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Business Insurance

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Update

Film Recovery, executives face retrial in worker's death

SPRINGFIELD, Ill.—Film Recovery Systems Inc., a sister company and three former executives will be retried for the 1983 job-related death of an employee after the Illinois Supreme Court last week refused to review a lower court ruling overturning criminal convictions in the case.

The former executives of now-defunct Elk Grove Village, Ill.-based Film Recovery and sister company Metallic Marketing Systems Inc. had been con-

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Walbrook questions continue

Efforts under way to build stronger U.S. casualty slip

By CAROLYN ALDRED and STACY SHAPIRO

LONDON—Policyholders will have to wait until after April 15 for any announcement concerning the future of Walbrook Insurance Co. Ltd. and the H.S. Weavers (Underwriting) Agencies Ltd. liability line slip, according to the chief executive of Walbrook's and Weavers' parent company.

"There are all sorts of things going on here to try to get the group back going again and there won't be anything to say until just after Easter," Peter Wilson, chief executive of London United Investments P.L.C., said Friday.

At the same time, the owner of Anglo American Insurance Co. Ltd., which writes 45% of the Weavers slip, confirmed it was negotiating with Zurich Insurance Group to replace Walbrook's capacity.

John Head, chairman of Head Insurance Investors (Bermuda) Ltd., Anglo American's owner, denied late on Friday reports in the London market that the Zurich negotiations had fallen through.

Dennis White, chief executive officer of Zurich Insurance U.K. Ltd. in Portsmouth, denied knowledge of negotiations. Peter Sale, general manager of Zurich Re (U.K.) Ltd., was unavailable for comment.

Any new insurers that may be added to the Weavers slip are "going to be looked at very carefully," noted one broker. "High capitalization and long-term commitment will be

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Expired coverage replaced; other policyholders cautious

By LINDA J. COLLINS

U.S. policyholders of the H.S. Weavers (Underwriting) Agencies Ltd. casualty line slip whose coverage renewed on April 1 are having little trouble replacing excess liability coverage, brokers report.

But, few Weavers policyholders whose coverage renews at a later date have decided to shift their coverage now to other markets, brokers add. That is important, they say, because shifting the coverage to other markets during midterm could create headaches due to the wording of the Weavers excess liability claims-made policy form.

In addition, underwriters apparently are not willing to write blanket retroactive coverage for Weavers policyholders that fear pending or future claims may not be paid by insurers that have participated on the Weavers line slip. However, brokers report some underwriters that are writing occurrence-based liability coverage to replace the Weavers claims-made coverage are offering policyholders seven years of tail coverage for events that occurred while Weavers was on the risk.

Walbrook Insurance Co. Ltd., which wrote 55% of the Weavers slip, suspended underwriting late last month pending release of an actuarial report on Walbrook's reserves (*BI*, April 2).

In addition, six other insurance subsidiaries of London United Investments P.L.C., which owns Weavers and Walbrook, sus-

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High court to hear case that contests punitive damages

By STACY ADLER

WASHINGTON—The U.S. Supreme Court could rule on the constitutionality of excessive punitive damage awards in a case it has agreed to hear.

The high court last week agreed to review a case in which a jury hit Newport Beach, Calif.-based Pacific Mutual Life Insurance Co. with $1.1 million in compensatory and punitive damages. In the case, a company agent committed fraud, resulting in the cancellation of a municipality's group health insurance policy even though

Supreme Court ruling increases employers' liability. Page 3

the city paid its premiums, court papers say.

But, some attorneys question whether this case is the best one for the high court to review in deciding the constitutionality of excessive punitive damages, because the jury in the underlying case did not specify how much of the award was punitive damages.

The Pacific Mutual case also raises several other issues involving punitive damages of great importance to corporate America, and the court could rule on those while not ruling on the constitutionality of excessive punitive damage.

In its appeal to the Supreme Court, Pacific Mutual questions whether:

- Excessive punitive damage awards violate a defendant's right to due process under the 14th Amendment of the Constitution.
- Allowing juries to award punitive damages at their discretion violates due process.
- A company can be held liable for punitive damages for employee actions not sanctioned by the company

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Capping doctors' fees

Plans fear Medicare cost shifts

By ADRIENNE C. LOCKE

Many group health insurers are expected to adopt a physician fee reimbursement system to shield against cost shifting by physicians trying to recoup lost Medicare revenues.

Health insurers offering both indemnity and managed care plans will adopt a system of physician reimbursement similar to the Medicare fee schedule approved last year by Congress, health care experts say.

But, experts point out that employers with managed care plans would have more control to prevent cost shifting to their employees as a result of the new Medicare reimbursement system. As a result, many employers will move from traditional indemnity health care plans to some type of managed care plan, experts predict.

Insurers and self-insured employers without enough clout to set up preferred provider networks—in which physicians agree to reimbursement based on such a schedule—could base their usual and customary payment of health care costs on the Medicare schedule. However, that could lead to cost shifting to employees, experts say (*BI*, Sept. 19, 1989).

Under the new Medicare physician reimbursement system, physicians would be paid predetermined amounts for specified services provided to Medicare recipients, similar to the rates set for specific hospital care procedures under the Medicare diagnostic related group system established in 1983.

The new Medicare physician fee-reimbursement schedule is still being hammered out (see story, page 27).

