

business insurance

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POSA

New developments prod officials to step up probe

By LEN STRAZEWSKI

NEW YORK—Investigators are stepping up their probe of Promotora De Occidente de Panama, S.A. (POSA), a defunct Panamanian reinsurance intermediary, *Business Insurance* has learned.

The U.S. attorney's office and the state Insurance Department in New York are returning to the investigation of POSA with renewed vigor, based on new information.

POSA, which stopped doing business in 1980, served as a managing general agency for five foreign reinsurance companies that were fronting for pools of Eastern European, South American and African reinsurers. It was most active during the insurance capacity crunch of the mid-1970s.

The agency, with offices in Panama, Mexico, France, Spain and New York provided reinsurance for a variety of coverages, including long-tail casualty, workers compensation, credit and surety bond risks (*BI*, July 13, 1981).

The five fronting companies, Seguros La Republica S.A. and Reaseguradora Patria S.A. of Mexico, Asguradoa Mundial S.A. of Spain, Korean Reinsurance Corp. of South Korea and Adas Reinsurance of Romania, are now paying POSA-related reinsurance claims slowly if at all.

Investigators say they are digging deeper into the activities of POSA based on several new pieces of information:

- A sworn statement taken recently in Paris from POSA founder Pedro Reyner, former insurance commissioner of Mexico.
- A New York Insurance Department survey, still being com-

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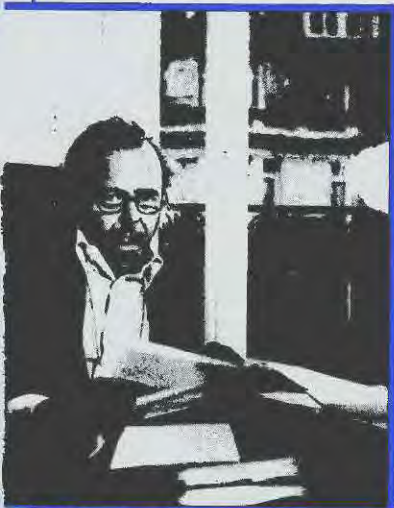


Photo: Karnew Intermediaries
Mr. Reyner

Policy covers withdrawal from multiemployer plans

By KATHRYN J. MCINTYRE

CHICAGO—Employers who are members of multiemployer pension plans can now buy up to \$1.1 million of insurance to cover their liabilities and legal expenses if they are forced to withdraw from the plan.

The new policy—pension plan involuntary withdrawal insurance—is being unveiled this week by the Chicago-based surplus lines broker NAS Ltd., which convinced underwriters at Lloyd's of London to offer the insurance.

NAS developed the policy at the request of a retail broker that has many clients that are members of multiemployer pension plans, especially in the coal and construction industries. It hopes to offer higher limits in the future.

NAS Chairman Sid Aronson says the product is designed to serve the needs of employers in all industries who are members of multiemployer plans.

The threat of huge liabilities incurred in an involuntary withdrawal from a multiemployer plan is "widespread and the problems are broad," Mr. Aronson says.

A union decertification or a drastic reduction in contributions to a plan as a result of events beyond an employer's control, including destruction of his business, could force an employer to involuntarily withdraw from a plan and create a withdrawal liability.

Pension plan involuntary withdrawal insurance provides two separate limits with their own deductibles to cover the employers' costs.

One limit and deductible apply to the withdrawal liability and the other limit and deductible apply to legal and actuarial expenses incurred in negotiating the withdrawal liability with the multiemployer

pension plan.

The limits available and deductibles are a function of the amount of insurance purchased for withdrawal liability. The limits available for withdrawal liability are \$100,000 to \$1 million (see chart).

The deductible for withdrawal liability coverage is 10% of the amount of withdrawal insurance purchased. The limit for legal and actuarial expenses also is 10% of the withdrawal liability limit while the deductible for that coverage is 1% of the withdrawal liability limit.

The base premiums listed in the chart will be increased or decreased depending upon the underwriters' assessment of the risk involved.

A policy that will reimburse \$1 million toward a withdrawal liability claim, after a \$100,000 deductible and 20% coinsurance, and \$100,000 toward legal and actuarial expenses with a \$10,000 deductible, will cost about \$11,500.

The 20% coinsurance, which applies only to the insurance of the withdrawal liability, can be eliminated for an additional premium of at least 25% of the base

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Policy limits and costs

Withdrawal insurance limit	Withdrawal insurance deductible	Legal & actuarial expense limit	Legal & actuarial expense deductible	Premium
\$ 100,000	\$ 10,000	\$ 10,000	\$ 1,000	\$ 2,875
250,000	25,000	25,000	2,500	5,750
500,000	50,000	50,000	5,000	8,050
750,000	75,000	75,000	7,500	9,625
1,000,000	100,000	100,000	10,000	11,500

Note: This table is an indication only. Actual quotations for limits, deductibles, co-payments, and premiums can be provided only after submission of a completed application.

Source: NAS Ltd.

\$5 billion in workers suits prompts inquiry

By EILEEN NORRIS

CHARLESTON, W.Va.—West Virginia employers are trying desperately to climb out from under an avalanche of employee lawsuits that has topped \$5 billion and is mounting daily.

Now they are pinning their hopes on a legislative commission to stop new employee lawsuits from being filed.

An effort to rescind the effect of a state Supreme Court decision that allowed an injured employee to collect workers compensation and still sue his employer in court failed during the last legislative session.

Meanwhile, the lawsuits just keep on coming. As of March, they totaled at least 250 (*BI*,

March 8).

Now, the Mandolidis Commission, named after the 1978 court case that sparked the controversy, is meeting to decide what judicial or legislative changes should be tried to help employers fend off the lawsuits.

"We have a problem of such gross proportion that something has to be done—and soon," says Frank C. Pulcrano, plant manager at ACF Industries in Huntington and a member of the 16-person commission of legislators and business and labor representatives.

The commission was appointed in March after two bills aimed at turning back the effect of the Supreme Court decision lost out under a legislative deadline.

In the Mandolidis case, the high court ruled that injured employees who receive workers compensation benefits also may sue their employers if they can show the employer's "willful, wanton and reckless disregard for safety" led to their injury.

Since that court decision, and especially in the last year, West Virginia employers have been deluged with lawsuits from injured workers who collect workers compensation and then seek additional compensation through the courts.

"We need to find a change in the law that will be supported by labor and business," said John McClaugherty, an industry attorney named to the commission.

But first the group has to evaluate the

exact impact of the Mandolidis case.

And that is proving to be a monumental task, says Mr. Pulcrano of ACF Industries.

One of the major stumbling blocks facing the commission is finding out exactly how many lawsuits have been filed to date, says the West Virginia Business & Industry Council.

Because the suits are filed in state and federal courts all over West Virginia and because some employers would rather quietly settle out of court, there is no one clearinghouse pulling all that litigation information together, says Pat Gallagher, manager of government relations with ACF Industries, a manufacturer of railroad cars.

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Underwriting losses catching up with major U.S. insurers
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Recall can help firm in product liability case
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update:

Manville files for reorganization

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Bankruptcy Act in U.S. Bankruptcy Court for the Southern District of New York. The petition stays all asbestos litigation against the company, which is facing more than 16,500 lawsuits.

In filing the petition, Manville blamed its liability insurers and the federal government for its situation, contending that it was not due to financial failure on the part of the company.

"The Chapter 11 (petition) might not have been necessary if the government had accepted financial responsibility for its role in causing much of the disease, or if our insurance carriers were reimbursing us on a current basis," Manville President John A. McKinney said in a prepared statement.

The petition comes just four weeks after UNR Industries Inc., another major asbestos defendant, filed a similar petition (BI, Aug. 9). The decision by Manville's board came after review of a report by an outside consultant that estimated the company could face 52,000 lawsuits and more than \$2 billion in liability.

The company is also battling with its insurers in California and Massachusetts over the interpretation of comprehensive general liability policies that will determine who will pay for asbestos claims.

As a result of the Chapter 11 petition, the company is seeking an additional \$5 billion in damages in the California litigation.

Earlier this month, Manville omitted its quarterly dividend.

The company emphasized it will continue to do business, and the petition will not affect employees' jobs, pay or benefits.

Slight change added to tax bill

WASHINGTON—The new tax bill is law, but Congress made a last-minute change in approving it Aug. 19 to give employers more time to comply with a key provision.

Congress altered a section that would have required employers to mail notices by Nov. 1 to retirees asking if they want taxes withheld from their pension benefits beginning next year (BI, Aug. 23). Under the final bill, employers are expected to mail withholding notices as soon as possible. As a practical matter, benefit experts say the notices should be mailed before the end of the year.

Bogardus also to head Howden

LONDON—The chairman of New York-based Alexander & Alexander Services Inc. says he will be spending half his time in London in an effort to tighten financial controls at London-based Alexander Howden Group P.L.C.

A&A last week announced a series of key management shifts that puts Mr. Bogardus more directly in charge of the Howden subsidiary.

In the Aug. 25 announcement, A&A said Mr. Bogardus, 54, chairman and chief executive of A&A, would take additional titles of chairman and chief executive of Howden and its subsidiary, Alexander Howden Underwriting Ltd., which manages 17 Lloyd's of London syndicates.

Mr. Bogardus replaces Kenneth V. Grob, 61, who resigned from both the A&A and Howden boards. Stock market analysts described this move as expected because Mr. Grob is past the customary British retirement age of 60. He will, though, be a Howden adviser.

A post-acquisition audit by A&A of Howden revealed both unexpected assets and liabilities in the books of its underwriting operations, A&A disclosed earlier this month (BI, Aug. 23).

"As a result of the audit, I felt I should have tighter controls on Howden's financial arrangements," Mr. Bogardus said.

A&A also said Michael J.A. Glover, 51, previously Howden's chief executive, will take the newly created title of chief operating officer and will report directly to Mr. Bogardus. In a third shift, A&A said Alan J. Page, 63, Howden's treasurer, has resigned and will serve as an adviser to Howden. No one was named immediately to replace Mr. Page as treasurer, but A&A said Ronald J. Berardi, 37, A&A's treasurer, will move to London as Howden's chief financial officer, retaining his A&A job for now.

Also, Ian R. Postgate is now deputy chairman of Alexander Howden Underwriting Ltd., replaced as chairman by Mr. Bogardus.

Finally, Tinsley H. Irvin, 48, who is chairman, president and chief executive of A&A's North American operating subsidiary, Alexander & Alexander Inc., and chief operating officer and president of the parent, was named to the Howden board.

P&G settles Rely suit

DENVER—Procter & Gamble has settled out-of-court the first Rely tampon product liability suit to come to trial. A retrial of the suit brought by plaintiff Deletha Dawn Lampshire was set to start last week.

Both sides requested the retrial after a federal jury ruled in March that P&G had sold a defective product and was negligent in marketing it, but awarded no damages to the plaintiff. Ms. Lampshire had asked for \$25 million in damages arising from her bout with toxic shock syndrome (BI, March 29).

Neither side would disclose terms of the settlement.

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PBGC burdens easing

Two of Braniff's plans could be mostly funded

By JERRY GEISEL

WASHINGTON—Braniff International Corp. may never fly its planes again, but the company's collapse isn't going to ground the Pension Benefit Guaranty Corp., as some had feared.

Braniff, which told a bankruptcy court this month that it intends to terminate its four pension plans, says two plans covering pilots and management employees may have enough assets to pay most of the promised benefits.

As a result, the PBGC, the federal agency that guarantees workers' pension benefits, may only have to bail out Braniff's two underfunded pension plans covering members of the Machinists and Teamsters unions.

This could cost the PBGC about \$37 million, half the \$70 million in liabilities it had predicted it might incur if Braniff terminated all four plans (BI, May 24).

That reduction is good news for the PBGC, which has seen its deficit rise sharply as more companies fold their pension plans during the current troubled economy.

And it's also welcome news for employers that eventually pay PBGC's deficits through higher pension termination insurance premiums. That premium, now \$2.60 a year per plan participant, already is set to

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Oklahoma firm may trade profits for plan termination

TULSA, Okla.—A 6-year-old Oklahoma-based automotive parts manufacturer will risk forking over a share of future profits to a federal agency to terminate a badly underfunded pension plan.

The high cost of terminating its pension plan, however, should discourage other companies from trying to do the same thing, experts say.

Facet Enterprises Inc. agreed this month to pay the Pension Benefit Guaranty Corp. about \$14 million over the next nine years to settle a 3-year-old dispute with the federal agency that guarantees workers' pension benefits.

Facet also agreed, beginning in 1986 and continuing through 2003, to give the PBGC a share of its annual profits any time they exceed \$250,000.

Every year profits exceed \$2,674,000, Facet will have to pay the PBGC \$1.2 million. That is the largest payment it will ever make, no matter how high profits may be in any year.

If Facet's profits are more than \$250,000 but less than \$2,674,000, its annual payment to the PBGC would range from \$125,000 to about \$1 million; the exact amount would depend on Facet's profits each year. Supplemental payments wouldn't be required if Facet's pretax profits slipped below \$250,000.

Last year, Facet's profits, before a special tax credit, were \$1.2 million.

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Lloyd's 1979 global results

(in thousands of U.S. dollars¹)

	Net premium income	Claims	Profit ²	Profit margin
Marine	1,728,429	1,680,439	149,769	7.01%
Aviation	407,757	411,822		
Non-marine	2,446,405	2,473,949	119,350	4.88%
Motor	418,388	370,571	32,855	7.85%
Short-term life	3,090	2,303	713	23.06%
Total	5,004,069	4,939,084	302,687	6.05%

¹Conversion rate: 1 pound:\$1.75

Source: Lloyd's of London

²After other income, including investment income and currency gains, and expenditures.

Lloyd's relies on investment income

By STACY SHAPIRO

LONDON—Lloyd's of London members are making very little profit from underwriting, according to Lloyd's recently released 1979 global results.

All three major Lloyd's markets—marine, non-marine and aviation—suffered pure underwriting losses during the 1979 accounting year.

Yet despite the horrendous underwriting results, Lloyd's members still made a combined profit of almost 173 million pounds (approximately \$302.7 million), only 2 million pounds (\$3.5 million) less than in the 1978 accounting year. The profit was mainly attributed to

investment income.

According to the 1979 results:

- Underwriting losses in the Lloyd's marine market hit a 10-year high. Claims rose to 960.3 million pounds (\$1.68 billion), while net premium income increased to 987.7 million pounds (\$1.72 billion).

Although the marine market's loss ratio stood at 97%, when considering other expenses "the final net result shows a pure underwriting loss for the first time in more than 10 years," said Malcolm Rumsey, chairman of the Lloyd's Underwriters' Assn.

- Underwriting losses soared for the second consecutive year.

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Laws in N.Y., Massachusetts may reduce Blues' advantage

By JAMES C. LAWSON

NEW YORK—Employers in New York and Massachusetts will have more flexibility in funding and designing their health benefit plans while possibly paying less for them under new legislation that prescribes how hospitals should budget and bill.

The new laws in both states will require hospitals to operate within a set budget and charge all payers—Blue Cross, commercial insurers, self-insurers, Medicaid, Medicare and individuals—more equitable rates for hospital services.

In Maryland, hospitals have been budgeting prospectively for eight years with positive results, and Maine and West Virginia are considering similar legislation (see story, page 28).

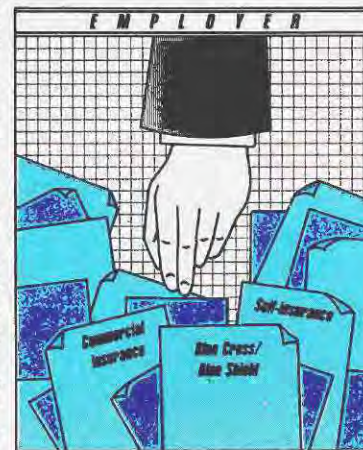
The New York and Massachusetts laws will offer employers more flexibility by gradually reducing or possibly eliminating the discounts on hos-

pital fees Blue Cross now enjoys. It has been able to negotiate lower rates than commercial insurers and self-insured companies because of historic ties with hospitals.

But with such discounts reduced or eliminated, employers would not be forced to choose Blue Cross to underwrite their health plans simply because its rates are lower. Without the discounts, Blue Cross premiums might not be that much less than those charged by commercial insurers or the cost of self-insuring.

The new laws also would mean that Medicaid and Medicare, which now reimburse hospitals at levels less than the cost of services, would pay the same fees as commercial insurers and self-insurers. This would eliminate cost shifting to third-party payers, who now pay more for hospital services to make up for what the federal programs don't pay.

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Graphic: Amy Palmer

RISK MANAGER OF THE YEAR AWARD

RISK MANAGEMENT HONOR ROLL

CANDIDATES NAME _____

Put a risk manager on the cover of BI

CHICAGO—Put the risk manager you admire most on the cover of the April 25, 1983, issue of *Business Insurance*.

The 1983 *Business Insurance* Risk Manager of the Year will be featured in that issue, which will be distributed at the annual Risk & Insurance Management Society Conference in Los Angeles.

To nominate a candidate to receive the Risk Manager of the Year award, request nominating forms from the Chicago office of *Business Insurance*.

All nominations must be received by Dec. 6.

The Risk Manager of the Year Award is sponsored by *Business Insurance* to increase recognition of the risk management profession and to recognize outstanding performance in the practice of risk man-

agement. The competition is judged by a panel of 10 independent judges.

Business Insurance created the competition in 1977 on the 10th anniversary of the magazine, and the first award was presented in 1978 to Howard T. Weber, director of insurance at 3M Co. in St. Paul, Minn.

Other winners of the award have been:

- Edward L. Erickson, director of insurance at American Broadcasting Cos. Inc. in New York in 1979.

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

- Duane C. Allen, assistant treasurer of Hanna Mining Co. in Cleveland in 1981.

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

The Risk Management Honor Roll was created in 1980 and the first Honor Roll was named in 1981 to recognize outstanding risk managers facing different challenges.

The Risk Management Honor Roll in 1981 included: Robert Bieber, then risk manager of Westchester County, N.Y., representing government entities; and William Ryan, insurance and risk manager of the University of Michigan in Ann Arbor, representing not-for-profit institutions.

The Risk Management Honor Roll in 1982 included: Spencer J. Traver, assistant treasurer of BFGoodrich Co. in Akron as runner-up; George N. Pierce, risk manager of Orange County, Fla., representing government entities; Paul B. Harvey, risk

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Underwriting losses starting to catch up with large insurers

By BILL DENSMORE

NEW YORK—Commercial property/casualty insurers, already wallowing in an ocean of scarlet-colored underwriting ink, appear to be heading for even rougher seas.

This year could be the first since 1975 that operating earnings sag.

The financial results posted by property/casualty insurers for the first half of 1982 showed no apparent relief for an industry feeling the effects of low rates and high underwriting losses.

In fact, analysts suggest that a risk manager faced with a variety of cheap renewal quotes should make sure that the chosen underwriter has the financial strength to remain solvent should investment income gains and premium volume growth continue to decline.

A *Business Insurance* survey of the first-half results of 25 leading property/casualty insurers shows:

- An aggregate 13.2% decline in operating earnings compared with the first six months of 1981. Assuming a first-half to second-half pattern similar to 1981, insurers' operating earnings could be down at least 10% at year-end.

- Aggregate underwriting losses for the surveyed companies reached \$2.03 billion, more than double the \$1.01 billion underwriting loss during the first half of 1981.

- The average combined ratio (after policyholder dividends) hit 109.3%, up 5.7 percentage points from 103.6% at the end of the first six months of 1981.

- Investment income rose to \$2.61 billion, up 14.8% from \$2.27 billion.
- Of the 24 companies reporting both written and earned premiums, written premiums rose a stingy 3.2% and earned premiums crept ahead 2.5%.

"Sorry, bad news!" wrote Crum & Forster executives when they reported a 29.6% decline in operating earnings to their shareholders for the first six months of the year.

BI ticker

The news was just as bad if not worse at other large property/casualty insurers. Large declines in operating earnings were posted by Chubb Corp. (52.3%), USF&G Corp. (39.3%), CIGNA Corp. (37.5%), The Continental Corp. (36.8%), The Hartford Insurance Group (24.2%), The Travelers Corp. (19.0%) and Kemper Corp. (11.7%).

Although these reports look terrible on the surface, there were some bright spots. For example, analysts are pleased by CIGNA management's drive to trim its earnings decline to 28.9% in the second quarter after a disastrous 49.3% first-quarter plunge. The analysts say they expect the results of the company, the product of a merger between INA Corp. and Connecticut General Corp., to stabilize by the end of the year.

And a handful of companies bucked the trend and reported sizable earnings gains.

Contributing to the huge loss figures were \$1.17 billion of weather-related catastrophe losses during the first half of the year, compared with \$715 million in such losses for all of 1981.

The American Insurance Assn.'s property claims services unit says catastrophe losses for an entire year have only exceeded \$1 billion twice since 1949. The previous record for a six-month period was \$620 million in 1974.

Three storms added another \$25 million in catastrophe losses during July and the first 20 days of August, according to the AIA, which defines a catastrophe loss as any single event resulting in at least \$5 million in insured losses.

A typical management view of the year so far was expressed by Donald R. Frahm, executive vp for property/casualty operations at The Hartford Insurance Group.

"For the next year or so we're going to continue to have a very competitive commercial marketplace," says Mr. Frahm, who adds that The Hartford had to ease attempts to raise rates because premium volume declined more than desired.

"We found our relationship with our agents was going the wrong way,"

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ARIA meeting

Product recalls can cut judgments, study shows

By
RHONDA L. RUNDLE

DENVER—A manufacturer that rapidly recalls a faulty product favorably impresses jurors who later hear product liability charges against the company, a mock trial study shows.

The findings should allay concerns of manufacturers that have hesitated to recall products they believed to be safe because they feared such action would prejudice jurors against them in subsequent product liability court battles.

"Product recalls can save (damage) money and win consumer confidence," summed up John C. Mowen, a professor of social psychology at Oklahoma State University in Stillwater, who presented his research results at the American Risk & Insurance Assn. meeting.

He noted that the study has profound implications for consumer products manufacturers like Procter & Gamble, which voluntarily recalled its Rely tampon. The company now faces more than 400 Rely lawsuits filed in courts around the country.

Mr. Mowen's research also tested a specific defense closing argument to see if it would reduce damage awards. Earlier studies have shown that initial high-damage requests by plaintiffs pull up jury judgments. Mr. Mowen hypothesized that a specific defense argument might break this so-called "anchor" effect.

"We asked mock jurors to make up their own

DENVER—University professors of risk management and insurance convened Aug. 15-18 at the Fairmont Hotel in Denver to honor the 50th anniversary of the American Risk & Insurance Assn.



