during construction, may not adhere to the architect's specifications, Mr. Lakamp explains.

The loss-control programs are being financed by assessing each CCAIA member either $25 or $12.50, depending on whether the member is a full architect or an apprentice.

The programs being developed by CCAIA would complement a host of liability management efforts by the American Institute of Architects in Washington, D.C., the CCAIA's national affiliate. Among the current loss prevention undertakings of the national organization is a national "standard of care" publication, as well as a book designed to make building owners more aware of the architect's role and responsibilities.

Earlier this year, the AIA considered forming a captive to write E&O coverage for its approximately 50,000 members, but decided against it. The captive could not price the coverage any lower than commercial insurers do, AIA concluded.

In California, architects' E&O coverage was the first to tighten when the professional liability market began to dry up, which was about six months to a year before other commercial casualty lines followed suit, says Bob Wessel, senior vp at Alexander & Alexander of California Inc.

The tight E&O market in California has made the architects' need to control professional liability claims even more acute.

More than three-quarters of California's architectural firms have fewer than 10 professionals, according to CCAIA. And small architectural firms—such as those with one or two professionals who might together pull in $100,000 in fees annually—are especially hard-hit by the market conditions.

A firm this size can expect to pay a premium of $25,000-$50,000 and satisfy a deductible of $25,000 for $500,000 in per claim and aggregate limits, Mr. Wessel says.

The most coverage an architectural firm could expect to find today is $20 million or $25 million, and that's assuming the policyholder has a relationship of several years with an insurer, Mr. Wessel says.

Architectural E&O coverage has been routinely written on claims-made policies for more than 20 years.

According to Mr. Lakamp, the biggest writers of architect E&O in the state are DPIC and Victor O. Schinnerer & Co. Inc., underwriting manager for CNA Insurance Cos. Underwriting manager Shand, Morahan & Co. also binds these California risks for Evanston Insurance Co. And, Western Risk Specialists, an American International Group Inc. managing general agent, writes the coverage for Lexington Insurance Co., another AIG unit. ■

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opinions

Kudos for doing a job well

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You can provide this recognition, no matter who you are, because anyone is eligible to nominate a candidate for The Risk Manager of the Year Award—staffer, boss, broker, insurer, consultant or colleague.

The very act of nominating someone for the Risk Manager of the Year award recognizes the person's accomplishments. It says, "I think you are doing a terrific job."

In addition, since the nomination must be endorsed as accurate by the risk manager's superior, the nomination creates more awareness among top management of the risk manager's accomplishments. Although top management today is well aware of the challenges confronting risk managers and is monitoring their performance, seeing all the risk manager's accomplishments compiled in a nominating statement is going to impress even the most informed of top managers.

Finally, the results of the competition, which are reported in *Business Insurance* complete with profiles of the winning programs, put the spotlight on your candidate and risk management programs that have succeeded and are on the cutting edge of risk management practice.

The winners of the award are announced and their risk management programs profiled in the issue of *Business Insurance* that coincides with the annual Risk & Insurance Management Society conference, the largest annual gathering of risk managers.

The chances that your candidate could be recognized in the competition are very good. The 10 independent judges of the competition could select as many as five risk managers to receive awards: The Risk Manager of the Year and four members of the Risk Management Honor Roll (see story, page 3).

Your candidate need not be a Fortune 500 risk manager. We have categories in the competition that recognize outstanding risk management in large and small companies, in government entities and not-for-profit institutions and in financial institutions.

Your candidate also need not be someone whose only responsibility is risk management. He or she could be a financial or administrative officer whose responsibilities include risk management.

And, your candidate need not be someone who already has a high profile in risk management. There are many risk managers today who are doing a terrific job for their employers but few others know it besides the employer and the risk manager.

That's one of the reasons we created the Risk Manager of the Year Award nine years ago: to recognize outstanding achievement by risk managers who for too long have toiled in obscurity.

We also created the award to heighten the recognition of risk management as a profession, especially as one that is shaped by creative individuals who respond to diverse needs of their employers.

Request a nominating form today by writing: *Business Insurance*, Risk Manager of the Year Award, 740 N. Rush St., Chicago, Ill. 60611.

The risk manager you admire will be delighted when you walk into his or her office and announce:

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letters

Market history repeating itself

To the editor: The insurance market, especially property insurance, is beginning to "soften."

This should be good news for the beleaguered risk manager. How can one tell?

- By a reduction in the number of applications being received by the specialty or surplus lines insurers that take up the slack when the standard insurers refuse business.
- By the number of policies returned for cancellation.
- By the number of producers telling the underwriters the prices charged by the competition.

When the market is constricting, it is not in the interest of the producer to broadcast the pricing of insurers willing to consider the business.

However, when the market softens, divulging lower pricing can be advantageous since most neophyte underwriters react like lemmings.

It is not much different from what transpired in past cycles.

When pricing becomes too low, the large "standards" invariably become ultra-conservative, resulting in lack of capacity.

It's up to the specialty or surplus lines insurers to drive up the rates and deductibles.

Then, when the prices go up, the standards step back into the fray, cutting prices, deductibles and invariably paying more commission.

So, the cycle begins all over again.

Herman Paul Schlander
Insurance broker
Pasadena, Calif.

Business Insurance welcomes letters from its readers. Please keep your comments as brief as possible. We reserve the right to edit letters for clarity or space. We will not publish unsigned letters. Send your comments to Letters to the Editor, Business Insurance, 740 N. Rush St., Chicago, Ill., 60611.

Let employees buy their own insurance

To the editor: COBRA, that ill-conceived conception of a Congress gone addlebrained, has created such a mess for employers that one must think of ways out of the quagmire.

Employers should cancel all employee health insurance plans and pay employees a per-hour increase (plus taxes involved) that will cover the cost of their health insurance.

To keep these costs within group premium limits, insurance companies will be invited to write polices for all employees who wish to be covered under a health insurance plan.

The employer will then be free of this new government trap, the employee will be free to buy as much health insurance coverage as he needs, and we all will be free to vote those scoundrels out of office.

Thom Williams
Wausau, Wis.

Industry should heed Bloom's 'nightmares'

To the editor: The "nightmares" outlined by Thomas Bloom in his perspective on the Insurance Services Office's new claims-made commercial general liability form (*BI*, Aug. 4) should be required reading for all within the insurance industry, for they surely will be noted with great interest by our friends in the legal profession.

Hopefully, someone out there was listening, as things cast in concrete do betimes, unfortunately, end up at the bottom cf rivers.

Christopher D. Bowles
Bowles & Foster Inc.
Southfield, Mich.

Ohio train derailment not largest in history

To the editor: You report that the Miamisburg, Ohio, evacuation (30,000 people) is believed to be the largest in history following a train derailment (*BI*, July 28).

How soon we forget! 250,000 people were evacuated following the "great Mississauga train disaster" in Mississauga, Ontario, in 1979.

I suspect the damages awarded to the evacuees were for minor expenses only.

W.J. Bowden
Assistant Superintendent of Agencies
Confederation Life Insurance Co.
Atlanta

■ *Editor's note: Lawsuits filed following the Miamisburg, Ohio, train derailment alleged it was the largest in history.*

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Accountants' captive

Continued from page 2

with fewer markets, reduced capacity and higher rates, according to Mr. Stone.

A few of the investors, Mr. Stone said, had no coverage at all. Others are part of a Crum & Forster Managers Corp. (Ill.) program sponsored by the American Institute of Certified Public Accountants.

This program, which had offered up to $5 million in coverage, was recently cut back to $1 million, noted Jay Pierson, a partner with the Hanover, N.H.-based accounting firm of Smith Batchelder & Rugg.

Mr. Pierson's firm, which participates in the Crum & Forster program, also has joined the captive.

The captive, which has been in the planning stages for about a year and a half, has so far generated $12 million, of which $3.6 million represents capitalization and the remainder premium income, Mr. Stone said.

The insurer, known as ALAC, is issuing a "broad-form, worldwide claims-made indemnity policy," said Mr. Stone. The insurer will provide either primary or excess coverage, depending upon what coverage the investor now has, he said.

For instance, Altschuler, Melvoin, whose $25 million in coverage written by Lloyd's of London underwriters was recently cut back to $10 million, will use the captive's $5 million capacity on an excess basis.

Deductibles and premiums vary depending on the investor's revenues, according to John Kenny, the partner in charge of the Southern California business of Houston-based Pannell Kerr Forster, the 14th-largest accounting firm in the United States.

The minimum annual premium is $160,000.

Mr. Kenny said his company, which now has "in excess of $10 million" in coverage from Crum & Forster subsidiaries and Lloyd's of London, has a $1.8 million deductible.

"We felt we were a preferred risk," Altschuler, Melvoin's Mr. Stone said, noting that medium-sized accounting firms do not generally have a substantial number of publicly held companies as clients.

Many claims against accounting firms, Mr. Stone pointed out, are generated as a result of work done for publicly held companies.

For this reason, he said, the "Big Eight" accounting firms will not be invited to join the captive.

Mr. Pierson said he does not know how, or if, the Crum & Forster program, which is up for renewal in October, will be coordinated with ALAC.

"We haven't really decided how we're doing it," Mr. Pierson said.

Mr. Kenny of Pannell Kerr Forster said his company joined the captive "to be sure we had alternate means" in case coverage was reduced.

No reinsurance for the captive has been arranged as yet, said Mr. Stone, who noted, "It's extremely difficult, if not impossible, to obtain reinsurance at this time."

ALAC is managed by Bermuda-based Minet affiliate Prescott Management, under the direction of David Walker, Mr. Stone said. ■

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Hawaii OKs captive law

By STEVE TARAVELLA

HONOLULU—Come July, businesses interested in forming a captive insurance company in the United States can choose an island domicile—Hawaii.

The captive law, approved by the governor May 29, takes effect July 1, 1987. Hawaii will then join five other states that permit captives—Vermont, Colorado, Tennessee, Virginia and Delaware.

The state will permit the formation of both pure captives—those established to insure only the risks of their parent companies—and association captives, formed to insure the risk of the members and affiliated companies.

Hawaii captives will be able to write all casualty insurance, including workers compensation; property insurance; surety and title insurance; marine and transportation; marine protection and indemnity (P&I) coverage; and wet marine and transportation. They also will be able to reinsure risks ceded by other insurers.

They will not, however, be permitted to write any business for third parties; health or life insurance; homeowners insurance; or personal automobile insurance.

The law exempts captives from most of the provisions of the Hawaii Insurance Law, but sets forth numerous new requirements similar to those applied by other U.S. captive domiciles.

For example, Hawaii captives are required to have their principal place of business in the state, and their directors must meet there at least once a year. The captive must be incorporated by at least three persons, at least two of whom must be Hawaii residents, and must appoint a local broker.

The amount of paid-in capital and surplus will be determined by the state's insurance commissioner, and may differ for pure and association captives. Different amounts may also be required from stock association captives than from mutual association captives.

The funds may be posted in cash or with an irrevocable letter of credit from a Federal Reserve System bank.

Each captive in the state will have to submit an annual financial statement to the Insurance Department detailing information such as known claims and expenses; claims and expenses incurred but not reported (IBNR); unearned premiums; and bad debts.

Failure to submit this annual report is one of nine causes for suspension or revocation of the captive's license. Another is failure to maintain actuarially appropriate loss reserves after one warning from the insurance commissioner.

Captives will have to consent to an annual, on-site financial examination by the state insurance department. They also must pay a $1,000 license processing fee and a $300 annual renewal fee. ■

California studying rate hikes

LOS ANGELES—The California Insurance Department is holding hearings this week in Los Angeles to investigate what Commissioner Roxani Gillespie calls "extraordinary rate hikes" by property/casualty insurers operating in California.

The hearings, which began earlier this month in San Francisco, will serve as the basis for a report from Commissioner Gillespie to Gov. Georgs2e Deukmejian.

The governor said in early June that he would review the current liability insurance crisis to see if any changes are needed in the state's regulation of the insurance industry.

Industry officials testifying at the hearings have said current insurance rates are justified by actuarial data, while consumer advocacy groups called for a complete overhaul of insurance regulation in California.

Meanwhile, the Commission on California State Government Organization and Economy has capped a seven-month study of the state's liability insurance crisis with 16 recommendations for tort and insurance reform.

The recommendations range from a $500,000 cap, with a cost-of-living allowance, on compensatory damages to prior state approval of rate increases exceeding 15%.

To highlight the severity of insurance problems in the state, the commission reported that the cost of commercial general liability coverage in California increased by an average of 81% in 1985.

Other findings by the commission include:

- Half of California businesses responding to a recent survey have raised prices to cover increased insurance costs.
- Virtually every city in the state is unable to obtain adequate general liability coverage.
- Of every dollar paid by insurers for liability claims, 54 cents goes toward legal costs.

Ms. Gillespie said she applauded the efforts of the panel, commonly known as the "Little Hoover Commission," and described the report as "good overall."

Although Ms. Gillespie said she did not agree with all the commission's recommendations, she said the report captures the same spirit of insurance reform advocated by Gov. Deukmejian.

One recommendation with which Ms. Gillespie disagreed would require the commissioner to approve rate increases exceeding 15%.

Ms. Gillespie instead recommended that companies increasing rates over a certain percentage be required to report those increases to the commissioner. If an insurer could not justify an increase, the increase could be denied by the commissioner.

Ms. Gillespie also disagreed with a recommendation by the panel that the insurance commissioner's post be replaced by a bipartisan, part-time, five-member commission.

"This period of crisis is not the time to depend on decisions made by a part-time committee," Ms. Gillespie stated.

Other reforms proposed by the panel include:

- Establishing a much stricter burden of proof for punitive damages claims.
- Placing monetary limits on attorneys' fees and establishing penalties for frivolous claims or defenses.
- Requiring periodic payments for all future damages exceeding $100,000.
- Establishing a statewide reinsurance pool for municipalities and public entities.
- Considering providing the state insurance commissioner with the authority to compel insurers to participate in market assistance plans, joint underwriting authorities and FAIR plans if voluntary participation is inadequate.
- Requiring insurers to take individual prior practices and claims history into account when establishing rates.
- Requiring insurers to disclose their loss data for California risks on a line-by-line basis.
- Increasing penalties and fines for insurers that do not comply with California insurance law and regulations.

around the states

Insurer liquidated

BEACHWOOD, Ohio—Merchants & Manufacturers Insurance Co., licensed only in Ohio, is now in liquidation with its liabilities exceeding assets by an estimated $4 million, the department says.

The insurer was in rehabilitation for less than a month when the Ohio Insurance Department decided to seek a liquidation order, said James J. Schiller, a Cleveland attorney and the department's outside counsel (*BI*, July 21).

Merchants & Manufacturers, which wrote fidelity and surety bonds as well as personal auto and homeowners insurance policies, was ordered liquidated Aug. 11, even though the liquidator has not yet determined its exact assets and liabilities. However, the department estimated its deficit at about $4 million based on several audits.

A chief reason for the insurer's financial difficulties was poor underwriting of bonds in the early 1980s, when the company was under different management, said Stafford McGuire, the Insurance Department's chief examiner.

New ownership and an infusion of between $3 million and $4 million in capital did not correct those problems, he said.

Few outstanding commercial property/casualty claims are pending against the insurer, but those claims, as well as claims from personal lines insurance policies, are

Continued on next page

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around the states

Continued from previous page

being paid by the Ohio Guaranty Assn. The guaranty fund will pay 100% of claims up to $300,000, Mr. McGuire said, though the fund will not cover claims involving construction bonds.

The exact amount of outstanding claims against the insurer has not been calculated, he said.

The insurers' owner, Walter Alpaugh, and its president, Edward E. Evans, were unavailable for comment.

Merchants & Manufacturers reported a policyholder surplus of about $1.2 million at year-end 1985. It wrote $6.5 million in net premiums last year.

Michigan work comp

LANSING, Mich.—Statistical evidence shows a "reasonable degree of competition" in the Michigan workers compensation insurance market, according to a report by Insurance Commissioner Herman W. Coleman.

"However, the current pattern of rate increases and decreased availability must continue to be monitored to ensure that competition maintains reasonable rate levels and restores availability as insurers financial condition improves," the report said.

The annual report was mandated by the Michigan Legislature in 1982 when it enacted legislation that allowed open rating of workers compensation insurance. That law took effect Jan. 1, 1983.

"The evidence indicates that the structure of the workers compensation insurance market is conducive to competition. No one carrier or group of carriers controls the market and over 100 insurer groups actively wrote workers compensation insurance in 1985," the report said.

"Concentration has increased since 1984, because some insurers cut back their business because of reduced capacity. However, concentration is still not high enough to seriously endanger competition," according to the report.

Manual rates of the leading work comp insurers in Michigan increased by 11.5% in 1985, according to the report. But, this has been accompanied by a significant rise in the proportion of employers insured through the state's workers compensation assigned risk pool—the Michigan Workers Compensation Placement Facility.

An estimated 4.6% of covered payroll in the state was insured through the assigned risk pool in 1985, compared with 1.5% in 1984, 1.6% in 1983, 2.5% in 1982, 3.3% in 1981 and 4.1% in 1980.