In general, the new physician reimbursement system will mean reduced reimbursement to specialty physicians such as cardiac surgeons and ophthalmologists, but higher reimbursement to primary

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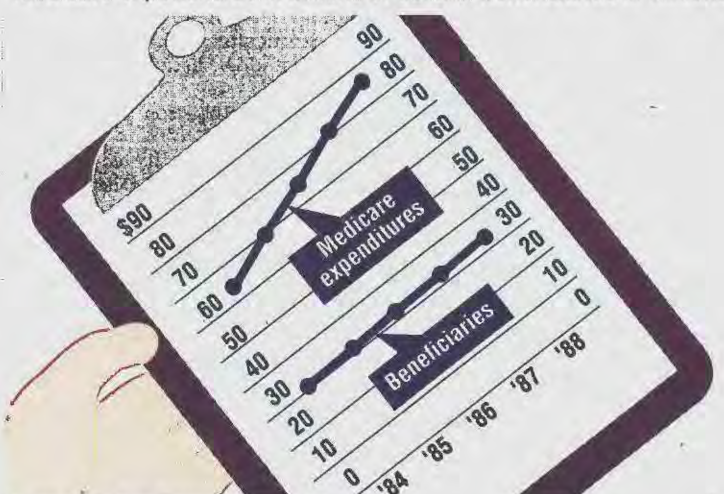
Medicare expenditures climb

Expenditures recently have outstripped the growth of beneficiaries.
Medicare expenditures in billions of dollars; beneficiaries in millions.



Source: Health Care Financing Administration

BI/HOLLY SEGUINE

President Bush asks business to help lead fight against AIDS Page 2

Section 89 opponent to seek new non-discrimination rules Page 3

Surety bond underwriters say capacity is up, rates are firm Page 3

Update

Retrial in Film Recovery case

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victed of murder and reckless conduct, while the companies were found guilty of involuntary manslaughter and reckless conduct in the death of Stephan Golab. A medical examiner found that Mr. Golab died of acute cyanide poisoning after inhaling cyanide fumes in the plant.

But, the 1st District Illinois Appellate Court in January overturned the convictions. The court ruled that the two charges on which the executives were convicted were "legally inconsistent." It also found it inconsistent for the trial judge to find the corporate defendants guilty of involuntary manslaughter on the basis of the managers' actions (*BI*, Jan. 22; Feb. 5).

However, the court found enough evidence to order a new trial in Cook County Circuit Court.

Cook County State's Attorney Cecil Partee charged the state supreme court court has "provided no guidelines whatsoever for the prosecution of future cases." He also said the court's refusal to hear prosecutors' appeal could "set back the case of workplace safety immeasurably."

Defendants had said the appellate court ruling shows that verdicts must be consistent and legal precedent must be observed.

MIG reorganization plan

LOS ANGELES—A Los Angeles Superior Court judge approved a proposed Mission Insurance Group Inc. reorganization plan in which about $28 million in cash and stock would be placed in trust for MIG's insolvent insurance units.

MIG is to receive the subsidiaries' shells, which include the corporate charters that are considered valuable, said Dana Brooks, a Los Angeles attorney. Her firm, Rubinstein & Perry, represents California Insurance Commissioner Roxani Gillespie, Mission's liquidator.

Under the plan, unveiled in January (*BI*, Jan. 8), MIG will put in the trust all the subsidiaries' assets and liabilities, including about $14 million owed by major MIG stockholder Great American Insurance Co., Ms. Brooks said. MIG also would put 29% of a new stock offering—estimated at $14 million—into the trust, she said.

The MIG insurance units are insolvent by an estimated $1.5 billion to $2 billion, depending on how much reinsurance the liquidator recovers.

The plan is subject to approval by a federal bankruptcy court, which has set a hearing for May 9.

Keene's coverage running low

NEW YORK—Former asbestos manufacturer Keene Corp. may be running out of insurance to pay asbestos bodily injury and property damage claims, according to papers filed with the Securities and Exchange Commission last week.

"Substantially all" of Keene's remaining $143 million in coverage for existing and future claims is tied up in litigation, according to the annual report of its parent, New York-based Bairnco Corp.

Until those cases are resolved, Keene will "pay directly the costs of asbestos-related bodily injury litigation," the report said.

At year-end 1989, about 70,300 asbestos bodily injury claims and 83 property damage claims were pending against Keene. New claims continue to be filed, the report said.

Ford settles suit for $6 million

DEARBORN, Mich.—Ford Motor Co. says it has "adequate financial resources to respond to" a $6 million settlement of a personal injury lawsuit charging the company with negligence for installing only lap seat belts rather than lap-and-shoulder belts in the rear seats of Escorts built before 1990.

The suit was filed by a California family after one son was killed and another was left a paraplegic in a 1988 accident.

Ford would not disclose details of its product liability coverage, but Robert Ozment, manager of corporate insurance, said last January that Ford's "basic philosophy is to buy catastrophic insurance." Marsh & McLennan Cos. Inc. is Ford's broker.

"I don't think there are many insurance carriers that are writing product (liability insurance) at a low attachment point these days," said a broker that places automobile product liability coverage.

In the late 1970s, Ford began assuming a $2 million self-insured retention for product liability and purchased $100 million in excess insurance (*BI*, Feb. 1, 1988; May 19, 1986).

In 1986, Ford revealed in public documents that it had "little or no" product liability insurance that year because of its limited availability "at reasonable premiums."

Federal quake cover proposed

WASHINGTON—Two bills that would establish a federal earthquake insurance and reinsurance program are before the U.S. House of Representatives.

H.R. 4480 contains provisions sought by the property/casualty industry and its Earthquake Project, which has promoted a federal role in earthquake coverage for several years (*BI*, Oct. 23, 1989).

Under the bill, a newly created federal insurance and reinsurance facility would provide primary coverage and excess-of-loss reinsurance. Coverage also would be extended to volcanic risks.

The bill was introduced April 4 by Reps. Al Swift, D-Wash., and David Dreier, R-Calif., with seven co-sponsors. No companion legislation has been introduced in the Senate.

Another bill introduced the same day would establish an earthquake insurance system similar to the National Flood Insurance Program. H.R. 4462, the National Earthquake Insurance and Reinsurance Act of 1990, would require the federal government to identify earthquake-prone communities, which would have to develop building codes and land use plans to reduce earthquake losses. Communities that fail to develop such plans could not participate in the insurance program and would not be eligible for federal construction assistance.