About 230 ARIA academic and industry members attended the annual meeting devoted to presentation of scholarly research papers, discussion of insurance industry issues and a special tribute to ARIA founder and promoter of insurance education, Solomon S. Huebner.

Founded in 1932 as the American Assn. of University Teachers of Insurance, the organization now boasts more than 2,000 members and subscribers to its official publication, the *Journal of Risk and Insurance*.

A complete report on the ARIA meeting by Los Angeles Bureau Chief Rhonda L. Rundle continues on page 10.

minds about the damages—not to start with the figure the plaintiff requested," said Mr. Mowen.

Trying to counteract a plaintiff's damage request is tricky, the outcome showed. There was some tendency for damages to rise when no recall was made and the argument was used, said Mr. Mowen. But the results do not show a clear result.

Forty juries were used in the study, made up of registered voters in the Oklahoma. Each volunteer received \$10, which they contributed to civic groups that recruited them for the study.

The participants were asked to complete a questionnaire, which contained demographic and personal questions. The volunteers were assigned to six-person juries.

They were taken to private rooms where they listened to a 30-minute audio tape of a trial. The facts were deliberately construed so that the jurors

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Computers can simplify bid process

DENVER—A \$2,500 investment in a microcomputer and appropriate software can help a risk manager drive home his point in the corporate boardroom.

Simple computer models illustrate the bottom-line impact of losses under varied risk funding and loss assumptions to top management in a clear, understandable format.

"We present complicated issues like bid quotes and retro analyses to groups of managers—and we want to do so without being patronizing or blurring the importance of our results," observes Joseph F. Casey, corporate risk manager for A. Duda and Sons Inc., an agribusiness located outside Orlando, Fla.

Mr. Casey and David R. Klock, a professor at the University of Central Florida in Orlando, have developed a number of microcomputer applications to risk management, which they presented at the recent meeting of the American Risk & Insurance Assn. in Denver.

"We come to you with a new toolbox, not a set of

new theories," noted Mr. Klock. Computer programs that the alphabet brokers have spent thousands of dollars to develop can be replicated on an Apple computer using Visicalc software in about 30 minutes, he added.

Mr. Klock said the Apple microcomputer he used cost about \$2,300 and the software another couple of hundred dollars. More powerful Apples and other microcomputers have greater memory capacity and potential to perform more sophisticated analyses than those presented by Mr. Klock and Mr. Casey.

One application discussed by Mr. Casey demonstrates the effects on workers compensation insurance by employing workers overtime, adding a second production line or using new vs. senior employees on a job.

"The standard premium may go up 10% due to production line expansion," noted Mr. Casey.

But what if top management wants to know the impact on workers compensation costs of other po-

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2 Braniff plans funded

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rise to \$6 on Jan. 1, pending congressional approval. Braniff wants to terminate the management and airline pilots' pension plans as soon as possible.

But those plans probably have enough assets to enable Braniff to buy annuities that would pay for "significantly" all of the participant's vested benefits, said Braniff Senior Vp Sam Coats.

The Teamsters' and Machinists' plans, however, are so underfunded—liabilities exceed assets by at least 3-to-1—the PBGC will have to take them over.

But when it does, vested participants are not going to receive everything that Braniff promised.

Braniff substantially increased benefits, as a result of collective bargaining agreements, but the PBGC under federal law does not fully guarantee benefit hikes made within the last five years.

The agency phases in its guarantees of benefit improvements at a rate of 20% per year. For example, if a company increased its pension benefits by \$5 a month so that a worker retiring this year received \$25 a month for each year of service instead of \$20, the new higher benefit wouldn't be fully guaranteed

by the PBGC until 1987.

The PBGC limits its guarantees of benefit improvements to protect the agency from employers that might otherwise dramatically increase benefits and then decide to terminate their plans, dumping the liabilities on the PBGC.

In the Braniff Teamsters' plan, which has about 2,500 vested participants, benefits were almost doubled in 1979 so that a person retiring that year received \$15 a month for each year of service, up from \$8.35. Since then, benefits have been raised to \$22 a month. Similar increases were added to the Machinists' plan with 1,760 participants.

These recent benefit hikes are a major reason why the Machinists' and Teamsters' plans are underfunded. Under the Employee Retirement Income Security Act, employers don't have to fund benefit improvements immediately.

According to a preliminary actuarial statement, the average monthly pension benefit now received by a retired Braniff Machinist is about \$480. The average benefit collected by a retired Teamster is between \$350 and \$430 a month.

The PBGC and Braniff say they don't know yet how much benefits will be reduced when the PBGC takes over the pension plans.

Facet trades profits to end pension plan

Continued from page 2

In return for the \$14 million in guaranteed payments and the possible profit payments, which together could total as much as \$35 million, the PBGC will take over Facet's pension plan. While the plan has \$33 million in liabilities, the PBGC, under the law, would be liable for only \$19 million in benefits to Facet employees and retirees that vested.

The settlement, which still must be approved by a federal judge, is a victory for both sides.

Facet can escape a mountain of pension liabilities, which were a serious drain on corporate profits. It believes it will slash its annual pension expense by about \$2 million when it turns the plan over to the PBGC and sets up a new one for hourly employees.

On the other hand, the PBGC escapes a possible court decision that would have encouraged other em-

ployers to dump their underfunded pension plans onto the agency, saddling it with billions of dollars in liabilities that would have bankrupted its insurance program.

Because of its dramatic implications for employers and the PBGC, the Facet case became a cause celebre in pension circles.

It began in 1974 when the Federal Trade Commission forced Bendix Corp. of Southfield, Mich., to reduce its operations in the automotive parts industry on antitrust grounds.

As a result, Bendix created a new company—Facet Enterprises Inc. Bendix unloaded \$70 million in pension liabilities on Facet, but transferred just \$18 million in pension assets.

Facet later sued Bendix and in 1979 Bendix agreed to turn over another \$15 million in pension assets to the young company.

But that still left Facet with more than \$30 million in pension liabilities. And Facet said it could not afford to pay for those liabilities.

"Our situation is unique in American business history," said Facet President James R. Malone. "The federal government was responsible for creating a situation that we could not live with. No other companies had to start out with these kind of liabilities."

As a result, Facet tried to shut down its pension plan, transfer the liabilities to the PBGC and start a new plan that it could afford.

But the PBGC refused to accept the termination, which would have added millions of dollars in liabilities to the PBGC's debt.

In an April 24, 1980, letter to Facet attorneys, Robert Nagle, then executive director of the PBGC, said the purpose of the pension insurance program is to protect workers' pensions, and not to provide bail outs for financially pressed firms.

Mr. Nagle warned that if Facet were allowed to shift its liabilities to the PBGC and begin a new retirement plan free of debt, other corporations with huge pension liabilities would follow suit.

"The consequences of our acceptance of the type of proposal you are advancing could be either a huge shift of pension costs to PBGC's premium payers, or the total collapse of the insurance system," Mr. Nagle wrote.

Facet then sued the PBGC in federal court, asking the court to order the PBGC to recognize the termination. Facet also lobbied for congressional support.

At the same time, Facet and the PBGC tried to come to terms out of court, but negotiations reached a standstill.

Facet's Mr. Malone said the PBGC's Mr. Nagle wouldn't negotiate. Mr. Nagle said the negotiation avenue was open, but Facet only offered about half of what the agency thought was needed to settle the case.

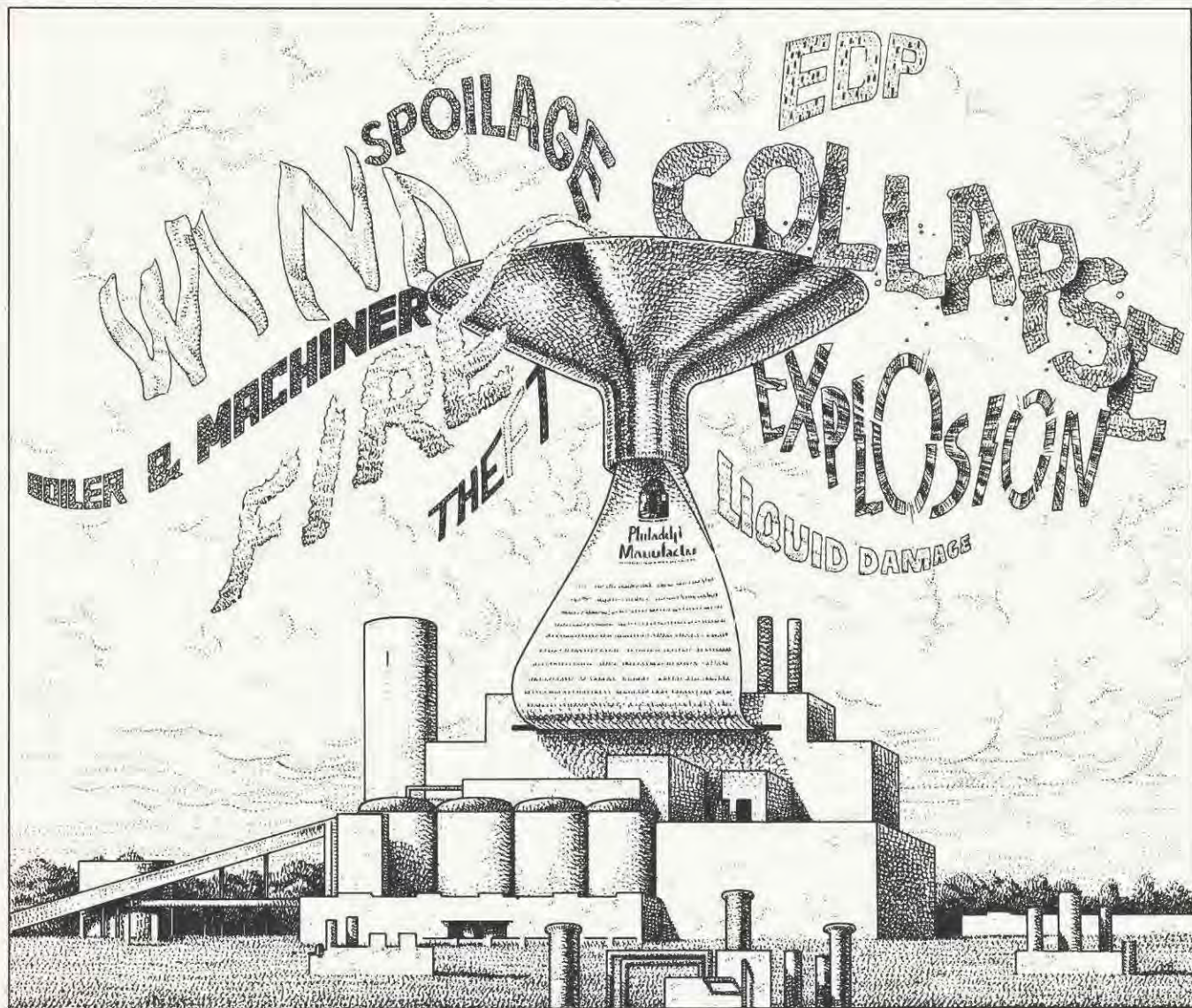
Negotiations got on a fast track when Mr. Nagle left and was replaced by Edwin Jones, a New York pension and tax attorney.

"Mr. Jones believed we were sincere and that we wanted to remain a viable economic entity. He wanted this settled," Mr. Malone said.

But according to Mr. Nagle, Facet agreed to pay a lot more than they were willing to initially. Facet's Mr. Malone said its bargaining stance was to structure an agreement it could afford and to minimize the risk that the PBGC would have to pay anything.

Mr. Jones described the settlement as fair "in terms of what they will have to pay and what we will receive." The high settlement cost should discourage other firms that may be considering dumping their pension liabilities onto the PBGC, Mr. Jones said.

—By Jerry Geisel



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AMA to hold risk management, benefit meetings

CHICAGO—The second-largest gathering of risk and employee benefit managers from around the country, the American Management Assns. National Conferences, will be held Sept. 20-22 in Chicago.

The 39th AMA meeting, which attracts more risk and benefit managers than any other gathering except the annual Risk & Insurance Management Society Conference, is "designed to keep people current—both new and experienced risk and employee benefit managers," said Richard Hackenbush, vp of the AMA's Insurance & Employee Benefits Council and staff vp and assistant treasurer of Allegheny International Inc. in Pittsburgh.

"The conference says a lot to the small and medium-sized companies, not just to large companies." The gathering is actually two meet-

ings held simultaneously: The National Conference on Risk & Insurance Management and the National Conference on Employee Benefits Management.

The risk and insurance management conference will begin on Monday, Sept. 20 with a keynote presentation entitled "The Insurance Industry and its Increasing Relationships to Banking and Financial Institutions" by Charles A. O'Malley, chairman and president of Fred S. James & Co. Inc. in New York.

Later that morning, W.N.M. Lawrence, deputy chairman of Lloyd's of London, will discuss the effect of the recently passed Lloyd's self-regulation bill.

A. Haeworth Robinson, a vp of William M. Mercer Inc. in Washington, will discuss "The Coming

Revolution in Social Security" at Monday's luncheon. A series of 24 concurrent resource sessions will be presented in the afternoon.

On Sept. 21, the morning general session will begin with "Professional Ethics: Standards for the Insurance Industry" with Lawrence Geneen, vp of Johnson & Higgins in New York. John R. Cox, chairman and chief executive officer of the Insurance Co. of North America unit of CIGNA Corp., will then discuss "Liberalization of Trade-In Services and the Future Implications to the Insurance Industry." Resource sessions are scheduled for the remainder of the morning.

After lunch, another general session will be held, entitled "1982: A Year of Paradox for the Insurance Industry," with Robert Dauer, edi-

tor and publisher of John Liner Letter in Wellesley, Mass. The remainder of Tuesday afternoon will be devoted to resource sessions.

Three speeches will be given at the Sept. 23 morning general session: "Property and Casualty Insurance Expectations in the 1980s" by Charles L. Ruoff, senior vp of The Continental Corp. in New York; "Hazardous Waste and Environmental Impairment Liability, Impact and Implications" with a yet-to-be-named speaker; and "Preparing the Association Captive and/or Risk Pooling Groups Against Large Exposure Claims and Litigation" by Alan D. Morris, president of Risk Control Corp. in Bethesda, Md. A summary and wrap-up of the program will then be delivered.

Fourteen resource sessions will be presented at the conference, of

which participants will be able to attend four. They include:

- "How to Use Risk Management Techniques to Improve Your Company's Insurance Program."
- "How to Form a Group or Association Captive."
- "Directors and Officers and Fiduciary Liability Coverages."
- "How to Develop a Sound Property Insurance Program."
- "How to Select and Evaluate Insurance Brokers and/or Affiliated Broker Services."

The employee benefits management conference will open on Sept. 20 with a panel presentation on "Approaches to Health Care Cost Containment" with Andrew J.J. Brennan, director of the Center for Health Help at Metropolitan Life Insurance Co. in New York; Dr. Walter McClure, president of the Center for Policy Studies in Minneapolis; and Arnold Glassman, manager of benefits, communications and programs at Atlantic Richfield Co. in Los Angeles.

The benefits conference and the risk management conference will be combined for Monday's luncheon presentation by Mr. Robertson. The afternoon is devoted to resource sessions.

On Sept. 21, the general benefit session is "Our Changing Society... and its Effects on Benefits Planning" with Connie Stear, vp of the Signal Division of Yankelovich, Skelly & White Inc. in New York, and Frank Pickett, director of personnel at Uniroyal Inc. in Middlebury, Conn. The remainder of Tuesday morning is devoted to resource sessions.

The afternoon general session presentation, "Where do Benefits Belong in the Organization Today?" will be given by Paul H. Brown Jr., director of benefits for Cadbury Schwepps U.S.A. Inc. in Stamford, Conn. The rest of the afternoon is devoted to resource sessions.

On Sept. 22, the general session will offer three presentations. The first is "The Use of Computers to Communicate Effectively" by Lloyd Mills III, a partner with Kwasha Lipton in Fort Lee, N.J. The second, "The Communications Gap: How Do Employees Perceive Their Benefits?" will be delivered by Linda Pappas, a senior consultant at Hay Associates in Washington. The third, "Developing a Total Employee Benefits Communications Plan," will be given by Donald L. Sheppard, vp of communication services at William M. Mercer Inc. in San Francisco. A summary and wrap-up of the program will follow.

Ten resource session will be held at the employee benefits conference. They include:

- "The New IRAs: Pros and Cons of Company Involvement."
- "ESOPs and TRASOPs: New Developments."
- "Job Sharing."
- "International Benefits: An Overview of Current Developments."
- "Funding: What Is It? How to Do It."

The AMA's National Conferences also will offer two special features: minimanagement seminars and a tour of the Illinois Insurance Exchange. The minimanagement seminars are entitled "Time Management" and "How to Project a Positive Executive Image."

The minimanagement seminars and the tour need pre-registration.

The fees for the conferences, which will be at the Palmer House, are \$405 for AMA members and \$465 for non-members. To register or to obtain a registration form, contact the AMA Registrar, American Management Assns., 135 W. 50th St., New York, N.Y. 10020; 212-246-0800.

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ARIA conference

Regulators to focus on reinsurers: Professor

By RHONDA L. RUNDLE

DENVER—State insurance commissioners will be forced to regulate reinsurers more closely to prevent a chain reaction of insurer insolvencies, predicts a university professor.

The number of reinsurance options available to ceding companies has increased sharply in recent years, points out Bernard Webb, professor of actuarial science and

insurance at Georgia State University in Atlanta.

Not all of these reinsurers are technically or financially qualified to compete in today's sophisticated and risky insurance market, warns Mr. Webb. Many are foreign companies beyond the reach of U.S. regulatory authorities.

But U.S. regulators can and will exercise greater authority over the kinds and sources of reinsurance purchased by admitted companies,

emphasized Mr. Webb in a speech at the recent American Risk & Insurance Assn. meeting held Aug. 15-18 in Denver.

Mr. Webb also predicted increasing professionalism among regulators and action by legislators and insurance departments to require treatment of investment income in insurance ratemaking, increased federal intervention in insurance regulation and retreat from open competition in personal lines.

The trend toward one-stop shopping for personal financial services means that insurance companies are competing directly with banks, savings and loans, investment brokers and mutual funds for Individual Retirement Accounts and other investment funds.

"It is only a question of time until the other financial institutions demand that insurers be subject to the same federal regulations that affect them," declared Mr. Webb.

He believes the federal government's regulation of insurance will increase sharply after President Reagan leaves the White House. "Prior to this administration, the federal government was moving slowly but steadily to erode the scope of state regulation," he said.

There has been a lot of talk and a few regulations have been issued, but the insurance industry has succeeded in stalling any real movement toward inclusion of investment income in ratemaking, said Mr. Webb.

He thinks the delaying action will come to an end soon, "either because the industry will take notice of the damage being done to their image or because legislators and commissioners will lose patience with the industry's tactics." Continued high interest rates will spur action on this front, he added.

"In the next few years I expect to see most states requiring meaningful consideration of investment income in ratemaking. The current regulations in this area are largely shams," Mr. Webb said.

An examination by Mr. Webb of rate filings in several states that require consideration of investment income showed that insurers were using the calculation to justify a traditional 5% loading for underwriting profit. The filings had been approved by regulators with no questions asked.

"There are some very real problems involved in the consideration of investment income in ratemaking," acknowledged Mr. Webb. For example, how much profit should an insurer be allowed to make? The profit margin should vary by line of insurance according to the risk involved, Mr. Webb said. But how do you measure the riskiness of a line?

Massachusetts has used beta, a technical measure of risk from the capital asset pricing model, in ratemaking for automobile lines. Beta, in combination with statistical variance on the rate of return, has been considered in New York. Both measures have weaknesses, but nothing better has been suggested to date, said Mr. Webb.

To address these kinds of complex issues, greater professionalism and technical competence will be required of insurance regulators in the future, Mr. Webb said. "I am not suggesting that politically appointed or elected commissioners will disappear, but I do believe they will find it necessary to hire and to listen to more qualified technical people."

Mr. Webb also expects many states that have adopted open competition for property/casualty insurance to return to prior approval for personal lines. There are signs that legislators are becoming less enchanted with new open competition laws, he reports.

Legislators are primarily concerned with personal lines, he added. "People have more votes than corporations."

Buyers must be well-informed about products and pricing to compare the options available to them. They must be able to shift from one insurer to another to take advantage of the best deal. And there must be no joint price fixing among companies, whether legal or illegal.

The personal lines insurance market flunks all three tests, says Mr. Webb. And more and more legislators are becoming aware of these shortcomings.