The assigned risk pool generated about 8.4% of the state's premium in 1985, compared with 3.1% in 1984, 3% in 1983, 3.4% in 1982, 3.6% in 1981 and 4.6% in 1980.

And, the assigned risk pool accounted for 10.1% of the workers compensation policies issued in 1985, compared with 7% in 1984, 7.6% in 1983, 9.3% in 1982, 10.2% in 1981 and 9.8% in 1980.

Other statistical information in the report shows that Michigan employers paid an estimated $600 million in workers compensation premiums in 1985, less than two-thirds of the $930 million paid in 1980.

A "significant portion" of that reduction can be attributable to open rating, the report noted.

However, substantial savings also could be credited to legislated changes in benefits and eligibility requirements and other improvements in loss experience, the report continued.

But, the statistics also show that premiums in 1985 increased by about $77 million compared with 1984. According to the report, this increase stems from a rise in covered payroll due to the improvement in the economy as well as rate increases.

"An increase in rates and a decline in availability was unavoidable after the sub-par financial performance of insurers in recent years and the marked decline in their capacity," noted the report.

"At the same time, rates should not become excessive in relation to costs. Consequently, future market developments should be closely monitored to ensure that competition prevents rates from becoming excessive and improves availability as insurers' capacity is restored."

Pollution conviction

ROCKFORD, Ill.—A former plating company plant manager is now in prison while appealing a three-year sentence for asking an employee to illegally dump hazardous waste. The company was fined $600,000.

The convictions were the first by a jury under the Illinois Criminal Damage to the Environment Act, which took effect in January 1984.

The jury convicted John Lee Boyce, plant manager at Alloy Plating Corp. in Rockford, of asking employee Kenneth E. Domin to dispose of plating waste on a regular basis.

Mr. Domin was arrested on March 9, 1984, in Loves Park, a Rockford suburb, while dumping hazardous waste down a car wash drain. The waste, poured from twenty 55-gallon drums, contained cyanide and a concentration of metals, notably cadmium and chromium, said Dennis Porter, the assistant attorney general who tried the case.

Mr. Domin pleaded guilty to two counts of calculated criminal disposal of hazardous waste and one count of unauthorized use of hazardous waste. He was sentenced in June 1985 to three years' probation, 30 days in jail, a $1,000 fine and 200 hours of community service work.

Mr. Domin also served as a witness to obtain an indictment against Mr. Boyce and Alloy Plating, Mr. Porter said.

"(Mr. Domin) said he was asked to do it by Boyce," Mr. Porter said.

Since Mr. Domin pleaded guilty and was sentenced, he technically is the first conviction under the state's new law, Mr. Porter said. But, Mr. Boyce and Alloy Plating, which pleaded innocent, were the first convictions obtained after a jury trial, he noted. The proceedings were held in Winnebago County Circuit Court, but physically were held in a neighboring county because of pretrial publicity, he added.

Mr. Boyce was found guilty of five counts of calculated criminal disposal of hazardous waste, six counts of unauthorized use of hazardous waste, five counts of criminal disposal of hazardous waste, five counts of reckless disposal of hazardous waste and two counts of conspiracy.

Although he was convicted on all five charges, he was sentenced only on two: three years in prison on the calculated criminal disposal charge, and one year on the unauthorized use charge. The sentences, which were handed down July 16, are to run concurrently.

Gordon C. Ring, the Rockford attorney who represented Mr. Boyce, is appealing the verdict. He also filed a motion for his client to be free on bond during the appeal process. The lower court judge had denied a similar request to allow Mr. Boyce to remain free. Mr. Boyce turned himself over to authorities Aug. 15.

"There is no question that this first prosecution of its type in the state was. . .a highly political case," Mr. Ring said.

Alloy Plating, which since has been dissolved and its assets sold to a company that operates a facility on the site, was fined $500,000 on the calculated criminal disposal charge and $100,000 on the unauthorized use charge.

The owners of the firm were not charged because a criminal case requires knowledge of the act or furtherance of the crime, Mr. Porter explained.

No other similar cases are pending in the courts, but several are under investigation, he said. ■

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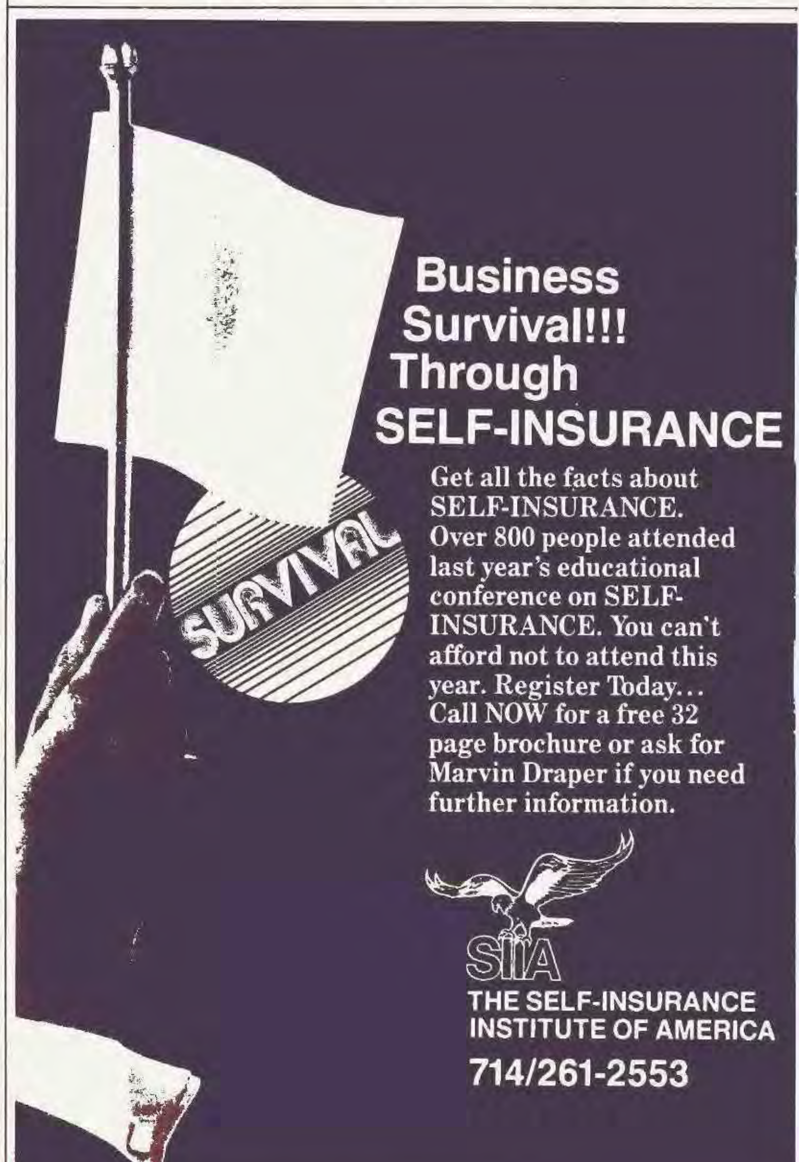

markets

Fred S. James to buy Nashville brokerage

Fred S. James & Co. Inc. will acquire The Armistead Group Inc., a Nashville, Tenn.-based brokerage.

Under the agreement, James will acquire all of Armistead's business for cash and future satisfaction of some of Armistead's outstanding debt, for a combined total of $32.5 million, a James spokesman said.

Fred S. James, a subsidiary of Lloyd's of London broker Sedgwick Group P.L.C., is the fifth-largest broker in the nation, with 1985 gross revenues of $391.5 million. Armistead is the 37th-largest broker ranked by *Business Insurance* based on 1985 gross revenues of about $12 million.

Armistead's clients specialize in such fields as manufacturing, retail sales, finance, energy services, shipping and construction.

In Nashville, Armistead operates as Polk & Sullivan Inc.; in Knoxville, Tenn., as Broadus-Anderson & Associates Inc.; in Birmingham, Ala., as Garner, Meshad, Wood Agency; and in New Orleans as Geiseler Simmons Corp.

"This agreement is part of our strategy to increase our presence in the South," the James spokesman said. He could not say when the acquisition will be completed.

Pension administrator

Equitable Life Insurance Co. of Iowa has formed a new subsidiary to help employers design and administer pension plans.

Benefit Architects Ltd., based in Des Moines, specializes in administering defined benefit and defined contribution plans, said President Richard Higgins.

For companies designing new pension plans, the company will prepare plan documents to be filed with the government and communicate the new plans to workers.

For companies whose plans are already up and running, Benefits Architects prepares summary plan descriptions; Form 5500 annual reports for the Internal Revenue Service; summary annual reports; joint and survivor notifications that inform participants of their rights to elect or reject survivor benefits; and benefit statements for employees who are leaving the company but are entitled to receive a benefit from the plan.

Benefits Architects also will furnish quarterly benefit statements to participants in defined contribution plans, like 401(k) savings plans, and annual statements to participants in plans that have one contribution a year, like profit-sharing plans.

Benefit Architects is located at 504 Locust St., P.O. Box 1635, Des Moines, Iowa 50306; 515-345-6868.

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Delta Dental Plan of Massachusetts, which has been administered by Blue Cross/Blue Shield of Massachusetts for 17 years, is now totally independent.

Delta, an independent company that began as Dental Services of Massachusetts in 1966, had contracted with the Blues since 1969 for administrative services, such as claims administration, said Delta Executive Vp William J. Clinton.

"We left the Blues in March," Mr. Clinton said, "because as we talked to employers, we found that they were more interested in having a separate plan that concentrated only on dental care and no other health specialty," he said. Employers wanted Delta to administer their claims, he explained.

"Also, the dentists participating in our organization wanted to work more closely with an organization that would expand in the state. On our own, we have a chance to grow," he added.

Some 4,100 dentists provide services through Delta, which covers more than 500,000 people in Massachusetts and generates an annual premium volume of about $45 million, said Mr. Clinton.

Delta is located at the Wellington Business Center, 10 Cabot Road, P.O. Box 9104, Medford, Mass. 02155; 617-391-2700. ■

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Delaware bill

Continued from page 1

tled the "Comprehensive Health Care Cost Containment and Quality Enhancement Act."

Mandating that all employers offer employees at least the right to buy health insurance is designed to "begin eliminating cost-shifting through the hidden tax," according to Mr. Levinson.

The hidden tax, he explained, is the charge hospitals pass on to all health care payers to cover the cost of care they cannot recover from patients who are not insured.

While the legislation does not force employers to pay any of the health care premium for employees, Mr. Levinson says, "I'm betting the odds are that most employers will offer to pay some part."

Including wellness incentives in group health care plans is particularly important to Mr. Levinson, who had endorsed an earlier version of the legislation that would have mandated that all health plans in Delaware provide coverage for health promotion programs and premium reductions or rebates for participating covered employees.

The original Senate bill that would have mandated the incentives was amended by the House to make the incentives voluntary for employers now offering group health plans.

Now, under the current legislation, the inclusion of such benefits and premium reductions or rebates is mandatory only for employers that do not currently offer group health insurance.

Mr. Levinson hopes that providing "certification" for plans that voluntarily include such benefits will encourage more employers and insurers to add wellness incentives to their plans. Self-insurers that provide such benefits also could obtain state certification of their plans and communicate that to their employees.

'With this bill, we are practicing risk underwriting in health insurance,' says David N. Levinson, Delaware's insurance commissioner and a proponent of S.B. 517, the 'Comprehensive Health Care Cost Containment and Quality Enhancement Act.'

"With this bill, we are practicing risk underwriting in health insurance," said Mr. Levinson.

Providing premium reductions for covered employees who practice healthy lifestyles could reduce premium costs, especially for employees paying their entire health insurance bill, Mr. Levinson said. "Because studies indicate that 50% of all health care costs are related to lifestyles, I would say the maximum theoretical savings employees will have is 50%," he said.

The health promotion programs that would have to be covered by a plan to qualify as certified would include periodic physical examinations and preventive screenings relative to an individual's age, sex and health condition; adult immunizations; and rehabilitation services.

The healthy lifestyles that would mandate premium reductions or rebates are to include: no smoking; regular exercise; weight maintenance; blood pressure screening; stress control; non-abuse of drugs; moderate alcohol consumption; and the use of automobile seat belts.

Penalties, or "disincentives," such as increased deductibles or copayments, would be levied against employees who fraudulently certify their participation in health promotion programs or maintenance of a healthy lifestyle.

Regulations will be written governing the specifics of health promotion programs and how premium reductions or rebates will be administered, Mr. Levinson said.

Employers in Delaware say they are concerned about some of the provisions contained in the bill, including the mandate that employers offer employees the right to buy health insurance.

"The best way to help people with their health care costs is to make sure they have jobs with adequate compensation," says Pat Donahue, manager of health care cost containment for Dover-based International Playtex Inc. and acting vice chairman of the Delaware Health Care Coalition.

The coalition is made up of 38 major Delaware employers that provide health care insurance to more than half the population in the state, according to Mr. Donahue.

"We think that the bill contains some very good ideas, but we have some reservations about some of the technicalities in the bill," he added, referring to the wellness incentives and premium reductions.

"How much does an incentive for not smoking translate into dollars? I just don't know how to calculate this," Mr. Donahue said.

Some benefits consultants agree.

"I have an actuarial background and I know there aren't many statistics that tell how much you can really save from a wellness program," said Tom Donlon, a principal in the Chicago office of William M. Mercer-Meidinger Inc.

Also, because the certification of health plans is voluntary, "I question whether it's worth legislative action since there is no penalty if you don't submit your plan to be Delaware-certified," Mr. Donahue said.

Mr. Levinson, however, noted that employers in the coalition have expressed concern to him that the voluntary certification could cause them problems in both administration and in employee relations. Employers are particularly concerned that unions will demand certified health plans, Mr. Levinson said.

Some employers don't want to offer certified health plans "because they don't want to educate their employees about wellness," he commented.

Mr. Levinson said the bill is part of a package developed by Delaware's Health Care Cost Containment and Quality Enhancement task force. Mr. Levinson, who is chairman of the Health Promotion and Chemical Abuse Task Force of the National Assn. of Insurance Commissioners, appointed the Delaware task force in 1985 to study health care cost issues. ■

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Municipal cover

Continued from page 2

The city alleged in its lawsuit that The Home, which is based in New York and domiciled in New Hampshire, breached its contract, misrepresented facts and attempted to charge excessive and discriminatory rates in violation of the Ohio Insurance Code.

Norwood, which has 27,000 residents, asked for at least $50,000 in compensatory damages and $4.5 million in punitive damages.

Under the settlement of the suit, reached earlier this summer, The Home agreed to reinstate the city's general liability policy under the 1985 terms and conditions, including reinstating the $500,000 in per-occurrence limits. The policy expires Dec. 14 and will not be renewed, according to the settlement agreement.

As part of the settlement, Norwood also agreed to withdraw its complaint against The Home and request that the Insurance Department end its investigation.

However, Norwood's request did not stop the probe because the complaint was only one of 12 that had been filed against The Home. Other municipalities that submitted complaints were Madison Township; the counties of Trumbull, Seneca, Summit and Henry; the communities of Niles, Beachwood, Findlay, Martins Ferry, Athens and Columbus Grove.

In addition, Brook Park has filed a complaint against National Union Fire Insurance Co. of Pittsburgh, Pa., an American International Group Inc. unit, according to an Insurance Department spokesman.

Both insurers will be asked to explain their pricing policies at hearings that will focus on the insurers' alleged violations of insurance code prohibitions against excessive pricing as well as alleged violations of filing requirements, Ohio Insurance Director George Fabe said.

As part of its investigation, the Insurance Department subpoenaed records from both insurers, which had supplied the department with some, but not all of the information it requested.

"They stonewalled us for information," Mr. Fabe said.

Spokeswomen for the two insurers declined to comment except to say that their companies are cooperating with the Insurance Department.

The department also hired the Tillinghast division of consultant Towers, Perrin, Forster and Crosby to perform actuarial work in connection with the inquiry.

Regardless of the outcome of the state inquiry, Norwood is expected to try to replace the expiring coverage, now written by The Home, before the end of the year.

Norwood's Mr. Kelly complained that The Home's willingness to settle controversial claims may hurt Norwood's ability to find replacement coverage.

In the past three or four years, The Home has paid out at least $30,000 in claims on behalf of Norwood, including a $25,000 settlement to a woman injured in a sidewalk-related case although sidewalk maintenance in Norwood is a homeowner's responsibility, Mr. Kelly said.

He said he favors intervention by state insurance officials and perhaps increased regulation of property/casualty insurers to make sure that municipalities can find necessary coverage. ■

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update

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benefit beat

Ford offers new programs to trim health care costs

Four new health care cost-containment programs for Ford Motor Co. hourly employees and retirees have been introduced by the Dearborn, Mich.-based automaker and the United Auto Workers union.

The new Ford programs include case management for catastrophic illnesses, cardiac rehabilitation, a hospice program and a prescription drug plan.

