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update

Los Angeles court approves rehabilitation plan for MIC

LOS ANGELES—Los Angeles Superior Court last Thursday approved Mission Insurance Co.'s proposed rehabilitation plan, paving the way for the transfer of MIC's direct policyholders into Mission American Insurance Co.

Attorneys for Mission American, the California Insurance Department and MIC's ceding insurers now will draft a final agreement. The depart-

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Libel cover crisis puts the press on U.S. media

By JUDY GREENWALD

NEW YORK—Jim Thompson, editor and co-owner of the 8,000-circulation weekly Courier in Savannah, Tenn., had "never even been threatened" with a libel suit.

Yet, when he recently sought to renew his libel insurance, he learned his Employers Reinsurance Corp. policy, which had cost him $325 in premium, would now cost $1,900.

And the deductible on the $1 million policy would jump to $10,000 from the $1,000 it had been previously.

Mr. Thompson eventually obtained a policy with a $2,500 deductible for $357 under a program sponsored by the National Newspaper Assn. But the policy was issued with the warning that "I could expect that to double next year," Mr. Thompson says.

Observers say Mr. Thompson's experience is typical. As the number of markets offering libel insurance shrinks, policy limits are decreasing while deductibles are increasing, and excess layers are becoming harder to find.

'You've got to find a polite way of saying, "We're sorry we called your dumb brother dumb."'

And while everyone is being hit by the higher rates, they particularly hurt the small- and medium-sized newspapers and broadcasters, which may not have the financial resources to pay higher rates and will risk going bare.

Observers warn that if media companies are forced to go without libel insurance, journalists may become reluctant to pursue important stories for fear of attracting libel suits their employers could ill-afford.

They say the problems in the libel insurance market are similar to those found in other specialty lines, including directors and officers liability and medical malpractice insurance.

But, there are additional problems peculiar to libel insurance as well, most notably the rising cost of defending libel suits despite the ultimate success of the media defendants in the overwhelming majority of these cases.

The picture is further complicated by a Supreme Court that many observers say has not been very friendly to journalists because it declined to expand First Amendment protections (see story, page 20).

Meanwhile, news organizations are paying more for their libel insurance, and less coverage is available.

Rates and deductibles "have gone through the roof," with some insurers increasing rates as much as 200% to 300%, says Ann Heavner, assistant vp at Johnson & Higgins in New York.

Rates for newspapers increased 85% in October, says Walter Coady of Walterry Insurance Brokers in Clinton, Md., which handles the 1,100 community newspapers in the National Newspaper Assn. program.

Media/Professional Insurance Inc. in Kansas City, Mo., is the managing general agency on the program. It had originally written on behalf of Chicago-based CNA

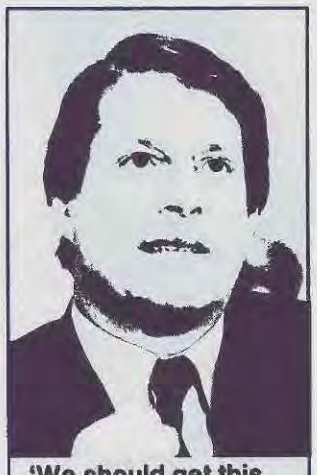
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'We should do everything to help purchasers of insurance to help themselves,' said Sen. James Sasser.



'This is a good, self-help remedy. . . (it) ought to pass Congress,' observed Sen. John D. Rockefeller IV.



'We should get this legislation passed by spring or summer,' Sen. Albert Gore Jr. suggested to his colleagues.



'We need the Risk Retention Act,' urged Bruce J. Parker, on behalf of the National Solid Wastes Management Assn.

Senators flock to support bill to expand Risk Retention Act

By JERRY GEISEL

WASHINGTON—Legislation to expand the federal Risk Retention Act is off to a flying start.

Senator after senator enthusiastically endorsed a proposal by Sens. Robert Kasten, R-Wis., and John Danforth, R-Mo., to permit businesses, trade groups and municipalities to purchase all forms of commercial casualty coverage—except workers compensation—as a group or to form a captive insurer to pool their risks.

These groups would be largely exempt from state regulation under an expanded Risk Retention Act.

At a standing-room-only Senate Commerce Committee hearing last week, legislators urged speedy passage of the measure, S. 2129, introduced Feb. 28, as an important first step to ease the liability insurance crisis by making it easier for buyers to cover their own exposures.

"Businesses should have the option to establish risk retention groups on their own. We should do everything to help purchasers of insurance to help themselves," said Sen. James Sasser, D-Tenn.

Sen. John D. Rockefeller IV, D-W. Va., said: "This is a good, self-help remedy. This is a bill that ought to pass Congress."

"While this bill is not intended as a cure-all for the current liability insurance crisis, it will provide immediate relief for many who are now not able to obtain general liability coverage," said Sen. Kasten.

"We should get this legislation passed by spring or summer," added Sen. Albert Gore Jr., D-Tenn.

A parade of witnesses, representing trade groups whose members can't find commercial insurance, endorsed the proposal because it would remove state obstacles to self-insuring.

"It would take us years and years to form a licensed, national insurance company," said Karen Ehrnman, government relations coordinator for the American College of Nurse-Midwives in Washington.

"We do not have years and years," Ms. Ehrnman said, noting that the trade group has been turned down by 17 different insurers after its master professional liability policy was can-

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Insurers sue satellite contractors

By STEPHEN TARNOFF

SANTA ANA, Calif.—Seven insurance companies are suing to recover more than $11 million from the manufacturers of the orbital delivery systems of two telecommunication satellites that failed in early 1984.

In separate suits filed in state court, the insurers charge McDonnell Douglas Corp. of St. Louis, Morton Thiokol Inc. of Chicago and HITCO of Newport Beach, Calif., with negligence and strict liability for the failure of the Westar VI, originally owned by Western Union Telegraph Co., and the Palapa B2, originally owned by the Indonesian government.

The two satellites failed to reach geosynchronous orbits 22,300 miles above Earth following the launching from the space shuttle Challenger in February 1984.

Insurers paid more than $180 million to Western Union and the Indonesian government for the losses. The seven insurers that filed the suits want to recover the more than $11 million that they paid.

The insurers' lawsuit is the latest unusual twist following the loss of the two satellites.

After insurers paid the losses, several insurers mounted a campaign to launch the first-ever space salvage effort. The insurers paid $10.5 million for the astronauts aboard the space shuttle Discovery to rescue the wayward satellites in November 1984. The insurers intended to sell the probes to recover some of their losses, but no one has yet purchased them (*BI*, Feb. 13, 1984; Nov. 19, 1984).

The insurers' suit also names as "involuntary plaintiffs" numerous other insurers and reinsurers of the two satellites. However, those companies have so far declined to join the

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Court OKs Mission bailout plan

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ment does not expect opposition to the final plan because it is expected to follow the intent and substance of the earlier letter agreement, says Norris W. Clark, chief of financial analysis for the California department in Los Angeles.

The final agreement, which Mr. Clark said could be more than 150 pages, is not expected for at least a month.

Mr. Clark also says that he observes "excellent cooperation" from regulators in Texas and Missouri, who also must approve the final plan.

Ceding companies representing 70% of MIC's outstanding reinsurance liabilities have agreed to the plan, according to Mr. Clark. However, he noted that additional companies can join the plan by April 1.

The rehabilitation plan was developed to spare state guaranty funds from paying direct policyholders of MIC, after the insurer was declared insolvent last year by the California department. The department found that MIC was insolvent by $169.5 million (*BI*, Nov. 11, 1985).

Jartran back in Chapter 11

MIAMI—Miami-based Jartran Inc., Frank B. Hall & Co. Inc.'s financially troubled truck leasing subsidiary, again filed Chapter 11 proceedings March 4 in U.S. Bankruptcy Court in Miami.

Hall acquired Jartran in December 1981 to avoid takeover attempts by Ryder Systems Inc., the truck leasing company.

Jartran first was in Chapter 11 proceedings from the time of its purchase by Hall in December 1981 until January 1985, when it emerged from the proceedings after a reorganization plan.

Hall has been actively trying to sell or otherwise dispose of Jartran since last summer (*BI*, Aug. 12, 1985).

Hall reported nearly $5 million in Jartran-related losses in the first half of 1985. The broker also reported a $94.5 million third-quarter loss due to Jartran and to reserve strengthening for its discontinued underwriting operations, although it did not specify how much of the loss was related to Jartran.

Hall has not released year-end 1985 results, but the brokerage firm has stated that further writeoffs may be taken in the fourth quarter.

The brokerage has recently been involved in negotiations in Florida with potential buyers of Jartran, but the company filed for Chapter 11 protection because "the discussions with purchasers had fallen through," said Thomas G. O'Brien III, Hall's vp, secretary and general counsel.

In the filing, Jartran listed $37 million in assets and $114 million in liabilities. Jartran also reported a loss of nearly $22 million in 1985 on revenues of $100 million, according to the filing.

Coalition to fight tort reform

WASHINGTON—Some 35 consumer groups have formed a new coalition to fight the drive of manufacturers and insurers to overhaul the civil justice system.

The new group, The Coalition for Consumer Justice, will conduct a grassroots campaign to defeat business-backed proposals to place caps on damage awards, limit contingency fees and eliminate or reduce punitive damage awards.

Joan Claybrook, a member of the new coalition and president of Public Citizen, an organization supported by Ralph Nader, said the insurance industry is pressing for legislation to take away consumer rights while not revealing how much money they are paying out for claims on a line-by-line basis.

Ms. Claybrook, who served as administrator of the National Highway Traffic and Safety Administration during the administration of President Carter, also said a federal office of insurance should be established to monitor the industry and that the Federal Trade Commission should be given new authority to investigate insurance companies.

Court rules on police immunity

WASHINGTON—Police officers can be liable to pay damages resulting from suits for unreasonable arrests and searches, even if they obtain arrest warrants, according to a recent decision of the U.S. Supreme Court.

In a 7-2 decision handed down last week, the justices said police officers do not have absolute immunity from liability suits filed by those they arrest.

"In the case of the officer applying for a warrant, it is our judgment that the judicial process will on the whole benefit from a rule of qualified rather than absolute immunity," according to the court's decision.

The case, *Malley et. al. v. Briggs et. al.*, involved the arrest of a real estate developer and his wife by a Rhode Island state trooper on drug charges.

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Senate panel staff resurrects proposal to tax health benefits

By JERRY GEISEL

WASHINGTON—Senate committee staffers are reviving a controversial proposal to tax employees on corporate contributions to employee health care benefits.

A revenue-raising option proposed by Senate Budget Committee staff members would tax employees on employer health care contributions that exceed $200 per month for either individual or family coverage.

This proposed tax, if approved by Congress, would raise $16.7 billion in new federal revenues over the next three years, according to committee papers.

Meanwhile, in a week of fast-changing developments affecting employee benefit plans:

- The House of Representatives late last week approved a so-called budget reconciliation bill, H.R. 3128, that would require employers to extend their group health insurance programs to employees' divorced and widowed spouses.

The budget bill also would more than triple the annual insurance premium employers pay the Pension Benefit Guaranty Corp. and make it more difficult and expensive for companies to terminate underfunded defined benefit pension plans.

- Senate Finance Committee Chairman Robert Packwood, R-Ore., provided an analysis of how his committee will decide certain benefit issues as it hammers out a tax overhaul bill.

In a speech last week in Washington before life insurance underwriters, Sen. Packwood said committee members would like a higher 401(k) salary deferral limit than the $7,000 limit in the House tax bill, but didn't know if that would be possible.

But Sen. Packwood said the committee would be unlikely to accept a House provision that reduces contributions to Individual Retirement Accounts by amounts deferred to 401(k) plans.

Currently, the maximum annual deferral to a 401(k) plan is $30,000 and the amount deferred does not affect maximum IRA contributions.

Sen. Packwood, as expected, ruled out taxing employees on employer health care contributions, according to those attending the meeting.

However, Budget Committee staffers say in a discussion paper released last week that the tax-free status of employer-paid health care benefits is a "subsidy" that costs the federal government billions of dollars in revenues annually.

"A limit on that subsidy may be an appropriate way to broaden the base of the revenue system," the discussion paper says.

Placing a cap on the amount of tax-free health care contributions would make the tax treatment of those benefits similar to the treatment of term life insurance benefits, the discussion paper notes.

Under Section 79 of the Internal Revenue Code, em-

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PCW names told losses will increase

By STACY SHAPIRO

LONDON—Losses at Lloyd's of London syndicates once managed by PCW Underwriting Agencies Ltd. are expected to increase, according to a letter from the syndicates' current managers.

Members of the PCW syndicates already face up to 130 million pounds in losses ($188.5 million at current exchange rates) from 1979 through 1982, largely as the result of U.S. liability claims.

However, recent reports say losses may rise to between 200 million to 250 million pounds ($290 million to $362.5 million) as Lloyd's accounts for 1983 close under its three-year accounting system.

Additional Underwriting Agencies (No. 3) Ltd., the syndicates' current manager, admitted in a recent letter to PCW members that there will be further losses, though the agency could not quantify the losses.

AUA No. 3 also says it has no intention of asking members to pay any additional losses.

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MAP, tort reform measure may ease N.Y. liability woes

By DOUGLAS McLEOD and MEG FLETCHER

NEW YORK—Thirty-one New York state municipalities that had been facing a total lack of liability insurance coverage will now be insured by 21 major property/casualty insurers through the state's market assistance program.

In addition, a tort reform bill designed to help all New York public entities—and some not-for-profit corporations—find affordable liability insurance coverage was passed by the state Assembly last month and is awaiting action by the Senate.

Representatives of 20 insurers agreed to offer liability coverage with a $1 million aggregate limit to the 31 municipalities during a meeting last month called by New York Insurance Superintendent James P. Corcoran.

A 21st company—The Home Insurance Group—agreed after the meeting to offer coverage.

Three other insurers represented at the meeting declined to offer such coverage, according to an Insurance Department spokesman, who would not identify the companies.

Of the 24 insurers represented at the meeting, 16 also agreed to provide coverage on a rotating basis to other "acceptable" municipalities applying through the MAP in the future.

Several other insurer representatives said at the meeting that they may be able to commit to this rotating program in the near future, the department spokesman said.

"I am pleased to see that a number of insurance companies have responded to our request to assist our local governments during this crisis," Mr. Corcoran said in a statement.

"The (insurance) industry must face up to the fact that it bears a heavy burden of responsibility for where we are right now and

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Lloyd's brokers get E&O advice

By STACY SHAPIRO

LONDON—Some Lloyd's of London brokers are facing huge losses on their own errors and omissions insurance policies because they are not providing adequate services to their clients, E&O underwriters say.

According to underwriters who lead E&O coverage for Lloyd's brokers, some brokers overlook renewals of policies; fail to carry out clients' instructions; use defective policy wordings; use insolvent insurers and reinsurers on policies; and sometimes just outright cheat clients through fraud and dishonesty.

As a result, Lloyd's brokers found it difficult to renew their E&O insurance during recent year-end renewals. Rates inceased substantially, though brokers would not specify the increases sought.

And, Lloyd's largest brokers found it nearly impossible to buy the 150 million to 200 million pounds ($213 million to $284 million) of coverage that some large brokers had purchased in the past (*BI*, Jan. 6).

Lloyd's brokers, depending on their size, must have at least 2 million to 20 million pounds of E&O coverage.

To justify the substantial rate increases, three Lloyd's underwriters who lead 90 percent of Lloyd's brokers' coverage wrote a letter to all Lloyd's brokers on how claims are caused and how Lloyd's brokers can limit losses.

The letter, issued on Jan. 17, is signed by Lloyd's underwriters Robin Jackson, director of Merrett Syndicates Ltd.; Ian Gavine of Langton Underwriting Agents Ltd.; and Richard Thomson, of Sedgwick Forbes (Lloyd's Underwriting Agents) Ltd. They lead a Lloyd's brokers' E&O facility that has been in existence since 1970 and is administered by Lloyd's brokers Thomas R. Miller & Son (Insurance) Ltd.

"We wanted to point out why claims take place," Mr. Jackson told *Business Insurance*. "The letter has been taken very seriously."

"It is a bad record and the underwriters are not crying wolf," said one Lloyd's broker who spoke on condition of anonymity. "But I think it (the letter) outlines what all responsible brokers know. I don't see what the fuss is all about."

The letter begins, "Every Lloyd's broker must by now be aware of the increase in size and frequency of E&O claims against brokers. The cost of the E&O policy is now unacceptably high to the broker. Insurers do not make money out of the class; we have to find ways of reducing the loss cost."

Claims stem from a variety of circumstances, most of which result directly or indirectly from "inadequate management control," says the letter.

"The broker's files and records do not always enable him to prove that he is blameless," says the letter. "In some cases the claims are caused by more or less delib-

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Court cites pollution exclusion to deny cover

By STEPHEN TARNOFF

RALEIGH, N.C.—Citing the pollution exclusion clause, the state Supreme Court is denying liability insurance coverage to the operator of a waste collection and transportation service facing a suit to recover the costs of cleaning up a landfill.

In a unanimous opinion Feb. 18, the court ruled that Waste Management of Carolinas Inc., doing business as Trash Removal Services Inc., cannot recover defense costs from its insurers because its alleged pollution was not "sudden and accidental."

In reversing the state Court of Appeals, the high court said the pending allegations against TRS "fit squarely within" the language of the pollution exclusion clause.

As a result of the decision, TRS's insurers from 1974 until 1980—Peerless Insurance Co. and Pennsylvania National Mutual Casualty Insurance Co.—won't have to pay for TRS's defense costs in fighting litigation brought by the federal government.

Peerless insured TRS under a manufacturers' and contractors' liability insurance policy from August 1974 through Aug. 12, 1979. Penn insured TRS under a comprehensive general liability policy from June 17, 1979 through June 17, 1980.

According to one source, aggregate limits of the policies were less than $500,000 per year.



Last week, an attorney for Waste Management said the company was still considering whether to file a petition for rehearing with the state Supreme Court.

A company spokesman would not say how much in defense costs is at stake.

This victory for the insurers follows many victories for policyholders who have convinced courts around the country to find coverage for gradual pollution claims even when the policy said it excluded coverage for all but sudden and accidental pollution.

The suits against TRS arose after the federal government in January 1980 sued various parties associated with the Flemington Landfill, located in New Hanover, N.C.

The government's suit alleged that waste material disposed at the landfill had leached into and contaminated groundwater beneath it, rendering well water for area households hazardous for human consumption.

The suit was filed under section 7003 of the Resource Conservation & Recovery Act and sought injunctive and monetary relief.

The landfill's owners and operators and the county, who were named in the lawsuit, subsequently filed third-party complaints against TRS seeking indemnity for any liability they were found to have.

Those complaints alleged that TRS represented that the solid waste material delivered to the landfill was not hazardous or contaminated.

They also alleged that if the government's allegations were true, TRS had been careless and negligent in transporting and disposing of hazardous wastes and had not taken proper care to prevent the deposit of waste material at the landfill.

TRS subsequently requested a defense from Peerless and Penn against the third-party complaints. However, both denied either a duty to defend or an obligation to indemnify TRS.

In June 1982, TRS filed a declaratory judgment suit against the two insurers asking the court to interpret the coverage under the policies.

The trial court subsequently held that under the pollution exclusion clause the insurers were not required to defend TRS.

The state appellate court later reversed the trial court, finding that the policies were ambiguous and that insurers were obligated to defend TRS in the litigation (*BI*, March 18, 1985). Peerless and Penn then appealed to the state Supreme Court.

In its decision, the court sought to determine whether the policies sold to TRS by Peerless and Penn covered events that were

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Court limits coverage for losses stemming from PBB-tainted feed

By STEPHEN TARNOFF

GRAND RAPIDS, Mich.—Michigan Chemical Corp. can tap only $28 million in coverage to pay claims stemming from contamination of livestock feed that forced the destruction of more than 40,000 animals, a federal judge has ruled.

Michigan Chemical made only one misshipment when it mistakenly sent bags containing a toxic chemical that was subsequently mixed with livestock feed and sold to farmers, resulting in more than 1,000 claims against the company, the judge ruled.

As a result, Michigan Chemical's misshipment, which took place in May 1973, constituted only one "occurrence" for purposes of triggering the company's liability insurance coverage, U.S. District Judge Benjamin F. Gibson ruled.

The decision, based on motions for summary judgment, means Michigan Chemical, which has since merged with Velsicol Chemical Corp., can tap only the $28 million in coverage under the limits of its 1973 policy to pay the claims.

Michigan Chemical, contending that there was more than one occurrence, sought to trigger an additional $28 million in coverage under its 1974 policy and perhaps coverage under other policy years as well.

Michigan Chemical and Farm Bureau Services, a cooperative that sold the contaminated feed to dairy farmers, has paid more than $45 million to satisfy approximately 1,300 claims filed because animals had to be destroyed after eating the tainted feed. Between 40 and 50 suits are still to be decided.

Last week, an attorney for Michigan Chemical said the company would probably appeal Judge Gibson's ruling.

The decision comes approximately two years after a federal appellate court ruled that the "cause of the property damage," which was the misshipment or misshipments of toxic polybrominated biphenyl (PBB), determined the number of occurrences (*BI*, March 12, 1984).

The court then sent the case back to the district court to determine if

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Documents allege C&F hiked reserves to lower Canadian tax

By JUDY GREENWALD

TORONTO—Crum & Forster Inc. officials are holding discussions with Canadian tax authorities over whether a C&F unit deliberately overstated claim case reserves by $1.2 million in 1980 to reduce its taxable income.

A request last year by the Canadian Department of National Revenue for a search warrant sought permission to search the headquarters of Crum & Forster of Canada in Don Mills, Ontario, for documents to support suspicions that it assisted United States Fire Insurance Co., another C&F unit, in violating the Canadian Income Tax Act by making "false and deceptive" statements in its 1980 tax return.

Business Insurance has obtained a copy of the request for the warrant, submitted May 21, 1985, by Revenue Canada, as the tax agency is also known, to the judicial district of York.

The documents sought included U.S. Fire's general ledger, financial statements and correspondence.

A C&F spokesman at its corporate headquarters in Morristown, N.J., said: "Documents have been produced as requested." The company had no further comment beyond acknowledging discussions between corporate officials and Canadian tax authorities.

According to documents submitted to support the request for the search warrant, those involved in the decision to increase the reserves were highly placed officials of Crum & Forster Corp., which is C&F Inc.'s service and managing arm, and Chicago-based L.W. Biegler Inc., an underwriting manager and another C&F Inc. subisidiary. Biegler was recently renamed Crum & Forster Management Corp. (Ill.).

A C&F spokesman had no comment as to whether these officials are still employed at C&F or Biegler.

The documents include a memo exchanged between two Biegler officials that refers to a claim file that was "artificially increased in order to assist Crum & Forster of Canada."

The documents also quote a New York consultant contacted by Revenue Canada who concludes U.S. Fire may have been overreserved by as much as $3.3 million as of December 1980 and December 1981.

Donald Y. Chen, an investigator with Revenue Canada in Toronto, told *Business Insurance*: "The only thing I can say to you is to confirm the information you have obtained. The investigation is still going on."

Mr. Chen said the investigation was the result of a "normal audit."

Mr. Chen's superior, John Beach, section head of special investigations, said: "Our policy at Revenue Canada is, we won't confirm or deny any information in relation to investigations we are doing."

According to the documents, Crum & Forster of Canada, as agent and manager of U.S. Fire, added an "artificial reserve" of about $200,000 for 1980 to each of six claim case reserve files.

The reserves were for business brokered by

Continued on next page

U.S., Canadian skaters to face off at RIMS



By JOANNE WOJCIK O'HARE

The idea came to the two hockey warriors as they clashed on the ice during their semiannual old-timer league battles.

"You could say, we collided in mid-ice," chuckled Felix Kloman, principal at Tillinghast, Nelson & Warren Inc. in Darien, Conn.

He and Georges Balcer, risk manager at Consolidated Bathurst in Montreal, had been facing off in league play for the past six years. They enjoyed the game so much that "we said, what we really ought to do is hit heads at the (Risk & Insurance Management Society) conference" in Toronto, April 13-18, Mr. Kloman said.

When the two called Rita Epstein, RIMS' communications director in New York, "she laughed," Mr. Kloman recalled. But, their suggestion that the event could be used to raise funds for the Robert S. Spencer Memorial Foundation Inc., which awards scholarships to insurance students, was taken seriously.

The RIMS Hockey "All Stars" will meet at St. Michael's College Arena in Toronto at 4:30 p.m. on Sunday, April 13. Tickets are $10 and can be purchased in advance from the Canadian or the U.S. offices of RIMS.

Mr. Kloman, a member of the Darien Winter Club who has been participating in "old-timer" hockey leagues since 1959, will lead Team USA, while Mr. Balcer, a member of the Beaconsfield Old-Timers' Hockey Assn., will captain Team Canada.

Although hockey may seem too violent a sport for men whose jobs are to identify potential loss situations and control or reduce them, both Mr. Kloman and Mr. Balcer promise this game will be purely recreational.

Both of their old-timers' leagues strictly forbid intentional body contact or "slap shots," in which the player raises his stick before striking the puck.

"A player's stick must be on the ice at all times," explained Mr. Balcer. "That eliminates a certain amount of velocity," thereby reducing the risk of injury.

Everyone on the rink also is required to wear a helmet and pads, and some even wear masks.

And, league players who fight are severely penalized. "They're banished from the league," Mr. Balcer warned.

While members of the U.S. team will be covered under their employer's group health plans, members of Team Canada will be covered by the national socialized medical program, which provides health care to all Canadian citizens, Mr. Balcer said.

Canadian citizens pay the government a monthly fee for basic health care and hospitalization services (*BI*, Nov. 14, 1983).

The Spencer Foundation plans to buy one-day coverage for the event, according to a RIMS spokesman. St. Michael's College Arena also purchases general liability insurance through Mitchell Ryerson Ltd. in Toronto, according to an arena spokesman. He could not provide details of the coverage.

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Crum & Forster

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Biegler and written by U.S. Fire Insurance through Crum & Forster of Canada.

Until April 1981, the documents note, underwriting and claims services were actually handled by Professional Liability Insurance, a division of Toronto-based Tomenson Saunders Whitehead Ltd., now a Fred S. James & Co. subsidiary. However, Professional Liability Insurance is not a subject of the investigation and is not mentioned in the documents except to say it provided these services.

According to the documents, U.S. Fire reported earned premiums in Canada of $14.4 million in 1980. The company reported claims and adjustment expenses of $11.2 million and $467,000 in taxable income, according to the documents.

The $11.2 million in claims and adjustment expenses included a total of $5.5 million in case claims reserves for professional liability business, the documents say.

But, according to the documents, $1.2 million that should have been reported as taxable income was put into reserves instead.

Without that addition, the company's claims and adjustment expenses for professional liability business would have totaled only $4.3 million, which means the company's taxable income would have been $1.7 million.

Several documents support this contention, according to the search warrant request. This includes an internal memorandum from a vp at Crum & Forster Corp. to another C&F employee, who is not identified by title. The memo, dated Feb. 12, 1981, was obtained by Revenue Canada from the correspondence files of a high official at Crum & Forster of Canada.

The memo states: "It has come to my attention that LWB (L.W. Biegler) Canada has additional losses which must be booked in 1980. Such losses aggregating approximately $1,200,000 will be coded as front-end reserve increases. This will necessitate a rerun of losses from the entry point through. . .annual statement (as it affects losses).

". . .Production of the output reports should be expedited but not in a crisis environment. Your judgment should be the controlling factor here."

Attached to the memo was a piece of paper with a line that reads across, "MP800, $200,000 and $1,200,000." On the same paper is listed six numbers that are apparently individual claim file numbers.

Also included in the search warrant request is a May 21, 1981, memo sent to a senior vp of Biegler in Chicago from the C&F Corp. vp. It states: "You will remember that last year we had to increase reserves on six Canadian claims. As these claims are reviewed in the normal course of operations during 1981, please communicate. . .the adjustments in the reserve. So that we are certain that each claim is dealt with, let us plan to have everyone reviewed no later than Oct. 30."

In addition, a letter dated June 15, 1981, was sent by the Biegler senior vp to an assistant secretary at Crum & Forster Corp. that states: "Attached is a copy of a memo regarding the closing of a claim file which was increased by $200,000.00 in December 1980. Please make the proper reclassification in our Profit Center."

Attached to this letter is an interoffice memo dated June 11 sent to the Biegler senior vp from a Biegler vp in Chicago. The subject is one of the file numbers listed on the piece of paper attached to the Feb. 12 memo, number 95-500150.

The memo states: "We will retire the above caption file during the first week of July. I call this matter to your attention as this file was artificially increased in order to assist Crum & Forster of Canada."

The search warrant request states that documentation "consistent" with this memo that referred to the remaining five files listed on the piece of paper were found in the L.W. Biegler office in Toronto.

The company said last month it is closing this office (*BI*, Feb. 24).

According to the documents, Crum & Forster later in 1981 lowered the reserves for at least three of the claims by approximately the amount they were increased earlier in the year.

An internal memo from a C&F official, whose position is not clear, to the C&F Corp. vp states: "Please note that our September Canadian loss reserves were reduced by $200,000 on claim 95-500297 and $200,000 on claim 95-500505.

"Would you please make certain that the profit center statement for October is adjusted by $400,000 for this portion of the September incurred losses?"

A week later, on Oct. 9, a letter from the same official to the C&F Corp. assistant secretary states: "Canadian claim 95-500390 was adjusted during normal claim development in the July Canadian loss coding.

"Would you please make the appropriate profit center adjustment to properly reflect this $200,000 reserve take down?"