The market for medium- to large commercial lines complies quite well with the first two tests and reasonably well with the third. Open competition remains popular with the commercial insurance industry and its regulators, he noted. ■

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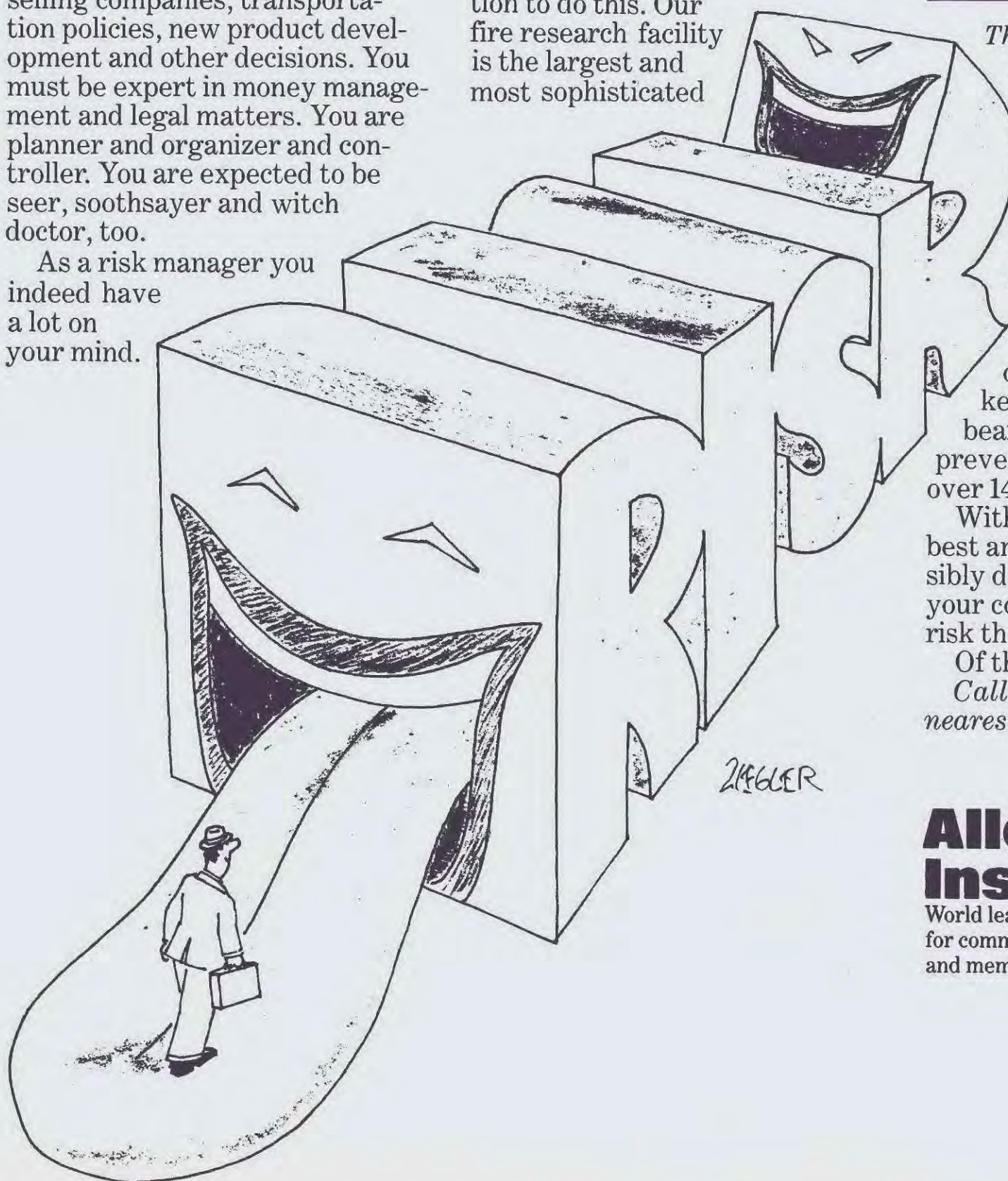
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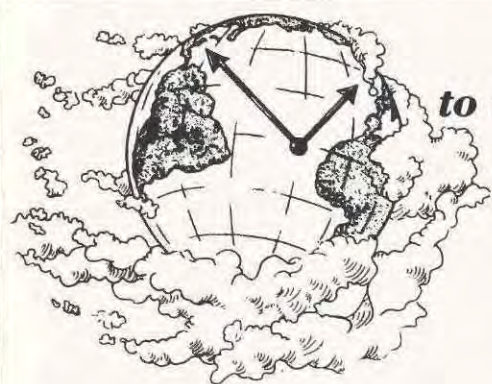
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Recalls can reduce jury awards: Study

Continued from page 3

would find liability because Mr. Mowen wanted to evaluate the amount of damages under different scenarios.

Four different tapes were prepared and played to different juries. Each jury listened to only one trial. The only variations were recall vs. no recall of the product; and use vs. non-use by the defense attorney of the "anchor-breaking" argument in his closing remarks.

The plaintiff asked for \$450,000 in actual and \$8 million in punitive damages.

Mr. Mowen hypothesized that actual and punitive damages would be greatest when a recall had not been made and that damages would be lower when the anchor-break-

ing argument was used. The first hypothesis proved correct; the second could not be clearly accepted or rejected.

The jurors appeared to take their roles seriously, noted Mr. Mowen. "We had a hard time getting them out of there after they reached a decision."

The jurors' verdicts were recorded both individually and as juries. They tended to award more damages individually than when grouped as a jury. There seems to be some kind of group polarization effect that brings down the award, Mr. Mowen said.

The average awards of the individuals and juries were:

- \$541,000 by juries when no recall was made.
- \$442,000 by juries when a recall had been made.
- \$966,000 by individuals without the recall.
- \$578,000 by individuals with the recall.

The only personality or demographic factors that correlated with individuals' awards were preliminary attitudes toward business. This suggests that a defense attorney should try to ascertain these attitudes of prospective jurors during the jury selection portion of a trial, said Mr. Mowen.

Mock jury research is just one way that social psychologists are studying courtroom strategies and jury selection processes, he added. One technique used by researchers is to set up "shadow juries" of individuals who sit in on an actual trial and give feedback to researchers on a daily basis concerning the progress of the case.

Survey research considers the attitudes of a community toward the parties. Another type of analysis considers the relationship between jurors and the plaintiff or defendant. Such links, similarities or dislikes may cause jurors to be sympathetic or antithetic toward the parties.

Interest in jury behavior is increasing in light of higher damage awards and a trend toward multiple lawsuits, added Mr. Mowen. From 1975 to 1979 average court judgments increased to \$346,600 from \$264,000, he said. In California the average award climbed to \$400,000 in 1980, up from \$367,000 the year before.

Researchers are also studying the potential negative effects on a major manufacturer's consumer franchise when publicity is focused on a proliferation of product liability lawsuits.

"We ask how damage awards can be reduced by the application of knowledge and research methods found in the behavioral science and marketing literature," said Mr. Mowen.

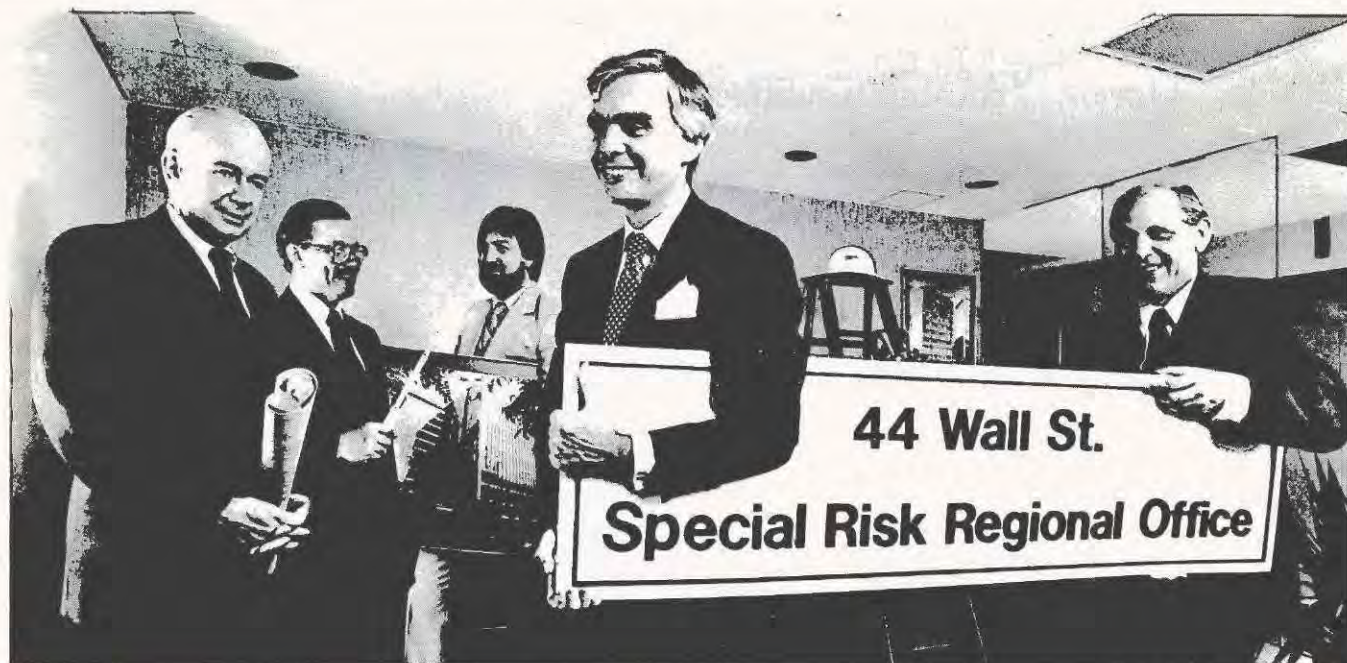
Beane leaves RIMS for IIAA

NEW YORK—The Risk & Insurance Management Society is looking for a new general counsel and director of legislative affairs.

That vacancy occurred when Reg Beane left the society this month to join the Independent Insurance Agents of America as vp-federal affairs in New York.

Mr. Beane represented RIMS on a wide variety of issues that affected corporate buyers of insurance during his six years with the society.

For example, Mr. Beane played a key role in the drafting of Vermont 1981's captive law that gives captives freedom from rate and form regulation and imposes no investment restrictions on pure (single-parent) captives.



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Professors help employers evaluate day care

By RHONDA L. RUNDLE

DENVER—Two university professors are designing a decision model for employers to help them evaluate and implement day-care benefits for their employees.

Curiosity about day care as an employee benefit has increased among employers since the Economic Recovery Tax Act, which took effect Jan. 1, made such benefits tax-deductible for businesses (BI, June 21).

An estimated 600 companies na-

tionwide now offer child-care benefits in some form, reports Ann Costello, assistant professor of insurance at the University of Hartford, who spoke at the recent American Risk & Insurance Assn. meeting in Denver.

More than 100 Connecticut companies are currently considering child-care benefits, she said.

"Employers need an approach to follow in designing this benefit," Ms. Costello explained. She is preparing such a decision model in

partnership with Kathleen H. Sloan, another assistant professor at the University of Hartford.

Their findings will be published in December, but Ms. Costello discussed some general ideas about day-care benefit plan design at the ARIA meeting.

"Do your homework first," Ms. Costello stressed to employers attending the conference. "Don't discuss the possibility of such benefits with workers unless you are committed to offering them. Wait until you are ready to move before sur-

veying workers about the alternatives they prefer."

A major insurance company in Hartford conducted a survey of employees to ascertain their interest in child-care benefits and was flooded with positive responses by parents of 5,000 children.

But an open-ended survey does not generate good data about the number of people likely to participate in a day-care program, noted Ms. Costello. Costs to the employee, if any, and details of the specific day-care options or program must

be sketched out to obtain reliable feedback.

"Day-care benefits are expensive, so employers should look at them from a productivity viewpoint," said Ms. Costello. "Go out and analyze your absenteeism among people of child-bearing age. Don't limit your survey to women," she urged.

This study will tell an employer if there is a problem—and if the company can partially offset the costs of day-care with productivity

Continued on page 16

Use computer to evaluate insurer bids

Continued from page 3

tential workplace changes? With an Apple computer in the boardroom, the risk manager can present ready estimates of such workers compensation costs.

Microcomputers also can help the risk manager present bids submitted by brokers and insurers in a common format to facilitate comparison.

"It is incumbent upon the risk manager to find a way to present such information to top management," stressed Mr. Casey.

Simple microcomputer programs can generate visual displays of loss probabilities in the form of histograms.

Losses under varying assumptions about retention and insurance levels can be simulated using random numbers generated by the program.

To illustrate other applications of Visicalc software, Mr. Klock and Mr. Casey presented to conference participants a sample report that plotted a theoretical company's so-called risk utility curve. The chart demonstrated that the more risk adverse to the company, the more the company is willing to pay to transfer that risk.

Perhaps the most practical risk management application of microcomputers is presentation of insurance bid comparisons to top management.

Casualty insurance bids for Casey/Klock Enterprises, a fictional company, might assume a certain standard premium and estimated workers compensation, general liability and automobile liability losses, for example.

Would the company be better off under conventional insurance, self-insurance, an incurred loss or paid-loss retrospectively rated plan?

The microcomputer grinds out net cost figures under the different loss-funding alternatives. It also reports a claims-to-cost ratio, and minimum and maximum premiums.

If the risk manager wants to revise the loss forecast, he or she can calculate the premium cost at varying loss levels.

Microcomputers are whizzes at analyzing self-insurance reserves and discounting them to present value under appropriate rates determined by the company.

If inflation abates or soars, the self-insurer may wish to reassess the value of its long-tail liabilities on the computer.

No matter what assumptions about inflation, losses or risk funding alternatives a corporation's top management adopts, the risk manager adept at manipulating a microcomputer can provide immediate feedback about the impact of those assumptions on the corporate bottom line.

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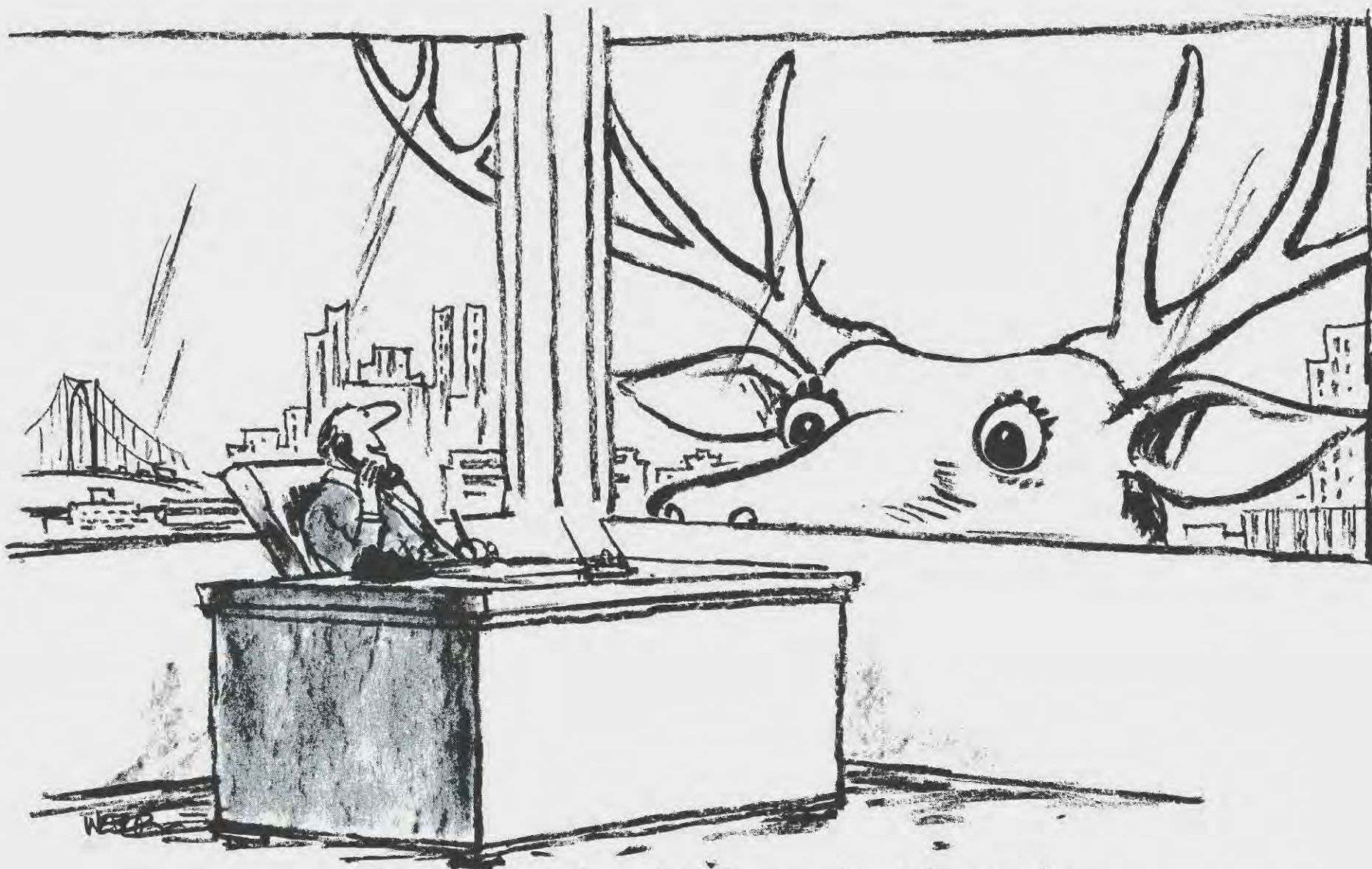
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Professors aid in day-care decision

Continued from page 14
gains.

Day-care benefits do bring positive changes in absenteeism and turnover, declared Ms. Costello. She described a sock manufacturer in Hickory, N.J., which has virtually eliminated turnover among workers in an industry characterized by 250% to 300% turnover.

Two years after starting a day-care center for their employees, Intermedics Corp. in Freeport, Texas, saved 15,000 man-hours formerly lost to absenteeism and reduced employee turnover by 60%.

Other employer goals might include improved recruitment of specialized workers, stepped-up employee morale, a shift to a flexible benefit plan or enrichment of an existing benefit package.

Find out what day-care services

already exist in the marketplace, urged Ms. Costello. Start-up costs can run as high as \$2,000 per child, so it is usually more economical to subsidize employee use of existing facilities rather than to establish a new program.

Child-care costs vary dramatically across the country, noted Ms. Costello. Average per-week child-care costs are more than \$300 in New York, about \$60 per week in Atlanta and only \$30 per week in Virginia, she reported.

Analysis of costs also requires understanding the difference between types of services for children in different age groups. Toddlers are 18 months to 3 years; preschoolers are 4- to 6-year-olds. Day care for young children costs more.

Many employers automatically assume their workers prefer child-

care facilities that are located at the workplace, observed Ms. Costello. But many parents don't want to see their children during the day, her research has found.

The people who run child-care centers don't like frequent parental visits, which can be disruptive, and employers fear on-site centers will distract employees from their jobs. On-site centers also pose the biggest potential liability problems for employers.

"Particularly worrisome is the kidnapping exposure," noted Ms. Costello. In a case where the parents are divorced and one has custody, the child may be more than willing to leave the day-care center with the other parent.

Location of the day-care center is crucial, however. Laws in many states require that sick children be

sent home to avoid infecting other kids. But parents may prefer day-care centers in their own neighborhood so they do not have to transport their children long distances by car, bus, train or subway.

After surveying employees, employers may prefer to subsidize the operation of one or more existing day-care centers, she explained. Hours of operation must address the needs of employees against marginal costs. Employers may assume total or only partial costs.

Equity poses some potential questions about day-care benefits, Ms. Costello pointed out. Childless employees and others who cannot use the new benefit may feel it is unfair. But the same complaint can be raised against other benefits like tuition reimbursement and subsidized parking, she argued.

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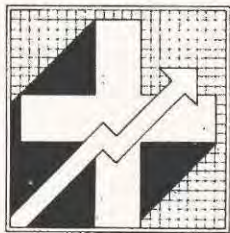
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State regulators facing similar problems: Panel

DENVER—The problems facing insurance industry regulators—cash flow, credibility and coping with changing products—transcend state lines.

Regulators are strapped for budget money at a time when falling interest rates and fierce competition are raising concerns about insurer solvency. Complex new products, often misunderstood by the public, widen the door to consumer fraud.

Many of these common concerns require academic study by insurance educators, agreed several state insurance commissioners, including J. Richard Barnes of Colorado, Roger C. Day of Utah, Patsy Redmond of Nevada and Lyndon Olson Jr. of Texas, who participated in a panel discussion at the recent American Risk & Insurance Assn. meeting.

Shrinking budgets are making regulators more sensitive than ever to the need for enhanced administrative efficiencies.

"We must work smarter, not just harder," stressed Mr. Day. Regulators must take advantage of computer technology to do their jobs. Speed must be incorporated into regulation just as it has been into private industry, he declared.

Maintenance of insurance company solvency is still the primary focus of regulators, he added. "We need better information faster in order to act as needed."

Computer capability also would

help regulators evaluate the quality of reinsurance underwritten by alien companies. Many of the players in this field are not sophisticated enough to fully understand what they are doing, Mr. Day said.

One area ripe for academic attention is the impact of the increasing amount of self-insurance on the traditional insurance mechanism. If the better risks aggregate into self-insurance, what happens to the spread of risk among groups that remain in the commercial insurance market?

"The group insurance model is not working well for health insurance in Utah," Mr. Day said. "Blue Cross/Blue Shield is steadily losing market share in Utah and appears to be a losing proposition."

"I am especially concerned about the growth of self-insured employee benefits plans," agreed Mr. Barnes. "They are OK if the group includes 35,000 lives and is properly run. But what happens to a small 20-person group if one employee suffers a serious heart attack?"

Regulators are also keeping a close eye on the advent of over-the-counter personal financial services including the availability of life, accident and health insurance and money market certificates at department stores like Sears, Roebuck & Co.

The public needs educating about these new products. So do agents and brokers, who are marketing innovative policies like universal life insurance, Mr. Barnes said.

"There are too many agents who have been in the business for 20 years but have one year of experience 20 times over," he quipped. Mr. Barnes does not expect insurance companies will ever require agents to pursue continuing education. That will only come through regulation, he said.

Commissioner Olson of Texas voiced strong opposition to the Risk Retention Act, which was passed by Congress last September. The law permits manufacturers to pool their product liability risks and self-fund them free of most state regulation.

"There is nothing sacred about state regulation, but what can the U.S. Commerce Department know about this business?" he asked. "The act is a dog, it's irresponsible—I get worked up about it."

The implications of the Risk Retention Act are very broad, he stressed. It started as a self-insurance mechanism to bypass state regulation for product liability risks. But some of its promoters are now trying to extend it to other lines besides product liability, Mr. Olson said.