The programs are designed to stem increasing medical costs, explained Jack Dunn, supervisor of employee insurance in Ford's employee benefits department.

"Our costs increase by leaps and bounds every year. Ford's total health care costs for both hourly and salaried employees is about $790 million," he said.

Mr. Dunn could not estimate projected savings from the programs, but he noted that the union and Ford have worked together on developing cost-containment measures for the last decade.

Ford's Michigan employees are covered under a first-dollar, self-insured indemnity health plan with no coverage limits, he said. Claims under the plan are administered by Blue Cross & Blue Shield of Michigan. Ford employees in other areas of the country are covered by similar plans serviced by a variety of claims administrators. Various HMO options are also available.

The new case management program is available nationwide to 150,000 active hourly employees and surviving spouses covered under Ford's indemnity health plan and retirees not covered under Medicare, Mr. Dunn said.

The case management program is designed to suggest less costly, alternative treatments for patients suffering from chronic or terminal illnesses that would require long-term hospital care. The program adds coverage for services that normally are not covered under the medical plan, such as private-duty nursing in the patient's home or nursing home care, Mr. Dunn said.

The case management program, which was implemented June 1, is centrally administered by BC/BS of Michigan, he said.

Participation in the program is strictly voluntary, and there is no penalty for not following the review team's suggestions.

The other three new programs are available to 80,000 employees, retirees not covered under Medicare and surviving spouses in the southeastern Michigan area.

Beginning Oct. 1, Ford will offer a cardiac rehabilitation program that will provide early outpatient care for cardiac patients. To participate, employees pay $25, which is refunded upon completion of the two-phase program, Mr. Dunn said.

The first phase of the program, to be conducted at Henry Ford Hospital and Sinai Hospital, both in Detroit, will include closely monitored exercise and testing immediately after cardiac patients are released from the hospital.

The second phase also will include exercise, but will be conducted at "outreach" centers, such as Ford's employee fitness center.

The hospice program, which began May 1, covers care and treatment in special facilities for terminally ill patients as well as counseling services for relatives.

Finally, a new prescription drug program will be offered beginning Sept. 1.

Under the new program, to be administered by Medicost Pharmacy Program Inc. of Southfield, Mich., Ford employees will pay $2 per prescription if they use a Medicost-affiliated pharmacist. Those not using a pharmacist affiliated with Medicost will pay $5 per prescription, encouraging employees to use the contracted pharmacists.

Under the Ford's current prescription drug program, administered by BC/BS, employees pay $5 per prescription.

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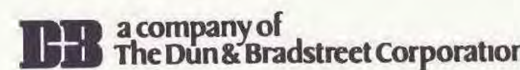

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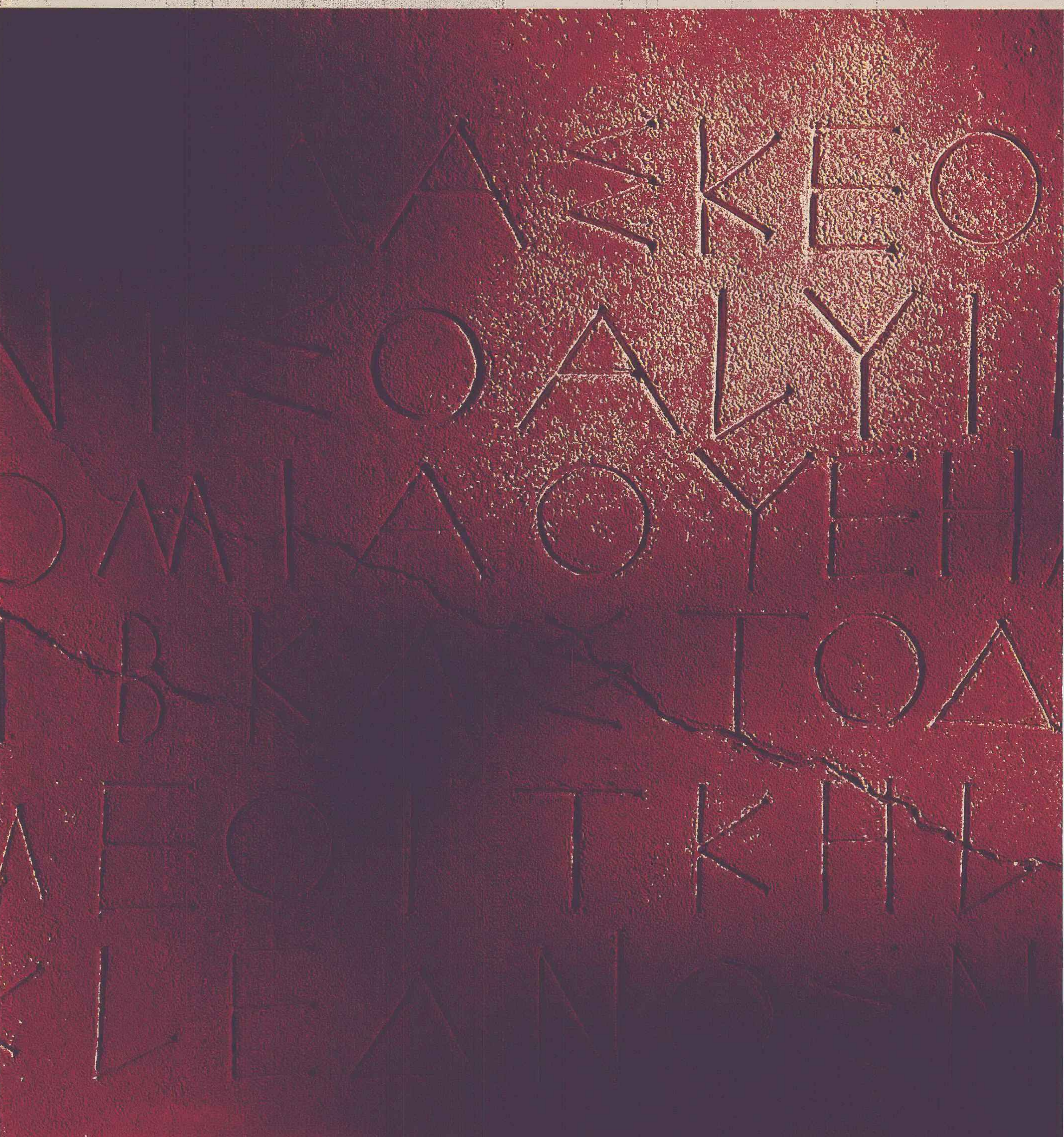

Continued from page 26

operating units and different pension plans to pass the non-discrimination rules.

But, some experts envision problems for corporations. For example, a company might flunk the test if it maintains two pension plans for a single division—one plan for salaried employees, many of whom could be highly compensated, and a second, less-generous plan for hourly employees.

To avoid problems, companies could establish non-qualified pension plans to cover highly compensated employees, experts say.

The new non-discrimination rules for pension plans would go into effect on Jan. 1, 1989.

New non-discrimination rules for welfare plans, like group health and life insurance programs, will not be available until the official conference report and bill is published next month.

Pension plan reversions

The conference bill retains a provision in both the House and Senate bills that imposes a new 10% excise tax on assets recaptured when overfunded pension plans are terminated.

To prevent a last-minute rush of plan terminations, the effective date of the tax was made retroactive to Dec. 31, 1985.

But the conferees slightly modified the reversion provision so that asset reversions transferred to an Employee Stock Ownership Plan through Dec. 31, 1988, will not be subject to the excise tax.

The Senate bill did not contain this expiration date, while the House provision did not contain any exemptions for ESOP transfers.

Other benefits

The conferees accepted the House provisions to extend the tax-favored status of employer-provided educational assistance and group legal benefits through 1987. The tax-favored status of both benefits expired Dec. 31.

The Senate bill had called for an indefinite extension.

The conference bill also sets a cap—equal to one-eighth of the Social Security wage base (currently $5,250)—on the maximum annual tax-free educational assistance benefits an employee can receive. No dollar cap was placed on group legal benefits.

Conferees also accepted identical provisions in the House and Senate bills to kill Section 124 of the tax code, under which employees are not taxed on an employers' cost of providing van pooling services.

Offshore insurers

The conference agreement replaces a House provision that would have increased the federal excise tax on reinsurance premiums paid to foreign insurers to 4% from 1% with a new provision that will be costly for owners of some offshore insurance companies.

Under current tax law, income earned by an offshore insurer is not subject to current taxation if the insurer is not a controlled foreign corporation. To escape being a controlled foreign corporation, an insurer needs at least 11 owners, all of whom own less than 10% of the insurer.

Under the conference bill, current tax would be imposed on each shareholder—regardless of the extent of ownership—that owns stock in any foreign insurance company that is 25% or more U.S.-owned with respect to income from insuring risks of U.S. stockholders and related parties. A similar rule would apply to mutual companies.

However, this new taxation rule would not apply to foreign insurance companies whose stock is publicly and freely traded.

The provision "will cause the taxation of owners of broad-based association captives," observed James Cameron, a partner with Baker & McKenzie in New York.

These would include the new offshore insurers formed recently, such as A.C.E. Insurance Co. Ltd.

"A very big tax advantage is being taken away," added Ernst & Whinney's Mr. Tepper.

Sources say the provision was added by House members who criticized new treaties with Barbados and Bermuda to exempt those domiciles from federal excise taxes on direct and reinsurance premiums (*BI*, July 28).

"This is meant to get more tax revenue even if the excise taxes are eliminated," one source said.

Insurer taxation

Property/casualty insurers will face an estimated $7.5 billion in new taxes over the next five years under the conference bill.

For example, insurers will be taxed on tax-exempt income generated by investments acquired on or after Aug. 7, the date the committee decided the issue.

Under this provision, an insurer will be required to reduce its deductions for additions to loss reserves by an amount equal to 15% of the tax-exempt income generated from investments acquired after Aug. 7.

For example, if an insurer set up a $200 million loss reserve and earned $100 million in tax-exempt income from investments made after Aug. 7, the company could only deduct $185 million of those reserves from its federal income taxes.

In addition, insurers will be taxed on a portion of existing unearned premium reserves and future increases in unearned premium reserves.

Under the measure, 20% of an insurer's unearned premium reserve existing at year-end 1986 will be subject to federal income taxes over the next six years. In addition, 20% of any year-to-year increase in the unearned premium reserve would be included as taxable income.

For example, if an insurer's unearned premium income increased to $300 million from $100 million, 20% of that $200 million increase—or $40 million—would be taxable income.

Finally, insurers no longer would be able to take immediate, full tax deductions for reserves established for future losses. Instead, insurers would be required to discount their loss reserves based on the midterm applicable federal rate, which is the market rate of return on U.S. government obligations with remaining maturities of between three and nine years.

More detailed rules on the reserve discounting provision will be published in the conference report due next month.

The impact of the new taxes on insurance rates is uncertain.

"Certainly, it won't help us keep costs down," said Steve Broadie, tax counsel with the Alliance of American Insurers in Washington.

While property/casualty insurers aren't pleased with the new taxes, they are relieved that the conferees rejected several "onerous" provisions in the House-passed tax bill, such as a special minimum tax directed specifically at property/casualty insurers, Mr. Broadie said.

"It is not as much damage as had been proposed," added Michael Gilliland, tax counsel for the American Insurance Assn.

Blue Cross/Blue Shield

Blue Shield plans will lose their current tax-exempt status, effective next year, under a provision in the conference bill.

The Blues say they are studying the impact of the legislation.

BC/BS officials had earlier said the loss of the plans' tax-exempt status could force them to toughen underwriting rules governing small employers. ■

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Circulation Breakdown*

Commercial Consumers

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CEO's Presidents and Owners . 2,983
Vice-presidents, General Managers and Other Administrative Personnel 2,758

Financial:

Chief Financial Officers and Vice-presidents of Finance 2,018
Secretaries, Treasurers, controllers and other Financial Personnel .. 6,484

Risk/Employee Benefits:

Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, saftey, security, industrial relations, human resources and employee/labor relations.... 8,111

Sub-total 22,354

Associations 483
Government, unions and educational institutions 1,252

Commercial Consumers

Sub-total 24,089

Insurance Agents and Brokers 10,285
Insurance Companies 6,739
Financial Institutions 748
Actuaries, Attorneys, Adjusters, Appraisers and Consultants 3,808
Others allied to the field 1,308
TOTAL 46,977

* Source Business/Occupational breakdown of qualified circulation, Nov. 25, 1985 issue, as submitted to BPA for December 1985 BPA Publisher's Statement.

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Tax bill

Continued from page 1

Employers also will have to cope with new non-discrimination rules for both pension and welfare plans that will add a new layer of complexity to plan administration.

The legislation keeps the maximum defined contribution and defined benefit limits at $30,000 and $90,000, respectively, but the defined contribution limit will be frozen until the defined benefit limit reaches $120,000 through indexing to inflation.

The conferees' agreed to continue the tax-favored status of educational assistance and group legal benefits through 1987, which means the long-term future of those benefit programs will have to be settled another day.

On the property/casualty side, the tax bill will subject shareholders of group-owned offshore insurers to current taxes on captive income related to insuring shareholder risks. This change will be accomplished by essentially changing the definition of a controlled foreign corporation.

"From pure tax considerations. . .offshore captives may be no better off than domestic captives," said Edward Tepper, a partner with Ernst & Whinney in New York.

U.S. property/casualty insurers, according to trade association estimates, may face as much as $7.5 billion in new federal taxes, through new taxes on portions of insurers' tax-exempt income and unearned premiums and through the discounting of reserves for tax purposes.

Observers believe that at least some of this new tax burden inevitably will be passed on to insurance buyers.

In addition, the conference bill strips away the tax-exempt status of Blue Cross/Blue Shield plans, a provision that Blues' officials have warned could force the plans to toughen their underwriting standards.

With the final enactment of the conference bill considered a certainty, many believe that the constant congressional tinkering, especially with pension and savings plans, will decrease in the future.

But there is little satisfaction with the massive mandated pension and savings plans changes.

"We are still being driven by tax considerations, and issues are not being resolved on the basis of retirement income policy," said Everett Allen, a vp in the Philadelphia office of Towers, Perrin, Forster & Crosby.

"Congress still has not developed and implemented an effective retirement income policy. . .divorced from revenue considerations," said Gerald Uslander, a principal in the Louisville, Ky., office of William M. Mercer-Meidinger Inc.

"Tax considerations often prevailed rather than good benefits policy," added Stuart J. Brahs, executive director of the Assn. of Private Pension & Welfare Plans in Washington.

While the Tax Reform Act of 1986 may have resolved a slew of pension issues, there is no doubt that Congress now will turn its attention to welfare plans.

"The theme on the next round of legislation will be access to health care plans and funding of post-retirement health care plans," predicted Mr. Butterworth.

Following are details of provisions in the bill that affect employee benefit and risk managers:

401(k) plans

The conference bill allows 401(k) plans to continue, but the savings programs will be more difficult and expensive for employers to administer and less attractive to employees.

Conferees accepted provisions in both bills that slash the maximum annual 401(k) deferral to $7,000 from the current $30,000. The new limit will be indexed to inflation, apparently starting in 1988.

In addition, 401(k) plan discrimination will be tested by comparing deferrals made by a newly defined group of highly compensated employees with deferrals made by lower-paid employees.

While the summary of the bill doesn't define this new group of highly compensated employees, sources expect the group will be defined as:

- Employees who own more than 5% of a company.
- Employees earning more than $75,000 annually.
- Employees earning more than $50,000 annually who also are among the highest-paid 20% of the company's workforce.
- Officers who earn at least 1½ times the maximum defined contribution limit, or $45,000.

This lengthy definition of highly compensated employees contrasts sharply with the current non-discrimination test, which simply compares deferrals made by the highest-paid one-third of a company's employees with the lower-paid two-thirds.

Aside from making the definition of a highly compensated employee more complex, the conference bill adopted the House bill's actual deferral percentage (ADP) test for 401(k) plans, which is much tougher than current rules.

Under the conference bill, the average salary deferral elected by the highly compensated group cannot exceed the greater of these two amounts:

- 125% of the ADP of the lower-paid employees.
- The lesser of either 200% of the ADP of the lower-paid employees or the ADP of the lower-paid employees plus 2%.

By contrast, the current average deferral percentage test is much more generous to higher-income employees.

Under the current test, the average salary deferral elected by the top-paid one-third cannot exceed the greater of two amounts:

- 150% of the ADP of the lower-paid two-thirds.
- 250% of the ADP among the lower-paid two-thirds as long as the difference between the average of the two groups does not exceed 3%.

It isn't clear when the new non-discrimination rules will go into effect, though some believe it could be as early as Jan. 1.