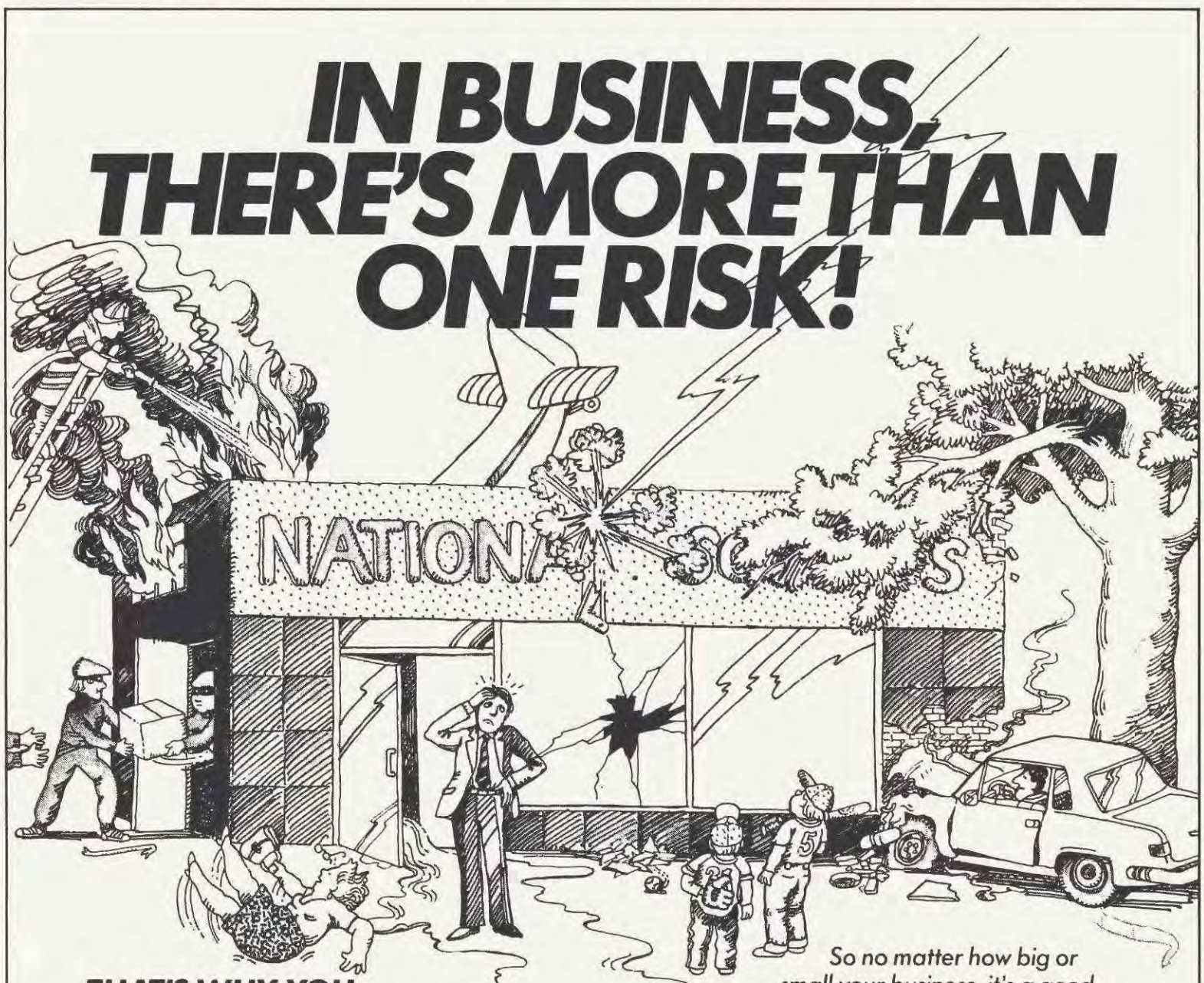
In addition, according to the search warrant request, a Revenue Canada officer found in C&F of Canada's offices two computer printouts for losses outstanding as of Dec. 31, 1980. One indicated a case reserve outstanding of $4.25 million, while the second showed a $5.45 million case reserve outstanding, or a $1.2 million difference.

Also discovered were discrepancies between printouts listing the reserves on the six claim files referred to in the correspondence. The discrepancies totaled $200,000 in five cases and $199,250 in a sixth.

The search warrant request also notes that a Revenue Canada official asked the New York-based firm of E. James Sterigiou Inc., Risk Consultants, Casualty Actuaries and Insurance Advisers, to analyze U.S. Fire Insurance's loss reserves as of Dec. 31, 1980, and Dec. 31, 1981.

According to the request, Mr. Sterigiou said in his report that "based on our review, we conclude that the company was overreserved by about $1.9 million to $3.3 million, with a conservative best gross of $2.2 million during this period."

Mr. Sterigiou had no comment when contacted by *BI*. ■



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78% of pension plans fully funded: Study

A record 78% of large company pension plans now have assets that equal or exceed their benefit obligations, according to a survey by The Wyatt Co.

However, this represents a slowing in the trend toward increased funding levels. For example, the number of fully funded plans—with assets equal to or greater than the current value of the accrued benefits of participants—jumped to 73% in 1984 from 25% in 1979.

The study also showed that 84% of the surveyed plans in 1985 had sufficient assets to cover all vested benefits, compared with 82% of plans in 1984 and 45% in 1979.

"This slowdown in the trend toward fully funded plans suggests that companies are taking advantage of strong investment performance to reduce their plan contributions, either to conserve cash or redeploy assets elsehwere," said Sylvester Schieber, director of Wyatt's Research and Information Center.

The survey noted that one indication of strong investment performance was the finding that 38% of plans had assets of 150% or more of accrued benefits in 1985, up from 32% in 1984 and only 6% in 1980. ■

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Pollution exclusion

Continued from page 3
alleged in the third-party complaints against TRS.

The policies provide defense coverage for property damage liability when caused by an "occurrence," which is defined as "an accident, including continuous or repeated exposure to conditions, which results in bodily injury or property damage neither expected nor intended from the standpoint of the insured."

However, under the "pollution exclusion" clause in the policies, coverage is excluded for bodily injury or property damage arising from various types of discharges or emissions of pollutants—unless they are "sudden and accidental," in which case the exclusion does not apply.

According to the court, the third-party complaints against TRS alleged that it intentionally disposed solid wastes during the landfill's operation, which contributed to contamination of groundwater beneath the landfill.

They also alleged that contributions and negligent acts and omissions by TRS and others caused the contamination of the aquifer and water supply in the Flemington area.

In addition, the complaints did not allege that the dumping or the contamination occurred either suddenly or accidentally but rather suggested a gradual seepage of contaminants into the aquifer, the court added.

Unlike the Court of Appeals, the state Supreme Court first ruled the policies were not ambiguous.

"Although it is possible to perceive ambiguity in the policy language, it strains at logic to do so," the court said.

"A common sense reading of that language reveals that the exclusion narrows a virtually limitless class of events termed 'occurrences' which can occur suddenly or over the course of time, to non-polluting events or to polluting events that occur 'suddenly and accidentally.'"

In addition, contrary to Penn's and Peerless' arguments, the court also ruled the pollution constituted an "occurrence" under the policies.

"Whether events are 'accidental' and constitute an 'occurrence' depends upon whether they were expected or intended from the point of view of the insured," the court said, noting that if they were expected or intended there was no occurrence.

"... it was not the routine dumping but the arguably unintended leaching of contaminants into the groundwater that constituted the 'occurrence' for the purpose of TRS's insurance coverage," the court said.

Nevertheless, the court said that coverage was excluded under the pollution exclusion clause because the pollution was not "sudden and accidental."

"...the events alleged in the pleadings and supported by the deposition fit squarely within the language of the exclusion clause," the court said.

"Waste material that has leached into and contaminated groundwater is clearly excluded by the plain terms of the pollution exclusion.

"And because the 'sudden' release or escape of contaminants was neither expressly nor impliedly alleged in the pleadings or deposition, the alleged occurrences remain outside the policy coverage."

An attorney for Waste Management said the impact of the case may be limited since it involves interpretations of comprehensive general liability policies while in recent years environmental impairment liability policies have been marketed.

In addition, courts have come down in favor of policyholders on the issue in other jurisdictions, said D. Kendall Griffith, with the Chicago firm of Hinshaw, Culbertson, Moelmann, Hoban & Fuller.

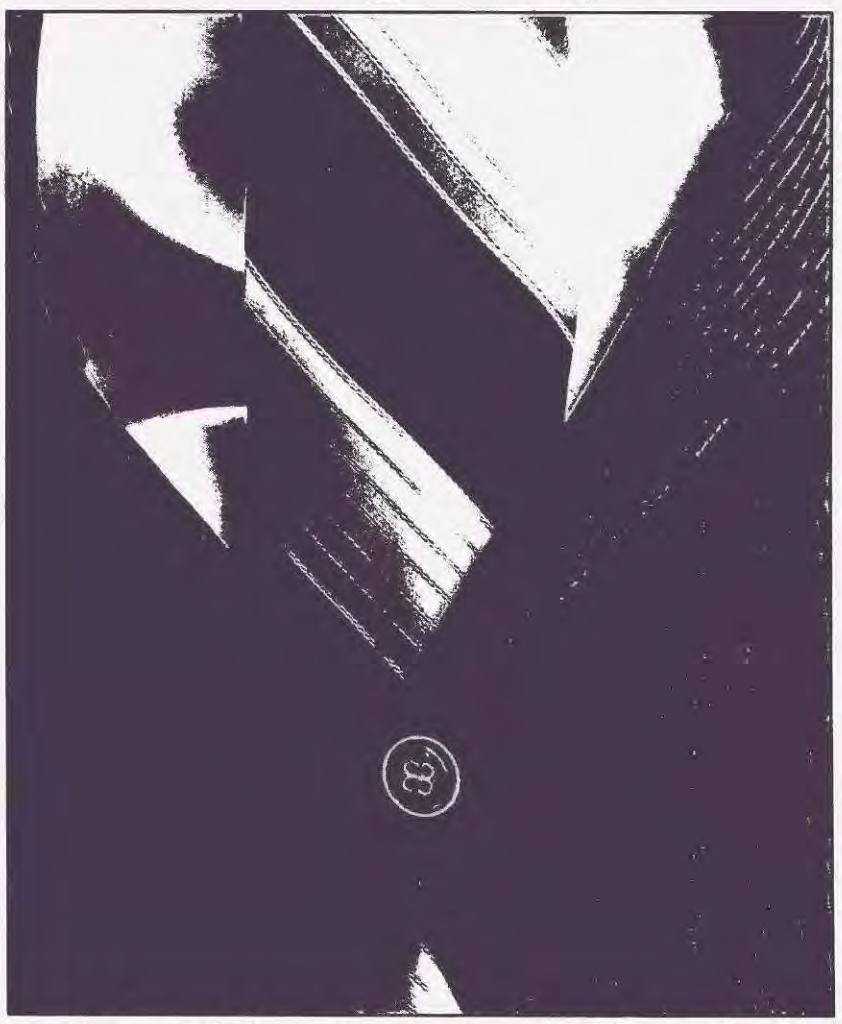
An attorney for Penn, however, said the decision was significant. "I think it is a landmark decision and will have nationwide application," said Walter E. Brock, Jr., with the Raleigh firm of Young, Moore, Henders & Alvis.

Mr. Brock said it was "one of the few" cases in which a court of last resort has addressed the issue and that it should benefit insurers and policyholders.

"It clarifies in this state uncertainty as to what the law is," he said. "A risk manager will know what he's got know and underwriters will know what they have underwritten."

The American Insurance Assn., the Alliance of American Insurers, certain underwriters at Lloyd's of London and attorney Eugene R. Anderson filed friend of the court briefs in the case. ■

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Agent, broker plead no contest to fraud

By DOUGLAS McLEOD

ANCHORAGE, Alaska—A California insurance agent and an Alaska broker have pleaded no contest to charges they defrauded Alaska on insurance policies covering deposits of state funds.

The agent, Lawrence R. Sellars, and the broker, Lambert Peterson, each pleaded no contest to one felony fraud count under a plea-bargain reached with the state attorney general last December.

Mr. Sellars—former president of Orient-Pacific Insurance Agency Inc. of Laguna Hills, Calif.—was placed on probation for 30 months and ordered to pay $75,000 in restitution, said David Mannheimer, assistant Alaska attorney general.

Mr. Peterson was also placed on probation for 30 months and ordered to pay restitution of $25,000 and a fine of $50,000.

Under the agreement, the attorney general dropped three felony fraud charges against each man.

The two were convicted and sentenced in 1983 on all four fraud counts, but the conviction was overturned on the grounds the two men—who were represented by the same lawyer—should have had independent counsel. A retrial had been scheduled for last September.

The no-contest pleas involved insurance arranged by Mr. Sellars and Mr. Peterson on millions of dollars in state funds deposited in several Alaska credit unions in 1979 and 1980 (*BI*, Sept. 23, 1985.)

The coverage, written by now-insolvent Union Indemnity Insurance Co. of New York, had limits of $2 million per credit union.

However, the state charged Mr. Peterson issued certificates covering deposits of up to $19 million in one credit union. The Union Indemnity certificates had the name "Regal Insurance Co." typed on them, and Mr. Sellars and Mr. Peterson claimed Regal—for which Mr. Sellars was purportedly an agent—provided coverage excess of Union Indemnity's $2 million limit.

The state charged that Mr. Peterson pocketed more than $100,000 in premiums on these certificates.

Dennis Ward of the California Insurance Department said Mr. Sellars' agent's licenses could be summarily revoked if he is found to have committed a felony.

The department is awaiting a certified copy of an Alaska Superior Court judge's order and will then refer the matter to its attorneys, Mr. Ward said.

Mr. Sellars had no comment on the plea-bargain except to say he resigned as president of Orient-Pacific in January. He said he remains president of The Sellars Insurance Market Inc., a Laguna Hills agency moving to Newport Beach. ■

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opinions

Speedy action is critical

AMENDMENTS PROPOSED to broaden the scope of the Risk Retention Act of 1981 should be passed as soon as possible, but at least by summer.

There's no time to waste in providing businesses with new risk funding alternatives.

Under amendments to the act introduced in the Senate on Feb. 28, businesses, certain professionals and municipalities could form purchasing groups to collectively buy insurance or create risk retention groups to collectively self-fund all liability risks except workers compensation (see story, page 1).

Currently, the Risk Retention Act offers the risk retention group risk financing alternative only to product manufacturers, distributors, wholesalers or retailers to cover their product liability risks. The purchasing group option is more widely available, but the purchase of product liability insurance must be one of the group's purposes.

Businesses, unable to purchase affordable commercial liability insurance—and sometimes any insurance at any price—deserve, as soon as possible, the opportunities to solve their insurance problems offered by an expanded Risk Retention Act.

Basically, the act makes it easier for businesses to join together to buy insurance or collectively self-fund their risks by eliminating the problems of satisfying varying state insurance laws around the country.

We recognize that opening up group insurance purchasing and group self-insurance creates new risks, such as poorly designed group insurance programs and the possibility that some risk retention groups could under-reserve for future losses. However, we believe that businesses in these groups will do a good job of policing their own activities because each will want to be sure that its coverage for losses is sound. Furthermore, we believe that the regulation of these groups in one state, as called for in the act, will suffice to prevent most, if not all, problems.

It's particularly important that Congress act quickly to expand the Risk Retention Act, or else history could repeat itself.

The concept of a risk retention group grew out of studies of the product liability insurance crisis of the mid-1970s. But, it took until the fall of 1979 for the act to be developed, and it took Congress more than two years to pass the Risk Retention Act. By the fall of 1981, when the law was passed, businesses had already suffered through the worst of a tight insurance market and commercial product liability insurance was becoming readily available.



If Congress stalls these amendments for two years, commercial insurers will be well on their way to financial recovery, and we expect the crisis in insurance pricing and availability will be easing. But, for two years, companies will have been damaged by inadequate risk financing programs to the extent that some could be driven out of business or choose to close their doors.

The sooner these amendments are passed, the sooner businesses can develop desperately needed solutions to the grave problems of high-priced insurance and even worse, no insurance.

letters

Claims-made form will justify expense of an RMIS

To the editor: I would like to suggest an additional reason for "Justifying RMIS Expense" as outlined in David A. Tweedy's Perspective article (*BI*, Feb. 24): the impact of the claims-made policy.

There will be six different limits to be considered as to adequacy of coverage in the primary layer only, with all of them entering into the excess layers after the limit is exhausted.

Any insured negotiating a claims-made policy will be faced with a myriad of problems in determining acceptable levels of coverage without a risk management information system developed specifically to process claims data in the required format to respond to those six separate limits.

After the coverage is in force, the risk manager will be faced with monitoring each limit and aggregate during the policy term. When does the risk manager put the excess carrier on notice that the limits or aggregates have been exceeded? How will the risk manager keep management advised of the current status of insurance coverage?

The RMIS will need each loss by date of accident, by date of occurrence, amounts paid, reserves, allocated expenses (including defense costs), all coded to respond to the various limits and aggregates being imposed by the claims-made policy. In addition, the RMIS should have a loss-development capability to make some reasonable projection as to the ultimate cost of claims on an actuarial basis.

It has been suggested that an insured's only protection against late notice defenses by excess insurers will be to file loss runs with the excess carrier on a regular basis, perhaps quarterly, but at least annually. Such loss data, in the format suggested above, will not clearly answer all problems as to where the insured rests at any one time with the various limits and aggregates, but it will certainly be capable of alerting all parties to potential problems of coverage, or exhaustion thereof.

These concerns can only be addressed by an RMIS that is capable of handling volumes of data.

Manual handling of such data will be time consuming and subject to error of allocation of losses to the proper limits or aggregates.

C.W. Hall
President
Parentis Risk Management Inc.
Middletown, N.J.

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

Cancellation penalties no longer warranted

To the editor: Let me offer one reasonable concession to the insurance buyer, albeit a Band-Aid solution, in this outrageous seller's marketplace.

The short-rate cancellation penalty imposed by insurers, while perhaps well-founded in more reasonable times, now only adds insult to injury. These penalties can result in thousands and often hundreds of thousands of dollars in terms of large commercial placements. No insured should be penalized to this extent should the market soften or a more equitable alternative become available.

As most buyers have experienced, there is often little alternative available than to accept renewal terms provided at the 11th hour. Typically, this includes incumbent insurers providing restricted coverage at vastly increased premiums on a take-it-or-leave-it basis.

While uninformed "knee-jerk" legislative proposals—such as capping premium increases and blocking midterm cancellations and non-renewals by insurers—are well intentioned, these quick-fix methods will only serve to drive insurers from the marketplace or take other evasive action, which is in no one's best interest.

My proposition: Ban the short-rate penalty or at least lay it to rest until such a time as insurers, whose very existence depends on us, treat their clients on a more respectable basis.

Dean Skelton
Risk & Insurance Manager
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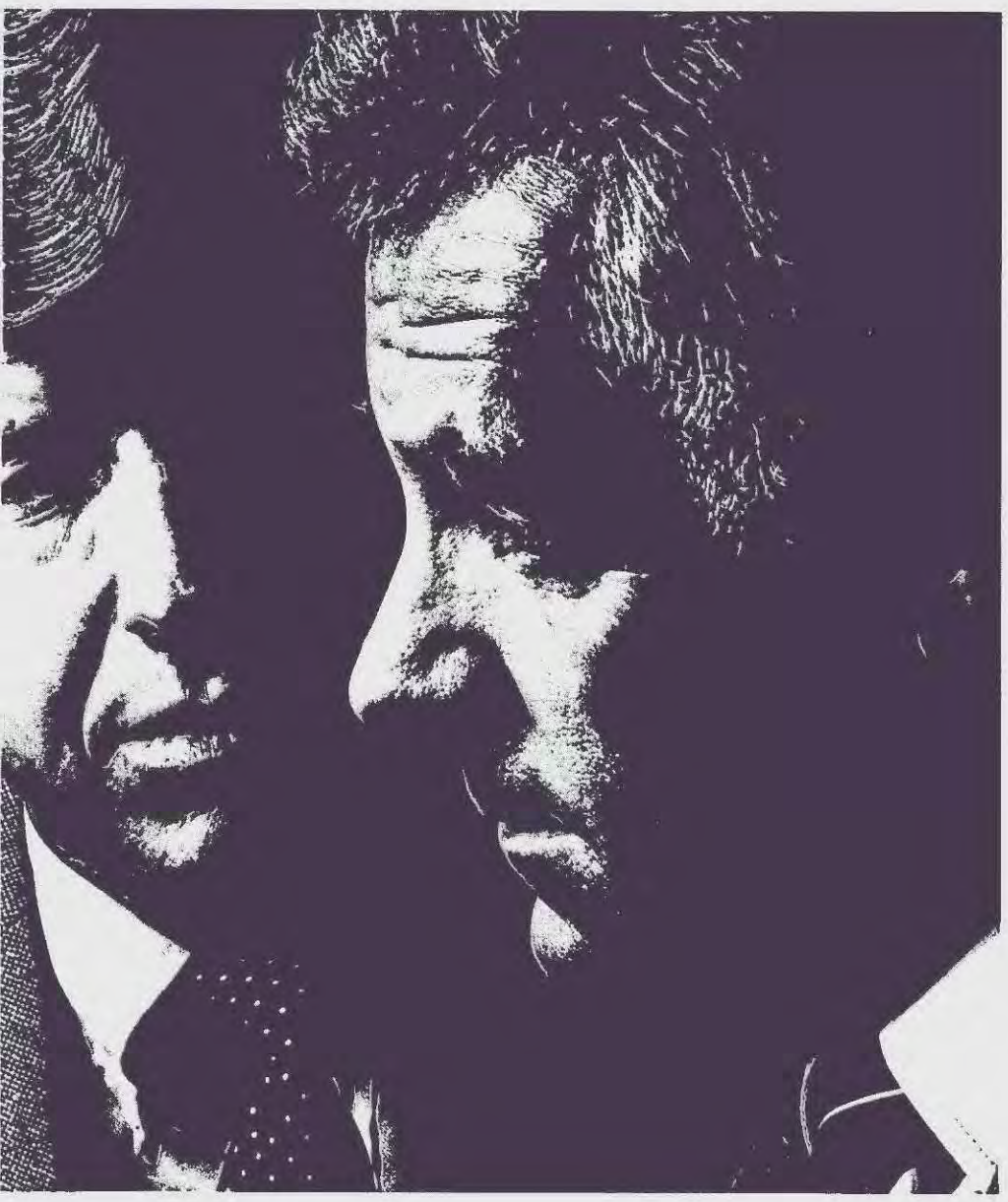
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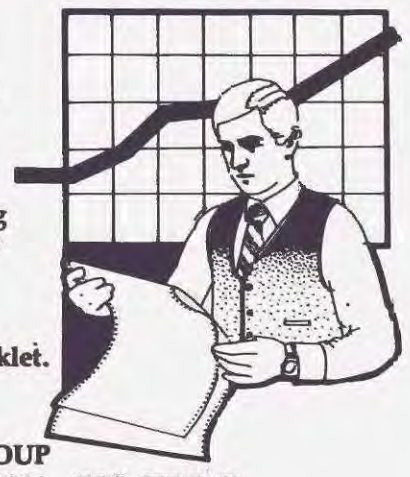
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comings & goings: buyers

Hawaii hotel chain announces new insurance, benefit posts

Lisa Smith, 43, has been promoted to vp-employee benefits and risk management at Outrigger Hotels Hawaii, based in Honolulu. In this position she will be responsible for the 19-hotel chain's employee benefit programs, including health insurance, pension plans and profit sharing plans. She will also supervise Outrigger's risk management department, which administers property/casualty insurance and safety programs. Ms. Smith joined Outrigger in July 1985 as director of risk management. Previously, she had served in risk management positions for Mountain Bell Telephone Co. and the city of Albuquerque, N.M. She will report to W. David P. Carey, Outrigger's executive vp and general counsel. Ms. Smith holds the Associate in Risk Management designation, and is a director of the Hawaii Chapter of the Risk & Insurance Management Society. She was formerly a director of the Rocky Mountain Chapter of RIMS.



Ms. Smith

* * *

Outrigger Hotels Hawaii has also promoted **Debra Lee Eggers**, 29, to the position of employee benefits and insurance manager. In this capacity, she will oversee the day-today administration of insurance matters, including policy changes, claims handling and litigation. She will report to Ms. Smith. Ms. Eggers joined Outrigger in June 1984 and was named risk manager in May 1985. She was previously a licensed real estate broker with Hawaii Land Management Inc. in Honolulu. Ms. Eggers holds a bachelor of arts degree in international communications and a master of business administration degree from the University of Hawaii in Honolulu. She is a director of the Hawaii Chapter of the Risk & Insurance Management Society and is working toward the Associate in Risk Management designation.

* * *

Kristin Davis, 41, has been promoted to assistant vp-risk/insurance management at Carteret Savings Bank in Morristown, N.J. In this newly created position, Ms. Davis is responsible for protecting the assets of the banking corporation from accidental loss, while also managing its commercial insurance portfolio. Ms. Davis will report to Frank A. Willis, Carteret's senior vp/controller. Prior to joining Carteret, Ms. Davis was an underwriter with Chubb & Sons Inc.'s financial institutions department in New Providence, N.J. She holds bachelor of arts degrees in English literature and history from the University of Redlands, Calif. Ms. Davis is a deputy member of the Risk & Insurance Management Society and is studying for the Associate in Risk Management and the Chartered Property Casualty Underwriter designations.

* * *

Robert J. Walters has been named risk and insurance manager at Hotel del Coronado in San Diego. Mr. Walters will be responsible for coordinating the property, liability, safety and workers compensation exposures of the hotel and its investment properties, as well as claims administration and loss control activities. The three-hotel complex, which was where "Some Like It Hot" was filmed, employs about 1,500 people and has a 30-member police force. Mr. Walters, 55, had been an independent risk management consultant in California. Prior to that, he was director of risk administration for San Diego County. He received a B.A. in political science from Lehigh University in Bethlehem, Pa. He reports to hotel President Scott Anderson.

•

We'd like to report on any staff changes in your company's risk management, safety or employee benefits department. Just drop a note to Paul Winston, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611, or call 312-649-5442. Please send a photograph, too.



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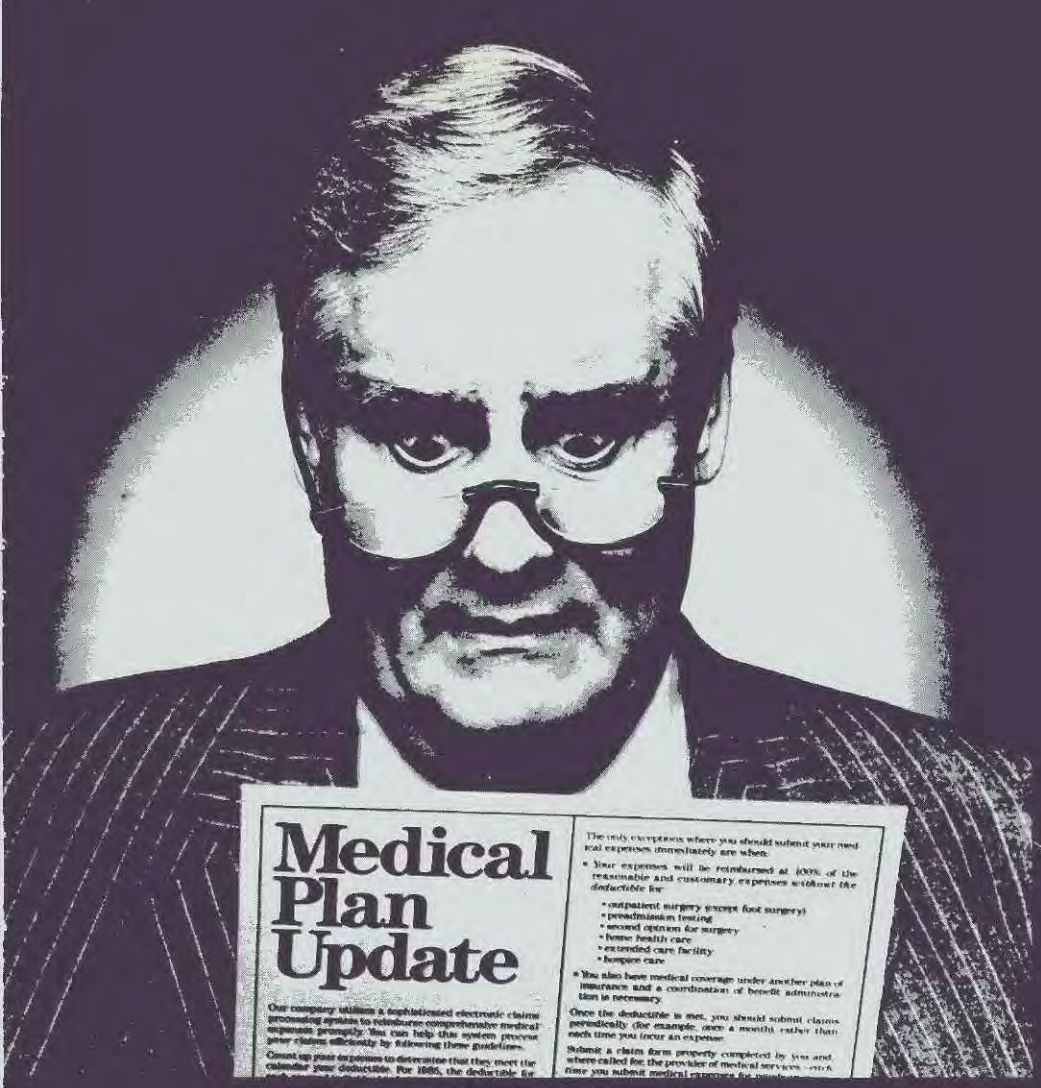
Q. How often is the claim data updated?
A. Every 24 hours—every business day.