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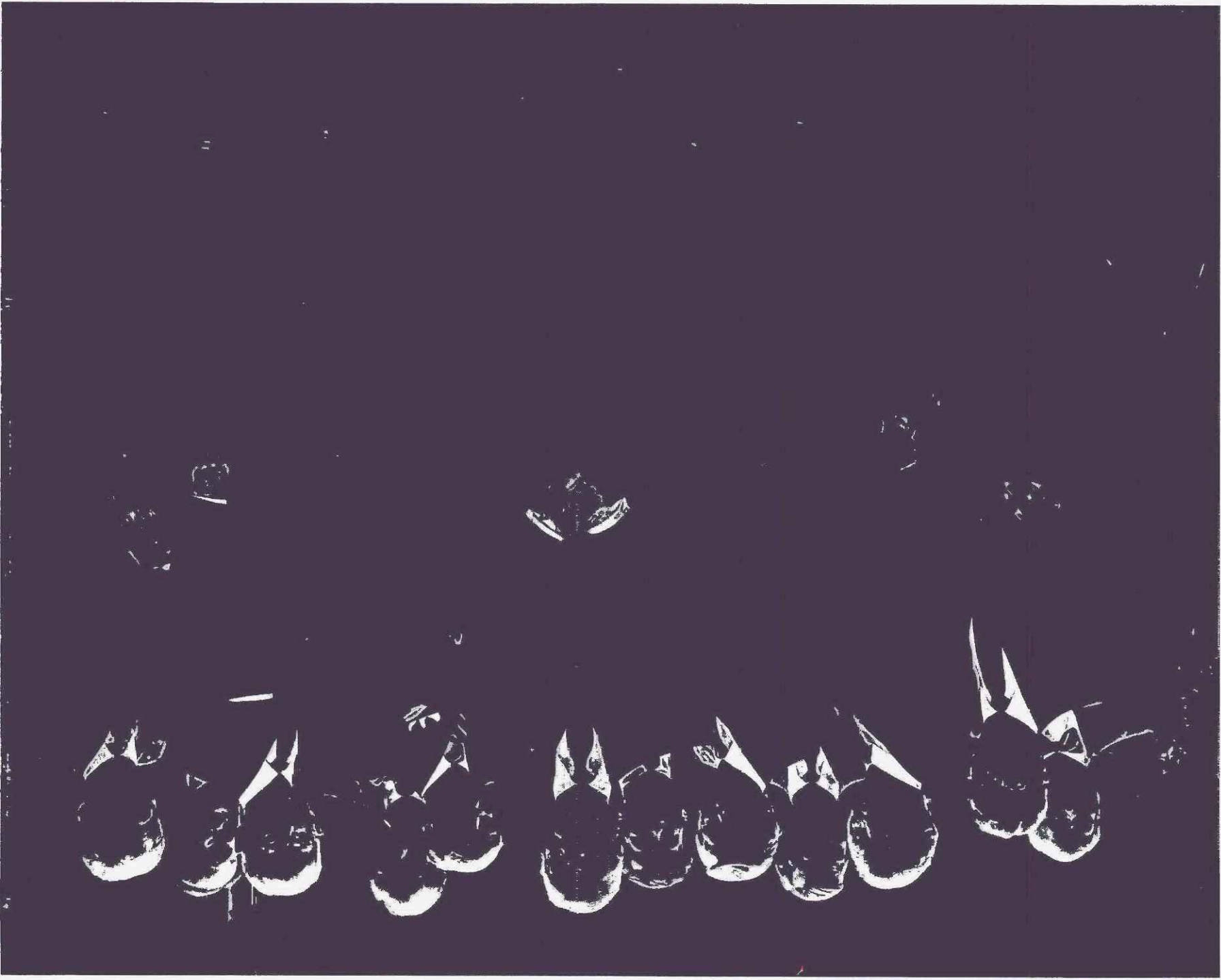
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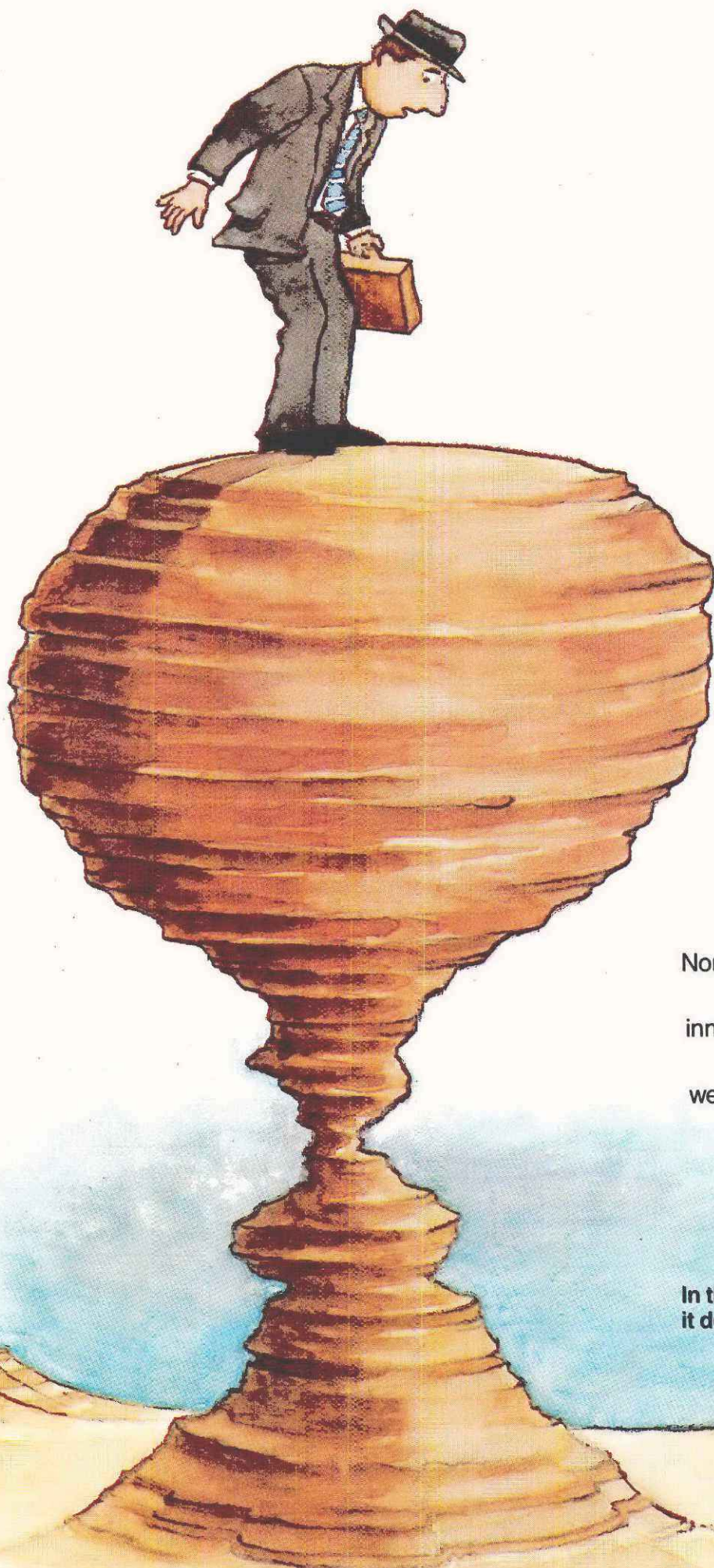
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perspective

ISO summary of the proposed CGL policy

THIS IS a copy of the executive summary of the proposed comprehensive general liability insurance policy drafted by the Insurance Services Office.

The full proposed CGL policy was printed in the *Perspective* section of *Business Insurance* on July 26. The executive summary, written by ISO, serves as a companion piece to that proposed policy. Comments on the proposed policy may be sent to organizations listed in the July 26 editorial.

The policy and executive summary are reprinted with the permission and cooperation of ISO.

The major goals of the revision are to:

- Consolidate and modernize. The new policies combine and uniformly present in a single contract the full range of coverages commonly afforded today. Together with a highly simplified and streamlined rating structure now being developed, the consolidation will facilitate policy writing, rating and automated handling at every point in the process.

- Provide new coverage triggers. The current policy triggers coverage exposure at the time bodily injury or property damage "occurs." These provisions are replaced by a "first discovery" (manifestation) timing trigger in one of the new policies; and by a "claims-made" trigger in the other.

- Introduce comprehensive aggregate limits. One of the two aggregate limits will apply to any loss covered by the policies. There is one aggregate limit for products and completed operations liability, exactly as in today's coverage. All the other coverages combined will be subject to a separate aggregate limit. These limits will specify at the outset the total amount available for indemnification.

The new ISO CGL policies are designed to accomplish these goals with significant benefits and minimal disruption to insurers, producers and policyholders. The new policies contain a comprehensive scope of coverage that will be priced using a uniform, simplified classification and rating procedure. Such comprehensive coverage is available today, but only through a complex series of forms and endorsements with disparate pricing mechanisms.

The new timing triggers will not substantially change the current claims-handling and settlement patterns for the vast majority of cases. In the first-discovery version, the policy in effect when a person's injury or damage is first discovered provides the coverage. In the claims-made version, the policy in effect when the first claim is made for a person's injury or damage provides the coverage. Since time of discovery and the time injury occurs are essentially simultaneous in accident cases—by far the most prevalent ones—the first-discovery trigger will leave today's claims-handling practices almost completely intact. The claims-made version introduces some change, in that the claim will actually be made later than the injury occurs. But claims-made has advantages in terms of precision.

To guarantee continuity of coverage if an insurer cancels or refuses to renew, both policies contain a "tail" provision. The insured may purchase this extension of coverage at a price ceiling specified in the manual. Discoveries or claims made within three years of the termination date would then be eligible for coverage under the policy, so long as the injured person or damaged property was already exposed to the cause of injury or damage as of that date.

By introducing significant change only where it is needed, both policies should avoid disruption and uncertainty in the marketplace.

ISO is now conducting the most extensive industry review it has ever undertaken. The exposure draft and detailed analysis of the old and new policies are being circulated to insurers, producers, corporate buyers and others in the industry. Response to this review will be thoroughly analyzed before the final product is determined.

The proposed new ISO Commercial General Liability policies incorporate in one policy form the basic scope of coverage provided today in the ISO Comprehensive General Liability policy and the Broad-form Comprehensive General Liability endorsement. However, the presentation of coverage has been substantially reorganized and streamlined.

Conceptual changes

The draft incorporates two major conceptual changes: revised timing provisions for the determination of coverage and a revised structure for limits of liability which imposes overall aggregate limits on all the coverages of the form.

Timing provisions

The proposed policies contain two timing mechanisms for the determination of coverage—a first-discovery mechanism and a claims-made mechanism. These are displayed side-by-side in the draft for ease of comparison. Under the first-discovery version, coverage for all injury or damage sustained by any one person as a

result of an occurrence is assigned to the policy in effect at the time of first discovery. The claims-made version assigns the coverage to the policy in effect when the first claim is made for that injury or damage.

All injury or damage caused by the same occurrence and first discovered (or first made claim for) during the policy period will then be subject to the "each-occurrence limit."

Other notable features include:

First discovery—The coverage pattern will be unchanged from today's in the vast majority of cases, where the discovery of injury or damage is simultaneous with its cause. For long-term, delayed-emergency cases, coverage will be assigned exclusively to the policy in effect as of the first discovery of each claimant's injury or damage. Thus, all claims for injury or damage covered by a given policy should be identified and settled within a few years of the policy expiration date. This will facilitate ratemaking. At the same time, there will be a minimal impact on normal claims-handling procedures.

On the other hand, first discovery is not a precisely defined concept in cases where a long period of time intervenes between initial exposure and conclusive diagnosis. The exposure-draft stipulates that, for bodily injury, first discovery must be made by the injured person (unless incapacitated), thereby diminishing the likelihood that several different discovery dates could be alleged in a given claim. Although the possibility remains that controversy will arise over what constitutes first discovery under certain circumstances, no more than one first-discovery or claims-made policy will provide coverage.

Claims made—The provisions are similar to those already in existence in the ISO Professional Liability and Pollution Liability contracts and in many independent insurer programs. Under this option, there is even less uncertainty in the determination of coverage than with the first-discovery language, since the submission of a claim is generally a more precisely identifiable event than the first discovery of injury.

Optional three-year tail—Both versions contain an optional three-year "tail" period to protect the policyholder if the company cancels or refuses to renew (except for non-payment of the premium). If the injured person or damaged property has been exposed to the cause of the injury or damage as of the termination date, the tail, if purchased, will guarantee coverage for resulting discoveries or claims made within three years of that date, based on a maximum price specified in the manual.

Limits of liability

The exposure draft contains a consolidated set of policy limits to reflect the revised coverage structure. Like today's CGL policy, it imposes an aggregate limit on payments for products-completed operations losses. It also imposes an additional, separate aggregate limit of liability collectively on all other coverages of the policy. Thus, there is an absolute ceiling on insurer liability to pay damages under the contract.

Beneath these dual policy aggregates, there are various "occurrence" and "per-person" limits, which are described in the accompanying detailed explanatory material (Section 14).

Other changes and features

The structure of the draft is a substantial departure from traditional presentations of coverage. The concept of "covered injury" allows a uniform presentation of the many components of the contract and a compact expression of the requirements for coverage. The resulting treatment of the complex area of property damage, including broad-form property damage, has been simplified (see Sections 3, 5 and the business risk exclusion and named insured's premises and property risk exclusion in Section 12).

The present scope of coverage has been followed in most respects. Some exceptions are:

- The worldwide products coverage, which has been expanded to include products made or sold in the United States or Canada if the original suit for damages is brought there, regardless of the place of the intended use or consumption of those products (see Section 15—definition of policy territory).

- The contractual liability coverage, which has been restricted to tort liability assumed from anyone and no longer applies to owned automobiles, aircraft or watercraft (see Section 15—definition of insured contract).

- The liquor liability exclusion, which has been narrowed so that the policy covers the liability of owners or lessors (see Section 12—the alcoholic beverages exclusion).

- Coverage for the underground explosion and collapse haz-

ards, now optionally excluded and separately rated, which is provided as part of the basic coverage of the exposure draft.

Currently under development to accompany the consolidated and restructured coverages of the draft is a revised rating and classification structure for general liability. For each classification, there will be two rates embracing all the coverages, including those separately priced today, and (where possible) a single inflation-sensitive basis of exposure. This will substantially simplify the rating process. The revised rating structure is being designed for maximum compatibility with automated systems requirements.

Section-by-section explanation

The following is a section-by-section explanation of the exposure draft compared with the existing ISO General Liability policy jacket, comprehensive GL coverage part and Broad-form Comprehensive GL endorsement.

1. Coverage A—liability

This basic coverage grant presents the insuring agreement in a consolidated and simplified fashion.

Note that the claim or suit must be for covered injury or damage as defined in subsequent sections of the policy.

Note also that the claim or suit must be for damages as defined in Section 3 of the draft. This imposes some of the existing restrictions on coverage, particularly in the area of property damage; these are described in the commentary for Section 3.

Defense is provided, as in today's contract, in addition to the policy limits.

References to current form: Policy jacket—insuring agreement; CGL—Section I—Coverage A—bodily injury liability; Coverage B—property damage liability. Broad-form endorsement—Section II—personal injury and advertising injury liability coverage; Section V—fire legal liability coverage—real property.

2. Definition persons insured

This is a reorganization and simplification of the current provisions of the CGL and broad-form endorsement.

The current provisions relating to insured operators of mobile equipment have been omitted. As part of its review of the general liability policy forms, ISO will review the entire treatment of mobile equipment subject to motor vehicle registration, no-fault and financial responsibility laws. In the process, coverage for operators of such equipment will be restored.

The basic coverage for spouses of partners has been removed on the assumption that it can be provided through endorsement where necessary and appropriate.

Coverage is no longer afforded for liability arising out of the conduct of defunct partnerships or joint ventures which are not named insureds.

References to current form: Policy jacket—Condition 9 (Assignment); CGL—Section II—persons insured; Broad-form endorsement—Section X—additional persons insured.

3. Coverage A—Definition of damages

This section complements the "covered injury" structure of the policy by specifying the kinds of damages that will—and will not—be paid when there is covered injury or damage. The first section of the definition is non-restrictive: i.e., it does not embrace all elements of "damages" which are payable under the policy.

The second element of the definition eliminates the payment of certain kinds of damages even when there is covered injury. This is especially significant in the area of property damage coverage, where only some kinds of direct and consequential damages are payable when coverage attaches. The damages payable for covered property damage, as defined in Section 5, will not include loss, cost or expense to which the business risk exclusion (Section 12) applies. This clarifies the workings of this complex coverage area. (See also Section 15—definition of property damage.)

References to current form: CGL—Section I—exclusion (i); Broad-form endorsement—Section II—exclusion (B)(1).

4. Definition of covered bodily injury

This section correlates to the coverage grant (Section I) by setting forth all requirements for "covered bodily injury." It contains the two alternate triggers of coverage—"first discovery" and

Continued on next page

perspective

Proposed CGL policy summary

Continued from previous page

"claims made"—described in the first part of this analysis.

Bodily injury is covered only if it is caused by an occurrence in the policy territory, triggered during the policy term according to the rules, and not eliminated by the applicable exclusions.

References to current form: Policy jacket—definition of "bodily injury;" definition of "occurrence;" CGL—Section IV-policy territory.

5. Definition of covered property damage

The comments for Section 4, above, apply here also. The revised definition of "property damage" (see Section 15) includes both elements of the current definition (physical injury and loss of use of uninjured property).

See also the comments for Section 3, above.

References to current form: Policy jacket—definition of "property damage;" definition of "occurrence;" CGL—Section IV-policy territory.

6. Definition of covered fire damage

There is no substantial change. The coverage is presented directly through the concept of covered injury rather than through exceptions to exclusions. Covered damage is property damage. Note also that the coverage is excess, as in today's form (see Condition G). See also Section 14—limits of liability.

References to current form: Broad-form endorsement—Section V—fire legal liability coverage—real property.

7. Definition of covered personal injury

8. Definition of covered advertising injury

These sections have been reorganized and simplified. The contractual exclusion now appears in the definition of "damages" (Section 3).

References to current form: Broad-form endorsement—Section II—personal injury and advertising injury liability coverage.

9. Coverage A—Supplementary payments

This section has been simplified. There is no specific reference to premiums on appeal bonds, as they are expenses incurred by a company which chooses to pursue an appeal. First aid at the time of an accident will now be treated, within the policy limits, as part of Medical Payments (Sections 10 and 11).

Payments for bail bonds for traffic offenses are omitted pending the overall review of mobile equipment coverage (see Section 2).

Payments for loss of earnings have been increased from \$25 to \$100 per day.

References to current form: Policy jacket—supplementary payments.

10. Coverage B—Medical payments

11. Definition of covered medical expenses

Coverage in these sections has been streamlined and simplified. Note that Section 10 requires covered bodily injury, so that all applicable exclusions of Section 12 apply also to this coverage. Note also that:

- Payments for first aid are included in this coverage rather than under supplementary payments.
- The exclusion of independent contractors' operations has been eliminated, expanding the coverage subject to the other exclusions.
- Coverage is expanded, for tenants in residence, to all non-occupied areas.
- The current partial coverage for employees of non-resident tenants is eliminated.

References to current form: Broad-form endorsement—Section III—premises medical payments coverage.

11A. Time when claim is made and reported (Claims-made policy only)

This section contains rules for determining when a claim for bodily injury or property damage is considered to be made. It is used in the coverage triggers of Sections 4, 5, 6 and 10 in the "claims-made" policy.

12. Exclusions

The aircraft, automobile and watercraft exclusion is now applicable to the contractual liability coverage (see definition of "insured contract" in Section 15). Aircraft, automobile and watercraft coverage not eliminated by this exclusion is made excess

through Condition G, Section 16.

References to current form: CGL—Section I—exclusions (b) and (e); broad-form endorsement—Section I—contractual liability coverage—Part (C).

The alcoholic beverages exclusion has been narrowed so that the policy affords coverage for both the statutory and common-law liability of the owner or lessor of premises that are used for dispensing alcoholic beverages, unless the owner or lessor is in that business.

References to current form: CGL—Section I—exclusion (b); broad-form endorsement—Section IV—host liquor law liability coverage.

The business risk exclusion specifies those elements of loss, cost or expenses which are not considered "damages" and hence will not be paid in the presence of covered property damage (see Section 3 and the definition of property damage in Section 15).

Reference to current form: CGL—Section I—exclusions (m), (n), (p); broad-form endorsement—Section VI—broad-form property damage liability coverage—Part (A)(3).

The contractual liability exclusion clarifies the existence of coverage when the insured is liable both in tort and under contract. The second part of the current wording is unnecessary because of the revised definition of "insured contract," which also introduces some restrictions into this coverage (see Section 15).

Reference to current form: CGL—Section I—exclusion (a).

The employers' liability exclusion specifically states that claims or suits brought by others because of a worker's excluded injury will not be covered under this contract.

Reference to current form: CGL—Section I—exclusion (j).

The expected injury or damage exclusion is removed from the definitions and made explicit.

References to current form: Policy jacket—definition of "occurrence;" broad-form endorsement—Section XI—extended bodily injury coverage.

The mobile equipment exclusion combines two current exclusions. Note that snowmobiles are no longer excluded from coverage.

Reference to current form: CGL—Section I—exclusions (c) and (d).

The named insured's premises and property risk exclusion is not expected to produce different results, in most cases, with respect to owned, occupied, rented or borrowed property; alienated premises; property in the care, custody or control of the insured; or property on which operations are being performed at the time of the damage (see Section 16). It is substantially simplified with respect to the current provisions of the broad-form endorsement.

It assumes that property in the care, custody or control of an employee of the named insured in the course of the named insured's business activities is in the care, custody or control of the named insured and hence excluded. Note also that Section 2 (e)(3) of the draft complements Section (a) of this exclusion.

The current exception for elevators has been eliminated. The exclusion of property in the care, custody or control of the named insured thus applies when the damage arises from the use of elevators.

See also the business risk exclusion, above, for the complementary treatment of completed operations.

Reference to Current Form: CGL—Section I—exclusion (1); broad-form endorsement—Section VI broad-form property damage liability coverage—Parts (A)(1) and (A)(2).

The pollution exclusion contains additional specifications of what is meant by "sudden and accidental."

Reference to Current Form: CGL—Section I—exclusion (f).

The war risk exclusion is supplemented by a separate exclusion which applies to covered medical expenses (see Section 11).

Reference to Current Form: CGL—Section I—exclusion (g).

The nuclear energy exclusion will not be changed. It is currently added by endorsement.

13. Extended discovery period option— Coverage A

This provision complements the first-discovery and claims-made timing mechanisms of Sections 4, 5 and 6. It is described above in the discussion of "timing provisions."

14. Limits of our liability—Coverages A and B

The limits of liability have been redesigned to reflect the consolidated coverages of the draft and to impose one of two aggregate limits on each coverage.

The fire damage and medical expense limits will be set, respectively, at \$50,000 per fire and \$5,000 per person. These will be further subject to the occurrence limit, which applies also to other

bodily injury and property damage. The occurrence limit and the separate "per-person" limit for personal and advertising injury are then subject to either the products-completed operations aggregate or the general policy aggregate, whichever is applicable.

References to current form: CGL—Section III—limits of liability; broad-form endorsement—Section II(C)—personal injury and advertising injury liability coverage—limits of liability; Section III, premises medical payments coverage—limits of liability; Section V (B), fire legal liability coverage—real property.

15. List of defined terms

Unless otherwise noted, these definitions are comparable to those in the "Definitions" section of the current policy jacket.

The definition of automobile is substantially unchanged.

The definition of bodily injury is substantially unchanged; death resulting from bodily injury is included among "damages" in Section 3.

The definition of insured contract restricts coverage to torts for which the insured has assumed liability. There is no coverage for any liability assumed by the insured for injury or damage arising out of acts of God or non-tortious actions. Coverage under the policy applies whether the tort is committed by the insured's indemnitee, by that indemnitee's indemnitee or by anyone in the chain of indemnification.

The current exception to this definition has been removed, thereby eliminating coverage for contractual liability for the use or maintenance of automobiles, aircraft or watercraft owned by, rented or loaned to an insured.

Exception (3) acts in connection with Section 6 and the contractual liability exclusion to limit coverage to the insured's own tort liability for fire damage.