Also, under the bill any distribution from a 401(k) plan before an employee reaches retirement age (generally 59½) will be subject to a 10% excise tax unless the

Continued on page 26

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The new tax bill at a glance

	IRAs/ 401(k)s	Pension vesting/ maximums	Pension asset reversions	Education/ legal benefits	Offshore captives	Insurer taxation
Conference bill	IRA: No pretax contributions for pension plan participants whose income exceeds $50,000 for joint filers, or $35,000 for individual filers. Pretax contributions retained for those not covered by pension plans. 401(k): $7,000 maximum annual deferral, with indexing. New, more complex non-discrimination rules.	Vesting: Full vesting after 5 years or 20% vesting after 3 years and 20% annually for next 4 years. Maximums: $90,000 for defined benefit; $30,000 for defined contribution, which is frozen until defined benefit maximum reaches $120,000 under indexing.	10% excise tax; except on amounts transferred to an ESOP through Dec. 31, 1988.	Education: Tax-free to one-eighth of Social Security wage base: $5,250 in 1986. Tax exclusion expires on Dec. 31, 1987. Legal: No tax through 1987.	Imposes current tax on shareholders of offshore captives with 25% or more U.S. ownership on income received from insuring risks of U.S. stockholders and related parties.	Property/casualty: Discounts loss reserves; taxes a portion of tax-exempt income and unearned premium income. BC/BS: Removes tax-exempt status.
Current law	IRA: Permits an annual $2,000 tax deduction for contributions. 401(k): $30,000 maximum annual deferral. Simple non-discrimination tests.	Vesting: Multiple schedules, generally after 10 years. Benefits: $90,000 for defined benefit; $30,000 for defined contribution, both scheduled to increase.	No excise tax on pension plan reversions.	Education: Tax exclusion expired Dec. 31, 1985. Legal: Tax exclusion expired on Dec. 31, 1985.	Income now tax-exempt until repatriated to U.S.	Property/casualty: No discounting of loss reserves; no tax on unearned premium and tax-exempt income. BC/BS: Tax-exempt.

Tax bill

Continued from page 25

distribution is rolled over into an Individual Retirement Account or used to buy certain annuities.

The bill bars tax-exempt organizations and state and local governments from establishing new 401(k) plans, though plans already formed would be grandfathered.

While the new restrictions will tarnish the appeal of 401(k) plans, consultants expect the programs to remain popular.

"The plans remain the best retirement savings vehicle in town," says Buck's Mr. Rumack.

However, employers may have to increase matching contributions to ensure that a high percentage of employees continue to participate, Mr. Uslander of Mercer-Meidinger said.

Employers also will face the daunting task of communicating the new 401(k) rules to employees, noted Hewitt's Mr. Butterworth.

IRAs

The conference bill will deny millions of people tax deductions for contribution to Individual Retirement Accounts, which were once embraced by the Reagan administration and by Congress as a retirement-savings device.

Effective next January, only wage earners not covered by corporate pension plans will retain the automatic right to contribute up to $2,000 annually to an IRA on a tax-deductible basis.

The deductibility of IRA contributions by those covered by pension plans will be keyed to their adjusted gross income. Pension plan participants filing individual returns with adjusted gross incomes of less than $25,000 or participants filing joint returns with adjusted gross incomes under $40,000 still will be allowed to make a $2,000 annual tax-deductible contribution to an IRA.

However, a sliding scale will determine the maximum deductible IRA contribution that can be made by individual filers with adjusted gross incomes between $25,000 and $35,000 and joint filers with adjusted gross incomes between $40,000 and $50,000. That scale has not yet been published.

Tax-deductible IRA contributions will be eliminated for individuals with adjusted gross incomes exceeding $35,000 and couples filing jointly with adjusted gross incomes exceeding $50,000.

However, funds in existing IRAs will continue to earn tax-free interest until withdrawn, and non-deductible IRA contributions can still be made. In addition, individuals still will be able to roll over pension and savings plans distributions into an IRA.

The IRA provision adopted by the conferees is a compromise. The Senate bill proposed eliminating deductible IRA contributions for anyone covered by a pension plan. The House bill called for reducing IRA contributions by the amount deferred to a 401(k) plan.

The conferees voted to limit IRA eligibility primarily because the revenue loss attributed to IRA contributions was greater than originally anticipated.

Pension plan vesting

As benefit experts had predicted, the conferees accepted the Senate bill provisions that require rapid pension vesting schedules and set new pension integration rules.

The House bill lacked vesting and integration provisions.

Under the conference bill, employers will have to offer one of two minimum vesting schedules: 100% vesting after five years of service or 20% vesting after three years of service, with vesting continuing at a rate of 20% annually until a worker is 100% vested after seven years.

For most employers, the new vesting schedules, which will apply to both defined benefit and defined contribution plans, must be in place by Jan. 1, 1989.

Most employers currently use 10-year vesting schedules.

Vesting provisions for pension plans offered under collective bargaining agreements will go into effect after the expiration of the agreement or Jan. 1, 1991, whichever is earlier.

However, 10-year vesting still will be allowed for multiemployer pension plans.

The new rapid vesting schedules will create administrative hassles and significantly increase pension costs for employers with a high rate of employee turnover.

Pension activistshave championed five-year vesting, arguing that 10-year vesting schedules discriminate against women who, they say, are more likely than men to leave the workforce after a few years because of family responsibilities.

While five-year vesting will mean more pension plan participants will collect benefits, the size of those pension benefits could be small.

"For people who, for example, leave a company while in their 30s, you really are talking about an insignificant benefit," said Hewitt's Mr. Butterworth.

The pension integration provision, which has the same effective dates as the vesting provision, will change the way companies can integrate their pension plans with Social Security benefits.

Currently, many employers now reduce benefits payable under defined benefit plans by an amount equal to 50% of a retiree's Social Security benefits.

For example, assume that a retiree is entitled to a monthly $500 corporate pension benefit and a $600 Social Security benefit. Under a 50% offset, the pension benefit could be reduced to $200.

While there is some ambiguity because of some last-minute technical changes, it appears that under the conference bill a pension benefit generally cannot be reduced by more than 50%.

Thus, the pension benefit payable to the retiree in the preceding example could be reduced only to $250.

How much a company's pension costs will increase will depend on the extent to which it integrated its benefits with Social Security.

"For some smaller companies, costs could go up significantly," said Mr. Butterworth.

Maximum pension limits

The conference bill retains the current maximum limits on pension benefits and contributions—with some new twists.

The maximum annual benefit that can be provided from a defined benefit plan will remain $90,000, while the maximum annual contribution to a defined contribution plan will stay at $30,000. These limits were contained in the Senate bill, while the House had sought a $77,000 defined benefit limit and a $25,000 defined contribution limit.

Current law froze these maximums until 1988, when they were scheduled to increase with rises in the Consumer Price Index.

Under the conference bill, only the defined benefit limit will be indexed to inflation in 1988. The defined contribution limit will be frozen at $30,000 until the defined benefit limit hits $120,000. After that, the maximum defined contribution will be set at 25% of the maximum defined benefit.

Pension non-discrimination

The conference bill sets new pension plan non-discrimination rules that benefit observers say are much improved over earlier proposals.

A pension plan will have to pass one of three tests to be considered non-discriminatory and thus be able to retain its tax-exempt status. Those tests are:

- Seventy percent of a company's non-highly compensated employees must be covered by the plan. The provision, however, does not define who is considered a highly compensated employee.
- The percentage of non-highly compensated employees covered by the plan must equal at least 70% of the percentage of highly compensated employees covered by the plan.
- A "fair-cross-section" of employees must be covered by the plan and the average benefit provided to non-highly compensated employees must be at least 70% of the average benefit provided to highly compensated employees.

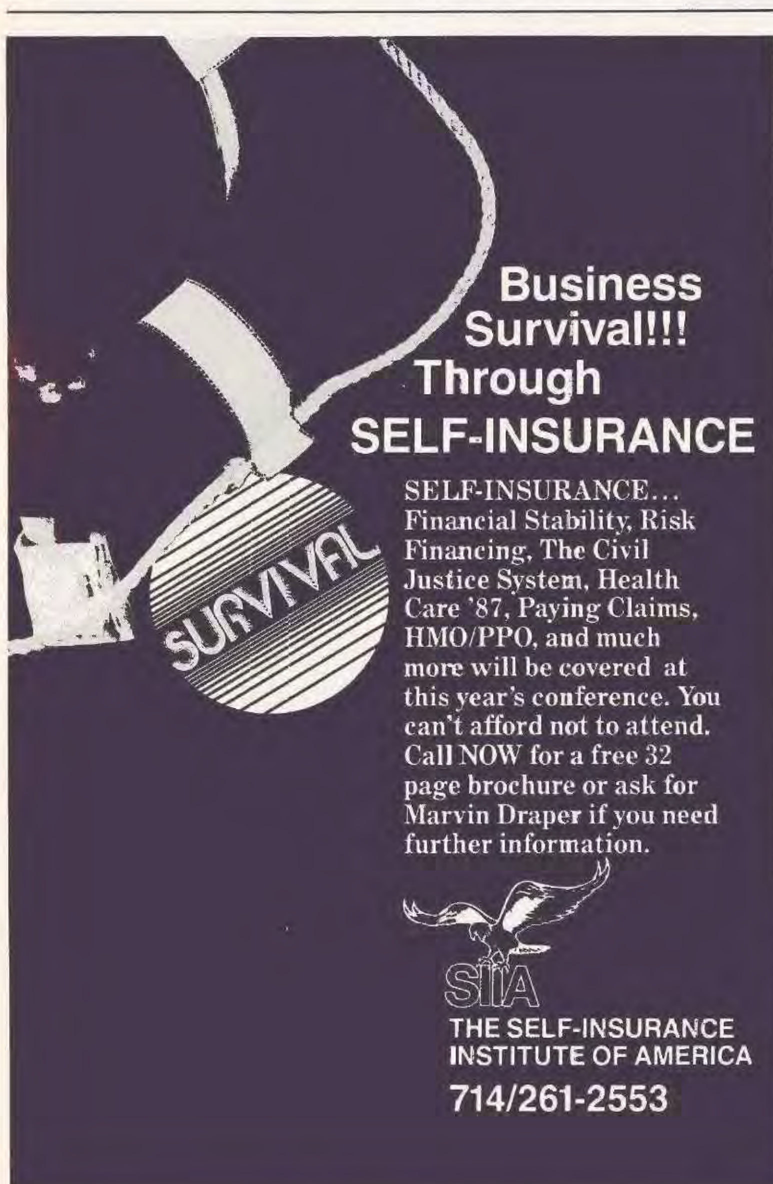
In addition, discrimination testing could be done on a line-of-business or operating-unit basis.

For example, if a company maintains different lines of business—such as an oil drilling division and a retail sales division—each division's pension plan could be tested separately.

If, for example, 70% of the oil division's non-highly compensated employees were covered under its plan and 70% of the department store non-highly compensated employees were covered under the retail store plan, the company's pension plans would be considered non-discriminatory. It would not be necessary for 70% of all non-highly compensated employees to be covered under one plan to pass the non-discrimination test.

This separate line-of-business testing, not found in some earlier tax proposals, is essential to enable corporations with different

Continued on page 27



Workers comp

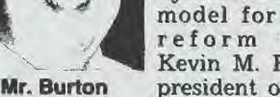
Continued from page 3

courts have done," Mr. Crosby said.

Mr. Feinberg

Mr. Crosby seemed doubtful that the myriad of tort reform measures enacted or considered by state legislatures this year will really improve the civil justice system.

"Will we have brought back predictability and certainty to the liability marketplace? I can't really say. . . .If we had a more established system, like workers compensation, where benefits are set and rates are set. . .perhaps we would have a better system," he said.

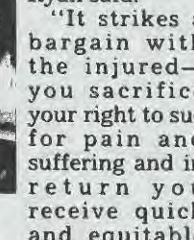


Mr. Burton

Also strongly recommending the workers compensation system as a model for tort reform was Kevin M. Ryan, president of the National Council on Compensation Insurance, the national, New York-based ratemaking and research organization.

"I very clearly feel that workers compensation is the system that responds to the tort reform needs," Mr. Ryan said.

"At the turn of the century, workers compensation legislation was significant tort reform. In its essence, it substitutes medical benefits and economic assistance for pain and suffering," Mr. Ryan said.



Mr. Crosby

"It strikes a bargain with the injured—you sacrifice your right to sue for pain and suffering and in return you receive quick and equitable medical coverage and recompense for lost wages," he said.

In suggesting the workers compensation system as the model for reform, Mr. Ryan said there are several questions to be explored, but most importantly: Is the workers compensation system as a private insurance enterprise sufficiently attractive to convince insurance companies to continue to capitalize it?

Because workers compensation costs can extend over a period of many years, it takes time to determine how well or poorly work comp insurers have fared, Mr. Ryan noted.

"A best estimate for the year just past is a pretax loss of $1.2 billion. Bad as the 1985 record is, it is an improvement over 1984," he said.

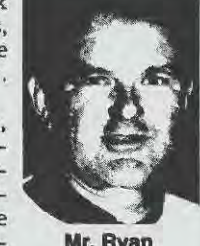
"The best part of this dismal picture is the change in the appreciation for adequate prices, both from the seller as well as the regulator. Despite continued high rate increases in workers compensation, an awareness is growing that the heavy discounts, both mandated by regulator and implanted by competitor, must be exorcised from the system," Mr. Ryan said.

He cited other potential problems that should be considered by those looking at the workers compensation system as a model for tort reform.

One is capacity, he said.

"Happily, workers compensation has not been the source of capacity problems because of its residual market systems," he said, referring to the state assigned risk pools for workers compensation.

"In a technical sense, there is never an availability crisis in workers compensation because the business the carriers refuse to write voluntarily will be written through residual market mechanisms—the assigned risk plans and pools, and the state funds," Mr. Ryan said.



Mr. Ryan

"However, workers compensation insurers are in business to write workers compensation. So when they start turning down large numbers of risks, it is a sure sign of a system not working. In a sense, the growth of the residual market can be seen as an analogue to the availability crisis in other lines," Mr. Ryan said.

And, another problem confront-

Continued on page 20

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Workers comp

Continued from page 19

ing both workers comp and tort systems, is the battle between insurers and trial lawyers, Mr. Ryan said.

"Workers compensation, while the best system, is in need of some reform to pull it back from the greedy grasp of some segments of the legal profession," he said.

"In workers compensation alone, we estimate a 1986 total net premium of $17.7 billion—$12.6 billion of that amount will go to incurred losses, with the remainder going to pay various taxes and expenses, including legal costs," he said.

"One of the reasons for the problem is that the legal profession has grown larger than it needs to be. We all have a tendency to blame the government for encumbrances to industry, but I think the entanglement of lawyers in virtually every business decision has played a role in the dulling of our competitive edge," he said, suggesting that the legal profession is going to have to accommodate itself to the changing American economy.

Besides these "short-term" concerns, Mr. Ryan also noted a few longer term problems that are specific to workers compensation:

- Occupational disease.
- Benefit utilization.
- Erosion of the exclusive remedy doctrine.

The discovery of an increasing number of occupational diseases has resulted in the "blurring of the distinction between work-related causes and the exigencies of life itself, most of which is spent outside the place of employment," Mr. Ryan said.

Case law has expanded the scope of both occupational disease and employer responsibility, even in non-disease cases, he noted.

"I think that we may begin to see an integration of on- and off-the-job disability and health insurance as the distinction between" illnesses and job-related injuries "becomes blurred," Mr. Ryan said.

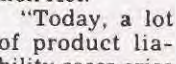
And, benefit utilization, according to Mr. Ryan, is an example of how new problems are created while solving old problems.

The increased benefit levels implemented over the last decade have made it more attractive for injured workers to stay home and collect workers compensation than to go back to work, he said.

And, the erosion of the exclusivity of workers compensation, "threatens to burst the bounds of the workers compensation system and drop immeasurable new liabilities on businesses and their insurers," said Mr. Ryan (see story, page 21).

But even with all these "problems," Mr. Ryan still believes the workers compensation system is "a system that works well—a system that perhaps works well enough to be directly or indirectly expanded to face the needs of tort reform."

So far, the workers compensation and tort systems have only begun to mesh to prevent overlapping benefits in product liability cases, according to Victor E. Schwartz, a Washington attorney, and a key drafter of the federal Product Liability Risk Retention Act.


Mr. Schwartz

"Today, a lot of product liability cases arise out of the workplace. . . .So (workers) compensation costs, when related to products, will be borne by the employer," said Mr. Schwartz, with the firm Crowell & Moring.

A proposed product liability bill now pending in Congress addresses in part workers compensation, Mr. Schwartz said, adding that more than 40% of the damages paid and litigation costs in product liability claims stem from workplace claims.

"What often happens is that the workmen compensation insurance (company) joins in the product liability suit, stands in the shoes of the claimant and collects the workmen compensation award from the manufacturing defendant. That's what subrogation is," he said.

That would be changed if the pending federal product liability bill—S. 2760—is approved. The bill is scheduled for a hearing before the Senate Judiciary Committee Sept. 9, and after that, could be sent to the Senate floor for a vote.

Specifically, the bill, approved by the Senate Commerce Committee Aug. 14, would offset product liability awards by workers compensation benefits received by those injured in workplace accidents and eliminate subrogation actions between an injured worker's employer and the manufacturer found liable (*BI*, June 30). Among other changes, the bill also would:

- Eliminate joint and several liability for non-economic damages in product liability suits.
- Eliminate most punitive damage awards against pharmaceutical and aircraft manufacturers whose products were approved by the Federal Drug Administration or the Federal Aviation Administration.