In addition, the federal government would reinsure private earth-

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Sedgwick E&O loss

Reinsurance not properly placed: Court

By CAROLYN ALDRED

LONDON—Sedgwick Group P.L.C. says its errors and omissions insurance will cover all of a multimillion-dollar judgment against the London brokerage for failing to obtain proper reinsurance for a huge shipbuilding risk.

The judgment stems from a then-record $300 million claim paid by insurers after three liquified natural gas tankers built at the Avondale Shipyards in New Orleans in the late 1970s were declared unusable (*BI*, Oct. 26, 1987; Aug. 11, 1980).

Lloyd's of London marine underwriter Richard Youell and seven other insurers were among those that paid the Avondale claim. They then sued Lloyd's broker Bland Welch & Co. Ltd., which was later acquired by Sedgwick, claiming the broker failed to place adequate reinsurance for the so-called Superhulls program.

Sedgwick, which was one of the brokers on the coverage written for the Avondale tankers, hired Bland Welch to help it place reinsurance to support the coverage.

The insurers claimed they wrote large portions of the risk thinking their reinsurance followed the terms of the primary coverage. However, differences in wording between the primary insurance policies and the reinsurance contracts rendered the reinsurance unenforceable.

As a result, the insurers claimed damages of more than $20 million, plus interest, from Sedgwick because they were unable to collect from their reinsurers, said Richard Dedman, partner with Barlow Lyde & Gilbert, a London-based law firm that represented the insurers.

Mr. Dedman estimated that the total award against Sedgwick—which was to be announced late last week—would come to approximately $40 million.

If so, the award will be one of the largest negligence awards ever against a reinsurance broker in England.

The judgment is important because it states that a "reinsurance broker has a duty to make sure that his client understands what is in his (reinsurance) cover, even though the client is a professional," said Mr. Dedman.

High Court Justice Phillips in the decision also pointed out that a reinsurance broker has a duty to look after his clients' interest and not just act solely on their instructions, said Mr. Dedman.

"The judgment will be of great interest because cases involving substantial amounts like this usually are settled out of court. It's not often you get a legal judgment on such an issue," he pointed out.

Justice Phillips ruled on March 27 that the brokers, including

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BI to list loss control consultants

The May 28 issue of *Business Insurance* will contain the fourth annual directory of property loss control consultants, published in conjunction with a Spotlight Report on property loss control issues.

Insurance companies, brokers and other firms that provide loss prevention inspections, building plan reviews, loss prevention research, training seminars and other loss control consulting services to companies, institutions and government entities are eligible to be listed as long as the service is provided on a fee-for-service basis.

The directory is published as an editorial service; there is no charge to be included. However, loss control consultants must request, fill out and return a *Business Insurance* questionnaire by April 23 in order to be listed.

If you provide loss control consulting or engineering services and you have not yet received a questionnaire, you may request one by writing Sara Harty, Editorial Assistant, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611-2590; or by calling 312-280-3195.

Bush asks business to help lead campaign against spread of AIDS

By ADRIENNE C. LOCKE

ARLINGTON, Va.—President Bush is calling on employers to take a leadership role in the battle against the spread of AIDS.

The president also cataloged his administration's response to the AIDS epidemic last month during the National Leadership Business Conference on AIDS.

"Business is in a powerful and unique position to influence the response to AIDS and HIV infection," President Bush said in a speech interrupted several times by demonstrators who oppose the administration's AIDS policy.

President Bush criticized discrimination against people with acquired immune deficiency syndrome and the human immunodeficiency virus, which develops into AIDS.

"This is a fight against a disease, not a fight against people," he said.

"We don't fire them, we don't evict them and we don't cancel their insurance," President Bush emphasized.

The president said he supports "passing a law as embodied in the Americans with Disabilities Act," which would prohibit discrimination in employment, access to public and private transportation and telecommunications services.

The Senate passed its version of the bill, S-933, sponsored by Sen. Tom Harkin, last September. The House bill, H.R. 2273, introduced last year by former Rep. Tony Coelho, D-Calif., is still in committee and has 244 co-sponsors.

People with AIDS or HIV infection should not be punished for being sick but should be treated the same way as those with any other serious illness—"with dignity, with compassion, care and confidentiality," President Bush said.

But demonstrators shouted for additional federal funding for AIDS programs and criticized the administration's AIDS policy.

President Bush responded: "I can understand the concern that these people feel, and I hope that if we do nothing else by coming here, I can help them understand that not only do you care, but we care, too."

President Bush noted that tens of thousands of new cases of AIDS and HIV infection are reported in the United States each year and that many experts do not foresee the epidemic slowing. However, he said the federal response to the AIDS epidemic is "unprecedented."

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Inside

- This week's editorial applauds two states' efforts to make health insurance more affordable for small employers by limiting state coverage mandates. **PAGE 8**
- An NAIC panel approves a proposal to limit reinsurers' ability to offset debts owed to insolvent ceding companies at the NAIC's spring zone meeting. Coverage begins on **PAGE 11**
- In Perspectives, Henry L. Strong of JMW Settlements Inc. explains how to protect structured settlements from renegotiation. **PAGE 19**
- Employer-provided child care benefits may become more widely available in the United Kingdom following a government decision to abolish a tax on employee use of workplace nurseries. **PAGE 23**
- Insurers may be able to seek compensation from the London police for property damage caused in violent anti-tax riots. **PAGE 23**

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Good surety risks find capacity up, rates firm

By MICHAEL SCHACHNER

Competition is heating up for good surety risks, but underwriters are sticking with tougher underwriting standards, according to brokers and underwriters.

Yet, while underwriters are looking for new surety business, they are not slashing rates, brokers and underwriters point out. Rates are stable or even rising slightly for preferred accounts and increasing even more for marginal risks, they said.

Instead, underwriters are competing for good risks by offering additional capacity, said John Stough, vp at Alexander & Alexander Services Inc. in Louisville, Ky.