Q. Fantastic. By the way, what does The Really Big Manufacturing Company make?
A. A little bit of everything.

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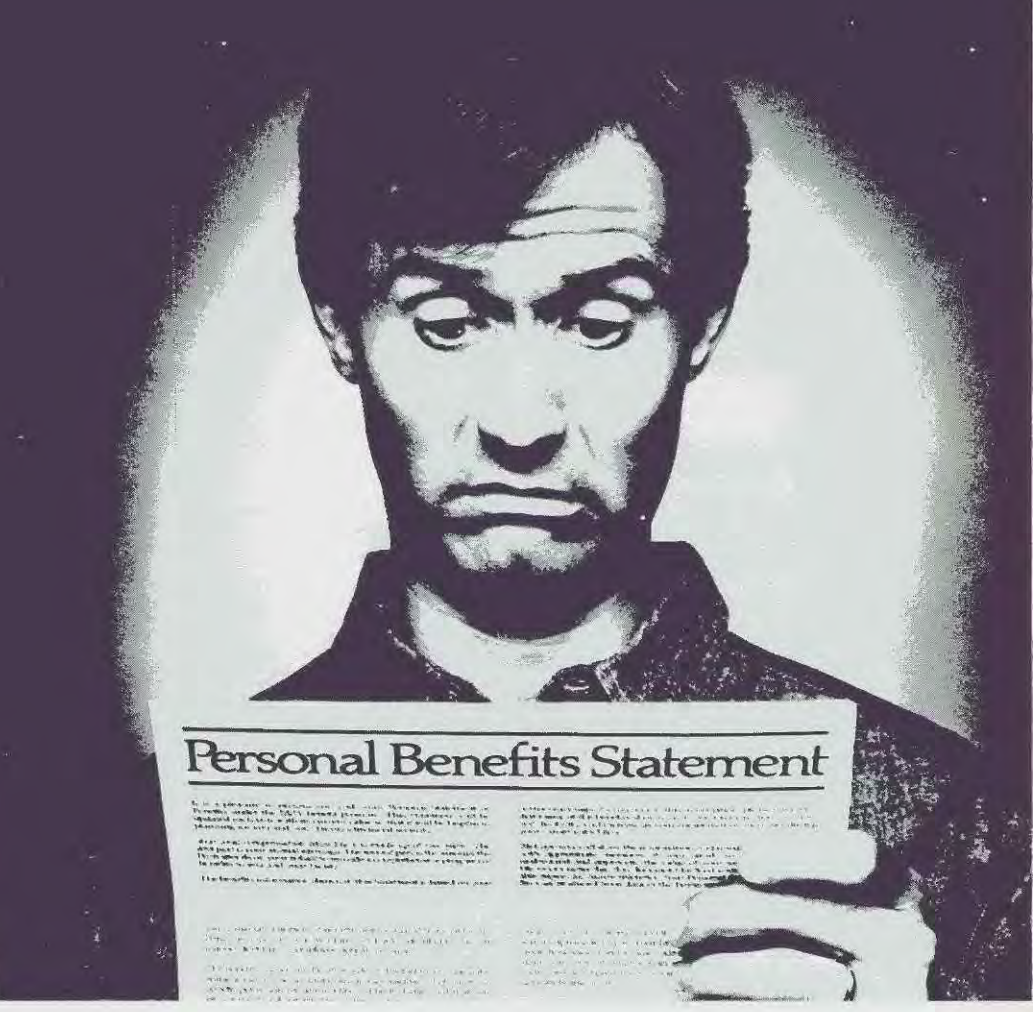
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Satellite market still tight, but surviving

By STACY SHAPIRO

LONDON—There still is a viable market for satellite launch insurance following the space shuttle disaster, sources say.

But, that market is at least as tight as it was before the Jan. 28 explosion that killed seven astronauts (*BI*, Feb. 3).

"The market is very difficult at the moment," confirmed Mohammed Dahbi, head of the aviation and aerospace division of broker Faugere & Jutheau in Paris.

The shuttle disaster had no serious impact on launch insurance rates, brokers say, because there were no insured satellites aboard the shuttle (*BI*, Feb. 3).

But, rates were out of sight before the disaster and they remain at 20% to 25% of insured value.

Since the disaster, Arianespace has launched an unmanned Ariane rocket carrying two satellites.

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One, a science probe owned by Swedish Space Corp., is a government satellite and was not insured.

The other satellite, SPOT, is owned by the French Space Agency and was insured for 400 million francs (about $58 million), by the launch-only policy Arianespace offers its clients. SPOT is the first satellite to be insured under the program, Mr. Dahbi says.

Arianespace set up the program last year because satellite coverage was not available at stable prices. It covers the cost of a relaunch if the probe does not reach proper orbit (*BI*, Dec. 16, 1985).

Arianespace plans to launch another rocket this week with two satellites on board. The Brazilsat II, which is valued at about $70 million, was not insured two weeks before the launch (*BI*, Feb. 24).

The other satellite, G-Star 2B, owned by GTE Corp. is already insured for about $85 million under a policy placed in 1983. It is the last in a five-satellite series.

Finally, insurers have suffered a $25 million loss on a unique program covering two probes owned by a consortium of Arab states.

When Arabsat I was launched last year, it was insured for $25 million for only launch-related costs at a rate of 20% of insured value. The launch failed, and the satellite is a total loss, sources say.

Arabsat II, which suffered a minor loss but is working, is fully insured for $45 million at 9.5% of insured value, along with the $25 million of launch coverage (*BI*, Feb. 4, 1985).

Satellite consultant

Jardine Glanville (Interplanetary) Ltd. in London has been named a consultant to an 8-month-old JC SAT, a joint venture by a U.S. and two Japanese firms.

The brokerage and consulting firm is a subsidiary of Jardine Insurance Brokers Worldwide in London.

JC SAT is scheduled to launch two communications satellites aboard the space shuttle; one launch is scheduled for December 1987 and one is scheduled for April 1988. JC SAT is a joint venture by Hughes Aircraft Co.'s Communications Group and the Japanese companies Mitsui and C Itoh.

The pending acquisition of broker Emett & Chandler by Jardine Insurance Brokers Inc., another subsidiary of JIBW, will help "enormously" in handling coverage for JC SAT, says John G. Buchanan, JIBI senior vp in San Francisco.

He also said JIBI views its subsidiary's consulting post as an opportunity to "crusade" for stability in the satellite insurance market. Underwriters have overreacted to recent satellite losses by raising rates too high, he said.

He notes that among E&C's brokerage clients are Morton Thiokol Inc. in Chicago and Northrop Corp.'s Aircraft Division in Hawthorne, Calif., which are major builders of satellite components.

"We definitely will end up being the leaders in this business in the next four or five years," he says.

Nuclear pool dropout

At least one Lloyd's of London underwriter has left the British nuclear insurance pool because of concern about future liabilities.

Roger Bradley, marine underwriter for R.W.S. Bradley & Others, decided last November not to continue to support the British nuclear insurance pool because "it is not an insurable proposition."

"I don't think that I made that decision too early," he added.

He noted that since the pool began in 1957, underwriters have earned 42 million pounds in premiums and have had very few claims.

But, he said the nature of the pool changed a few years ago, when the British Central Electricity Generating Board, the largest nuclear plant operator, decided to self-insure all power stations' property risks and leave the pool to cover liabilities.

"Premiums were thus reduced from 9 million pounds a year to 1 million pounds and the pool was left with the liabilities," he said.

He also noted that recently, leaks of radioactive water have been discovered at British nuclear power stations, particularly at the Sellafield plant.

Sellafield, which is operated by British Nuclear Fuels, is not insured with the nuclear pool; all liabilities will be paid by the British government, which operates British Nuclear Fuels.

But, Mr. Bradley fears the government may sell British Nuclear Fuels and its risks someday may come to the pool. "I feel that I don't want my names on my syndicate to be exposed to anything like that."

Mr. Bradley says he does not lead the British nuclear insurance pool, but says he was "high up on the slip." He still participates on the American, Canadian and international nuclear insurance pools, but has reduced his participation.

Syndicate stopped

The Committee of Lloyd's of London has directed Lloyd's underwriting agency E.R.H. Hill (Agencies) Ltd., managing agent of Lloyd's syndicate 800, to cease underwriting all new and renewal business until "such time as it revokes or varies the direction."

Lloyd's says the aviation syndicate, with about 1,900 names and 24 million pounds ($34.6 million) in capacity, was close to exceeding its underwriting limits for 1986.

The agency has 28 days to explain to Lloyd's why and how it should continue underwriting for syndicate 800.

A spokeswoman for the agency said the syndicate has stopped writing "for the time being." She added that the syndicate had not exceeded its capacity limits "yet."

Underwriter for the syndicate is J.A. Westcott.

Davison joins firm

Ian Hay Davison, former chief executive of Lloyd's of London, is returning part time to accounting firm Arthur Andersen & Co.

Mr. Davison will be an adviser to the worldwide firm of Arthur Anderson & Co. Societe Cooperative, according to Duane Hullberg, managing partner and chief executive of the company.

Comment on Lloyd's

Sir Patrick Neill, chairman of the Parliamentary committee investigating Lloyd's of London, has invited public comment.

The committee is investigating Lloyd's regulation in response to calls to include Lloyd's under a bill to regulate the financial services agency that currently is being considered in Parliament.

"Our main task will be to look at the regulatory arrangements which are being implemented by the Council of Lloyd's following the 1982 Lloyd's Act," Sir Patrick said.

"We wish to establish whether these arrangements provide adequate protection. . . .If we find that they do not, we shall consider what further regulatory provision to recommend," he said.

Specifically, the committee is seeking comments on whether:

- Satisfactory arrangements exist for judging the fitness of underwriting agents.
- The information supplied to prospective members is sufficient to let them make informed judgments about the consequences of Lloyd's membership and the performance of different syndicates.
- All problems of conflict of interest are adequately covered.
- It is necessary or desirable to establish some means of compensating members for serious underwriting losses other than from normally acceptable business risks.
- Proper arrangements exist and are implemented to ensure that action is initiated and pursued against offenders within Lloyd's.
- The bylaws, regulations and codes of practice are adequate.
- The current constitution of Lloyd's is adequate and effective in overseeing the operation of the Lloyd's market and the protection of Lloyd's members.

Comments should be sent by March 27 to Jonathan Phillips, secretary of the Committee of Inquiry into Regulatory Arrangements at Lloyd's, Room 510, Sanctuary Buildings, 20 Great Smith Street, London SW1P 3DB, England.

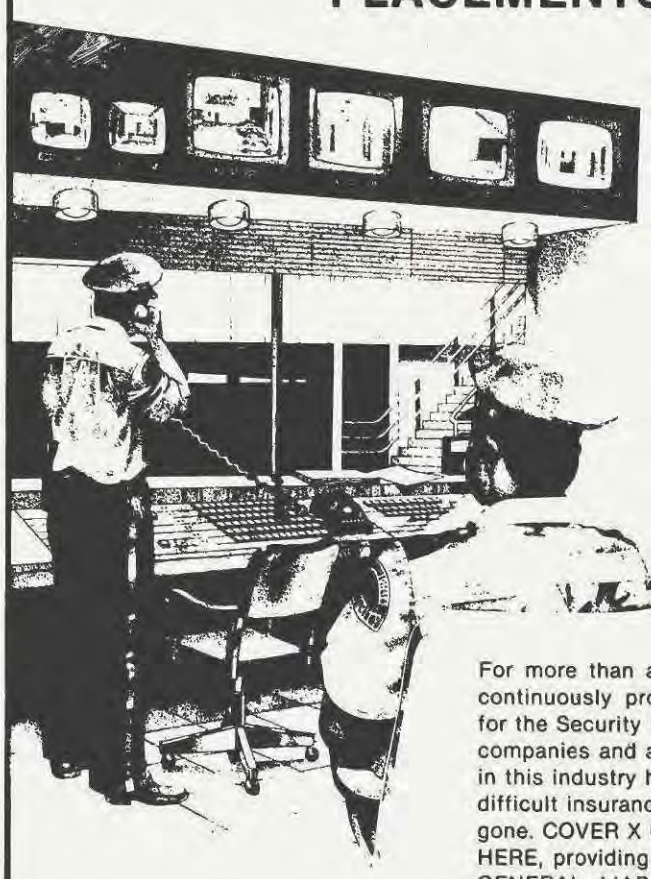
Comings and goings

Christopher Keville appointed chairman of broker C.T. Bowring Space Projects Ltd. He was formerly managing director. He succeeds Anthony H. Bolton, who remains on the board of the company. Mr. Bolton is also deputy chairman of C.T. Bowring & Co. Ltd. and chairman and chief executive of Bowring Aviation Ltd.

In addition, **Brian G. Moore** named managing director of Bowring Space Projects and **Simon Harker** named assistant director. Both formerly worked for Leslie & Godwin Aviation Ltd.

Ray Salter has been named a director of Willis Faber P.L.C.'s principal international broking subsidiary, Willis Faber & Dumas Ltd., and deputy managing director of its North American reinsurance division. Mr. Salter is currently a director of Willis Faber's reinsurance broking subsidiary, Carter Wilkes & Fane (Holding) Ltd. ■

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Several Texas groups pushing for tort reform

By MICHAEL BRADFORD

ARLINGTON, Texas—Support for tort reform is gathering momentum in Texas as buyers and insurers seek ways to limit high court awards.

About 50 North Texas business representatives crowded into a hotel conference room on Feb. 27 in Arlington to testify before the Texas Assn. of Business.

Their comments and those from similar meetings statewide will be presented by the TAB to state legislative committees and policymakers studying tort reform.

The TAB Insurance Crisis Forum meetings are among a number of activities in the state that recently have focused attention on high damage awards, increased liability insurance rates and the lack of capacity in some lines.

Other Texas efforts to bring attention to the need for tort reform include those of the Texas Civil Justice League, a lobbying group formed recently by insurers, professional groups and members of the medical community.

In addition, several insurers and buyers testified in January before the Legislature's House/Senate Joint Committee on Liability Insurance and Tort Law. Witnesses at that hearing claimed the civil justice crisis was having a "direct and devastating effect on the insurance industry," as one speaker put it.

Mike McCrary, chairman and chief executive officer of Transport Insurance Co. in Dallas, testified at that hearing that the insurance industry "doesn't suffer any illusions about the complexity of the problems," adding, "the effects of the reform can be almost immediate."

"The psychology of the marketplace is such that as soon as insurers have some confidence in their ability to reasonably predict what will happen, they will begin making their product available," he said, speaking for the Assn. of Fire & Casualty Cos. in Texas.

At the TAB meeting in Arlington, risk managers, controllers, benefit managers and other business representatives recounted a litany of insurance "horror stories" detailing sky-high jury awards against their companies and instances in which workers compensation and liability insurance costs have risen as much as 800%.

For example:

- The medical malpractice premium for a Dallas-area medical center jumped to $792,000 from $70,000 after the center filed $20,000 in claims.
- A tire company with 39 workers in Fort Worth saw workers compensation premiums rise to $37,221 in 1985 from $15,614 in 1983 with little claims experience.
- A Texarkana firm that repackages chemicals and pharmaceuticals says it will be out of business April 1 if it does not find adequate product liability coverage.
- A Dallas manufacturer of separation and infiltration equipment with $10 million in sales was unable to find product liability coverage this year. And, the cost of the company's workers compensation coverage rose more than 50% in 1986 even though it filed no claims in 1985, a spokesman said.

Workers compensation rates in Texas rose an average of 30.9% on Oct. 1 (*BI*, Sept. 23, 1985).

Gene Fields, supervisor of employee benefits at General Motors Corp. in Arlington, suggested that because work comp costs helped push up overall production costs, high premiums were partly responsible for the Detroit-based automaker's decision not to produce its Saturn and GM-10 cars in Texas.

Mr. Fields said GM paid about $1,460 per employee for workers compensation coverage at the Arlington plant, compared with costs of $46 per worker at GM's Wilmington, Del., plant; $89 per worker at the GM facility in Doraville, Ga.; and $984 per worker at its Van Nuys, Calif., site.

Part of the problem with high workers comp costs in Texas, the group agreed, are restrictions that generally prohibit businesses from self-insuring work comp exposures.

Larry Durland, chairman of the committee, said work comp self-insurance is one issue that will be presented to the state Legislature. The Houston-based TAB also has set hearings March 13 in San Antonio and March 20 in Austin. ■

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California legislator urges replacing tort system

By CAROL CAIN

CHICAGO—A state assemblyman from California wants to either overturn or overhaul the tort system under which liability claims are settled.

Alister McAlister, D-Sacramento, proposes replacing the tort system with a health and disability insurance system.

Under such a plan, similar to a system used in New Zealand, injured persons would receive immediate compensation regardless of fault, or whether the injury occurred in the workplace, on the highway or in the home.

"The tort system is in an advanced state of decline and fall. There is no solution other than to abolish it and replace it with health and disability insurance for everyone sustaining accidental injuries from whatever cause," Mr. McAlister said last month in an address to claims managers from CNA Insurance Cos., who were in Chicago for their annual meeting.

Mr. McAlister, an attorney, is chairman of the California Assembly's Finance and Insurance Committee. This was his first opportunity to expound on his ideas outside of his home state.

Although their laws differ, each state is "in a pickle," according to Mr. McAlister, who said his solutions can be used in every state.

CNA wanted its claims managers to hear the legislator's views to encourage discussion of alternatives for changing the civil justice and tort systems, a CNA spokesman said, adding that CNA does not necessarily endorse his views.

Mr. McAlister expects to introduce his legislation, which he calls an "overturn bill," in the California Legislature this month. The system would operate on a no-fault basis, paying claims without the time and expense of determining liability, he said. Further details have not yet been worked out.

"No one would get rich off of my system," he said, but injured persons would get medical care and compensation for lost wages.

He compared his idea to the New Zealand system, which has been in effect for eight years.

The New Zealand system "is fair, productive and I would say the best system in the world," he said, adding that the New Zealand system is socialistic and would have to be changed somewhat to be compatible with the U.S. economy.

According to Mr. McAlister's plan, each individual would buy health and disability insurance, rather than liability insurance.

Besides his "overturn bill," he also plans to introduce a measure to "overhaul" the tort system. This measure will call for provisions already used under California's medical malpractice laws, he said.

For instance, it would limit judgments for pain and suffering awards, allow periodic payments instead of lump-sum settlements and limit attorneys' contingency fees.

And, though Mr. McAlister does "not have great faith in tort law" or punitive damages, he suggests there may be a need to retain such a system for heinous conduct.

But, in those cases, the legislation will propose placing caps on punitive damage awards.

"There ought to be some kind of cap on punitive damages . . . at least no more than two or three times the economic limit," he said.

His measure also calls for abolishing California's joint and several liability doctrine.

"I would associate myself with all these reform measures," Mr. McAlister said. "But even if you did all that, you still would have a lousy system. So I say you have to go beyond that," he said.

To accomplish such a task, he believes there needs to be a coalition of employers, employees, physicians, insurers and other groups to go up against trial lawyers.

"There's a potential coalition out there that can change things, but it has got to focus . . . if you want to accomplish anything like this legislatively, you have to join forces," Mr. McAlister said. If not, the courts will continue to design and administer the system, he said.

In commenting on Mr. McAlister's proposal to use a health and disability insurance system, Edward J. Noha, CNA's chairman and chief executive officer, said: "You can't get there from here in one shot. But can the insurance industry handle it? Yes."

The major concern about such a system would be the vast amount of persons who are uninsurable and couldn't pay for such insurance themselves, Mr. Noha said.

"While I think there is merit to Mr. McAlister's proposal long term, I think his 'overhaul' bill has a better chance," Mr. Noha said.

Insurers, he said, are convinced that a change in the civil justice and tort reform system is needed and must be tackled on a state-by-state, rather than federal, basis.

The insurance industry also supports a unified effort to change the system, Mr. Noha said, and in Illinois, the goal is to create a better business climate and more jobs.

"So it's an excellent opportunity, but it's not easy because of the egos and personalities involved," Mr. Noha said.

"The insurance industry is at the breaking point because the basic idea of insurance—speading the risk and pooling funds to pay for losses—has been stretched well beyond prudent limits for liability insurance.

"The insurance industry cannot pass along all the costs of underwriting the civil justice system's expanding definitions of liability," Mr. Noha said.

"We encourage public debate and diverse opinions on ways to get this overburdened system back under rational and predictable control." ■



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New York MAP

Continued from page 2

where we are going in the future."

The New York MAP was organized by the Insurance Department last year to assist in the placement of coverage for towns, villages, school districts and public benefit corporations.

To date, 91 municipalities have applied for coverage through the MAP, and 79 of these have found coverage with commercial insurers, according to the New York department. And, 11 have received extensions of their existing policies while the MAP looks for replacement coverage.

The 31 municipalities that were offered coverage last month either had no coverage or had policies that were due to expire soon.

The 21 insurers may choose whether to offer the towns claims-made or occurrence-based coverage, the department said.

Deductibles on the policies are expected to be similar to those of expired policies, and in most cases will be in the $5,000 to $10,000 range, the spokesman said.

The spokesman added that premiums will be determined on a risk-by-risk basis and are expected to be reasonable, though Mr. Corcoran warned that in many cases municipalities will pay higher premiums for less-extensive coverage through the MAP.

Reaction to the MAP coverage among municipal insurance buyers is mixed.

"At this point, we are very pleased to have it," said Joyce Braustein, clerk/treasurer of the village of Roslyn Estates, N.Y., one of the 31 towns that found coverage in last month's meeting.

The village's new coverage with Maryland Casualty Co. is effective March 1, though the town has not yet received a premium quote, Ms. Braustein said. She added, though, that any reasonable premium will be approved by the village trustees.

However, Martin Lang, supervisor for the town of Southhampton, said he isn't certain how good a deal the MAP coverage is. If deductibles and premiums are significantly higher than under expiring policies, "we would be better off sticking our premium in the bank and crossing our fingers," he said.

Southhampton—an affluent resort community in eastern Long Island—plans to close its public beaches this summer if it cannot replace its liability insurance, part of which expired last December and another part of which expires March 15.

The 21 insurers that agreed to provide coverage include: Aetna Life & Casualty Co., American International Group Inc., Chubb Group, CIGNA Corp., CNA Insurance Cos., Commercial Union Insurance Cos., Continental Insurance Group, Fireman's Fund Insurance Co., General Accident Insurance Group, The Home Insurance Group and Kemper Group.

Also: Liberty Mutual Insurance Cos., Maryland Casualty Co., Nationwide Group, Royal Insurance Group, St. Paul Group, Travelers Group, United Community Insurance Co., United States Fidelity & Guaranty Group, Utica Mutual Insurance Co. and Wausau Insurance Cos.

Meanwhile, all state public entities and some not-for-profit corporations would receive relief under the tort reform bill passed Feb. 11 by the Assembly.

However, the Democratic-controlled Assembly is not expected to act soon on H.B. 8517A, the Republican-sponsored Public Entity Liability Insurance Reform Act of 1986, according to Jeffrey Lovell, an aide to Sen. James Donovan, R-Chadwick, who co-sponsored the bill with Sen. Warren Anderson, R-Binghamton and Sen. Joseph Bruno, R-Rensselaer.

The bill will remain in the Assembly Insurance Committee at least until a commission appointed by Democratic Gov. Mario Cuomo issues a report later this month on market conditions, Mr. Lovell said.

All 10 provisions of the bill apply to public entities—including schools, municipalities and volunteer fire departments—and private school bus contractors.

Five of the 10 provisions also apply to not-for-profit corporations incorporated as "Type B" organizations under New York's corporation law, Mr. Lovell said.

If passed into law, the provisions that apply to both public entities and not-for-profit corporations:

- Eliminate joint and several liability by limiting tort liability to the equitable share of the judgment.
- Allow periodic payment of tort judgments of $250,000 or more.
- Create a compensation schedule for plaintiff attorneys.
- Impose penalties against both a plaintiff and plaintiff's attorney if a judge rules that they filed a frivolous lawsuit.
- Allow a judgment to be reduced by payments from collateral sources like workers compensation.

The remaining provisions, which apply only to public entities and private school bus contractors, would:

- Permit them to join a reciprocal insurance program under the supervision of the superintendent of insurance.

A reciprocal insurance company is a non-profit mutual company in which members share losses. New York law allows municipalities to self-insure, but does not let them group together without authorization, Mr. Lovell said.

- Establish a separate property/casualty rating classification for public entities to protect them from dramatic shifts in the commercial market.
- Create a risk management credit pogram with guidelines established through the state Insurance Department.
- Require 60 days' notice for midterm cancellations and non-renewals.
- Establish a non-jury section of the state Supreme Court, the state trial court system, to hear all contract or tort actions against public entities.

While supporters hope the entire bill will be passed, some of the provisions are written independent of others so they could be considered separately, Mr. Lovell said.

The bill is designed to help public entities and, to a lesser extent, not-for-profit corporations find affordable, quality coverage, he added.

Some 229 public entities were affected when Utica Mutual Insurance Co. decided not to renew general liability coverages for New York cities and counties last August (*BI*, May 20, 1985). ■



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More companies lose directors to D&O crisis

By STEVE TARAVELLA

The latest D&O casualties include Lear Petroleum Corp., DeltaUS Corp. and Armada Corp.

The directors and officers liability insurance market continues to wreak havoc on corporate boardrooms, where directors' chairs are being vacated in ever-increasing numbers.

A striking number of U.S. businesses have lost outside directors over the past year because their directors, in the absence of D&O coverage, feared exposing their personal wealth to lawsuits (*BI*, Jan. 27).

Among the latest victims of the D&O market, one of tightest being experienced during this hard insurance cycle, are: Lear Petroleum Corp. in Dallas; DeltaUS Corp. in Tyler, Texas; and Armada Corp. in Detroit.

Eight of Armada's 10 directors resigned Feb. 3 because the company was unable to replace its expiring D&O insurance for a reasonable price, according to Lowell Robinson Jr., vp-finance, chief financial officer and one of only two directors who did not leave the company.

Of the eight who resigned, two also held inside positions. One was an Armada vp and president of the company's alloy division, and the other was Jerry Luptak, Armada president, chairman and chief executive officer.

Mr. Luptak remains president, but he has left his positions as chairman and chief executive officer.

For limits of $10 million, Armada's D&O insurer sought a renewal premium of $720,000 and a retention of $750,000, Mr. Robinson says.

This is up from Armada's previous annual premium of $45,000 and retention of $125,000.

He declined to identify the insurer, and says several brokers are still searching for replacement coverage.

Armada, which manufactures automotive exhaust systems, has filled two of the eight vacancies. However, the company still is operating without a chairman or chief executive officer.

DeltaUS, an oil and gas drilling company, lost seven of its nine directors Feb. 25 when it could not replace its expiring D&O insurance.

All seven were outside directors, leaving Delta in the hands of two directors who are officers as well, according to Donald L. Frankel, president and one of the two remaining directors.

The other remaining director is Chairman Keating V. Zeppa. Mr. Frankel declined to identify the limits or the underwriter of the expiring coverage.

Lear Petroleum announced last month that four of its outside directors have left the company since last November because the company could not obtain D&O insurance at "reasonable costs."

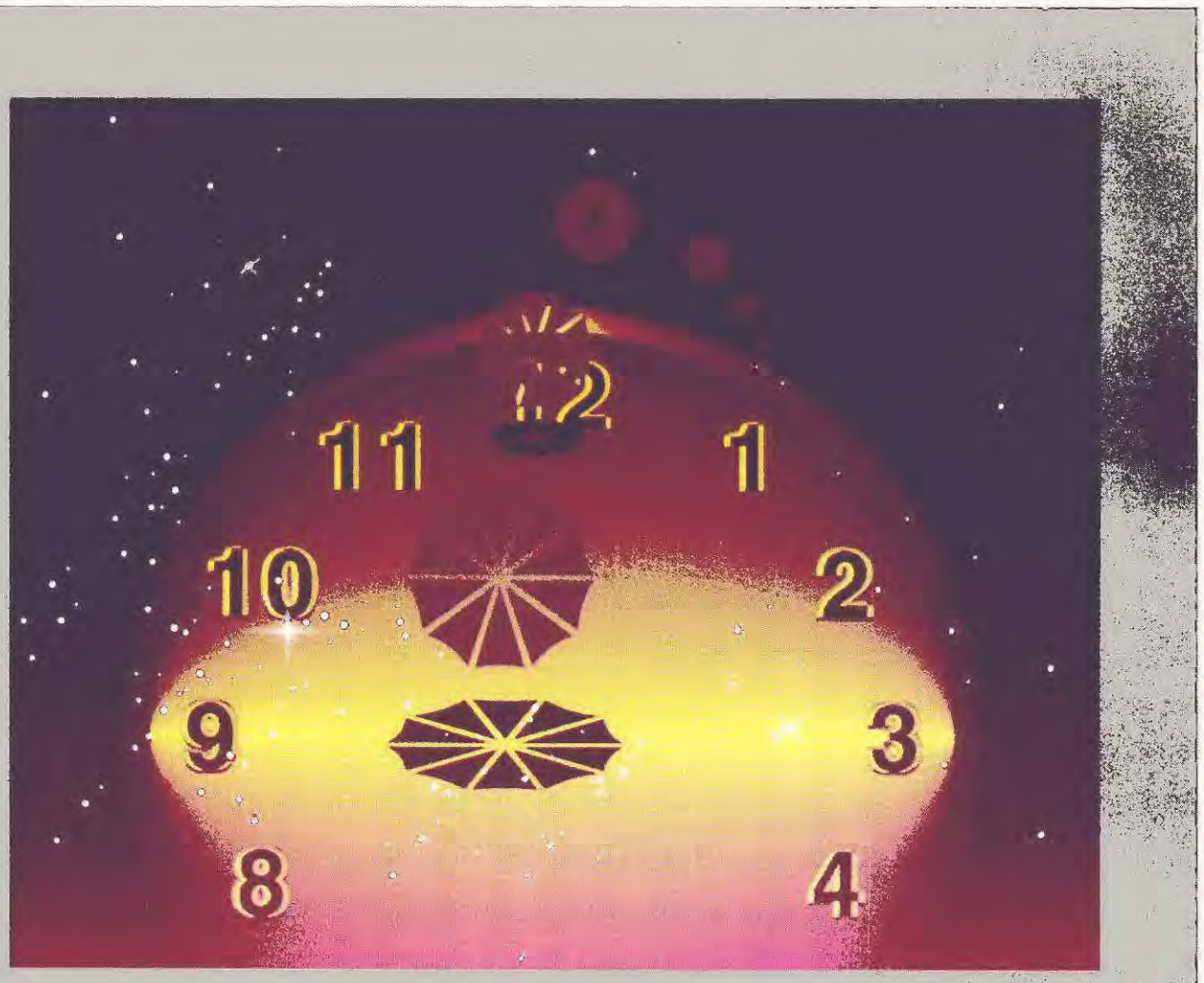
Two Lear directors resigned in November and two others quit last month, leaving a five-member board. Lear, an oil and gas exploration and production company, would not comment beyond that announcement.

Also, five outside directors and the chief executive officer of a Houston business resigned last November when the company decided to reject the only D&O quote it could find, reports the company's president, who spoke on the condition that the business not be identified.

That policy carried a $265,000 price tag for limits of $5 million, compared with the expiring $10 million policy at a $10,000 premium, he says.

The policy offered at renewal also bore additional restrictions, such as exclusion of coverage for claims stemming from a merger or acquisition or for claims related to Securities and Exchange Commission activities.

Three of the six individuals who left have since been replaced, all with inside officers. ■



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IMPERFECT 'MODEL' ACT

Post-insolvency guaranty fund laws causing chaos

By Albert B. Lewis

THE NATIONAL ASSN. of Insurance Commissioners adopted a model act in 1969 providing for a post-insolvency assessment insurance guaranty fund, and every state except New York has adopted a form that is similar to the model act. New York has adopted its own guaranty fund act.

But, these statutes are causing chaos in the event of actual insolvencies and liquidations.

The chaos will make lawyers richer and policyholders poorer, and cause extended litigation between states and claimants.

Federal legislators are sure to respond in an attempt to solve the problem—or inadvertently contribute to it.

The difficulties with the so-called model statutes is that although many are similar, too many are materially different.

While some states provide coverage of up to $50,000 per claim, others provide coverage of up to $1 million per claim.