Punitive damages still could be awarded if drug or aircraft manufacturers withheld relevant information from the FDA or FAA.

- Allow punitive damages only if a plaintiff could prove by "clear and convincing evidence" that a defendant exhibited a "conscious, flagrant indifference to the safety of those persons who might be harmed by a product."
- Punish attorneys who file frivolous lawsuits or frivolously delay cases by making them liable for other parties' legal fees and for court costs.

The bill "was designed to penalize lawyers," and "will not do much to compensate victims," said Donald Elisburg, administrator of the Occupational Health Legal Rights Foundation, created by a unit of the AFL-CIO.

No one is asking why pain and suffering damages and non-economic damages are awarded in the first place and what will happen if they're eliminated, he said.

James Ellenberger, assistant director of occupational safety, health and social security for the AFL-CIO in Washington, agreed. He noted that a major result of the "liability crisis" is to focus on proposals that take away from victims.

Mr. Schwartz, however, noted that problems in the tort system can be eased if something is done about joint and several liability and punitive damages.

"Until you stabilize the tort laws, you're going to have a problem," he said, without offering any specific solutions.

Mr. Ellenberger

Mr. Ellenberger said that "any discussion of product liability or tort reform ought to involve submitting the insurance industry to more public scrutiny."

Such scrutiny is part of a package of recommendations adopted in May by the AFL-CIO's Executive Council. In its policy statement on liability insurance and tort law, the AFL-CIO urges the federal and state governments to adopt balanced changes in both systems designed to accommodate the legitimate, yet conflicting interests of providers and of injured persons.

But, to those who would consider the workers compensation system as a model for tort reform, Mr. Ellenberger advised: "You have to remember, workers compensation is a social insurance program. . .that spreads the cost of illness and injury to our society." ■

Railroads should be part of comp system: Attorney

By CAROL CAIN

ORONO, Maine—While many experts are proposing ways to alter or change the workers compensation system, one attorney says railroads want to be part of that system.

"If railroads could go under a workers compensation system tomorrow, they would be delighted," J. Thomas Tidd, vp and general counsel for the Washington-based Assn. of American Railroads, said at the 10th Annual National Symposium on Workers Compensation.

Historically, railroad employees are not covered by state or federal workers compensation statutes. Instead, they are covered by the Federal Employer's Liability Act of 1908, which forces them to sue their employer to recover for occupational injuries.

The FELA is a "great misnomer," Mr. Tidd said. "It doesn't affect all federal employers, just the railroad industry" and certain seamen.

"It's a lousy act," he added.

Because railroad employees are not covered by a no-fault workers compensation system, railroads must frequently go to court to defend negligence charges brought against them by injured workers.

And, because employees generally have to prove only the "slightest" negligence on the part of the employer to be awarded damages, railroads often are open to tort judgments of millions of dollars, Mr. Tidd said.

The AAR wants legislation introduced in Congress next year that would repeal the FELA and replace it with a bona fide workers compensation system, he said.

"We would settle, I think, for any reasonable compensation system," such as the federal Longshoremen's and Harbor Workers' Compensation Act, which covers dock workers, Mr. Tidd said.

The AAR hopes that labor unions and other employers will support the legislation.

It's a logical time to intensify the effort to repeal the FELA because of all the attention focused on the tort system, Mr. Tidd said.

"It's getting worse, and more expensive (for railroads)," he noted, adding that the current act also is unfair to workers, some of whom do not receive compensation for injuries.

The FELA, which predates state workers compensation systems, grew out of the "gross inequities" to workers that existed at the turn of the century, Mr. Tidd said.

Because the railroad industry at the time was the single largest industry in the country, it was logical for the federal government to intervene to protect railroad workers, he explained.

However, the railroad industry today is one of the safest of the heavy industries, Mr. Tidd said.

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Exclusive remedy shield not absolute: Expert

By CAROL CAIN

ORONO, Maine—Neither employers nor labor unions can presume they will be shielded from legal actions by the "exclusive remedy" provision of state workers compensation statutes, a labor attorney says.

"The long and the short of it is that no organization can assume it is going to be immune from action based on traditional theories of exclusiveness or pre-emption or other doctrines that protect the employer or union entity," said Donald Elisburg, a Washington attorney who also is administrator of the Occupational Health Legal Rights Foundation.

The foundation, formed by a unit of the AFL-CIO, was designed in part to teach workers and employers how to prevent occupational diseases (*BI*, April 8, 1985).

Mr. Elisburg spoke at the 10th Annual National Symposium on Workers' Compensation held last month at the University of Maine.

State workers compensation systems hinge on the exclusive remedy doctrine, under which employers enjoy tort immunity in exchange for accepting absolute liability for all work-related injuries.

Some workers compensation experts contend the exclusive remedy doctrine also gives employers immunity from criminal prosecution for workplace accidents or diseases (*BI*, June 24, 1985).

For instance, Mr. Elisburg cited the Cook County, Ill., case against officers of the defunct Film Recovery Systems Inc., who were found guilty of murder after a worker allegedly died following exposure to cyanide gas. That case is now under appeal (*BI*, July 8, 1985).

"The evidence in that case is a classic example of deliberate action in mislabeling chemicals and exposing employees to an awful toxic hazard. Until Film Recovery, the only remedies would be a workers compensation recovery, or possibly, in some jurisdictions, a civil recovery against the employer for intentional tort," Mr. Elisburg said.

"The surprising thing about Film Recovery. . .is not about the case per se; the surprise is that there aren't more brought. And, if the newspapers are any indication, local prosecutors are beginning to see a new product in criminal prosecutions of employers for employment related injury and death.

Besides criminal prosecution, employers also continue to face the threat of lawsuits filed by employees following workplace injuries, he noted.

Employees go outside the work comp system and sue their employers for several reasons, Mr. Elisburg said, including:

- They believe the workers compensation benefits they are awarded are insufficient.
- Statutes of limitations under the workers compensation laws expire.
- Injured workers don't receive damages for pain and suffering or punitive damages under workers compensation laws.
- Workers "are just plain angry."

Various courts have upheld an injured worker's right to sue outside the workers compensation system and such action will continue, Mr. Elisburg predicted, noting the best-known cases include:

Mr. Elisburg

- *Mandolidis vs. Elkins Manufacturing Co.*, a West Virginia Supreme Court ruling (*BI*, March 26, 1984; Feb. 14, 1983; Jan. 17, 1983; and Aug. 30, 1982).
- *Blankenship vs. Cincinnati Milacron*, an Ohio Supreme Court case (*BI*, April 11, 1983; Nov. 8, 1982; and April 26, 1982).

The 1978 *Mandolidis* case involved an injury to a worker who operated a saw without a safety guard. The plaintiff argued that the employer, who had previously been cited for an Occupational Safety and Health Administration violation, knew it was dangerous and that other employees had been injured, Mr. Elisburg said.

The West Virginia Supreme Court held that deliberate intent to produce such injury or death encompassed both specific intentional torts and willful, wanton and reckless misconduct, he said, noting that the court's decision later was repealed by action taken by the state Legislature.

The Legislature overruled the court's broad ruling that deliberate intention means willful and reckless misconduct. It modified the scope by setting out an elaborate circumscribed set of requirements, which if satisfied, will support a damage action in aggravated cases of knowingly maintaining unsafe workplaces in violation of statutes or regulations, he said.

The 1982 *Blankenship* case involved employees who claimed permanent disability as a result of exposure to noxious fumes while working.

The employees claimed the employer knew that poisonous fumes in the plant were causing disease and that the company failed to correct the hazardous conditions, failed to warn the employees, failed to provide medical examinations as required by law and failed to report the hazardous conditions to the various state and federal agencies as required by law.

It was charged that the employer's conduct constituted intentional, malicious wrongdoing, and willful and wanton disregard of the employees' health, Mr. Elisburg said.

"The Ohio Supreme Court held that the workers compensation laws do not give employers immunity from lawsuits when an employee claims that the employer intentionally caused the injury," Mr. Elisburg said.

"The Ohio court determined that the laws protected the employees and employers only in the event of unforeseen accidental injuries and that intentional injuries are outside the scope of the workers compensation act," he said.

"Therefore, the court held that the employees could sue in tort for failure to warn and report on the dangerous conditions," Mr. Ellisburg said.

The *Blankenship* decision is "very unusual," according to Mr. Elisburg, and, "it's generally considered that Ohio is probably the only place now where you can get this kind of result."

Under workers compensation reform legislation passed by the Ohio Legislature this year, which took effect Aug. 22, employees are permitted to sue employers. However, the new law defines "intentional tort," which the court had not defined (*BI*, June 9).

The new law defines intentional tort as an act committed with the intent to injure another or committed with the belief that the injury is substantially certain to occur, meaning the employer acts with deliberate intent to cause an employee to suffer injury, disease, condition or death.

Mr. Elisburg also noted employee suits may be allowed in "situations involving a cause of action for aggravating or contributing to a workplace illness or injury by concealing the information about workers' health."

He referred specifically to the December 1985 ruling by the New Jersey Supreme Court in *Millison vs. E.I. du Pont de Nemours and Co.* (*BI*, Dec. 30, 1985).

The case involved employees of New Jersey Du Pont plants who were exposed to asbestos and claimed the company and staff physicians failed to warn of the dangers associated with asbestos exposure and intentionally concealed its hazards, he said.

The workers also charged that results of medical tests showing the effects of asbestosis were "fraudulently concealed" and that employees were allowed to return to jobs where they were further exposed, he said.

The New Jersey Supreme Court ultimately ruled that the injured workers could not sue Du Pont outside the workers compensation system for damages caused by their initial asbestos exposure. However, the court allowed the workers to press their claim against Du Pont and its physicians for any additional exposure allegedly caused by their concealment of asbestos-related diseases, Mr. Elisburg said.

"The suggestion in this intentional harm business is that in the area of toxics, even though you've got long-latency diseases, you may have duty to warn—you have right to know," Mr. Elisburg said.

"The Du Pont case was interesting because it also permitted these workers to sue the doctors who knew what was going on, but didn't tell them. If one were to project into the future and were representing employers in this area, you would still have to say: 'Don't be so secure in the fact that this exclusiveness doctrine is going to be rigidly upheld.'

"It will depend on the egregious nature of the assault on the individual. It will also depend on the political climate. Certainly, it depends on the degree of prior activity that was going on."

Such "prior activity" includes whether the employers had been cited by OSHA or state agencies for health and safety violations, he said.

Workers compensation-related legal actions could affect labor unions as well as employers, Mr. Elisburg pointed out.

"In situations similar to employer erosion, cases allowing tort actions against labor unions for work-related injuries may be encroaching upon the federal pre-emption doctrine, which has historically had the effect of insulating unions from tort liability," Mr. Elisburg said.

Plaintiffs who file tort suits against labor unions argue that when a union attempts to protect its members from dangerous working conditions, it assumes the common law duty to do so in a reasonable and prudent manner. And, if a union fails to meet this standard of proof, plaintiffs can argue it is guilty of negligence and liable for damages under state tort law, Mr. Elisburg said.

"Generally, unions have defeated this theory and escaped liability for workplace injuries by asserting one of two defenses," he said:

- Convincing a court that it is the employer's ultimate responsibility to prevent hazardous working conditions and that the union's role in enforcing collectively bargained health and safety provisions is merely advisory, with no duties attached.
- Successfully challenging state court jurisdiction by arguing that the federal duty of fair representation pre-empts state tort law, which otherwise would impose liability on unions for injuries resulting from negligent enforcement of collectively bargained safety provisions.

In situations where unions assist an employer to manage the company's affairs, the unions generally have included in the labor contract a provision noting that "regardless of a safety committee, regardless of what else we're doing, it is the employer's responsibility to run the show and assume all responsibility," Mr. Elisburg said.

"Unions are going to have to balance very carefully the degree of their involvement in the health and safety operations of an employer, while making clear the employer's ultimate responsibility. ■

Insurers absent from comp conference

ORONO, Maine—Insurers were conspicuously absent from the 10th Annual National Symposium on Workers' Compensation, but so were other participants who normally attend the work comp think tank held each summer on the University of Maine campus.

"A lot of companies cut back on their travel budgets," surmised workers compensation consultant J. Howard Bunn Jr., who organizes the event with Robert B. Collyer, another consultant.

However, Mr. Bunn acknowledged that some insurers also may have stayed away because they are "upset" about last year's legislative mandate requiring workers compensation insurers in Maine to reduce rates by 8%. This mandate, according to insurers, is particularly unfair since they believe an average 130% increase in rates is needed to stabilize the market (*BI*, June 23).

Despite the absence of insurers, workers compensation issues were taken up with New England vigor by the 80 employers, lawmakers, state work comp administrators, insurers and labor union representatives who attended the July 13-18 conference.

Topics of discussion and debate included second injury and special funds, employees' involvement in the workers compensation system, medical issues like AIDS in the workplace and pending federal legislation.

The symposium first was held in 1977 as an outgrowth of the attention workers compensation received in the 1970s by the Report of the National Commission on State Workmen's Compensation Laws, various congressional proposals and the activities of the federal Interdepartmental Task Force on Workers' Compensation, Mr. Bunn said.

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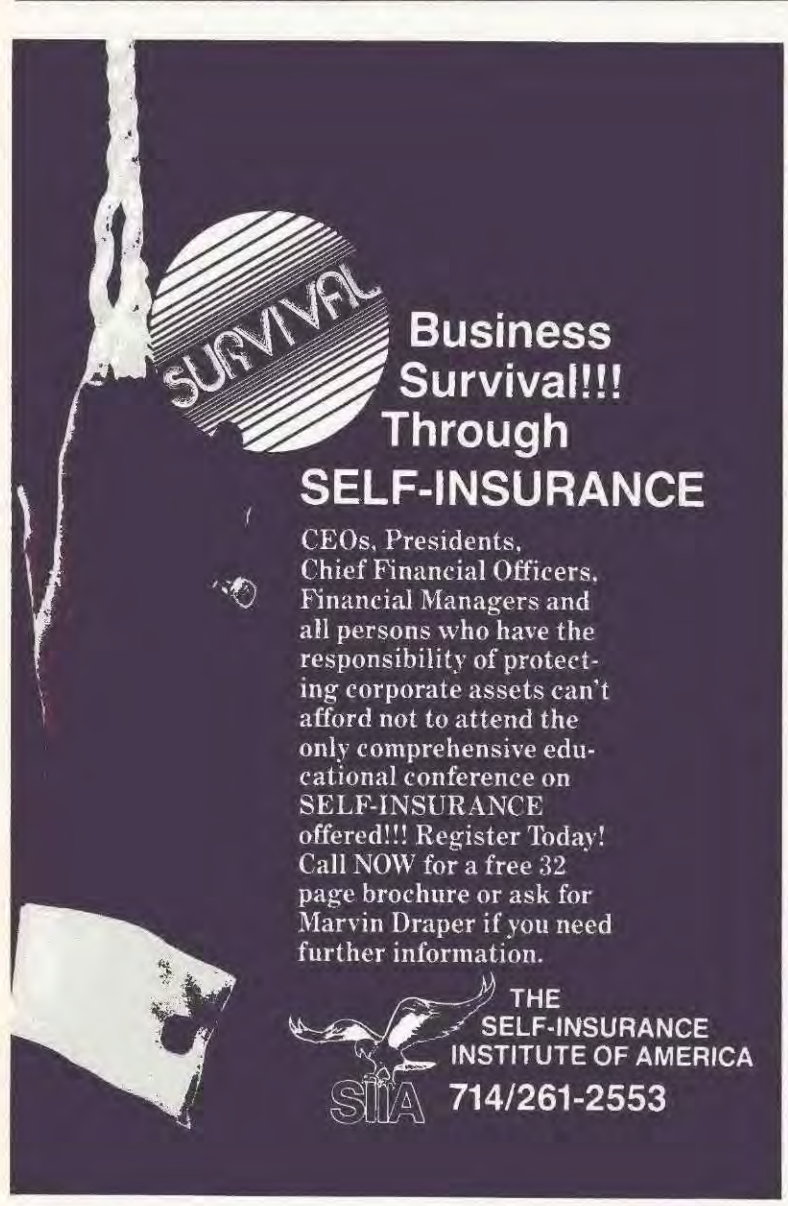

Nominees evaluated in 10 different areas

Ten criteria will be used to score the nominations submitted for the 1987 *Business Insurance* Risk Manager of the Year Award and Risk Management Honor Roll.

