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update

Judge says Blue Shield limits on physician rates are illegal

BOSTON—Blue Shield of Massachusetts cannot limit how much its member physicians can charge patients, a federal judge ruled last week.

Judge Andrew A. Caffrey ruled that Blue Shield is engaging in price-fixing in violation of the Sherman Antitrust Act by requiring physicians to accept its payment system.

Some 60% of Massachusetts residents are insured through Blue

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Fair deal

Louisiana exposition liability limits reach $150 million

By CAROL CAIN

NEW ORLEANS—Up to $150 million in liability coverage and a $40 million abandonment policy are in place for the Louisiana World Exposition.

Better known as the New Orleans World's Fair, the multimillion-dollar waterfront extravaganza will run for 184 days from May 12 to Nov. 11.

Although neither fair officials nor insurers will release information on limits of particular coverages, sources say primary and umbrella liability policies provide $150 million in coverage for both the construction phase and the operational phase of the fair.

The bulk of the primary liability coverage is underwritten by United States Fidelity & Guaranty Co. in Baltimore, according to Joe O'Connor, a vp with Laurence Eustis Insurance Agency of New Orleans, one of three agencies that placed the fair coverage.

Auto, workers compensation and general liability coverage are provided through what the agents call an "owner-controlled" wrap-up package, which includes a separate policy for each of the coverages, he said.

USF&G also is underwriting the fair's errors and omission coverage and other "sundry" coverages, like fidelity bonds, Mr. O'Connor said. Liability coverage for medical services provided on-site also is covered by the fair's general liability policy, but the Oschner Medical Institutions of New Orleans, which will staff an on-site infirmary, also has its own medical malpractice insurance, he said.

A special policy for directors and officers liability is underwritten by several other insurers, with Western World Insurance Co. Inc. in Ramsey, N.J., as the primary underwriter, he said.

First State Insurance Co. in Boston is the lead underwriter for the umbrella coverage, which has both specific and aggregate limits, Mr. O'Connor said. The next layer is written by International Insurance Co. in Morristown, N.J.

The fair's loss experience to date has been so good that USF&G recently returned about $63,000 of the premium the fair paid for liability coverage and a further refund is expected, sources say (see story, page 24).

While the primary and umbrella liability insurance will cover just about any situation that arises, fair officials are still considering whether to purchase kidnap and ransom insurance, said Ann Brown, the fair's vp of legal affairs.

The fair's property coverage is written by the Insurance Co. of North America of Philadelphia.

The fair is operated by a not-for-profit corporation, which leases, rather than owns, the fair site.

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Airlines to face steep rate hikes during renewals

By STACY SHAPIRO

LONDON—Airlines are facing sharp rate increases as they renew their hull and liability aviation insurance.

The airlines that already have renewed their coverage—including several U.S. carriers—have been socked with rate increases of up to 70% in the London market—and the vast majority of 1984 renewals have yet to be negotiated.

Aviation insurance experts also point out airlines probably will not be able to coax U.S. and French underwriters to undercut the rates set by London insurers, as they have done in years past. Tight capacity is forcing most airlines to increase the amount of coverage they place in the London market, even though the rates may be a bit higher.

For instance, Air Florida Inc. placed 36% of its coverage with London underwriters this year, up from 25% in 1983, even though the London insurers quoted hull and liability rate increases of 25%, according to London insurance sources (see story, page 31).

And Michael C. Shermer, vp of risk management at Federal Express Corp. in Memphis, Tenn., increased London's participation in his company's coverage to 40% from 35% last year, despite an 11% increase in hull coverage rates and a 40% hike for liability coverage.

Mr. Shermer noted that Federal Express did not find significantly lower rates in the U.S. insurance market, just tighter capacity, though he would not specify the rates quoted by U.S. underwriters.

One U.S. insurance source noted that rate increases from U.S. markets are mirroring the increases in London, calling the London aviation market a "barometer" for rates worldwide.

One London underwriter estimates that airlines with substantial loss records are being hit with average overall renewal rate hikes of 40%.

A. Kent Robinson, a senior vp at broker Johnson & Higgins in New York, says rate hikes in the London market are averaging 37.5% for hull coverage and 23.5% for liability coverage.

"We are certainly girding ourselves for severe terms out of the London market," he says.

Unlike past years when rate increases have tended to moderate as more airlines' programs were renewed, London aviation insurers say that rates may rise even higher as renewals continue.

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Insurers' sad song may play one more time

By JUDY GREENWALD

NEW YORK—The property/casualty insurance industry's operating results may sound like a broken record this year after playing the same old tune in 1983.

Intense price competition, the battle for market share and overcapacity again teamed up to boost the industry's underwriting losses last year while cutting deeply into operating income.

And, analysts and insurer officials say the industry will be singing the blues for most of this year, too.

While reinsurers and some specialty markets report that capacity is beginning to tighten and some rates are starting to rise (*BI*, March 5), analysts say any wide-scale firming in prices will happen too late in the year to have significant impact on insurers' operating results.

"It's going to be a stinker, to put it mildly," says Michael A. Lewis, a vp and analyst at E.F. Hutton & Co. Inc. in New York, who predicts widening underwriting losses and low levels of cash flow throughout 1984. "It's not going to be a good year for the property/casualty group."

Last year wasn't good for the insurers, either. According to *Business Insurance's* survey of major property/casualty underwriters:

- Underwriting losses grew 40.9% in 1983, a bit less sharply than the 58% hike in 1982. The surveyed insurers posted an aggregate underwriting deficit of $5.78 billion. And, only one of the surveyed insurers, The Hartford Steam Boiler Inspection & Insurance Co., managed to post an underwriting gain for the year.
- Likewise, the aggregate combined ratio, after policyholders' dividends, grew to 114.8% from 111.0% in 1982 and 107.4% in 1981.
- Investment income grew a moderate 12.5% to $6.26 million, compared with only a 9.2% increase in 1982. However, much of this growth was supplied by large gains at several companies, including USF&G Corp., American General Corp. and Fireman's Fund Insurance Cos.
- Net written premiums rose 5.2%, compared with just a 1.6% gain in 1982.
- However, net operating income, the insurers' bottom line, fell 10.4%, compared with a 9.6% decline the previous year. Only 12 of the 24 insurers reporting operating income results to *Business Insurance* managed to increase their profits.

James A. McIntyre, president and chief executive officer of Fremont General Corp., which reported the largest drop in operating income among the surveyed insurers, blamed the company's poor results on "bad underwriting experience including inadequate pricing, excessive claims and mismanaged business."

Mr. McIntyre expects Fremont to do better in 1984 because the company has "retrenched" in most of the lines that caused the negative impact, including reinsurance and general property/casualty lines.

Even the most successful of the surveyed insurers aren't that proud of their results in 1983 and don't convey much hope about the operating prospects for 1984.

"We see difficult times ahead, with a very

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ticker

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update

Limits on doctors' rates struck

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Shield, which contracts with an estimated 97% of the state's physicians.

The so-called "ban on balance billing" began in 1968 and is supported by state law, noted an opponent of the system, Dr. William Munier, executive vp of the Massachusetts Medical Society. According to that ban, doctors who have contracts with Blue Shield may only charge fees under the health plan's payment system.

"(Blue Shield) will vigorously contest any finding that the ban against balance billing is inconsistent with antitrust laws," said John L. Thompson, president of the Blue Shield of Massachusetts. The ban on balance billing will continue until the issue is resolved by a higher court or the Legislature, a company spokesman said.

Ford settles 'air bag' suit

BIRMINGHAM, Ala.—A $1.8 million out-of-court settlement last week between Ford Motor Co. and a woman injured in a Ford Pinto may be the first case in which the plaintiff sued because an air bag was not part of the car's safety features.

James Pratt, attorney for plaintiff Rebecca Burgess, says the case is the first that alleged a car was unsafe because air bags were not included. He also said internal Ford documents showed the car could have been made safer by installing air bags.

Mr. Pratt, of the Birmingham firm of Hogan, Smith Alstaugh, Samples & Pratt, said it was "hard to believe Ford was not concerned about going to trial" and that a jury verdict against the company would have had wide ramifications on all makers of cars. He added that the settlement could have a big impact on future suits.

"The air bag had nothing to do with settlement of the case," a Ford spokesman said. "The charge about the air bag is totally false."

Ms. Burgess suffered permanent brain damage following a front-end collision involving a 1975 Ford Pinto.

Disability law invalidated

LOS ANGELES—A Los Angeles District Court judge has ruled that a state law mandating employers to grant up to a four-month maternity leave to pregnant employees and to hold their jobs open is not valid unless those same disability benefits are available to men.

Judge Manuel Real supported the contention by employers that the 1978 law requires companies to offer preferential disability benefits to women on maternity leave they would not otherwise offer men on medical disability.

"The issue is preferential treatment vs. equal treatment," says George Sawyer, vp of legislation and programs for the California Chamber of Commerce, one of the plaintiffs in the suit against the the state Department of Fair Employment and Housing.

"Employers in California felt the leave policy was not in compliance with federal law," Mr. Sawyer said. They contended that under the Federal Civil Rights Act, women should not be granted leave for disability "by pregnancy, childbirth or related medical conditions" if men are not granted the same leaves.

ESCO to appeal tax ruling

PORTLAND, Ore.—ESCO Corp. will appeal a federal court ruling that it is not entitled to take tax deductions for reserves it established for workers compensation claims (*BI*, Jan. 2).

U.S. District Court Judge James Redden earlier ruled that ESCO, a privately held company with about 1,500 employees in Portland, could not take the deductions because it had not determined its liabilities with "reasonable accuracy."

Carnival covered for accident

SARASOTA, Fla.—Insurers of Blue Grass Shows Inc., a carnival based in Tampa, Fla., are expected to cover any claims that result from an amusement ride accident that injured 15 people on the opening day of the Sarasota County Fair last week.

According to initial safety reports, a car of the Super-Himalaya ride left the track after a cotter pin became loose. The car, which did not carry any passengers, struck a retaining wall, scattering debris on nearby spectators, only one of whom was hospitalized.

According to the state Bureau of Public Fairs and Expositions, Blue Grass Shows has a $1 million combined single-limit liability policy with Continental Casualty Co. in Chicago, a unit of CNA Financial Corp., and a $4 million combined single-limit excess policy with Granite State Insurance Co. of Manchester, N.H.

The ride was owned by an independent operator, according to James Murphy, president of Blue Grass Shows. He said the firm is checking if that operator has insurance, but expects to cover the accident under the carnival's policies.

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House expected to consider benefit proposals this week

By JERRY GEISEL

WASHINGTON—Benefit managers should keep their eyes on the House of Representatives.

The House this week is expected to begin consideration of a deficit reduction bill, H.R. 4170, which, among other things, would severely restrict the funding of tax-exempt 501(c)(9) benefit trusts (*BI*, March 19). The House vote could begin March 29.

Meanwhile, the Senate Finance Committee last week completed action on its deficit reduction bill, S. 2062. That increases the chances that the full Senate could take up its bill early next month.

Even though congressional consideration of the bills is far from over, the benefit provisions in the two measures already are very different.

Major differences in the benefit provisions contained in the two bills include:

- 501(c)(9)trusts. The House bill says reserves held by a trust cannot exceed 75% of the average benefits paid during an employer's previous and current years.

For example, if a trust paid $100,000 in benefits in 1983 and $150,000 this year, new contributions would be barred if they boost the trust's reserves to more than $93,750.

These restrictions would virtually wipe out the use of the trusts to fund employers' long-term benefit obligations, like long-term disability and post-retirement health care coverages, consultants say.

Many trusts that now provide LTD benefits maintain reserves of between 500% and 900% of the previous year's benefit payout, a reflection of the fact that LTD benefits may be paid to a disabled employee for many years.

By contrast, the only new restriction on 501(c)(9) trusts contained in the Senate bill would be to disqualify a trust if more than 25% of benefits go to key employees, such as those who own more than 5% of a company.

That restriction is aimed at small professional corporations that have allegedly been using the trusts as a tax-avoidance scheme.

A 501(c)(9) trust, named for that section of the Internal Revenue Code authorizing it, allows employers to receive tax deductions for contributions to the trust.

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Sedgwick to help pay bush fire loss

By STACY SHAPIRO

LONDON—Two Sedgwick Group P.L.C. units will join underwriters in paying about $75 million of the more than $100 million in claims pending against an Australian utility accused of starting massive bush fires.

The settlement, reached last week, ended an eight-week trial over who is liable for claims pending against the State Electricity Commission of Victoria (*BI*, Jan. 30).

Underwriters had refused to pay the claims against the SECV after they alleged the Sedgwick units—Sedgwick Ltd. and Sedgwick International Ltd.—misrepresented the risk and did not disclose all facts when they placed the utility's insurance in June 1982.

The SECV claimed that if underwriters did not pay the claims, Sedgwick should (*BI*, Jan. 30).

Under the agreeement worked out among Sedgwick, the underwriters and the SECV, the utility will receive a total of $75 million Australian ($72 million U.S.) from the brokers and insurers, less than the approximately $100 million it had requested.

Allan McDonald, an Australian attorney representing the SECV, told a London High Court last

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RIMS announces changes in conference schedule

NEW YORK—The 22nd annual Risk & Insurance Management Society conference is just a week away, and risk and benefit managers should note some schedule changes announced by RIMS.

Two miniseminars have been added to the conference to be held April 2-6 in New York City:

- M21.1, "Risk and Insurance Management in Brazil," to be held from 2:30 p.m. to 4:30 p.m. April 3.
- M76.1, "Systems Performance Insurance," which deals with debt insurance, to be held from 2:45 p.m. to 4:45 p.m. April 5.

Six other miniseminars have been canceled, according to RIMS:

- M17, "Employer Coalitions: How to Work Within the Spheres of Influence," scheduled from 2:30 p.m. to 4:30 p.m. April 3.
- M40, "Bonding and Risk Management," scheduled from 2:45 p.m. to 4:45 p.m. April 3.
- M56, "Investment Tax Credit Recapture Insurance," scheduled from 2:45 p.m. to 4:45 p.m. April 5.
- M61, "Ocean Marine Update," scheduled from 2:45 p.m. to 4:45 p.m. April 5.
- M64, "Legislative Advocacy—How to Be Effective," scheduled from 10:45 a.m. to 12:15 p.m. April 5.
- M74, "Nuclear Liability Exposures of Companies Selling to Nuclear Facilities," scheduled from 2:45 p.m. to 4:45 p.m. April 5.

Portions of two other miniseminars have been canceled. M67, "Planning for and Reacting to Catastrophe," and M77, "Coping With Stress in the Business World," both of which had been scheduled for both April 3 and April 5, will meet only April 3.

The topic of another miniseminar has been changed. M11, originally scheduled as "Nine Steps to a Workable Flexible Benefits Program," instead will provide an update on regulations governing flexible benefit plans.

RIMS also reports that contributions to the Spencer Foundation fund-raising reception that will kick off the conference have reached $76,100 (*BI*, Feb. 20).

Sponsors that have donated at least $5,000 include General Re Corp.; Johnson & Higgins; the New York, Atlanta and Minnesota RIMS chapters; Fred S. James & Co. Inc.; Marsh & McLennan Cos. Inc.; *Business Insurance*; American International Group Inc.; and

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Broker settles suit for $1.3 million

By STEVE TARAVELLA

NORTH HOLLYWOOD, Calif.—San Francisco-based Kindler & Laucci Insurance Brokers is paying $1.3 million to a North Hollywood-based brokerage to settle a 5-year-old unfair competition lawsuit.

The August 1979 suit accused Kindler & Laucci, now a subsidiary of E.H. Crump Cos. Inc., of improperly receiving business from William W. Holdren after he left McCord & Holdren, the North Hollywood brokerage, in October 1978.

McCord & Holdren also sued Mr. Holdren in a separate action that charged he violated a non-compete agreement by diverting accounts to Kindler & Laucci. That suit was settled in 1979.

The non-compete agreement and an employment contract prevented Mr. Holdren from soliciting business from McCord & Holdren clients for six months after leaving the firm, says Jerry L. McCord, president of McCord & Holdren. Mr. McCord had been Mr. Holdren's business partner for some 13 years.

Mr. Holdren would not comment on the dispute.

Kinder & Laucci made no admission of wrongdoing in agreeing to the settlement, and maintains its position that the company is not liable.

"The settlement will have no effect on our current operating results and, in fact, will eliminate some of the contingent liabilities for the Crump organization," reads a statement prepared by the company shortly after the settlement was reached last month.

Kindler & Laucci also maintains that Mr. Holdren said he was not bound by a non-compete agreement.

The brokerage is funding the award through reserves originally set aside for the case by Reliance Insurance Co., from whom Crump purchased Kinder & Laucci in October 1981, says William B. Mallory, Crump's vp and general counsel in Memphis, Tenn.

The suit raises two important issues affecting insurance agencies and brokerages, according to observers:

- Can an agency or brokerage assume business from a new employee who produced the accounts at another firm without compensating the former employer?
- What are the responsibilities of an agency that assumes business from a new producer if that person is being sued by his former employer?

Mr. Holdren was vp, corporate secretary and a 50% shareholder of McCord & Holdren when he left the company to join Kindler & Laucci's Long Beach, Calif., office in October 1978, taking with him several key employees and about 100 clients, according to Mr. McCord.

The clients, many of whom were trade associations, represented commissions of about $750,000; McCord &

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Benefit sleuths discover bogus health claims

By SALLIE J. DRURY

The health care claim didn't look that unusual at face value.

The charges were not extraordinary; the listing of services rendered seemed to be in order. And, it wasn't even that uncommon for the claim to direct payment to the insured rather than the health care provider, since the provider may have required immediate payment.

But, since the claim was for more than $500, the administrator set it aside. Claims for more than $500 with payment directed to the insured must be verified.

That verification process uncovered an alleged fraud involving more than $20,000 by an employee of a self-insured government entity with 42,000 workers. The entity's administrator, Aetna Life Insurance Co. of Hartford, Conn., sniffed out the discrepancy through the investigative action of its Fraud Squad.

"Fraud is costing the insurance industry about $20 billion a year, and that represents 10% to 20% of each individual premium," said James L. Garcia, manager of the Fraud Squad.

"That $20 billion is about 6% of the total cost of health care; so for self-insured companies, it's about 6% of their costs."

Graphic: Amy Palmer

Although insurers and administrators can only guess at the amount of fraud that exists since no one can tell how much goes undetected, several experts speculate that between 3% and 10% of all claims are intentionally discrepant.