Some states prohibit claimants with a certain maximum net worth from being eligible for any guaranty fund coverage.

Other states exclude products liability and limit claims to economic loss only.

In addition to differences in the amount of the guaranteed claim, the broad definitions of a covered claim under the laws raise interstate conflicts of law as to coverage.

These questions will cause serious delays and litigation to determine state guaranty fund coverage.

New York state has its own definition of a covered claim: "a claim based upon a policy insuring property or risks located or resident in this state."

The model act defines a covered claim as a claim in which the claimant or the policyholder is a resident of the state at the time of the insured event, or that the property from which the claim arises is located permanently in the state.

Either definition leaves more questions than answers.

In first-party property coverage, neither the model act nor the New York act pose a conflict, since location of the risk or property from which the claim arises is obvious.

But, under the model act in cases of third-party casualty coverage in which the claimant and the policyholders have different state residences, two state guaranty funds could be covering the claim.

And, if the property that caused the loss were located in another state, still another guaranty fund could be liable for the claim.

If the property involved were located in New York state, New York's guaranty fund statute could provide the coverage.

In a large casualty loss claim involving several state guaranty funds with different limits, the policyholder is materially interested in having maximum coverage by having the state guaranty fund with the maximum per-claim limit respond.

Product liability coverage may contain more multistate problems.

The location of a product liability risk could be the state where a product is sold, leased, used, ingested, repaired, assembled or manufactured.

The question of which state guaranty fund will pay a multistate claim against an insolvent insurer's policy is a problem that currently is facing all casualty policyholders of the now-insolvent Ideal Mutual Insurance Co. and Union Indemnity Insurance Co.

Ideal, a New York-domiciled insurer that was declared insolvent in early 1985, was licensed in all of the 50 states and wrote a large amount of liability coverage, including products liability for firms located throughout the United States.

On Feb. 19, 1985, notices were published and mailed to all Ideal Indemnity policyholders and claimants stating the term of the order of liquidation.

The notice contains the following statement:

"All persons and policyholders against whom actions are now pending who do not come within the provisions of Section 7601, 7603 and 7604 of the New York Insurance Law concerning the Company (Ideal) may be liable on its policies or contracts and which have been defended up to date of the order of liquidation" by an attorney "retained by the Company are advised that the. . . retention of said attorney has been terminated by the entry of the order of liquidation.

"Each such person is therefore advised to contact the insurance department, guaranty fund or association in your state," the Ideal Indemnity notice continued.

In another part of the notice from the insolvent insurer, claimants are advised to file a proof of a claim before Feb. 7, 1986, whether or not a claim has been filed against them.

Union Indemnity was found to be insolvent in July 16, 1985, in New York, and its policyholders face a similar announcement.

Policyholders of these two insolvent insurance companies are left in a quandary.

First, policyholders must determine if the claims that are known to them are covered by sections 7601, 7603 and 7604 of the New York Insurance Law.

Determining just what is meant by the New York insurance statute on risks located in the state is enough to challenge courts and lawyers, let alone policyholders.

In addition, the direction "to contact the insurance department, guaranty fund or association in your state" creates the second problem: defining which state is "your state" when a policyholder has offices or operations in several states.

And, even if some answers to these questions can be determined regarding reported claims, where does the policyholder file a proof of an incurred-but-not-reported claim?

But, which state's guaranty fund is contacted may be critical to the policyholder's ability to obtain coverage for the claims.

How can the policyholder determine whether Sections 7601, 7603 and 7604 of the New York Insurance Law apply to these claims?

As the notice of the liquidator states, if New York state's statutes do not apply, then the policyholder should contact some other guaranty funds.

But, which fund is contacted may be critical to the policyholder's ability to obtain coverage for the claims.

A policyholder in a state that limits the payment to $50,000 per claim and is a defendant in a suit that exposes it to a claim well over $50,000 is left personally exposed for the difference.

A policyholder with a net worth that prohibits coverage by a state's guaranty fund is even more exposed.

The unequal provisions in the states' statutes will cause policyholders to seek a state guaranty fund that will maximize their coverage.

For example, a policyholder in a state with low claim coverage will attempt to find coverage in the state where the plaintiff is a resident, if that state has a greater coverage.

Policyholders will be filing proofs of claim with selected state guaranty funds, and these funds may reject these claims on statutory grounds.

The litigation that will ensue will be prolonged, extensive and include more than one state.

Some litigation involving prior insolvencies already has occurred and may be used as a guide.

For example, the New Jersey Property Liability Association refused coverage on a first-party claim arising out of a policy that covered a steel dredging barge.

The claim was for damage to the barge occurring in the Atlantic Ocean off Long Island, N.Y.

The property liability association claimed that the barge was not in New Jersey, and therefore, it did not qualify as being property that was permanently located within the state.

The plaintiff, a corporation domiciled in the state of Delaware, claimed coverage as an insured resident of the state.

The New Jersey Superior Court awarded insurance coverage, finding that the company was a resident of the state of New Jersey.

The plaintiff corporation's domicile in Delaware was discounted by the court, which held that irrespective of a corporation's domicile, its residence was determined by its being licensed by the state of New Jersey to transact business, and by its operation of its principal place of business in New Jersey.

These facts were sufficient for the court to find coverage under the New Jersey statute, which uses the definition of the model guaranty fund act.

Eastern Seaboard Pile Driving Corp. vs. New Jersey Property Liability Insurance Guaranty Association (175 N.J. Super 589, 1980).

However, the New Jersey superior Court's decision in the Eastern Seaboard case differed from its previous decisions in two cases: *State vs. Garford Trucking Inc.* (4 N.J. 346, 1950) and *Red Star Express Lines vs. DeStefano* (104 N.J. Super 102 (app. Div. 1968)). Both of these cases involved motor vehicles.

In the case of Garford Trucking Inc., a New Jersey corporation was charged with operating an unregistered motor vehicle in New Jersey in violation of state law. The defendant claimed it was exempt because it was licensed to do business in several states, operated its trucks and its business in these states, and had registered its trucks in only one of these states.

But, the court held that the corporation could not become a non-resident of New Jersey, its domiciled state, saying it could not shed its residence "which is inseparable from domicile" (4 NJ 351).

In Eastern Seaboard, the court found this language did not suggest that a corporation may not become a resident of a jurisdiction in addition to that of its origin, and it quoted the Garford decision:

"Unlike a natural person, a corporate entity cannot change its domicile at will although it may have a residence elsewhere for the transaction of its business. . . . Ordinarily, domicile includes residence but one may have several residences or places of business. . . a domestic corporation whose domicile and residence in this state are inseparable incidents of the charter, which gives it being, does not become a 'non-resident' by transacting business in another sovereignty, even though it may also have

Continued on next page



Albert B. Lewis is a partner in the New York law firm of Cole & Deitz.

ASK A BENEFIT MANAGER

Will pension changes affect benefit planning?

Q **I understand the Financial Accounting Standards Board recently issued new requirements concerning accounting for pension plans. What are these requirements, and what impact do you think they will have on pension benefit design and planning?**

A The Financial Accounting Standards Board recently issued Statement Nos. 87 and 88, which replace previous accounting standards or requirements governing the way a company reports pension plans in its financial statements.

These new statements will form the basis of "generally accepted accounting principles" for pension accounting in the future.

FASB No. 87 governs the way pension plans are reported in a company's income statement, balance sheet and financial statement footnotes; FASB No. 88 governs specific transactions such as pension plan terminations, pension benefit accrual freezes, significant layoffs or plant shutdowns and early retirement incentive programs.

The requirements of FASB No. 87 governing the way pensions are reported in a company's financial statements are:

- Balance sheet recognition. As under current accounting practices, companies will be required to recognize on their balance sheets the difference between the amounts expensed against income for pension plans and the amount actually contributed to the pension plans.

In addition, a minimum liability will have to be recognized if the "accumulated benefit obligation" is greater than plan assets measured at market value. The "accumulated benefit obligation" is defined as the present value of pension benefits without regard to future salary increases. (The unfunded accumulated benefit obligation generally will not affect stockholder equity because an intangible asset equal to the additional liability also will be recognized.)

- Pension expense. FASB No. 87 requires companies to use a *uniform* actuarial cost method—the Projected Unit Cost Method—to determine its pension expense or cost.

The net pension expense for a defined benefit pension plan now will consist of:

- A plan's normal or current service cost.
- Interest cost, using a discount rate at which the plan's pension obligation could be settled (for example, Pension Benefit Guaranty Corp. rates).
- Actual return on plan assets.
- Amortization of prior service costs. Generally, more rapid amortization of these costs is required than under current practices.
- Gains or loses. These include the difference between the actual rate of return and the expected rate of return on plan assets—using long-term rates—and the amortization of unrecognized gains or losses from previous periods over the average remaining service lives of employees if it exceeds 10% of the market-related asset value or projected benefit obligation.

Based on the date FASB No. 87 is effective for a company, the net asset or net pension liability will be amortized using a straight line method over the employee's remaining service period; if the period is less than 15 years, a company can use 15 years.

FASB statement No. 88 requires—in certain circumstances—that an employer recognize immediately the unrecognized past service cost or net gain or loss when it terminates a plan, buys annuities or cashes out pension benefits, shuts down a plant, freezes benefit accruals under a plan or offers early retirement incentive programs.

The new requirements of FASB Nos. 87 and 88 differ significantly from the current requirements for accounting for pension expense. Specifically:

- The actuarial cost method prescribed by FASB No. 87 differs from methods approved under the Employee Retirement Income Security Act. For many companies, the prescribed method will produce a pension expense above the Internal Revenue Service maximum tax-deductible amount or below ERISA minimum funding requirements.
- Statement No. 87 requires the use of two different interest rates: one, such as the current PBGC rates, for the liability component of net costs, and another, a longer-term rate, for the asset component of net cost.
- Statement No. 87 requires the application of a uniform amortization period for prior service costs.
- There are expanded disclosure requirements associated with the new standards.

Both FASB Nos. 87 and 88 are effective for fiscal years beginning after Dec. 15, 1986, except that any additional balance sheet liabilities do not have to be reported until two years later.

Implementation of the new standards will require careful review and is a complex decision involving, among others, the following considerations:

- The net obligation at implementation of the new standards will depend on the value of plan obligations and on the plan's asset performance as of the implementation date. If plan assets drop, the required amortization of the balance would increase future expense.
- The assumptions used to measure the initial projected benefit obligation will affect gains and losses for an extended period of time.
- Special transactions, such as pension plan terminations, should be reviewed against the requirements of the new standards.
- More volatility in a company's pension expense probably will be generated by the new standards because the settlement rate of interest will change from year to year and the new standards require generally shorter periods of prior service cost amortization.

Undoubtedly, the new standards—especially FASB No. 87—will give accountants a greater influence in determining a company's pension plan decisions.

In fact, the effect of pensions on a company's net worth and income may well result in the accounting process becoming the major factor in pension planning, including plan design and funding—areas of responsibility that traditionally have been assigned to the actuary.

Pension accounting no longer simply will reflect a company's pension funding policy, and the design and operation of a pension plan—for example, projected updates in career pay or cash-balance pension plans or lump-sum settlements or annuity purchases—certainly will be affected by the new standards.

Therefore, employee benefit professionals would be well-advised to familiarize themselves thoroughly with the requirements of the new standards so they can interact effectively and credibly with their company's accountants in shaping decisions regarding their company's pension plans. ■

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

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


Mr. Duva

This month's column, on employee benefit issues, is written by Joseph Duva, director of employee benefits and compensation at SCM Corp. in New York. Ralph F. Perry Jr., vp and director of risk management at Amfac Inc. in San Francisco, answers risk management questions. And, William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions.

Mr. Duva's and Mr. Perry's columns appear alternately on the second Monday of each month. Mr. Miner's column appears on the first Monday of every other month. Mr. Duva's next column will appear in May.

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

Post-insolvency guaranty fund laws chaotic

Continued from previous page
a residence there for certain purposes" (4 NJ 352-353).

In the Red Star Express case, the plaintiff was a New York-domiciled corporation transacting business in New Jersey. It sought payment for damage to its truck, which occured in New Jersey.

The plaintiff alleged it was a resident of New Jersey and eligible under the New Jersey Guaranty Fund's definition of claim coverage.

The court held that because the truck was registered in New York state, it did not contribute to the fund from which payment was to be made, and that it was the legislative intent that payment would be made only to those entities that had contributed to the fund.

The court also ruled that Red Star's registering the truck in New York was further evidence that it did not consider itself a resident of New Jersey. The New Jersey statute required "every resident of this state" to register its vehicles in New Jersey.

The Ideal and Union Indemnity problem highlights a basic inequity in the guaranty legislation of the states: Policyholders paying the same premium to the same regulated insurance company will be left with unequal guaranty fund coverage.

These New Jersey decisions may leave more unanswered questions for Ideal policyholders than they answered.

The decisions establish residency as existing in the state of domicile, and they establish additional residency in other states based upon several factors, including licensing to do business in a state and the establishment of an executive office or principal place of business in a state.

These factors create more state involvement and more confusion for the policyholders of insolvent companies.

If the difficulties inherent in the various state laws are not enough, the state of Texas set a cutoff date for Ideal policyholders' claims to be filed as Jan. 14, 1986, and Nebraska set the deadline as Sept. 13, 1985.

But, Ideal policyholders were advised of a cutoff date of Feb. 7, 1986, by the insurance superintendent for the state of New York.

The Ideal and Union Indemnity problem highlights a basic inequity in the guaranty legislation of the states: Policyholders paying the same premium to the same regulated insurance company will be left with unequal fund coverage.

In addition to being confusing and unfair, this inequity in the uniform guaranty legislation may hold another danger: It may cause the federal government to pre-empt the state jurisdiction. ■

Libel coverage

Continued from page 1

Insurance Cos., but CNA withdrew from the libel insurance market in January after it was the insurer for Time Inc. and CBS Inc. in the costly *Sharon vs. Time* and *Westmoreland vs. CBS* libel cases.

Media/Professionals' policies are now being written on behalf of SAFECO Corp. of Seattle.

Walterry also brokers a program endorsed by the Public Broadcasting Service and the Corp. for Public Broadcasting whose rates increased 50% as of Jan. 1, says Mr. Coady. Deductibles on the SAFECO program increased to $2,500 from $1,000. In-house limits of $5 million are available.

In most cases, rates have increased at least 100%, says Larry Worrell of Media/Professionals. Mr. Worrell says Media/Professionals now offers $5 million in limits through SAFECO, but expects to increase this to $10 million within a couple of months.

At one time, Mr. Worrell says, up to $100 million in limits were available, and rates were so low companies would buy an additional $10 million to $20 million in coverage with little thought. But as a result of legal expenses, "the whole thing kept tumbling down again," he says.

Many media risks also carry umbrella policies that include libel risks, notes Mr. Worrell. Previously, these policies would drop down to the $2 million level and include $15 million to $20 million in excess coverage.

But now, he says, umbrella insurers are either excluding libel altogether, or dropping down only to the $5 million or $10 million level. And in certain cases, $5 million in coverage excess of $1 million could cost as much as $50,000 to $100,000.

"It may not have any relation to premiums in the first million," he says.

"The market is drying up fast," says Dan Fetzer, president of the Insurance Center of N.C. Inc. in Greensboro, N.C. Mr. Fetzer places insurance for the Charlotte, N.C.-based Jefferson-Pilot Broadcasting, whose broadcast properties include 11 radio stations, two TV stations and a sports syndication division. Obtaining umbrella coverage, he adds, is "almost impossible."

"You would find it difficult today to find more libel insurance rather than the base, working level," says James H. Matthews Jr., director-risk management at Knight-Ridder Newspapers Inc. in Miami, Fla.

Knight-Ridder obtains its coverage from the Mutual Insurance Co. of Bermuda, a captive created by the American Newspaper Publishers Assn., which offers up to $10 million in policy limits. He would not discuss where his company obtains its excess coverage.

Besides Media/Professionals and Mutual of Bermuda, the other major writer of libel insurance today is Employers Re, but it is a somewhat reluctant player, says Michael Fitt, the company's chairman.

Employers Re has considered getting out of the libel insurance business, which is one of the few lines it writes directly, says Mr. Fitt.

But, Employers Re was the first to offer libel insurance more than 50 years ago, and after such a long period, "You don't get out of it lightly," says Mr. Fitt.

"We decided to hang in and try to straighten it out," he says. He adds, though, that if this were Employers Re's only line of business, instead of being its smallest department, "we would have been bankrupt a long time ago."

Mr. Fitt was reluctant to say how much Employers Re offers in policy limits, but says it compares "favorably" with the $10 million offered by Mutual. Deductibles have been increasing "all over the lot," he says.

'Publications are paying more attention to the risk of libel. . . .But as to whether that stops you from writing a story about the police chief—I don't think so,' says Ralph E. Gentry, director-risk management at Times Mirror Co.

Other insurers that still write libel coverage include Fireman's Fund Insurance Cos. of Novato, Calif., which concentrates on small newspapers, as well as small-to-medium sized TV and radio stations, according to Ray Gardner, vp in Fireman's Fund's excess and special risks department. "The door's open," he says.

He says Fireman's Fund can provide $1 million in policy limits, while the insurer's excess department can provide $5 million in excess coverage.

Mr. Gardner says there has not been a great increase in the rates compared with hikes in the general liability area, but could not be more specific.

Others that write some libel insurance include New York-based Seaboard Surety, a St. Paul Cos. Inc. unit, and underwriters at Lloyd's of London, notes Mr. Fetzer. Lloyd's underwriters, however, no longer will accept any new, direct business, says J&H's Ms. Heavner.

American International Group Inc., through its National Union Fire Insurance Co. of Pittsburgh, Pa., unit, also writes a "very limited amount" of libel insurance for publishers on a direct basis, says Ms. Heavner, noting that AIG, Employers Re and Lloyd's are all active in the libel reinsurance market as well.

Ms. Heavner says particularly in light of rising premiums, it is impossible to estimate the current size of the libel insurance market. She observes, however, that AIG and Lloyd's are among those less active than they once were, while Chubb Group has withdrawn completely. A Chubb spokesman could not be reached for comment.

The impact of rising premiums varies, often depending on the size of the policyholder. For the major publications, "insurance, and the cost of libel, is still not a major element of the cost of publication," says Ralph E. Gentry, director-risk management at Los Angeles-based Times Mirror Co. "It's not something that's going to keep them from publishing."

A 10% rise in the cost of newsprint could kill a publication, but not a 50% hike in the price of libel insurance, he adds.

Mr. Gentry says Times Mirror, which uses Mutual to insure its eight newspapers and seven television stations, has had increases of more than 50% on some of its policies, and more on others. The hikes were "needed and necessary," says Mr. Gentry.

"Libel insurance has had substantial losses, particularly in the area of defense costs," he notes.

The greatest impact of the rate hikes has been on the smaller publications, says Ms. Heavner. "Those are the ones that are really hurting."

Peggy Lambert, insurance administrator at the National Assn. of Broadcasters, which sponsors a Media/Professionals program, says companies previously did not pay much attention to libel insurance. "It wasn't a major line item on the budget," she says.

Now, with rates in some cases tripling, they are taking it "more seriously," says Ms. Lambert, describing the palpable sense of relief broadcasters express when they learn NAB, which represents small and medium-sized broadcasters, has an affordable program.

Observers warn if media companies' premium rates continue to rise, it could have a negative impact on journalism in the United States.

"Many of them are going bare already," says Ms. Heavner, and this has a "potential chilling effect" on the stories they are willing to report.

"Smaller organizations involved in controversial matters really can't get insurance anymore," says Media/Professional's Mr. Worrell. Journalists should have the protected right of expressing their opinions, but "you can't price your product to them."

Mr. Worrell says several years ago, when he was working at Employers Re, he was approached by a "mom-and-pop" publishing company and an author about obtaining libel insurance for a book exposing a controversial California cult leader.

But Mr. Worrell was forced to turn them down because the company could not even have afforded to absorb the deductible that would have been required. As a result, the book, about the Rev. Jim Jones of the Peoples' Temple, was never published. The November 1978 suicide/massacre of more than 900 of his followers in Guyana occurred shortly thereafter.

The tragedy conceivably could have been avoided had the libel insurance been obtained and the book published, says Mr. Worrell. "That's how the public suffers from these things," he says.

Even some financially secure companies say rising libel costs have affected their business.

There's been a great deal of concern and interest in the newspaper industry overall over how to handle dissatisfied people without generating a lawsuit, says Knight-Ridder's Mr. Matthews.

"You've got to find a polite way of saying, 'We're sorry we called your dumb brother dumb,'" says Mr. Matthews.

"Publications are paying more attention to the risk of libel," says Times Mirror's Mr. Gentry. His company's law department works closely with editors to make sure they understand the risk of libel.

"But as to whether that stops you from writing a story about the police chief—I don't think so," he says.

Fueling the hike in libel insurance, say observers, are defense costs. They estimate that as much as 80% of what is paid out by insurance companies on behalf of clients is for defense, not awards.

Pointing to the defense costs generated by the Westmoreland and Sharon cases, among others, Mr. Matthews says, "If you were an underwriter, you probably would take your ball and play some other game."

Defense costs in the Westmoreland case, for example, totaled $6 million (*BI*, Oct. 21, 1985).

But media attorney Richard N. Winfield of New York-based law firm of Rogers & Wells decries the "hoopla" surrounding the cases.

"These cases are to some extent an aberration," he said. Involved here were zealous plaintiffs, deep resources and political agendas.

In addition, in both cases there was the issue of principle on one side and "machismo" on the other, he said—"a recipe for exceptional defense costs."

But observers still say defense costs in general are skyrocketing. "That's making a bad situation worse," says Employers Re's Mr. Fitt. "The legal fees are just unbelievably high."

Observers say the high cost of legal defense led Mutual in 1984 to tell its policyholders they must pay 20% of all legal fees and expenses above the deductible.

Mr. Gentry praises this as a "good move. It forces companies to ask: 'Do we need to have 10 depositions instead of five?' " A Mutual spokesman could not be reached for comment.

Five or 10 years ago, says Ms. Heavner, the average cost of a defense was about $20,000. Now, she says, "you're talking $150,000-$200,000" just as a starting point.

Mr. Worrell notes that aside from its impact on rates, the high cost of defense is pushing up deductibles. If it costs a company $12,000 to $15,000 to defend a particular lawsuit, then that company's deductible would probably increase to $15,000 to $25,000, he says.

"You want protection from the really bad ones," he says. The rest should be part of the cost of doing business.

One of the benefits of spending so much on defense is that so few suits are ultimately successful, say observers.

Henry Kaufman, general counsel at the Libel Defense Resource Center in New York, a research facility funded by media companies, trade organizations and insurers, says well over 90% of libel cases are won by the media.

This percentage takes into account cases that are won as well as those that are dismissed; those filed for publicity reasons, then abandoned because they have no merit; and those originally won by the plaintiff, then overturned on appeal.

"Only a small percentage of cases are successfully pursued by plaintiffs," says Mr. Kaufman.

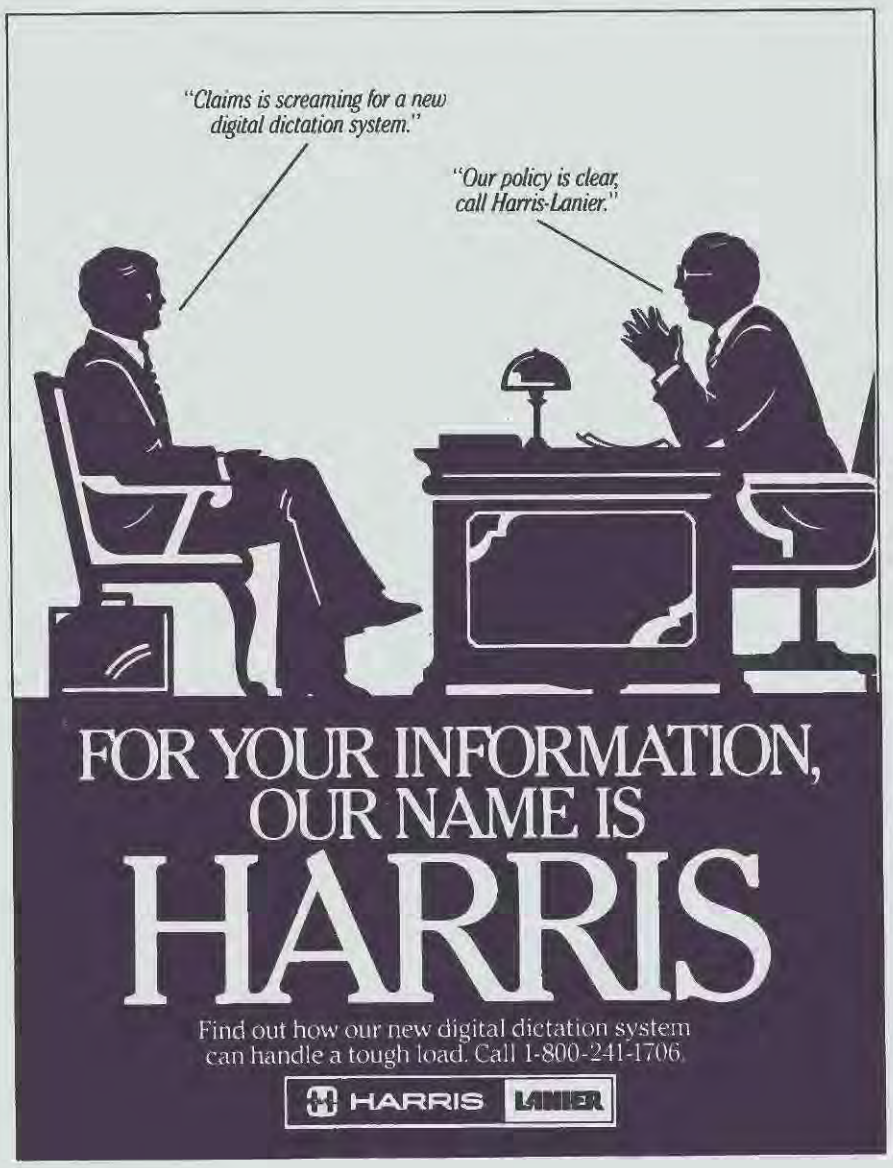
This does not present a complete picture, however. Mr. Kaufman notes, for instance, that data are not available on settlements.

One incentive to settle is the poor success rate of cases that do reach juries. Three out of four cases that reach juries are decided against the media.

And juries are frequently generous in the awards they dispense, says Mr. Kaufman. Damage awards average $2 million, according to the center's study of 150 cases.

Eventually, says Mr. Kaufman, 60% to 70% of jury's decisions are overturned on appeal, and the average amount of money ultimately

Continued on next page



Libel coverage

Continued from previous page
awarded averages $100,000. But this is only after costly appeals.

There have been sporadic efforts to address some of the problems facing media companies, in particular on the issue of punitive damages, says Mr. Kaufman. Of the average $2 million awarded by juries, he notes, $1.5 million represents punitive damages.

These efforts have not been very successful, but Mr. Kaufman observes that media companies hope to benefit if there is a general move toward tort reform.

On the other hand, he says, some feel that in the First Amendment area it is "inappropriate" to "ask for help" from a legislature.

Observers say complicating this issue is that media companies' decisions to defend, rather than settle, cases are not necessarily based on economics.

"Our choices are relatively limited if we're going to be a free press," says Knight-Ridder's Mr. Matthews. The issue of freedom of the press is "not one you can solve with the normal tools."

Lawyers are following clients' instructions to defend libel suits because there are "overriding principles," particularly when publishers are facing a well-funded adversary "that wants to rewrite history," says Rogers & Wells' Mr. Winfield.

"It's almost to be expected that these are costly battles," he says, suggesting as a possible solution public financing "because of the issues involved." ■

High court to decide media cases

NEW YORK—Members of the news media and their attorneys are keeping a wary eye on the outcome of two cases that are expected to be decided by the U.S. Supreme Court during its current term.

One of the cases, *Liberty Lobby vs. Jack Anderson*, "will determine whether summary disposition before trial is going to be encouraged in libel suits," says Richard N. Winfield, a media attorney with the New York-based law firm Rogers & Wells.

"That has been an important protection for the press," said Mr. Winfield. By being able to get summary dispositions in libel suits, he noted, media companies can avoid the expense of jury trials, as well as the problem of coping with jury prejudice. This case will determine whether that procedure can still be used.

The second case, *Hepps vs. Philadelphia Newspapers*, revolves around whether the burden of proof will be shifted so that instead of the plaintiff having to prove what was said about him was false, the defending media company would have to prove what it said was true.

"That's an important procedural issue," says Mr. Winfield.

The attorney notes that one case decided by the current Supreme Court reaffirmed the landmark *New York Times vs. Sullivan* decision of 1964, which provided constitutional protection for the media in libel cases.

But aside from that case, says Mr. Winfield, "There has been no expansion by the Supreme Court of the protections of the press, and there have been some notable reductions on the protections on the press in the field of libel in the past 12 years."

The outcome of these two cases, he says, "will give a fuller reading on the views of the Supreme Court. There is probably no clear consensus in the court about the scope of the protections under the First Amendment for the press.

"However, the core, the fundamental protections of the New York Times against Sullivan, still persist, and the press continues to prevail in all but a handful of libel suits that go to trial.

"It is, however, costing them more in insurance premiums to fight for that protection and to maintain their freedoms," he says. ■

Firm offers consumer data free in recall cases

MELVILLE, N.Y.—JFY Inc.-Audit America, which collects and sells demographic information on consumer product use, is offering its data free of charge to businesses caught in product recall emergencies.

The company made the offer after a death caused by cyanide-contaminated capsules forced Johnson & Johnson to recall its Extra-Strength Tylenol product (*BI*, Feb. 24).

J&J has not yet responded to JFY's offer. The data offered to J&J, which JFY says would cost a J&J competitor about $700,000, include addresses and phone numbers of almost 7 million Tylenol users in the United States. The data have been collected over the past two years.

JFY surveys consumers to gather product usage information to sell to a manufacturer's competitor.

The company made the offer because "it appeared nobody in the business community was offering (J&J) a helping hand," says Ray Amira, executive vp of JFY.

"An act of terrorism is all the more reason why the business community should join hands to help each other, even if it's your competitor," he explains. The offer would be extended to any company facing an emergency product recall, he says.

The 6-year-old, privately held JFY characterizes the offer as "a matter of corporate America sticking together. The bottom line here is warning the consumer," a company spokeswoman says. ■

Comp self-insurers face bankrupt firms' claims

By CAROL CAIN

CHICAGO—Illinois employers that self-insure their workers compensation risks are now responsible for outstanding claims that were filed by former employees of bankrupt self-insurers.