Reference to current form: Broad-form endorsement—Section I—contractual liability coverage.

The definition of loading or unloading is unchanged.

Reference to current form: Endorsement GL 00 19—amendatory endorsement—additional definition.

The definition of mobile equipment is essentially that of the ISO Business Auto Policy. This definition will be part of the overall review of mobile equipment (see Section 2).

The definition of named insured's products is substantially unchanged.

The definition of occurrence now functions to require accidental cause for covered injury or damage, and to activate the "each occurrence" limit. The exclusion of expected or intended injury is separately stated in Section 12.

The definition of policy territory is unchanged except that:

- The "extended policy territory" broadens the coverage to goods or products made or sold in the basic territory, rather than those sold for use or consumption in it.

- Medical payments are not excluded from the coverage for temporary travel abroad.

The definition of products-completed operations hazard combines the current separate definitions.

The definition of property damage has been revised. Loss of use of physically injured property is covered as an element of consequential damages in Section 3. Either element of the definition in the draft is covered property damage if caused by an occurrence in the policy territory, triggered during the policy period and not subject to any of the exclusions which apply to property damage. The damages payable because of any such covered property damage will not, according to Section 3, include loss, cost or expense to which the business risk exclusion (Section 12) applies.

The new definition of suit introduces no change.

The definition of war is currently in the exclusion.

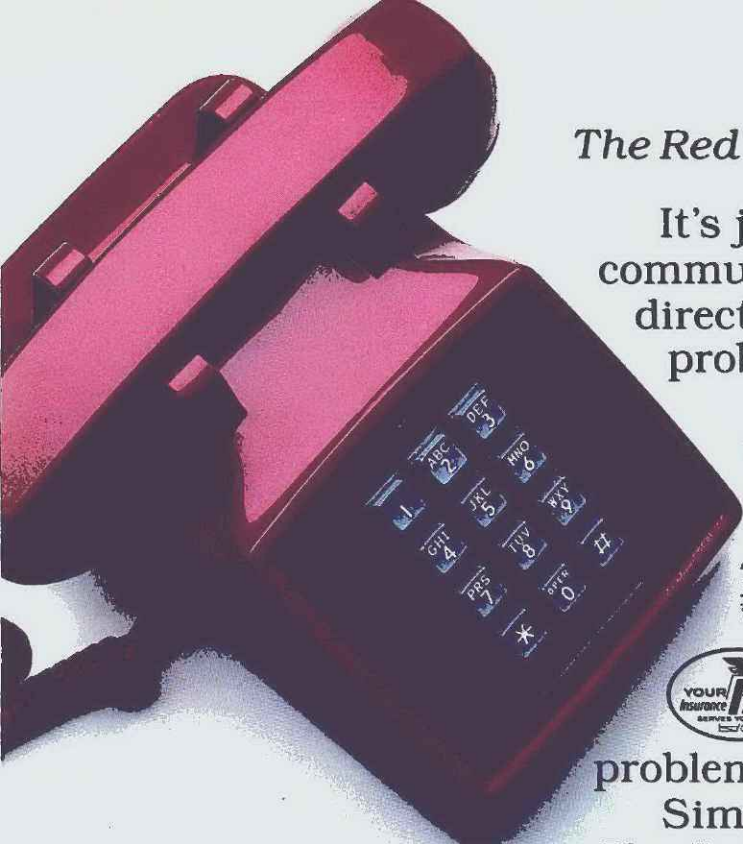
16. Conditions

Only the following conditions have changed: Condition D—Special rights and duties of the first-named insured—has been added to specify the contractual obligations of the first named insured when there are several named insureds.

Condition E—Separation of named insureds—makes the contract severable with respect to each named insured. The policy is therefore to be read as though it had been written separately for each named insured in the declarations, except with respect to the limits of liability. Thus the named insured's premises and property risk exclusion eliminates coverage for property damage to a named insured's property if an employee of that particular named insured is liable for the damage. But coverage remains for an employee of one named insured with respect to property damage to the property of another named insured or bodily injury to the other named insured's employees (cf Section 12).

Condition G—Other insurance—liability—establishes excess provisions for aircraft, automobiles and newly acquired organizations (see Section 12—the automobile, aircraft and watercraft exclusion and Condition C).

Condition M—Cancellation—provides for 30 days' notice if the company cancels for reasons other than premium non-payment. ■



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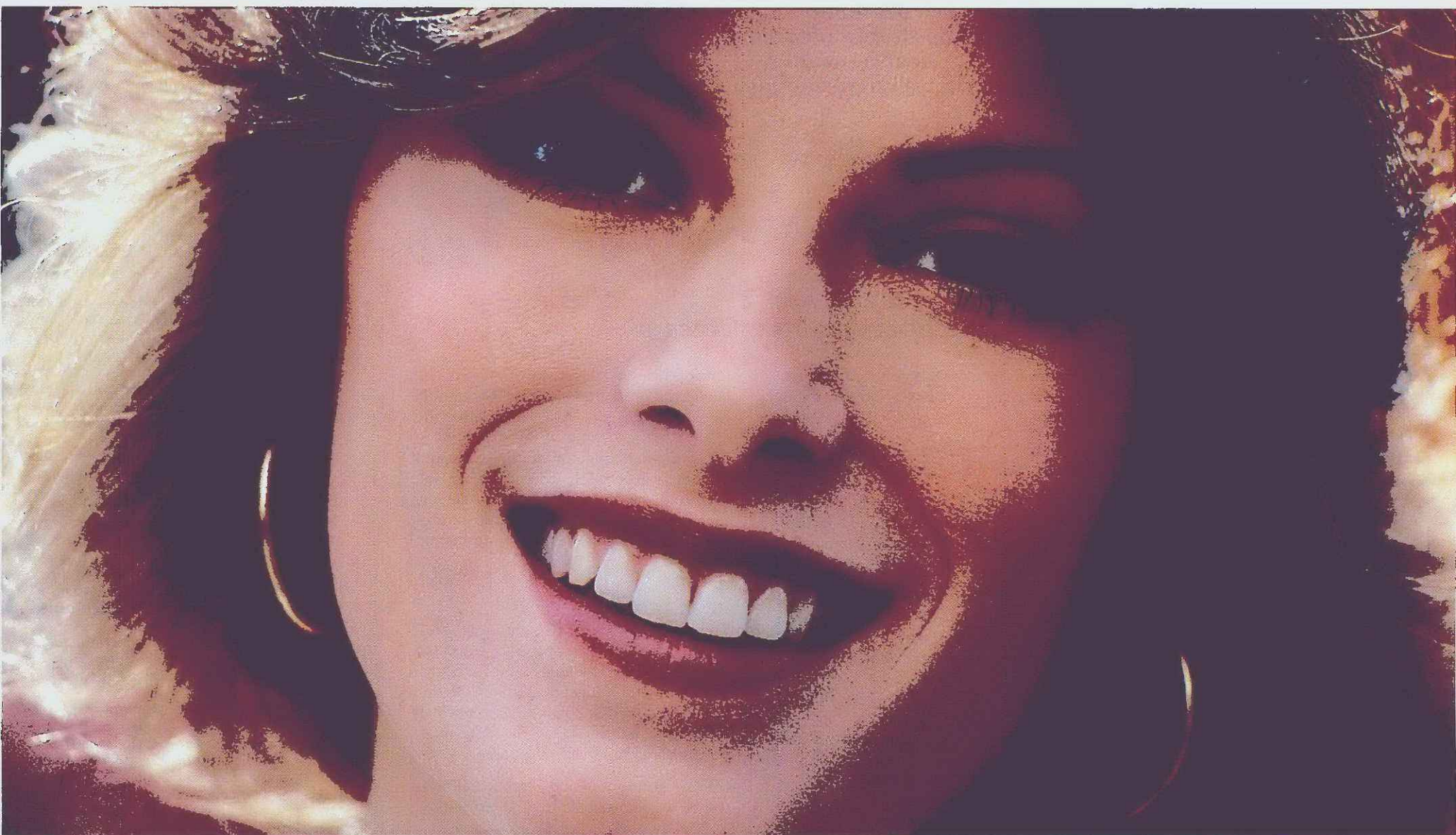
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ANOTHER REASON WHY THE TRAVELERS IS A LEADER IN INSURING SMILES.

Withdrawal liability policy

Continued from page 1

premium, notes NAS President Thomas Cath.

The retail broker, McDonough Caperton Insurance Group in Charleston, W. Va., originally sought the coverage because "some of our clients participate in multiemployer programs and they had a real need to cover this exposure," said Executive Vp W. Marston Becker.

"There was nothing available in the marketplace, and we felt it was a unique area to develop an insurance product," he said.

London broker Hogg Robinson brought NAS and McDonough Caperton together and is now the broker for the new coverage.

McDonough Caperton, NAS and attorneys involved in multiemployer plans say employers will want this insurance to cover their new withdrawal liabilities created

by the Multiemployer Pension Plan Amendments Act of 1980, even though the coverage only extends to involuntary withdrawals.

Only the marketplace, which will see the policy for the first time this week, will decide. Of two attorneys familiar with the Multiemployer Amendments Act and told of the policy, one found it interesting and the other was somewhat skeptical.

To understand the policy and the risk involved, one has to understand multiemployer pension plans.

These plans, which grew in number after World War II to equalize pension costs in competitive industries, are operated jointly by unions and management in particular industries. They are funded under union contracts by employers' contributions, usually based on an amount per hours worked by

the union members.

Until the Multiemployer Amendments Act was passed in 1980, employers could stop contributing to a plan with no additional liability for benefits promised unless the plan folded within five years of their withdrawal. The 1980 amendments were designed to encourage employers who participate in multiemployer plans to stay in them and to force them to pay some of the liabilities when they leave (BI, Dec. 8, 1980).

Employers now leaving a multiemployer pension plan are liable for a portion of the plan's unfunded vested pension benefits, with no limit on liability such as the 30% of net worth limit that applies to employers who terminate their own pension plans.

An employer withdrawing from a multiemployer plan, whether voluntarily or involuntarily, can be assessed a withdrawal liability of more than its net worth to cover its share of the plan's unfunded vested

benefits.

Johnson Motor Lines of Charlotte, N.C., for example, is facing a withdrawal liability bill of \$16.9 million from the Central States, Southeast & Southwest Areas Teamsters Pension Fund, more than double the company's net worth (BI, July 20, 1981).

As many as 500,000 employers are estimated to participate in multiemployer plans, although some say as few as 100,000 are subject to this law.

The Pension Benefit Guaranty Corp. estimates that about 200, or 10% of all multiemployer plans, are in some degree of financial difficulty. Already, pension benefits earned by employees may exceed the plan's assets because employer contributions have fallen short of the benefits promised.

Other plans could be heading for financial problems because the industries they serve are declining and contributions could start falling.

An employer's withdrawal liabil-

ity upon leaving a plan is based on both its participation in the plan and the plan's total unfunded vested benefit liability. Under the most common formula, the employer's liability would be equal to its share of total contributions to the plan.

If, for example, 20 employers each contributed \$100,000 to a multiemployer plan, a withdrawing employer would be 5% responsible for the plan's unfunded vested benefits, even if none of its own employees had vested benefits.

Although small employers, therefore, usually have a smaller share of the liability than large employers, the liability imposed can be burdensome for both large and small employers, Mr. Aronson of NAS notes.

NAS also is marketing the insurance not only as a protection for employers against the cost of liability upon involuntary withdrawal from a multiemployer plan, but also as a benefit to unions and their workers to guarantee funds for pensions, NAS executives say.

The new pension plan involuntary withdrawal insurance covers the employer when the involuntary withdrawal from a multiemployer plan results from any one of the following four situations:

- A complete or partial withdrawal resulting from a change in the collective bargaining representative after a union election or because the incumbent union no longer wants to represent the employees.

This provides coverage for employers when the withdrawal results from employees decertifying their union representation, or if they choose to replace their current union with another. Also, the employer is protected if the current union decides to end its collective bargaining relationship with the employer. However, coverage does not apply if the current bargaining representative is recognized again within three years.

- Partial withdrawal, as defined by the act, caused by a reduction in operations resulting from an occurrence or condition outside the policyholder's control.

This applies, for example, if an employer's contribution base units decline more than 70% over three years. This could occur when an employer's share of a market declines or because demand for the particular product decreases and the same number of employees are not needed.

- Complete withdrawal resulting from physical destruction of an employer's business which does not result from an intentional act or omission by the policyholder.

This protects an employer whose company is destroyed by fire, flood or some other catastrophe and as a result is no longer making contributions on behalf of laid-off or terminated employees.

- Complete withdrawal resulting from a mass withdrawal of all employers from the multiemployer plan.

This protects an employer if all employers stop contributing to the multiemployer pension plan, provided that the policyholder did not support such an action.

The policy requires the employer to act as a reasonable man would in reviewing, and if necessary, challenging the plan's determination of withdrawal liability. The policy will reimburse the policyholder to the limits purchased as the withdrawal liability payments are due based on the schedule set by the plan trustees.

"We feel we found something where there is real need," said Mr. Aronson of NAS.

"To the employer who has a concern that fluctuations in the market could put him into involuntary withdrawal, this is a chance to relieve some of the pressure," said William H. Howe of the Washington

Continued on next page

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Continued from previous page
ton, D.C., law firm of Loomis, Owen, Fellman & Howe, which advised NAS on the policy.

"Certainly one of the areas of perceived unfairness in the multiemployer act is that through no action of the employer, he can be faced with liability," notes Peter Turza, an attorney with Gibson, Dunn & Crutcher, who in his previous position as a Senate committee staffer helped write the multiemployer law and is now involved in multiemployer litigation.

The only problem Mr. Turza foresees is in marketing the insurance. "Sometimes we find employers aren't fully aware of their potential risk under the multiemployer legislation," Mr. Turza said. "We find it frequently in larger companies, believe it or not.

"Large employers are used to thinking about their own plans," he explained. "The company does not think about multiemployer plans in which it has obligations around the country that individually are minor compared with the company plan."

Some multiemployer plans are fully funded and in good financial condition, Mr. Turza noted. When an employer withdraws from a soundly or fully funded plan, the withdrawal liability is minimal, he said.

An employer considering this coverage will want to do the same leg work the underwriters will do in rating the risk. The employer has to look at the plan's unfunded vested benefits and the allocation formula to estimate its liability.

Although union decertification, mass withdrawals by employers and catastrophes destroying business are not all that common, Mr. Turza observed, the coverage for partial withdrawal as a result of declining contributions is very interesting.

"The biggest thing is the employer's perceived risk and to the extent this gives him comfort."

Less enthusiastic about the coverage and somewhat skeptical is Richard Fay, a partner with Reed, Smith, Shaw & McClay in Washington, who also is defending some employers involved in multiemployer litigation.

"From the employer's viewpoint, it covers the extraordinary events, not the ordinary events," he observed. "Where you need coverage is the ordinary events.

"I see all kinds of definition problems," he added, after listening to the definitions of insured events, especially the second insured event of partial withdrawal due to a reduction in covered operation resulting from an occurrence or condition outside the policyholder's control.

"Losing market share doesn't happen suddenly," he observed.

Mr. Fay also expressed concern that the financial condition of a multiemployer plan can change during the 12-month policy period to the detriment of the insurers.

Mr. Aronson of NAS said it is "difficult to discuss 'what-if' situations" regarding coverage, especially regarding claims related to business decisions that reduce market share or lead to withdrawal from a market.

"Involuntary withdrawals have to be measured against the wording. We're looking at a fortuitous event. We don't want this coverage to be used to circumvent the intent of the law."

The adjuster will have to determine if the event was involuntary or intentional, Mr. Aronson suggested. An employer forced out of a particular business by competition may qualify for coverage if he doesn't go back into that business.

"This is reimbursement and not a

liability form. We are dealing with the reasonable man rule," Mr. Aronson said. The test: Did the policyholder act as any reasonable man would in a similar situation?

"The insurance is written with the idea that an employer doesn't want to go out of business," noted Mr. Howe of NAS's counsel. "To the employer who has a concern that fluctuations in the market could put him into involuntary withdrawal, this is a chance to relieve some of the pressure."

Mr. Becker of McDonough Caperton admits the policy is not cut and dry or black and white on every instance. "We tried to include all areas that can arise due to events beyond the employer's control," he said.

Coverage disputes would be subject to arbitration.

No one can estimate how many withdrawals from multiemployer plans will be involuntary. "I do know there are employers concerned about involuntary withdrawal, like partial withdrawal," said Mr. Howe. "They are concerned that through no fault of their own they will find themselves in withdrawal or decertification (by a union)."

Mr. Cath of NAS admits that there may be some employers whose risk of withdrawal liability is too big to underwrite, either because the employer's business is foundering or the plan's unfunded liabilities are too large. He expects, however, "The people who will buy it will be the people who are hopeful they won't have to withdraw."

NAS works only with other brokers. Risk and benefit managers interested in the insurance will have to ask their retail brokers to contact NAS, at 100 S. Wacker Drive, Suite 2006, Chicago, Ill. 60606; or at 225 Santa Monica Blvd., Suite 910, Santa Monica, Calif. 90401. ■

Lloyd's underwriters leading policy

NAS Ltd. convinced two underwriters at Lloyd's of London to lead the two coverages provided under the new multiemployer pension plan involuntary withdrawal insurance policy.

Graham Williamson is leading the withdrawal liability reimbursement and Robin Wilshaw is leading the actuarial and legal expense coverage said NAS Chairman Sid Aronson.

When quoting a risk, NAS will determine what it thinks the employer's withdrawal liability from a multiemployer plan would be based on a number of factors, including the plan's assets and liabilities and the employer's participation in the plan.

The base premiums listed in the chart (on page 1) will be increased or decreased to reflect the amount of risk.

"Some of it is mechanical, some of it is judgment," said NAS President Thomas Cath.

A lot more judgment will have to be applied to risks with tremendous withdrawal liabilities, Mr. Cath said. "We will need more information on the status of the company within its industry."

A policyholder must warrant on the date the insurance takes effect that he has no knowledge of any event or circumstance which could reasonably be expected to give rise to a claim under the policy.

When the policyholder does learn of any occurrence likely to give rise to an insured event, or upon receiving notice of complete or partial withdrawal from the trustees of a multiemployer plan, it must notify the underwriters immediately.

Even when good risks start to turn sour, however, the underwriters can't just back out of the policy. The policy can be terminated only for non-payment of premium. And, a policyholder can retain the coverage for an additional two years—at an increased price—even when the underwriters don't want to renew.

If the underwriters do not offer to renew the insurance, which is written on a claims-made form, the policyholder can get a one-year extension from the date of expiration for an additional premium computed at a rate no greater than 200% of the rate used to determine the premium for the expiring policy.

The policy can be extended for an additional year after the first extension for an additional premium computed at a rate no greater than the 300% of the rate used originally.

When quoting each risk, NAS will quote a price for all the available limits. Mr. Cath anticipates that most employers will want to buy \$750,000 to \$1 million of coverage since they don't know how their liabilities could change in the future.

NAS also will be contact multiemployer pension plan administrators to explain the insurance. "The intelligent thing is for all plan administrators to offer this to their plan members so they are protected against worries and liabilities, which are somewhat unknown," Mr. Cath contends.

Mr. Cath is hopeful that NAS soon will be able to increase the limits available.

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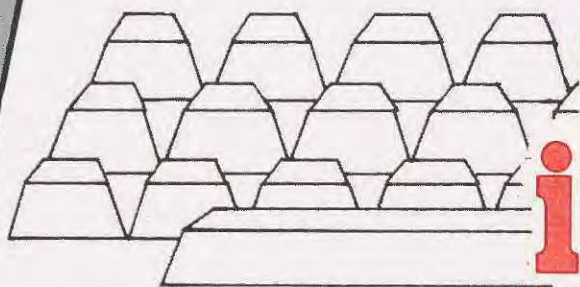
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	OCT 4	Sep 22
FINANCIAL SERVICES: FOR CAPTIVES & SELF-INSURERS	OCT 11	Sep 28
Employee Benefits Board Survey	OCT 18	Oct 6
REINSURANCE: NAI Conference	OCT 25	Oct 12
	NOV 1	Oct 20
NEW ENGLAND MARKET REPORT	NOV 8	Oct 26
Risk Management Board Survey	NOV 15	Nov 3
INTERNATIONAL INSURANCE	NOV 22	Nov 9
	NOV 29	Nov 17
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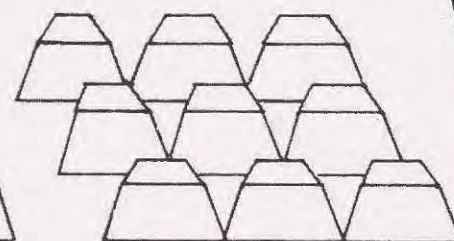
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Two states attacking health cost shifting

Continued from page 2

In the long run, this would mean lower health care costs for these third-party payers. Costs also could drop when hospitals are forced to control costs to live within their preset budgets.

However, if the federal Health Care Financing Administration does not approve waivers to allow the higher Medicaid and Medicare payments, the new laws will not take effect.

"We'd have to start all over again if we can't get the waiver approval," explains Peter Slocum, an aide for New York Sen. Tarky Lombardi Jr., the sponsor of the New York bill and chairman of the state Health Care Financing Committee.

If the waivers are granted, the Massachusetts law would go into effect Oct. 1 and New York's would take effect Jan. 1 when hospitals begin their new fiscal years.

"The new laws are going to give employers more flexibility in how they're going to provide their benefits," explains John Hickey, a partner with benefit consultant Kwasha Lipton in Fort Lee, N.J.

"In the past, an employer with a large number of employees was almost forced to use the Blues because of the large amount of discounts they enjoyed," he explained. "To not use them would mean you'd be willing to pay an additional 15% to 20% for your health plan."

Currently in Massachusetts, the difference between what Blue Cross and commercial insurers pay for hospital services can be as much as 10% to 15%, benefit experts say.

And in New York, the difference can be as high as 35%.

Under the new legislation the difference will be reduced to 15% in New York next year and by 1.4% to about 9.4% in Massachusetts.

By 1985, both states will decide exactly what size differential Blue Cross will have, if any.

In New York, the state Hospital Review & Planning Council will determine whether the Blue Cross discount should be maintained, revised or eliminated, Bernard Backer, senior vp with consultant Martin E. Segal Co. in New York, said in a memorandum explaining the new law.

"If maintained or revised, such discounts will not exceed 12%, effective Jan. 1, 1986," the memo adds.

The law sets the differential at 15% for 1983 and 1984 and drops it to 12% for 1985.