Dennis Perler, senior vp-domestic contract surety for CIGNA Bond Services Inc., a unit of Philadelphia-based CIGNA Corp., agreed. Underwriters are competing in such areas as service, turnaround time and incentives to agents to produce business, he said.

Competition is greatest for general contractors, prime subcontractors and highway and heavy engineering contractors with $25 million to $50 million work programs, Mr. Perler said. "There seems to be a specially competitive environment for accounts with backlogs of between $25 million and $50 million. But above that, many sureties drop off because of limitations on capacity," he said.

Tougher standards and a construction industry shakeout helped boost the surety bond market to its second consecutive year of underwriting profits in 1989 after five straight years of losses.

However, some observers warn that renewed competition for surety business could imperil underwriting results.

Industrywide results for 1989 are not yet available, but several of the largest surety underwriters reported underwriting profits. However, premium growth for those underwriters ranged from a 5.5% decrease to an 8.3% increase.

The surety industry in 1988 reported a 2% underwriting profit on gross written premiums of $1.87 billion—more than $1 billion of which was attributable to contract bonds. Contract bonds guarantee

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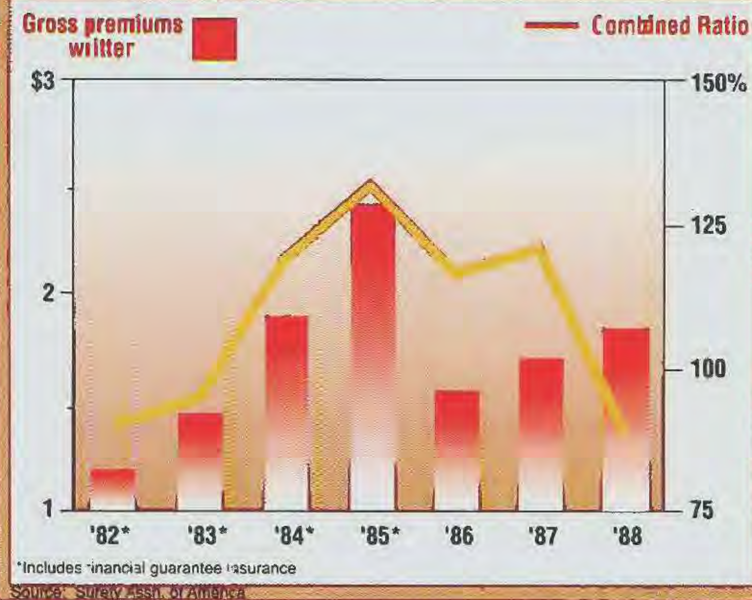
Surety results improve

Surety insurers expect to post underwriting profits in 1989 when industry results are released this spring. The 1988 underwriting profit was the first in five years. Dollars are in billions.



BI/JOHN SMITHER

High court says migrant workers can sue firms for work injuries

By MEG FLETCHER

WASHINGTON—Agricultural employers that purchase workers compensation insurance face expanded—and possibly uninsured—liability for migrant and seasonal workers' on-the-job injuries.

The U.S. Supreme Court unanimously ruled late last month that migrant and seasonal workers seriously injured in a 1985 accident while riding in their employer's van can sue the company for damages under the federal Migrant and Seasonal Agricultural Worker Protection Act of 1983.

Even though workers collected benefits under the state workers compensation law, they can sue Adams Fruit Co. of Auburndale, Fla., under the migrant workers act, the court ruled. Florida law makes work comp benefits workers' exclusive remedy for on-the-job injuries.

The MSAWPA "does not establish workers compensation benefits as an exclusive remedy. . .even where state workers compensation schemes purport to establish their benefits as exclusive of all other relief," Justice Thurgood Marshall wrote for the court.

However, court awards of actual damages under the MSAWPA "may be offset" by workers comp benefits, Justice Marshall said in affirming an 11th U.S. Circuit Court of Appeals decision (*BI*, Sept. 4, 1989; Oct. 9, 1989).

Employer groups and insurers warn that the decision could leave employers liable for huge awards that may not be covered under the employers liability section of workers comp insurance policies. That section provides coverage for tort and other damages alleged by an injured worker that are not covered under state work comp statutes.

"This is the most significant breach of the exclusive remedy provision of workers compensation that has ever occurred," said Michael Stientjes, assistant counsel for the 3.8 million-member American Farm Bureau Federation in Park Ridge, Ill.

"It is a terrible decision, straight from the ivory tower," said Douglas Stevenson, a Chicago attorney and executive director of the National Council of Self-Insurers.

"Farmers now face millions of dollars in damages," said James Holzhauer of Mayer, Brown & Platt, a Chicago law firm which filed amicus briefs on behalf of several farm employer groups.

Although the decision involves a Florida case, a "very strong" argument could be made that the Supreme Court's unanimous decision will have a "strong impact" on any state with migrant and seasonal workers, said Brian G. Fox, corporate counsel for the National Council on Compensation Insurance in New York. The NCCI is the primary ratemaking and statistical organization for workers compensation insurers.

Laws in about three dozen states now require agricultural employers to buy workers compensation insurance for migrant and seasonal workers. Large employers in other states often voluntarily purchase the coverage.

"It is the most significant decision involving migrant and seasonal workers and workers compensation," agreed David Arizmendi, director of the Farm Worker Educational Legal Defense Fund in Keene, Calif.

"It will make the workplace safer by economic necessity" and may help reduce workers' exposure to pesticides and demands placed on them by unreasonable harvest quotas, he said.

The "worst" potential result of the decision is that lawsuits could

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Section 89 opponent may draft new bill

Benefit discrimination hit

By ADRIENNE C. LOCKE

ARLINGTON, Va.—A legislator who was one of the driving forces behind the repeal of Section 89 non-discrimination rules is considering a new proposal to discourage discriminatory benefit practices.