An estimated 1,200 to 1,300 such claims—with an estimated value of $3.5 million—are now pending, either with the Illinois Industrial Commission or in Circuit Court. Many are several years old with payments due this year.

These claims were filed against an estimated 31 self-insurers that have gone bankrupt in Illinois in recent years, according to Charles Kusar, executive assistant to the chairman of the Illinois Industrial Commission, which administers the state's workers compensation system.

Current self-insurers will be assessed a pro rata share of the outstanding liabilities against their bankrupt brethren. According to H.B. 1263—legislation signed by Gov. James Thompson in December that took effect Jan. 1—the assessment is based on a self-insurer's most recent contribution into the Rate Adjustment Fund. Both insurers and self-insurers pay into this trust fund, from which pensions are paid to injured workers with permanent total disabilities.

The maximum amount for any single assessment against a self-insurer is 0.6% of the contribution it made into the Rate Adjustment Fund during the previous calendar year. And the maximum annual assessment under the new law is 1.2% of that contribution.

"No self-insured is very happy with the idea that it may have to pay someone else's liabilities. But we realize that laws of this type are needed to protect the integrity of self-insurers in the state," said Chicago attorney Thomas D. Nyhan, executive secretary of the Illinois Self-Insurers Assn.

Some 1,200 corporations self-insure their workers compensation in Illinois, according to Mr. Kusar. That number increases to almost 1,700 if divisions within a corporation are included, he said.

Besides these assessment provisions, H.B. 1263 also called for the creation of a seven-member Self-Insurers Advisory Board within the Industrial Commission. The commission's chairman will be head of the group, while five of the remaining six members are self-insurers. The seventh member is appointed from the public.

IIC Chairman Mervin N. Bachman appointed the advisory board last month and its first meeting is slated for March 12.

The advisory board will review the claims pending against the bankrupt self-insurers and determine whether to settle or oppose each claim, said James Spizzo, a Chicago attorney and legislative liaison to the ISIA.

This board also has the authority to hire outside counsel to litigate any contested claim, and to collect existing bonds, sureties and excess insurance to satisfy outstanding claims.

It also will assist the IIC in reviewing both new and renewal applications for self-insurance. The IIC is responsible for approving applications for individual employers that want to self-insure.

"It was the belief and hopes of the parties that we won't have this board functioning after (the outstanding claims) are paid. . .We hope the need for the board will be short term," Mr. Spizzo said.

Benefit managers support risk-based PBGC premiums

BROOKFIELD, Wis.—Premiums paid to the Pension Benefit Guaranty Corp. should be risk-related, say more than 75% of benefit managers who responded to a National Opinion Panel survey by the International Foundation of Employee Benefit Plans.

But, many of them acknowledge that risk-related premiums probably would not really work.

Under such a setup, the PBGC premium would be based on the financial condition of the employer's plan. Employers whose plans were financially sound, and therefore were less likely to dump them onto the PBGC, would pay less than those with underfunded plans.

However, many of the respondents pointed out that it would be difficult to determine an equitable premium rate structure.

And, more importantly, companies in financial trouble probably could not afford to pay the higher rates they would be charged.

Also, 75% of the respondents said that, to minimize PBGC liability, the Internal Revenue Service should demand some type of security from employers seeking a waiver from minimum pension plan funding standards.

Some 61% said that reform of the PBGC program should take precedence over a rate hike, and 63% said a company that terminates an underfunded pension plan but continues in business should be liable to the PBGC for 10% of its pretax profits in addition to 30% of its net worth.

But, 59% said that plan members should not participate in a company's decision to terminate an adequately funded pension plan.

In other benefit issues:

- 52% of the respondents think the United States is facing a health care crisis, but only 44% think the crisis will result in a two-tiered system of health care—one for the rich and one for the poor.
- Some 69% predict a growing trend toward long-term nursing care insurance.
- 76% believe that acquired immune deficiency syndrome should be covered under employee benefit plans just like any other catastrophic illness.

Free copies of the survey are available from the Public Relations Department of the IFEBP, P.O. Box 69, Brookfield, Wis. 53008-0069. ■



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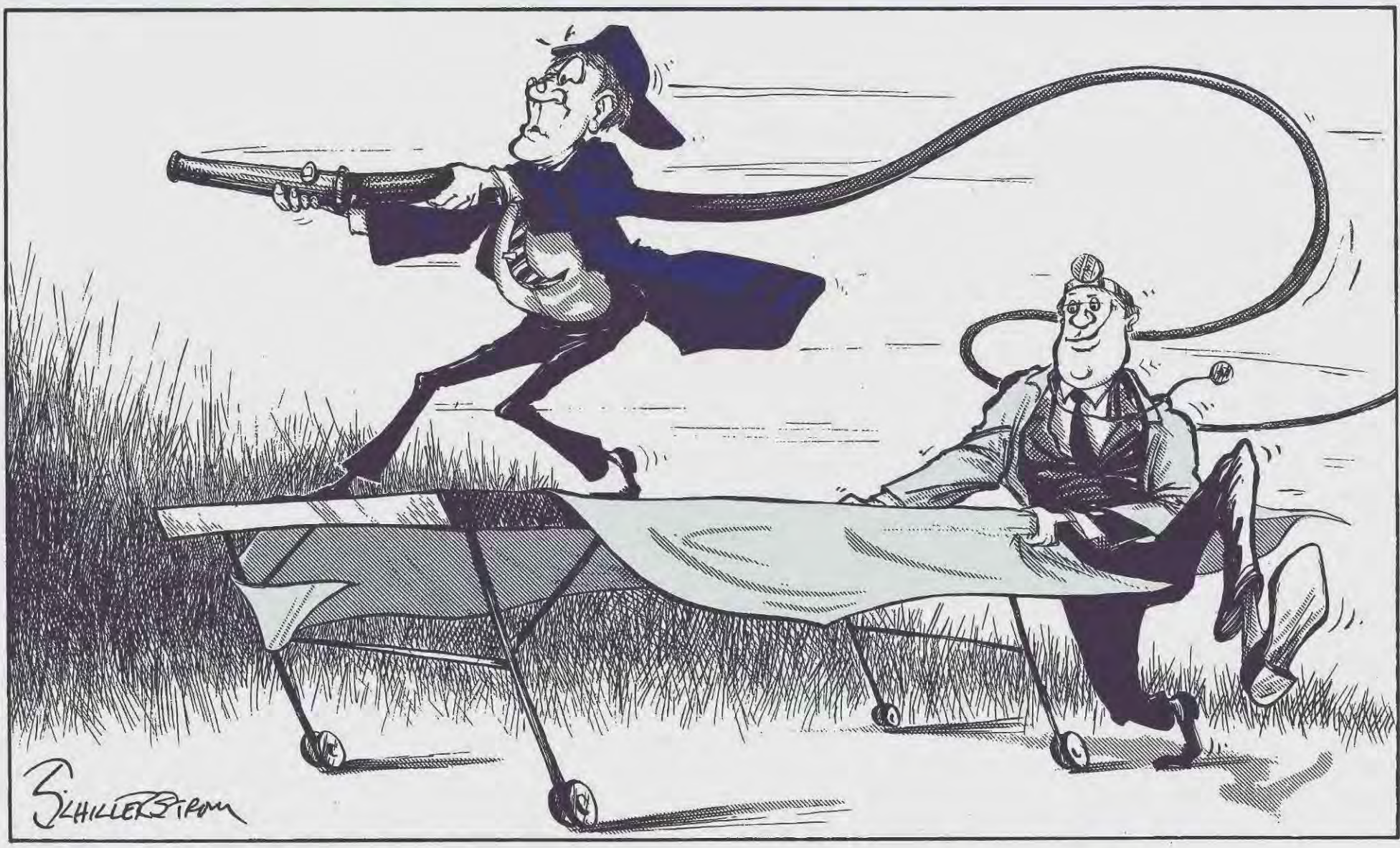
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Snuffing out swindlers

Hodgepodge of statistics makes it hard to measure success of arson prevention

By MICHAEL BRADFORD

Despite major efforts by insurers and other organizations, it's not clear whether anti-arson crusaders are making headway in extinguishing fraud-fueled fires that cause more than a billion dollars in property damage annually.

Arson experts contend that it's difficult—if not impossible—to determine any kind of a trend in the incidence of arson-for-profit since statistics have only been gathered in the last few years.

And, some feel those statistics may not be a reliable measure of the arson problem because some of the data-gathering systems are new and not completely developed.

While some statistics show the number of structural arsons is declining, other data indicate a slight increase in all types of arson. Experts attribute the discrepancy to varying reporting methods, and they caution property insurers and government entities not to be too optimistic about the success of arson prevention.

"They're all saying arson is under control," says John Barracato, director of the arson/fraud unit at Aetna Life & Casualty Co. in Hartford, Conn., referring to the statistics.

However, Mr. Barracato remarks, "We're no closer, in my opinion, than we were a decade ago. It's totally out of control."

Mr. Barracato is concerned that the seemingly encouraging national arson statistics, culled from data gathered by the Federal Bureau of Investigation and the National Fire Prevention Assn., could give officials a false sense of security.

Such complacence is dangerous, he says, because it could result in reductions in anti-arson programs and a subsequent resurgence in arson activities.

"You're going to see a steady increase in arson because of federal cutbacks," he warned. "Any time there are huge profits at little risk, you're going to see an increase."

The National Fire Administration already has scaled down its anti-arson training programs because of budgetary limitations, Mr. Barracato explained. And, federal grant money for local governments' anti-arson programs is not as abundant as it once was, he says.

According to the FBI, which compiles its statistics from law enforcement agency reports of confirmed arsons, the latest available annual figures show that the number of structural arson cases fell 1% in 1984 from

Continued on next page

Insurers prescribe harsh punishments to cure epidemic of health care fraud

By MICHAEL BRADFORD

Health insurers say there's one way to cure an epidemic of health claims fraud: stiff punishments.

But, even though insurers note that courts are now more likely to hand out prison sentences and fines to convicted fraud artists, instead of just ordering restitution, health claims fraud is still growing.

Health care insurance fraud "has almost become a growth industry," says Robert Miller, vp of group claims at Prudential Insurance Co. of America in Roseland, N.J. "It's definitely on the upswing."

"It's no secret that the trend is up," agrees James Guzzi, director of the claims division of the employee benefits department at The Travelers Corp. in Hartford, Conn. "It has been for some number of years."

While insurers generally say it's hard to document the increase in fraudulent health care claims, Mr. Guzzi says the number of incidents has probably jumped 10% to 20% in the last two to five years.

The Insurance Crime Prevention Institute in Westport, Conn., says staged automobile accidents are the only fraudulent activities they are asked to investigate more often than intentionally altered medical bills (see story, page 20L).

Until 18 months ago, fraudulent medical bills were not among the top five activities most investigated by the ICPI, which investigates reports of fraudulent activities for its 420 property/casualty insurance company members.

Insurers estimate they pay about $1 million each day for fraudulent health claims, compared with total health claims payments of about $1 billion per day.

And, while the number of fraudulent claims submitted by providers and patients are nearly equal, insurers note that most of the money paid out for fraudulent claims goes to providers.

As a result, some health insurers and medical providers are banding together to form the National Health Care Anti-Fraud Assn., a group that is attacking health care fraud from several fronts.

The association is hoping its membership will be mostly "front-line" personnel, like fraud specialists, investigators and claims processors, said James Garcia, the association's chairman and director of the employee benefits division fraud squad at Aetna Life & Casualty Co. in Hartford, Conn. Currently, the group has around 200

Continued on page 20I

Arson prevention

Continued from previous page
1983.

In its Uniform Crime Report, the FBI says that industrial and manufacturing structures suffered the highest average losses—$82,178 per offense—from arson, which caused $855 million in overall property damage in 1984.

For all structures, the average loss was $16,310.

The FBI, which first began recording arsons in 1979, says confirmed arsons of mobile property—including motor vehicles, boats, airplanes and other types of movable property—rose 2% in 1984, and that 91% of the cases involved motor vehicles.

Overall, all forms of arson climbed 2% nationwide in 1984, according to the FBI. Preliminary reports indicate the incidence of all types of arson in the first six months of 1985 increased 3% over the same period in 1984.

But, the FBI issues a warning with its Uniform Crime Report on arson: "Caution is recommended when viewing arson trend information. The percent change figures may have been influenced by improved arson reporting procedures during the collection's relatively limited timespan. It is expected that year-to-year statistical compatibility will improve as collection continues."

That, say some experts, is one of the reasons they are cautious about being optimistic when discussing arson fraud. They feel that as reporting procedures improve, many cases of fraud that would have been overlooked by earlier methods will be detected.

The FBI agrees that the 2% increase in arson in 1984 is a sharp contrast to the 11% decrease it reported in 1983 because more agencies are compiling statistics, and their methods are improving.

An FBI spokesman confirmed that some cities are not sophisticated in their arson reporting techniques. He explained that Boston, for example, reported only 160 cases of arson in 1984 because the city first began gathering that data late that year.

The National Fire Protection Assn., which began tracking arson under its current methodology in 1977, categorizes its figures differently than the FBI. It records the number of incendiary and suspicious fires.

An incendiary fire is one for which there is hard evidence suggesting it was intentionally set. A suspicious fire is one that lacks such concrete evidence, but for which there is reason to believe arson was the motive.

The latest association figures show a nationwide drop of 9% in incendiary and suspicious fires that damaged commercial and residential structures in 1984, the last year for which statistics are available.

According to the NFPA, there were 110,500 incendiary and suspicious structural fires in 1984, compared with 122,000 in 1983.

The NFPA gathers its statistics from a random sampling of approximately one-tenth of the nation's fire departments.

In 1984, incendiary and suspicious fires in commercial and residential structures caused slightly less than $1.41 billion in damage and 530 deaths, compared with $1.42 billion in damages and 970 deaths the previous year, according to the NFPA.

The decline in structural incendiary and suspicious fires has been steady since 1981, when the NFPA reported 154,500 cases that resulted in $1.65 billion in damages. In 1982 there were 129,000 fires that caused $1.6 billion in damages.

But while structural arson is on the decline, incendiary and suspicious fires in vehicles are on the upswing, according to the NFPA figures. In 1984, those fires increased 5% to 50,500, causing $138 million in damages.

John Hall Jr., director of the NFPA's fire analysis division, warned in the report detailing the NFPA's findings that although "we should be encouraged by the decline in arson, we should be wary of any simple explanations of our success. . . .We are a long way from controlling arson, but we are moving in the right direction."

He said recently: "The analogy I always use is that we have been climbing up this mountain for many years. Now we're over the top but we've got a long way to go to the bottom."

Mr. Hall said the NFPA statistics are "very reliable," but he pointed out that his organization's numbers and the FBI's have to be looked at separately because they report different occurrences and are gathered from different sources.

For instance, the NFPA's numbers don't show arson cases connected with the burning of forests or grasslands, he explained, and the FBI includes that number in its overall figure.

"You've got to recognize that arson statistics and trends are difficult to assess," said Rick Hammond, executive director of the Insurance Committee for Arson Control in Schaumburg, Ill.

He emphasized that "there are a number of indications by various cities and organizations that it hasn't decreased and is still a problem of significant magnitude."

The FBI's caution against drawing conclusions from its statistics "is particularly important when considering whether the fight on arson should be increased or decreased," Mr. Hammond noted.

"When you see figures decrease, sometimes you see efforts diminish," he added. "That is not necessarily proper."

Mr. Hammond pointed out that those responsible for the campaign against arson are often heard to remark: "Arson is like crabgrass—once you stop fighting it, it springs back up again."

Aetna's Mr. Barracato noted that his company's experience does not follow the national statistics: While statistics show that structural arson may be somewhat under control, the number of structural arson claims and the subsequent damage estimates received by Aetna are increasing.

According to Mr. Barracato, Aetna saw a 9.4% increase in structural fires related to arson in 1985. Policyholders reported 1,995 fires that caused losses of more than $25,000, resulting in total property damage of $189 million. In 1984, there were 1,822 structural fires above the $25,000 mark that caused $162.5 million in damages.

In 1984, Aetna's investigators determined that $8.3 million in damages were caused by arsonists who intended to defraud the insurer. Last year, $9.7 million in damages could be attributed to arson-for-profit motives, according to Aetna's investigators.

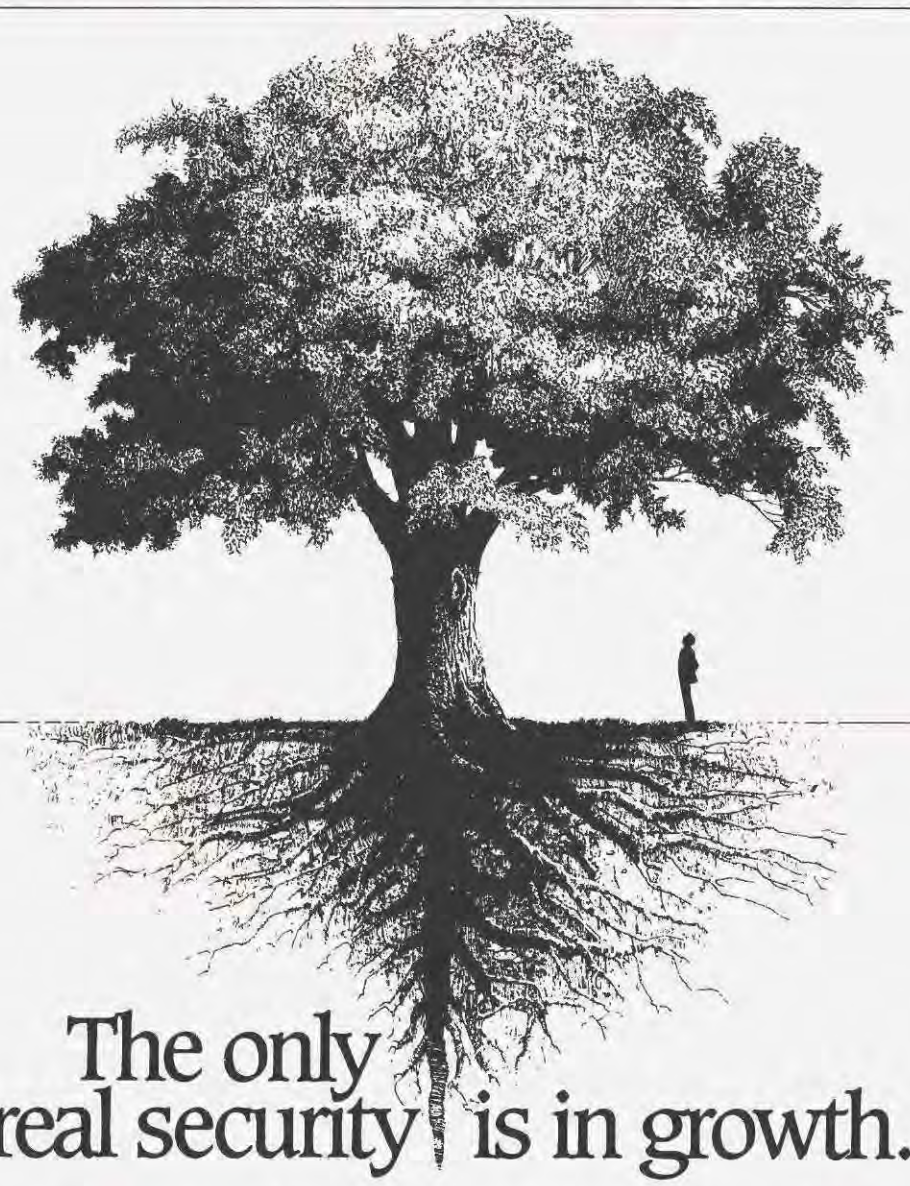
Mr. Barracato says that as a rule, half of all structural fires can be considered arson. The main reasons for committing arson in Aetna's experience, he notes, are profit and revenge.

Since its inception in 1979, the Aetna fraud unit has denied 533 structural fire claims for a total potential savings of $49.8 million. However, not all the claims have been determined by the courts to be arson-related.

James Mullins, vp-claims at CNA Insurance Cos. in Chicago, said, "I don't see that we need to get any feelings of comfort from our efforts to control arson. We're just now scratching the surface.

"We have a long way to go in controlling arson and fraud," he

Continued on page 20D



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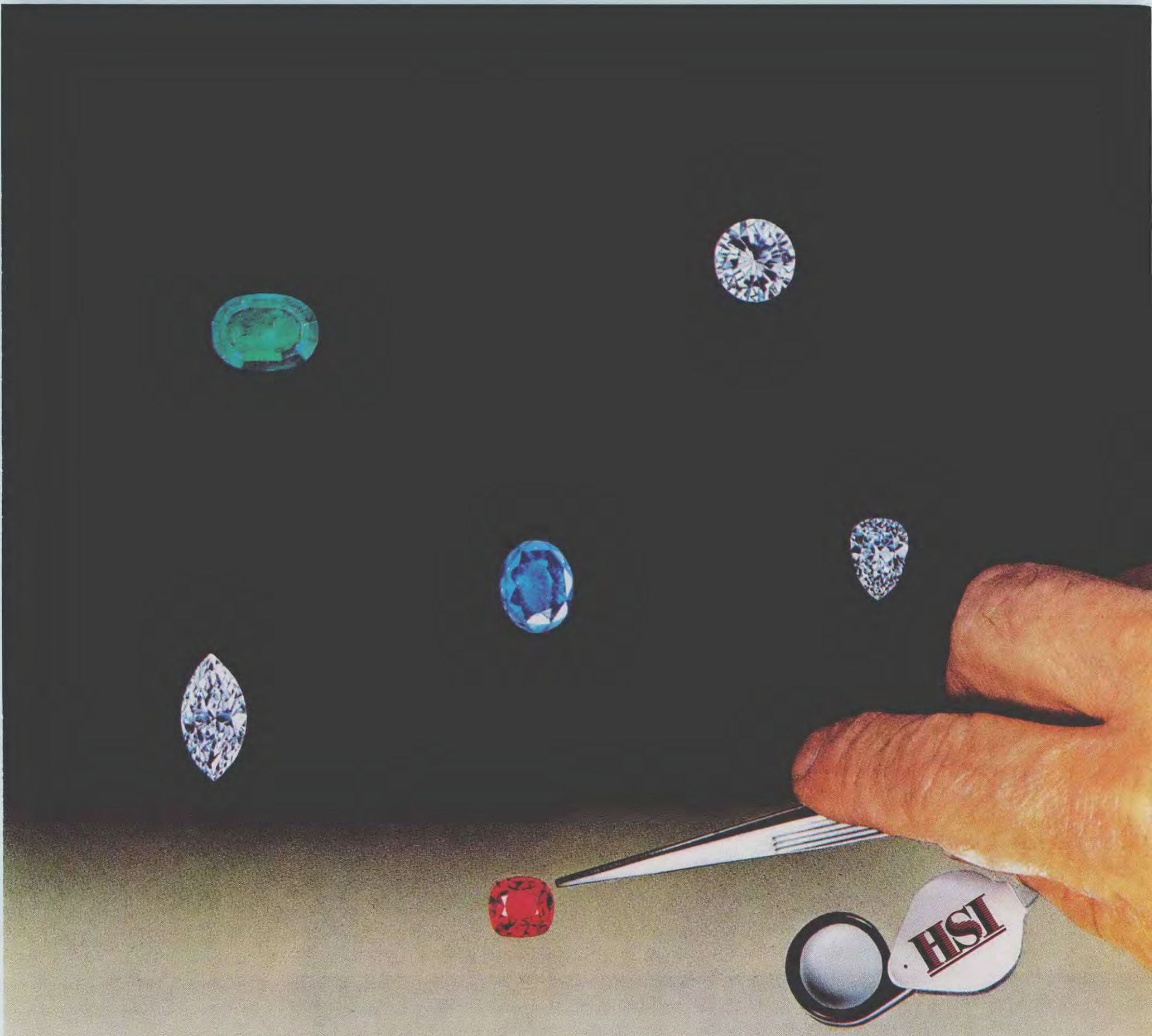
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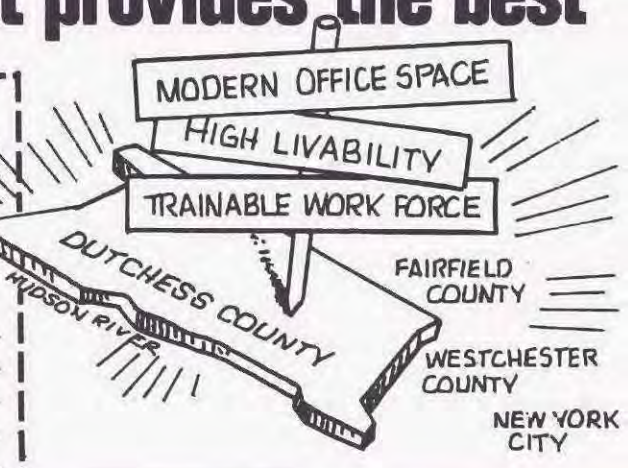
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Arson prevention

Continued from page 20B

added.

Still, Mr. Mullins credits the insurer's increased arson detection activities with having an effect on the number of fraud cases uncovered.

CNA is one of several insurers that have special investigative units to work on arson fraud cases. "Our activity has increased tenfold over the last 10 years," noted Mr. Mullins.

The result of CNA's arson-detection skills has been a steady increase in denied claims.

In 1985, CNA saved around $5 million in claims that were determined to be fraudulent and arson-related, and this year Mr. Mullins predicts $7.5 million to $10 million will be saved.

Other reports conclude that insurers' anti-arson efforts are paying off.

The U.S. Bureau of Alcohol, Tobacco and Firearms, which investigates fires at industrial and commercial operations, says its investigations saved insurers $77.3 million in claim payments during the year ending last October.

Bureau investigations during that period resulted in 180 criminal cases associated with fires that caused about $500 million in property damage, said a bureau spokesman, who noted that many of the cases have not yet been closed and no savings have yet been recorded.

In 1984, the bureau saved insurers $43.2 million in 136 cases of arson that resulted in $219.3 million in damages.

The spokesman said insurers have been saved $269 million because of the bureau's efforts in the past six years.

If there are actual declines in the number of structural arson cases, as the FBI and NFPA statistics suggest, some experts feel it is because potential arsonists are getting the message that improving technology is making detection easier.

"I think the overall property field adjuster is a little better trained in detecting arson," said F.E. "Buzz" Ward, vp-first party claims at Fireman's Fund Insurance Cos. in Novato, Calif.

He added that because adjusters and investigators are better trained, insurance buyers may believe that arson is not as "riskless" as it once was.

The State Farm Group has increased arson-detection training and investigation for its claims adjusters during recent years, according to a spokesman.

"Until the last four years, we never made a conscious effort to turn claims people into arson investigators," he said. "Now we are doing that."

"We've probably made some inroads because we've paid more attention to it," the spokesman noted.

Mr. Mullins of CNA said new chemical tests are allowing investigators to determine with more certainty what kind of accelerants were used to start a fire. "Our base of knowledge is much better," he added.

Because insurers say around 65% of arson cases are residential, they are especially interested in how one facet of the improved anti-arson technology will deter neighborhood fires.

A high-tech effort called the Arson Information Management System is in place in four cities and, after 18 months, it appears to be reducing the number of arson incidents, according to the ICAC's Mr. Hammond.

The AIMS Project, jointly funded by the ICAC and the Ford Foundation, is a computerized system that has been developed with the input of insurers, government officials, law enforcement agencies and neighborhood organizations.

Its purpose is to identify potential arson risks in neighborhoods in Louisville, Ky.; Providence, R.I.; Kansas City, Mo.; and Dayton, Ohio.

Using software developed by the NFPA, the system is designed to apply certain criteria that will help pinpoint arson targets.

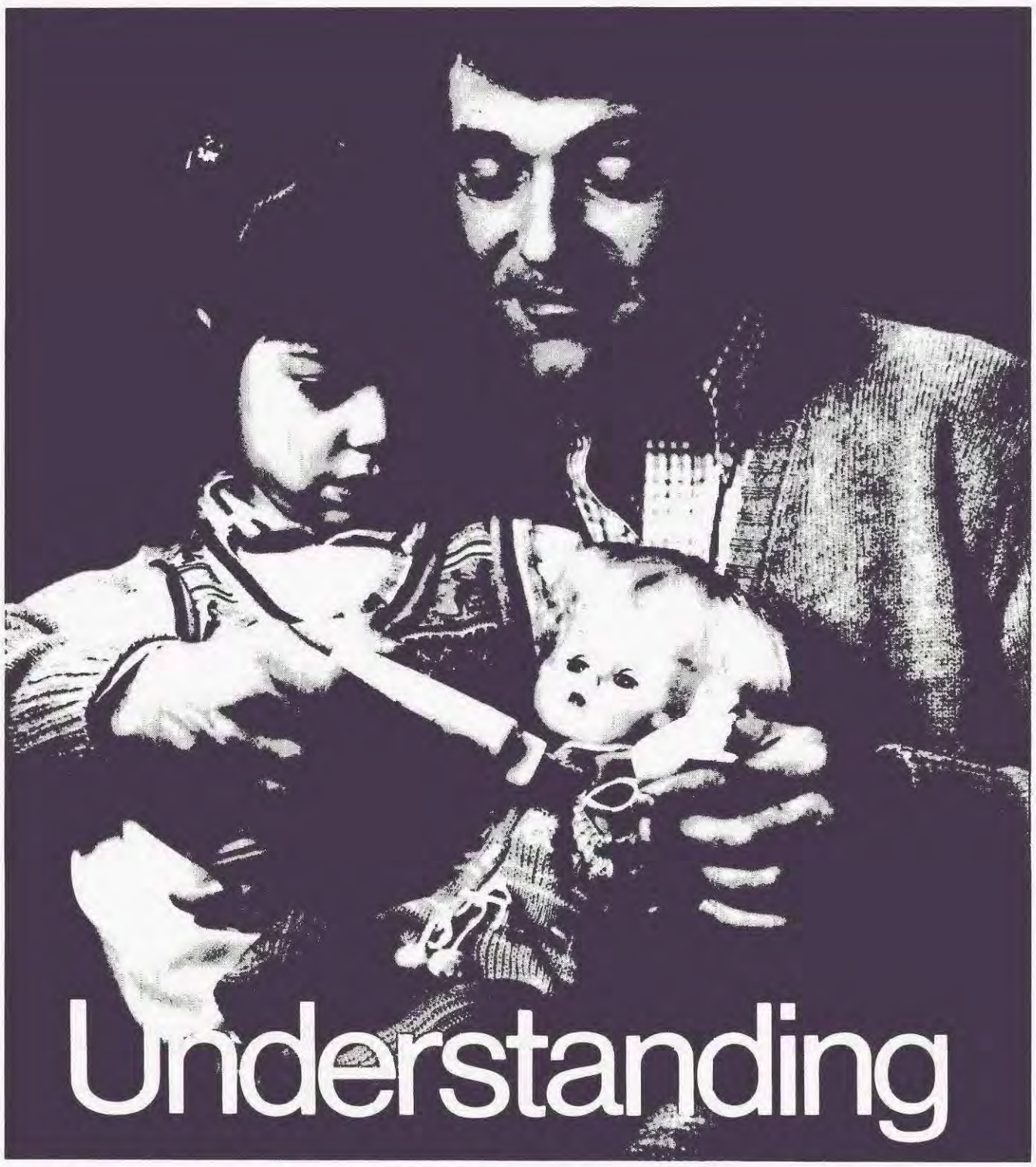
For instance, AIMS will identify sites that may not be up to fire code standards.