Aetna, as well as other insurers and administrators, is serious about the subject of fraud. "We're not in the business of forgiving felonies," Mr. Garcia said. "The Fraud Squad was established in June 1982, and we have 100% convictions so far on the cases that have been settled."

But, the case involving the public entity was discovered earlier this year and has not been settled.

"The employee is still working for us, since we have the authority to administer benefits, not to hire and fire, although that may be tested by the time we are through with the case," the benefits manager for the entity said.

In addition, Aetna turned up another case for the entity, involving husband and wife employees. In this case, the couple allegedly falsified small drug and office visit bills amounting to approximately $3,500. The discrepancy was detected when a pediatrician was shown providing services for an adult.

Although the amount of money is "not huge," the case is being pursued on principle, the benefits manager said. "Together, the two cases add up to about $25,000, but the issue is the manner in which the money was taken," she said.

Most benefit managers admit they do not actively discover fraudulent claims, relying instead on their insurers or administrators to do the sleuthing.

"It's really up to the carrier to monitor (for fraud)," said James R. Russell, benefits manager for S.C. Johnson & Son Inc. in Racine, Wis.

"We had a problem with fraudulent medical claims seven or eight years ago. At that time claims came through our office before they were sent to the carrier, but still it was the carrier that actually caught the potential fraud."

"Our administrator guards against duplicate coverage, that sort of thing, for us," said Karen B. Stral, supervisor of group insurance administration for Square D Co. in Palatine, Ill.

"We are pretty well-controlled through the carrier," said Glenn W. Witt, corporate staff vp and director of personnel for Meredith Corp. in Des Moines.

"We think we have pretty good controls, and our auditors audited our administrator and were very pleased," said Robert Penzkover, director of employee benefits at Quaker Oats Co. in Chicago.

Nevertheless, insurers and administrators say employers can join in their efforts to prevent and detect fraud.

"Education is obviously the starting point," said Robert J. Cardinal, president and chief executive officer of Mass Insurance Consul-

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Trust fund proposed for Manville claimants

By STEPHEN TARNOFF

NEW YORK—The latest plan for compensating victims of asbestos-related diseases who have sued Manville Corp. includes setting up a trust fund on their behalf.

Active discussions among the committees representing asbestos plaintiffs, unsecured creditors and Manville are under way on what is known as the Jamison plan.

"Right now it is very hot," said Arthur Olick, an attorney with the New York firm of Anderson Russell Kill & Olick who is representing Manville's co-defendants in asbestos litigation.

The plan, which no one will say much about and which is not spelled out in any court documents, was suggested by John Jamison, dean of the School of Business Administration at William & Mary University in Williamsburg, Va. He also is a member of the unsecured creditors committee representing Goldman Sachs & Co.

Mr. Jamison declined to comment on the proposal but apparently several variations are being considered.

One variation calls for establishment of a trust fund and the appointment of a board or several boards of trustees to administer it on behalf of asbestos claimants.

The trust would hold a certain percentage of Manville stock and claimants would be compensated from dividends paid on the stock.

Another variation is to set up a trust that would control 80% of Manville stock and hold a convertible debenture issued by Manville for the value of the shares. Manville would pay interest on the note, which would be used to finance asbestos claims.

Manville, plaintiffs' attorneys and unsecured creditors have discussed the trust fund concept and plaintiffs' attorneys and unsecured creditors reportedly reached an agreement in principle on the idea.

The attorney for the asbestos litigants—Robert J. Rosenberg of the New York firm Moses & Singer—declined to comment on the negotiations, other than to say the status was "very fluid."

He did not deny, however, that plaintiffs and unsecured creditors have an agreement in principle. "That (whether there is an agreement in principle) goes awfully far," he said last week. "It wouldn't be completely wrong and wouldn't be completely right."

At least one faction of plaintiffs' attorneys is strongly opposed to the trust fund plan.

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Hospitals, doctors banding to lower malpractice costs

By LEN STRAZEWSKI

NEW YORK—When hospital administrators and their attending physicians join forces, lower medical malpractice insurance rates and lower claims costs could be the reward.

At least that's what administrators at Lenox Hill Hospital and North Shore Hospital in New York and the two St. John's Episcopal Hospitals on Long Island are hoping. And they will be joined in their experiment by Cabrini Hospital in New York and Staten Island Hospital April 1.

These hospitals are among several New York health care facilities that have stopped self-funding their medical malpractice risks and instead are purchasing group medical malpractice coverage from commercial insurers. However, these new groups include not only other hospitals but physicians at the participating facilities, too.

'(A) lack of cooperation eventually leads to higher awards,' Mr. Dangelo says.

To build an attractive premium volume for insurers as well as refine risk management tactics, the hospital/doctor groups are combining coverage for the hospitals, staff and many of their attending physicians under a single primary liability policy followed by layers of excess coverage.

The total coverage, topping $200 million for the Lenox Hill group, surpasses limits previously offered to the hospitals and attending doctors under individual plans.

Cost savings under the Lenox Hill group's three-year, no-cancellation and no-deductible policy underwritten by National Union Fire Insurance Co. of Pittsburgh, Pa., and 14 other liability insurers, are expected to be "substantial," according to Michael D. Dangelo, assistant general counsel and risk manager for Lenox Hill Hospital, a 690-bed facility.

But the real economy will come from the lower legal expenses and fewer jury awards that the hospitals expect from a united risk management approach, he says.

"Generally, hospitals and attending physicians purchase medical malpractice insurance separately," explains Mr. Dangelo. "That means that whenever there is a malpractice lawsuit, the hospital, staff and attending doctors are named co-defendants and are represented by several attorneys from several insurance companies. The legal fees involved in a such a lawsuit are tremendous."

Defense tactics also vary among attorneys, frequently confusing juries and leading to "finger pointing" among the co-defendants, he remarks.

"Each attorney wants to do the best he or she can for his or her clients," Mr. Dangelo says. "That means that each defense tries to lay off the responsibility to another co-defendant. It is our feeling that this lack of cooperation is felt by juries and eventually leads to higher malpractice awards.

"By channeling the defense, having all the defendants represented by the same counsel and working together, we believe that jury awards could be reduced, leading to lower malpractice costs for everyone," he says.

"And it looks like our brokers and insurers are willing to go along with us and prove that this philosophy works."

The real test, Mr. Dangelo says, will come as

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Divide asbestos awards by market share: Court

By STEVE TARNOFF

MIAMI—A Florida appellate court is the first appeals court in the nation to adopt the market-share theory of liability in asbestos litigation.

In *Copeland vs. Celotex Corp.*, the Third District Court of Appeals ruled that defendants in asbestos-injury lawsuits are required to apportion liability and damages according to their share of the total market.

The apportionment applies even though plaintiffs cannot identify which company's product caused their injuries, the decision written by Judge James R. Jorgenson said.

The decision follows, with technical modifications for asbestos, the ruling in *Sindell vs. Abbott Laboratories*, a landmark California Supreme Court decision that first used the market-share theory in a suit involving the anti-miscarriage drug DES.

The Florida decision, handed down March 6 by a 2-1 margin, overturned a lower court ruling that dismissed the plaintiffs' case in part because they failed to allege exposure to a product manufactured by Celotex Corp.

The decision now goes to the state supreme court, at the urging of the appellate court, to determine if the market-share theory applies in Florida.

The suit against Celotex and 15 other manufacturers and distributors of asbestos was brought by Lee Loyd Copeland and his wife, Vaudeen, under theories of negligence, implied warranty and strict liability.

Mr. Copeland, suffering from asbestosis and cancer, was exposed to asbestos insulation products during installation and "rip-out" operations, but he said that the products' brand names were unidentifiable after removal from their original containers.

He sued the manufacturers and distributors that as a group supplied "virtually all" of the asbestos products to which he was exposed.

Celotex, meanwhile, alleged that the complaint was insufficient because it did not link a Celotex product to Mr. Copeland's injuries.

The appellate court agreed that the plaintiff ordinarily has the burden of proving that a particular defendant caused the harm, but that this would not apply in asbestos cases.

The court noted that this traditional theory of causation isn't realistic in light of scientific and technological advances that create harmful products which can't be traced to a specific producer.

Noting that it could rely on prior tort doctrine that would effectively deny recovery to those injured by such products or "fashion remedies to meet changing needs," the court chose to create a new remedy.

"The response of a state of Florida's prominence at the close of the 20th century must be to choose the latter path," the court said.

In its decision, the court relied on Sindell and *Hardy vs. Johns-Manville Sales Corp.*, a federal court decision that also applied the market-share theory in an asbestos case, but was later overturned on other grounds.

The Sindell decision said the market-share theory was in part appropriate because it was more just for negligent defendants to bear the cost of the injury than innocent plaintiffs, particularly where there is a delayed effect of the injurious product, the Florida court commented in its opinion.

In addition, Judge Jorgenson noted the Sindell decision said it was reasonable to

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Broker settles lawsuit for $1.3 million

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Holdren generated about $3.6 million in commissions annually at that time, he estimates.

According to Mr. McCord, Mr. Holdren went to the brokerage's offices over a weekend, loaded some 35 boxes of client records and files into his van and left.

The files that Mr. Holdren took were all for property and casualty accounts, though some of them included group health and other benefit-related coverages, says Mr. McCord, who calls the accounts "some of the cream of the business.

"I immediately began trying to get them back because they were the property of the company, not his own," Mr. McCord says.

Officers of a company depart with valued papers more frequently than most people realize, notes David Daar of Miller & Daar, the Beverly Hills law firm representing McCord & Holdren. "But this is something of a first. It doesn't appear anyone (before this) has really challenged the right of agencies to use the producer as a ready source of business.

"If the case had been tried, the issue of interest to the industry may have sounded a note of caution as to whether insurance agencies can be held accountable under well-recognized principles of law, applicable to so-called unfair competition and trade secrets," notes Mr. Daar.

After he took the records, Mr. Holdren was fired as a McCord & Holdren employee, but retained his position as one of the company's directors because of his 50% share of the company's stock, Mr. McCord says.

Mr. McCord succeeded in obtaining a temporary restraining order on Nov. 6, 1978, which required that Mr. Holdren return the papers. McCord & Holdren notified Kinder & Laucci's executive officers in San Francisco of the action against Mr. Holdren, and threatened to sue the company if Mr. Holdren solicited business from McCord & Holdren clients.

Mr. McCord says that Mr. Holdren used loopholes in the restraining order to continue to handle the accounts he had carried away, but that a preliminary injunction issued on Dec. 26, 1978, barred him from working as a producer.

In May 1979, Mr. Holdren reached a settlement with his former employer. He agreed to give up his 50% stake in McCord & Holdren, resign as a director of the company and make "certain other individual settlements to my benefit," Mr. McCord says.

Under that settlement, Mr. Holdren could conduct business, again, but was prevented from contacting any of McCord & Holdren's approximately 4,000 clients, with the exception of the 100 accounts he originally brought to Kindler & Laucci.

Mr. Holdren has since filed a motion in Los Angeles County Superior Court to dissolve or modify the permanent injunction barring him from soliciting business from other McCord & Holdren clients on the grounds that it violates state business competition statutes, says Crump's Mr. Mallory.

After its suit with Mr. Holdren was settled, McCord & Holdren filed suit against Kinder & Laucci, seeking the return of alleged photocopies of certain files and an unspecified amount in damages suffered because of alleged improper business practices.

Kindler & Laucci claims Mr. Holdren told the company that he was not bound by a non-compete agreement, says David Hoskins, vp and manager of the company's Long Beach office where Mr. Holdren now works. Mr. Hoskins adds that McCord & Holdren's letter informing Kindler & Laucci of the agreement was assumed to be only a standard notice usually sent by brokers when a salesman leaves.

McCord & Holdren's business suffered when Mr. Holdren left, Mr. McCord notes, explaining that the brokerage staff was reduced to 40 today from 120 in January 1978.

"His leaving had a very major negative effect; it's taken us several years to recover," Mr. McCord says.

About 6% of the clients that Mr. Holdren took to Kinder & Laucci have returned to McCord & Holdren, he notes.

In May 1982, McCord & Holdren began operating as Pridemark McCord & Holdren. In light of the long legal battle, why would the brokerage agency retain Mr. Holdren's name?

"That's a good question," Mr. McCord says. "We just have a great deal of money, time and effort put into the image of McCord & Holdren, which is widely known." ■

Manville trust fund

Continued from page 3

Attorney George Rosenberg with the Los Angeles firm of Green O'Reilly, Agnew & Broillet said he was "vehemently against it," and that the trust fund concept was a "modification of the M1-M2 plan" and impairs the rights of future and present claimants.

Manville's M1-M2 plan calls for spinning off a new company (M2) that would retain the company's non-asbestos business and provide the cash for funding Manville's asbestos liabilities.

Another company (M1) would retain the company's asbestos liability and the right to the company's insurance proceeds.

Cash from the company's U.S. operations would be split with 50% going to M1 for asbestos victims and 50% to M2 to pay commercial creditors.

Mr. Rosenberg, whose clients include about 800 present claimants and also the Los Angeles Unified School District, said such a plan would be "unethical, immoral and unconstitutional.

It's a modification of an old song," he said.

Mr. Rosenberg added that part of the reason some plaintiffs' attorneys appear to support it stems from recent rulings by U.S. Bankruptcy Court Judge Burton R. Lifland that were adverse to the plaintiffs' positions.

He ruled that Manville's petition for reorganization was not in bad faith and that future claimants had interests in the bankruptcy.

Asbestos litigation co-defendants, which recently were allowed to form an official creditors committee by Judge Lifland, have not been invited to participate in any of the trust fund negotiations, Mr. Olick of Keene said. They have received indications that they will be brought in eventually, he added.

Manville filed for reorganization Aug. 26, 1982, under federal bankruptcy laws because of overwhelming asbestos litigation. All litigation against it was stopped and about 23,000 claims are pending against it. ■

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opinions

Act–before it's too late

BE WARNED CEOs, treasurers and risk managers concerned about Congress' plan to change the rules for accrual accounting by amending the decades-old "all-events" test governing tax deductions for reserves set up for current liabilities to be paid in the future:

There's not a lot of time left to dally.

If you want to mount a lobbying effort against passage of the proposal contained in deficit reduction bills pending in both the House and Senate (H.R. 4170 and S. 2062), you will have to move full steam ahead immediately.

The House is expected to begin voting on its revenue-raising bill March 29 and the Senate could start its debate as early as next week.

Furthermore, although much of our reporting on the proposal has centered on how the bill would bar deductions for self-insured workers compensation reserves, thus eliminating the effectiveness of a valuable risk-funding alternative, the impact of such a bill on business would be much more widespread.

What Congress proposes is to replace the all-events test with an economic performance test that would bar deductions for liability reserves until an employer's liability actually is discharged by payment.

This would affect not only funding for self-insured workers compensation risks but also any self-insured reserves established to pay liabilities that now pass the all-events test.

Incidentally, although some have raised concerns that this bill also would affect payments into 501(c)(9) trust funds for group medical and long-term disability coverages, it will not. The pending bill states it will not disrupt deductions for reserves that are otherwise authorized by the tax code.

Nonetheless, this pending change in tax accounting should concern not only the risk management department but the accounting department and indeed top management, too.

And, any risk manager or treasurer who thinks his or her CEO may not be aware of this legislation should inform the boss now, so he or she won't be surprised in a few months should the proposal become law.

We note that the National Council of Self-Insurers, the Risk & Insurance Management Society and the National Assn. of Insurance Brokers have made efforts, to varying degrees, to fight the proposal. But, we strongly urge them to step up their defense of the all-events test and do all that they can before Congress hastily overhauls this tax accounting rule.

Mea culpa

IN THE MARCH 12 issue, we handed down to you the Ten Commandments of controlling health care costs. Now we remind ourselves of one of the key commandments of journalism: Thou shalt watch thy language and choose thy words carefully.

Yes, the seventh commandment should have read: Thou shalt reward the thrifty. Not the spendthrift! We want to thank everyone who pointed out our error and assure you we are repenting for our sin.

The only way we would want to see anyone reward the spendthrift is with higher health care deductibles, higher copayments and a larger share of premiums costs.

letters

Solution to reduce litigation would create more

To the editor: In your editorial, "Combating Courtroom Abuse" (*BI*, Feb. 27), you favor a proposed federal court rule to empower a trial judge to assess costs, including attorney's fees, against a plaintiff who recovers a verdict for less than the defendant's settlement offer. You see this rule as a way to discourage prosecution of weak cases and outrageous demands.

You ought to consider the reverse side of that rule; if a defendant is required to pay the plaintiff's attorney's fees when its offer is less than the amount of the verdict, then insurers of defendants may find the rule more costly than beneficial.

A trial judge is far more likely to impose penalties to be paid by a defendant's insurer than by an uninsured plaintiff, particularly one who has been damaged, albeit to a lesser degree than he had thought.

You suggest that judges will not assign court costs when the suit is continued in "good faith." I believe the proposed rule would permit imposition of sanctions against a party that has refused settlement out of ignorance, false hope or poor judgment, though he acts in complete good faith.

In any case, 10 years of litigation have proven that good faith and bad faith are difficult legal concepts, and that the last thing we need is more litigation over what those terms mean.

I believe that the problem of frivolous plaintiffs' litigation is overdrawn, that the scales of justice are not in any danger of collapse and that the problem will be resolved by the natural process of change in public attitude. That process is a far more effective control than tampering with our rather successful system of civil justice.

George W. Roussos
Cullity & Kelley
Manchester, N.H.

Computer specialists can be consultants, too

To the editor: Congratulations on your excellent Spotlight Report on "Risk Consultants: Large and Small." I'm delighted to see that the definition of risk management "consultant" now is expanding to include specialty firms that provide risk management information systems and the attendant "consulting" that goes with the design, developing, implementation and operation of a full feature risk management information system.

In growing up with this business, we have traditionally thought of consultants as "those other learned professionals." Now we are delighted to find that we also are included among this broader interpretation.

We failed to respond to your risk management consultants questionnaire and perhaps too modestly told your very cordial staff member who phoned that we were simply not "consultants." Apologies for our being so shortsighted. Corporate Systems' revenues for 1983 were just in excess of $10 million. Our 170 employees operating in two branches serve the risk information needs of slightly more than 1,600 accounts in the United States, Canada and Australia. Approximately 90% of our revenues are derived from continuing services, while approximately 10% are earned through special system design, consulting and programming services.

Guyon Saunders
Corporate Systems
Amarillo, Texas

Dollars vs. pesos

To the editor: In the Perspective article, "Colombia Mandates Earthquake Coverage" (*BI*, Feb. 6), you mention the deductible of 2%, which carries a minimum quote at $10,000. I am sure many of your readers will assume this is $10,000 U.S., but the dollar sign is also used in this country to mean the Colombian peso, currently standing at 91 to the dollar.