Rep. John LaFalce, D-N.Y., said he has a "special responsibility" to address this issue, having introduced the Section 89 repeal legislation last year that drew congressional attention to the onerous non-discrimination rules.

Section 89 was fully repealed last November (*BI*, Nov. 13, 1989).

However, the issue of welfare plan discrimination in favor of highly compensated employees remains a "problem," Rep. LaFalce told attendees of the Employers Council on Flexible Compensation's FlexComp 90 Meeting, held last month in Arlington.

Even though he said Congress is unlikely to consider new non-discrimination legislation so soon after Section 89's repeal, Rep. LaFalce said he wants to keep the issue alive in people's minds.

Rep. LaFalce provided a rough outline of what his non-discrimination proposal would entail:

- All employer-provided health care plans would be subject to non-discrimination rules.
- Employer-provided health care plans would have to meet an "eligibility" test to determine if a sufficient percentage of employees are eligible for benefits.

"Perhaps 90%, as defined in the bill passed by the Senate in 1989," he suggested. Under a Senate Section 89 reform bill passed last year, core health care coverage would have to be available to 90% of all employees for health care plans to pass the test (*BI*, July 3, 1989).

- Group health insurance premiums would be deemed "excessive" if the average premium paid by employers on behalf of highly compensated workers is greater than 133% of the premium paid for non-highly compensated workers.

In introducing his proposals earlier this year, Rep. LaFalce suggested that highly compensated employees could be defined as persons earning $50,000 or more.

- Employers would not be allowed to deduct as ordinary business expenses the excessive premiums paid for group health insurance on behalf of highly compensated employees.

"Reasonable limits" on the tax deductibility of employee benefits "would be appropriate," Rep. LaFalce said earlier this year.

"Taxing excessive benefits—so long as it is done in a non-cumbersome way—seems to me to be a reasonable way of ensuring that the right to discriminate is not subsidized by the vast majority of employers," he explained.

Speaking before the ECFC conference, Rep. LaFalce said too many employee benefits are exempt from taxation.

The federal government should not be in the business of subsidizing discrimination "either directly or indirectly," by "expenditure or through the tax code," he said.

Rep. LaFalce acknowledges there are areas of his proposal that still need to be worked out before it is viable: eligibility issues such as how part-time and seasonal workers are affected; and non-dis-

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Two separate Texas juries award $40 million for wrongful deaths

By CHRISTINE WOOLSEY and MICHAEL BRADFORD

BROWNSVILLE, Texas—A chemical company and a nursing home facing separate $40 million judgments awarded by Texas juries plan to appeal the verdicts.

Settlement offers for lesser amounts were rejected in both cases.

A jury in Brownsville on March 22 awarded $43 million, including $30 million in punitive damages, to the family of two brothers who died aboard their fishing boat in July 1988. Both had inhaled gas emitted by a chemical—made by Parsippany, N.J.-based General Chemical Corp.—that fishermen use to preserve the color of shrimp.

Punitive damages generally are insurable in Texas.

The plaintiffs had offered to settle for $3 million and the company's promise to add a warning on the label that the chemical could be fatal in some circumstances.

But General Chemical's insurer, National Union Fire Insurance Co. of Pittsburgh, Pa., a unit of American International Group Inc. of New York, rejected the settlement offer.

An attorney for General Chemical, which has only $27 million in product liability insurance, said the company would sue its insurer for full coverage of the award if the judgment is upheld on appeal.

And in Houston, a jury also on March 22 awarded $40.6 million, including $35 million in punitive damages, to the family of a patient of the Seven Acres Jewish Geriatric Center Inc. who was found strangled in her restraints.

Several settlement offers were rejected in the case, although none of the parties will say whether the nursing home wanted to settle.

The General Chemical case centered on the adequacy of a warning on its sodium minobisulfite, a preservative used on a fishing boat to maintain the color of iced shrimp.

In their suit, the parents of Gustavo and Jose Eduardo de la Lastra contended that a label did not adequately warn of the preservative's dangers.

General Chemical countered that the brothers misused the preservative.

The parents "just wanted to get the label changed," said plaintiffs' attorney Guy Allison of Allison & Huerta in Corpus Christi, who would have accepted that and $3 million.

National Union wrote $2 million in primary product liability coverage for General Chemical above a $500,000 retention, Mr. Allison said. National Union also wrote a $25 million layer excess of $2.5 million, he said.

National Union would not comment, but an attorney for General Chemical, John Black of Wiech & Black in Brownsville, confirmed the coverage.

"Everyone in the courtroom was trying to get (the insurer) to settle on this case," Mr. Allison said.

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Punitive awards

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- A civil defendant hit with punitive damages should be afforded the same protections as a criminal defendant. For example, the burden of proof could be raised to "clear and convincing" evidence from "a preponderance" of evidence.
- Judicial review of punitive damage awards by juries sufficiently guards against excessive awards.

"This case gives the Supreme Court an opportunity to address a full range of issues affecting punitive damages," said Pacific Mutual attorney Bruce A. Beckman of Adams Duque & Hazeltine in Los Angeles.

"The court has a whole range of options," said Mr. Beckman, explaining that the court could rule on any or all of the issues.

Last year, the Supreme Court ruled that excessive punitive damages do not violate the 8th Amendment's excessive fines clause (*BI,* July 3, 1989). Four justices, though, indicated that excessive punitive damage awards could run afoul of the 14th Amendment's due process clause.

After denying dozens of requests for review, the Supreme Court accepted review of the Pacific Mutual case on April 2.

The Pacific Mutual litigation stems from a suit by four employees of Roosevelt City, Ala., who lost their group health insurance as a result of fraud committed by Lemmie L. Ruffin Jr., a Pacific Mutual agent, according to court papers.

Mr. Ruffin sold Roosevelt City a group life insurance policy underwritten by Pacific Mutual and a group health insurance policy underwritten by Union Fidelity Life Insurance Co. of Trevose, Pa.