In cases where structures are dilapidated or don't meet local standards, owners can be pressured to improve the property, Mr. Hammond explains.

"It allows the police department to monitor property to ensure that arson does not occur," he added.

Because the program has been operating for just 18 months, no firm statistics on its performance are available.

Still, Mr. Hammond says indications are that it has resulted in a significant reduction of fires in all four cities. ■



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Insurers fight arson with wise underwriting

By MICHAEL BRADFORD

But, insurers are beginning to concentrate more on underwriting practices that can help prevent arson. They say there are several "red flags," that can warn an underwriter of a potential arson risk.

Insurers increasingly are coming to the realization that wise underwriting is an effective weapon against arson losses.

For example, one insurer recounts the woeful tale of a risk that never should have been written, but was—and ended up as a paid claim.

The risk was a fire waiting to happen—a recreational facility on an island, with no access except by boat. The park was made almost entirely of wooden structures, the insurer remembers. "It burned down," he said. "Sometimes they slip through the cracks."

The fire was investigated as an arson, but it burned so completely that, "if it was an arson or not, it burned so hot that it could have never been proven," the insurer says.

But, insurers are beginning to concentrate more on underwriting practices that can help prevent arson.

And, they say, there are several "red flags," that can warn an underwriter of a potential arson risk.

Insurers agree that such red flags include:

- A business that has not been around a relatively long time or is financially unstable.
- A business without a fire prevention program in place.
- A business whose fire protection coverage has been canceled in the past.
- A company with a poor fire loss record.
- A company that has over-extended itself financially.
- A company with a history of turnover of ownership.



Mr. Hammond

"Needless to say, underwriting plays a large role in the control of arson activities," says Rick Hammond, executive director of the Insurance Commission for Arson Control in Schaumburg, Ill.

The ICAC promotes careful underwriting through a committee that works with insurers to help them hone skills to spot potential arson situations. And, the ICAC publishes a manual to spot risks.

Still, Charles G. King, an arson investigator with about 30 years' experience, said insurers generally are not doing nearly enough.

"They are still not looking at potential losses," says Mr. King, who founded Charles G. King & Associates, an arson consulting and investigation firm in New York. "They are not looking at the actual cash value of a risk."

He notes that a few companies are doing a good job in the effort to wipe out arson. But, he says most "haven't even scratched the surface."

Mr. King also says insurers should communicate with one another in their anti-arson efforts.

"There has to be more cooperation from company to company. They don't talk to each other enough," he says. "If they could find some common ground in comparing losses, I think that would do a lot."

And, Mr. King says there should be more seminars and meetings to educate insurers and others.

One such seminar is scheduled by the ICAC, which will hold the National Arson Forum in Chicago on May 21-22.

The seminar, which the ICAC is calling a "summit meeting," will bring together insurers, attorneys, law enforcement officials, legislators and others.

"This meeting will offer all groups with a natural interest an opportunity to weave their efforts into the blanket that we hope will smother the arson fires burning across our nation," said Thomas Brace, Washington state fire marshal and president-elect of the International Assn. of Arson Investigators.

Information on the National Arson Forum is available from Mr Hammond at the ICAC, 1501 Woodfield Road, Suite 400 West. Schaumburg, Ill. 60195-4980; 312-490-8670. ■

A message to agency companies on

The Dangers of Midterm Cancellations

During 1985, market conditions caused many companies to close down markets, double and triple prices and reduce agents' commissions in order to recoup some of the losses incurred through several years of ill-advised cash-flow underwriting.



James H. Davies

Another disturbing trend to surface in 1985 was cancellation of commercial policies in midterm. This unfair practice often places commercial clients and agents in difficult situations, forcing them to scramble to find coverage during already tight market conditions.

If midterm cancellations continue, we can expect state legislators and regulators will try to place more restrictions on our business that will remain long after temporary market problems subside.

Some federal lawmakers as well have begun to explore availability/affordability problems. We should not give them an additional reason to investigate our industry.

While we at PIA understand the role reinsurers play in triggering terminations and the market conditions that cause them, we feel the added pressure of midterm cancellations is unhealthy for the shortterm interest of consumers and agents, and for the longterm interest of insurers and the industry as a whole.

That's one reason PIA's Board of Directors recently urged all companies to discontinue cancelling policies before expiration, except under very limited conditions.

If your company is engaging in this practice, we ask you to reconsider your action and its longterm consequences.

If your company has adopted voluntary standards concerning midterm cancellations, please share them with us. We welcome your comments on this important issue.

J. H. Davies

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Coverage cancellation laws may hurt arson prevention

By MICHAEL BRADFORD

'Insurers should be able to act quickly' to prevent suspected arson, Mr. Davis says.

States that enact laws restricting midterm policy cancellations and non-renewals may be removing an effective weapon in the fight against arson, says a legal expert.

"Insurers should be able to act quickly" in certain circumstances that could lead to arson, says John R. Davis, senior legislative analyst in the government affairs department at the Alliance of American Insurers.

But in several states, acting quickly is prohibited by regulations that will not allow insurers to cancel coverage midterm or not renew coverage except under certain conditions. Mr. Davis says at least 20 states have issued warnings, adopted emergency regulations or proposed permanent ones to restrict cancellations and renewals.

According to Mr. Davis, regulations that prohibit an insurer from getting off a risk quickly can create a greater exposure to arson in cases of "constructive abandonment," when a structure has been vacated or left in disrepair.

Mr. Davis argues that when insurers discover constructive abandonment, they should have the right to cancel a policy within five days.

Some states do allow insurers to cancel a policy within five days if constructive abandonment is discovered, he notes, while other states have a 10-day cancellation requirement.

But, while insurers in those states do have the ability to act quickly to cancel a potential arson risk, underwriters in other areas are subjected to regulations that require them to give up to 90 days' notice before canceling a policy.

States began enacting the regulations in an effort to protect policyholders, as insurers began canceling certain coverages midterm, refusing to renew policies and raising rates in ways some regulators say are unjustified.

"We're concerned with something, and they're concerned with something else," Mr. Davis said of regulators' efforts to protect policyholders. "They are covering up something that could be a problem later on."

But there could be a compromise, Mr. Davis suggests.

If regulators require 60- or 90-day notice of cancellations, they should include provisions allowing insurers to cancel within five days if constructive abandonment is found and within 10 days for nonpayment of premiums or misrepresentation of the risk that is insured, Mr. Davis said.

Ralph Jackson, director of advocacy programs at Allstate Insurance Co. and chairman of the Insurance Council for Arson Control, also emphasized the need for insurers to be able to respond quickly to constructive abandonment.

"If you have a five-day notice, you could put a 24-hour guard on the property" to protect against any arson attempts, he said. "It would be expensive, but you could do it.

"But when you've got a 30-day, 60-day or 90-day period, the expense would be difficult to support," he added.

Mr. Davis pointed out that a five-day cancellation provision is found in most coverage provided by Fair Access to Insurance Requirements plans, joint underwriting associations in 26 states that provide coverage for urban structures. The FAIR plans, he pointed out, are often exempt from state rules governing cancellation and non-renewal.

The FAIR plans grew out of the years of urban upheaval in the 1960s, Mr. Davis explained. At that time, downtown buildings were often the site of riots and fires, and insurers cut back on the coverage they provided.

Under the FAIR Plan, all property insurers in the state are required to provide coverage for city buildings as part of the underwriting association. ■

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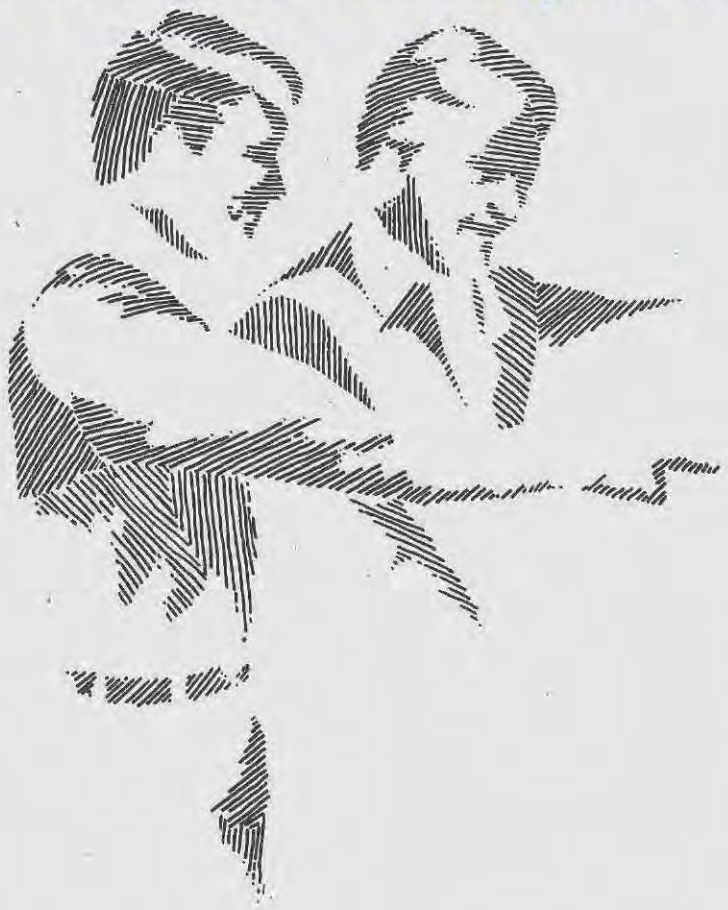
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Auto accidents create opportunities for fraud

By MICHAEL BRADFORD

Staged automobile accidents present "an absolute panorama" of opportunities for committing fraud, insurance fraud experts say.

M. Wayne Walker, area supervisor in Atlanta for the Insurance Crime Prevention Institute, explains that insurers are faced with the possibility of several different types of fraud from a staged automobile accident.

Claims for medical bills, lost wages and property damage stemming from staged accidents are a few of the ways "victims" steal money from insurers, he said.

"The vehicle as a tool to defraud an insurance company is invaluable," said Mr. Walker. "Some people use it to make a living."

The methods for staging accidents are nearly unlimited, he noted.

"There's all kinds," Mr. Walker said. "One is where several people will pile into one or two vehicles and arrange to have a mild fender-bender by running a stop sign or red light. The police respond and write it up. Then the people go to the doctor complaining of backaches or neck aches and receive treatment. It will continue to a point where the bills exceed a threshold.

"Then they settle for pain and suffering, which is usually paid in addition to medical bills," he said.

Another favorite is the "phantom vehicle" ploy, Mr. Walker explained. For example, a driver might claim a car swerved in front of him and caused him to hit a tree.

In such a ruse, the driver will contend that he cannot identify the offending vehicle and will file a claim under uninsured motorists' coverage for damage that was actually staged.

According to the ICPI, its insurance company members referred fewer claims for investigation of suspected fraud related to staged accidents in 1985 than in 1984. In 1985, there were 831 such investigations, compared with 942 the previous year.

But even though there has been a drop in the number of total referrals by insurers, the ICPI reported that the number of referrals for auto accidents outnumber requests to investigate other types of fraud.

According to the ICPI, one scheme in Pennsylvania involving staged auto accidents has resulted in a 45-count indictment against four individuals who have been charged with bilking insurers of more than $1 million over a 10-year period.

The ICPI participated in the investigation that resulted in the indictment, which includes 43 charges of mail fraud and two counts of interstate transportation of securities obtained by fraud.

The indictment charges that following alleged accidents, the defendants lured police officers and medical emergency squads away from legitimate duties to lend credence to the false claims. In addition, medical bills from extended hospital stays were submitted to insurers, the ICPI reports.

If convicted, one of the defendants could receive a maximum prison term of 236 years and a $750,000 fine, and his wife could face a sentence of 103 years in jail and a $500,000 fine, according to the ICPI.

While the ICPI reports a decline in the number of referrals to investigate suspicious accidents, some insurers say individually they are noticing an increase in claims stemming from staged accidents.

Robert Smith, manager of the special investigative unit at Omaha Indemnity Co. in Omaha, Neb., said he has seen "a substantial rise in that type of incident."

Most of the staged accidents occur in densely populated metropolitan areas like New York, southern Florida and the freeway-laced region of southern California, he said.

Mr. Smith is also a member of the National Assn. of Special Investigative Units, a 2-year-old organization of individuals who develop and share techniques to detect insurance fraud.

The group recommends certain basic techniques to keep in mind when reviewing an auto accident claim to detect whether an accident has been staged.

Adjusters should be careful to note if claimants are hesitant to give information regarding an accident, says Mr. Smith, including details on how the accident occurred, where it happened and other circumstances.

Perpetrators of automobile insurance fraud also give adjusters a clue when they hire an attorney very soon after the alleged accident. "That gives you a block for getting information because you have to go through the attorney."

While an attorney may be hired immediately, claims are often filed as late as 10 months after the faked accident, Mr. Smith said.

In many states, like California, laws require claims to be settled within one year of the accident, said Mr. Smith, or a lawsuit can be brought against the insurer. If a claim isn't submitted until 10 months after the accident, "that limits the time for investigations. If there is a big time difference in when the accident happens and when the claim is filed, it makes you wonder why."

The ICPI's Mr. Walker said adjusters also should observe the demeanor of the claimant in suspicious cases. "Notice how pushy they are. People who file most fraud claims are very pushy," he said.

If a claimant is well-versed in insurance terminology, it could be a tip-off that the claim is fraudulent, advises Mr. Walker. "Most people aren't that familiar with insurance language," he added.

Claims adjusters also should closely check the relationships of persons involved in accidents, noted Mr. Walker.

Pat Pastirik, manager of claims security at GEICO General Insurance Co. in Washington, D.C., agreed that relationships among those involved in an accident have to be examined closely.

Sometimes a driver will buy a policy and stage an accident with a friend who is driving a rented vehicle that is also insured, he noted.

Mr. Pastirik said investigators also should make sure that any damage is consistent with the type of accident reported.

And one basic check that is often overlooked by adjusters involves the car's title and registration.

"Make sure the car is registered to the person filing the claim," he warned, to make sure that the driver is not borrowing a damaged car in an attempt to file a fraudulent claim. ■

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Financial:
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Secretaries, treasurers, controllers and other financial personnel . . . 6,484

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

Sub-total . . . 22,354

Associations . . . 483
Government, unions and educational systems . . . 1,252

Commercial Consumers Sub-total . . . 24,089

Insurance agents and brokers 10,285
Insurance companies . . . 6,709
Financial institutions . . . 748
Actuaries, attorneys, adjusters, appraisers and consultants . . . 3,808
Others allied to the field . . . 1,308

TOTAL . . . 46,977

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

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Health care fraud

Continued from page 20A

members (see story, page 20L).

One of the association's goals is to form a national communications network that will keep tabs on providers previously convicted of fraud.

Part of the network's function will be to alert members when a provider convicted of fraud moves to another state, he explained.

Often, Mr. Garcia pointed out, a physician who has lost his medical license in one state will move to another and set up a new practice.

The network also would advise members when a provider has been banned from participating in Medicare and Medicaid programs.

In addition, the network is establishing a central indexing system that will keep tabs on all fraudulent activities committed by a provider against all insurer members, Mr. Garcia explains.

"Often, the courts will want to know how much a provider has ripped you off," he said. "For example, Aetna would be lucky to have 5% of a provider's business and 2% of a hospital's business," he said, noting that the amount of fraud committed by a provider against a single insurer might not be great, but it can be quite large when all insurers are considered.

The index would group "all fraudulent activities together for the court to see," he said.

According to Mr. Garcia, health care fraud is on the upswing because there is "more incentive to do it."

Health care cost-containment programs, while helping keep down the total price of health care, have also cut into the income of some providers, Mr. Garcia explained. A healthier society also has decreased some providers' earnings, he added.

Those factors, combined with the increased competition generated by new medical school graduates, provide incentives for some physicians to make up lost income illegally, he pointed out.

But one incentive is beginning to disappear, says Mr. Garcia. In years past, providers did not fear being prosecuted for health care fraud because it was considered a "white-collar crime and the courts were not paying much attention to it," he explained. "Now it is seen as a major problem. . .and providers are getting prison terms."

Most health claims fraud cases are prosecuted as mail fraud, Mr. Garcia explained, because billing is usually done by mail. Mail fraud, a federal offense, is a felony that carries a maximum of five years in prison and a $1,000 fine for each count.

In addition, theft or embezzlement charges may be brought against the perpetrator.

In Michigan, a new state law—the first of its kind—the carries stiffer penalties for anyone convicted of health care fraud that involves a third-party payer.

Under the Health Care False Claims Act, which was passed by the Michigan Legislature last April, the maximum sentence for fraud in Michigan is a four-year prison term and/or a $50,000 fine for each count. If conspiracy is proven, the jail term can be increased to 10 years.

Several providers have already been charged under the law since it went into effect last April.

Gregory Anderson, director of Blue Cross/Blue Shield of Michigan's financial investigations department, said copies of the law have been distributed to insurers across the nation to encourage them to lobby for similar legislation in other states.

William Huston, director of financial investigations for Blue Cross/Blue Shield of Northern Ohio, believes that prosecution is the strongest deterrent to health care fraud.

Health care fraud is on the upswing because there is 'more incentive to do it,' Mr. Garcia says.

The Cleveland-based plan zeros in on prosecution, not restitution, when it discovers fraud. Only when a conviction is handed down or officials feel criminal intent can't be proven does the case go to the plan's corporate counsel, who seeks restitution.

If a provider is convicted, the plan then refers the case to the state medical practice board, which has the power to suspend or revoke the physician's license.

Continued on page 20K

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Health care fraud

Continued from page 20I

From mid-1983 until year-end 1985, the financial investigations department's activities resulted in 61 criminal indictments involving $2.8 million in fraudulent claims. Mr. Huston pointed out that while prosecution is the plan's goal, much of the money taken in fraudulent claims is ordered repaid.

The northern Ohio plan's financial investigations unit devotes 80% of its time to checking out allegations of fraudulent activities, Mr. Huston noted. Most of their tips come from a toll-free hot line that generates around 300 calls per month.

Blue Cross/Blue Shield of Michigan formed the first financial investigation unit among the Blues plans in 1980.

In 1984, the unit stopped payment on fraudulent health-care claims it estimates would have cost $21.6 million.

And, the number of cases opened by the unit increased 48% in 1984 compared with the previous year.

Many of the cases handled by the Michigan Blues' investigative unit also originate from a hot line, according to a BC/BS spokeswoman.

She explained that patients are sent an explanation of any benefits paid in their names. If the policyholder finds any inaccuracies in the explanation or suspects fraud, he or she is urged to call the hot line, which receives 300 to 400 calls per month.

About one-third of those calls are serious enough to open an investigation, the spokeswoman added.

While experts say the number of fraud cases perpetrated by providers may not greatly outnumber ones instigated by patients, the dollar amount of fraudulent claims submitted by providers is viewed as much more serious than patient fraud.

"It's about 50-50 as far as the number of instances," says Mr. Garcia.

"But in dollars, it's heavily on the provider side. They have the tools to commit fraud, where the individual is limited in capacity."

For example, the most common type of health care fraud by individuals is to change a bill for prescription drugs in cases in which reimbursement is sent directly to the individual rather than a provider, Mr. Garcia explains.

"Prescription drugs are the easiest," he noted. "If a bill is for $1.98, it can be changed to $4.98 or $14.98."

While Mr. Gracia said there are hundreds of ways for patients to commit fraud, he added that the possibilities for providers are virtually unlimited.

And complicated schemes can result in big payouts for fraudulent providers, he said.

Mr. Garcia referred to a provider who purchased state-of-the-art equipment for his practice that required a cardiologist to operate.

"The machine was very expensive," Mr. Garcia noted. "To get the insurance companies to pay for it, he was billing every patient for use of the equipment.

"A lot of times the machine was not even hooked up and no cardiologist was in the office" on the dates when procedures were billed, he said.

In addition, the provider was writing so many prescriptions "that if the patients had taken them, they wouldn't be living today," Mr. Garcia said.

The provider didn't stop with fake prescriptions and phony services, Mr. Garcia added. "He was opening his office from 10 p.m. till 2 a.m. for drug traffic."

The provider, whose medical degree was eventually found to be invalid, had submitted $350,000 in fraudulent claims to Aetna alone. He is currently serving a 10-year prison term.

While experts say the number of fraud cases perpetrated by providers may not greatly outnumber ones instigated by patients, the dollar amount of fraudulent claims submitted by providers is viewed as much more serious.

Travelers' Mr. Guzzi agreed that fraudulent "general" health claims are pretty evenly split between providers and employees, adding that an employer's benefit manager may sometimes be involved in a conspiracy.

Fraud relating to dental insurance is mostly committed by providers, while individuals are most likely to be engaged in fraud connected to disability coverage, according to Mr. Guzzi.

Fraud cases run the gamut from the mundane to the bizarre, Mr. Guzzi said, referring to an incident in which a man cut off his own leg, then faked a motorcycle accident and laid the leg nearby.

The man was eventually charged with fraud after trying to collect for the dismembered limb.

Fraud directed at the Medicaid and Medicare programs has followed the trends tracked in the private market, according to experts.

Barbara Zelner, Medicaid fraud counsel for the National Assn. of Medicaid Fraud Control Units in Washington, D.C., could not provide specific statistics on how much Medicaid fraud has increased.

But she said that several states in the past two years have established fraud control units to fight the problem, bringing to 37 the total number of states with such operations.

"That indicates that there is enough fraud to keep everybody busy," she said.

The state units conduct investigations into fraud and patient abuse, explained Ms. Zelner. When enough evidence is gathered to win an indictment, the case proceeds according to state laws.

She noted that Medicaid programs are empowered only to seek prosecution of patients if they conspire with a provider to commit fraud.

"We don't target individuals because most of the money is not stolen by recipients."

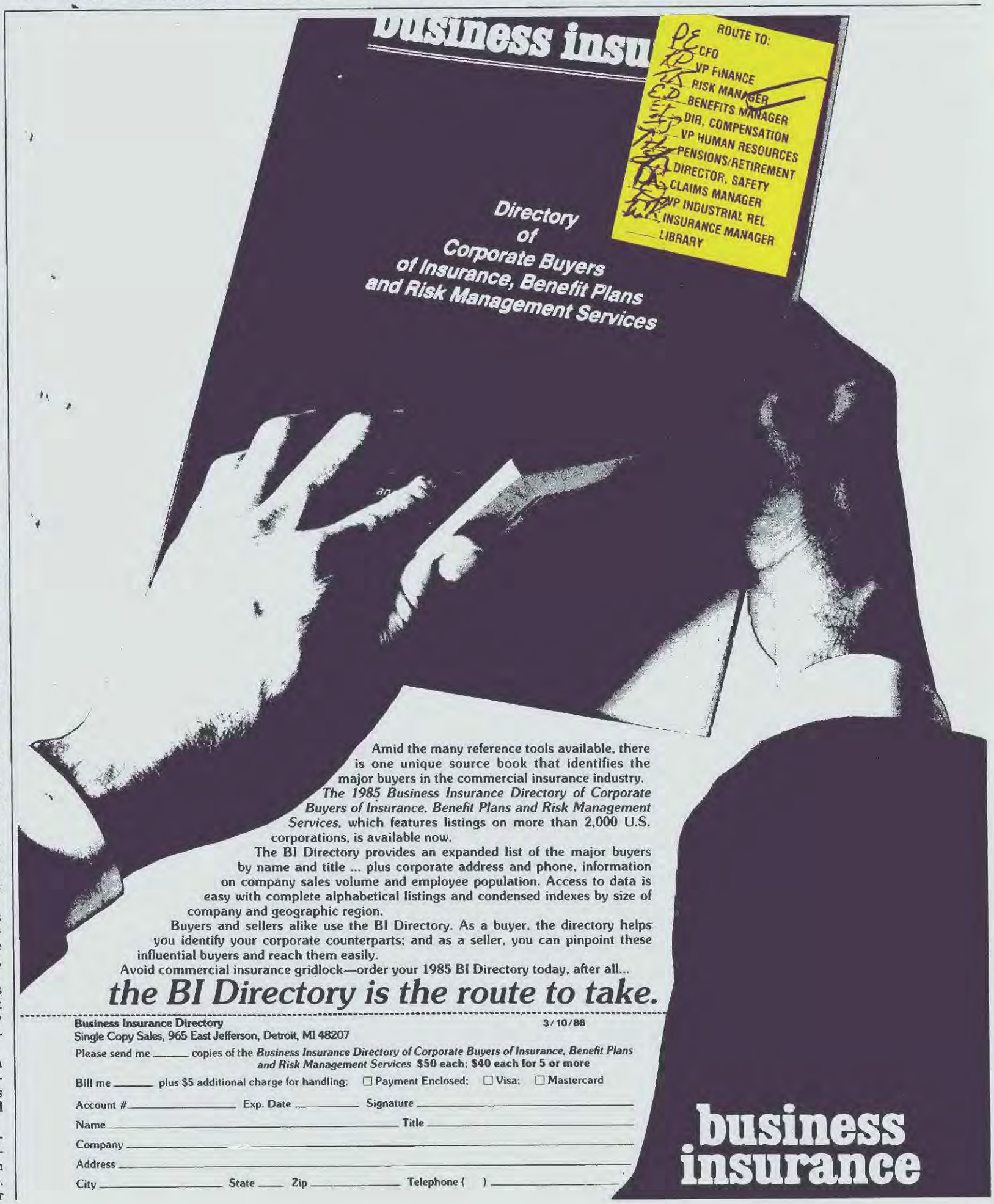
But, like fraud against commercial health insurers, many Medicaid cases involve providers who file false claims, she said, noting that these providers are prosecuted. "They may be billing for more services than they actually provided or for fictitious services," she said.

According to Ms. Zelner, much of the Medicaid fraud problem is connected with prescription drug claims. Two Minnesota pharmacists, for instance, were recently charged with fraud after billing Medicaid $30,000 for hundreds of fake prescriptions, she said.

While insurers and government agencies are stepping up their fight against health care fraud and courts are more often handing out fines and prison terms to those who are convicted, insurers don't expect to claim victory soon.

"There are so many different ways, and anybody can commit fraud," remarks Mr. Garcia.

And Mr. Guzzi remarked, "I hate to use it, but I think the 'tip of the iceberg' cliche prevails in this area." ■



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business insurance

Early detection best prevention: Insurers

By MICHAEL BRADFORD

Insurers, serious about stopping health care insurance fraud, won't comment publicly about most of the methods they use to detect the practice.

But insurers do say there are certain basic steps that can be taken to cut down on the chance that fraud will occur.

And, they note, early detection of fraud means insurers do not have to rely on sophisticated—and secretive—techniques of proving fraud.

James Guzzi, director of the claims division of the employee benefits department at Travelers Corp., advises other insurers to scrutinize bills from health care providers to see if they have been altered. That is the most common form of fraud, he said.

However, detecting such alterations can be difficult because of the sophistication of current photocopying machines, Mr. Guzzi noted.

"A photocopy of the top of a valid bill may be matched with a copy of the bottom of a phony bill," he warned.

"We had an outlandish case in which a computer programmer was producing the best-looking hospital bills you have ever seen. When we went to the hospital, they thought it was their bill. Only until we asked them to please check did they find out it was phony."

Mr. Guzzi said that although the responsibility for detecting fraud rests with the health insurer, employers can help make fraud less of a possibility.

He noted that several different benefits staff members should be responsible for a company's claims environment." When one employee directs all health care claims gathering and filing oprations within a business, it increases the opportunity for that person to commit fraud, Mr. Guzzi warned.

In a situation in which one employee directs a business' entire benefits operation, employees should submit health claims directly to the insurer, he said, adding that the insurer should check employee's benefits eligibility against a list provided by the employer.

"Truthfully, it is the insurer's responsibility" to detect fraud, says James L. Garcia, director of the employee benefits division's fraud squad at Aetna Life & Casualty Co. But he adds that employers can help the effort because "there are things that the insurer may not be aware of."



Mr. Garcia

For example, Mr. Garcia points out, in seasonal businesses that shut down for part of the year, a physician may for a fee certify workers as disabled until work begins again.

"That is the kind of thing an employer must let us know about," said Mr. Garcia.

"At the heart of any program is the initial detection at the examining level, then it can be referred to experts," remarks Robert Miller, vp of group claims at Prudential Insurance Co. of America in Roseland, N.J.

He advises using computer systems that monitor specific trends and spot patterns. For example, a system might be able to identify an unusually high number of claims from a certain source.

Employee education must be a priority of employers, notes Mr. Miller. He said the popularity of cost-containment programs should be evidence to workers that "employers are not a bottomless pit for health care dollars."

Mr. Miller pointed out that "like everything else, everybody is being hurt by fraud. So it is going to take everybody to prevent it. Employers can impress upon employees the impact of health care fraud. Because of it, the cost of health care benefits will be greater.

"I agree it is the insurer's responsibility" to combat health care fraud, he said. "But the numbers indicate that it is a larger problem than just the insurance industry. It is a national problem."

William H. Huston, director of financial investigations for Blue Cross & Blue Shield of Northern Ohio, said there are two things an insurer needs to battle fraud: "A long-term, top-level corporate commitment to an anti-fraud program and a unit staffed by professionals with law enforcement or legal backgrounds."

He said the Blue Cross/Blue Shield plans' financial investigation units have an advantage over fraud departments set up by large insurers because of the "geographical restraints" the large companies face.

"My responsibility is northern Ohio," said Mr. Huston. Devoting his staff's energy and attention to one area means the unit can be more effective than if it had to worry about fraud nationwide.