In all our reports, we expressly state if an amount is in U.S. dollars or Colombian pesos to prevent misunderstanding between two different currencies.

Bernard James
National Technical Director
DeLima & Cia.
Bogota, Colombia

Are FSAs cost-containment tools?

To the editor: In the Feb. 27 issue, the article by Jerry Geisel on employers' defense of flexible spending account programs quoted Peter Hutchings of Kwasha Lipton as saying: "Flexible benefit techniques have proven to be one of the most effective tools in controlling health care costs."

I am very curious about the factual base for such a conclusion and wished that the story would have mentioned factual data, however limited, to support such a finding.

The logic of a flexible spending account does not necessarily support, in some quarters, the hope of a remedial effect on the incessant increase in employers' health care costs.

Ralph N. Galascione
Principal
Westland Benefits
San Diego

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Divide asbestos awards by market share: Court

Continued from page 3
measure the likelihood that any of the defendants supplied the defective product by what percentage of the entire industry's production of the product was sold by each.

"Thus, if a manufacturer supplied 7% of the entire production of the defective product, it would bear 7% of the total liability to a given plaintiff," the Florida court opinion said

Quoting the Hardy decision, the court also said that the market-share theory should apply because it was impossible for the plaintiff to isolate the precise exposure or identify the manufacturer's product that caused the disease.

It also added that the market-share theory is fairer to smaller producers.

In a partial dissent, Judge Joseph Nesbitt cited several reasons why the market-share theory should not apply in this case or in general.

For one, Sindell involved a case where the plaintiff could not identify any manufacturer that caused its injury. In this case, the plaintiff could identify several products he used, Judge Nesbitt said.

"Where, as here, the plaintiff is able to identify at least one manufacturer who caused his injury, the reasons for imposing market share liability do not exist," Judge Nesbitt said.

In addition, Judge Nesbitt said that the market-share theory does away with one of the fundamental bases of tort liability—causation and fact—and also brings into play a number of practical problems that cannot be overcome.

> 'I'm certain (the Florida Supreme Court) will decide to overturn it,' Mr. Jordan-Holmes says.

"I find that there are so many difficulties with the allocation that it cannot be said that any manufacturer's liability would approximate the damages he has caused," the judge added.

He said the court failed to define what a substantial share of the market is, what the relevant market would be and how to interpret the defendant's ultimate liability.

Finally, Judge Nesbitt said that the philosophy behind the decision —that it is better to favor innocent plaintiffs over proven wrongdoers —is not satisfied since the connection between actual harm and the alleged wrongdoing is too tenuous.

"Relieving the plaintiffs of the burden of identifying the actual tortfeasor encourages the injured party to become lazy," the judge added.

"There is no motivation to seek the truth; as a matter of fact, in some situations it would be better for the plaintiff not to identify a particular defendant.

"The end result, of course, is that plaintiffs involved in industrywide litigation fare better than the ordinary injured party who must take his defendant as he finds him," he said.

An attorney for Celotex called the decision "very unusual," partly because the appellate court decided, without being urged by either side, that the market-share theory should apply.

In fact, both plaintiffs and defendants had agreed that the Sindell decision should not apply, said Clark Jordan-Holmes, an attorney for Celotex with the Tampa firm of Shackelford, Farrior, Stallings & Evans.

"I'm certain they (the state Supreme Court) will decided to overturn it," Mr. Jordan-Holmes added. "I don't think Florida will ever adopt Sindell."

Plaintiffs' attorney Louis S. Robles of the Miami firm of the same name, said the decision is very significant as it relates to burden of proof.

Mr. Robles also said that the decision does not require plaintiffs to follow the market-share theory if other theories of liability are available.

Although the appellate court urged the supreme court to take the case, the defendants still are required to initiate an appeal. Celotex is expected to do so.

Mr. Jordan-Holmes said he was "almost positive" that the high court will take the case, noting that it almost never turns down a case certified by an appellate court.

Defendants originally named in the case include Armstrong World Industries Inc., The Flintkote Co., GAF Corp., Owens-Corning Fiberglas Corp., Owens-Illinois Inc., Johns-Manville Sales Corp., Eagle-Picher Industries Inc., Combustion Engineering Inc., H.K. Porter Co. Inc., The Celotex Corp., Raymark Industries Inc., Unarco Industries Inc., Pittsburgh Corning Corp., Nicolet Industries Inc., Fibreboard Corp. and Keene Corp.

Some of the defendants have settled out of the case, Mr. Robles said. ■

RIMS announces schedule changes

Continued from page 2
Royal Insurance Co.

Donors that have contributed from $2,500 to $5,000 include GAB Business Services; Kemper Group; Reed Stenhouse Cos. Ltd.; Bayly, Martin & Fay International Inc.; Rollins Burdick Hunter Co.; Atlantic Mutual Cos.; The Hartford Steam Boiler Inspection & Insurance Co.; and National Underwriter Co.

Other parties contributing to the reception include Alexander & Alexander Inc.; Frank B. Hall & Co. Inc.; Woodrow B. Anderson; Rita Epstein; P. Richard Hackenburg; Ron Judd; Mike Maliavsky; James C. Newton; Charlotte Spencer; Jeane P. Thomson; the Los Angeles RIMS Chapter; the Society of Property & Casualty Underwriters; Crawford & Co.; Ashford Holding Corp.; Risk Planning Group Inc.; A.M. Best Co.; and Edwin Knetzger.

RIMS has pledged $75,000 to sponsor the reception. All excess funds will be turned over to the Robert S. Spencer Memorial Foundation scholarship fund, which provides funds for college students majoring in risk management and insurance studies.

To contribute to the fund, or for more information, contact RIMS at 212-286-9292 or Spencer Foundation President James C. Newton at 404-658-9000.

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Becker to succeed Lalley as Ideal Mutual president

comings & goings: industry

B. Frederick Becker has been appointed president and chief executive officer of New York-based Ideal Mutual Insurance Co. and subsidiary Optimum Holding Corp.

Mr. Becker succeeds **Edward P. Lalley,** president and chairman of Ideal Mutual and Optimum, who is retiring. Mr. Lalley continues in his post as chairman until the May 16 annual meeting.

Mr. Becker joined Ideal Mutual and Optimum in 1982 and was vp of benefits and financial services and corporate secretary prior to his recent promotion.

Before joining the companies, he was president of McDonough Caperton Benefits Group.

In a related matter, **John E. Quinn**, executive vp-sales of both companies, was named vice chairman of Ideal Mutual Insurance Co. In addition, Ideal Mutual/Optimum says **Fred L. Packer,** executive vp of both companies, has resigned.

Other insurer changes:

Friend R. Nagle elected vp of Fidelity & Deposit Co. in Baltimore. He will head the F&D surety bond department. Mr. Nagle had been assistant vp at the company.

Carolyn L. Tomecek appointed vp of field operations for CNA Insurance Cos. in Chicago. Ms. Tomecek is responsible for field business, customer services, including claims and loss control, and all field services. She had been vp-administration at CNA.

Walter H. Hallowell appointed senior vp in charge of sales, underwriting and administration for the domestic property/casualty operations of Continental Corp. in New York. Mr. Hallowell is responsible for the agency, field administration, productivity research and development, sales management and domestic home office underwriting departments. He was previously vp and manager of Continental's Eastern region.

In addition, **Donald O. Scruggs** named vp/manager of the Eastern property/casualty region for Continental Corp., located in Livingston, N.J. Mr. Scruggs had been vp in charge of personal lines at the group coverage home office in Piscataway, N.J.

Terence L. Russell elected president of the insurance division of Ryder System Inc. in Coral Gables, Fla. The division includes Southern Underwriters Inc., a managing general agency, and Capital Assurance Co., a reinsurer. Mr. Russell was most recently a senior vp-development at the company.

Agents/brokers

Alexander Irvine promoted to executive vp and director of property/casualty services for Corroon & Black of Illinois Inc. in Chicago. He joined the company in 1977 and was most recently deputy director of property/casualty services.

Other suppliers

Richard S. Betterley appointed president and chief executive officer of D.A. Betterley Risk Consultants Inc. in Worcester, Mass. He formerly was a senior consultant. In addition, **Delbert Betterley** named chairman of the firm. Delbert Betterley, who had been president, retains his post as principal consultant.

George M. Ruddy joined Edward R. Reilly & Co. Inc. in New York, an adjusting firm, as vp and senior adjuster.

Carol J. King, Thomas F. Martucci and **James L. Smith Jr.** have been elected principals with Towers, Perrin, Forster & Crosby's reinsurance division. Ms. King is in the Eastern treaty department in Philadelphia. Mr. Martucci is a member of the property facultative department in Hartford, Conn., and Mr. Smith is in the Western treaty department in San Francisco.

James L. Anderson promoted to senior vp of Hayes & Associates, a Booke & Co. subsidiary, in Winston-Salem, N.C. Mr. Anderson serves as a consultant and director of program development at the company.

Excess/surplus

Robert Tiemeyer named vp and manager of the Houston office of Geo. F. Brown & Sons Inc. Mr. Tiemeyer had been with a Houston insurer. Brown is a wholesale special risk property/liability brokerage. ■

comings & goings: buyers

Robert J. Montes named Walgreen benefit manager

Robert J. Montes was appointed manager of benefits at Walgreen Co. in Deerfield, Ill. Before his promotion, Mr. Montes was coordinator of organization planning at Walgreen, which he joined in 1980. He replaces **Ellen Friedman,** who joined Ameritech Corp.

Mr. Montes

Mr. Montes earned his bachelor of science degree at Marquette University in Milwaukee in 1978. He also earned a master of education degree in industrial psychology from Springfield College in Springfield, Mass., in 1979. Mr. Montes reports to Madeleine Palmieri, Walgreen's corporate manager of compensation and organization planning.

* * *

Sun Chemical Corp. in Fort Lee, N.J., has named **Ernest J. Reach** manager of employee benefits. In this new position, Mr. Reach will plan, develop, evaluate and maintain the life, disability, health, dental, pension and retirement programs at Sun. Before joining the chemical company, he was manager of employee benefits at U.S. Industries in Stamford, Conn. Mr. Reach received his bachelor of science degree from Upsala College in East Orange, N.J., in 1953. He reports to Jesse Battino, assistant director of personnel.

Mr. Reach

* * *

Steven R. Sershen was promoted to employee and benefits manager, a new position, at Steiger Tractor Inc. in Fargo, N.D. In that position, Mr. Sershen develops and administers benefit plans and directs employment activities at Steiger. He had been an insurance specialist at the company, which he joined in 1981. He graduated from Moorhead State University in Moorhead, Minn., in 1977 with a bachelor of arts in business administration. He has earned the Chartered Life Underwriter designation and is a Chartered Financial Consultant. Mr. Sershen reports to Jerome Sullivan, Steiger's vp and controller.

* * *

Nancy Reppert is now risk manager of Pinellas County, Fla., in Clearwater. She is responsible for all county insurance programs, loss-control programs and workers compensation. Ms. Reppert had been the risk manager for the city of Dallas. She replaces **Robert J. Ellis,** who is the first executive director of the Colorado Intergovernmental Risk Sharing Agency in Denver. Ms. Reppert attended the University of Arizona in Tucson. She is also a certified legal assistant. Ms. Reppert reports to Robert LaSalla, chief assistant city administrator.

* * *

Terry C. Renwick has joined Hillenbrand Industries Inc. in Batesville, Ind., as risk management claims manager, a newly created position. He had been workers compensation and liability claims supervisor for the states of Michigan and Indiana at American States Insurance Co. in Indianapolis. He earned his bachelor of science degree from Central Michigan University in Mount Pleasant, Mich., in 1972. He also has earned the Chartered Property & Casualty Underwriter designation and the Associate Claims Certificate. Mr. Renwick reports to H. Jay Varner, Hollenbrand's director of risk management.

•

Business Insurance would like to report on any staff changes in your company's risk management, safety or employee benefits department. Just drop a note to Claudette Dampier, Assistant Copy Editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611, or call 312-649-5282. Please send a photograph, too.

West Virginia rejects comp amendment

CHARLESTON, W.Va.—A 1983 West Virginia law that softens the effects of a 1978 state Supreme Court decision, which allows injured workers to sue their employers in addition to receiving workers compensation, remains intact after an attempt to amend the law failed.

S.B. 728, introduced by Sen. John "Si" Boettner, D-Charleston, would have allowed injured employees to seek punitive damages when suing their employers. However, the bill failed to move out of the Senate Judiciary Committee before the Legislature adjourned March 10.

The Supreme Court, in Mandolidis vs. Elkins Manufacturing Co., ruled that injured employees who receive workers compensation benefits may sue their employers if it can be shown that the employer's "willful, wanton and reckless disregard for safety" led to the injury.

around the states

Since that ruling, more than 250 individual suits seeking more than $5 million have been filed (*BI*, Aug. 30, 1982).

To combat the effects of the high court ruling, the Legislature passed a law in 1983 that says suits against employers would be dismissed if they did not meet one of two tests that would prove that the employer deliberately exposed the worker to an unsafe condition (*BI*, Feb. 14 1983; Jan. 7, 1983).

That law was based on recommendations of a special business/labor commission. Sen. Boettner said that, at the last moment, the commission deleted provisions that would have allowed injured workers to seek punitive damages.

"I disagreed, but I felt I had to uphold the recommendations," he said. The senator believes that without punitive damages, safety laws have no teeth.

Difference of opinion

PROVIDENCE, R.I.—The National Council on Compensation Insurance is asking for an average 30% increase in workers compensation rates in Rhode Island, while the Insurance Division of the state's Department of Business Regulation thinks a reduction is in order.

"Our actuarial analysis shows rates should be increased, not decreased," said Peter Burton, director of government affairs for NCCI's Northeast region in Bloomfield, Conn. According to that analysis, rates should be increased an average 87.8%, he said, but the NCCI filed for increases averaging only 30%.

A hearing on the rate proposal, which has a proposed May 1 effective date, has not been set, but the NCCI will be among those that testify at a March 27 hearing, called by the Insurance Division to determine if rates should be reduced instead of increased.

A 1982 amendment to the state's workers compensation law, which among other things increased benefits and established a back-to-work program, was supposed to cause rates to drop, Mr. Burton said, explaining why the Insurance Division has called the hearing.

The last change in Rhode Island's workers compensation rates was in September 1982, when a 21% increase was approved.

Small group rates

TRENTON, N.J.—Premium rates on small group, as well as individual, Medicare complementary coverage provided by New Jersey's Blue Shield Medical-Surgical Plan rose 20.2% in early March.

The coverage pays the $75 deductible and 20% copayment in federal Medicare Part B protection, which covers physicians' charges.

Without the premium increases, Blue Shield's Medicare complementary coverage would lose $6.47 million this year, Deputy Commissioner of Insurance Charles N. Steel said. The increase is expected to produce $6.9 million in additional income.

Mr. Steel attributed the projected shortfall to continually rising doctors' fees and changes in federal law that shift some health care costs from Medicare A, which covers hospitalization expenses, to Medicare B coverage.

For small group subscribers (fewer than 50 members), monthly payments will rise to $13.26 from $11.03 because of the increase.

Public advocate

AUGUSTA, Maine—The state's public advocate will intervene, on the public's behalf, at future hearings on a pending 30% average increase in workers compensation rates.

Gov. Joseph E. Brennan signed legislation last month allowing the state's public advocate, who usually represents the public in utility rate proceedings, to perform the same job on a one-time basis during this year's workers comp rate increase hearings.

The legislation also provides for a seven-member advisory commission to assist in defining the issues for the public advocate, along with a $70,000 budget, primarily for consultants.

Those hearings, yet to be scheduled, probably will be held at the end of April or the beginning of May.

The Maine Chamber of Commerce & Industry was among supporters of the legislation and also expects to intervene at the rate hearings (*BI*, Feb. 27, 1984).

The National Council on Compensation Insurance, which filed for the 30% rate increase, has said that the state actually needs a workers compensation rate increase averaging more than 100%.

"The rates in force now are losing money," said Peter Burton, director of goverment affairs for the NCCI's Northeast region.

But while insurers continue to call for higher rates—the last rate hike was enacted in March 1981—the state's business community says work comp rates are too high. In fact, increases in workers comp cost, including benefits costs, in recent years have forced some employers to flee to other states where costs are lower. ■

RIMS officers

SPRINGFIELD, Ill.—Curt Turner, insurance supervisor for Illinois Power Co. in Decatur, has been elected president of the Risk and Insurance Management Society's Central Illinois Chapter.

Don Ballentine of Central Illinois Public Service Co. in Springfield was elected vp and Jim Ott of Moorman Manufacturing Co. in Quincy was elected treasurer. ■

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Illinois proposal would base comp rates on hours worked

By CAROL CAIN

SPRINGFIELD, Ill.—A proposal to base workers compensation rates on the number of hours worked by employees is trekking through the Illinois House.

H.B. 2341, which amends the Illinois Insurance Code by requiring that insurers compute workers comp rates on the man-hours worked by a policyholder's employees, was passed by the House Rules Committee March 7 and is waiting to be assigned to another committee.

The bill now would apply to all employers, but General Assembly observers say the bill may be amended to apply only to the construction industry.

The Illinois bill is similar to a Pennsylvania proposal, which has been stuck in legislative committees since November. Similar proposals have been killed in Iowa, Nebraska, Oklahoma and Maryland.

The state of Washington is the only one in the country that uses man-hours to compute workers comp rates, a system that was started when the state formed its workers compensation system in 1911.

The other 49 states use a rating system that multiplies a job classification rate times $100 of payroll. For example, if a secretarial classification had a rate of $2 and secretarial payroll was $20,000, the cost of the premium would be $400 ($2 multiplied by $200).

Proponents of the man-hour rating proposal are primarily high-wage, unionized construction companies that say their employees' high salaries force them to pay unfairly high workers compensation premiums.

But, some refute the construction industry's complaint by noting that higher-salaried employees receive larger benefits when they are injured. Some studies also have shown that higher-paid workers receive more expensive medical care.

"We've got a number of studies that illustrate the whole system right now moves and works together," said Larry Hochstetler, director of government, consumer and industry affairs in Illinois for the Natonal Council on Compensation Insurance, a workers compenation ratemaking organization based in New York.

"Medical costs are higher for higher-paid employees, hospital costs are higher for higher-paid employees and rehabilitation costs seem to follow the same pattern," he said.