The city sent its premium payments for the group life policy directly to Pacific Mutual, but premiums for the Union Fidelity policy were sent to Mr. Ruffin. But rather than forwarding the premiums to the company, Mr. Ruffin pocketed the money, court papers say.

When Union Fidelity did not receive the payments for the health coverage, it canceled the city's group health policy.

The situation came to light when a city employee, Cleopatra Haslip, was hospitalized for kidney treatment and discovered she had no health insurance to cover $2,500 in medical expenses.

Three other city employees also left uninsured for medical expenses joined the suit against Mr. Ruffin and Pacific Mutual for fraud, breach of contract and bad faith.

Attorneys would not say why Union Fidelity was not sued.

On Aug. 7, 1987, the jury awarded the four employees nearly $1.1 million in compensatory and punitive damages. An appeals court—and later the Alabama Supreme Court—rejected Pacific Mutual's bid to have the verdict overturned.

In its appeal, Pacific Mutual argues: "Punitive damages law, as presently applied, is overwhelmingly lacking in fundamental fairness."

It continues: "Juries are sent to deliberate with no meaningful standards to guide them as to the amount of punitive damages awardable. This unbridled discretion leads to arbitrary and unpredictable awards."

However, the plaintiffs in the underlying litigation counter that "decisions made in the absence of precise legislative formulations are (not) necessarily arbitrary and unfair. So long as discretion is exercised within reasonable constraints, due process is satisfied."

Several factors, though, make this case less than ideal for a ruling on the constitutionality of excessive punitive damages, according to some attorneys.

For example, jurors did not distinguish between compensatory and punitive damages.

As a result, "nobody knows how much of the award is punitive," said Bruce J. Ennis Jr. of Jenner & Block in Washington, D.C., who represents the city employees in the Pacific Mutual litigation.

"It is not possible to determine the relationship between punitive damages and compensatory damages," he said.

"There are so many cases where punitive damages are clear, it does not make sense for the Supreme Court to take this case," said Victor Levit, an insurer attorney of Barger & Wolen in Los Angeles.

But, Mr. Beckman, Pacific Mutual's attorney, counters that this is a good case for reviewing due process implications of excessive punitive damage awards.

"The only actual damages in this case were about $3,800 in medical expenses," Mr. Beckman said. "The award was pretty much all punitive damages."

And, he noted, both sides presented the case to the Alabama Supreme Court as one involving about $1 million in punitive damages.

Defense attorney Victor Schwartz of Crowell & Moring in Washington, D.C., agreed that the case was a good choice for the Supreme Court because "it brings into sharp relief punitive damages and deep pockets."

"This case shows the tendency of juries to throw huge punitive damage awards against deep-pocket defendants," Mr. Schwartz said, adding that the jury would not have awarded $1.1 million against Mr. Ruffin alone.

But, it is possible that the Supreme Court will not rule on the constitutionality of excessive punitive damages and instead address only the narrow issue of whether a company may be held liable for punitive damages for actions taken by an employee, according to attorneys.

"They have dodged the bullet in the past and may dodge it again in this case," said Phillip Stano, counsel for the American Council of Life Insurers in Washington, D.C.

Mr. Stano pointed out that the Supreme Court has reviewed three cases in recent years involving punitive damages without ruling on the constitutionality of unrestrained awards.

Whether companies can be held liable for employees' actions is also very important for business, according to attorneys.

"It is very unfair" to punish a corporation for the unapproved actions of employees, Mr. Levit asserted.

"A company can only do so much to control its employees," he said. "In any kind of big company, you can have somebody who turns out to be a rotten apple."

A pro-business ruling from the Supreme Court in this case "would send a message to business that courts will be fair to business," Mr. Levit said.

The court's ruling also could have an "enormous" impact on tort reform efforts, according to Martin Connor, president of the American Tort Reform Assn. in Washington, D.C.

"Depending on how much direction the court gives, legislation (to limit punitive damages) may not be necessary," he said.

Briefs must be presented to the court within the next three months, and oral arguments are expected in October or November.

A ruling is not expected until the end of the year.

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Pacific Mutual Life Insurance Co. vs. Cleopatra Haslip, Cynthia Craig, Alma M. Calhoun and Eddie Halgrove; United States Supreme Court, No. 89-1279.

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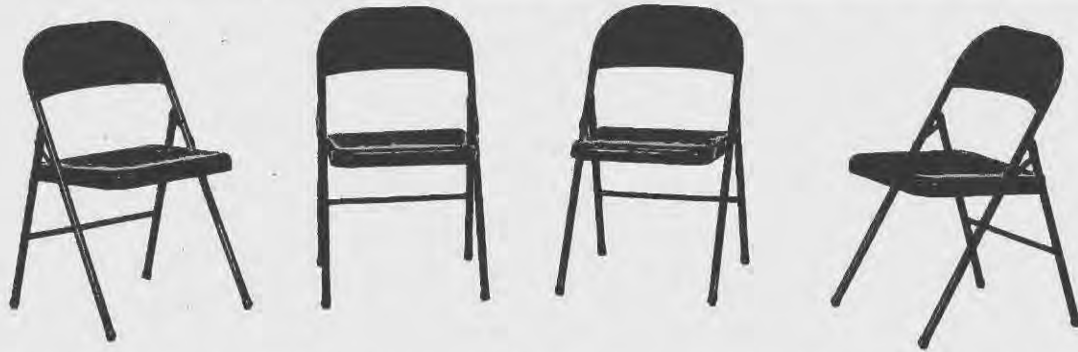

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Ohio adopts managed mental health plan

By MICHAEL SCHACHNER

Benefit beat

The state of Ohio projects it will save at least $4.5 million in the first year of its new managed mental health care and substance abuse treatment program.

