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...news, views and reviews from the Center for Justice & Democracy

CENTER FOR JUSTICE & DEMOCRACY **NEWS**

Dear Friend,

This issue of *Impact* deals with the insurance industry, whose role in creating this country's periodic insurance "crises" is often-ignored in political debates over so-called "tort reform."

History shows that property/casualty insurance companies have repeatedly threatened to pull the rug out from under the U.S. economy to get what it wants, whether it be a post-9/11 "bailout" or limits on people's rights to sue. It freely intimidates lawmakers and creates an atmosphere of "crisis" to promote its legislative agenda while at the same time escaping any meaningful public scrutiny or regulatory control.

In 2002, the Center for Justice & Democracy created Americans for Insurance Reform, a coalition of over 100 public interest groups around the country that wants to bring attention to the insurance industry's business and accounting practices and seek reform. AIR has published many studies over the last few years that have helped reshape the political debate. For more information about AIR, visit its web site at http://insurance-reform.org.

We appreciate your support.

Joanne Doroshow
Executive Director

IN THIS ISSUE: INSURANCE INDUSTRY SCANDAL

AIG Under Investigation

For decades the insurance industry has engaged in questionable business and accounting practices that put profits before the interests of policyholders and the public at large. And it's all been done with very little scrutiny by regulators, that is, until now.

Following the lead of New York State Attorney General Eliot Spitzer, federal and state regulators are now taking a hard look at financial manipulation by the insurance industry. The latest investigation involves American International Group (AIG), one of the world's biggest insurance companies and a major medical malpractice writer. According to a civil lawsuit filed by Spitzer and New York State's Insurance Superintendent in May 2005, AIG and its former top two officials - ex-Chairman and CEO Maurice "Hank" Greenberg and former CFO Howard Smith - orchestrated an accounting scheme to deceive regulators and investors about the company's financial condition.

More specifically, under Greenberg's direction and approval, AIG allegedly engaged in fraudulent business transactions, hid underwriting losses, created false underwriting income and repeatedly misled state regulators about AIG's ties to offshore entities, purposely exaggerating the strength of its core underwriting business to prop up its stock price.

"The irony of this case is that AIG was a well-run and profitable company that didn't need to cheat," Spitzer said in a May 26, 2005 press release. "And yet, the former top management routinely and persistently resorted to deception and fraud in an apparent effort to improve the company's financial results."

Among the more egregious misconduct alleged is that Greenberg personally proposed and negotiated two deals with insurer General Re's CEO in 2000 and 2001 that artificially bolstered

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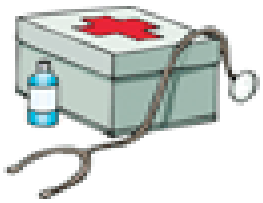
Medical Malpractice Insurers: Only Themselves to Blame

We've heard it all before: the unbearably high costs of frivolous lawsuits and huge jury verdicts are forcing medical malpractice insurers to abandon policyholders, leave states or pull out of the market altogether. What's the industry's solution? Limit the ability of sick and injured patients to hold negligent doctors, hospitals, HMOs, nursing homes, and drug makers accountable in court.

Yet industry insiders know that med mal insurers have only themselves to blame.



Time and again, the collapse of med mal insurance companies has been directly brought on by their own mismanagement and fraud. As Donald J. Zuk, chief executive of Scpie Holdings Inc., a leading malpractice writer in California, told the *Wall Street Journal* in June 2002, "I don't like to hear insurance-company executives say it's the tort [injury-law] system - it's self-inflicted."

The following examples

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AIG Under Investigation continued . . .

AIG's reserves by $500 million. The purpose, according to the complaint, was to "give the investing public the impression that AIG had a larger cushion of reserves to pay claims than it actually did."

Manipulation of reserves set aside to pay claims has been considered a major factor precipitating the medical malpractice insurance "crisis" for doctors in recent years. In hard markets (i.e., dropping investment income, rising insurance premiums), as we have recently experienced, insurers increase reserves as a way to justify premium increases. In fact, the recent insurance "crisis" rests significantly on a jump in reserves in 2001.

In June 2002, a front page *Wall Street Journal* artide exposed the insurance accounting practice of manipulating reserves, widely used in the early 1990s, which made the medical malpractice insurance business appear far more profitable than it really was - similar to the allegation now being made against AIG.