"A change. . .to another type is going to harm, rather than help a great majority of employers in Illinois," he said.

About 75% of Illinois employers would pay higher workers comp premiums under a man-hour system, while the remaining 25% would see only a modest reduction in rates, Mr. Hochstetler said.

The push for a man-hour-based system is "an example of once again trying to shift around the payment structure, but without a change in the benefit structure," said Steven Rosenbaum, manager of the workers compensation and unemployment insurance program for the Illinois Chamber of Commerce.

Like other critics, Mr. Rosenbaum said it's relatively easy for workers comp insurers to verify payroll, since these records are required by the Internal Revenue Service.

Other critics note that it would take a minimum of five years to change workers compensation rating systems. In fact, that is one of the reasons Washington state has never switched to a payroll-based rating system.

The state discovered through an extensive study that it would be too expensive and complicated to change, said Rick Slunaker, assistant director of the Washington Department of Labor and Industries in Olympia. ■

Program offers personal lines payroll deductions

Sentry Insurance Co. is introducing a nationwide payroll deduction program for personal lines insurance.

The program is designed for companies with 50 or more employees that have computerized payroll systems.

Sentry first sets up the policies and how much premium will be deducted with individual employees. The employer's computerized payroll program then calculates individual deductions according to types of coverages selected by employees.

Employers are tapped only to insert or program the deduction data into their computerized payroll programs.

To participate, however, employees must meet Sentry's usual underwriting criteria.

When purchasing a personal lines coverage, workers generally make a down payment, usually equal to two months' premium.

The remaining premium is spread out in equal payments over the rest of the policy period—usually six months or a year—with no finance charge added to it.

For further information, contact Jerry Sexton, Corporate Personal Lines Marketing Specialist, Sentry Insurance Co., 1800 North Point Drive, Stevens Point, Wis. 54481; 715-346-6615.

Market guide

A Chicago-area and northern Illinois group insurance and related services guide is now being published.

The "1983-84 Chicagoland Group Insurance Guide" lists group insurers for health, life, dental, vision, disability, prescription drug, auto and homeowners coverage.

The guide also has a section on companies that provide administrative services only, aggregate and specific stop-loss coverage, minimum premium, premium delay and retrospective-rating programs.

It also contains short sections on third-party claims administrators and group brokers.

Although it's billed as the Chicagoland guide, a few companies from states surrounding Illinois are included.

The guide costs $24.95, plus $1 postage and handling. To order, write Chicagoland Group Insurance Guide, P.O. Box 93, Gilberts, Ill. 60136; 312-931-1113.

Automated info

A computerized claims and insurance statistics system is being offered to large companies by Royal Insurance Group and Corporate Systems, a risk management information systems firm.

Royal FACTORS (Fast Access Claims Tracking and Online Retrieval System) is a flexible program that can be tailored to each client company's needs.

Risk managers can use a desktop computer to retrieve the information in formats they specify.

Risk management programs available in the FACTORS program include:

- Claims tape edit. It displays claims by alphabetical order, date, location or type of claim.
- Casualty report series. It presents claim and premium summaries, frequency and severity analyses details and claims information.
- Financial. It shows claim and premium summaries and a list of large claims with incurred values.
- Safety scoreboard. It reveals frequency and severity analyses. Claims data on injuries can be analyzed in exposure units, such as man-hours.
- Statistical forecasting. This feature presents prediction of loss probability based on past performance.

The FACTORS system is compatible with Apple II, Ccurier, IBM PC, Rainbow and Scanset computers. Clients can use direct line access or dial-up modems to tap the system.

The cost of FACTORS depends on the program elements and access method the client chooses.

For more details, contact H. William Devitt, National Accounts Department, Royal Insurance, 150 William St., New York, N.Y. 10038; 212-553-3479.

products & services

Loss-control course

INA Loss Control Services Inc., an affiliate of CIGNA Corp., has expanded a safety seminar so that any company nationwide can offer the course to its employees.

The one-day seminar, entitled "Back Injury Prevention Using NIOSH Guidelines," is available to non-CIGNA policyholders, as well as the company's current clients.

The course, which is based on standards issued by the National Institute of Occupational Safety and Health, uses work practices guides and also features instruction on how to use a a slide-rule calculator that analyzes proper lifting procedures.

The seminar costs about $1,400 for up to 20 participants, the recommended class size. For information, contact David Knight or Susan Collins of INA Loss Control Services at 800-231-3147. In Pennsylvania call 215-241-5800.

Case preparation

Forensic Research Consultants Ltd. of New York, a data base research service, has created a new program to reduce the costs of preparing medical malpractice and negligence cases.

The new system, know as MED QUEST, reviews information on specific cases as well as summarizes domestic and international precedents. Reports are generally available within 48 hours.

Forensic Research Consultants, headed by Elliot Stone, a former New York deputy assistant attorney general, has a staff of 11, including a consulting physician, pharmacologist, and dentist as well as nurses and medical researchers.

For more information of the MED QUEST program, contact Forensic Research Consultants Ltd., 114 Liberty St., New York, N.Y. 10006; 212-752-0112. ■

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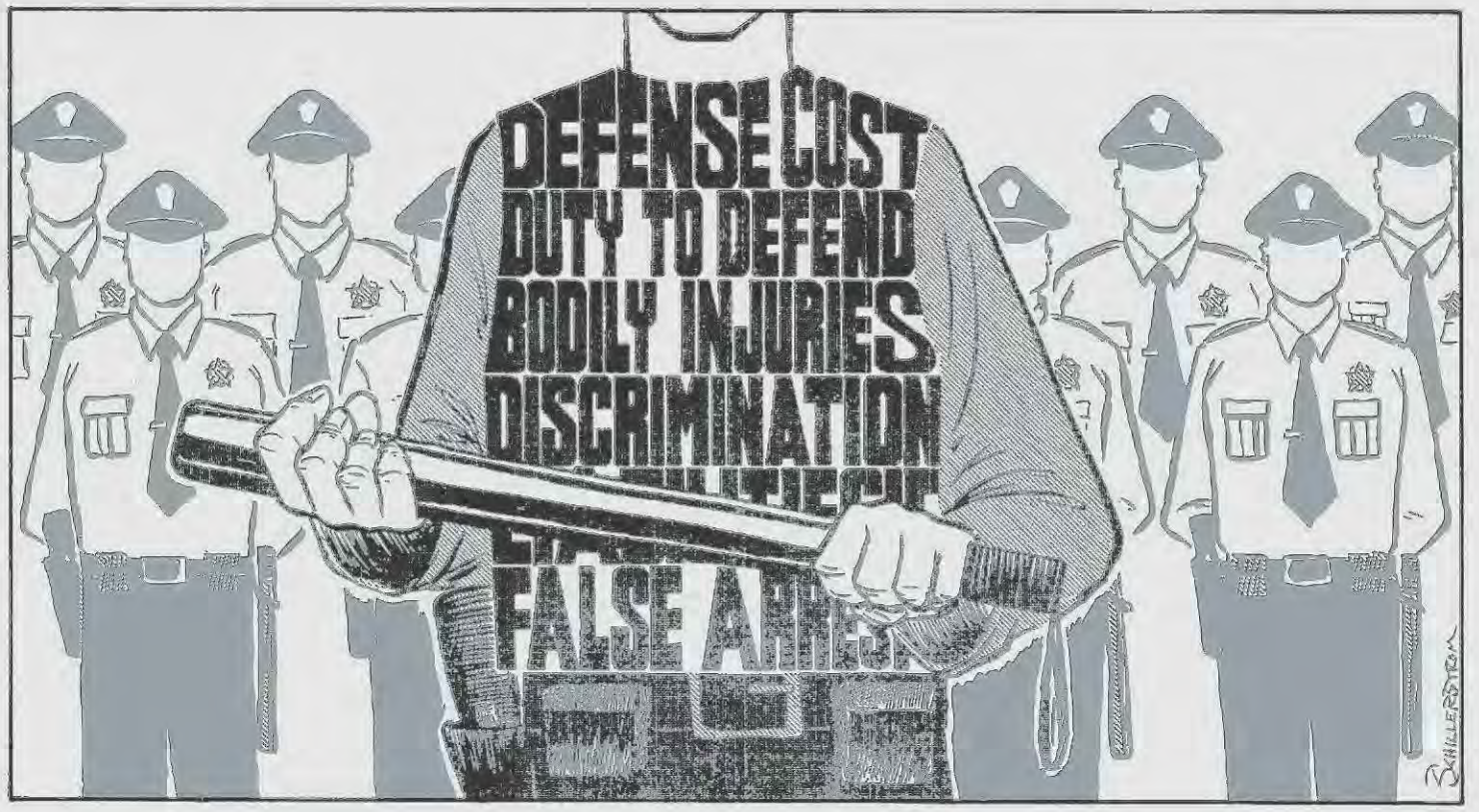
LAW ENFORCEMENT LIABILITY

Protecting the force with the right coverage

By Gerald P. Brunker



RECENT COURT rulings have made it easier for criminals, suspects and other third parties to bring lawsuits against law enforcement and criminal justice personnel.

Courts also have recognized the theory of vicarious liability of the defendant's superiors, including the mayor, municipal manager, county executives and other public officials.

Both the increased frequency and the severity of law enforcement-related suits present a new catastrophic liability exposure to many public entities (*BI*, Feb. 27; Sept. 12, 1983).

While many lawsuits do not result in settlements or judgments, they all have to be defended at a cost that, in itself, can be significant.

Compounding the problems for risk managers in public entities is the variety of insurance coverages available for this catastrophic liability exposure.

Let's take a look at that coverage and the insights needed by risk managers responsible for public liability insurance.

The standard comprehensive general liability contract can be used to structure several varieties of coverage that may be applicable to law enforcement-related activities. The most limited approach would be to purchase a standard CGL policy with no coverage endorsements.

Another approach would be to purchase a personal injury endorsement that would provide coverage for:

- False arrest, detention, imprisonment or malicious prosecution.
- Wrongful entry or eviction or other invasion of the right of private occupancy.
- Publication or utterance of libelous or other defamatory or disparaging material, or in violation of an individual's right to privacy.

However, this coverage endorsement has a contractual liability and employment-related exclusion.

Another CGL contract coverage alternative is to purchase a broad-form comprehensive general liability endorsement. Among the 12 coverage extensions generally found in this kind of endorsement that are most relevant to law enforcement activities are:

- Contractual liability.
- Incidental medical malpractice liability.
- Extended bodily injury coverage.
- Employees as insureds.

In addition, the broad-form CGL endorsement contains personal injury coverage, but has several exclusions that may apply to law enforcement activities. These exclusions relate to liability assumed under any contract or agreement and to any personal injury arising from the willful violation of a penal statute or ordinance committed by or with the insured's knowledge or consent.

Gerald P. Brunker is assistant vp of Tillinghast, Nelson & Warren Inc., a management and actuarial consulting firm in Dallas.

Both of these exclusions can normally be removed from a policy at no additional cost or at nominal charge.

Due to the narrowness or inadequacy of the coverage provided in a CGL policy, a number of alternative insurance markets and association-sponsored programs have developed separate law enforcement professional liability contracts that may or may not provide the coverage desired.

The presence of these specialty insurance products can introduce two problems.

The first problem is determining whether a particular specialty contract provides any broader coverage than would be provided in one of the CGL alternatives. The second is properly dovetailing coverages between the separate specialty contract and the CGL contract.

In contrast to the CGL contracts, these specialty contracts normally are not subject to bureau or state board regulation of policy forms or rates. Therefore, some of these contracts may provide coverage that is not even as broad as a CGL policy. Only a careful reading and analysis of the policy will enable the risk manager to determine the extent of coverage.

If a separate law enforcement professional liability contract is actually purchased, it is still advisable to purchase the comprehensive general liability contract with the broad-form CGL endorsement.

Modifications may need to be made to the standard policy language to have coverage that responds to the exposures of a specific public entity.

Moreover, many of the separate law enforcement contracts that are available provide coverage on an occurrence basis, not on a claims-made basis.

If a public entity purchases a separate law enforcement contract that provides broader occurrence-based coverage than previous comprehensive general liability coverages, then that entity should request quotations for prior acts coverage on a difference-in-conditions basis over prior CGL coverages.

Of course, if a separate law enforcement contract on a claims-made basis is available to the public entity, this policy should provide for unlimited prior acts coverage, subject to a prior litigation or prior knowledge limitation.

Since these separate law enforcement professional liability contracts are not standard contracts, the proposed policy language must be reviewed to properly evaluate the adequacy and appropriateness of the coverage in any particular contract.

There are a number of coverage considerations that must be made in a proposed law enforcement professional liability contract. These include:

- The extent of coverage.
- The named insured language.
- The exclusions contained in the policy form.
- The format for the payment of defense costs.
- The degree of input the public entity will have on the selection and control of defense counsel in case of a lawsuit.

This is not an exhaustive list of components that should be evaluated in a proposed policy, but some of the major considerations.

If a separate CGL contract and a separate law enforcement professional liability contract are purchased, these contracts are often referred to as underlying coverages. The primary objective with these underlying coverages should be to purchase the desired protection at a reasonable cost.

However, once this has been done, the job is only partially complete.

In addition to the underlying coverage, the next step is to find umbrella liability protection to provide excess limits of liability over the underlying coverages.

The umbrella will provide coverage where there is no underlying coverage, subject to a self-insured retention. Most umbrella liability insurers are satisfied with $1 million of underlying coverage.

If the CGL and the law enforcement professional liability contract are occurrence-based, the program probably has been properly structured.

If the law enforcement contract provides claims-made coverage, however, it would be advisable to modify the umbrella coverage by endorsement to also provide claims-made coverage.

This change is required because most umbrella liability contracts do not provide any claims-made language in their insuring agreements. The "trigger" for both policies should be the same.

Since the purpose of the umbrella liability coverage is to provide the catastrophe limit of liability, it is important to assess the financial solvency of either the insurance company or the municipal pool or any type of association-sponsored program chosen to write the coverage.

Currently, some of the most appropriate criteria used in assessing financial solvency of U.S.-based insurance companies are found in the "Best's Insurance Reports" annual property/casualty edition. It's available in many public libraries or from an agent, broker or consultant.

Some critical issues need to be considered in structuring a prudent liability program that responds to the exposures confronting public entities' law enforcement activities.

The key to structuring a successful program is an insurance specification to collect information from the market so risk managers can make knowledgeable, intelligent decisions. Without this approach, in today's litigious climate, public entities may find their insurance programs inadequate. ■

Forecasting damages for a truck fleet

By the Insurance Institute of America

A.R.M. exercises

These questions represent the types of questions asked, and the possible answers, in the examinations for the Associate in Risk Management designations.

LOSS FORECASTING, the core of most risk management decisions, is the subject of this question. It is one of the steps in the risk management decision process around which the A.R.M. program is structured.

Q: Because accurate estimates of future losses are crucial in making many risk management decisions, errors in these estimates can lead to incorrect decisions.

For example, a local bakery may make poor decisions on how to treat the physical damage exposure for its fleet of 10 delivery trucks. The bakery could incorrectly estimate the possible frequency or severity of physical damage.

In each of the following situations involving the bakery's trucks, explain specifically why the indicated error in estimating future losses is or is not likely to have an effect on the indicated decision.

1. In deciding on a per-loss deductible for physical damage insurance on the trucks, the bakery underestimates the frequency of minor damage to them. (4 points).

2. In deciding whether to equip the trucks with fire extinguishers, the bakery overestimates the frequency of truck fires. (2 points).

3. Having decided to retain all physical damage losses to the trucks while in use, the bakery is deciding whether to insure the trucks against fire while parked in a garage. The bakery underestimates the likelihood of fire in the garage where the trucks are kept and serviced. (4 points)

A: **1.** Underestimating the frequency of minor damage to the trucks is likely to have two effects on the bakery's decision regarding this loss exposure.

First, underestimating minor losses is likely to lead the bakery to select a larger per-loss deductible than if it had an accurate estimate of these minor losses because the bakery will tend to underestimate the cost of small losses.

Second, an underestimate of the frequency of minor losses also may lead to a failure to recognize the full value of loss-control measures, which could reduce losses. Therefore, the underestimate may lead the bakery to disregard the full use of loss-control measures.

2. The reduction in fire losses is an important potential benefit of purchasing fire extinguishers; therefore, if the bakery overestimates frequency of fire losses to its trucks, it is likely to overstate the value of these extinguishers and, as a consequence, probably will invest more in them than it would if it had an accurate estimate of these losses.

(Note: Since the cost of truck fire extinguishers is rather small in comparison to the investment in trucks, it also could be argued for full national examination credit that the firm should purchase these extinguishers regardless of its error in estimating the frequency of truck fires.)

3. In all likelihood, underestimating the frequency of garage fires would lead the bakery to purchase insufficient fire insurance on the parked trucks. The bakery would tend to overstate its ability to retain these losses.

On the other hand, because the potential severity of loss to the trucks while in the garage is very high in relation to the bakery's resources, good risk management would call for purchase of fire insurance on the trucks while in the garage, regardless of any error in estimating the probability of garage fires.

In this instance, therefore, the underestimate of loss frequency may not effect the bakery's choice of risk management techniques. ■

These questions and answers are drawn from the curriculum for the Associate in Risk Management designation, which is awarded by the Insurance Institute of America. For more information on the content of the A.R.M. program, write Risk Management Department, Insurance Institute of America, P.O. Box 314, Malvern, Pa. 19355.

Emotional strain insufficient basis for comp benefits

legal briefs

EMOTIONAL STRAIN leading to a heart attack while undergoing a polygraph test, which was not accompanied by unusual physical strain or overexertion, was an insufficient basis upon which to predicate workers compensation, according to a Florida appellate court.

Fred Zanfardino was employed by a wholesale grocery warehouse. He was required, as a condition of employment, to take a polygraph, or lie-detector, examination.

During an investigation of theft in the warehouse, he took and failed two such tests.

A few minutes after taking a third polygraph test, Mr. Zanfardino complained of numbness in his leg. By the time he reached the hospital, he was pronounced dead on arrival because of a ruptured aorta.

It was determined that he had a pre-existing disease, arteriosclerosis of the aorta, which predisposed him to aneurysms. The workers compensation commissioner awarded benefits to his beneficiary.

The appellate court reversed.

According to the court, physical exertion had to be found to establish a compensable injury. The court said the polygraph test, as had been conducted, was essentially passive.

"A change in blood pressure or respiration rate," the court emphasized, "from emotional stress is not physical overexertion. . . ."