With the plan set to take effect July 1, Ohio would be the first state government to carve out mental health and substance abuse benefits from its health care plan and contract them out to a managed care firm, according to Scott Solsman, the state's benefits administrator.

Under the contract, Ohio Biodyne Inc. will provide mental health and substance abuse services to about 63,000 state employees and dependents enrolled in Ohio Med, the state's self-insured comprehensive medical/surgical, dental, vision, and psychiatric and substance abuse care program.

Biodyne, a subsidiary of South San Francisco-based American Biodyne Inc., will contract with a statewide network of psychologists, psychiatrists, social workers and treatment facilities to offer the services.

Should Ohio take an optional two-year extension of the $6.9 million one-year contract, additional savings could exceed $21 million, said Scott Fruchter, chief operating officer of Costeffex Employee Benefit Management Inc., a regional benefit consultant in Cleveland that managed the proposal and contracting process on behalf of the state.

"We are excited about the program, especially having a state being a leader. They're usually followers," he said.

Rising mental health and substance abuse costs were the reason for seeking managed care, explained Ohio's Mr. Solsman. "Like many employers, we were facing significant cost increases. We thought we had to do something to control costs."

Mental health and substance abuse treatment cost the state $7.5 million to $8.5 million in 1988, with costs rising at 27% per year, said Mr. Fruchter. "Without the Biodyne program, the state probably would have spent between $11.5 million and $13 million on mental health in 1990."

State employees will receive preventive benefits such as smoking cessation programs, weight and stress management programs and marriage counseling.

The new managed care program will completely restructure mental health and substance abuse treatment for state employees.

Under the Biodyne plan, mental health benefits will be covered in full. Employee visits to doctors are unlimited and there are no caps or annual maximums on benefits. Employees will pay a $10 co-payment per outpatient visit and a $100 co-payment for hospital admissions.

Under the state's old mental health and substance abuse program, employees paid 20% of the cost of a limited number of office visits and 50% of outpatient costs above the limit.

Mr. Fruchter said the average cost to an employee for outpatient counseling was about $18 per visit under the old plan.

Employees also were required to pay a $100 individual deductible per year and a $200 family deductible for inpatient services, plus 20% of annual expenses up to $750 per person and $1,500 per family, Mr. Fruchter said.

Under the new program, employees seeking mental health or substance abuse treatment will have to obtain precertification from Biodyne staff. The company will monitor utilization and thoroughly review all care, but "we won't limit utilization. Everyone needing care will receive it," a spokeswoman said.

In fact, to a degree Biodyne will actually encourage utilization of mental health services.

To ensure that utilization of mental health and substance abuse services does not decline under the new program, Biodyne has placed a portion of its annual fee at risk if utilization falls below projected levels.

Costeffex's Mr. Fruchter explained that the firm's $6.9 million annual fee is based on projected utilization rates of 63 hospital days per year per 1,000 covered lives, and 625 annual outpatient days per 1,000 lives.

If inpatient utilization falls to 50 to 63 days, Biodyne will refund half the savings that reduction represents.

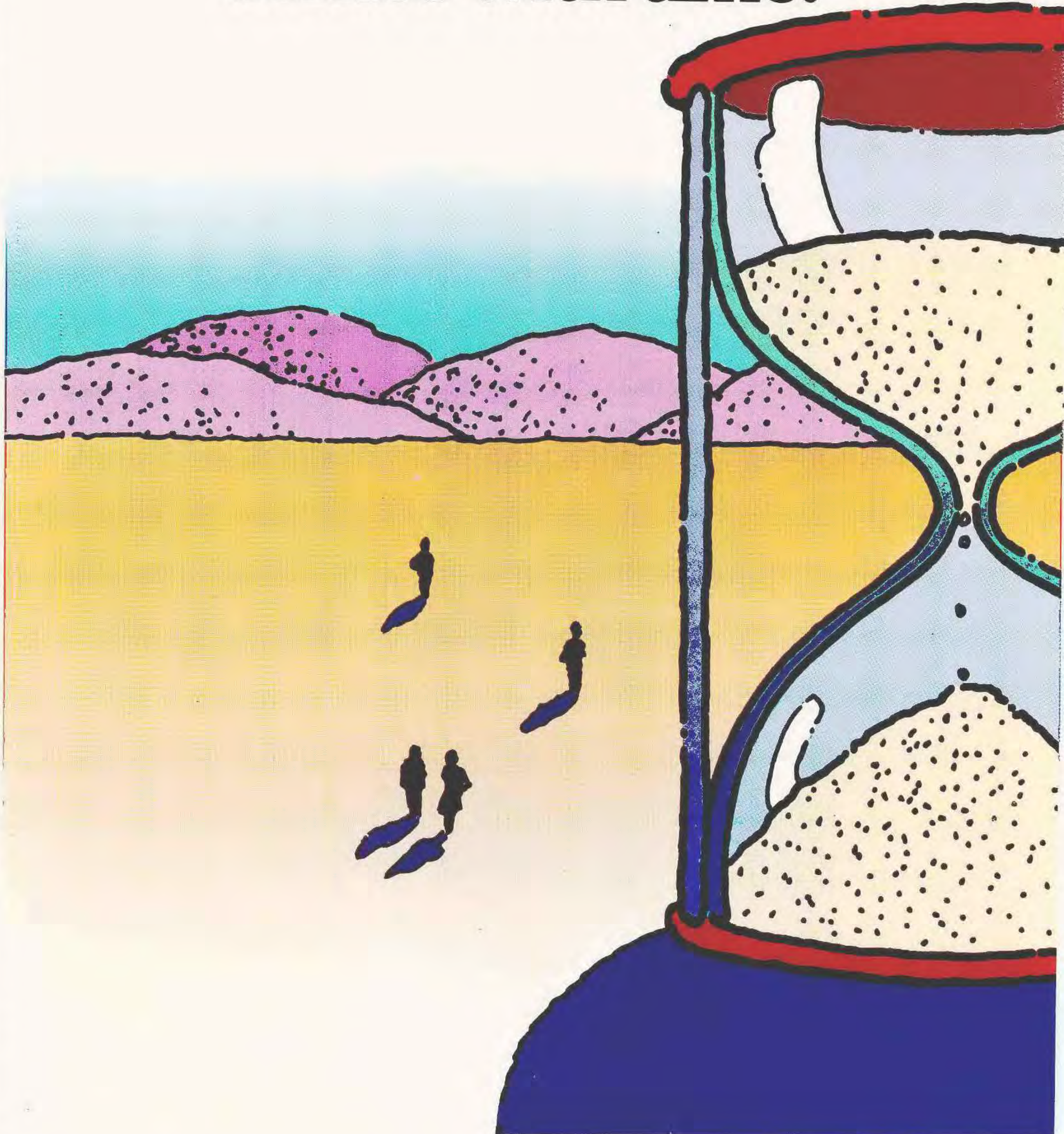
For example, if only 55 inpatient days occur, Biodyne will calculate the savings Ohio experiences as a result of eight fewer inpatient days per year and refund half of those savings to the state.