In Massachusetts, a joint study committee is expected to decide by 1985 if it is economically necessary for Blue Cross to have any discount, explains Edward Brennan, counsel for Senate Majority Leader Daniel Foley, sponsor of his state's bill. Until 1985, the differential will hold at 9.4%.

Not insuring with Blue Cross also will enable employers to introduce health plans that promote cost containment by making employees pay higher deductibles or larger copayments. Blue Cross programs, on the other hand, are often full-service plans that pay 100% of claims, Mr. Hickey said.

Edward Brady, manager of U.S. employee benefits operations for Digital Equipment Corp. in Maynard, Mass., agrees.

"Staying with a commercial insurer offers us a potential to design our program, thus helping us to establish a better relationship with our employees," explains Mr. Brady, whose company employs 47,000.

"It allows us more flexibility to add our own cost-containment measures than does Blue Cross.

There may be a lesser outlay with Blue Cross, but you have to give up something."

Digital's health plan is underwritten by John Hancock Mutual Life Insurance Co., which has been the computer manufacturing company's health insurer for 25 years.

In July, Digital strengthened its second surgical opinion program so that the health plan will only pay 80% of employees' surgical charges if they fail to get a second surgical opinion. The company will pay 100% of all surgical charges for employees who get a second opinion.

Mr. Brady, however, does not think the Massachusetts legislation goes far enough in lowering the Blue Cross differential.

Continued on next page

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N.Y., Massachusetts laws could cut health costs

Continued from previous page

"It's (the legislation) a step in the right direction, but it didn't go as far as we'd like to have seen it go. This has taken us closer to parity, but it's not there."

The director of compensation and benefits at Loews Corp., a New York-based entertainment management firm, is optimistic about the long-term effects of the legislation.

"If the hospitals were charging us the same that Blue Cross is paying, then we would all benefit. Hopefully, this will sort of even out things," says Jane Deuval.

Equitable Life Assurance Society of the United States writes the hospitalization and major medical coverage offered through Loews' flexible benefit plan.

Theodore Allison, a vp with the government and industrial rela-

tions department of Metropolitan Life Insurance Co. in New York, also believes the legislation is a step in the right direction.

"For insurance buyers," he notes, "the programs are designed with built-in cost-containment measures. They provide an incentive for hospitals to contain costs."

Cost containment comes when hospitals begin living within their budgets and are forced to hold down fees, benefit experts say.

Under the laws, hospitals would be required to prospectively set their own budgets using the previous year's expenditures, case mix—the predicted number of patients covered by Medicaid, Medicare, Blue Cross, commercial insurers or paying individuals—and an inflation factor set by state regulators.

Hospital budgets would then be approved by state regulators who

would then tell all payers what their share of the budget would be. Hospitals would have to live within the preset budget or be penalized the following year with a reduced budget, explains John R. Hurley, assistant general counsel of the Health Insurance Assn. of America.

Hospitals that come in under their budget will be allowed to keep the difference.

Without these controls, it is estimated that hospital costs in Massachusetts would grow about \$500 million over the next six years, based upon the current rate of growth in hospital costs, industry officials contend. With the new law, cost increases should be cut 7% a year.

The laws in both states also establish bad-debt pools to assist hospitals.

In New York, a statewide bad-debts and charity-care pool will aid hospitals that have been troubled with bad-debt patients and too many free-care patients.

The pool, expected to total about \$300 million by 1985, will be funded by a yearly surcharge to be paid by Medicare, Medicaid, Blue Cross and commercial health insurers. It will

range from 2% in 1983 to 4% in 1984.

In Massachusetts, the legislation establishes a \$10 million pool for financially strapped hospitals. Unlike the New York bad-debt pool, however, this fund can only be utilized by hospitals in extremely poor economic situations, explains Mr. Hurley.

New York officials are hopeful the Medicare waiver will come within the next two weeks.

New York submitted its request in April, several months before enacting its legislation. While officials are hopeful of approval, some fear it could come with some strings attached, especially since the Reagan administration has announced further budget cuts in the Medicare and Medicaid programs.

"We're cautiously optimistic that we'll get the approval," explains Jack Knowlton, administrative director of the New York Council on Health Financing, a 15-member state-appointed hospital financing study group.

"We feel things are moving right along," he said. "But because of what's currently happening with the economy, we might find ourselves having to do some negotiat-

ing. "We feel we'll be successful, however, because for the last several years the health care cost increase for Medicare and Medicaid in New York has been less than it has been in other states across the country."

The waiver, in New York, would raise Medicaid expenditures about \$1 million during the first year.

In Massachusetts, Mr. Brennan is optimistic the waiver will be granted "because with our law, we're helping to contain medical costs."

"We can give assurance that there will be some control on health care costs," he adds.

Although the waivers would mean Medicaid and Medicare initially would pay more for hospital care, over the long-term the government programs would enjoy the same savings as Blue Cross and commercial insurers.

"It would be short-sighted to deny the waiver," suggests Mr. Allison of Metropolitan Life. "In the long run, everyone would benefit from the law. On the basis of that rationale, they (the federal government) should grant the waiver." ■

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Prospective budgeting not new

Prescribing how hospitals should budget and attacking health care cost shifting is not a new idea.

Maryland became the first state to incorporate such a system in 1974, when it adopted legislation that required hospitals to predetermine their operating budgets.

The legislation also reduced the discount that Blue Cross could negotiate with health care providers. Historically, Blue Cross has enjoyed discounts that most commercial insurers couldn't get.

Two years after establishing its prospective budget system, Maryland obtained waivers from the federal government allowing Medicare and Medicaid to pay a greater share of its hospital costs.

By making Medicare and Medicaid pay more of its hospital bills, industry officials say, the state reduced some of the cost shifting to other third-party payers, like commercial insurers, and ultimately to

corporate insurance buyers.

The result has been lower hospital cost increases, explains Peter Slocum, an aide for New York state Sen. Tarky Lombardi, sponsor of a similar law that was recently enacted in his state (see related story). In 1976, Maryland hospital costs per admission increased only 14%, 2% less than the national average, according to John R. Hurley, assistant general counsel of the Health Insurance Assn. of America. Costs increased 9% percent in 1978, 6.5% less than the national average, and they rose 9.5% in 1979, 3.5% less than the national average.

Although the Maryland system was designed to gradually reduce cost shifting, it doesn't have every hospital payer paying exactly the same amount because Blue Cross plans still enjoy discounts—up to 6%—because of their community service and non-profit status, explains Harry Sutton, a vp in the

Minneapolis office of Towers, Perrin, Forster & Crosby.

Despite this, most industry officials still tout the Maryland program as being a successful plan that will serve as a model for others.

Other states which have or are considering legislation that create prospective budgeting systems and reduce Blue Cross differentials similar to the Maryland law include:

● **Maine**—The governor has circulated drafts of a bill that would set a prospective budget review system in place. The proposal also would address cost shifting and establish uniform costs for third-party payers. The proposal is expected to be introduced next year.

● **West Virginia**—Gov. John D. Rockefeller IV supports prospective budget review legislation, which could be passed next year, according to Mr. Hurley.

● **Illinois**—The state enacted a prospective budget plan in 1978, but the law has never taken effect because the state, unlike Maryland, had to obtain federal approval before portions of the law could be instituted, and that approval was delayed for a time.

The original legislation expires Oct. 1 and was not renewed by legislators following an outcry from the Illinois Hospital Assn., which had originally supported the program, explains Thomas O'Hare, director of health care management programs for the Health Insurance Assn. of America.

The Illinois Hospital Assn. initially supported the law because it feared a more restrictive federal program would have been established, explains Mr. O'Hare.

The Illinois legislation would have guaranteed hospitals a profit margin, allowed them to have input into the system and would have guaranteed hospitals they would have been allowed to charge enough to support themselves, Mr. O'Hare says.

Ohio is another state considering legislation that would control health care cost shifting, but unlike the other states, a prospective budgeting system has not been proposed.

Ohio legislators have introduced a bill making it unlawful for hospitals to grant discounts to one third-party payer without offering the same discount to other payers. ■

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Lloyd's releases '79 results

Continued from page 2

utive year in the aviation market. Claims climbed to 235.3 million pounds (\$411.8 million), against net premium income of 233 million pounds (\$407.8 million) for a loss ratio of 100.9%. It is only the second time since 1957 that Lloyd's aviation market posted an underwriting loss.

● Lloyd's largest market, the non-marine market, again posted an underwriting loss. Claims totaled 1.41 billion pounds (\$2.47 billion) while premiums totaled about 100 million pounds less, for a loss ratio of about 101%.

● Overall, the world's oldest insurance market just barely posted an underwriting gain. Lloyd's total premium income, including the relatively small motor and short-term life markets, totaled 2.86 billion pounds (about \$5 billion), an all-time high. But claims almost matched the increase by soaring to 2.82 billion pounds (\$4.94 billion), for a loss ratio of 98.6%.

With the gloomy underwriting results, Lloyd's relatively high profit surprised most observers.

"Last August, an overall profit for 1979 of more than 172 million pounds seemed about as likely as the United States losing the America's Cup," said Lloyd's Chairman Sir Peter Green. "But it is no less welcome for being a surprise, and the market, as a whole, is to be congratulated."

More than three-fourths of the profit is derived from investment income, Sir Peter noted. "About 79% of the balance was derived from investment income. So, when looked at it in purely underwriting terms, 1979 did little more than break even, which explains the gloom currently being expressed in many sectors of the market."

Lloyd's income, other than premiums, totaled 264 million pounds (\$462 million) for the 1979 accounting year, compared with 129 million pounds (\$225.8 million) in non-claim expenses and losses.

Sir Peter said that cash-flow underwriting is a dangerous practice, adding that underwriters could find themselves in trouble if investment income determines bottom-line figures and dictates underwriting policy.

"At this point, insurance gives way to speculation, and underwriters are no longer masters of their own fate," he said.

Lloyd's traditionally uses a three-year accounting system, which is why the results for 1979 were just released. The results are based on an audit of 17,278 Lloyd's members doing business during that year in the aviation, marine, motor, non-marine and short-term life markets. The number of members audited is a 23% increase over 1978.

"By leaving accounts open for three years, during which all premiums received and all claims paid are attributed to the calendar year in which the business was signed, Lloyd's is able to present a more accurate picture of a year's trading," says a statement accompanying the 1979 results.

To close an account, underwriting syndicates estimate the amount of non-reported losses for the accounting year. This estimate is entered into the 1979 account as a claim and carried over to the 1980 account as a reinsurance premium. This procedure is called "reinsurance to close."

Lloyd's also released preliminary figures for the 1980 and 1981 accounts, although they won't be closed until the three-year period expires.

For 1980, aggregate premium income totals about 3.3 billion pounds (\$5.78 billion), more than reported in the final 1979 results, while claims so far total only 895 million pounds (\$1.56 billion). In 1981, un-

derwriters have so far earned 1.4 billion pounds (\$2.45 billion) in premiums and paid out 160 million pounds (\$280 million) in claims.

The non-marine insurance market was hit hard by weather-related losses in 1979, said Richard Ballantyne, chairman of Lloyd's Non-marine Underwriters Assn. Hurricane Frederic, which slammed into the U.S. Gulf Coast, cost the world insurance industry \$752 million. Hurricane David, which struck the West Indies, cost another \$122 million in insured losses.

The non-marine market is also readying itself for an influx of asbestosis claims that may affect the 1979 account, even though it has been closed. Lloyd's underwriters are reserving about \$20 million for claims that have not yet been reported, Mr. Ballantyne said.

"Many of the syndicates in Lloyd's started underwriting after the asbestosis losses had become apparent, and so should be unaffected," said Mr. Ballantyne.

"Others may well have seen the danger coming and have taken steps to minimize the total impact," he said.

Mr. Ballantyne said that Lloyd's has, so far, paid very few asbestos claims, but he expects they'll soon start paying more since policies from U.S. insurers' limits are nearly exhausted.

The aviation market in 1979 also faced its share of disasters. For example, Lloyd's may still be paying claims from the 1979 American Airlines DC-10 crash in Chicago that killed 273 people, the largest aviation claim in history, according to Barry Coleman, chairman of the Lloyd's Aviation Underwriters Assn. In all, 19 Western-built jets were lost and 877 passengers were killed that year.

"The 1979 account was a bad year

all around," said Mr. Coleman. "Rates were depressed in virtually all areas due to a market that was seriously suffering from overcapacity, and the safety record for airline jet aircraft was poor."

However, the market's premium income continues to grow, he said. "The 1979 account is up by 45% over the previous year, the 1980 account is up by 37% and the 1981 account by 30%," he said. The increases are attributed to rising aircraft values, the strong dollar and the hardening of the aviation premium rate.

Although aviation premium rates increased 20% to 25% upon renewal this year, claims have increased, too (BI, July 5). Mr. Coleman said he hopes that rates for U.S. airlines rise another 25% next year.

Only 12 jets were lost and 353 passengers killed in 1981, but so far this year, 18 jets have gone down, totaling \$176 million in hull losses. That's a 50% increase over the 1981 total.

The 1979 and 1980 marine market accounts did not suffer from any major natural disaster, Mr. Rumsey said. But "run-of-the-mill" claims combined with depressed premium rates produced loss ratios of more than 120% for some syndicates in 1979. Relief may be coming, however, because marine insurance rates may go up again soon, he said.

The marine market earns most of its income from the offshore oil industry, whose platforms are insured for up to \$1.5 billion each. But at the same time, the size of offshore claims is increasing too. Mr. Rumsey pointed out.

"Already 1982 has seen two of the largest losses ever to occur—the Ocean Ranger, which sank off Newfoundland (BI, Feb. 22), and the Indian platform, Sagar Vikas, which is expected to be a total loss following a blowout near Bombay," Mr. Rumsey said. "The loss is estimated to exceed \$80 million in each case."

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Officials renew POSA probe

Continued from page 1

piled, that reveals several major commercial insurers—including Northbrook Excess & Surplus Insurance Co., American International Group and AFIA—purchased reinsurance from POSA. The Insurance Department and executives of these companies are now trying to determine how much was paid in reinsurance premiums and what is recoverable.

- Testimony by one of the principals involved in the Den-Har/Sasse Syndicate fraud case linking principals of Promotora De Occidente (New York) Ltd., a POSA service company, to unrelated reinsurance problems of Argonaut Insurance Co.

But, a grand jury investigation, now more than 1½ years old, still has not answered several key questions necessary to further action:

- Who really owned and operated POSA?
- How much in premiums was taken in by the agency and how

much was sent to retrocessionnaires?

- Where were underwriting decisions made and by whom?

The questions are particularly difficult for investigators because no two figures interviewed by investigators or *Business Insurance* agree on even the most minor details of what may turn out to be one of the most complex reinsurance tangles.

Mr. Reyner, whose accusatory letters to state insurance commissioners last year prompted the POSA investigation, contends that he was run out of his own company by four U.S. partners who among themselves owned 50% of POSA of Panama.

The partners were Raymond E. Karlinsky and Maurice Newman, owners of an insurance service firm, Karnew Associates in New York, and operators of POSA (New York); Myron Patt, president of CJV Intermediaries in New York, a reinsurance intermediary; and

Sam Neulinger, a long-time business associate of the other three.

Messrs. Karlinsky, Newman, Patt and Neulinger, however, told investigators that they only worked for POSA, producing or servicing reinsurance business.

In late 1979, they had agreed to purchase the company from Mr. Reyner for about \$1.5 million payable over four years and had made a down payment, they say. Shortly thereafter, Mr. Reyner abandoned the company and never claimed the down payment from an escrow account, they say.

"It's not true," Mr. Reyner told *BI* in a telephone interview from his residence in Heßborn, West Germany, a small town 50 miles north of Frankfurt. "Karlinsky and I were partners from the beginning and the others were his partners."

Mr. Reyner said his business partnership with Mr. Karlinsky began as early as 1970 or 1971, before the founding of POSA, which he contends was in 1972 or 1973.

"I traveled to Los Angeles from Mexico to meet Thomas Werger (a California broker), with whom it was suggested I do business. He was in the hospital and it was suggested I meet with another in his place. The person was Karlinsky, who I met with his partner Jack Goepfert," Mr. Reyner recalled.

Mr. Karlinsky was a former insurance broker who lost his license in the late 1960s for placing risks with the failed State Fire & Marine Insurance Co. Mr. Goepfert was a surplus lines broker.

"We formed a reinsurance intermediary company called Inter-Global Intermediaries," Mr. Reyner recalled of the 1971 meeting.

The three-fold relationship did not last long, however, he said.

"I soon received information about Goepfert's other activities and told Karlinsky we could not work together as long as Goepfert was a partner. So we stopped doing business."

Mr. Reyner's concerns about Mr. Goepfert were confirmed much later. Mr. Goepfert was convicted in April 1981 in Philadelphia for fraud involving the sale of phony construction performance bonds.

And then in 1982 in New York, Mr. Goepfert and co-defendant Allen Assael pleaded guilty to three counts of fraud and one count of conspiracy to commit fraud. They used a brokerage called U.S. Excess to divert about \$1 million from Den-Har Underwriters in Florida and owed to the Sasse Syndicate of Lloyd's of London.

"In 1972 or 1973," Mr. Reyner continued during the telephone interview, "Karlinsky came back to me and said that he had split with Goepfert, so we proceeded to form POSA to sell four retrocession pools through the five fronting reinsurers (Adas, La Republica, etc.)."

In the beginning, POSA underwrote reinsurance according to its binding authority for the fronting companies and the retrocessionnaires in Panama. It had service offices in various European cities, and U.S. business was produced by CJV Intermediaries (also called CJV Associates) and Mr. Karlinsky personally, said Mr. Reyner.

The New York office, POSA (New York) Ltd., was an operating name for the Newman/Karlinsky-owned Karnew Associates. POSA (New York) was originally designed to be only a service office to receive and forward premium and issue reinsurance contracts for the Panama office, Mr. Reyner said.

From 1975 to 1979, however, more business was produced by the New York office as POSA negotiated a series of reinsurance treaties on long-tail casualty risks, sources involved in the investigation say.

"Everything was being done by Karlinsky and Newman in New York," said Mr. Reyner. "I couldn't even get to see the books. I have no idea how much money was involved in the company at this time, but I know they were accepting business excluded by our agreements: credit insurance, U.S. casualty, workers compensation and surety bonds," he said, repeating the charges he has made to state insurance departments that prompted the investigation.

Mr. Reyner said that after he suffered a minor heart attack in 1978, he was inactive in POSA until he returned in 1979. When he returned, he found the company gutted and out of his control, he later told investigators.

After attempting to sort out the activities, Mr. Reyner said he left Panama in late 1979. He said he began writing letters to state insurance commissioners warning them of POSA's activities. The letters were mailed in 1980.

He repeated his charges in person to New York Insurance Superintendent Albert B. Lewis and Assistant U.S. Attorney Betty Santangelo during a meeting in London in March. A sworn statement, still protected by grand jury confidentiality, was later taken in Paris and submitted to the New York U.S. attorney's office, he said.

Maurice Newman, formerly vp of POSA (New York) and partner in Karnew, tells a much different story about the rise and fall of POSA.

During an interview at his new office at 300 Mercer St. in the Greenwich Village section of New York City, Mr. Newman blamed POSA's problems mostly on Mr. Reyner. Mr. Newman says Mr. Reyner was unable to document agreements he said he made with the retrocessionnaires.

Mr. Newman, a Chartered Property and Casualty Underwriter, moved his Karnew office from 730 Third Ave. to the primarily residential apartment building on Mercer Street to cut expenses, he said. He is operating as a reinsurance consultant, principally for two former POSA fronting insurers.

POSA, Mr. Newman contends, was formed in 1971 by Mr. Reyner only, adding that neither he, Messrs. Karlinsky, Neulinger nor Patt were involved in the founding or ownership of the Panamanian company.

His company, Karnew, was later hired by POSA as a service office only to keep accounts and prepare policies, Mr. Newman maintains. Mr. Reyner promised Messrs. Karlinsky, Newman, Neulinger and Patt a portion of the ownership in return for their help in building the business, he added.

"All we had was sweat equity," Mr. Newman told *BI*.

After Mr. Reyner's heart attack, Mr. Newman said, "We suggested that he retire to his vineyard in Germany, let us run things and

we'd send him his salary. We met in Paris in 1978 and we offered to buy the company for about \$1.4 million and paid him \$165,000 into an escrow account with the remainder payable over four years. We have since made another payment."

Mr. Newman contends there is no reasonable explanation of why Mr. Reyner didn't collect the money paid for POSA or why he sent letters to state insurance commissioners.

Mr. Reyner contends he didn't know where to find the money and thought he had been duped.

If someone owed you \$1.5 million, wouldn't you go after it?" Mr. Newman asked.

He admits that after Mr. Reyner ceased to be active in POSA, reinsurance sales began to deteriorate and claims payment from retrocessionnaires started to slow. He says it was because the insurance marketplace had turned competitive again and insurers no longer needed the reinsurance capacity offered by the POSA pools. Some reinsurance business continued to be underwritten in Panama until Mr. Reyner's letter crusade against the new POSA operators became public.

"If Reyner hadn't started writing those letters, forcing us to stop doing business, we probably would've stopped in 1979 or 1980 and just conducted an orderly run-off. There was no more need," Mr. Newman said.

All totaled, Mr. Newman said POSA handled at most \$80 million that was paid to the retrocessionnaires of POSA from 1975 to 1979. He says \$35 million involved U.S. business. A much smaller amount of cash passed through POSA (New York), however, he says.

"If I ever saw \$10 million or \$15 million here, that's a lot," he said. "Most reinsurance accounting involves offsets of various sorts so there is never that much cash premium changing hands."

At one point in 1981, claims totaling \$21 million filed by the fronting insurers of POSA were not paid by the retrocessionnaires. Claims yet to come are unlikely to exceed \$100 million on the \$80 million in premiums, Mr. Newman contends.

In 1981, four of the five fronting insurers sent representatives to New York to form an oversight committee in charge of speeding payment from retrocessionnaires. Adas, the Romanian company, conducted its own review.

"We decided after three meetings that the insurers were more likely to get paid if they approached the retrocessionnaires themselves," Mr. Newman related. "I am still working for two of the companies now, La Republica and Mundial, interpreting the contracts and assisting with the records."

Suits demanding payment of claims are moving through the courts.

Insurance Corp. of Ireland, which bought reinsurance from POSA, has won a judgment against three of the original five fronting reinsurers, Adas, Patria and La Republica. The high court in London awarded the Irish insurer \$300,000 plus interest and court costs for a claim resulting from a 1978 North Sea oil rig accident (*BI*, Aug. 31, 1981).