Hammersmith Inc. vs. Zanfardino, District Court of Appeals of Florida, Dec. 16, 1982, *rehearing denied*, Jan. 31, 1983 (*BI*/02/A.-$5).

Dissolved business can insure

A New York appellate court ruled that a dissolved corporation had the power to keep property insured against fire and other hazards until the winding up of its financial affairs was completed.

The Igbara Realty Co. owned a one-story building rented out as a store. On March 27, 1979, the corporation was dissolved pursuant to New York law for non-payment of taxes.

Subsequently, the New York Property Insurance Underwriting Assn. issued a fire insurance policy on the property effective Feb. 23, 1980.

On May 31, 1981, a fire occurred. Igbara Realty filed a claim for damages, which was rejected. Igbara sued the underwriting association. The trial court dismissed the suit.

The appellate court reversed. According to the court, under New York law, a dissolved corporation can carry on no business except for the purpose of winding up its affairs.

"Inherent in winding up its affairs," the court said, "must be the power to take care of the corporation's property until winding up is completed."

Taking care of the corporation's property, the court emphasized, included the power to keep the property insured against fire and other hazards.

Igbara Realty Co. vs. New York Property Insurance Underwriting Assn., New York Supreme Court, Appellate division, June, 1983 (*BI*/03/A.-$5).

Officers' acts covered

A Georgia appellate court ruled that equitable tolling principles apply to discovery-of-loss clauses in fidelity insurance contracts of mutual funds in view of the absolute control exercised by fund officers over the mutual fund.

Several mutual funds were insured under fidelity policies issued by Peerless Insurance Co., covering loss through any fraudulent or dishonest acts committed by their employees.

The policies provided indemnity only for losses discovered not later than one year from the date of the policy period. The policies expired Sept. 18, 1970. The first notice of fraud or dishonest acts giving rise to the claim of loss came in early 1973.

Although the funds knew they had suffered losses, they claimed they could not have discovered the true cause of the losses, the employees' dishonesty. They could not have known the true cause, they noted, until the wrongdoers—the fund officers—relinquished control of the funds' operations.

The funds sued to recover their losses. The trial court ruled for Peerless.

The appellate court noted that California courts recognized the validity of discovery-of-loss provisions in fidelity insurance policies.

This discovery of loss is especially important where you have a situation of adverse domination.

In this case, the very persons who control the corporation are the ones that carry out the wrongdoing or criminal act, "the concepts of diligence in uncovering an insurable loss and employee concealment are inapposite."

Because of the nature of mutual funds, with assets belonging to the shareholders, the court concluded that it was equitable to consider it a tolling of the discovery clause.

Admiralty Fund vs. Peerless Insurance Co., California Court of Appeal, May 26, 1983 (*BI*/04/A.-$5).

Compensable death

An employee's death from a bullet wound received while making a delivery of an order of cement at a job site was compensable, according to an Indiana appellate court.

Robert A. Zion Jr. drove a cement truck for his employer. After delivering and discharging cement at a construction site, he began rinsing the truck chutes. During that task, he was struck in the head by a richocheting bullet. Mr Zion died six days later.

The fatal shot was fired by a boy from an apartment window who was aiming at street lights in a parking lot adjoining the construction site.

Mr. Zion's family sought workers compensation benefits, as well as medical and funeral expenses. The trial court ruled for the family.

The employer argued on appeal that for an accident to arise out of the employment, the risk of such an accident must be reasonably produced by or associated with the conditions of employment. The employer contended that those conditions did not exist in this case.

But, the court said that because Mr. Zion was at the job site and doing what he was employed to do, all at his employer's behest, that was sufficient to support the finding that the injury arose out of the employment.

Suburban Ready Mix Concrete, Etc. vs. Zion. Court of Appeals of Indiana, Jan. 19, 1983 (*BI*/05/A.-$5). ■

These abstracts were prepared by Cases Unlimited Inc. A copy of an entire decision may be obtained by sending a check for $5, made out to Cases Unlimited, to Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. List the number for each opinion.

In the April 2 issue, three articles on captive insurance companies will be featured in the Perspectives section. The articles will focus on the purpose of captives: Are they now obsolete? Or, are they more useful now than ever? And, do captives serve the public interest?

The Perspective section, which is a forum for readers' opinions, is compiled and edited by Assistant Copy Editor Claudette Dampier. She can be reached at 312-649-5282.

Tort reform bill headed for committee vote

By JERRY GEISEL

washington

WASHINGTON—Federal product liability reform legislation is headed for its first major congressional test this year.

The Senate Commerce Committee is expected to vote March 27 on a tort reform bill, S. 44, introduced by Sen. Robert Kasten, R-Wis.

The measure, which business groups say is necessary to restore more balance and certainty to the legal system, would establish a uniform federal product liability law and, thus, pre-empt varying state tort laws.

Key provisions in the Kasten legislation, which consumer and legal groups charge would take away plaintiffs' rights, include:

- Setting a statute of limitations to require plaintiffs to file suit within two years of the time they were injured.
- Requiring that the portion of a punitive damage that exceeds the compensatory damages paid to a plaintiff be used for a "public purpose" designated by the court.
- Eliminating liability for a manufacturer if its products were altered or modified without its permission and the modification was the cause of a consumer's injury.
- Eliminating a plaintiff's right to sue if he or she was injured by a capital goods product, like a printing press, 25 years or more from the time the product was manufactured.

Sen. Kasten's bill had been scheduled for a vote last September, but the vote was scrubbed after Sen. Slade Gorton, R-Wash., was prepared to introduce about a dozen amendments to the bill (*BI*, Sept. 26, 1983).

Since then, Sens. Kasten and Gorton and their staffs have been meeting to work out differences, which have been largely resolved (*BI*, Oct. 24, 1983).

Business groups are optimistic that new differences won't emerge and that they have enough support to obtain committee approval next week.

Retirement savings

Workers, by the millions, are doing more than just talking about saving for their retirement.

In 1982, the number of tax returns filed with deductions made for contributions to Individual Retirement Accounts almost tripled to 12 million, according to the Internal Revenue Service.

Total payments to IRAs jumped to $28.4 billion in 1982, a 492% rise over the year before.

This big splurge in IRA contributions is the direct result of liberalized rules Congress enacted when it approved the Economic Recovery Tax Act of 1981.

Those rules, which went into effect in 1982, allowed employees for the first time to set up IRAs even if they were already covered by a corporate pension plan.

That one change alone made some 40 million people eligible to contribute to an IRA for the first time.

PBGC advisers

President Reagan will reappoint three members of the Advisory Committee to the Pension Benefit Guaranty Corp to serve three-year terms.

The three members are: Joseph Geronimo, vp of the pension products division at Bankers Trust Co. in New York; Perry Joseph, business manager for the Carpet, Linoleum, Hardwood & Resilient Tile Layers' Local Union No. 1310 in St. Louis; and Roger Martin, senior vp at MGIC Investment Corp. in Milwaukee.

The committee advises the PBGC, the federal agency that guarantees workers' and retirees' basic pension benefits, on policies and procedures.

Tighter security

The federal government is beefing up security at the various congressional office buildings on Capitol Hill.

Special visitors' entrances have been set up at each of the buildings. All visitors, including lobbyists, must pass through metal detectors installed at the entrances. In addition, all bags and briefcases are inspected by members of the Capitol Hill police force.

At the Capitol building itself, security is especially tight. Dozens of police officers man stations and patrol the halls leading to the House and Senate visitors' and press galleries.

Alphabet soup?

Pension plan sponsors need more stability from federal legislators, regulators and judges, according to the American Academy of Actuaries.

"ERISA is followed by MEPPAA, which, in turn, is followed by TEFRA. Regulation upon regulation is piled on the system from no fewer than four agencies (DOL, IRS, PBGC, EEOC)," the academy said.

In testimony submitted to the Labor Department, Stephen Kellison, the academy's executive director, said that the continued turmoil has made rules so complex that the typical pension plan sponsor has trouble coping with the continuous changes.

ERISA stands for the Employee Retirement Income Security Act of 1974; MEPPA is the acronym for the Multiemployer Pension Plan Amendments Act of 1980; and TEFRA stands for the Tax Equity and Fiscal Responsibility Act of 1982.

DOL is the abbreviation for the Department of Labor; IRS, of course,stands for the Internal Revenue Service; PBGC refers to the Pension Benefit Guaranty Corp.; and EEOC is the abbreviation for the Equal Employment Opportunity Commission.

Takes PBGC post

Royal Dellinger, a former Labor Department official, has been named deputy executive director of the Pension Benefit Guaranty Corp.

In the position, Mr. Dellinger will be involved in the management of the PBGC's assets. The PBGC acquires assets when it takes over underfunded pension plans.

Mr. Dellinger has been an acting assistant secretary at the Labor Department's Employment and Training Administration.

Prior to joining the Labor Department, Mr. Dellinger, a certified public accountant, was a partner in the accounting firm of Dellinger & Dellinger of Los Angeles.

New benefit hearings

The growth and future tax status of employee benefits may be the subject of another Senate Finance Committee hearing.

As the committee completed action this month on a deficit reduction bill (*BI*, March 19), several senators, including Chairman Robert Dole, R-Kan., said hearings are needed to focus on the growth of tax-free benefits.

The hearings probably would be conducted by Sen. Robert Packwood, R-Ore., who chairs the Taxation and Debt Management subcommittee. ■

Fair coverage

Continued from page 1

However, several property owners, including the city of New Orleans, dictated the type of coverage and the limits the fair had to carry, Mr. O'Connor said.

"(The INA policy) is written on a blanket basis, for all the buildings and contents, and it includes business interruption," Mr. O'Connor said. Any special items, like coverage for a cargo shipment, also are written through INA, he said.

There is also a special $40 million abandonment policy underwritten in the London market, mainly by Lloyd's of London underwriters.

It will cover cancellation, postponement, curtailment or abandonment of the fair, in whole or in part, for any cause beyond the control of the fair and participants.

For example, if a hurricane were to force the fair's cancellation, the policy would respond. It would cover expenses and gross revenues contracted in advance, but would not cover loss of anticipated revenues. The policy, which does include war risk coverage, will not cover losses if the fair is forced to close due to a lack of financial support or a nuclear accident.

Purchase of this special coverage was required by the state, city and more than 100 private businesses that secured a $40 million bank loan to the fair corporation.

"Most of the insurance requirements were put in place because of the private corporations," noted Jim Brandt, vp of planning. "If the fair loses money, these (loans) will be paid off so the fair is not at risk."

This master program of property and casualty insurance, as Mr. O'Connor likes to refer to it, was written to cover the construction phase of the fair and then automatically cover the operational phase when the fair opens.

The same insurers were used for both phases so there would be "no argument" over coverage, Mr. Levick said.

All of the exhibitors, concessionaires, contractors and other fair participants are covered under the program and contribute to the cost of the insurance through their rents or entry fees.

They must carry the coverages, with the exception of workers compensation, which they may provide themselves, Mr. O'Connor said. But most will purchase their workers compensation coverage through the fair's master program because it's cheaper, he added.

However, a few fair participants are not allowed to purchase coverage through the fair program. These include fireworks personnel, ride operators, security personnel and anyone involved with watercraft or aircraft.

The three agencies that placed the fair coverage—Eustis Insurance Agency, Querbes & Nelson Inc. in Shreveport, La., and Fulton & Johnson Insurance Agency in New Orleans—sat on the insurance committee. A consultant—Dwight Levick, president of John Liner Insurance & Risk Management Advisers Inc. in Wellesley, Mass.—then reviewed the policies.

The Eustis agency will handle any claims filed against the fair.

While the fair's property/casualty coverage is handled through the commercial market, group health insurance coverage for fair employees is self-insured. The plan applies only to the fair's full-time staff, which totals 432 this month, but is expected to increase to 1,000 by summer. The plan does not cover the more than 2,000 contractors on site this month, nor the almost 10,000 concessionaires, exhibitors and other participants.

"Our employees on the average are younger and more educated. Our loss potential is favorable. That's why we're self-funded," said Martin Katz, vp of finance.

The health plan has a deductible of $100 per person and $300 per family for both hospital and major medical charges. After the deductible, employees are required to pay 20% of the costs up to $500, excluding the deductible. The fair will pay 80% of the costs until that $500 out-of-pocket limit is reached and then will pay 100% of costs up to $15,000. After that, medical charges will be paid through specific stop-loss coverage with North American Life & Casualty Co. of Minneapolis, Minn, said Dana Zeno, personnel coordinator.

In addition, the fair has a self-insured accident policy that pays 100% of the first $300 of hospital charges if the employee is hospitalized due to an accident. After that $300 limit, the other provisions of the group health policy apply, Ms. Zeno said.

There also is dental coverage with a $50 deductible per person and a $150 deductible per family.

Employees pay nothing toward the cost of the health, accident or dental coverage. ■

Stressing safety saves money for fair—even before it opens

By CAROL CAIN

NEW ORLEANS—The Louisiana World Exposition, better known as the 1984 New Orleans World's Fair, hasn't even opened yet but it already is setting records—safety records that are resulting in insurance premium returns.

And "special event" veterans who are responsible for the behind-the-scenes activities have laid the groundwork so that the safety reputation of the construction phase of the exposition will continue throughout the 184-day extravaganza, which will open May 12.

Included in the loss-control plan is an on-site emergency medical facility and a security force supplemented with professional off-duty police officers.

"We've made it plain. We expect a safe area. We're a highly visible project," said Pete Sullivan, site construction manager and director of safety.

Work on the multimillion-dollar construction project began in July 1982. Since then—a 21-month period—there have been 46 reported accidents, resulting in $92,000 in claims, Mr. Sullivan said.

In the most serious accident, hot tar from a roofing project fell on a worker below, he said.

And there have been some back injuries, but nothing of any magnitude, reported Joe O'Connor, vp with the Laurence Eustis Insurance Agency in New Orleans, one of three agents handling the fair's insurance coverage (see story, page 1).

"The first year's experience, casualty-wise, resulted in a return premium," Mr. O'Connor said. He added that if the record continues, when the construction phase is completed in two months, there will be an additional premium refund.

While fair officials are keeping details on the limits of the specific coverages and the premium paid to themselves, one official noted the fair recently received a return premium check of about $63,000 from United States Fidelity & Guaranty Co. in Baltimore, which is underwriting most of the liability coverages for the fair.

That may represent only half of what the fair will eventually have returned when construction is completed, the official said.

"USF&G's return of premium on construction operations is a direct reflection of the fine internal management and staff attention to safety consciousness that has lowered cost through the fair's fire and safety program," a USF&G spokesman said.

The safety program on the site operates on several different levels. First, each contractor (there are about 30 now, plus numerous subcontractors) has to have on site a safety manual approved by the fair staff, Mr. Sullivan said.

And then there are the safety meetings and inspections. "They (contractors) get deluged with inspections," Mr. O'Connor said.

Once, early on, Mr. Sullivan actually stopped work on a $40 million project at the fairgrounds.

"The situation had gone on for a couple of weeks and we didn't see any reaction (on the part of the contractor) to the problem," he said. Mr. Sullivan explained that since most of the site sits on 60 feet of old Mississippi riverbed, every structure being built has to be supported on pilings—huge, tubular supports that are driven into the ground.

"They're hollow and about 20 inches in diameter," Mr. Sullivan noted. "The contractor failed to cover the holes. . .we had about 5,000 of them," he said. So, Mr. Sullivan stopped worked in that area until the holes were filled.

When work is stopped on a project, the delay costs contractors money. They, in turn, have taken heed of these warnings

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Fair stresses safety

Continued from page 24

and the result has been a safer operation, Mr. Sullivan said.

The enforcement of safety rules also applies to those visiting the construction site.

"We have visiting personnel from other countries. When they visit they have to wear hard hats—everyone does. And there's no high heels allowed, and we try to get them to wear (safety) glasses too," Mr. Sullivan said.

The construction project is also routinely inspected by USF&G and representatives from the contractors' home offices, he said.

Officials from the Occupational Safety and Health Administration also visit the site, he said.

But a lot of the responsibility falls back on the contractors, which also have their own safety engineers who make both spot and weekly inspections, he said.

And there's also a weekly "toolbox" safety meeting held by each contractor, he said, explaining that workers gather at 7:30 a.m. around the toolboxes for informal but regular, meetings.

"We started out tough in safety," Mr. Sullivan said, and now he and others hope it pays off in the final days of construction as the push is on to complete the project on time.

"As you get closer to opening, things get more frantic and you have more accidents," Mr. O'Connor said.

But fair organizers, many of whom are veterans and have served in the same or similar capacity on previous world's fairs or major sporting events like the 1980 Winter Olympics in Lake Placid, N.Y., also are concerned with the prevention of accidents after the fair opens.

Paul Creighton, vp of operations, and Ed Cureton, superintendent of emergency service, are among those focusing their attention on this next phase. Mr. Creighton has worked for four world's fairs, and both he and Mr. Cureton worked at the "unofficial" 1982 world's fair in Knoxville, Tenn.

"A lot of things we did there (Knoxville), we'll do here," Mr. Cureton said. But they'll be bigger and more sophisticated, he added.

For instance, the Louisiana fair will have an on-site emergency services facility, which will contain not only a fire department, but an infirmary.

The base infirmary, staffed at all times with doctors and nurses from the Ochsner Medical Institutions in New Orleans, will be similar to a hospital emergency room, Mr. Cureton said.

The Ochsner institutions include a clinic, hospital and medical research facility. It's considered the largest group medical practice in the South.

Equipment worth more than $600,000 was donated to the fair by manufacturers and will be returned when the fair closes.

"We will offer not just adequate medical care, but outstanding care," Mr. Cureton said.

Two full-size ambulances, four miniambulances and four emergency golf carts also are part of the emergency services operation.

During the Knoxville fair, 12 persons suffered cardiac arrests, Mr. Cureton said, but 10 of them were revived because of the equipment and staff available.

The base infirmary also will dispense over-the-counter drugs, like aspirins and antacids. Those receiving these drugs will be asked to sign a standard Red Cross release form, Mr. Cureton said. Refrigeration also will be available for special medications of fairgoers.

There will be no charge for any treatment on site or for any medication administered, he noted.

At the Knoxville fair, more than 40,000 people were treated at the on-site facility. While malpractice lawsuits are a worry for any medical facility and medical personnel, none arose in Knoxville.

Emergency cases aren't the only ones for which fair officials are planning.

"The major problem at Knoxville was the ladies and young girls who stood in line early, ran into the fair and fainted 20 minutes later," said Mr. Creighton. "We got on the radio and TV and told everyone to have a good breakfast. That cut our 'drop rate' in half."