"Getting personally involved is impossible" for large insurers, he said, while "my investigators get directly involved in undercover work." ■

Anti-fraud group offers sleuthing tips

The National Health Care Anti-Fraud Assn. is hoping to expand its membership of health insurers and medical personnel in an effort to control health care insurance fraud.

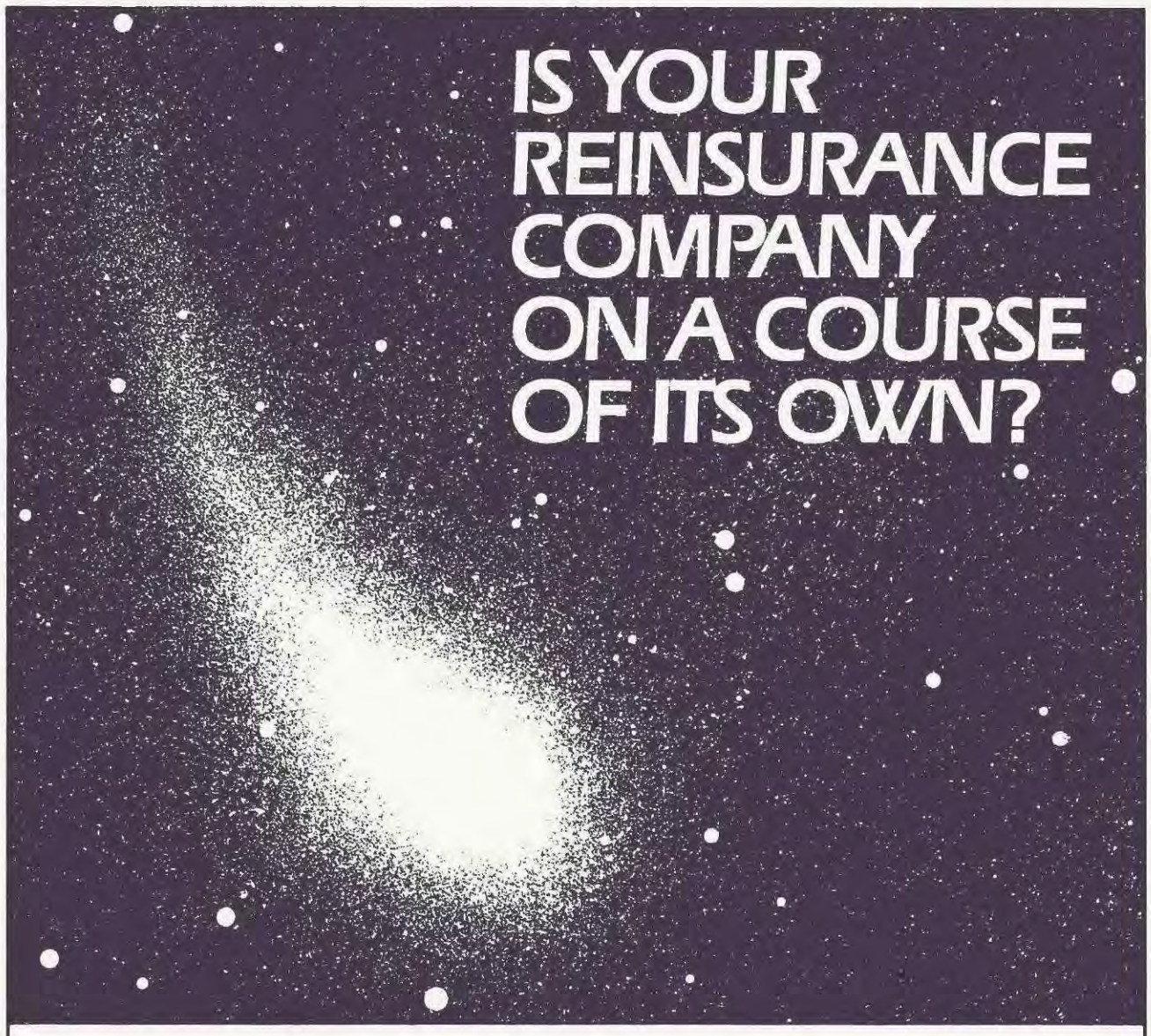
The association's aim is stop fraud partly by sharing information on detection techniques, forming a central indexing system to keep track of all fraudulent health care activities and creating a communications network that will let members know if providers convicted in one state have set up shop in another.

The association also sponsors an annual seminar.

The association is currently offering individual memberships for $25.

James L. Garcia, chairman of the association, said the group is seeking members who are "front-line operators" like fraud specialists, investigators and claims processors.

More information on memberships is available from Mr. Garcia at Aetna Life & Casualty Co., 151 Farmington Road, Hartford, Conn. 06156; 203-636-7135.



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update

Court rules on police immunity

Continued from page 2

A grand jury declined to indict the couple, and the charges were dropped. Subsequently, the couple filed a lawsuit against the trooper, alleging violation of their constitutional rights.

Equitable, HCA to form firm

NEW YORK—Equitable Life Assurance Society of the United States and Hospital Corp. of America plan to form a new company that will offer employers various alternative health care delivery systems, insurance and financial service products.

The new company will be formed by combining Equitable Group & Health Insurance Co., an unincorporated division of New York-based Equitable, and Health Plans, a subsidiary of Nashville, Tenn.-based HCA.

Details of the joint venture are sketchy, according to representatives of both companies, which announced their intentions last week.

"Our current plans are that between 60 and 90 days, we will be in a position to execute a formal letter of agreement," said Larry J. Larkin, who is senior vp of both Equitable and its group health division.

There has been speculation that the new company will be an insurance company, but Mr. Larkin said it may be designed so that a subsidiary or division of the new company would be the insurance arm.

The joint venture still needs the approval of each company's board of directors as well as several government regulators, Mr. Larkin said.

"We expect to be in business by the fourth quarter of this year and possibly earlier," Mr. Larkin said.

A name for the new company, as well as the location of its headquarters, have not been determined.

HCA was unwilling to discuss the joint venture until an agreement was finalized, according to a spokesman.

Equitable is the third-largest life insurance company in the United States. About one-third of its business is group health insurance.

HCA, which is 18 years old, owns or manages 463 hospitals in 44 states and seven foreign countries. The company also owns or manages several alternative health care delivery systems, including health maintenance organizations, preferred provider organizations and self-insurance trusts.

In explaining the reason behind the planned venture, Mr. Larkin said that at one time the emphasis in health care systems was on pricing, and most recently it has been on access.

However, Mr. Larkin said, now and in the future, the focus will be on quality. And, he said that both Equitable and HCA have a reputation for quality and professionalism that will enhance the joint venture.

Corroon proposes stock split

NEW YORK—Corroon & Black Corp. is asking shareholders to approve a 2-for-1 split in its common stock and has increased its quarterly dividend.

Shareholders will vote on the stock split at the broker's annual meeting April 24. If approved, the split would be effective shortly thereafter.

Corroon & Black common stock was selling at about $63.50 a share last week.

In addition, the nation's sixth-largest broker has declared a 30% increase in its quarterly dividend to 32.5 cents per share of common stock. The dividend is payable April 1 to shareholders of record on March 17.

3M official up for OSHA post

WASHINGTON—President Reagan will nominate John A. Pendergrass, an industrial hygienist at Minnesota Mining & Manufacturing Co., to be the new chief of the Occupational Safety and Health Administration.

Mr. Pendergrass, 60, a former president of the American Industrial Hygiene Assn., joined 3M in 1964 and has held a number of industrial hygiene positions with the company.

He also has served as an industrial hygienist with the Tennessee Valley Authority, Boeing Co. and American Cyanimid Co.

Mr. Pendergrass' nomination requires Senate confirmation. The top position at OSHA has been vacant for eight months.

N.Y. tramway back in action

NEW YORK—The Roosevelt Island tramway resumed operations last week after it was decided the state could self-insure the tram's liabilities without legislative approval.

The tramway had stopped running Feb. 15 after its excess liability insurance program fell apart.

Gov. Mario Cuomo, a Democrat, had attempted to get legislative approval of a bill that would have permitted the state to self-insure the tram's liabilities, but he ran into opposition from the Republican-controlled Senate (*BI*, March 3).

It was decided instead to self-insure by modifying the contract between the Roosevelt Island Operating Corp., the government agency that supervises the tram, and the tram's private operator, said a spokesman for the governor.

This contract had required that RIOC obtain liability insurance. However, this has now been amended to say RIOC would assume the tram operator's liabilities.

No legislative approval of this change is required, according to the spokesman.

"We have found a way around the Republicans' refusal to cooperate in solving this problem," Gov. Cuomo said in a statement.

datebook

MARCH 24-26. The 50th Loss Managers Conference in Orlando, Fla., sponsored by the Property Loss Research Bureau; $70 for members; $190 for non-members. Property Loss Research Bureau, 1501 Woodfield Road, Suite 400 West, Schaumburg, Ill. 60195-4978; 312-490-8650.

MARCH 24-28. Fundamentals of Industrial Hygiene Monitoring course in Long Grove, Ill., sponsored by National Loss Control Service Corp.; $500; $450 for two or more registering at the same time. Also **May 5-9; Sept. 8-12; Nov. 10-14.** National Loss Control Service Corp., K-3, John N. Garis, Long Grove, Ill. 60049; 312-540-2026.

MARCH 25. The Claims-Made and New Occurrence Revolution seminar in New York, sponsored by the College of Insurance; $295 for first registrant from an organization; $265 each additional attendee. Also **April 15, April 22.** Risk Research Center of the College of Insurance, One Insurance Plaza, 101 Murray Street, New York, N.Y. 10007; 212-962-4111, Ext. 358.

MARCH 25. Risk Management of PCBs in Electrical Systems seminar in Kansas City, Mo., sponsored by Electro-Test Inc.; $175; $30 discount for cash payments. Also **March 26** in St. Louis; **March 27** in Little Rock, Ark.; **April 1** in Jackson, Miss.; **April 2** in New Orleans; **April 3** in Atlanta; **April 8** in Detroit; **April 9** in Cleveland; **April 10** in Pittsburgh; **April 15** in Houston; **April 16** in Dallas; **April 17** in Oklahoma City; **April 22** in Cincinnati; **April 23** in Columbus, Ohio; **April 25** in Indianapolis; **April 29** in White Plains, N.Y.; **April 30** in Hartford, Conn.; **May 1** in Boston; **May 6** in Nashville, Tenn.; **May 7** in Columbia S.C.; **May 8** in Raleigh, N.C.; **May 13** in Chicago; **May 14** in Des Moines, Iowa; **May 15** in Minneapolis; **May 20** in Long Island, N.Y.; **May 21** in Clifton, N.J.; **May 22** in Niagara Falls, N.Y.; **May 28** in Baltimore; **May 29** in Harrisburg, W.Va. Electro-Test Learning Center, P.O. Box 159, 3470 Fostoria Way, San Ramon, Calif. 94583; 415-866-8568.

MARCH 25-26. 1986 Employee Benefits Conference in New York, sponsored by The Conference Board Inc.; $595 for associates; $665 for non-associates. The Conference Board Inc., P.O. Box 4026, Church Street Station, New York, N.Y. 10261-4026; 212-759-0900.

MARCH 25-27. Laboratory Safety Course in Chicago, sponsored by the National Safety Council; $375 for members; $470 for non-members. Registrar, Safety Training Institute, National Safety Council, 444 N. Michigan Ave., Chicago, Ill. 60611; 312-527-4800, Ext. 5105.

MARCH 31. Buying Insurance in a Hard Market course in New York, sponsored by the American Management Assn.; $375 for members; $425 for non-members. Also **April 17** in Chicago, **May 1** in Los Angeles, **May 22** in Atlanta. AMA, P.O. Box 319, Saranac Lake, N.Y., 12983; 518-891-0065.

MARCH 31-APRIL 3. Third Annual Conference on the Environment, Health and Safety in Atlanta, sponsored by the Environmental, Health and Safety Division of the Georgia Tech Research Institute; $155. Ann Harbert, Georgia Tech Research Institute/EDL/Environmental, Health and Safety Division, Atlanta, Ga. 30332; 404-894-3806.

APRIL 1. The New Commercial General Liability Policies: Impact on the Insurance Buyer course in New York, sponsored by the American Management Assn.; $375 for members; $425 for non-members. Also **April 18** in Chicago, **May 2** in Los Angeles, **May 23** in Atlanta. American Management Assn., P.O. Box 319, Saranac Lake, N.Y. 12983; 518-891-0065.

APRIL 1-4. Reinsurance Accounting & Finance for Cedents & Assumers in Crotonville, N.Y., sponsored by Robert W. Strain Seminars Inc.; $1,295. Also **Sept. 2-5** in Ossining, N.Y. Strain Seminars Inc., P.O. Box 1000, Wingdale, N.Y. 12594; 212-677-5974 on Mon.—Wed.; 914-832-9384 on Thurs., Fri.

APRIL 2-4. Electrical Fires Investigation in Madison, Wis., sponsored by the Department of Engineering Professional Development at the University of Wisconsin; $450. Ken Greenwald, Department of Engineering Professional Development, University of Wisconsin, 432 N. Lake St., Madison, Wis. 53706; 800-262-6243; 800-363-3020 in Wisconsin.

APRIL 2-5. Corporate Benefits Management Conference in Phoenix, Ariz., sponsored by the International Foundation of Employee Benefit Plans; $530 for members; $605 for non-members. Also **May 7-10** in Atlantic City, N.J.; **Aug. 3-6** in Monterey, Calif. International Foundation of Employee Benefit Plans, Attention Registration Department, 18700 W. Bluemound Road, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

APRIL 3. Insurer/Reinsurer Insolvency workshop in Jacksonville, Fla., sponsored by the Society of Chartered Property and Casualty Underwriters; $80 for members; $95 for non-members. Mari Jennings, Professional Services Department, Society of CPCU, Kahler Hall, Providence Road, CB#9, Malvern, Pa. 19355; 215-251-2741.

APRIL 3-4. How to Audit and Check Insurance Policy Costs and Coverages course in Honolulu, sponsored by the American Management Assn.; $675 for members; $775 for non-members. Also **April 10-11** in Dallas; **April 17-18** in Philadelphia; **May 8-9** in Los Angeles; **May 15-16** in Burlington, Mass.; **May 22-23** in Atlanta. American Management Assn., P.O. Box 319, Saranac Lake, N.Y. 12983; 518-891-0065.

APRIL 6-9. 1986 Health Care Cost Management Conference in Miami, sponsored by the International Foundation of Employee Benefit Plans; $450 for members; $525 for non-members. Registrations Department, International Foundation of Employee Benefit Plans, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

APRIL 6-9. Association Benefits Management Conference in Hollywood, Fla., sponsored by the International Foundation of Employee Benefit Plans; $450 for members; $525 for non-members. Registrations Department, International Foundation of Employee Benefit Plans, 18700 W. Bluemound Road, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

APRIL 6-9. Annual Conference—State and Local Government Benefit Assn. in Atlanta, sponsored by the Georgia State Merit System; $100 for members; $125 for non-members. SALGBA Conference, State Merit System, 200 Piedmont Ave., Atlanta, Ga. 30334; 404-656-4063.

APRIL 6-11. The Basic Course in Reinsurance in Princeton, N.J., sponsored by The College of Insurance; $895 for College sponsors; $1,050 for others. Ronnie Kranis, Professional Development Programs, The College of Insurance, One Insurance Plaza, 101 Murray St., New York, N.Y. 10007; 212-962-4111.

APRIL 7-8. Offshore Captive Insurance Seminar in Houston, sponsored by Risk Alternatives Inc.; $395. Charlene Gilliam, Risk Alternatives Inc., Box 707, Salado, Texas 76571; 817-947-5048.

APRIL 7-8. Health Care Cost Containment Workshop in New York, sponsored by Health Research Institute; $495. Also **April 21-22** in Portland, Ore.; **May 5-6** in Chicago; **May 12-13** in Washington; **June 2-3** in Houston; **June 23-24** in Atlanta; **July 14-15** in Denver; **July 21-22** in San Jose, Calif.; **Aug. 11-12** in Minneapolis; **Sept. 22-23** in New Orleans; **Oct. 6-7** in San Francisco; **Oct. 27-28** in Boston; **Nov. 10-11** in New York; **Nov. 17-18** in Dallas; **Dec. 8-9** in Chicago. Health Research Institute, 49 Quail Court, #200, Walnut Creek, Calif. 94596; 415-676-2320.

APRIL 7-8. Pension Consultants Conference in Sand Key, Fla., sponsored by Charles D. Spenser & Associates; $425. Charles D. Spenser & Associates Inc., 222 W. Adams St., Chicago, Ill. 60606; 312-236-2615.

APRIL 7-11. Safety in Chemical Operations course in Chicago, sponsored by the National Safety Council; $595 for members; $740 for non-members. Registrar, Safety Training Institute, National Safety Council, 444 N. Michigan Ave., Chicago, Ill. 60611; 312-527-4800, Ext. 5105.

APRIL 9. Maryland All Industry Day in Baltimore, sponsored by the Insurance Company Representatives of Maryland; $20. Insurance Company Representatives of Maryland, P.O. Box 41, Lutherville, Md. 21093.

APRIL 9. Advanced Cost Containment workshop in New York, sponsored by Health Research Institute; $250. Also **April 23** in Portland, Ore.; **May 7** in Chicago; **May 14** in Washington; **June 4** in Houston; **June 25** in Atlanta; **July 16** in Denver; **July 23** in San Jose, Calif.; **Aug. 13** in Minneapolis; **Sept. 24** in New Orleans; **Oct. 8** in San Francisco; **Oct. 29** in Boston; **Nov. 12** in New York; **Nov. 19** in Dallas; **Dec. 10** in Chicago. Health Research Institute, 49 Quail Court, #200, Walnut Creek, Calif. 94596; 415-676-2320.

APRIL 9. Health Improvement/Wellness workshop in New York, sponsored by Health Research Institute; $250. Also **April 23** in Portland, Ore.; **May 7** in Chicago; **May 14** in Washington; **June 4** in Houston; **June 25** in Atlanta; **July 16** in Denver; **July 23** in San Jose, Calif.; **Aug. 13** in Minneapolis; **Sept. 24** in New Orleans; **Oct. 8** in San Francisco; **Oct. 29** in Boston; **Nov. 12** in New York; **Nov. 19** in Dallas; **Dec. 10** in Chicago. Health Research Institute, 49 Quail Court, #200, Walnut Creek, Calif. 94596; 415-676-2320.

APRIL 13-18. "Reach for the Top"—Risk & Insurance Management Society 24th annual conference in Toronto. $595 for members; $695 for non-members; reduced fees available for those attending only part of the conference. RIMS Conference Department, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

APRIL 13-18. The College of Insurance Management Program in Tarrytown, N.Y., sponsored by The College of Insurance; $895 for College sponsors; $1,050 for others. Ronnie Kranis, Professional Development Programs, The College of Insurance, One Insurance Plaza, 101 Murray St., New York, N.Y. 10007; 212-962-4111.

APRIL 14-15. Health Policy Conference in Washington, sponsored by the American Medical Care & Review Assn.; before March 28: $375 members; $425 non-members. After March 28: $425 members; $550 non-members. AMCRA, 5410 Grosvenor Lane, Suite 210, Bethesda, Md. 20814.

APRIL 14-15. Cost Containment and the Restructuring of the U.S. Health Insurance Industry conference in New York, sponsored by Bear Stearns & Co. and Communitech Market Intelligence; $595; $495 for additional registrants from the same organization. Sharon Barrett Curry, Communitech, P.O. Box 67, Yorktown Heights, N.Y. 10598; 914-245-7764.

APRIL 14-18. Practising Law Institute Insurance Week series in San Francisco, including: Introduction to Commercial Insurance; Hazardous Waste, Toxic Tort, and Products Liability Insurance Problems; Director's and Officer's Liability Insurance and Self-insurance; Bad Faith Litigation and Insurer vs. Insurer Disputes; and Insurance Litigation and Coverage Issues. Cost per seminar is $215; five-day rate is $900. Practising Law Institute, Dept. 105-F9, 810 Seventh Ave. New York, N.Y. 10019; 212-765-5700.

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~~Feb 17~~	~~Feb 4~~
~~Feb 24~~	~~Feb 11~~
~~Mar 3~~	~~Feb 19~~
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Mar 31	Mar 19
Apr 7	Mar 26
Apr 14	Apr 1
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May 5	Apr 23
May 12	Apr 30
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May 26	May 13
Jun 2	May 20
Jun 9	May 28
Jun 16	Jun 4
Jun 23	Jun 10
Jun 30	Jun 18
Jul 7	Jun 24
Jul 14	Jul 1
Jul 21	Jul 8
Jul 28	Jul 16
Aug 4	Jul 23
Aug 11	Jul 29
Aug 18	Aug 6
Aug 25	Aug 13
Sep 1	Aug 19
Sep 8	Aug 26
Sep 15	Sep 3
Sep 22	Sep 9
Sep 29	Sep 16

business insurance

New York: (212)210-0133
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Satellite suits

Continued from page 1

suit.

Insurers bringing the Westar VI lawsuit are Appalachian Insurance Co. of Johnston, R.I., a subsidiary of Allendale Mutual Insurance Co.; Commonwealth Insurance Co. of Vancouver, British Columbia; Industrial Indemnity Co. of San Francisco, a Crum & Forster unit; Mutual Marine Office Inc., an insurance underwriting manager in New York; and Northbrook Excess & Surplus Insurance Co. of Northbrook, Ill., a unit of Allstate Insurance Co.

Plaintiffs in the Palapa B2 suit are Lexington Insurance Co., part of American International Group Inc. in New York; Talbot, Bird & Co. Inc., a New York-based insurance management firm, part of London-based Guardian Royal Exchange P.L.C.; and Northbrook Excess & Surplus.

Insurers in both suits are represented by the Washington firm of Shaw, Pittman, Potts & Trowbridge.

The suits were filed Jan. 16 in California Superior Court in Orange County and refiled Feb. 19. One of the defendants, McDonnell-Douglas, exercised its right to remove the case to federal court in Los Angeles. However, the insurers are seeking to have the case returned to state court.

According to the suits, McDonnell-Douglas manufactured upper-stage rocket boosters known as Payload Assist Modules (PAMs) for use in putting the satellites into geosynchronous orbit around the Earth at an altitude of approximately 22,000 miles after deployment from the shuttle. In geosynchronous orbit, the satellite would remain over the same point on the Earth's surface.

Morton Thiokol manufactured the solid rocket motors used in the PAMs, including the STAR 48 motor, and HITCO manufactured exit cones, which are part of the motors, the suits say.

The suits allege that the defendants manufactured a PAM-D model upper-stage rocket booster, including the STAR 48 solid rocket motor and exit cone, and that McDonnell-Douglas sold it to Western Union for use in putting the Westar VI into orbit following deployment from the space shuttle.

'Space exploration and vehicles are not units off a Ford line,' comments Barry Wrenn of HITCO.

McDonnell-Douglas also sold the PAM-D to Hughes Aircraft Co., which built the Palapa B2 for the same purpose.

The suits charge that defects in the design and manufacture of the PAM-D, including the STAR 48 solid rocket motor and exit cone, existed when the PAM-D left the defendants' possession.

These defects caused the damage to the satellites when the exit cone of the PAM-D's STAR 48 motor disintegrated shortly after ignition and the PAM-D failed to put the satellites into geosynchronous orbit, the suits allege.

The suits also charge the defendants "negligently and carelessly" designed, manufactured and tested the PAM-D, including the STAR 48 rocket motor and exit cone.

They also allegedly failed to warn users of dangers and defects in the PAM-D upper-stage rocket boosters, failed to remedy the defects and failed to instruct users on methods of eliminating them, the suits add.

The failure of the satellites resulted in the "total loss" of the satellites, rendering them "totally useless" as telecommunications satellites, the suits say.

After the loss, Western Union made a $105 million claim against its underwriters for all damages caused by the loss. That included a $5.5 million claim against Appalachian, Commonwealth, Industrial Indemnity, Mutual Marine and Northbrook, the suit says.

After the Palapa B2 loss, insurers paid a claim for $75.4 million, including $5.8 million by Lexington, Talbot, Bird and Northbrook.

Last week, Barry Wrenn, general counsel for HITCO, criticized the insurers for bringing the suits.

"My initial reaction is that the case represents a situation where the insurers have taken a risk, been paid a premium and now are crying foul because they had to pay off," said Mr. Wrenn.

"Our position is the loss was exactly what the underwriters signed up for," he said, adding that it appears they are now taking the position they really did not want to act as insurers.

"Space exploration and vehicles are not units off a Ford line," he said. "It's that kind of risk we're all taking right now."

Mr. Wrenn added plaintiffs' attorneys filed the case in state court and then took the case to the London market for support from other insurers, but he said he knows of no other insurers that have joined.

A spokesman for McDonnell-Douglas Astronautics in Huntington Beach, Calif., said the company has been served with the suit and is evaluating it. "We feel we have a very good defense," the spokesman said, but declined to elaborate.

An Morton Thiokol official said the company had been served with the suit but declined comment.

The Westar VI was insured in three layers as part of a three-satellite insurance package originally placed in 1981. The coverage lasted for 36 months.

The first $80 million layer was led by Richard Maylam, Lloyd's underwriter for aviation syndicates managed by Alexander Howden Underwriters Ltd. The second layer of about $20 million was led by Lloyd's underwriter Stephen Merrett, chairman of Merrett Holdings P.L.C. The third layer was led by Orion Insurance Co. Ltd. in London.

"Involuntary plaintiffs" included in the Westar VI suit are the primary and excess insurers of policies, brokered by Alexander & Alexander Inc. for Western Union.

They include: Mr. Maylam; John Daniel Ltd.; Peter Cameron-Webb, formerly an underwriter at Lloyd's of London; Mission Insurance Co.; St. Eustasius Insurance Co.; Stewart Smith East, Inc.; United States Aviation Underwriters; American Centennial Insurance Co.; Northumberland Insurance Co.; International Technology Underwriters; AFIA; William H. McGee & Co.; Gibraltar Insurance Co., Kenneth B. Shevlin Inc.; Midland Insurance Co.; Great Southwest Fire Insurance Co.; and Employers Insurance of Wausau.

Also, California Union Insurance Co.; Columbia Casualty Co.; St. Paul Insurance Co.; Great American Insurance Co.; Munich Reinsurance Co.; Generali; Yasuda Fire & Marine Insurance Co.; CLAL; Mr. Merrett; and Orion Insurance Co. Ltd.

The Palapa B2, was insured as part of a two-satellite, 36-month insurance program originally placed Nov. 1, 1982, by broker Corroon & Black/Inspace Inc. of Washington and Lloyd's broker Crawley, Warren Ltd. in London.

The satellite was insured by a consortium of Indonesian insurers led by Jasa Insurance Co., the state insurance company, and reinsured by 150 underwriters around the world. The reinsurance is led in London by Mr. Merrett at Lloyd's.

Named as involuntary plaintiffs in the Palapa suit are various underwriters at Lloyd's that reinsured the policy issued by Jasa to Perusahaan Umum Telekomunikasi (PERMUTEL), a public telecommunications services of the Republic of Indonesia.

Involuntary plaintiffs named include: Mr. Merrett; International Technology Underwriters; Aviation Office of America; Stewart Smith East Inc.; L.W. Biegler Inc.; Marine Indemnity Insurance Co.; Great American Surplus Lines Insurance Co.; AFIA; Transit Casualty Co.; Insurance Corp. of Ireland; the Illinois Insurance Exchange; Ocean Marine Indemnity; Gulf Coast Marine Inc.; NUA Inc.; Orion Insurance Co. Ltd.; and Generali. ■

Health care tax cap revived

Continued from page 2

ployees are taxed on employer-paid premiums for term life insurance coverage exceeding $50,000.

A tax on employers' health care contributions has been proposed many times before. For example, the Treasury Department in its original tax overhaul plan proposed taxing employees on employer health care contributions that exceeded $70 a month for individual coverage and $175 a month for family coverage.

The Reagan administration also has endorsed such a tax on numerous occasions.

Some observers thought a health care tax was dead and buried after the House rejected taxing health care benefits during debate on the tax bill it passed last year.

Experts note, though, that a health care tax will continue to be considered by congressional committee staffers and legislators because of its revenue-raising potential.

"A health care tax is always there. It is perceived as a quick way to raise big bucks," said Edward J. Davey, vp-technical analysis at Johnson & Higgins in New York.

"Because of Gramm-Rudman, there is pressure across the board for additional revenues," said Frank McArdle, director of education and communications at the Employee Benefit Research Institute, a Washington-based benefits think-tank. Gramm—Rudman is the new federal law that requires gradual reductions in federal budget deficits.

The Senate Budget Committee staffers' health care tax proposal is one of many revenue-raising options now before the committee, which last week began to draft a budget resolution for the 1987 fiscal year.

Budget resolutions do not carry the weight of law, but only set general spending and revenue targets. Those targets can be implemented only by the passage of specific legislation.

A budget reconciliation bill, H.R. 3128, which was passed by the House late last week, implements some of the proposals in the 1986 budget resolution.

H.R. 3128, if passed by the Senate, would have far-reaching effects on corporate health and pension programs.

Tacked onto H.R. 3128 is a provision requiring employers to extend their group health care programs for three years to a former spouse of an employee and for 18 months to employees who lose their jobs (*BI*, Sept. 30, 1985).

'A health care tax is always there. It is perceived as a quick way to raise big bucks,' says J&H's Mr. Davey.

If an employer does not meet these two provisions, the company would lose its tax deduction for health care plan expenses.

However, employers would be allowed to charge spouses and former employees a premium of up to 102% of the cost of coverage.

For most employers, this extension of coverage would have to begin by July 1.

However, employers with 20 or fewer full-time employees would not have to comply with this health care coverage extension.

This new benefit mandate would cause administrative problems for employers, which would have to track, try to collect premiums from and process claims for people with whom they have no employment relationship, experts have warned.

Another health care provision in H.R. 3128 would require employers to extend their group health care plans to employees and spouses age 70 and older. These older workers now receive their primary health care coverage from the federal Medicare program.

The provision, as now drafted, would be retroactive to March 1 and apply only to companies with at least 20 full-time employees.

On the pension side, H.R. 3128 would raise the annual PBGC insurance premium to $8.50 per plan participant from the current $2.60. This increase would be retroactive for plan years that begin on or after Jan. 1 (*BI*, Jan. 6).

The legislation also would create a major new set of rules covering the termination of underfunded single-employer pension plans. Under the new rules, an ongoing, financially stable company could not terminate a pension plan until all vested benefits—plus special plant shutdown and special Social Security supplemental benefits—are funded.