AIG's transactions with General Re are also at the center of investigations by the Justice Department and the SEC, which recently filed a civil lawsuit against senior executives at General Re, accusing them of aiding and abetting AIG's securities fraud. As of publication, two former General Re executives agreed to plead guilty to criminally conspiring with others to doctor AIG's books to boost the appearance of its financial health.

Besides those allegations of fraud, Spitzer's suit also alleges a separate scheme in which AIG improperly booked workers' compensation premiums to reduce the company's taxes and other assessments. The complaint cites 1991 interview notes from AIG's newly hired General Counsel, who learned from multiple employees that top AIG officials, including Greenberg, condoned the practice. One interview witness recounted a meeting in which Greenberg asked "are we legal?" When an employee responded 'If we were legal, we wouldn't be in business,' then 'MRG [i.e., Greenberg] began laughing and that was the end of it.'"

A 1992 memorandum from the same General Counsel, warning Greenberg that misbooking workers' comp premiums was "permeated with illegality," has also been presented as evidence against the former CEO.

"The result is that AIG makes millions of dollars illegally each year," the lawyer wrote. "The situation is so serious that it could threaten the continued existence of senior management in its current form." He added that a jury might find AIG guilty of civil and criminal fraud, in addition to securities and racketeering law violations, and recommended corrective actions, all of which were ignored.

Other documentation - including a 1989 internal company memo with notations about AIG's "avoiding proper WC tax + [state assessment] charges" and "$20-30M tax and [state assessment] dodge"- reportedly shows that AIG knew it was breaking the law with respect to booking workers' comp premiums.

In the wake of Spitzer's investigation, AIG has admitted that many of the transactions examined were improper, fired implicated staff and restated its financial earnings. Yet the company still faces several investigations by Spitzer's office, other state attorneys general and insurance regulators, as well as shareholder lawsuits.

In one case, AIG and 21 present and past officers, including Greenberg and Smith, allegedly breached their fiduciary duty to a Louisiana pension fund by engaging in self-dealing that diverted millions of dollars in undeserved commissions to themselves. Other lawsuits have been brought on behalf of Ohio and San Francisco pension funds, which claim to have suffered financial harm from AIG's violations of securities laws.

Unfortunately, the rampant corruption uncovered at AIG is not an anomaly. As New York Attorney General Spitzer told a Senate committee in November 2004, "The problems we have uncovered in the insurance industry are profound, complicated and national in scope," adding that systemic nationwide reform is "urgently needed." In the meantime, at least 42 states are reported to have launched some type of inquiry into insurers' business practices. The FBI is also working with the SEC and state insurance commissioners in a criminal probe to determine whether insurance fraud is an industry-wide problem.

"We have a very wary eye on the insurance industry because of AIG and the situation there," Chris Swecker, assistant director of the FBI's criminal investigative division, told reporters at a May 2005 press briefing. "We do not want to get caught napping on this, so we are taking a very, very hard look at cases like AIG and trying to determine if that is an indicator of something more serious and something more pervasive."

Given the industry's record of corporate citizenship, regulators have good reason to be concerned.

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Medical Malpractice Insurers: Only Themselves to Blame continued…

illustrate how med mal insurers' own business and accounting practices have wreaked havoc on the American public.

Reciprocal of America

Insurance commissioners in Tennessee and Virginia have filed federal racketeering charges against former Reciprocal executives, among others, after the company collapsed in 2003, leaving thousands of doctors and hospitals in the South and Midwest without coverage. The executives allegedly used deceptive accounting practices to hide the company's financial problems from state insurance regulators and took "business trips" to luxurious vacation resorts while Reciprocal was falling apart.

In February 2005, the company's former president and CEO and a former executive vice president pleaded guilty to federal fraud charges. The former president and CEO was later sentenced to 12 1/2 years in prison; the former executive VP was sentenced to five years in prison.

Reliance

In February 2005, Pennsylvania's Insurance Commissioner agreed to settle charges against 18 former Reliance officials responsible for the company's financial collapse in 2001. According to the suit, during the late 1990s top officers and directors allowed Reliance's chairman to drain cash from the company to support his lavish lifestyle and business debt, propelling Reliance into bankruptcy, and then hid the company's true financial condition from regulators and the public. The $85 million settlement is subject to court approval.

PHICO

In November 2003, Pennsylvania's Insurance Commissioner settled charges against 15 former executives of the defunct PHICO for $10 million. The suit alleged that board members paid millions in stock dividends to parent companies while PHICO's surplus was declining and then failed to act as the nation's seventh-largest med mal insurer fell into financial disaster, collapsing in 2001.