The 10 independent judges of the annual competition will score each candidate on a scale of one to 10 according to how well he or she:

- Established and implements an effective risk management program within the organization.
- Tackled and solved one or more major problems for his or her organization.
- Innovatively applies the diverse tools of risk management and insurance.
- Creatively and effectively uses the insurance markets to structure an insurance program that serves the needs of the organization (specifically addressing the types of policies purchased and manuscripted policies, if any, developed).
- Established a workable intelligence system inside and outside the organization, culminating in a flow of information about events and activities that affect the organization's risk management and insurance. (How the risk manager secures information on risks from other departments and the use of risk management information systems are addressed in this criterion.)
- Skillfully performs the functions of management in the overall organization and within the risk management/insurance department. (The functions include planning, organizing, directing and controlling.)
- Achieves the most effective program at the optimum cost over the long term.
- Developed technical expertise in any or all of the broad categories included within risk management, leading to a better managerial grasp of the operations aspects of the job.
- Exhibits an attitude and performs activities fostering the advancement of the risk management profession (such as professional activities, speaking engagements, teaching and related activities).
- Develops in his or her career (as exhibited by job history, including current job description, education, honors and memberships).

Nominations

Continued from page 3

N.Y., representing government entities; and William Ryan, insurance and risk manager of the University of Michigan at Ann Arbor, representing not-for-profit institutions.

Mr. Bieber is now president of Ebasco Risk Management Consultants Inc. in New York.

No one was named to represent companies with sales of less than $300 million.

In 1982, the Risk Management Honor Roll was expanded to recognize a runner-up to the Risk Manager of the Year when the judges' scores are very close. Spencer J. Traver, then assistant treasurer of BFGoodrich Co. in Akron, Ohio, was named runner-up.

Mr. Traver is president of Pine States Risk Management Inc. in Charlotte, N.C.

Other 1982 Honor Roll Members were: George N. Pierce, risk manager of Orange County, Fla., representing government entities; Paul B. Harvey, then risk manager of Ponderosa Homes in Irvine, Calif., representing small companies; and Gene M. Marsh, then executive vp for risk management for the General Conference of Seventh-day Adventists in Takoma Park, Md., representing a not-for-profit entity.

Mr. Marsh is now president of California Hospital Assn. Insurance Services Inc.

The Risk Management Honor Roll in 1983 included: Jerri Nelson MacMillian, then risk manager of Aetna Life & Casualty Co.'s real estate investment department—now subsidiary Realty Investors Inc.—in Hartford, Conn., representing large corporations; and Robert L. Sinclair, then risk manager of the Metropolitan Government of Nashville and Davidson County, Tenn., representing a government entity.

Mr. Sinclair is now director of risk and insurance management at Vanderbilt University, also in Nashville.

No winner was named representing companies with less than $300 million in sales.

The 1984 Risk Management Honor Roll included: Sidney D. Blatt, risk and administrative manager of the Holloway Cos. in Wixom, Mich., representing corporations with less than $300 million in annual sales; and Gene Snyder, administrator of the Department of General Services' Risk Management Division for the state of Oregon.

No winner was named representing not-for-profit institutions.

The 1985 Risk Management Honor Roll included: Susan N. Weiner, executive director of the division of risk management for Dade County Public Schools in Florida, representing a government entity; and Eva F. Goodrich, manager of insurance and risk management for Cincinnati Electronics Corp., representing corporations with sales of less than $300 million.

No winner was named representing not-for-profit institutions.

The 1986 Risk Management Honor Roll included: Delmer Ison, risk manager for the Washington Metropolitan Area Transit Authority, representing government entities; and William E. Rogers, director of community health services and risk management for Conemaugh Valley Memorial Hospital, representing not-for-profit institutions.

No winner was named representing small companies or financial institutions.

To nominate a candidate for the 1987 *Business Insurance* Risk Manager of the Year Award, request a nominating form by writing: *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611.

Information supplied in the nominating statements, which must be endorsed by the candidate's superior, will be kept in strictest confidence. Only the names of the winners will be announced. ■

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Wyoming names regulator

CHEYENNE, Wyo.—A former president and owner of a multiline insurance agency in Wyoming says his experience as an agent is one of the assets he brings to the state insurance commissioner's post.

Gordon W. Taylor Jr., 38, took over as Wyoming insurance commissioner last month from Monroe Lauer, who had been serving as acting commissioner. Mr. Lauer was appointed by Gov. Ed Herschler to replace Robert W. Schrader, who resigned in March (*BI*, May 5).

"One of the things that I am bringing to the department is a working knowledge of the insurance industry," Mr. Taylor says.

"Frankly, I do believe we have an insurance crisis in this country and believe we need to work with insurance companies.

"A lot of communication is needed," he adds.

Mr. Taylor is a graduate of the University of Wyoming in Laramie, where he majored in English and social studies.

He taught junior high and high school for three years before operating a small chain of clothing stores.

Mr. Taylor became a licensed agent for Metropolitan Life Insurance Co. in 1974, and in 1977 he joined First Insurance Agency in Glenrock, Wyo., a multiline agency. Mr. Taylor bought the firm a year later and sold it in 1984.

Just prior to his appointment as insurance commissioner, Mr. Taylor had been a vp at Security Bank in Glenrock, where he was responsible for personnel and marketing.

Mr. Taylor also will continue to serve as one of three Converse County commissioners, an elected position, as well as insurance commissioner until his term as insurance commissioner expires in January, he said.

Mr. Taylor also is a director for the Glenrock Chamber of Commerce.

Mr. Lauer, who had been acting insurance commissioner since March, returned to his previous job as manager of the insurance section of the Wyoming Department of Administration and Fiscal Control. ■

INSTALLING A SYSTEM

Final steps in RMIS process are just as important as the first

By David A. Tweedy

FINALLY, THE arduous journey toward establishing a risk management information system is nearly over.

You have carefully identified your company's risk management information system needs through a methodical needs determination process. Through a comprehensive cost/benefit analysis and preliminary study, you have convinced senior management of the worth of the RMIS project.

Then, you have formed a needs identification committee to conduct extensive interviews, both inside and outside the company, to consolidate information flows, gaps and pressure points.

System specifications were designed to respond to the data and information needs procured in the preceding step.

Next, a carefully run bid project was conducted with outside RMIS vendors (including the corporation's own data processing department) to find the best response to your needs in hardware, software and personnel areas. A vendor was selected and is now ready to begin installation.

What's next? Is your work over? Certainly not!

Although you may be tempted to relax at this stage, it is now that you must continue to exert considerable energy to make sure that the risk management information system is implemented in the most expeditious fashion, yet with full adherence to the specifications and the assurance that your department employees have a full grasp of how to use the system.

Then, you must continue to monitor the development of the system as it is used over the next few months to ensure that any and all "bugs" are worked out of the system and that the vendor's service department is adequately responding to both small and large problems (and there will be problems).

The implementation—or system installation—phase should not be rushed. This is especially true for large, time-sharing/mainframe-based systems.

After all, you have just invested a lot of the company's money into this RMIS; be sure it is "plugged in" correctly.

No matter how sophisticated the system or responsive the vendor, a myriad of minor to major problems—which can easily be resolved during the implementation stage—could make your decision look disastrous to senior management if they are overlooked.

The key parts of the implementation phase are:

• Personnel training.

Your RMIS specifications should have included a section on your requirements for the vendor to train your department's personnel in operating the system—from data base input to ad hoc inquiries to full reports.

Most vendors will include this service within their proposal, but you should be sure that you are ask for it in your specification.

You need as much flexibility as possible, since you do not want to "sign off" on the system until you are certain that all presonnel—including data entry clerks, line or staff managers and yourself—can fully operate the new system.

Depending on the size of the RMIS, many vendors offer a variety of training courses.

With the larger systems, such as mainframe products and corporatewide systems, the client's system users will participate in weeklong (and sometimes longer) training programs at the vendor's site. Refresher courses are also offered as the vendors make changes in the systems they support.

Some vendors will train the system users at the client's location. Both methods have their advantages and disadvantages. But, whichever method is chosen, be certain that the vendor will provide a complete training program with "hands-on" use of the system.

The training program should focus on both familiarizing the users with how to operate the system as well as how to solve common problems that may arise during data entry or report generating functions.

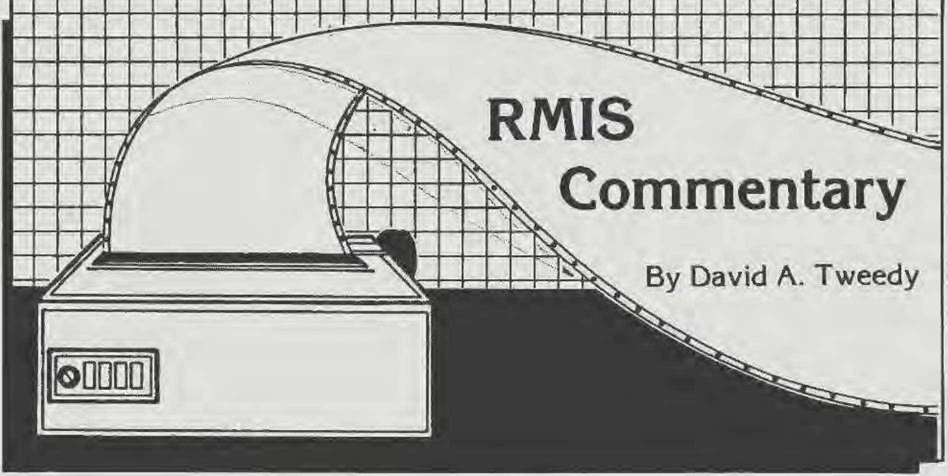
The old Chinese proverb of teaching the student *how* to fish rather than simply *giving* him the fish is quite applicable here.

• System testing.

The other key part of the implementation phase is the actual on-site installation of the equipment and communication lines.

Obviously, for stand-alone systems, the procedure will be less complex. The software is simply tested within the hardware environment. Ad hoc or standard reports should be run by the vendor in the presence of the risk manager and the support personnel who will use the system.

The more complicated setups—such as the time-sharing systems, especially those that use a personal computer to perform side analyses within the overall system structure—require much more testing.



Telecommunications hookups with a master data base located elsewhere in the country should be rigorously tested to ensure an accurate transmission.

And, much attention should be focused on any customized feature of an RMIS to be certain that all parts of the system are operating as requested by the specifications.

• Installation time.

Depending upon the size and complexity of the risk management information system, the length of time from the approval date to final system installation will vary. At this point, the needs identification committee can be assigned different responsibilities for the varied modules or sections of the system.

For example, one committee member might be assigned to the data base creation, another to the installation of the financial models, another to the report-writing section, etc. Each of the committee members would be interfacing with the technical personnel of the vendor (or the company's internal data processing department).

Time deadlines should be reasonable, given the complexity of the system, the needs of the organization and the capabilities of the vendor.

Flexibility is the key; meeting a deadline is not nearly as important as making sure that the installed system will work.

The risk manager must use his or her judgment as to the rigorous enforcement of the various phases of installation.

After the actual system installation, the final stage is monitoring the RMIS to be sure that it continues to comply with the needs of the organization. Generally, there are three sections to this phase:

• Appoint a system project manager.

After the system is installed, the needs identification/RMIS committee can be disbanded. However, a project manager should be appointed to act as liaison between the company and the vendor (or the internal data processing department).

This person could be the risk manager, but preferably should be a staff member with familiarity with computer systems in general and the organization's RMIS in particular.

System changes, either at the direction of the company or vendor, should be cleared through the project manager. He or she would have responsibility for training—or directing the training—of new system users. He or she also would be the focal point for questions on system operation.

• A responsive maintenance agreement.

Another essential element of the monitoring phase is a solid maintenance agreement with the vendor.

Again, this may be requested in the bid specification and provided for in the proposal of the vendor.

Usually, this maintenance agreement will provide a specified number of hours on troubleshooting (answering system problems), providing specialized reports and guaranteeing that any innovations by the vendor will be provided to the client, which may or may not be included in the original cost.

A telephone hot line, to be used in case of emergencies, should be established with the vendor.

Most of the large, well-known vendors have such a service available. This is a very valuable asset if the system is "down" for any number of reasons and the risk manager faces a deadline for getting a particular loss report to senior management.

• Join a user group.

Many vendors are starting to establish such groups for the clients as a forum for discussing problems, requesting system enhancement and the like (*BI*, July 28).

Solutions found by co-members of a user group may ease the frustrations experienced by other members. Therefore, a user group can be a good source of applied expertise.

Implementation and monitoring are very crucial stages of the RMIS process—as important as the needs determination or the system selection phases.

No matter how well the specifications were designed and the system planned, improper implementation and monitoring could damage the credibility of the risk manager in the eyes of his or her superiors.

Because most risk management information systems involve considerable investment in terms of time and expense, a careful watch on the system is necessary.

David A. Tweedy is a risk management consultant for D.A. Betterley Risk Consultants Inc. in Worcester, Mass. He is the assistant editor of Betterley Risk Management Commentary and the author of RMIS Update, a yearly publication analyzing major risk management information systems and vendors. His column on risk management information systems appears the third Monday of every month.

perspective

ASK A RISK MANAGER

Keeping senior management abreast of insurance issues

Do you use any special techniques to bring senior management into your renewal discussions?

The initial response I have to this question is that I would assume that senior management is well-aware of the insurance market conditions and would be understanding of problems you are encountering.

Upon reflection, however, based on some of our senior managers' attitudes toward "insurance expense," I can understand your concern and your question. I know I sometimes wonder if senior management hears me or if they just believe this insurance crisis is affecting others and not our company's insurance program.

While news articles are helpful, many are long, and you must dig in the story to find a point that will make the point you might be interested in getting across. I find that articles from non-insurance publications on the insurance crisis sometimes have better "attention-getting" appeal, particularly if I am trying to get a message across to operations managers. Taking the time to highlight just one good point in an article always helps.

Staff meetings are a good way to air one or two insurance marketplace problems, and it is always worthwhile to relate a story that brings in a neighboring corporation's experience. Some say this makes your points believable. These staff meetings don't always reach enough levels of management, so you may want to hit the finance/controller group in your company at budget time.

We issue a detailed budget booklet each year for each group and profit center (we call them divisions) within our company. The book contains all the expense details you are expected to provide: actual expense for the preceding year and estimates for the current year.

I begin the explanation of all these numbers with a "one pager" of notes I call "Insurance Marketplace." This year the title is "Insurance Marketplace—Year 2." This memo explains the commercial insurance environment in which we operate and buy our "insured" program. The emphasis this year is on insurance companies' financial results, the effect the reinsurance business has in the marketplace and some of the major catastrophe losses that insurers have paid.

I try to avoid leaving the one-pager on a negative note, so I promote the need for continued strong risk control and safety management at divisional and local levels, pointing out that attention to this effort influences, by far, the greatest dollar expense in the budget: the self-insured expense.

Risk management demands broad knowledge of business

Why should an insurance professional want to get into the risk management business?

This is a question that has been challenging 98% of risk managers, particularly for the past two years.

Risk management, as it relates to fortuitous-type losses, risk control, loss funding and insurance, is still an emerging profession. This may be reason enough for some to make it appealing. Ten years ago, it had little of the stature it has today. Twenty years ago it was in its infancy. Some say it still is in its infancy today. This makes it appealing to many. I know it did for me.

Over the years, most risk managers came into the "insurance buyers" or "insurance managers" profession via the ranks of an insurance company, agency or brokerage. The focus was on buying insurance—transferring the risk for a good price. Most of the time was spent on negotiating coverage forms—the traditional "terms and conditions" of insurance contracts.

For some, the insurance world may have become boring. The insurance business is controlled in many respects, static in its operations, and some believe it cannot stimulate a person's imagination. Insurance-oriented relationships seem to surround a person 24 hours a day.

Perhaps this is not the case today, since the traditional insurance environment has been taken over by frustration, inadequacies in the marketplace and new risk financing opportunities.

Risk management in its theoretical sense can be a daily stimulating challenge as you work in a business world of short-term, profit-oriented people. You are close to the operations and financial sides of your business and are concerned with a diversity of business operations.

Financially, it seems to operate from one quarterly statement to the next. Most people around you are concerned with increasing sales and revenues and are submerged in the marketing activity that surrounds this effort.

The risk manager fits into this environment by supporting the sales and marketing activities in an all-encompassing way—concerned and involved in all phases of the business. He or she must have an intimate knowledge of all businesses within the corporation.

The risk manager's involvement in every aspect of the business is necessary if the effort to identify and measure risk is to be successful. How else can you confidently give those risks a dollar value and determine if they should be assumed, funded or transferred to others?

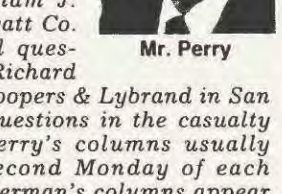
What other job offers this overall view of business activity?

This identification of the risk manager's job is just the beginning. We haven't touched on the activities surrounding the financial, claims, risk control and insurance management opportunities in risk management.

Would you like advice from an experienced colleague on a risk management, benefits management or actuarial problem? Four features in the Perspective section of Business Insurance can give you some answers.

Ask A Risk Manager, Ask A Benefit Manager, Ask A Benefit Actuary and Ask A Casualty Actuary answer written questions from readers on risk and benefits management issues and actuarial problems.