Meanwhile, Adas, without the assistance of Karnew, filed suit against the retrocessionnaires in Romanian court for payments it says it is owed. The case comes to trial in January, according to Adas U.S. attorney Bernard Hubscher, but has been virtually ignored in the past six months. Adas, he said, is not receiving payments from retrocessionnaires.

Not only the original ownership, but also the current ownership of POSA are unresolved. Mr. Newman says after Mr. Reyner left POSA, the documents of ownership

Continued on facing page

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Continued from facing page
were sent to Commerce Security Bank, a Cayman Island bank where Mr. Newman was a director. Now the stock documents are in the hands of POSA (New York) attorneys in London.

The issue of ownership, however, may be important only to the fraud investigation. There probably won't be any assets left when it is over, Mr. Newman said.

Karnew's responsibility for any unpaid claims is nil, maintains Mr. Newman, both as a matter of agency law and a matter of ethics. As agents with binding authority from the fronting reinsurers, POSA of Panama had the right to accept the business that the fronting reinsurers are now obligated to cover. Mr. Newman maintains that Karnew didn't underwrite or participate in risk transfer.

"The only reason the U.S. attorney was investigating us was that he hoped to tie us back to Goepfert,"

where he had a clear fraud case in the Den-Har/Sasse matter. But our only other connection with Goepfert was one case in which we were desperate to fill out a line. That's it," he said. "Our records have never been subpoenaed, only our checkbooks, as the U.S. attorney hoped to find some link to Goepfert."

Mr. Newman did not make clear whether he was buying or selling reinsurance when he dealt with Mr. Goepfert.

Mr. Newman contends that investigators are on the wrong track with new information that POSA principals were at all linked with the unpaid reinsurance problems of Argonaut Insurance Co. Argonaut is suing Halvanon Insurance Co. of Israel, and Korean Reinsurance, which was a POSA front, for unpaid claims.

Mr. Patt, who produced business for POSA through CJV, sold reinsurance to Argonaut underwritten

by Korean Re, Mr. Newman says. But this particular business was not reinsured by the POSA pools, he says.

Mr. Patt may have tapped POSA pools when trying to complete a line for Halvanon, Mr. Newman says.

Investigators with the U.S. attorney's office and the New York Insurance Department have compiled information that conflicts with Mr. Newman's version of POSA's activities.

Inram Corp., an excess/surplus brokerage controlled by Messrs. Newman and Karlinsky, placed risks with Argonaut, according to testimony before federal court during the Den-Har trial. Under immunity from additional prosecution, reinsurance intermediary Allen Assael told the court that as late as 1975, Inram placed risks with Argonaut that were underwritten by Mr. Newman.

Mr. Karlinsky, working with Mr.

Goepfert, reduced the risks covered by the policies to create return premium due from Argonaut to the policyholder, Mr. Assael said. The return premiums never reached the clients but was split between Messrs. Goepfert and Karlinsky, according to Mr. Assael's testimony.

The New York Insurance Department also disagrees with Mr. Newman's contention that it only looked at POSA's checkbooks. The department's fraud bureau subpoenaed all POSA records last year and fought Messrs. Newman and Karlinsky's attempt to block the subpoena. The subpoena was upheld in New York State Supreme Court on Feb. 1, and the department received some records, according to Paul Altruda, counsel for the fraud bureau.

Those records and data gathered by the New York Insurance Department also conflict with Mr. Newman's estimate that POSA handled \$80 million in net premi-

ums and up to \$150 million in gross premiums.

Sources in the Insurance Department say that, according to one formula used to estimate gross premium, U.S. insurers could have paid as much as \$300 million to POSA for reinsurance.

Shocked by the amount of money involved, Insurance Department researchers are redoing their calculations using a new formula, sources say.

The department won't say when its new estimates of POSA's premium volume from U.S. insurers will be available. When the figures are ready, they will be shared with the U.S. attorney's office.

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Scrutinize reinsurance contracts: Lewis

By LEN STRAZEWSKI

NEW YORK—Regulators and buyers of reinsurance and insurance must study reinsurance purchases to be secure, says the New York superintendent of insurance.

"I've never seen such fraud in my life until I started carefully monitoring the reinsurance business," remarks Superintendent of Insurance Albert B. Lewis.

"I wouldn't accept any reinsurance agreement as they stand now. There's fraud going on all over the world—and the biggest thieves are in the London market.

"The accounting practices which are supposedly well-accepted in the

reinsurance business there are ridiculous. They (some London underwriters and reinsurers) juggle their books from year to year to make them look balanced and pass on binding authority to almost anybody."

The New York Insurance Department has been involved in at least two reinsurance investigations: One involving reinsurance contracts placed for and with Promotora De Occidente de Panama, S.A., a Panamanian managing general agency, and another involving Argonaut Insurance Co. and Halvanon Insurance Co. of Israel.

The depth of the investigation was so startling, Mr. Lewis is rec-

ommending that the National Assn. of Insurance Commissioners design model laws to regulate international reinsurance treaties and the intermediaries that place risks with the reinsurance markets.

New York's own proposal to regulate the reinsurance market, Regulation 98, seeks to better regulate reinsurance intermediaries.

"It's always the same, in all the fraud cases I have looked at," explains Mr. Lewis, who is now writing a handbook on reinsurance transactions. "Poor record keeping is always the excuse. The intermediaries and reinsurers always claim that they are not geared for a large volume of business, agreements

were made verbally and not completely confirmed in writing or that the books are unclear.

"That's nonsense. This is the age of computers. There's no excuse for not keeping records."

Suspect reinsurance transactions also contain other telltale signs, according to Mr. Lewis, including:

- Extremely low reinsurance premiums for poor risks, usually long-tail casualty coverages, that nobody else seems to want.

- High and frequent commissions paid to reinsurance intermediaries. In one case under investigation, intermediaries at various levels of the transactions received more than 60% of the premium.

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\$5 billion in worker suits prompts inquiry

Continued from page 1

The largest lawsuit to date is a \$4 billion class action, and it is estimated that at least another 250 individual suits have been filed. They seek \$200,000 to \$2 million each, bringing total damages sought to about \$5 billion. But, it is believed many more have been filed but just not tracked down yet.

"We've got a three- to four-page incomplete list of ongoing litigation

and suits are still be filed every day," said Edwin Wiles, chairman of the Business & Industry Council, who is trying to survey the various courts in the state for Mandolidis-type suits.

But that list probably represents just "the tip of the iceberg," says Mr. Gallagher of ACF Industries. He believes the number of suits may have doubled since March, when a tally was last taken. BIC

expects to have an updated list of lawsuits in about three weeks.

The \$4 billion class-action suit was filed in 1981 on behalf of 142 workers at a Monsanto Co. plant in Nitro, W.Va.

It alleges that workers were not adequately protected against dangerous chemicals at the plant, which manufactures paper and agriculture and rubber products.

The attorney for the workers says the case is directly tied to the Mandolidis decision because Monsanto "knew or had reason to know" its work environment was dangerous to its employees. Thirty of the plaintiffs are survivors of dead workers.

The case against Monsanto is still pending before the U.S. District Court in Charleston.

In another case, a \$4 million jury award is on appeal to the state Supreme Court by Jumacris Mining Co.

In two actions against Eastern Associated Coal Co., the company has been ordered to pay one former worker \$1 million and another \$850,000 based on the Mandolidis decision.

Countless other cases are being settled out of court by employers that fear publicity will only prompt

more employee lawsuits.

Even employers that have not been hit by any suits fear the precedent set by the Mandolidis case.

"So far, we haven't been hauled in by a lawsuit based on this case," said Edger M. Pope, chief legal officer for International Nickel Co. Inc. in New York, but he fears it could be only a matter of time before it is.

"I'm in favor of legislation that would return us to pre-Mandolidis," added Mr. Pope, who represents employers on the new Mandolidis commission.

James Manolidis (whose name was mistakenly typed into the court record as Mandolidis) worked for Elkins Manufacturing Co. in Elkins, W.Va., when he accidentally cut off part of his hand with a saw he was operating.

That incident occurred just days after the company had been cited by a federal inspector for not having a safety guard on the saw.

Management told Mr. Manolidis to operate the saw without a safety guard, his suit claimed. The plaintiff later died of natural causes, but not before the state Supreme Court in 1978 said he had the right to sue. His wife settled the case out of court for \$5,000 after she was told that her husband's death would

hurt the chances of a successful trial.

The court based its decision on a case that dated back to 1917, when the state added a provision to the law allowing an employee to sue in court for death or injury if it resulted from an employer's deliberate intent to harm a worker.

In 1933, the West Virginia Supreme Court ruled an employee has the right to go to court to prove deliberate intent.

A judge involved in the Mandolidis case said a jury can infer an employer is intentionally harming a worker if the employer violates a safety rule and the employee is injured or killed.

West Virginia's AFL-CIO President Joseph Powell says employees should have the right to sue their employer if there is a disregard for safety.

The Mandolidis Commission, which is scheduled to meet on Sept. 14, hopes to have a recommendation by January, when West Virginia's Legislature reconvenes.

With representatives from both labor and business on the commission, it's believed whatever is worked out will have a good chance for enactment, said Mr. Wiles of BIC.

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• "Insurance Company Operations" (CPCU 05), to be offered Mondays from 5:15-8:15 p.m.

• "Management" (CPCU 07), to be taught in two different sections: Mondays or Tuesdays, both 5:15-8:15 p.m.

• "Economics" (CPCU 09), to be taught Mondays and Wednesdays from 5:15-7:15 p.m.

Registration for the classes will be held at the college's New York campus, 123 William St., Sept. 7-9 from 11:30 a.m. to 2 p.m. and from 4:30-6 p.m.

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Insurance Management:	
vps, directors, managers of insurance, risk, benefits, compensation, safety, security, etc.	5,948
Government, Associations, Unions, Educational Institutions	
	1,004
Commercial Consumers Sub-total	
	23,083
Insurance Agents & Brokers	
Insurance Cos.	9,829
Financial Institutions	4,944
Actuaries, Attorneys, Adjusters, Appraisers & Consultants	314
Others allied to the field	2,408
	854
TOTAL	41,232

*Source: Business/Occupational breakdown of qualified circulation, May 3, 1982 issue, as submitted to BPA for June 1982, BPA Publisher's Statement.

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Know a fine risk manager? Nominate him for *BI* award

Continued from page 3

manager of Porcero's Homes in Irvine, Calif., representing small businesses; and Gene M. Marsh, executive vp for risk management for the General Conference of Seventh-day Adventists in Takoma Park, Md., representing a tax-exempt entity.

Anyone involved in risk management for a corporation, institution or government entity can be nominated. The person need not practice risk management full-time, but the candidate must be a full-time employee of the corporation, institution or government entity. The candidate may be nominated by anyone familiar with his or her work, like a superior, the risk management staff, a colleague with another company or a broker, insurer or other service supplier.

The judges of the competition are 10 professionals representing all aspects of risk management and the commercial insurance industry. The panel includes former winners of the Risk Manager of the Year Award and people named to the Risk Management Honor Roll, executives from insurance companies, a large commercial brokerage company, a small commercial brokerage company, a risk management consultant and an insurance academician.

The names of this year's judges will be announced next month.

Each candidate will be scored by the judges on 10 criteria (see box). The candidate with the highest aggregate score will be named the Risk Manager of the Year.

The Risk Management Honor Roll will include those candidates with the highest scores in each employment category not represented by the winner of the Risk Manager

The judges' scorecard

Here are the 10 criteria against which the judges will score candidates for the *Business Insurance* 1983 Risk Manager of the Year award:

- 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.
- Established a workable intelligence system inside and outside the organization, culminating in access to a flow of information about events and activities that affect the organization's risk management and insurance.
- Skillfully performs the functions of management in the overall organization and within the risk management/insurance department.
- 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.
- Is developing his or her career.

of the Year Award. The employment categories are: large corporation (more than \$300 million in sales); small corporation (less than \$300 million in sales); government entity; and tax-exempt or not-for-profit institution.

All nominations must be submitted in a specially prepared folder with preprinted forms provided for supplying the necessary information.

In addition to the forms requesting the nomination and supporting material, each nomination must include a letter from the sponsor nominating the candidate and a letter of endorsement of the candidate by

an executive of his or her corporation or organization. The endorsement can come from the candidate's superior or any higher officer and must certify the accuracy of the information submitted in the nomination.

The information contained in the nominations will be held in strictest confidence by the judges and *Business Insurance* and will not be released without permission of the winning candidate.

Requests for nominating forms should be addressed to *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611; Attn.: Risk Manager of the Year.

Hearing scheduled on builders' pool

WILMINGTON, Del.—A national home builders' association, which is trying to convince Delaware's insurance commissioner that it has formed a risk retention group, will have a chance to present its case at a public hearing.

Insurance Commissioner David Elliott will hold a hearing Sept. 14 in Wilmington to determine if the Home Owners Warranty Corp.'s new captive insurance company, HOW Insurance Co., is a risk retention group authorized under the 1981 Risk Retention Act.

At issue in the dispute between Mr. Elliott and the 11,000-member

home builders' association is the definition of a product liability risk and whether a state's definition or the federal definition prevails when there is a difference.

Mr. Elliott says the warranty risks that the HOW insurance would cover are not product liability exposures, which are the only exposures a risk retention group can underwrite. He says home builders' exposures for defective products are surety and property exposures under Delaware law.

But HOW President Robert Reid says the warranty coverage is

within the Risk Retention Act's definition of product liability and the federal definition pre-empts any state definition. Mr. Reid earlier warned that HOW might take Mr. Elliott to court if he didn't recognize HOW as a risk retention group (*BI*, June 29).

As a risk retention group, HOW would be able to serve members in all states without being licensed in every state or use a fronting insurer to avoid run-ins with state regulators.

The Sept. 14 hearing will begin at 10 a.m. in the Carvel State Office Building, 820 N. French St.

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Summary of major property/casualty insurer first-half results, 1982

(all figures in thousands)

Corporate					Property/casualty operations							
Rank 1982	Consolidated revenues 1982	Aftertax ² operating income 1982	Aftertax ² operating income 1981	Percent change 1981-1982	Combined ratio 1982	Combined ratio 1981	Pretax underwriting income (loss) 1982	Pretax underwriting income (loss) 1981	Percent change 1981-1982	Aftertax net ¹ investment income 1982	Aftertax net ¹ investment income 1981	Percent change 1981-1982
1 The Home Group Inc.	\$1,115,830	\$67,351	\$48,871	37.8	114.6	110.2	(113,715)	(84,663)	(34.3)	150,272	120,226	25.0
2 American General Corp.	1,323,400	93,200	73,500	26.8	104.5	109.5	(13,300)	(27,300)	(51.2)	48,700	45,100	7.9
3 American Int'l. Group Inc.	1,700,800	196,984	159,814	23.3	96.9	95.1	23,885	38,608	(38.1)	132,608	108,209	22.5
4 General Re Corp.	739,500	97,800	84,000	16.4	101.3	99.4	(6,000)	1,300	—	83,500	71,700	16.5
5 Old Republic Int'l. Corp.	199,000	20,694	18,631	11.1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
6 Fireman's Fund Ins. Cos.	1,600,000	119,000	111,000	7.2	104.2	102.0	(50,300)	(33,400)	(50.6)	139,600	121,500	14.9
7 Mission Ins. Group Inc.	215,755	24,453	22,840	7.1	100.5	99.5	(424)	478	—	21,847	18,716	16.7
8 Aetna L&C Co.	6,934,400	223,300	209,800	6.4	115.2	111.9	(282,400)	(226,600)	(24.6)	228,500	204,900	11.5
9 The St. Paul Cos.	1,036,300	89,100	89,500	(0.4)	106.6	104.0	(46,400)	(25,600)	(81.3)	124,200	106,900	16.2
10 CNA Financial Corp.	1,594,474	57,125	58,482	(2.3)	116.3	111.7	(144,000)	(90,000)	(60.0)	183,200	140,600	30.3
11 Kemper Corp. (incl. life)	993,630	34,708	39,293	(11.7)	108.7	104.7	(41,422)	(20,415)	(102.9)	33,318	31,471	5.9
12 Reliance Ins. Co. & subs.	572,106	35,883	40,648	(11.7)	103.9	101.8	(17,541)	(9,350)	(87.6)	84,920	67,685	25.5
13 SAFECO Corp.	723,576	45,527	53,043	(14.1)	104.3	97.2	(15,823)	(9,553)	(65.6)	42,994	39,231	9.6
14 The Travelers Corp. & subs.	5,686,200	138,700	171,200	(19.0)	110.8	106.9	(184,700)	(114,500)	(61.3)	164,581	152,169	7.9
15 The Hartford Ins. Group	2,222,264	104,687	138,076	(24.2)	111.2	107.7	(118,984)	(76,004)	(56.5)	205,912	197,858	4.1
16 Crum & Forster	978,462	64,830	92,101	(29.6)	112.9	102.0	(110,539)	(16,633)	(564.6)	120,762	102,919	17.3
17 The Continental Corp.	1,686,035	57,379	90,726	(36.8)	112.5	108.7	(180,050)	(120,289)	(49.7)	150,144	135,135	11.1
18 CIGNA Corp.	5,690,097	178,421	285,688	(37.5)	115.1	107.0	(285,662)	(119,110)	(139.8)	289,770	256,585	12.5
19 USF&G Corp.	1,152,087	52,984	87,315	(39.3)	112.6	102.8	(125,552)	(32,176)	(190.2)	120,536	101,478	18.8
20 The Chubb Corp.	749,000	24,100	50,500	(52.3)	116.1	102.2	(37,900)	(5,400)	(601.9)	50,300	45,800	9.8
21 Ohio Casualty Corp.	417,786	8,986	23,470	(61.7)	107.4	99.7	(30,453)	2,146	—	39,025	34,717	12.4
22 Hartford Steam Boiler	106,980	1,772	8,776	(79.8)	99.5	91.0	355	6,415	(94.5)	8,358	7,368	13.4
23 Fremont General Corp.	207,827	2,399	14,367	(83.3)	118.8	100.1	(24,323)	(128)	—	17,273	16,464	4.9
24 Royal Group (U.S. subs.)	N/A	(2,100)	29,800	—	113.1	102.5	(92,800)	33,800	(174.5)	79,000	71,100	11.1
— Commercial Union Ins. Cos.	N/A	N/A	N/A	N/A	115.8	109.3	(132,800)	(81,200)	(63.5)	87,500	72,100	21.4
Cumulative	37,645,509	1,737,283	2,001,441	(13.2)	109.3	103.6	(2,030,658)	(1,009,574)	(101.1)	2,606,820	2,269,931	14.8

N/A: Not available.

¹Some companies report pretax only.²After taxes where available.

Insurers record lower earnings

Continued from page 3

Mr. Frahm says he does expect some firming of rates in 1983, but not enough to match an estimated 12% hike in insurers' costs.

For the first half of 1982, The Hartford posted a 3.5% decline in written premiums among its worldwide property/casualty subsidiaries. And Aetna Life & Casualty Co., which started to boost commercial rates last year, suffered a similar 6.7% drop in written premiums.

Overall, the surveyed insurers posted an average 3.2% gain in written premiums. The two companies posting the greatest property/casualty premium gains were Kemper Corp. (20.0%) and American General Corp. (16.0%).

Kemper management cited its share of underwriting results from Lumbermens Mutual Casualty Co., which was increased 5% to 40% on Jan. 1, as contributing "substantially" to an increase in both premiums and losses reported.

Reserve worries

Such slender composite premium growth has led some analysts to speculate that insurers worried about cash flow and earnings may not make adequate contributions to reserves to cover future losses.

If that's true, one analyst said, some insurers may be forced by regulators or mounting actual losses to make lump-sum additions to reserves at the end of the year.

"A bunch of these guys aren't putting money into the reserves because I don't think they've got it," one analyst said.

The Chubb Corp., acknowledging prodding by a routine examination by the New York Insurance Department, added a whopping \$60 million before taxes to its medical

malpractice loss reserves and reported a 52.3% drop in its six-month operating earnings. Management says the \$60 million cost Chubb 11.1% on its first-half combined ratio of 116.1%. Chubb's combined ratio stood at 102.2% at the end of the first half of last year.

"It is also important to point out that Chubb has now strengthened reserves in this line by \$140 million since the end of 1978," says analyst Denis J. Callaghan, a first vp of Dean Witter Reynolds Inc. in New York who follows insurance stocks. He notes that Chubb continues to write a medical malpractice program with the American Dental Assn. and the American Psychiatric Assn. but has trimmed its other medical professional liability programs since 1978.

Figures compiled by the Insurance Services Office from a sampling of nine medical malpractice insurers show a composite loss ratio for that class of business of 207% for the first quarter of 1982, up from 170% a year earlier. Losses have mounted steadily in medical malpractice since 1978, according to ISO's "fast-track monitoring system," and the line became unprofitable in late 1979.

At St. Paul Fire & Marine Insurance Co., the nation's largest medical malpractice underwriter, actual and unreported losses plus expenses in that line rose 19.8% to \$86.9 million in the first half, a company spokesman says.

"It just highlights the problem of this industry: that is you're selling a product, the price of which you're not going to know for several years," says James B. Stradtner, a general partner at Alex. Brown & Sons, the Baltimore-based securities brokerage.

Mr. Callaghan compiled information on the property/casualty industry's aggregate statutory sur-

plus at the end of the first quarter of 1982 and found that the figure represented a \$2.6 billion decline.

"This is the first time in over six years that the industry's surplus position eroded," says Mr. Callaghan, who blames the decline on a weak stock market, which has eroded the value of insurers' portfolios. Wall Street's recent rallies may change that picture in the third quarter.

Work comp losses

As fierce competition and a troubled economy generally trim commercial lines premium growth, they may begin to take a particularly harsh toll on insurers that write workers compensation coverage, some analysts warn. The line has been one of the few profitable ones in recent years.

Losses could result because premiums are based on payrolls and as payrolls shrink, so do premiums. To compound matters, work comp claims can also rise as workers are laid off, as General Motors Corp. recently discovered after it closed two California plants (BI, Aug. 9).

"When year-end audit premiums are reviewed, the unemployment situation may result in no additional premiums being paid to the companies," says analyst Myron M. Picoult, who follows insurance stocks for Oppenheimer & Co. Inc. in New York. "In fact, some credits may be due."

Fremont General Corp., which specializes in workers compensation coverage, posted a first-half operating earnings decline of 83.3%, the second-worst result reported in the survey. Fremont General's first-half combined ratio of 118.8%, up from 100.1%, was also the highest of the 25 companies surveyed. Fremont reported a 16 percentage

Continued on facing page

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Investment income increases begin to slow

Continued from facing page

point deterioration in the combined ratio for its work comp lines.