"Going to a world's fair is like work; there's stress, walking. You have to be prepared," Mr. Creighton said.

There will be rest stops, called oasis huts, set up throughout the site. These open-sided, covered facilities will have drinking water and benches available. Benches in shaded areas also will be scattered throughout the fair, Mr. Cureton said.

An estimated 11 million persons are expected to attend the fair—about 70,000 daily. And all those people mean a lot of garbage, about 40 to 60 tons per day, according to Mr. Creighton.

Removing garbage during fair hours with large dumpsters would create a tremendous potential for accidents, he said. So instead, garbage will be bagged and placed in refrigerated rooms during the day at several buildings throughout the fair. Then at night, after the fair is closed, large trucks will pick up the bags and haul them to the dumpsite, he said.

"We don't allow any motorized vehicles, with the exception of ambulances and fire trucks, on the site during the day. All of the vendors will have to resupply between midnight and 8 a.m.," he said.

In addition to its medical and cleanup programs, the fair also has fire prevention, hazardous materials and security programs.

"We have our own fire service—three pumps manned with off-duty city (New Orleans) fire personnel and one will be a hazard/fire truck," Mr. Cureton said.

The fire station is manned continuously and an on-site fire inspector makes the rounds five days a week, he added.

Fair officials also must be prepared for situations involving hazardous materials, Mr. Cureton said. A special fire inspector/hazardous materials person is still to be hired.

Electrical transformers on site that contain caustic material present one hazardous material problem, Mr. Cureton said. And, there are several railroad tracks that run through the middle of the site, and from time-to-time, trains will be carrying hazardous materials, he said.

As part of the safety program, those trains will be required to travel at extra-slow rates of speed while going through the fairgrounds.

In order to keep the people away from the trains, the tracks were isolated from fairgoers by bridges and floodwalls, Mr. Creighton said.

Security also plays an important role in the safety program.

Off-duty city policemen will be on site to handle things like pickpockets, said Jim Taylor, director of security. But for the most part, security will be handled by up to 270 persons who actually will be hosts and hostesses of the fair, he said. All these people also will be trained in cardiopulmonary resuscitation, he added.

"We're talking about people who give a helpful, friendly, welcoming-type image," Mr. Taylor said. These people, who probably will be college students and retirees, will be armed only with a radio, and will be instrumental in getting people to the medical facility, he said.

Professional police officers will be contacted by security people if there is a more dangerous situation, Mr. Taylor said.

"This way you don't have to worry about training and bonding," he added. ■

Hospitals, doctors join to buy malpractice cover

Continued from page 3
claims develop over the traditional six- to eight-year tail for malpractice claims. Only then will the hospitals know if the improved risk management plan reduces overall costs or only has shifted them to unlucky insurers that took a chance on letting the hospitals back into the commercial insurance marketplace.

Lenox Hill had self-funded medical malpractice risks since 1976, Mr. Dangelo says, but under the guidance of KM Insurance Brokers, a joint venture between New York brokers Walter Kaye & Associates Inc. and Merson & Co. Inc., the hospital and its colleagues made the switch to the insured plan Jan. 1.

The coverage begins with $1.3 million in combined single-limit primary malpractice liability coverage from National Union and is followed by $100 million in excess coverage underwritten in various layers by 14 other insurers.

This $100 million in excess coverage, according to Mr. Dangelo, is shared among the four hospitals and about 500 participating doctors with no per-claim or per-hospital coverage limit. It is exhausted when the total amount of malpractice claims and legal fees from the covered hospitals and doctors exceeds $100 million.

Above the shared excess coverage, each hospital also has an additional $100 million in excess coverage that applies only to its staff and attending physicians.

Claims for all of the doctors and hospitals are adjusted by Affiliated Risk Control Administrators in New York, a medical malpractice claims adjusting company, on behalf of the insurers.

Mr. Dangelo and broker Paul Merson of Merson & Co. Inc. would not say how much each hospital is saving this year by switching from self-insurance to the group plan, but Mr. Merson says the hospitals and doctors as a group now pay less than $15 million in premium for the coverage.

They will realize a savings of "millions of dollars" in premiums and legal fees, he claims.

Attending physicians who elect to purchase malpractice coverage under the group plan also receive a percentage discount off the individual rates published by Medical Liability Mutual Insurance Co. of New York, one of the largest physicians' malpractice underwriters in New York State.

"Attending physicians who participate in the group plan are also getting much more coverage for their premium," notes Mr. Merson. "Previously, $1 million per-claim and $3 million aggregate malpractice coverage was about all you could get in New York."

The idea of group medical malpractice insurance involving both hospitals and attending physicians is not new, but it's not widespread, either.

In the late 1970s, Harvard University hospitals formed a similar malpractice insurance purchasing structure. The Harvard group was soon followed by a hospital/doctor group, which included New York Hospital and Johns Hopkins University Hospital in Baltimore among other large facilities, brokers say.

Mr. Merson and his partner in KM Brokers, Walter Kaye & Associates, have also set up two other hospital/doctor groups, which the brokers term Voluntary Attending Physician, or VAP plans.

In 1982, Walter Kaye developed a VAP plan for four New York-area hospitals operated by the Federation of Jewish Philanthrophy, including Mount Sinai Hospital, Maimonides Medical Center, Montefiore Hospital & Medical Center and Beth Israel Medical Center.

In July, 1983, Merson & Co. designed a similar VAP program for seven other hospital and doctor groups in New York and Long Island, including New York University Medical Center, St. Luke's Roosevelt Hospital, Brooklyn Hospital, Brookdale Hospital & Medical Center, Misericordia Hospital, Long Island Hospital & Medical Center and Methodist Hospital.

"We were both heading in the same direction, so we got together and decided to work together on future projects. Hence, our joint venture as KM Brokers," Mr. Merson notes.

"We think this is the way most doctors and hospitals will begin to purchase malpractice coverage and we are already seeing other groups forming on the West Coast." ■

Lloyd's, IRS pact expires this year

LONDON—A 5-year-old agreement between Lloyd's of London and the U.S. Internal Revenue Service will expire at the end of 1984, but Lloyd's Chief Executive Ian Hay Davison expects the agreement will be renewed.

Under the agreement, Lloyd's members pay U.S. income taxes on the business their syndicates write in the United States. Lloyd's does not know how much members actually pay, "but it is substantial," Mr. Davisor. says.

Most Lloyd's members who are not U.S. citizens do not have to pay the tax, he said, since Lloyd's is not a U.S. corporation.

"They volunteer to do so," Mr. Davison notes.

In return, the Internal Revenue Service agrees not to challenge Lloyd's three-year method of accounting.

Although either party may break the agreement at the end of the year, Mr. Davison says he thinks that's unlikely. ■

Benefit sleuths discover bogus health claims

Continued from page 3
tants & Administrators Inc. in Chicago. "Get employees to realize the only money that insurance companies have, or that their company has if it is self-insured, is their own.

"We have to get over this hurdle that it's OK to take a little money from an insurance company because it's not going to hurt anybody. The truth is rates go up and it hurts everybody."

"It's the same thing as income tax," said Aetna's Mr. Garcia. "We are trained to stretch the truth as much as we can when income tax time comes. People view the money as big government's, although it's really their own, and on claims they view it as big business'. If they take $1,000 or $2,000, what does it matter?

"Sometimes I talk to these people and ask them if they'd do the same thing to a bank or a grocery store and they say, 'Never! That would be stealing!' They don't perceive this as theft. Employers can communicate the reality that fraud is a felony, with penalties of up to five years in prison and/or $1,000."

"Educate the employees, but without too much detail," advises Alvin Decker, second vp in the group claims division at Travelers Insurance Co. in Hartford. "They could be the people to commit the fraud, and you don't want to tell them how to do it."

Other insurers and administrators added that they were reluctant to reveal fraud detection methods to benefit managers, since they too are not immune from the temptation of fraud.

Neither are physicians and hospital personnel immune, and employee communications can help detect this type of fraud as well. Most insurers and administrators agree that while individual employees create a greater number of fraudulent claims, fraud from health care providers involves more dollars.

For instance, Blue Cross & Blue Shield of Ohio, uniting its offices statewide in a fraud detection effort, recently uncovered and settled a $93,000 case involving a Franklin County psychologist. "The psychologist was convicted of 10 counts of mail fraud," a spokesman for BC/BS said.

"Give employees a mechanism to report fraud on the part of the providers," Mr. Garcia advises benefit managers. "Encourage them to check their statement of benefits. We know of some companies that give employees financial incentives to detect errors."

"Take a look at services rendered for employees by overseas providers," advises Ted White, vp of claims for U.S. Administrators Inc. in Los Angeles. "Some countries have rings of fraudulent practitioners who, for very little money, will be glad to generate a bill for almost anything."

"Also, give employees a mechanism to report fraud they hear about through the rumor mill," Mr. Garcia adds. "The employees that commit fraud seem to like to brag about it, and other employees may hear about it."

Like the "rumor mill," smaller companies that review claims themselves may be able to detect discrepancies through personal knowledge.

"A personnel member may look at a claims form and if he or she knows that the person wasn't out on disability or in the hospital those days, look into that claim," said David T. Sandstrom, assistant vp and director of group claims for Hartford Life Insurance Cos. in Hartford, Conn.

"That doesn't really work for a larger company, and a lot of companies don't like the extra administrative work of looking over claims forms."

Even if companies do not have access to claims forms, "they could provide us with the most current lists of employees (enrolled in the plan)," said Carmela Miller, supervisor of fraud security operations for CIGNA Corp. in Bloomfield, Conn.

"People will loan their (insurance) card out to other people, or they'll try to collect from two insurance plans—their own and a spouse's," Mr. Garcia said. "Computer claims systems can track that, but they have to have accurate information on who's covered and on coordination of benefits."

Companies that administer their own claims, or that review claims before sending them to an insurer or administrator, can look for some of the same things insurers and administrators seek in the reviewing process. Some of these are:

- Erasures, strike-overs, different types of ink or handwriting, improper medical terms and signatures that do not match those on enrollment forms.
- An employee's address listed as a post office box.
- Photocopies. Many insurers and administrators do not accept photocopies of claims forms because of the high risk of fraud.
- A bill with charges obviously out of line with customary costs, or for more drugs than an individual could safely consume.
- Doctor visits or hospital admissions on weekends or holidays.
- Bills for individuals not enrolled in the plan.
- Expenses incurred close together, like two office visits in one day, or bills for repeated operations that cannot actually be repeated. "We had six claims for hysterectomies in a 5½-month time frame from one person," Mr. Garcia said.
- Bills containing expenses for procedures not normally associated with the diagnosis, such as an electrocardiogram used to diagnose a back problem, or extraordinarily long hospital stays.
- Doctors or hospitals located a long distance from the claimant.
- A different insurer's name listed on the bill.
- Frequent changes of address.
- Large bills that do not carry an assignment to pay the provider directly.
- Bills that do not name the services rendered.
- Repeated claims to one person or one address.

Once a discrepancy is determined, an insurer or administrator will go through a lengthy process of investigation.

"We go through the claims history and try to determine a pattern of abuse," Mr. Garcia said. "Once we determine that we have enough evidence for a case, we turn it over to the appropriate legal authorities —the Postal (Service) since the usual avenue for conviction is mail fraud, or the FBI if it involves drugs."

Despite the many cross-checking methods routinely used, there are still cases of benefit abuse that require extraordinary work, such as when a provider and insured are in collusion.

"The usual methods of checking don't work, but we have tracked down some cases like that," Mr. Garcia says.

"They will not be able to get away with (fraud) for any length of time," stressed the spokesman for BC/BS of Ohio. "The greater amount of money they try to get away with, the greater the chance of catching them. And sooner or later, we will catch them. We will prosecute. We will try to recover all the money taken illegally from us and our subscribers." ■

Florida to consider hospital budget bill

TALLAHASSEE, Fla.—Florida hospitals could be forced to modify their budgets by the state's Health Cost Containment Board if proposed legislation is approved by state Legislature.

The legislation would give the board authority to force hospitals to modify their budgets. Currently, the board, created by the legislature in 1979, only can review budgets and has no power to force revisions.

The board would be granted additional authority in an effort to contain future state hospital costs, according to James J. Bracher, the board's executive director.

Florida's Legislature goes into session in early April and is scheduled to adjourn in early June. ■

House may consider benefit proposals this week

Continued from page 2
The trust assets and the interest they earn are not taxed.

• Moratorium on benefit taxation. The Senate bill extends through 1985 a moratorium that bars the Treasury Department from issuing new rules on the taxation of benefits not covered by a specific section of the Internal Revenue Code. The moratorium expired Dec. 31.

By contrast, the House bill includes permanent rules on the taxation of non-statutory benefits. For example, the only taxable benefits that a cafeteria benefit plan could offer would be group term life insurance coverage exceeding $50,000 and extra vacation days.

Currently, some cafeteria plans offer a choice of taxable benefits, like financial counseling and group auto and homeowners insurance.

Observers expect that if the two bills pass the House and Senate and are sent to a conference committee to reconcile differences, the House will then adopt the two-year moratorium and drop its proposed permanent rules.

• Employee-funded pension plans. The House bill would bar employer-sponsored pension plans funded solely by employees.

The Senate bill, though, would change the order of withdrawals from these plans. If employees wanted to withdraw funds, they would first withdraw the accumulated interest, which is taxable, before they could withdraw their own contributions, which were made with aftertax dollars.

• Taxing group life insurance premiums for retirees. The Senate bill calls for taxing retirees on premiums their former employers pay for group life insurance coverage that exceed $50,000. Such coverage is now tax-free to the retiree.

The Senate life insurance proposal only applies to employees younger than 55 on Jan. 1, 1984.

The House bill also would tax retirees on group life insurance coverage exceeding $50,000, but it isn't clear when that proposal would go into effect.

• Individual Retirement Accounts. The House bill would retain the current schedule of tax deductions for contributions to an IRA. For example, an employee can contribute up to $2,000 a year to an IRA and receive a full deduction for the contribution; while an employee with a non-working spouse can contribute up to $2,250.

However, under the House bill, individuals could contribute an additional $1,750 on an after-tax basis. While individuals would not receive tax deductions, the additional contributions would accumulate interest tax-free until withdrawal.

The Senate bill, though, would gradually increase the maximum contribution an individual with a non-working spouse can make to an IRA to $4,000 from $2,250.

• Social Security. The Senate bill would allow churches that have religious objections to withdraw from the Social Security program.

The provision only would apply to churches that joined the program after Jan. 1, 1981. However, employees of religious organizations that drop out of Social Security still could participate in the program by paying the 11.3% FICA tax rate charged to the self-employed.

The House bill lacks a similar provision.

Despite these differences, the two bills share at least one identical benefit restriction. Both measures extend until 1988 a freeze on maximum pension benefits and contributions.

Under current law, the maximum annual contribution an employer may make to a defined contribution plan is $30,000, while the maximum annual benefit that a defined benefit plan may provide is $90,000.

The Tax Equity and Fiscal Responsibility Act of 1982 froze these limits until 1986, after which the caps were supposed to be raised to match the annual increases in the Consumer Price Index. ■

Bush fire claims

Continued from page 2
week that under the settlement:

• Sedgwick will pay $32 million Australian ($30.72 million U.S.), the largest amount to be paid by any of the parties involved in the dispute.

• The SECV's primary liability insurer, Gerling Konzern Allgemeine Versicherungs A.G. of West Germany, will pay $2 million Australian ($1.92 million U.S.). Gerling, which does business in Great Britain as Gerling-Konzern General Insurance Co., provided limits of $2.5 million Australian ($2.275 million U.S.).

• Insurers on the first excess layer, led by Lloyd's of London syndicates managed by J.H. Minet Agencies Ltd. and Fenchurch Underwriting Agencies Ltd., also will pay $2 million Australian. This layer, with a limit of $5 million Australian ($4.8 million U.S.), also included two other Lloyd's syndicates and 10 other insurers.

• Insurers on a second excess layer, led by Insurance Corp. of Ireland, will pay $39 million Australian ($37.44 million U.S.). This layer, with limits of $50 million Australian ($48 million U.S.), is actually an industrial special risks property policy with a third-party liability endorsement.

Although the SECV's coverage totaled about $52 million U.S., the utility filed claims exceeding $100 million because it regards the two fires it is accused of setting as separate occurrences.

Despite the settlement, some of the insurers on the risk may end up paying the SECV twice.

After the settlement was announced, a Sedgwick official noted the company's professional liability insurers would pay all but $36,750 U.S. of its share of the settlement.

Over the course of the trial, several of the insurers on the SECV's risk testified that they also wrote professional liability coverage for Sedgwick. For instance, Cyril Nokes, underwriter for the Warrilow Syndicate at Lloyd's of London, told the court that he insured both the SECV and Sedgwick, so his syndicate would pay no matter who was judged liable for the claims.

The Sedgwick official would not identify the insurers that wrote its professional liability coverage.

Airlines facing sharp rate increases

Continued from page 1

Barry Coleman, a leading Lloyd's of London aviation underwriter who writes for several syndicates, says momentum is increasing in London for even harsher rate hikes.

"Natural forces are applying to this season's rate increases and we can only see (rates) increasing more," Mr. Coleman says.

Those "natural forces" that are hardening the international aviation insurance markets include the record losses suffered by aviation insurers in 1983 and a tightening reinsurance market.

Aviation underwriters will eventually pay about $700 million for hull and liability losses in 1983, compared with an estimated 1983 premium volume of $500 million to $550 million.

"So underwriters need to increase rates by 40% just to break even," said one London underwriter.

Aviation insurers are also demanding higher rates because tightening reinsurance capacity is forcing them to retain more risk (*BI*, Jan. 9).

"What happened now is a direct reaction to Jan. 1 aviation underwriters' reinsurance renewals," says Jerry Frick, a managing director at broker Marsh & McLennan Inc. in New York.

"Ultimately, it is the reinsurers that have been burned and they have said you have got to get those rates up."

Although most of the major U.S. airlines have yet to renew their coverage, experts like Mr. Frick agree that they can expect large rate increases.

"Obviously, everyone is expecting a very difficult renewal season," he said. "And not just airlines, but airline manufacturers as well."

Mr. Frick explains that since many of the same underwriters that cover airlines also write coverage for manufacturers, last year's bad record is going to affect the manufacturers' rates, as well as the airlines'.

"Aviation underwriters are going to try to make more money across the board," he said. "And it is going to be a tough negotiation for each company."

Mr. Frick adds that brokers and risk managers may not shop around for the best rate as much as they have in previous years. "Risk managers are looking for a long-term commitment," he says.