Mr. Perry



This month's column, on risk management issues, is written by Ralph F. Perry Jr., vp and director of risk management at Amfac Inc. in San Francisco. Joseph W. Duva, director of employee benefits at Allied-Signal Inc. in Morristown, N.J., answers benefit management questions. William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions on benefit issues. And, Richard E. Sherman, a principal with Coopers & Lybrand in San Francisco, answers actuarial questions in the casualty field. Mr. Duva's and Mr. Perry's columns usually appear alternately on the second Monday of each month. Mr. Miner's and Mr. Sherman's columns appear alternately on the first Monday of each month. Mr. Perry's next column will appear in October.

Address your questions to ASK, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. Please give us your name, title and employer; however, Business Insurance will consider unsigned letters.

Disability with dual cause compensable: Court

legal briefs

Workers compensation benefits are still allowed if a worker's disability has two causes, one related to employment and one unrelated, a Virginia appellate court says.

Carlton Shelton, while at work, moved a heavy floor jack and immediately suffered a pain in his right shoulder. He previously had suffered a rotator cuff tear in the same shoulder that he had not claimed to be work-related. After his doctor had operated and indicated a complete repair, Mr. Shelton returned to work on his doctor's advice, but on light-duty work. He was examined by a second treating doctor who indicated that the second injury was work-related. Mr. Shelton filed for benefits, but was denied.

On appeal, the court concluded that the Industrial Commission had confused two rules of law: The "two causes" rule and the "just as probable" rule. Under the former, the court said, if a disability has two causes, one related and one unrelated, benefits are allowed. Under the latter rule, compensation is denied for a claimant's failure to sustain the burden of proof when it is just as probable that the disability resulted from a non-work-related cause. The case was remanded for further proceedings. *Shelton vs. Ennis Business Forms Inc.*, Court of Appeals of Virginia, Sept. 3, 1985.

Exclusionary clause

A California appellate court ruled an exclusion in an "all-risks" insurance policy was not ambiguous and clearly excluded coverage for the mere disappearance of the policyholder's property.

Southern Insurance Co. issued an all-risks policy to Domino of California that excluded coverage for the mere disappearance of property or loss or shortage of property disclosed in taking inventory. In 1978, Domino received a shipment of 4,800 units of sweaters at its warehouse, consisting of 200 cartons valued at $86,400. Two weeks later, Domino's clerk discovered the sweaters missing. Despite a search, the sweaters were never found. Domino submitted a proof of loss on October 1978, asserting a loss due to theft and a claim for $81,400 (after taking a $5,000 deductible).

Southern paid under a reservation of rights provision and then brought this suit seeking a declaration that it was not liable. The trial court ruled that the exclusion applied. *Southern Insurance Co. vs. Domino of California*, California Court of Appeal, Oct. 22, 1985.

These abstracts were prepared by Cases Unlimited Inc. Copies of these decisions are temporarily unavailable.

Prop 51 isn't helping municipalities: Survey

SAN FRANCISCO—The market for municipal liability coverage is extremely tight in California, despite the passage of Proposition 51, according to an Insurance Department survey.

Commissioner Roxani Gillespie said Aug. 19 that 24 insurers and reinsurers have agreed to initiate or consider offering municipal liability insurance in view of the passage of Proposition 51, a ballot initiative that eliminates joint and several liability for non-economic damage awards in third-party liability suits.

But, of the 18 primary insurers responding to the survey, only two—Continental Corp. and Liberty Mutual Insurance Co.—said without qualification that they would begin offering municipal liability coverage. Of the remaining 16, five said they are considering entering the market, while the other 11 will enter the market but with restrictions.

Commissioner Gillespie said the department believes Proposition 51 will "be a positive factor" in restoring the erosion of the municipal liability market, but she acknowledged that the market remains very tight. "There seems to be some respite from unavailability, but nothing dramatic to report yet," Ms. Gillespie said.

California insurers were asked by the department in July to reevaluate their plans to provide municipal liability coverage in view of the passage of Proposition 51, the commissioner explained.

Ms. Gillespie said the department will work with representatives of governmental entities to determine whether "insurers are doing their share to ease the availability and affordability crisis in municipal liability insurance."

In June, the governor's office announced a legislative proposal that would give the Insurance Department authority to establish voluntary market assistance programs for lines of coverage that are not readily available in the market.

California probe

Continued from page 2

Insurers that received the subpoenas were specifically named by insurance buyers or brokers as possibly involved in the alleged boycott of the municipal liability market, Mr. Dove said.

While he would not disclose the exact contents of the subpoenas, Mr. Dove said they essentially ask whether the insurer was ever asked to write municipal liability coverage in California and, if it refused to do so, why.

Marialice Foley, counsel to American Insurance Assn. Inc. in San Francisco, said there is "absolutely no evidence" that insurers boycotted the municipal liability market in an attempt to gain passage of Proposition 51.

She said the insurance industry is "such an independent-minded industry that insurers make their own marketing decisions individually."

Ms. Foley pointed to large losses and a tight insurance market as the reason for the dearth of liability coverage for California cities and counties.

The California Insurance Department is not involved in the investigation, according to John Farber, deputy insurance commissioner. Mr. Farber said the department has seen no evidence "of any kind of a conspiracy or concerted action" with respect to a boycott of the municipal liability insurance market. ■

datebook

SEPT. 9. Loss Control and Safety—The Bottom Line in Risk Reduction seminar in St. Louis, sponsored by the Public Risk & Insurance Management Assn.; $110 for PRIMA members; $160 for non-members. **Also Nov. 6** in Binghamton, N.Y.; **Nov. 14** in Tampa, Fla. Public Risk & Insurance Management Assn., Suite 400, 1120 G. St. N.W., Washington. D.C. 20005.

SEPT. 9. Questions on the New CGL and CP Policies? Ask the Claims Department workshop in Chicago, sponsored by the Society of Chartered Property & Casualty Underwriters; $100 for CPCU claims section members; $12 for CPCU members; $150 for non-members. **Also Sept. 16** in Boston, **Sept. 18** in San Francisco. Mari Jennings, Society of CPCU, Kahler Hall, 720 Providence Road, Malvern, Pa. 19355.

SEPT. 9-10. Principles of Petroleum Insurance '86 workshop in Dallas,sponsored by Professional Developmenet Institute; $450. **Also Sept. 24-25** in Houston, **Oct. 28-29** in Oklahoma City, **Nov. 11-12** in Fort Worth, Texas.Professional Development Institute, P.O. Box 13288, North Texas State University, Denton, Texas 76203-3288; 800-433-5676; within Texas 817-565-2483.

SEPT. 10. Coping with COBRA seminar in Chicago, sponsored by the Illinois State Chamber of Commerce; $45 for ISCC members; $70 for non-members. Carol Jensen, Illinois State Chamber of Commerce, 20 N. Wacker Drive, Chicago, Ill. 60606; 312-272-7373.

SEPT. 10-12. The Latest Word in Workers Compensation conference in Bloomingdale, Ill., sponsored by the Ilinois Self-Insurers Assn.; $85 for ISIA members; $125 for non-members. Illinois Self-Insurers Assn., Suite 3200, 69 W. Washington St., Chicago, Ill. 60602; 312-630-4304.

SEPT. 10-12. Techniques of Risk Management course in Honolulu, sponsored by the Risk & Insurance Management Society; $445 for RIMS member; $545 for nonmember; $45 more if registered after six weeks prior to course. **Also Sept. 15-17** in Dallas and **Dec. 10-12** in Atlanta. Risk & Insurance Management Society, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

SEPT. 11. Understanding the Actuarial Hocus-Pocus workshop in Los Angeles, sponsored by the National Institute of Pension Administrators; $125. Linda Brady, National Institute of Pension Administrators, P.O. Box 15466, Santa Ana, Calif. 92705;; 714-250-8749.

SEPT. 11-13. National Conference and Trade Show on the Management of Health Data in Miami, sponsored by the Coalition Clearinghouse for Health Action (U.S. Chamber of Commerce); $425. Duane Busa, Management of Health Data Expo, 4104 Ponce de Leon Blvd., Second Floor, Coral Gables, Fla. 33146; 305-448-6242.

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City applications and supplemental qualification questionnaires must be recieved in the Personnel Office by 5:00 p.m., September 16, 1986. These forms may be obtained at the Personnel Services Department, 301 King Street, Room 2500, Alexandria, Virginia 22313 or by calling 703/838-4422.

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The current contract is self-insured and renewed annually on Jan. 1. The plan covers approximately 26,000 active and retired employes plus 42,000 dependents. The plan includes: hospitalization, professional services and major medical. Proposals must be submitted for self-insured (ASO) claim processing services.
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For further information and a copy of the specifications write or call: Wis. Group Insurance Board, P.O. Box 7931, Madison, WI 53707. Telephone: 608-266-0207. Completed bid proposals are due in this office by Friday September 26, 1986.

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Punitive awards

Continued from page 3

However, that decision, which did not address the burden of proof for punitive damages, expanded the circumstances under which plaintiffs can recover from insurers for bad faith (see related story).

In the Linthicum case, a tumor diagnosed as benign had been removed from one of Mr. Linthicum's parathyroid glands in September 1980.

Shortly after the diagnosis, Mr. Linthicum's wife obtained medical insurance that also covered her husband from Nationwide under a group policy purchased by her employer, Arizona Optical Co.

The policy excluded coverage for illnesses for which the insured received medical care or treatment 90 days prior to the effective date of the policy. During that period, Mr. Linthicum had visited his family doctor for blood tests on three occasions and received medication.

Shortly after the policy's effective date, Mr. Linthicum was found to have cancer of the parathyroid gland, and doctors concluded that the tumor discovered in 1979 had been malignant, not benign as earlier diagnosed.

Nationwide subsequently determined that Mr. Linthicum's claim should be denied because he had been receiving treatment for cancer during the 90-day exclusion period, even though the malignancy was undiagnosed at the time, according to court papers.

Mr. Linthicum subsequently required care at home and as a charity patient at a local hospital, and, in the opinion of his family doctor, became paralyzed because of a delay in treatment. Mr. Linthicum died in February 1982.

Following his death, Mr. Linthicum's wife sued Nationwide and Wagnon for breach of contract and bad faith.

Among the acts by the defendants that the suit alleged warranted punitive damages were:

- Sending a denial-of-claim letter to Arizona Optical, not directly to Ms. Linthicum, even though the insurer knew she no longer worked for that company.
- Not disclosing the medical basis for the denial.
- Investigating all dependent claims filed in the first year of coverage for potential denial.
- Not directly asking any of Mr. Linthicum's doctors whether they had treated Mr. Linthicum during the 90-day exclusionary period before issuing its denial.
- Strictly construing its policy against the policyholder.
- Refusing to provide Ms. Linthicum with a copy of the policy.

The trial court jury awarded Mrs. Linthicum $14,951 for breach of contract, $150,000 for bad faith and $2 million in punitive damages.

The state Court of Appeals affirmed the breach-of-contract and bad-faith awards but reversed the punitive damage award. The state Supreme Court granted review of the punitive damages.

In its decision, the high court said punitive damages should be based on a wrongdoer's "evil mind" and aggravated and outrageous conduct.

Past attempts by plaintiffs to win punitive damages have resulted in an "ambiguous, overboard list of catch phrases" from which attorneys can choose, the court said.

The court said these have included: malice, spite or ill will; evil intent or bad motive; gross negligence; wanton, reckless or willful acts; fraud; intentional misconduct; oppression; extreme, aggravated or outrageous conduct; reckless disregard for or indifference to the rights of others; criminal acts; and acts in bad faith.

"The numerous expressions of the conduct and mental state required for punitive damages has broadened its scope but loosened its impact," the court said.

Because the type of conduct justifying punitive damages should be limited to "consciously malicious or outrageous acts of misconduct where punishment and deterrence is both paramount and likely to be achieved," the court concluded a narrower standard for punitive damages is needed.

"The key is the wrongdoer's intent to injure the plaintiff or his deliberate interference with the rights of others, consciously disregarding the unjustifiably substantial risk of significant harm to them," the court said.

The court also found that a more stringent burden of proof should be required to obtain punitive damages.

"Therefore, while a plaintiff may collect compensatory damages upon proof by a preponderance of the evidence of his injures due to the tort of another, we conclude that recovery of punitive damages should be awardable only upon clear and convincing evidence of the defendant's evil mind," the court added.

The court found insufficient evidence of an evil mind to warrant punitive damages against the defendants in the Linthicum case.

"Admittedly, Nationwide does appear to construe its policy strictly in its own favor," the court said. "Investigating all dependent claims filed within the first year for potential denial and denying all claims upon any possible supportable basis is definitely not in the insured's interest.

"Nationwide follows a tough claims policy, but it is not 'aggravated, outrageous, oppressive or fraudulent,'" the court said.

It added that if it had been shown that Nationwide deliberately ignored the Linthicums' rights and needs, then punitive damages might have been awardable. However, the court noted that Nationwide had reviewed the file several times because of the gravity of the situation.

"While the petitioner may not be satisfied with the procedures utilized in these reviews, they do not appear to be designed to deny valid claims."

Attorneys last week agreed on the ruling's broad significance.

"It is one of the most significant opinions the court has issued in the last 10 years," said Mr. Stahl, who represents the insurer trade groups.

Punitive damages have become a very serious problem in Arizona, Mr. Stahl said, and the threat of punitive damages has resulted in settlement of cases for more than they are actually worth.

Nationwide and Wagnon's attorney, Mr. Kornblum, also said the decision was "very significant."

"These are very major victories," said Mr. Kornblum of the San Francisco firm of Kornblum, Kelly & Herlihy. "It's the most significant insurance law decision in the punitive damages area outside of California in the last 10 years."

The California court, however, has made it easier to obtain punitive damages.

Attorneys also said the decision may be, in part, a recognition of the need for tort reform.

The state Supreme Court is not immune from the political climate, Mr. Stahl noted.

Plaintiffs' attorney Mr. Myers observed that the decision could be a response to a "real or perceived" tort crisis. "That certainly is a reasonable conclusion that can be drawn," he said.

Mr. Myers, with the Phoenix firm of Hofmann, Salcito, Stevens & Myers, also noted that "the incentive for lawyers to take a small case is gone," because the possibility of a large punitive damage recovery is greatly reduced. ■

Court expands grounds for bad-faith awards

By STEPHEN TARNOFF

PHOENIX, Ariz.—While the Arizona Supreme Court has made it more difficult for plaintiffs to collect punitive damages, another ruling by the court makes it easier to recover compensatory damages from insurers for bad faith.

The high court ruled last month in *Rawlings vs. Apodaca* that payment of the limits of an insurance policy and the performance of other expressed promises does not insulate an insurer from liability for breach of the implied covenant of good faith and fair dealing.

The implied covenant is breached—whether or not the insurer pays the claim—when the insurer's conduct damages the very protection or security that the policyholder sought to gain by buying the policy, the court said.

The case concerned a homeowners policy with a $10,000 limit written by Farmers Insurance Co. of Arizona for David and Elizabeth Rawlings. The policy covered the Rawlings' hay barn, which was destroyed in a fire that was started by the Apodacas, neighbors who were negligently burning trash. The Rawlings' total loss was $40,000. The Apodacas were covered by a $100,000 liability policy, also written by Farmers.

Although Farmers paid the $10,000 to the Rawlings under their policy, the Rawlings alleged that Farmers did not cooperate in investigating the fire and in the Rawlings' pursuit of a claim against the Apodacas to recover the uninsured portion of the loss.

The Rawlings' suit alleged that the Apodacas negligently caused the fire and that Farmers breached its obligation of good faith and fair dealing.

The trial court awarded the Rawlings $1,000 in compensatory damages from the Apodacas and $50,000 in punitive damages from Farmers. An appellate court affirmed the compensatory award, but reversed the punitive award. It said that because Farmers had paid the Rawlings' claim in full and without delay, it could not be liable for punitive damages for bad faith.

However, the Arizona Supreme Court noted that an insurance contract and the relationship it creates contain more than the company's bare promise to pay claims when forced to do so.

"We hold, therefore, that one of the benefits that flow from the insurance contract is the insured's expectation that his insurance company will not wrongfully deprive him of the very security for which he bargained or expose him to the catastrophe from which he sought protection.

In addition, the court found that because of the special relationship between an insurer and a policyholder and because Farmers intended to interfere with the Rawlings' rights to recovery, it could be liable for tort damages.

Finally, the Supreme Court remanded to the trial court the issue of whether Farmers should be liable for punitive damages under the "evil mind" standard (see story, page 3).