That would be a significant change from current law, under which a company can terminate a plan—regardless of its funding level—whenever it wants. If the plan doesn't have sufficient assets to pay PBGC-guaranteed benefits, the PBGC can take up to 30% of a company's net worth to cover the funding shortfall.

Companies with little or no net worth sometimes find it cheaper to terminate an underfunded plan, shift the liabilities to the PBGC and pay the penalty, if any, than to continue the plan.

Financially troubled employers still would be allowed to terminate underfunded plans but only if they pass at least one of the "distress" tests set up by the legislation:

- A Chapter 7 bankruptcy liquidation.
- A Chapter 11 bankruptcy reorganization, if the bankruptcy judge approves the plan termination.
- A determination by the PBGC that the employer is unable to pay its debts when due and is unable to continue in business.
- A determination by the PBGC that an employer's pension costs have become unreasonably burdensome as a result of a declining workforce.

Also, under the new rules, the cost of a terminating a plan would become far greater for many companies.

As under current law, the PBGC would have an automatic right to 30% of a company's net worth to pay for unfunded benefits that the PBGC guarantees.

But, in contrast to current law, the PBGC would be able to recover more from a company terminating a plan. If an amount equal to 30% of net worth is not sufficient to pay all guaranteed benefits, the employer would have to make additional payments to the PBGC until 75% of the guaranteed benefits are paid by the company.

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E&O claims

Continued from page 2

erate acts or omissions within the broking firm, sometimes amounting to dishonesty or just plain fraud; such cases can arise from pressures of work or domestic difficulties or from defects of character and business morality, or all three, none of which has been recognized by senior management."

Even when there is fraud or dishonesty involved, management is slow in recognizing it "and in some cases unwilling to believe it and hesitant to challenge it."

However, most E&O claims by brokers are due to mistakes within the firm, according to the underwriters.

Virtually all claims against brokers begin because a client has not had a valid claim paid by an insurer or reinsurer.

The claim may not be paid because:

- There is no cover. The broker may have overlooked renewals and deadlines, failed to carry out clients' instructions, confirmed cover before it was fully placed, did not record telephone calls, used defective wording, left gaps in the coverage or erred in the distribution of documentation.
- There is no insurer or reinsurer, because brokers have used defective security for the client's policy. The underwriters may be insolvent or have disappeared.

Fraud is 'above all, the area that can bring a broking house to its knees,' the letter says.

"It is important (particularly in reinsurance) that the broker does not hold himself out as some kind of guarantor of the reinsurance security he offers," according to the letter.

"The three main sources of claims in that category arise out of the company that is insolvent, the agency which exceeds the underwriting authority and the company which is solvent but just declines to pay for a variety of reasons ranging from the invasion of the Falklands to a basic shortage of cash," the letter says.

- There is fraud and dishonesty —"above all, the area that can bring a broking house to its knees," the letter says.
- The broker has a binding authority or uses a fronting arrangement with poor-quality underwriters.

The three Lloyd's underwriters suggest that there are ways in which the Lloyd's brokers can improve their E&O loss record.

For example, brokers can use a two-stage diary system to make sure they remember renewals and deadlines.

Detailed records should be kept of clients who decline to accept a quote and of important conversations, both in person and over the telephone.

Also, the person confirming the cover to the client should not be the same person who placed the risk to ensure that the client is not told he has coverage before the policy is actually placed.

And, more than one person should add the policy slip up to make sure that the order is placed properly.

Policy documents should be clear.

"There should be no mystery clauses which nobody understands," say the underwriters. And, the wording issued by the broker should be the same wording that the underwriter approved.

Also, with regard to claims-made wordings, "the person with the production of new or renewal wordings for primary or excess business must ensure that they fit in with expiring or underlying wordings."

The underwriters also say that brokers' files should be kept in good order.

To check security of underwriters, too, brokers must have an established system of checking for quality.

The underwriters say that the director of one large Lloyd's brokerage has comprised a list of areas to scrutinize, including financial results; country of domicile; ultimate ownership and inter-company relationships; reinsurance; management; and types of business written.

"It cannot be emphasized too strongly that this memorandum is not intended to set forth the extent or nature of the legal duties owned by brokers," the letter concludes.

"Its purpose is simply to identify areas which have been known to cause difficulties." ■

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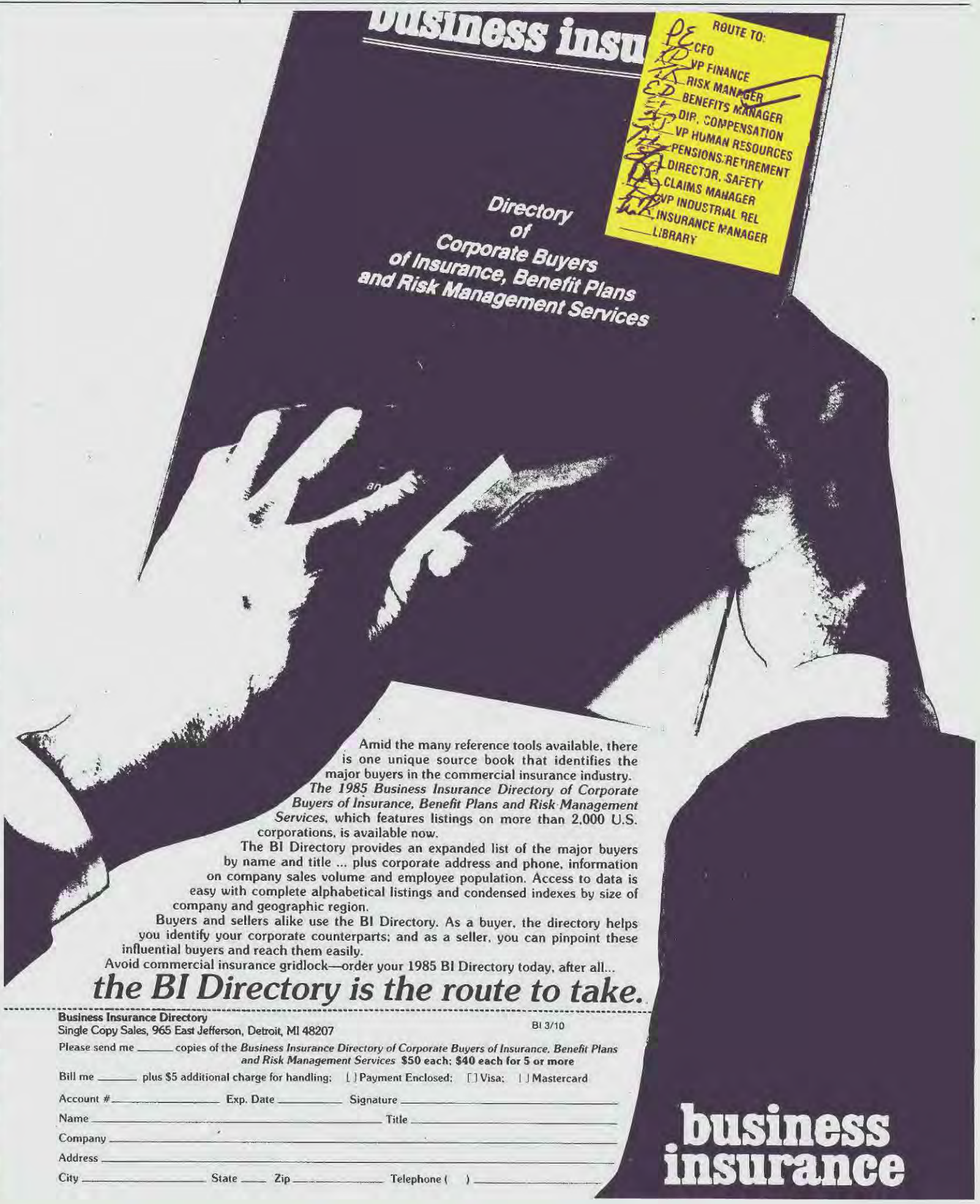
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business insurance

Liability from utilization review can be limited, experts say

By DONNA DiBLASE

Hospital utilization reviews can create new liabilities for employers, but these new risks can be mitigated, experts say.

"No one should be ignorant of the fact that we're making judgments about the administration of care," said David Rahill, a consultant with Johnson & Higgins in New York. "There is a liability that certainly exists if you cut off funding for a patient in the hospital."

But, employers can limit their liability by making sure the reviews are purely advisory in nature, that they are performed by competent medical personnel and that the ultimate decision on care rests with the employee and his physician—not with the employer.

"I don't think employers should be involved in the business of providing medical care—unless they are a provider," said Geraldine Alpert, a principal with William M. Mercer-Meidinger Inc. in New York.

The review firm also must realize its limitations, said Gary McIlroy, president of Health Risk Management Inc. in Minneapolis.

"The utilization review firm has to decide whether it is practicing medicine or rendering an opinion," he said. "Anytime you step beyond those bounds, you're moving into a risk which you have no business taking."

The point of utilization review is not to dictate care, said Larry Goelman, president of Huntington, Calif.-based Cost Care Inc. "We provide a consulting service. We make a determination on the necessity of care based on the patient's own medical history and then advise."

Employers and review firms say that a medically competent review based on individual cases and experience also helps reduce risk.

"We're in a business that involves risks, so we must have certain checks and balances in the system," noted Daniel Davis, senior vp at Wayne, Pa.-based Intracorp.

"If we have a situation involving denial of hospital days, we don't make a decision on our own, we use a physician adviser. And, we refer to a second physician if the first one concurs with our decision," he said.

Employers maintain that their intention in reviewing hospital use is not to influence care, but to make employees aware of all the options.

"The employer and the reviewer should function as an ombudsman—that is a helper, not an impediment," said Linda Havlin, a consultant with Lincolnshire, Ill.-based Hewitt Associates.

If an employee disagrees with the review, giving him an opportunity to appeal is another way an employer can limit its liability, says Wally Anderson, group insurance manager at Southland Corp. in Dallas.

Ms. Alpert offers further advice: "Employers can protect themselves by increasing their excess liability coverage and by including hold-harmless clauses in their contracts with utilization review firms."

Despite the inherent risks of hospital utilization review, there are advantages to the system, noted William Niehous, vp at Owens-Illinois Corp.

"Pre-notification has eliminated certain unnecessary operations by giving employees an opportunity to think about their options," Mr. Niehous said. "There are risks in anything, but in this program, it's the employee's option. We can advise them, but it's ultimately their decision." ■

PCW losses may increase

Continued from page 2

Sources told *Business Insurance* the new losses may include a 10% increase in the level of outstanding asbestosis claims, but an AUA No. 3 spokesman said "we cannot comment on numbers."

The AUA No. 3 letter, written Feb. 27 and signed by the agency's chairman, Sir Ian Morrow, told the members that it is "probable that there will be deterioration experienced by the incidental non-marine syndicates 618/948 . . . and on non-marine syndicate 157."

PCW members have been rocked by escalating losses since November 1982, when it was alleged that former PCW executives, including former PCW Chairmen Peter Dixon and Peter Cameron-Webb, misappropriated more than 39 million pounds ($56.5 million) of syndicate funds for their own benefit.

Lloyd's expelled Mr. Dixon last year and fined him 1 million pounds ($1.45 million) for his role in the misappropriation from the PCW syndicates (*BI*, Nov. 18, 1985).

PCW members received a reimbursement of 38.17 million pounds ($55.3 million) in 1984 from PCW's parent company, Minet Holdings P.L.C., and Alexander & Alexander Services Inc., whose subsidiary brokered reinsurance for the syndicates (*BI*, July 30, 1934).

To receive the funds, however, they promised not to sue Minet, A&A or A&A's subsidiaries.

Some 25 million pounds of this payment was misappropriated money that was later recovered by Minet, while the brokers themselves contributed about 13 million pounds.

Then, in May 1985, PCW members learned they would have to pay between 62 million to 130 million pounds ($90 million to $188.5 million) in losses from claims, principally on U.S. casualty business. So far, the majority of PCW members have refused to pay these losses.

Since then, Lloyd's, Minet, A&A and the PCW members have tried to reach some kind of agreement without going to court.

According to the letter from AUA No. 3, a "standstill" agreement was reached last Christmas under which PCW members could seek a court settlement if no final agreement was made before the statute of limitations on any possible criminal charges expired.

Subsequently, PCW members and AUA No. 3 drafted a lawsuit against about 40 defendants—including Minet, A&A and the Corp. of Lloyd's—that could be filed if no agreement is reached (*BI*, Aug. 26, 1985).

The standstill agreement expires March 31, but AUA No. 3 will not be able to estimate the syndicates' total liabilities by then, Sir Ian said in the letter.

"At that time, we will assess the progress we have made toward a satisfactory settlement for names and decide whether to commence litigation on names' behalf or to seek an extension to the standstill agreement," he said.

In the meantime, Jufcrest Ltd., which represents PCW members, and Richard Beckett Underwriting Agencies Ltd., which managed the syndicates from 1983 to 1985, are trying to recover money from several former PCW executives and the syndicates' auditors.

According to the letter, Mr. and Mrs. Cameron-Webb and Antony Oldworth, another former PCW official, are in "advanced stages of settlement" with Jufcrest to repay some funds to syndicate members.

Jufcrest Chairman David Thomson would not say how much may be recovered, adding that the first 13 million pounds recovered would be paid to Minet and A&A for the amount they contributed to the 1984 settlement.

In the meantime, a judgment has been obtained in a London High Court against Mr. Dixon to return more than $10 million.

But, Mr. Thomson says that no settlement is being negotiated because Mr. Dixon cannot be contacted. Lloyd's reported earlier this year that Mr. Dixon is living in Virginia.

In addition, Jufcrest continues to press a suit against the syndicates' auditors, Arthur Young McLelland Moores.

AUA No. 3 said in the letter it probably will not be able to produce syndicate accounts for 1985 that meet Lloyd's accounting bylaws.

"Whilst we will do our best to meet the deadline for submitting accounts to names and to Lloyd's (which is May 31), we believe it only right to notify all concerned that we do not think that will be possible," said Sir Ian.

However, there will be no further cash call made on PCW members and no request by members to take out loans, he said.

Whatever losses cannot be met by the syndicate members will be paid from Lloyd's Central Fund, so no policyholder will be affected, said the AUA No. 3 spokesman.

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Sub-total . . . 22,354
Associations . . . 483
Government, unions and educational institutions . . . 1,252

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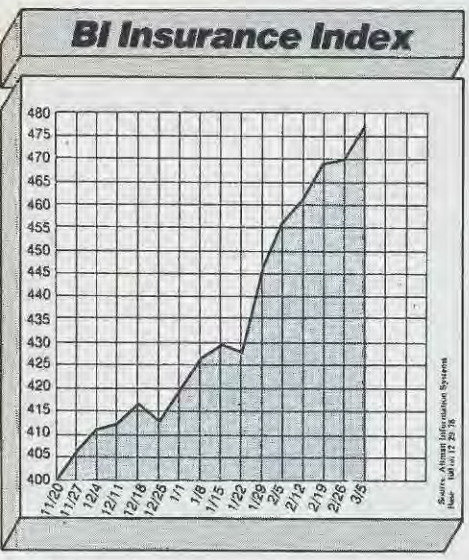
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Gdn Royal Exch	783	68.1	38.6	5.2	798—783
Royal	863	70.1	35.0	4.3	878—863
Sun Alliance	647	64.7	23.6	3.6	648—635
Brokers					
CE Heath	653	9.9	36.0	5.4	693—653
Hogg Robinson	308	12.6	13.4	4.4	315—308
JH Minet	253	12.0	10.7	4.2	262—253
Sedg Grp	387	16.8	17.1	4.4	393—387
Stew Wrightson	380	15.2	15.7	4.1	395—380
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Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

Quarterly results provide insight into broker progress

By LEONARD M. WILSON
Special to Business Insurance

QUARTERLY REPORTING time has come around once again. Reported results are a window on prospects for 1986 and, therefore, are worth scrutinizing for insights into the operating progress of the public insurance brokers.

Alexander & Alexander Services Inc. and Frank B. Hall & Co. Inc. have not yet reported. Both, though, have already indicated that the fourth quarter will be marred by write-offs from the lingering effects of problems in their underwriting subsidiaries.


Mr. Wilson

From an accounting standpoint, though, the charges will involve activities treated as discontinued. This insulates earnings comparisons for continuing operations, but still results in an adverse impact on net worth.

The brokers that have already reported their results posted gains attesting to the potency of premium rate increases. Our comments deal with fourth-quarter performance rather than year-end results, because of our interest in 1986 prospects rather than retrospective analysis.

The estimated year-over-year gains for property/casualty commissions in the fourth quarter of 1985 are:

- Marsh & McLennan Cos. Inc., 34%.
- Corroon & Black Corp., 33%.
- Arthur J. Gallagher & Co., 25%.

These figures, which relate to direct insurance brokerage, demonstrate the powerful momentum of commercial lines.

We estimate that increased premium rates accounted for 15 to 20 percentage points of the incremental revenues. Clearly, the brokers did not benefit fully from rate increases on commercial lines. Commissions, inevitably, must rise less than premiums in an environment of quantum price adjustments.

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The other major influence on commission growth was new business. Each of the brokers, even those not yet reporting, can claim an unusually strong influx of new business. Tight markets have traditionally favored the highly professional brokers, and the publicly owned brokerage companies are currently beneficiaries of that tendency.

Reinsurance brokerage also enjoyed a banner performance. Marsh & McLennan's domestic reinsurance brokerage rose an estimated 40% in the fourth quarter. The seller's market in reinsurance provided the thrust. The company's foreign reinsurance brokerage likely increased considerably less than domestic commissions. Selectivity at Lloyd's of London probably accounts for the disparity.

Surprisingly, employee benefits performed unusually well in the quarter. For Marsh & McLennan, the category advanced about 22%. Corroon & Black may have achieved a 30% increase, owing in large degree to specialty programs unrelated to traditional employee benefit products. By way of contrast, we estimate the natural rate of growth in pure employee benefits over the longer term at 10% to 15% annually.

The question that arises regularly is the status of self-insurance services. Arthur J. Gallagher, which has important representation in this area, provides a quantifiable index of the strength in self-insurance. Fees from self-insurance services posted a fourth-quarter rise of 27%. That pace is probably not sustainable, but there is little doubt that necessity of cost considerations has drawn insurance buyers to well-designed and well-administered self-insurance programs.

In the aggregate, including investment income, top-line growth averaged about 30% in the quarter. This pace should be sustainable at least through the first half of 1986. It is possible that in the latter part of this year, the sizzling rate environment could cool somewhat and, along with it, broker revenue gains.

On the expense side, the fourth quarter did not provide a great deal of comfort. Year-over-year expenses accelerated over the pace of the first nine months for each of the reporting insurance brokers. Other operating expenses, in particular, rose markedly.

The escalation in expenses could reflect disproportionately heavy accruals in some categories—in essence, a form of year-end adjustment. In addition, specific cost items, like errors and omissions insurance coverage, may have played a role in the expense deterioration.

Should fourth-quarter expenses be regarded as a red flag for 1986? Certainly, insurance brokerage costs have a well-defined tendency to mount with an acceleration in revenues.

A number of factors influence expense behavior. First, compensation, after a period of austerity, needs to catch up. Second, bonus and incentive formulas promote a substantial rise tied to production and profitability. Finally, insurance costs, bad debts and other expense categories are dictated by current operating conditions, and may not be fully amenable to control by management.

At this juncture, we hold the view that fourth-quarter expense performance does not cloud the earnings outlook for 1986. We expect that revenues will continue to outstrip the advance in expenses sufficiently to permit further profit margin expansion and pronounced earnings growth during 1986.

But we reiterate our view that if there is a snag in the offing, it will emanate from a failure to keep the lid on costs.

For now, though, we expect that 1986 will stack up as another year of exceptional earnings peformance of the publicly held insurance brokers. It is too soon to become uneasy over the question of premium rate adequacy, and the copious flow of new business should continue.

Aetna Life & Casualty Co.

Operating income at Aetna Life & Casualty Co. rose 135.7% to a record $430.2 million in 1985, compared with $182.5 million in 1984.

Fourth-quarter operating income at the Hartford, Conn.-based insurer rose 385.3% to $161.6 million in 1985 from $33.3 million in 1984.

Aetna's Commercial Insurance Division's operating income for 1985 was $23.7 million, compared with an $83.9 million loss in 1984.

Premiums written by the division rose 26.4% last year to $2.91 billion from $2.30 billion in 1984. The division's combined ratio decreased to 118.0% in 1985 from 125.2% in 1984.

Aetna subsidiary American Re-Insurance Co. posted 1985 operating income of $19.4 million, compared with a $27 million operating loss in 1984. American Re's combined ratio declined to 116.3% last year from 127.5% in 1984.

American Re reported written premiums of $730.2 million in 1985, up 65.4% from $441.5 million the previous year.

NAC Re Corp.

NAC Re Corp. reported a 1985 aftertax operating loss of $3.7 million, compared with a $2.4 million gain in 1984, despite a 117.6% increase in net written premiums to $26.6 million from $12.2 million.

NAC Re blamed the loss partially on a $6.2 million addition to reserves for business written between 1982 and 1984 and a special $1 million reserve established for doubtful reinsurance recoverable.

In the fourth quarter, Greenwich, Conn.-based NAC Re reported an operating loss of $4.8 million, compared with a $1.3 million operating gain in the fourth quarter of 1984. Net written premium increased 124.9% to $12.6 million from $5.6 million in the final quarter of 1984.

Celina Financial Corp.

Celina Financial Corp. said it will probably take a charge of at least $4.7 million against 1985 earnings for reserves added to its reinsurance operations, which are being run off.

The entity receiving the reserve boost is First National Indemnity Co., a subsidiary Celina formed last September to house the assets and liabilities of the former Ohio Reinsurance Corp., also a Celina unit. First National is now running off Ohio Re's business.

Celina sold Ohio Re as a shell to Kensu Holdings Inc. in Kansas City (*BI*,Sept. 16, 1985).

Celina will add to First National's assets, in part, by infusing $1.8 million in cash; contributing 35% (about $1 million) of Celina's equity interest in another subsidiary, National Term Life Insurance Co.; and by converting a $1.7 million intercompany receivable into equity. ■

BI Industry Stock Report

March 5, 1986 2/27/86 thru 3/5/86

Brokers		Price	% Chg.	P/E	$ Div.	% Yld.	High	Low	Vol.(000)
Alexander & Alexander Svcs	NYSE	33.50	-1.8	0.0	1.00	3.0	34.63	32.75	1,102.9
Baldwin & Lyons Inc	OTC	76.00	-0.3	16.8	0.80	1.1	76.00	76.00	0.0
Corroon & Black Corp	NYSE	65.25	2.8	20.7	1.00	1.5	66.63*	63.25	53.7
Crump E H Cos Inc	OTC	24.75	-1.0	23.6	0.25	1.0	25.00	24.25	356.1
Emett & Chandler Cos Inc	OTC	18.00	0.7	31.0	0.00	0.0	18.00	17.88	47.6
Gallagher Arthur J & Co	OTC	51.50	-7.2	23.4	0.40	0.8	56.50	51.50	109.8
Hall Frank B & Co Inc	NYSE	19.50	-5.5	0.0	0.00	0.0	20.63	19.50	607.0
Marsh & McLennan Cos Inc	NYSE	100.38	4.6	22.5	2.70	2.7	100.38*	96.75	259.6
Poe & Assoc Inc	OTC	18.25	0.0	0.0	0.80	4.4	18.25	18.25	5.2
AGENTS/BROKERS	AVERAGE			75.1		1.7			
Conglomerates & Holding Cos.									
American Express(Fireman's Fd)	NYSE	66.38	2.1	18.7	1.36	2.0	66.50*	65.75	5,533.9
Anderson Clayton(Ranger/PanAm)	NYSE	54.13	-1.1	30.9	0.00	0.0	54.75	54.13	124.6
Amaco Inc	NYSE	11.88	5.6	0.0	0.00	0.0	11.88*	10.88	1,501.3
Berkley W R Corp	OTC	44.00	-2.8	31.0	0.32	0.7	46.50*	44.00	156.2
CIGNA Corp	NYSE	68.25	0.0	0.0	2.60	3.8	68.75	67.75	1,474.3
CNA Finl Corp (CNA)	NYSE	69.00	-1.1	22.9	0.00	0.0	70.25	67.50	247.6
General Re Corp	NYSE	121.25	3.4	87.5	1.76	1.5	121.25*	117.75	616.6
ITT (Hartford Group)	NYSE	43.13	-2.0	22.8	1.00	2.3	45.00*	43.13	3,983.1
Sears Roebuck & Co. (Allstate)	NYSE	44.25	2.6	12.5	1.76	4.0	44.50*	44.25	4,287.4
Teledyne Inc (Argonaut)	NYSE	351.25	0.9	7.5	0.00	0.0	359.00*	351.25	225.5
Transamerica Corp (Occidental)	NYSE	37.75	-0.7	17.6	1.68	4.5	38.13	37.38	470.7
CONGLOMERATES/HOLDING COS.	AVERAGE			17.7		1.2			
Insurers									
Aetna Life & Cas Co	NYSE	60.50	2.1	15.8	2.64	4.4	61.75*	60.50	2,252.5
American General Corp	NYSE	39.88	0.3	12.3	1.12	2.8	40.13	39.50	1,395.6
Amern Heritage Life Invt Co	NYSE	40.38	2.2	15.1	1.20	3.0	40.75	40.00	3.6
American Indty Finl Corp	OTC	22.38	0.6	0.0	1.12	5.0	22.38	21.75	75.4
American Intl Group Inc	NYSE	126.75	3.3	31.6	0.44	0.3	126.75*	122.13	597.0
Aneco Reins Ltd	OTC	1.00	6.6	0.0	0.00	0.0	1.00	0.94	42.8
Avemco Corp	NYSE	33.38	-1.8	13.1	0.60	1.8	34.50	33.38	141.4
Business Mens Assurn Co Amer	OTC	30.25	2.5	14.0	1.10	3.6	30.25	29.50	87.2
Chubb Corp	NYSE	65.88	3.1	0.0	1.56	2.4	66.50*	65.13	298.5
Combined Intl Corp	NYSE	60.00	1.7	12.4	2.16	3.6	60.88*	58.75	157.7
Continental Corp	NYSE	50.63	3.8	0.0	2.60	5.1	51.00*	48.50	751.3
Crown Life Ins Co	OTC	245.00	0.0	14.8	0.00	0.0	245.00	245.00	0.0
Durham Corp	OTC	44.13	2.0	12.1	1.36	3.1	44.38	43.00	12.9
Farmers Group Inc	OTC	84.25	3.7	15.5	2.00	2.4	84.50*	81.00	441.5
Fairmont Finl Inc	AMEX	23.75	18.0	19.8	0.00	0.0	23.75*	20.63	172.4
Fireman Fd Corp	NYSE	38.50	8.1	0.0	0.30	0.8	39.38*	37.50	514.1
Fremont Gen Corp	OTC	28.63	-3.4	0.0	0.48	1.7	29.38	28.63	221.2
Great West Life Assurn Co	OTC	500.25	2.0	5.0	18.00	3.6	500.25*	490.00	0.0
Home Group Inc	AMEX	26.13	1.5	0.0	0.00	0.0	27.50	26.13	447.2
Hanover Ins Co	OTC	63.25	0.8	65.9	0.56	0.9	63.25	62.75	143.2
Hartford Steam Boiler Inspctn	OTC	69.50	0.0	12.8	2.00	2.9	70.00	68.50	62.2
Kans City Life Ins	OTC	32.25	7.5	12.7	0.87	2.7	32.25	30.25	17.0
Kemper Corp	OTC	95.50	0.8	20.7	1.80	1.9	99.00	95.50	290.2
Liberty Corp S C	NYSE	36.75	3.5	15.4	0.72	2.0	36.75*	35.25	14.6
Lincoln Natl Corp Ind	NYSE	59.00	1.7	13.7	2.00	3.4	60.38	58.50	340.2
Mission Ins Group Inc	OTC	2.75	0.0	0.0	0.00	0.0	2.75	2.75	630.5
Monumental Corp	OTC	36.25	2.1	12.3	1.40	3.9	36.63	35.25	67.3
Nac Re Corp	OTC	38.25	0.7	0.0	0.00	0.0	38.50	38.25	65.8
Nobel Ins Ltd	OTC	17.00	4.6	22.4	0.25	1.5	17.00	15.75	111.2
Northwestern Natl Life Ins	OTC	27.25	-2.2	13.5	0.80	2.9	27.88	27.25	355.4
Ohio Cas Corp	OTC	85.50	0.6	25.1	3.00	3.5	85.50	85.25	64.3
Old Rep Intl Corp	OTC	41.25	-1.2	11.1	0.74	1.8	42.00*	40.75	384.9
Orion Cap Corp	NYSE	36.25	6.6	0.0	0.76	2.1	36.63*	34.25	111.0
Protective Corp	OTC	24.75	0.0	9.2	0.66	2.7	25.25	24.75	154.9
Provident Life & Acc Ins Co	OTC	31.50	5.4	10.9	0.76	2.4	32.00*	31.00	271.6
St Paul Cos Inc	OTC	92.00	0.3	40.7	3.00	3.3	92.25	91.50	334.8
SAFECO Corp	OTC	56.00	2.8	17.0	1.60	2.9	56.50*	54.63	295.3
Sri Corp	OTC	19.63	4.7	0.0	0.80	4.1	19.88	18.75	276.5
Seibels Bruce Group Inc	OTC	22.00	2.3	12.2	0.80	3.6	22.00	21.50	86.2
Statesman Group Inc	OTC	7.00	7.7	0.0	0.05	0.7	7.00*	6.25	617.8
Tokio Marine & Fire Ins Co	OTC	258.00	2.1	48.6	1.05	0.4	267.00*	258.00	17.8
Torchmark Corp	NYSE	31.25	4.6	14.4	0.60	1.9	31.50*	30.75	870.7
Travelers Corp	NYSE	53.50	1.4	13.4	2.16	4.0	53.63	52.88	1,775.0
United Fire & Cas Co	OTC	32.50	0.0	15.2	1.20	3.7	32.50	32.50	2.6
United States Fid & Gty Co	NYSE	40.00	-0.3	0.0	2.20	5.5	40.88	40.00	1,825.1
Uslife Corp	NYSE	41.50	1.8	11.2	1.12	2.7	41.50	40.75	438.2
Washington Natl Corp	NYSE	31.13	4.6	14.1	1.08	3.5	31.13*	30.63	223.6
Zenith Natl Ins Corp	OTC	31.75	-0.8	0.0	0.68	2.1	31.75	31.50	275.6
INSURANCE COMPANIES	AVERAGE			15.7		2.4			

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