So far, airlines have found that insurers also are rejecting many of the old tricks the airlines have used in the past to avoid rate hikes

For example, some airlines have offered to accept increased deductibles, but such requests have fallen on deaf ears in London.

As one underwriter said "We want premiums, not deductibles."

And, airlines have little choice but to budget for increased insurance cost, says Mr. Shermer at Federal Express, whose aviation insurance costs rose almost 100% because of rate hikes and an increased fleet value.

Mr. Shermer explains that aviation risks are just too large for an airline to self-fund or attempt to insure through a captive.

"Captives will not work for airlines. You cannot get enough volume out of your own airlines' spread of risk to make it viable. Not one has been able to succeed."

Mr. Shermer admits that Federal Express tried to use some old bargaining tricks when he renewed the cargo carrier's coverage on March 1—and they didn't work.

First, as he done in previous years, Mr. Shermer says he shopped U.S. and French aviation markets to escape high London rates, but found capacity so tight that he increased the amount of coverage written by London insurers to 40% of the risk from 35% last year.

Mr. Shermer also says he thought he could exert some leverage since Federal Express had practically doubled the insured value of Federal Express' fleet to $850 million from $450 million in 1983.

The underwriters weren't buying, however. "There is no consideration for volume," he said.

With the rate increases and the additional insured value of its fleet, Mr. Shermer says Federal Express will pay 96% more in aviation insurance premiums in 1984 than it did last year.

Despite Mr. Coleman's assurance that higher rates are here to stay, Mr. Shermer says he will be "extremely irate" if he finds that rate increases moderate as more airlines complete their 1984 renewals.

Last year, for instance, he says U.S. airlines that renewed later in the year than Federal Express were given much better quotations.

"If that happens this year, I assure you there will be a revolution," he said. ■

IRMC approves new members

DENVER—The Institute of Risk Management Consultants has approved five new members.

The new members are:

- Thomas L. Atkins and Michael A. Rodman, both of J.H. Albert International Insurance Advisors Inc. in Needham Heights, Mass.
- Wayne J. Liesch of The Wyatt Co. in San Francisco.
- Kenneth S. Wollner of The Wyatt Co. in Chicago.
- John B. Toy Jr. of Mund McLaurin & Co. in South Pasadena, Calif.

With the new additions, IRMC now has 66 full members, two associate members and five lifetime members. The organization requires prospective members to comply with general, educational and professional qualifications before they can be approved. ■

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Airlines with rate hikes

LONDON—Stiff aviation insurance rate increases are the rule for airlines that have already completed their 1984 renewals, one London aviation underwriter says.

The underwriter, who requested not to be named, detailed for *Business Insurance* some of the rates quoted in renewal in which he has participated.

These renewals include:

- Air Florida Inc. Air Florida received a 25% increase in both hull and liability coverage rates from London underwriters, even though the airline filed only $64,000 in hull claims and $164,000 in liability claims in 1983.

However, underwriters noted that Air Florida's four-year loss ratio is 750% because of the 1982 crash of an Air Florida Boeing 737 jetliner in Washington, which killed 78 people (*BI*, Jan. 18, 1982). In 1982, Air Florida filed $15.4 million in hull claims and $66.5 million in liability claims, of which $48 million have not been paid because of pending claims.

Sources also say that Air Florida increased the amount of coverage it purchased in the London market to 36% from 25% during its latest renewal.

- Air Mexico. The Mexican carrier was hit with a 41% hull insurance rate increase, while liability rates rose 23%. Its loss ratio is not known.
- Lufthansa German Airlines. Lufthansa, whose five-year loss ratio is 133%, received a 27% hull rate increase and 14% liability rate increase.
- Turkish Airlines, with a 105% five-year loss ratio, accepted a 61% increase in hull rates and a 74% increase in liability rates.

Besides detailing coverage that has already been placed, the underwriter also revealed what London aviation insurers are asking from airlines whose coverage is to be renewed on April 1. These accounts include:

- Qantas Airways Ltd. The Australian airline will probably see its total premium costs rise 16% even though it has reduced its fleet value by 27%.

If the airline had not cut the value of its aircraft, its hull coverage costs would have risen 32%, while its liability insurance costs would have jumped 34%.

- Finnair. Although underwriters concede the Finnish carrier has a superb five-year loss record of just 12%, it will probably pay a 48.5% increase for hull insurance and a 34% increase for liability coverage, boosting its total premium cost to $2.2 million from $1.36 million.
- Britannia Airways, with an even better loss ratio of 6%, will pay 22% more for its coverage, based on a hull rate increase of 10%, a liability rate increase of 5% and a 20% increase in the value of its fleet.
- Joint Airline Insurance Program. This Canadian airline consortium, with a combined fleet value of $1 billion, will pay a 16% hull rate increase on hulls and 25% liability hike, even though its five-year loss ratio is just 33%. The airlines participating in the program include Nordair, Pacific Western Airlines, Wardair International, Quebec Air and Eastern Provincial Airways.

info

- "An Analysis of Proposals to Mandate Cafeteria Style Health Benefit Plans for Health Care Cost Containment" begins with **an overview of health care cost-containment and current analyses by the Department of Labor** on employee health benefit plans. The publication also discusses legislative proposals to implement cost-containment measures. This 62-page study is available for $3 by writing the International Foundation of Employee Benefit Plans, Publications Department, 18700 W. Bluemound Road, P.O. Box 69, Brookfield, Wis. 53005.

- "A Group Legal Services Plan to Provide Fast and Easy Relief from Legal Problems for Your Employees" and "Now. . .For Credit Union Members—Family Legal Assistance" are two-page promotional brochures describing **group legal services** plans. For a free copy of either brochure, write Group Legal Plans Corp., 142 Commercial St., Boston, Mass. 02109.

- **"Evaluating Unsprinklered Fire Hazards"** is a report that introduces basic concepts to aid understanding of a wide range of fire behavior when sprinklers are not present. Several formulas to estimate damage to unsprinklered metal structures are provided, and added safety factors have been incorporated in the formulas. To order, send $5.35 to Lisa Juliano, Society of Fire Protection Engineers, 60 Batterymarch St., Boston, Mass. 02110.

- A report, "Health and Welfare Fund Operations and Expenses," is available from the International Foundation of Employee Benefit Plans. This 47-page study, based on a survey of 500 trusts, establishes rough guidelines to aid trustees judging the **appropriateness of non-benefit expenses of a multiemployer health and welfare trust fund.** Foundation members can purchase this booklet for $7.50; the cost to non-members is $12.50. To order, write IFEBP, Publications Department, 18700 W. Bluemound Road, P.O. Box 69, Brookfield, Wis. 53005.

- A three-page brochure, "Smart's Health and Safety Products," lists the company's **informational booklets on a wide variety of topics,** such as asbestos, back care, total fitness and safety. For a free brochure, write Darrell Heppner, Smart's, 154 Sunnyside Drive, San Leandro, Calif. 94577.

- "OSHA: Safety and Health Is Our Middle Name" outlines the agency's efforts to encourage and enable workers and employers to develop and maintain effective **safety and health programs** on their own. The booklet provides details on how to get assistance from OSHA on safety and health training, education courses and grants, expert consultation and voluntary worksite safety and health programs. For a free copy, send a self-addressed mailing label to OSHA Publications, N-4101, Frances Perkins Building, Third Street and Constitution Avenue N.W., Washington, D.C. 20210.

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Insurers' sad song may play one more time

Continued from page 1

competitive marketplace out there," says Bernard C. Hlavac, vp and treasurer of Sentry Insurance Cos. in Stevens Points, Wis.

While Sentry increased its operating income by 258.5% last year, Mr. Hlavac noted that the company had suffered its worst year ever in 1982, inflating the year-to-year comparisons.

"We don't have much to crow about. It's almost like a one-year anomaly that we're reading."

Some of the other top performers noted that their income gains were unrelated to underwriting.

Reid K. Taube, assistant treasurer at USF&G Corp, whose income increased 50.3%, noted that underwriting continued to deteriorate but investment income posted a strong gain.

He attributed USF&G's good year to an equity strategy the company initiated in 1982, which focused the company's investments in common stocks with above-average yields and an active dividend rollover program.

American General Corp., which ranked third in the *BI* survey with a 43% operating gain, noted in its results that the large increase included realized investment gains of $32.2 million and a $37 million tax benefit, compared with a $4 million tax expense in 1982.

Analysts and insurers note that some of the major property/casualty insuers benefited from their results in personal lines.

SAFECO Corp., for instance, posted a 23.9% jump in operating income for the year, despite a $26.9 million underwriting loss, because of a strong year in personal lines, according to James W. Cannon, president of SAFECO's property/casualty companies.

"There was enough improvement in personal lines so firms could continue to compete with commercial business at unrealistic rates," says James B. Stradtner, a general partner at Alex. Brown & Sons in Baltimore.

This favorable operating environment, however, may not continue, warns Barbara Stewart, president of Stewart Economics in New York. The intense competition in the commercial lines is "causing companies to take another look at personal lines, so it may not be safe to count on taking for granted rate increases or premium growth in personal lines."

Insurers disagree over the effect rate hikes will have on 1984 results.

"Nineteen-eighty four probably will look mostly like 1983, with some modest improvement in the pricing," predicts Robert J. Haugh, president and chief operating officer of The St. Paul Cos. Inc.

While the price firming by some reinsurers will be reflected eventually in the primary market, it won't by any means be immediate, he says.

"It will be a long, slow recovery before those horrendous underwriting losses are reduced to some degree," Mr. Haugh says. "Don't look for a dramatic improvement by Dec. 31, 1984."

William G. Watt, executive vp at Royal Insurance Group in New York, notes that his company plans to raise rates on a selective basis on its package policies.

"We are dedicated to firming our prices," he says, even "if that means we have to lose a little market share."

A spokesman for American International Group Inc., which experienced its first year-end underwriting loss since going public, agrees the time is right for rate increases. AIG has started to raise some rates, he noted, and while it has not been entirely successful, "the fact that we're getting it at all is a start."

He also notes that while AIG suffered red ink in underwriting this year, "We did pretty damn well compared to the industry, given the odds that were against us." He added AIG expects to post an underwriting profitthis year.

Although Royal and AIG, among others, say they are trying to raise rates, most observers believe there will be no real movement until the latter part of the year.

Sean Mooney, an economist with the Insurance Information Institute in New York, agrees that nothing dramatic is likely to happen before late 1984, and discourages any optimism that reinsurers' rate firming will have immediate results.

> 'It will be a long, slow recovery before those horrendous underwriting losses are reduced to some degree. Don't look for a dramatic improvement by Dec. 31, 1984,' comments Robert J. Haugh of The St. Paul Cos. Inc.

"The reinsurers typically say they don't see rates firming all that much," he says. "We think something is happening, but we're not convinced it's strong enough to turn the whole commercial lines market."

The recovery in rates will be gradual, not like during the mid-1970s when "rates just went up dramatically across all lines and there was a tremendous rebound in underwriting results," says Frederick V. Hill, vp of Moseley, Hallgarten, Estabrook & Weeden Inc. in New York.

The difference between the two cycles, Mr. Hill notes, is that there is currently no uniform agreement among insurance buyers, regulators, underwriters, brokers and agents that there is a "dire necessity" to hike rates.

Unlike others, Mr. Hill believes that while there will be some improvement in rates, commercial policyholders will resist paying higher premiums and continue to search out cheaper markets, which will moderate the rate hikes.

Along the same lines, Gordon D. Luce of Brown Bros. Harriman & Co. in New York says many direct insurers may decide to absorb, at least temporarily, any hikes in reinsurance rates because of competition and the unwillingness of buyers to accept any increases.

"I haven't been convinced by anything I've heard that the competition will slacken in 1984," says David Anthony, a second vp and securities analyst with Smith Barney Harris Upham & Co. Inc. in New York.

Analysts warn that insurers may not be able to count on investment income to cover their underwriting losses as they have in the past several years.

Last year, "A very favorable securities market helped the balance sheets of most companies so they had the wherewithal to compete without paying the price," says Leandro S. Galban Jr., a vp at Donaldson, Lufkin and Jenrette Securities Corp. in New York.

But, that situation is changing now, he adds, noting that over the past three to four months companies have not received the same financial support from the securities markets. Mr. Galban estimates that the combination of lagging premium growth, a lack of cash flow and lower interest rates means that investment income will grow by less than 5% in 1984.

And Royal's Mr. Watt adds that a shortage of cash flow in the industry does "not put a lot of cash in everyone's hand to invest."

While rates and—to a lesser extent—investment income can be predicted with a fair degree of accuracy, the frequency and severity of claims cannot.

While analysts agree that last year's heavy weather-related losses —which totaled $1.5 billion—were a "wild card" that is unlikely to reappear in this year's deck, they profess less certainty about the frequency and severity of claims.

Analysts point out that claims frequency and severity, especially in workers compensation lines, increased significantly in 1983, though they could not supply statistics. And they cannot say whether this increase will continue in 1984.

"It's hard to call," says Jeffrey Cohen, vp at Paine Webber Mitchell Hutchins Inc. in New York. "Companies don't seem to be sure whether it's a trend or a statistical aberration," he says, adding that part of the increase can be attributed to an increase in employment, which causes more workers compensation claims.

The increase in work comp claims frequency could be attributable to injuries to employees just returning to the workforce who are not accustomed to their tasks, suggests Gloria L. Vogel, a vp in Legg Mason Wood Walker Inc.'s New York office.

Another burning issue in the insurance industry that will not disappear in 1984, the analysts note, is the adequacy of reserves.

While Fireman's Fund, which added $230 million to reserves last year, and Mission Insurance Group Inc., which boosted its reserves by $23 million, are the most heralded examples of insurers coming to grips with expected losses, they are not alone, analysts comment.

The Insurance Services Office reported that the industry was under-reserved by 10% at the end of 1982, and Robert V. Brokaw Jr., senior analyst with Miller Tabak Hirsch & Co. in New York, notes that additions to reserves in 1983 tended to cover losses incurred last year. Companies have not yet dealt with the problem of under-reserving in 1981 and 1982, he contends.

Still insurers did increase reserves substantially last year. A Smith Barney survey of 15 major companies found that the median increase in loss reserves among the insurers equaled 12.2% of earned premiums in the fourth quarter, compared with a 6% increase for the same period in 1982.

Reserving will become "an increasingly important area as the year unfolds, particularly in the commercial lines," predicts Mr. Anthony.

Finally, some analysts note that the industry must deal with the fact that it is running out of tax liabilities from prior years with which to offset underwriting losses.

About half of a property/casualty insurer's underwriting losses are ordinarily tax-deductible because they can be offset against these deferred liabilities. However, analysts note that many companies, after several years of underwriting losses, are running out of these deferred liabilities.

Aetna Life & Casualty Co. attempted to sidestep this problem by booking underwriting losses as tax-loss carryforwards—or assets—that could be offset by future liabilities. However, the Securities and Exchange Commission last year rejected this accounting practice because it said Aetna could not show "beyond a reasonable doubt" that it will show underwriting profits in the next 15 years (*BI*, Feb. 21, 1983).

While some dismiss the Aetna decision as a narrow issue, others think it holds wider implications.

"It's a very real issue for a lot of companies if they sat and did nothing. I think a lot of them will lose tax credits for 1985," says Mr. Stradtner at Alex. Brown & Sons.

Mr. Anthony at Smith Barney says that the dwindling of deferred liabilities may lead insurers to shift toward taxable investments and securites to generate additional taxable income with which to offset underwriting losses.

Continued on facing page

Summary of major property/casualty insurer 1983 results

(All amounts in thousands of dollars)

(Ranked by change in aftertax operating income)

		Corporate				Property/casualty operations							
Rank 1983		Consolidated revenues 1983	Aftertax[1] operating income 1983	Aftertax[1] operating income 1982	Percent increase (decrease) 1982-1983	Combined[1] ratio 1983	Combined[1] ratio 1982	Net premiums written 1983	Percent increase (decrease) 1982-1983	Pretax underwriting income (loss) 1983	Percent increase (decrease) 1982-1983	Pretax investment income 1983	Percent increase (decrease) 1982-1983
1	Sentry Insurance Cos.	445,995	40,988	11,432	258.5	104.6	109.9	737,087	2.1	(42,675)	(18.9)	112,545	10.4
2	USF&G Corp.	2,386,894	171,545	114,134	50.3	116.6	112.4	1,988,720[2]	0.6	(331,440)	24.0	362,736	31.8
3	American General Corp.	3,953,400	289,800	202,700	43.0	115.1	105.1	971,900	19.6	(118,600)	226.0	67,000	272.2
4	SAFECO Corp.	1,702,159	133,289	107,558	23.9	103.1	101.6	887,576	6.7	(26,875)	103.4	105,449	9.2
5	Old Republic Int'l (inc. life)[2]	407,700	50,900	42,700	19.2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
6	CNA Financial Corp.	3,284,300	144,300	121,200	19.0	119.7	118.2	1,567,900	(0.2)	(342,000)	11.0	401,300	10.0
7	Hartford Steam Boiler	217,672	18,954	16,275	16.5	98.7	97.8	155,241	5.5	2,699	76.2	17,305	6.6
8	The Chubb Corp.	1,761,303	84,400	74,200	13.7	108.8	110.3	1,241,200	12.1	(105,900)	(6.4)	132,400	9.2
9	The Travelers Corp. & subs.	12,002,100	342,600	309,900	10.6	112.9	111.2	2,887,400	(2.4)	(351,900)	—	514,900	18.4
10	American International Group	3,996,480	427,271	412,650	3.5	100.8	98.2	2,443,432	8.0	(23,779)	(170.2)	320,999	6.2
11	Aetna Life & Casualty	14,410,600	325,200	319,000	1.9	113.6	114.6	3,677,800	3.7	(461,400)	(10.3)	479,700	(6.8)
12	Reliance Ins. Co. & subs.	1,329,633	67,788	67,532	.0.4	109.9	106.4	1,177,553	10.0	(87,141)	88.9	164,700	(3.7)
13	The Hartford Ins. Group	5,149,119	231,732	236,717	(2.1)	114.0	111.6	3,014,876	1.2	(416,455)	21.3	450,769	(4.2)
13	Ohio Casualty Corp.	879,200	55,724	57,020	(2.3)	107.0	105.3	842,722	5.6	(59,446)	37.2	89,795	7.2
14	General Re Corp.	1,658,848	192,054	206,647	(7.1)	107.1	101.8	901,794	9.0	(55,358)	240.3	186,376	9.5
15	Crum & Forster Inc.	2,176,798	109,236	114,699	(4.8)	113.5	113.2	1,883,176	11.9	N/A	N/A	305,768	1.2
16	Kemper Corp.	2,221,988	68,351	74,982	(8.8)	112.2	109.4	858,064	(8.1)	(103,852)	19.5	73,557	(4.7)
17	CIGNA Corp.	12,563,800	400,500	490,100	(18.3)	121.3	116.7	3,529,272	(0.3)	(804,970)	(2.4)	564,792	2.5
18	The St. Paul Cos. Inc.	2,321,400	126,800	195,700	(35.0)	113.5	105.7	1,744,100	11.0	(231,100)	148.0	274,000	4.0
19	The Home Group Inc.	2,176,400	24,500	65,400	(62.5)	121.1	115.9	1,598,240	(5.2)	(333,200)	28.1	309,381	7.2
20	The Continental Corp.	3,946,566	14,499	105,210	(86.2)	117.4	112.8	2,400,877[2]	(7.8)	(395,535)[2]	20.3	298,936[2]	(1.9)
21	Fireman's Fund Ins. Cos.	3,783,939	30,117	244,076	(87.7)	126.0	104.5	2,780,737	5.4	(703,817)	501.8	415,307	27.1
22	Royal Group (U.S. subs.)[3]	N/A	(36,000)	(18,000)	(100.0)	114.0	111.1	1,246,000	(0.7)	(172,000)	275.0	179,000	9.8
23	Mission Ins. Group Inc.	483,167	(15,165)	47,816	(131.7)	124.7	100.8	400,840	22.8	(97,235)	3,562.3	46,913	(1.3)
24	Fremont General Corp.	533,960	(9,102)	5,572	(263.3)	129.9	119.9	241,756	(4.8)	(73,064)	39.4	43,125	10.9
—	Commercial Union Ins. (U.S.)	N/A	N/A	N/A	N/A	125.1	121.7	1,352,400[2]	(8.3)	(320,000)	4.6	189,500	7.2
—	Wausau Insurance Cos.	N/A	N/A	N/A	N/A	112.0	115.6	1,024,826	12.5	(128,686)	105.0	150,752	(19.2)
	Cumulative	83,793,421	3,249,293	3,625,220	(10.4)	114.8	111.0	41,555,489	5.2	(5,783,729)	40.9	6,257,085	12.5

[1] After dividends. [2] Statutory. [3] Before dividends; includes life business. N/A—Company did not provide data.