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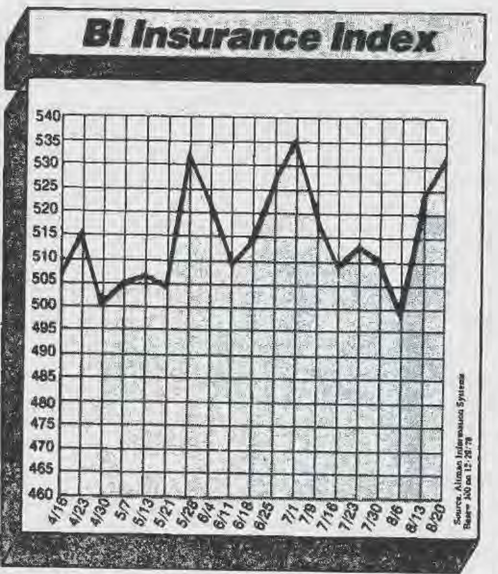

The *Business Insurance* index of insurance industry stocks continued to advance last week, closing at 531.6 points on Aug. 20, a 8.3 point jump. The *BI* index soared 24.7 points the previous week to close Aug. 13 at 523.4, up from 498.6 on Aug. 6. A total of 31 stocks posted gains, 21 declined and nine remained unchanged during the most recent trading period. Stocks posting the largest gains were: Aneco Reinsurance Ltd., up 33.3%; Tokio Marine & Fire Insurance Ltd., up 15.5%; Crown Life Insurance Co., up 10.4%; Selective Insurance Group Inc., up 9.5%; and Fremont General Corp., up 7.8%. Stocks that posted the biggest losses were: Great West Life Assurance Co., down 6.5%; General Reinsurance Corp., down 4.1%; Fairmont Financial Inc., down 3.9%; Arthur J. Gallagher, down 3.8%; and Zenith National Insurance Corp., down 2.7%. The major market indicators slightly outpaced the *BI* index's 1.6% average increase. The New York Stock Exchange composite advanced 1.6%, the Standard & Poor's 500 index climbed 1.7% and the Dow Jones 30 Industrials average surged 2.0% during the trading period.

British Issues

Aug. 19 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High-Low pence pence
Comml Union	308	23.7	18.3	5.9	314-305
Genl Accident	822	14.4	37.7	4.5	833-817
Gdn Royal Exch	827	15.9	46.5	5.6	832-818
Royal	822	11.6	42.2	5.1	831-814
Sun Alliance	667	22.2	28.2	4.2	667-653
Brokers					
CE Heath	495	7.9	38.0	7.7	505-495
Hogg Robinson	323	11.1	16.2	5.0	323-311
JH Minet	251	9.7	14.1	5.6	251-245
Sedg Grp	365	14.0	18.3	5.0	365-362
Stew Wrightson	423	13.4	19.0	4.5	433-423
Willis Faber	420	15.8	15.5	3.7	425-417

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

Second-quarter results confirm insurers' recovery is on track

By MYRON M. PICOULT

Special to Business Insurance

SECOND-QUARTER results for the property/casualty insurance industry continue to confirm the underwriting recovery that began to manifest itself in the first quarter.

Virtually all segments of the industry appear to be participating in the recovery.

Although written premiums continue to grow at a strong rate, earned premiums are now growing at a faster pace as previously initiated rate increases begin to work their way through the income statement.

Mr. Picoult

Notable is the fact that those underwriters that have been traditionally perceived as the "more quality-oriented entities" appear to be showing their colors.

Likewise, the stock market also seems to be placing somewhat more emphasis on these underwriters. We would expect this trend to continue.

As we have noted in several previous columns, we believe that the ingredients for a sustained recovery are present as long as key industry participants do not get carried away with their new-found and improving wealth.

The current level of profitability, while quite good when compared with prior years, is far from ebullient. It is fallacious to believe that a seven-year debacle can be corrected in 18 months.

Our review of major property/casualty insurance companies' second-quarter underwriting and operating results showed the following:

- Net written premiums among the 20 companies surveyed rose an average of 25.6%, which was a little below the first-quarter gain. All reporting companies posted net premium growth.

However, as was the case in the first quarter, there was a wide disparity in results. The percentage increases ranged from 1.8% for Kemper Group to 61.6% for American International Group Inc.

Nine companies were above the average gain and 11 were below the average. Approximately three-quarters of the companies recorded gains in excess of 20%.

- Earned premiums increased 27.3%. Unlike the first quarter, this increase outpaced the rise in net written premiums as the impact of prior rate increases begins to flow through insurers' income statements. This trend should continue for a while.

Seven underwriters' earned premium growth was above the average, while 13 posted below-average increases. Earned premium increases ranged from 7.6% at Fireman's Fund Insurance Cos. to 84.7% at AIG. These two companies also occupied the high and the low positions in the first-quarter survey.

- Pretax net investment income expanded an average of 17.5%. This was a tad stronger than the first-quarter gain.

Seven of the companies surveyed were above the average gain for the quarter, and 13 were below. The spread for the quarter ranged from a 4% decline in investment income at GEICO Corp. to a 67.3% gain at USF&G Corp.

Aftertax investment gains were lower as insurer managements continue to emphasize taxable instruments.

Cash-flow trends continue to show improvement. Most underwriters are now in a positive position.

Using what we have dubbed "the candy store approach," which calculates cash-flow as written premiums less underwriting expenses and paid claims, the only major underwriters in the minus column were CIGNA Corp. and Kemper. These companies were in the same position at the end of the first quarter.

- The surveyed insurers' aggregate combined ratio after policyholder dividends equaled 107.4% in the second quarter, compared with 116.4% in the second quarter of 1985.

This nine-point improvement compared with an 8.3-point improvement in the combined ratio in this year's first quarter.

Of the nine-point swing in the combined ratio, two points came from the expense ratio and seven points from the loss ratio. Nine underwriters posted second-quarter combined ratios that were better than average, and 11 posted ratios that were worse. However, both AIG and SAFECO Corp. were flirting with the 100% mark.

- The statutory premium-to-surplus ratio for the group was 2.43-to-1, while the reserve-to-surplus ratio equaled 2.79-to-1.

All of these ratios were virtually unchanged from the March 30 figures.

Loss reserves on average rose 18.1% and paid claims rose 3.2% in the quarter. The increase in reserves was a tad below the first-quarter number, while the paid-claim figure was materially lower.

The decline in paid losses in part mirrors a 63.7% decline in second-quarter catastrophe losses.

- Finally, property/casualty insurers' earnings continued to show significant improvement. In fact, all of the companies the we survey showed black ink for the quarter.

The only problem with the second-quarter results is that the "mortgaging" of some lines of business—the refusal to write certain lines— and some quasi-"redlining" is giving the industry a black eye. ■

Myron M. Picoult is senior vp and senior insurance analyst with Oppenheimer & Co. in New York. He is the past president of the Assn. of Insurance & Financial Analysts and a member of the New York Society of Security Analysts.

Aneco Reinsurance

Bermuda-based Aneco Reinsurance Underwriting Ltd. reported $3.4 million in net income for the first six months of 1985, compared with a $161,473 net loss in the first half of last year.

Premiums assumed declined 14.8% to $9.8 million in the first half of this year from $11.4 million in the first six months of 1985. Net premiums written dropped 7% to $2.7 million this year from about $9 million in the first half of 1985.

Trenwick Group

Trenwick Group Inc. reported net income of $1.5 million in the first half of 1986, compared with a $1.1 million net loss in the first six months of 1985.

Net written premiums totaled $23.9 million in the first half, a 124.4% increase over the $10.7 million in net premiums written in the first six months of 1985.

Westport, Conn.-based Trenwick's combined ratio improved to 110.7% in the first six months of this year from 141.2% in the first half of 1985.

TPA of America

TPA of America Inc. has filed a registration statement with the Securities and Exchange Commission for a public offering of $25 million in convertible subordinated debentures due in the year 2006.

The Los Angeles-based company will use proceeds from next month's offering to purchase a subsidiary of Northwestern Mutual Life Insurance Co., said David Adamoli, TPA of America senior vp and chief financial officer. He declined to identify the subsidiary.

TPA of America's first offering of convertible debentures will be underwritten by Bear, Stearns & Co. Inc., company spokesmen said.

FGIC Corp.

Net income at FGIC Corp., parent of municipal bond insurer Financial Guaranty Insurance Co., rose 108.5% to $17.2 million in the first half of 1986 from $8.2 million in the first six months of 1985 despite a decrease in gross premium volume.

Gross premiums written in the first half declined 16.1% to $64.1 million in 1986 from $76.4 million in 1985. However, net premium volume increased 9.1% to $56.9 million in the first half of 1986 from $52.1 million in the corresponding period of 1985.

Capital and surplus increased to $294.9 million as of June 30, compared with $207 million at year-end 1985.

In addition, the company has reported net proceeds of $104 million from a 4.6 million-share common stock offering made last month.

The company said it insured 35% of the estimated $8.6 million in new municipal issues offered during the first half. ■

BI Industry Stock Report

August 20, 1986 8/14/86 thru 8/20/86

Brokers		Price	% Chg.	P/E	$ Div.	% Yld.	High	Low	Vol.(000)
Alexander & Alexander Svcs	NYSE	39.00	0.3	260.0	1.00	2.6	39.38	38.88	309.8
Baldwin & Lyons Inc	OTC	24.00	0.0	30.8	0.16	0.7	32.00	24.00	0.3
Corroon & Black Corp	NYSE	36.75	-2.3	18.5	0.65	1.8	38.13	36.75	284.5
Crump E H Cos Inc	OTC	29.75	-0.8	23.1	0.25	0.8	30.25*	29.75	141.7
Gallagher Arthur J & Co	OTC	28.88	-3.7	23.3	0.20	0.7	30.00	28.88	152.8
Hall Frank B & Co Inc	NYSE	23.00	-2.1	0.0	0.00	0.0	23.63	22.50	138.6
Marsh & Mclennan Cos Inc	NYSE	69.75	3.0	24.6	1.50	2.2	69.75*	68.25	664.0
Poe & Assoc Inc	OTC	12.25	0.0	0.0	0.32	2.6	12.25	12.25	12.9
				=====		=====			
AGENTS/BROKERS	AVERAGE			-53.1		1.5			
Conglomerates & Holding Cos.									
American Express(Fireman's Fd)	NYSE	64.38	2.6	12.2	1.36	2.1	64.38	61.88	2,946.3
Anderson Clayton(Ranger/PanAm)	NYSE	55.88	0.0	31.9	0.00	0.0	0.00	0.00	0.0
Armco Inc	NYSE	6.88	-5.2	0.0	0.00	0.0	7.13	6.88	587.4
Berkley W R Corp	OTC	35.00	2.2	26.5	0.24	0.7	35.00	34.50	146.7
Berkshire Hathaway Inc Del	OTC	2990.00	0.3	727.5	0.00	0.0	3050.00*	2990.00	1.6
CIGNA Corp	NYSE	59.25	-0.6	0.0	2.60	4.4	60.75	59.00	1,976.4
CNA Finl Corp (CNA)	NYSE	63.63	-0.6	17.6	0.00	0.0	64.38	63.25	105.2
General Re Corp	NYSE	64.88	-4.1	28.2	0.88	1.4	67.50	64.88	731.2
ITT (Hartford Group)	NYSE	53.50	0.0	29.1	1.00	1.9	53.75	52.88	2,355.7
Sears Roebuck & Co. (Allstate)	NYSE	46.50	5.1	13.3	1.76	3.8	46.50	44.50	3,390.3
Teledyne Inc (Argonaut)	NYSE	321.75	-1.3	11.8	0.00	0.0	324.13	321.75	144.1
Transamerica Corp (Occidental)	NYSE	35.88	0.7	15.7	1.68	4.7	36.00	35.63	579.2
				=====		=====			
CONGLOMERATES/HOLDING COS.	AVERAGE			102.5		0.3			
Insurers									
Aetna Life & Cas Co	NYSE	62.25	-2.0	12.4	2.64	4.2	63.13	61.63	1,286.8
American General Corp	NYSE	41.50	1.2	12.4	1.12	2.7	41.50	40.38	849.9
Amern Heritage Life Invt Co	NYSE	41.63	-2.3	15.0	1.32	3.2	42.75	41.63	2.4
American Indty Finl Corp	OTC	17.50	2.9	0.0	1.12	6.4	17.63	17.25	16.1
American Intl Group Inc	NYSE	138.13	-0.6	22.5	0.44	0.3	140.50*	138.13	532.4
Aneco Reins Ltd	OTC	3.00	33.3	0.0	0.00	0.0	3.00	2.50	25.0
Avemco Corp	NYSE	31.13	0.8	16.4	0.50	1.6	31.38*	31.13	5.0
Business Mens Assurn Co Amer	OTC	27.75	2.8	22.7	1.10	4.0	27.75	27.25	19.9
Chubb Corp	NYSE	74.50	-1.0	55.6	1.56	2.1	77.00*	74.50	611.2
Combined Intl Corp	NYSE	58.75	-0.8	11.4	2.24	3.8	59.00	57.88	211.6
Continental Corp	NYSE	49.63	2.1	0.0	2.60	5.2	49.63	48.13	748.7
Crown Life Ins Co	OTC	375.00	10.4	3.8	6.40	1.7	375.00	375.00	0.0
Durham Corp	OTC	44.00	0.0	12.3	1.36	3.1	44.00	44.00	3.3
Farmers Group Inc	OTC	44.25	1.7	15.4	1.00	2.3	44.25	42.38	475.6
Fairmont Finl Inc	AMEX	18.63	-3.9	19.2	0.00	0.0	19.25	18.63	24.1
Fireman Fd Corp	NYSE	39.50	-0.3	0.4	0.30	0.8	40.13	39.38	583.5
Fremont Gen Corp	OTC	26.00	7.8	0.0	0.48	1.8	26.00	25.00	136.7
Great West Life Assurn Co	OTC	795.00	-6.5	8.0	18.00	2.3	795.00	795.00	0.0
Home Group Inc	AMEX	24.25	2.1	115.5	0.00	0.0	24.25	23.00	424.2
Hanover Ins Co	OTC	66.00	1.9	19.0	0.56	0.8	66.00*	64.75	43.0
Hartford Steam Boiler Insptn	OTC	49.50	2.6	27.8	0.84	1.7	49.50	48.63	103.4
Kans City Life Ins	OTC	33.00	0.0	13.0	0.87	2.6	33.00	33.00	12.2
Kemper Corp	OTC	32.50	0.0	14.8	0.60	1.8	33.25	32.25	827.0
Liberty Corp S C	NYSE	42.25	3.7	15.6	0.72	1.7	43.88	42.25	26.0
Lincoln Natl Corp Ind	NYSE	54.25	1.2	12.6	2.00	3.7	54.63	53.50	324.6
Mission Ins Group Inc	OTC	4.00	0.0	0.0	0.00	0.0	4.22	2.88	54.0
Monumental Corp	OTC	55.38	-0.2	18.7	0.00	0.0	55.50	55.13	28.9
Nac Re Corp	OTC	33.75	0.0	0.0	0.00	0.0	34.00	33.00	194.6
Nobel Ins Ltd	OTC	16.00	-1.5	21.1	0.37	2.3	16.50	15.88	67.5
Northwestern Natl Life Ins	OTC	30.25	2.5	11.2	0.86	2.8	30.88	30.25	324.1
Ohio Cas Corp	OTC	80.50	3.2	17.2	3.00	3.7	80.50	78.50	117.5
Old Rep Intl Corp	OTC	38.00	-1.6	12.7	0.78	2.1	39.50	38.00	260.7
Orion Cap Corp	NYSE	35.63	4.4	0.0	0.76	2.1	35.75	34.75	47.1
Protective Corp	OTC	21.88	1.7	11.8	0.70	3.2	21.88	21.50	117.4
Provident Life & Acc Ins Co	OTC	25.13	-2.0	9.2	0.84	3.3	26.00	25.13	379.8
St Paul Cos Inc	OTC	39.50	0.0	23.1	1.50	3.8	40.50	39.50	1,561.3
SAFECO Corp	OTC	63.00	2.4	15.0	1.68	2.7	63.13*	62.25	245.0
Seibels Bruce Group Inc	OTC	15.63	-3.1	0.0	0.80	5.1	15.75	15.50	21.3
Selective Ins Group Inc	OTC	23.00	9.5	0.0	0.92	4.0	23.00*	21.00	166.0
Statesman Group Inc	OTC	5.75	4.5	63.9	0.05	0.9	5.75	5.38	130.2
Tokio Marine & Fire Ins Co	OTC	604.50	15.5	113.8	1.66	0.3	604.50*	528.00	14.0
Torchmark Corp	NYSE	31.25	0.0	12.6	0.60	1.9	31.63	31.00	1,268.0
Travelers Corp	NYSE	46.50	1.1	11.6	2.16	4.6	47.38	46.50	1,212.2
Trenwick Group Inc	OTC	21.00	-1.2	0.0	0.00	0.0	22.00	21.00	132.2
United Fire & Cas Co	OTC	30.25	3.4	15.8	0.80	2.6	30.25*	30.00	31.6
United States Fid & Gty Co	NYSE	40.63	2.2	0.0	2.32	5.7	41.25	40.63	1,737.4
Uslife Corp	NYSE	44.25	0.9	11.6	1.12	2.5	45.50	44.25	137.6
Washington Natl Corp	NYSE	33.00	5.6	14.9	1.08	3.3	33.00	31.00	361.0
Zenith Natl Ins Corp	OTC	27.50	-2.7	47.4	0.80	2.9	28.25	27.25	159.3
				=====		=====			
INSURANCE COMPANIES	AVERAGE			9.3		2.0			

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