St. Paul

In 2001, one of the country's largest medical malpractice insurance companies, St. Paul, left the medical malpractice insurance market. As the *Wall Street Journal* found in a front page investigative article on June 24, 2002, St. Paul, with 20% share of the national market, pulled out after mismanaging their underwriting and reserves. In the 1980s, the company set aside too much money for malpractice daims. So, using a tricky accounting method, in the 1990s the company "released" $1.1 billion in reserves, which flowed through its income statements and appeared as big profits. Seeing these profits, many new, smaller carriers came into the market. Everyone started slashing prices to attract customers. From 1995 to 2000, rates fell so low that they became inadequate to cover malpractice claims. Many companies collapsed as a result. St. Paul eventually pulled out, creating huge supply and demand problems for doctors in many states.

(For more examples, see CJ&D's Mythbuster, "Medical Malpractice Mismanagement," found at http://www.centerjd.org/free/medmalmismanagement.pdf.)

Interesting Facts About AIG

What it sells: Auto, residential, property, general liability, umbrella, professional liability, employment practices liability, workers' comp and international coverages.

Contributions to federal candidates and parties during 2000, 2002 and 2004 election cycles: $4,618,522.

Recent profits: Net income in 2004 was $11.05 billion, an increase of 19.1% over 2003.

CEO 2004 compensation: Maurice Greenberg, former Chairman and CEO, $16,865,498.

Favorite quotations: "I don't want the stock below $66 so keep buying…. If you have to go to half a million [shares], go to half a million." Maurice Greenberg directing an AIG trader to aggressively purchase company stock for the purpose of propping up its price, February 3, 2005.

"We have always sought to adhere to the highest ethical standards and ensure that we are in compliance with the applicable laws and regulations that govern our businesses around the world." Maurice Greenberg after settling SEC and Justice Department charges of federal securities law violations, November 30, 2004.

"If a company is dishonest from the top down it should be dealt with as harshly as possible, but that is not the case with AIG." Maurice Greenberg defending AIG during a conference call with analysts, October 21, 2004.

"The problems facing American businesses are real and in most cases self-inflicted by the careless disregard on the part of a few CEOs of the responsibility they carry to create value for all of their constituencies - customers, employers and shareholders." Maurice Greenberg accepting *Chief Executive Magazine's* CEO of the Year Award, 2003.

The Uncaring Health Insurance Industry

From all the PR hype, you'd think that health insurers were in a state of financial crisis. Think again.

Health insurers' profits and their executives' salaries have skyrocketed, while they raise premiums and limit reimbursement to doctors. As reported by *Investors' Business Daily* on October 15, 2004, "Despite a weak economy and soaring medical costs, U.S. health insurers have raked in earnings at a far greater pace than the rest of corporate America, with annual profits and margins doubling in the last four years."

During that time, "[a]verage pay for the five top executives at [the top] health insurers almost doubled to $3 million a year." Over the same four-year period, health insurers raised premiums 59%, according to a 2004 Kaiser Foundation study.

Greed has become the business of insurance.

Doctors, fed up with the way health insurers operate, are taking culpable off-enders to court. For example, 700,000 physicians and various state medical societies have filed a class action lawsuit against Coventry, Humana, PacifiCare and UnitedHealthcare, alleging that the carriers systematically denied, delayed and diminished payments for medical services by using automated claims-processing systems to "downcode" and "bundle" claims as part of a racketeering conspiracy.

The companies "got together and created a software that allows them to hide behind a black box in terms of the way they adjudicate these claims," said Archie Lamb, a lawyer representing the doctors, after the U.S. Supreme Court allowed the suit to proceed as a class action in January 2005.

Other leading managed-care companies named in the original suit, namely Aetna, Cigna, HealthNet, Prudential and Wellpoint, have already reached settlements with the doctors totaling more than $1 billion. Trial against the remaining defendants is scheduled for September 2005.

Set to begin that same month is a class action lawsuit brought against St. Paul by nearly 40,000 physicians left without coverage. According to the case, in 1999 and 2000 St. Paul artificially inflated its earnings by taking nearly $1.1 billion from reserve accounts intended to cover doctors, a move that helped top executives to more than $45 million in bonuses, salaries and stock options.

Based on recent history, it appears that greed has become the business of insurance.

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