Continued from facing page

For instance, he said insurers could move funds from tax-free equities to investments in utilities.

In addition, other analysts and insurers express concern over the swapping of loss reserves among insurers to artificially boost their bottom lines.

In a sale of loss reserves, which is considered a reinsurance transaction, the insurer selling reserves pays another underwriter to assume the reserves and the attendant liabilities.

The seller usually pays less than the amount in reserve since the buyer can generate investment income on the reserves that could more than cover the future liabilities. The company selling the reserves reports as pretax income the difference between what it pays to sell the reserves and the actual amount it had reserved.

A group of American Express Co. shareholders recently sued the company because they claim that a swap of loss reserves between Fireman's Fund, an Amex subsidiary, and Insurance Co. of North America distorted the company's earnings report (*BI*, March 5).

The sale of loss reserves has definitely deteriorated the quality of earnings at some companies, notes Myron M. Picoult, a vp at Oppenheimer & Co. in New York. "The numbers stink. The numbers are dirty," he says.

"On a broad scale, (the sale of loss reserves) clouds up the picture and it does dirty up the figures," says the official of one major insurer who has not engaged in the practice.

As many as 40 such transactions may have taken place last year, one reinsurance executive told *BI* in October.

Results produced by one-time deals, such as the sale of loss reserves, "tax games" and under-reserving, can improve insurers' numbers, says Ms. Stewart of Stewart Economics. But, she points out that these practices reduce the margin for error and expose insurers to heavy losses should a catastrophe strike. ■

BI Industry Stock Report

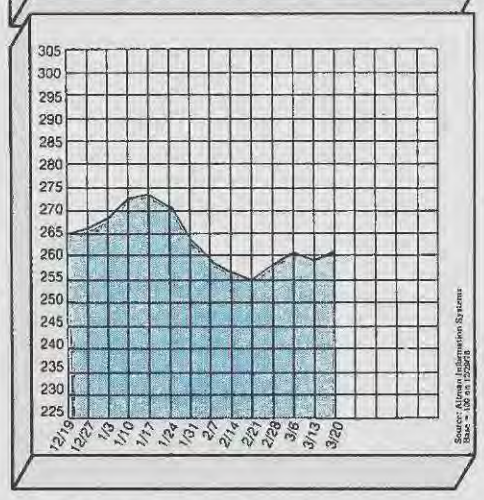
MAR. 20, 1984 3/14/84 THRU 3/20/84

Insurance Cos.		Price	% Chg.	P/E	$ Div.	% Yld.	High	Low	Vol. (000)
Aetna Life & Cas Co	NYSE	36.25	3.9	11.8	2.64	7.3	36.25	34.75	754.5
American Bankers Ins Group	OTC	13.50	0.9	9.5	0.50	3.7	13.50	13.13	32.8
American General Corp	NYSE	21.00	0.6	6.3	0.90	4.3	21.00	20.38	1,338.4
American Indty Finl Corp	OTC	20.50	-2.4	17.8	1.12	5.5	20.75	20.50	1.5
American Intl Group Inc	OTC	54.50	4.3	9.4	0.44	0.8	54.50	51.50	1,077.7
American Natl Ins Co	OTC	23.75	1.1	7.4	0.96	4.0	23.75	23.25	157.7
Aneco Reins Ltd	OTC	3.00	-7.7	8.8	0.00	0.0	3.13	3.00	14.5
Avemco Corp	AMEX	18.00	5.1	11.7	0.58	3.2	18.00	17.00	2.1
Banks Iowa Inc	OTC	51.50	0.0	19.1	1.52	3.0	51.50	51.50	14.5
Bitco Corp	OTC	16.25	-1.5	0.0	1.33	8.2	17.00	16.25	6.6
Carolina Cas Ins Co	OTC	4.75	0.0	0.0	0.00	0.0	4.75	4.75	3.7
Chubb Corp	OTC	65.88	-2.0	9.6	3.12	4.7	66.75	64.63	303.2
Combined Intl Corp	NYSE	32.00	-3.8	8.3	2.08	6.5	32.75	31.75	176.2
Continental Corp	NYSE	29.00	7.4	152.6	2.60	9.0	29.00	27.38	478.8
Crawford & Co	OTC	14.50	3.6	10.3	0.66	4.6	14.50	14.25	7.1
Crown Life Ins Co	OTC	122.00	0.0	8.0	3.20	2.6	122.00	122.00	2.5
Employers Cas Co	OTC	32.00	0.0	7.2	1.20	3.8	32.00	32.00	5.1
Equifax Inc	NYSE	25.38	-0.5	10.1	1.60	6.3	25.88	25.00*	19.2
Farmers Group Inc	OTC	37.88	-2.3	9.3	1.52	4.0	38.50	37.75	133.2
Foremost Corp Amer	OTC	26.00	7.2	12.0	0.96	3.7	26.00	24.25	81.7
Fremont Gen Corp	OTC	16.00	11.3	0.0	0.48	3.0	16.25	15.13	724.8
Great West Life Assurn Co	OTC	285.00	-5.0	10.3	12.00	4.2	300.00	285.00	0.5
Hanover Ins Co	OTC	51.75	2.5	6.8	0.88	1.7	51.75	50.50	27.8
Hartford Steam Boiler Insptn	OTC	51.25	-3.3	8.8	3.00	5.9	53.00	51.25	24.6
Jefferson Natl Life Ins Co	OTC	42.00	1.2	18.6	0.76	1.8	42.00	41.50	2.8
Kemper Corp	OTC	39.13	3.3	8.4	1.80	4.6	39.13	37.88	44.7
Lincoln Natl Corp Ind	NYSE	29.88	0.0	7.3	1.68	5.6	29.88	29.50	321.0
Mission Ins Group Inc	NYSE	20.75	-1.8	0.0	0.50	2.4	21.38	20.38	326.7
Nationwide Corp Ohio	OTC	41.75	0.0	15.3	0.70	1.7	0.00	DID NOT TRADE	
Northwestern Natl Life Ins	OTC	39.50	3.9	9.9	1.50	3.8	39.50*	38.75	23.2
Ohio Cas Corp	OTC	44.38	-1.1	9.1	2.68	6.0	44.50	44.25	39.3
Old Rep Intl Corp	OTC	32.30	-0.8	6.9	0.90	2.8	32.00	31.75	107.8
Orion Cap Corp	NYSE	24.63	2.6	12.1	0.76	3.1	24.75	24.00	47.3
Preferred Risk Life Ins Co	OTC	20.75	3.1	7.4	0.74	3.6	20.75	20.13	2.9
Provident Life & Acc Ins Co	OTC	68.50	0.0	7.2	2.60	3.8	68.50	68.50	13.5
St Paul Cos Inc	OTC	58.50	4.2	9.1	3.00	5.1	58.50	55.25	331.6
SAFECO Corp	OTC	59.63	2.8	8.4	2.60	4.4	59.63	58.25	65.1
Sri Corp	OTC	16.25	-1.5	8.1	0.68	4.2	16.75	16.25	79.0
Seibels Bruce Group Inc	OTC	18.50	1.4	12.0	0.80	4.3	18.75	18.25	132.6
Statesman Group Inc	OTC	9.63	-6.1	8.4	0.15	1.6	10.25	9.63	83.7
Tokio Marine & Fire Ins Co	OTC	126.25	0.0	25.5	0.96	0.8	126.25	124.75	9.0
Travelers Corp	NYSE	33.50	-1.5	8.2	1.92	5.7	33.50	33.13	746.1
United Fire & Cas Co	OTC	29.25	-0.8	21.8	1.60	5.5	29.50	29.25	0.1
United States Fid & Gty Co	NYSE	58.50	-0.4	9.7	4.16	7.1	59.38	58.00	264.2
United Svcs Life Ins Co	OTC	25.00	-1.0	7.1	1.00	4.0	25.38	25.00	6.3
Uslife Corp	NYSE	27.63	0.5	7.5	0.96	3.5	27.63	27.38	130.8
Washington Natl Corp	NYSE	22.13	-2.2	11.8	1.08	4.9	22.38	22.00	40.8
Zenith Natl Ins Corp	OTC	14.00	3.7	9.5	0.60	4.3	14.00	13.50	12.1
INSURANCE COMPANIES	AVERAGE			10.6		4.0			
Agents/Brokers									
Alexander & Alexander Svcs	NYSE	19.50	-1.9	0.0	1.00	5.1	20.00	19.50	445.5
Baldwin & Lyons Inc	OTC	37.00	0.0	68.5	0.80	2.2	37.00	37.00	6.4
Corroon & Black Corp	NYSE	25.00	5.3	15.6	1.00	4.0	25.00	23.63	37.0
Crump E H Cos Inc	OTC	11.25	0.0	15.0	0.40	3.6	11.75	11.25	24.1
Emett & Chandler Cos Inc	OTC	9.75	0.0	26.4	0.00	0.0	9.75	9.75	0.3
Hall Frank B & Co Inc	NYSE	22.88	0.0	24.1	1.35	5.9	23.50	22.50	258.5
Integrated Res Inc	AMEX	22.50	-3.2	7.3	0.00	0.0	23.25	22.50	173.1
Marsh & Mclennan Cos Inc	NYSE	47.25	5.9	13.5	2.20	4.7	47.25	45.00	282.2
Poe & Assoc Inc	OTC	5.00	0.0	0.0	0.00	0.0	5.00	5.00	0.0
Reed Stenhouse Cos Ltd	OTC	12.13	2.1	15.8	0.60	4.9	12.38	12.00	117.5
AGENTS/BROKERS	AVERAGE			19.3		3.5			
Conglomerates/Holding Cos.									
American Express(Fireman's Fd)	NYSE	30.88	5.6	12.2	1.28	4.1	30.88	29.38	3,458.9
Anderson Clayton(Ranger/PanAm)	NYSE	29.25	0.0	32.9	1.32	4.5	29.50	28.75	12.8
Armco Inc	NYSE	19.38	1.3	0.0	0.40	2.1	19.63	19.13	321.0
Baldwin Utd Corp	NYSE	2.25	5.9	0.0	0.00	0.0	2.38	2.13	650.8
CIGNA Corp	NYSE	40.75	1.2	7.7	2.60	6.4	40.75	40.00	439.1
City Investing Co. (Home Ins.)	NYSE	35.25	7.2	8.2	2.00	5.7	35.25	33.50	1,070.1
CNA Finl Corp (CNA)	NYSE	26.00	2.0	9.2	0.00	0.0	26.00*	24.50	86.0
Control Data (Comml. Credit)	NYSE	37.50	0.0	8.9	0.66	1.8	38.63	37.25	766.2
General Re Corp	NYSE	57.63	-1.1	13.5	1.44	2.5	59.50	57.63	461.2
ITT (Hartford Group)	NYSE	41.00	2.2	9.1	2.76	6.7	41.00	40.50	1,572.5
Optimum Hldg Corp	OTC	3.88	10.7	29.8	0.00	0.0	3.88	3.25*	10.2
Sears Roebuck & Co. (Allstate)	NYSE	33.88	-2.2	8.9	1.76	5.2	34.00	33.75	2,594.5
Teledyne Inc (Argonaut)	NYSE	169.88	1.6	11.4	0.00	0.0	170.25	168.38	483.1
Transamerica Corp (Occidental & Fred S. James)	NYSE	23.50	-1.1	8.5	1.56	6.6	23.50	23.25	414.8
CONGLOMERATES/HOLDING COS.	AVERAGE			14.3		2.9			

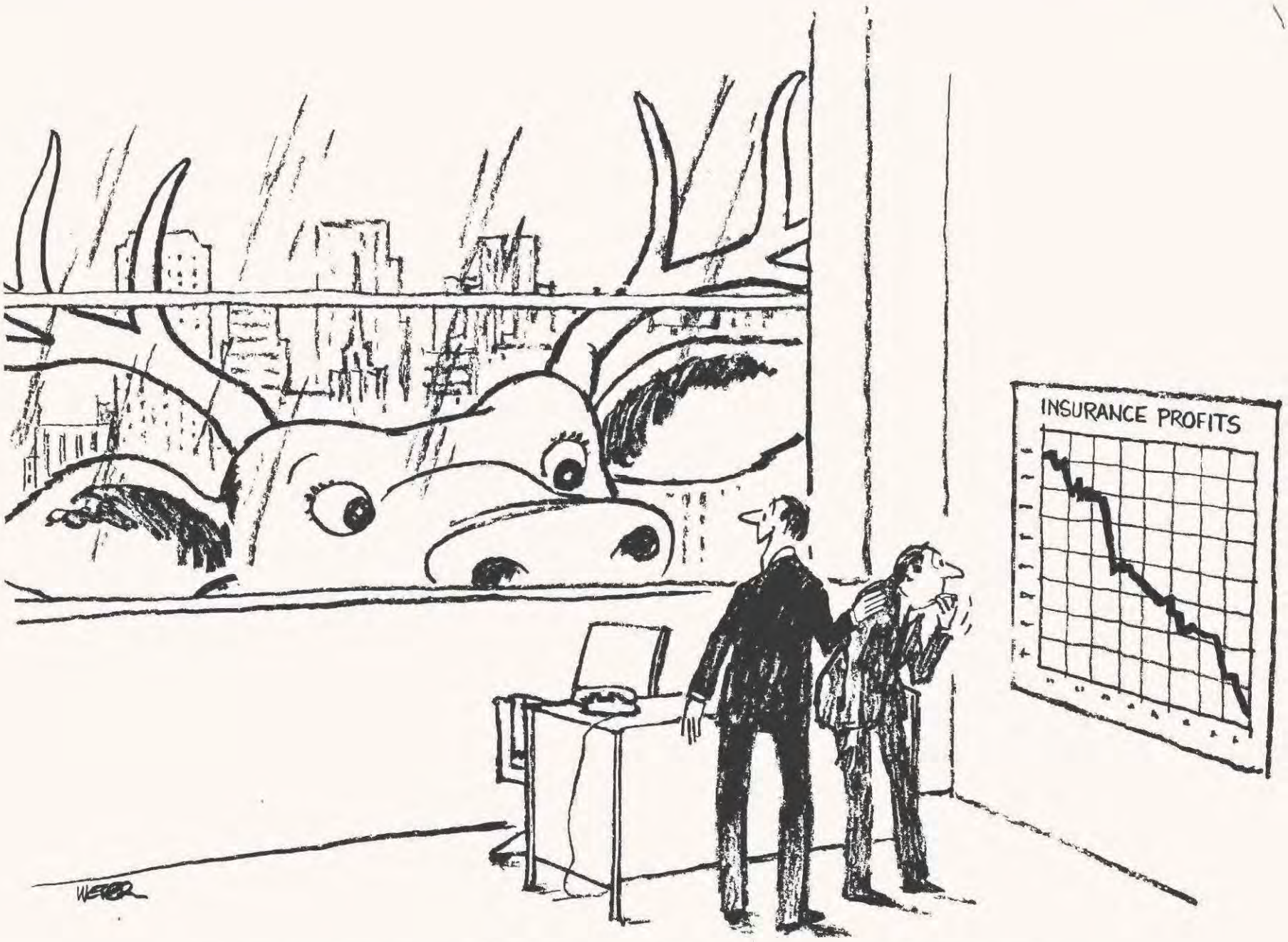
*Record high/low since Jan. 1, 1983

System design: Altman Information Systems

BI Insurance Index



The *Business Insurance* index continued to climb as the insurance industry stock average rose 2.2 points to 261.2 from 259.0 for the trading period ending March 20. Twenty-six stocks closed up, 14 were unchanged and 21 issues posted losses. The leading gains were reported by Fremont General Corp., 11.3%; Optimum Holding Corp., 10.7%; Continental Corp., 7.4%; Foremost Corp. of America, 7.2%; and Marsh & McLennan Cos. Inc., 5.9%. The biggest losses were posted by Aneco Reinsurance Co. Ltd., 7.7%; Statesman Group Inc., 6.1%; Great West Life Assurance Co., 5.0%; Combined International Corp., 3.8%; and The Hartford Steam Boiler Inspection & Insurance Co., 3.3%. The *Business Insurance* index, which rose 0.8%, lagged behind the NYSE composite increase of 1.2%.



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