Crum & Forster's first-half combined ratio of 112.9%, while lower than other multiline competitors like CNA, Royal, CIGNA, Aetna, Commercial Union and Chubb, rose more steeply—10.9 percentage points—than any company other than Chubb or Fremont. Crum & Forster said the combined ratio for its workers compensation lines rose seven percentage points.

CIGNA cited "large declines" in workers compensation premiums as partially responsible for a 4.7% decline in property/casualty written premiums, and The Travelers confirmed that its combined ratio on workers compensation shot up to 106.7% in the first half from 91.8% in the half of 1981.

The Travelers said most of the increase could be attributed to normal fluctuations in the relationship between the payment of losses and the collection of additional premiums on retrospectively rated policies.

Overall, The Travelers held its combined ratio to 110.8%, up from 106.9%, a relatively small deterioration. For all property/casualty lines, the company reported catastrophe losses of \$30.2 million for the first half, compared with \$13.8 million a year earlier.

The Travelers Chairman and Chief Executive Officer Edward H. Budd told shareholders that renewal prices have not matched rising costs and "it will be well into 1983 before price increases will have a favorable impact on results."

The steepest increases in overall combined ratios—besides Fremont, Chubb and Crum & Forster—were posted by Royal Group Inc.'s U.S. subsidiaries and USF&G Corp. Royal's combined ratio shot up to 113.1% from 102.5%, while USF&G's rose to 112.6% from 102.8%.

Investment income slows

As competition in commercial lines grew fiercer during 1980 and 1981, underwriters relied upon lusty gains in investment income to maintain profitability despite underwriting losses. However, the first-half results show they may not be able to do that much longer.

Investment income grew 14.8% during the first six months of 1981 among the 25 surveyed insurers. At year-end 1981, it had risen to 17.0% for the year among a similar group.

Two factors affect investment income

BI ticker

gains. The first is premium volume and the second is the prevailing interest rates in the nation's money markets. Both factors are trending badly for insurers.

With virtually no growth in premium volume, insurers experience a leveling of the amount of cash available for investment until losses and expenses are paid. At the same time, falling interest rates mean that cash earns less during the period in which it is invested.

Among the 23 insurers that reported both earned and written premiums to BI, earned premiums totaled \$18.5 billion for the six months ended June 30. But losses and underwriting expenses totaled \$20.3 billion. The shortfall was made up by investment income of \$2.4 billion, with a tidy \$630 million left to be applied to earnings and/or surplus.

After the first six months of 1981, however, the amount remaining was \$1.2 billion, primarily because of much lower losses and only slightly lower investment income.

The message to insurers: It appears that investment income won't make up for big underwriting losses much longer.

Other highlights

Here are a few specific highlights from the second quarter and the first half:

• The Home Group Inc., which owns The Home Insurance Co., topped the companies surveyed by BI with a 37.8% first-half gain in aftertax operating income.

For the first time in recent years, the New York-based insurer published a detailed quarterly financial statement separately from its parent, City Investing Co. Executives say the report is part of an effort to make agents, brokers and insureds more aware of The Home's quarter-by-quarter accomplishments.

"As you are probably aware, there were a lot of rumors about The Home, none of which had any credence at all," says John Tetro, The Home Insurance Co.'s controller. "And one of the ways to put those to rest is through the issuance of these statements."

As the statement notes, \$19.7 million of The Home Group's first-half operating income was derived from a gain on the Jan. 1 sale of its Seaboard Surety Co. unit to The St.

Paul Cos. Inc.

Without the Seaboard sale or the results of two non-insurance subsidiaries, The Home Group's pretax operating income would have been \$39.7 million, a 4.0% increase over the first half of 1981. Such a result would have dropped The Home to the No. 9 position.

The Home's combined ratio after policyholder dividends of 114.6%, while higher than the survey average of 108.8%, is comparable to two giants of the industry, CIGNA Corp. (115.1%) and Aetna (115.2%).

• Houston-based American General Corp., nearing completion of its \$1.5 billion merger with NLT Corp., an underwriter of primarily life and health insurance based in Nashville, Tenn., surprised stock analysts with a 26.8% first-half gain in aftertax operating profits. The two companies say their merger would create the nation's fourth-largest investor-owned insurer on the basis of assets.

Management said property/casualty earnings rose 44% on revenues of \$414.9 million.

In addition, American General was the only insurer among 25 checked by BI to report a decrease in its combined ratio—to 104.5% from 109.5% in the first six months of 1981.

• Chicago-based CNA Financial Corp., which reported a stunning 20.9% gain in operating income for the first quarter of 1982, reported a 2.3% decline for the first six months because of mounting losses and expenses in its consolidated life/casualty operations.

In addition, CNA's unusually high losses in the first quarter of 1981 made the first quarter of 1982 appear better than it really was.

CNA's property/casualty losses in the first half were in the same range as its competitors', but it reported a 30.3% first-half gain in pretax investment income for Continental Casualty Co. and its subsidiaries, the best of the companies reporting investment income data.

Both analysts and the company attributed the earnings fluctuations to CNA's life/health operations.

• Among the other commercial property/casualty insurers checked, only two reported combined ratios under the underwriting break-even figure of 100%: American International Group (96.9%) and The Hart-

ford Steam Boiler Inspection & Insurance Co. (99.5%). Four others that had posted combined ratios under 100% in the first half of 1981 were on the other side of the fence in 1982. They are Mission Insurance Group Inc., which rose to 100.5% from 99.5%; SAFECO Corp., which rose to 104.3% from 97.2%; General Re Corp., which rose to 101.3% from 99.4%; and Ohio Casualty Co., which rose to 107.4% from 99.7%.

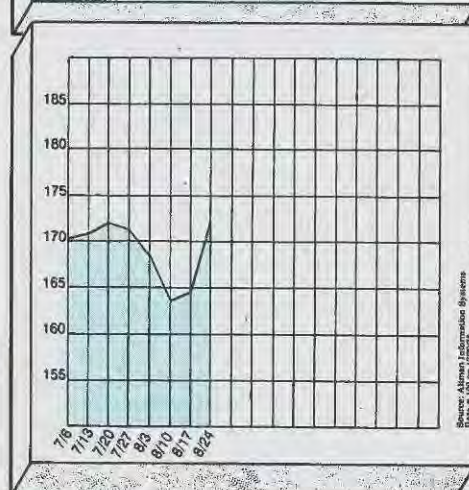
• Armco Insurance Group Inc. is not required to disclose operating or underwriting results publicly because it is a group of subsidiaries of Armco Inc., the diversified specialty-steel manufacturer based in Middletown, Ohio. However, it is the major component of Armco's financial services group, for which summary results are reported quarterly to the Securities and Exchange Commission.

A BI analysis of the financial services group figures, supported by discussions with Armco executives, suggests that Armco's property/casualty earned premiums for the six months declined 0.2% to \$296.7 million. Estimated underwriting losses were \$44.8 million for the half, up 59.4% from the same period in 1981, and pretax investment income rose 10.3% to \$46.0 million.

The entire financial services group, which includes leasing and life insurance subsidiaries, suffered a first-half operating loss of \$27.7 million, according to the figures reported to the SEC, compared with a \$17.9 million profit in the first half of 1981.

In addition to Armco, Commercial Union Insurance Cos., a subsidiary of British-based Commercial Assurance Co. Ltd., is not required to report its operating results. And Old Republic International Corp. does not release its underwriting data.

BI Insurance Index



Insurance industry stocks posted a strong recovery during the week ending Aug. 24 as the Business Insurance stock index zoomed 7.8 points to 172.4 from 164.6. Forty-six issues gained, 10 declined and 12 were unchanged. The leading gains were reported by Foremost Corp. American, 19.6%; Provident Life & Accident Insurance Co., 17.4%; Employers Casualty Co., 15.1%; Combined International Corp., 14.4%; and Marsh & McLennan Cos. Inc., 13.9%. The largest losses were posted by Reed Stenhouse Cos. Ltd., 4.5%; Excelsior Insurance Co., 4.3%; Frank B. Hall & Co. Inc., 3.8%; and Optimum Holding Corp., 2.9%. The 4.7% rise in the index lagged behind the increases posted by the major market averages.

British Issues

24 Aug Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	
Comml Union	138	14.5	16.86	12.2	139	130
Eagle Star	350	12.5	21.43	6.1	351	348
Genl Accident	292	10.8	23.21	7.9	292	282
Gdn Royal Exch	306	7.7	25.00	8.2	306	292
Phoenix	268	10.7	24.00	9.0	268	258
Royal	385	10.4	36.07	9.4	385	375
Sun Alliance	780	9.8	61.43	7.9	780	770

Brokers		Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	
CE Heath	352	9.6	18.71	5.3	357	352	
Hogg Robinson	100	7.7	8.57	8.6	101	99	
JH Minet	141	12.8	5.43	3.9	143	141	
Sedg Grp	173	11.2	8.57	5.0	175	173	
Stenhouse Hldg	113	10.0	7.28	6.4	117	113	
Stew Wrightson	272	9.7	18.57	6.8	275	272	
Willis Faber	507	12.7	21.43	4.2	507	505	

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

BI Industry Stock Report

AUG. 24, 1982										8/18/82 THRU 8/24/82									
Insurance Cos.										AUG. 24, 1982 8/18/82 THRU 8/24/82									
		Price	% Chg.	P/E	\$ Div.	% Yld.	High	Low	Vol. (000)			Price	% Chg.	P/E	\$ Div.	% Yld.	High	Low	Vol. (000)
Aetna Life & Cas Co	NYSE	36.75	5.0	5.9	2.52	6.9	36.75	34.13	1,267.4	United Fire & Cas Co	OTC	29.00	1.8	7.6	0.88	3.0	29.00	28.50	0.5
American Bankers Ins Group	OTC	7.38	-1.7	3.5	0.48	6.5	7.38	7.38	154.9	United States Fld & Stry Co	NYSE	37.13	3.8	7.8	3.60	9.7	37.13	35.75	356.8
American Gen Ins Co	NYSE	36.63	6.9	3.0	2.20	6.0	36.63	34.00	265.8	United Svcs Life Ins Co	OTC	12.88	13.2	4.7	1.00	7.8	12.88	11.88	28.7
American Indty Fint Corp	OTC	13.50	2.9	10.1	1.12	8.3	13.50	13.25	21.0	USLife Corp	NYSE	17.50	11.1	3.7	0.84	4.8	17.75	16.25	295.8
American Intl Group Inc	OTC	64.25	9.4	9.8	0.48	0.7	65.00	59.25	580.3	Washington Natl Corp	NYSE	17.75	1.4	8.5	1.08	6.1	18.25	16.63	113.3
American Natl Ins Co	OTC	13.00	-1.0	5.5	0.76	5.8	13.13	13.00	35.6	Zenith Natl Ins Corp	OTC	14.00	9.8	6.5	0.76	5.4	14.00	12.50	41.0
American Sta Life Ins Co	OTC	17.50	0.0	5.6	0.80	4.6	17.50	17.50	0.7	INSURANCE COMPANIES									
Aneco Reins Ltd	OTC	2.75	0.0	0.0	0.00	0.0	2.75	2.75	2.7	AVERAGE									
Aveco Corp	AMEX	10.00	-1.2	6.3	0.54	5.4	10.38	9.88	10.5	6.4 5.2									
Banks Iowa Inc	OTC	36.50	1.4	6.9	1.48	4.1	36.50	36.00	8.9	Agents/Brokers									
Bitco Corp	OTC	27.50	0.0	4.3	1.92	7.0	27.50	27.50	0.9	Alexander & Alexander Svcs	NYSE	22.50	-2.2	8.2	1.94	8.6	23.50	22.50	368.7
Carolina Cas Ins Co	OTC	6.50	0.0	6.4	0.32	4.9	6.50	6.50	3.7	Baldwin & Lyons Inc	OTC	34.50	0.0	6.0	0.80	2.3	34.50	34.50	0.7
Chubb Corp	OTC	34.13	11.9	5.4	2.92	8.6	34.13	31.25	507.5	Corroon & Black Corp	NYSE	20.50	1.9	10.1	1.76	8.6	20.50	20.38	10.3
Combined Intl Corp	NYSE	21.88	14.4	6.2	1.80	8.2	22.00	20.00	422.7	Crump E H Cos Inc	OTC	8.63	0.0	16.0	0.40	4.6	8.63	8.63	1.1
Continental Corp	NYSE	22.63	6.5	6.8	2.60	11.5	23.13	21.38	1,043.9	Emett & Chandler Cos Inc	OTC	8.50	0.0	12.7	0.00	0.0	8.50	8.50	42.0
Crawford & Co	OTC	14.00	5.7	10.3	0.56	4.0	14.00	13.50	2.1	Hall Frank B & Co Inc	NYSE	25.00	-3.8	9.7	1.70	6.8	26.50	25.00	177.2
Crown Life Ins Co	OTC	70.00	7.7	5.2	3.10	4.4	70.00	64.50*	0.1	Integrated Res Inc	AMEX	16.00	3.2	5.4	0.00	0.0	16.25	15.50	53.7
Crum & Forster	NYSE	24.75	7.0	4.8	1.76	7.1	24.75	22.75	558.0	James Fred S & Co Inc	NYSE	22.38	0.6	10.9	1.60	7.2	23.00	22.25	54.1
Employers Cas Co	OTC	26.75	15.1	11.8	1.20	4.5	26.75	23.00	22.7	Marsh & McLennan Cos Inc	NYSE	34.75	13.9	10.5	2.20	6.3	34.75	32.00	260.6
Equifax Inc	NYSE	35.13	1.1	10.0	2.60	7.4	35.25*	34.25	24.0	PennCorp Fnl Inc	NYSE	8.00	-1.5	5.6	0.16	2.0	8.25	8.00	220.9
Excelsior Ins Co	OTC	11.00	-4.3	28.6	0.70	6.4	11.00	11.00*	0.0	Poe & Assoc Inc	OTC	9.00	0.0	10.2	0.80	8.9	9.00	9.00	1.1
Farmers Group Inc	OTC	33.88	9.3	9.5	1.24	3.7	33.88	31.50	306.2	Reed Stenhouse Cos Ltd	OTC	10.50	-4.5	15.2	0.60	5.7	11.13	10.50	8.0
Foremost Corp Amer	OTC	29.00	19.6	8.6	1.12	3.9	29.00	25.00	30.4	Rollins Burdick Hunter Co	OTC	14.00	1.8	10.0	1.32	9.4	14.00	13.50*	37.1
Great West Life Assurn Co	OTC	180.00	0.0	6.9	10.00	5.6	180.00	180.00	2.0	AGENTS/BROKERS									
Hanover Ins Co	OTC	29.00	5.5	3.9	0.88	3.0	29.00	28.00	22.5	AVERAGE									
Hartford Steam Boiler Insnptn	OTC	35.75	6.7	7.1	2.80	7.8	35.75	33.75	11.4	8.7 5.7									
Jefferson Natl Life Ins Co	OTC	38.00	1.3	10.6	0.76	2.0	38.00	37.50	1.6	Conglomerates/Holding Cos.									
Kemper Corp	OTC	26.50	11.0	4.7	1.80	6.8	26.50	25.00	44.6	American Express(Fireman's Fd)	NYSE	43.50	7.4	7.6	2.20	5.1	45.13	41.38	2,092.1
Lincoln Natl Corp Ind	NYSE	38.50	11.6	6.7	3.00	7.8	38.50	34.63	99.2	Anderson Clayton(Ranger/PanAm)	NYSE	22.63	0.6	5.0	1.32	5.8	22.88	20.88	71.1
Mission Ins Group Inc	NYSE	19.50	13.9	4.5	0.80	4.1	19.50	18.00	194.6	Armco Inc	NYSE	16.63	0.8	6.5	1.20	7.2	16.63	16.00	699.5
Nationwide Corp Ohio	OTC	26.00	-1.0	7.4	0.70	2.7	26.25	26.00	1.4	City Investing Co. (Home Ins.)	NYSE	20.25	7.3	6.3	1.70	8.4	20.25	19.38	397.1
Northern Natl Life Ins	OTC	20.63	10.0	4.5	1.50	7.3	20.63	19.13	81.6	CNA Fint Corp (CNA)	NYSE	12.88	0.0	5.4	0.00	0.0	13.25	12.88	18.6
Ohio Cas Co	OTC	33.13	0.0	6.1	2.36	7.1	33.50	33.00	281.2	Control Data (Comm. Credit)	NYSE	27.75	11.6	6.6	0.55	2.0	28.25	26.63	2,128.1
Old Rep Intl Corp	OTC	17.88	1.4	4.1	0.92	5.1	18.00	17.75	51.4	General Re Corp	NYSE	41.75	8.4	9.3	1.08	2.6	41.75	39.25	431.1
Preferred Risk Life Ins Co	OTC	18.00	2.9	5.1	0.92	5.1	18.00	18.00	2.9	Gulf Utld Corp	NYSE	21.38	11.0	7.5	1.32	6.2	21.38	19.63	143.0
Provident Life & Acc Ins Co	OTC	40.50	17.4	5.8	2.44	6.0	40.50	35.00	35.2	Cigna Corp	NYSE	37.75	2.4	5.3	2.30	6.1	37.75	36.00	933.5
Ryan Ins Group Inc	OTC	33.00	0.0	13.3	0.16	0.5	33.00	33.00	11.7	ITT (Hartford Group)	NYSE	26.75	5.4	6.1	2.68	10.0	27.00	25.63	1,743.5
St Paul Cos Inc	OTC	43.00	8.9	5.7	2.60	6.0	43.00	40.88	800.8	Optimum Hldg Corp	OTC	8.25	-2.9	6.5	0.00	0.0	8.50	8.25	21.8
Safeco Corp	OTC	34.25	10.0	6.3	2.20	6.4	34.25	32.13	168.3	Sears Roebuck & Co. (Allstate)	NYSE	22.13	9.3	6.3	1.36	6.1	23.00*	20.00	8,050.9
Sri Corp	OTC	20.50	9.3	4.6	1.12	5.5	20.75	19.75	63.3	Baldwin Utld Corp	NYSE	24.00	-1.0	5.1	0.88	3.7	24.13	22.00	769.8
Selbels Bruce Group Inc	OTC	21.00	4.3	12.4	0.80	3.8	21.00	20.63	12.0	Teledyne Inc (Argonaut)	NYSE	88.10	5.0	0.0	0.00	0.0	88.25	77.50	1,677.7
Statensman Group Inc	OTC	5.63	7.1	5.1	0.15	2.7	5.63	5.38	14.9	Transamerica Corp (Occidental)	NYSE	19.75	12.9	6.0	1.40	7.1	20.00	17.88	523.3
Tokio Marine & Fire Ins Co	OTC	82.75	10.7	6.6	0.92	1.1	82.75	78.25	12.6	CONGLOMERATES/HOLDING COS									
Travelers Corp	NYSE	21.88	10.1	5.7	1.64	7.5	21.88	18.75	1,457.6	AVERAGE									

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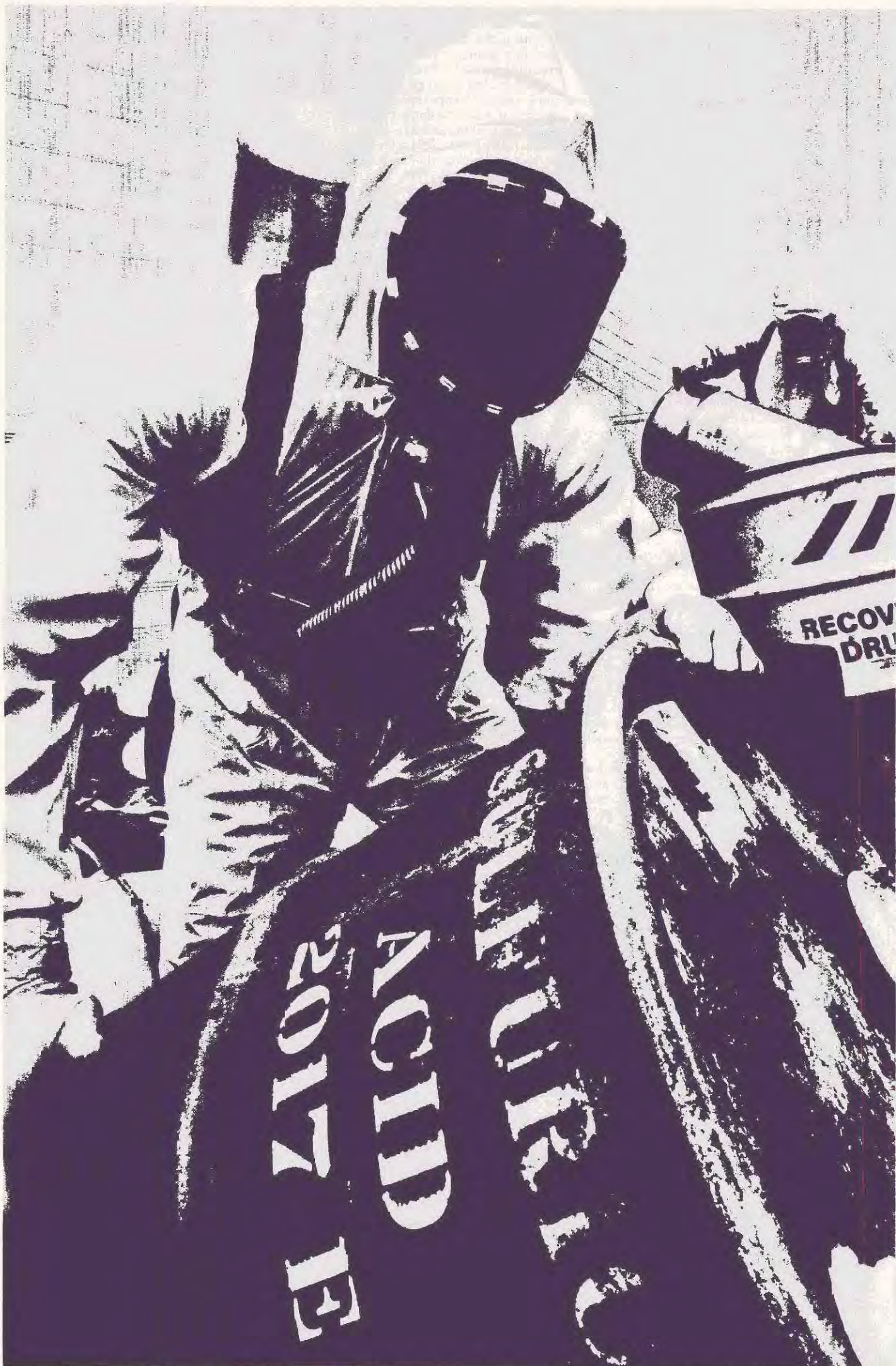
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