For each increment of 10 fewer admissions below 50, Biodyne will also give the state $250,000.

For example, if only 40 to 50 employees per 1,000 enrollees are hospitalized during the year, Biodyne will refund half the resulting savings plus it will give the state $250,000.

State employees will not be forced into hospitals just so Biodyne meets those goals, said Mr. Fruchter.

Instead, the goals "will just make employees more aware of the services available to them. I think if utilization is looking like it will fall below projected levels Biodyne will communicate to employees what services they should be using," he said. ■



Migrant workers

Continued from page 3

be brought for accidents already settled under a state's workers compensation law, said Clyde Turbeville, executive vp and general manager of the American Agricultural Insurance Co. in Park Ridge, Ill., which provides reinsurance to several U.S. farm bureau-affiliated insurers.

The statute of limitations for such federal claims is identical to a state's statute of limitations for tort actions —three to six years on average—several attorneys noted.

"This could have a terrible financial impact on an employer," Mr. Turbeville said.

Migrant and seasonal workers protected by the MSAWPA may be able to recover broader damages—such as non-economic damages—under the federal law that are not available through the state's workers compensation system, some attorneys say.

Those systems typically provide full medical benefits and tax-free indemnity benefits that usually are capped at two-thirds of an employee's average weekly wage. Additional benefits are available in the event of an employee's death.

Under the MSAWPA, damages for an employer's intentional violations of safety and health provisions include "damages up to and including an amount equal to the amount of actual damages, or statutory damages of up to $500 per plaintiff per violation, or other equitable relief."

"In addition to the private bar, legal services attorneys will be very active in pursing these actions," predicted Scottie Butler, general counsel of the Florida Farm Bureau Federation and affiliated companies in Gainesville, Fla.

Agricultural employers facing this threat should contact insurers or self-insurance funds to see if they have coverage for this new exposure, several sources say.

Insurer spokesmen currently disagree over the extent to which this exposure is covered, though a greater consensus may emerge once their policies are analyzed in light of the Supreme Court decision.

The NCCI's Mr. Fox said damages awarded under the MSAWPA could "arguably" fall under the employers liability portion of a typical workers compensation policy. The NCCI plans a meeting soon to analyze the ruling's implications for coverage.

If the risk is covered, workers comp costs for agricultural employers are likely to increase, he said.

However, the typical $100,000 in per-occurrence limits contained in a typical employers liability policy may be insufficient in some cases, said Mr. Turbeville. Many agricultural employers do not purchase additional employers liability limits, he said.

A third-party administrator said there is "a real question" as to whether a court award under the MSAWPA would be covered under the employers liability portion of a workers compensation policy.

The policy may not respond if employers are found guilty of gross negligence or willful and wanton conduct, said Joe Keene, president of Claims Capabilities Inc., which handles claims for the Florida Fruit & Vegetable Assn.'s Self-Insurers' Fund in Orlando, Fla.

While an insurer would probably defend a policyholder in such a case, it may advise him to have his own personal legal counsel to deal with allegations that are not covered by insurance, he added.

In addition, many employers have employers liability policies that exclude coverage for injuries for which workers compensation benefits are paid, said the Florida Farm Bureau's Mr. Butler.

Liberty Mutual Insurance Co., the nation's largest work comp underwriter, would not comment until completing a review of the ruling, a spokeswoman said.

In addition, insurer spokesmen are urging employers to begin thoroughly investigating workplace injury claims filed by migrant and seasonal workers. Employers should determine fault, so that information is available should lawsuits under MSAWPA later arise, Mr. Keene said.

Employers also may want to try to limit their exposure to MSAWPA claims by hiring more permanent workers instead of migrant and seasonal laborers, Mr. Turbeville said.

Finally, employers may want to lobby state and federal legislators to help reduce the ruling's impact, Mr. Butler said.

For example, the Florida Farm Bureau may ask legislators to eliminate the requirement that employers provide work comp insurance for migrant and seasonal workers, he said.

However, most lobbying activity will be directed at changing the migrant workers act, he said.

Ironically, the American Farm Bureau was a major supporter of the MSAWPA because it encouraged states to require employers to provide work comp benefits to migrant and seasonal workers, Mr. Stientjes said.

If employers are successful in lobbying states to eliminate workers compensation coverage for these workers, the workers will suffer, he added.

The Adams Fruit case was filed on behalf of a group of orange pickers who were injured when a company van transporting 19 workers was involved in an accident in 1985.

They alleged that Adams Fruit violated motor vehicle provisions of MSAWPA, including not providing enough seat belts and overloading the van, and violated record keeping requirements by failing to post a list of workers' rights under the law.

A U.S. District Court in Tampa granted the employer partial summary judgment in October 1987 and ruled that "the liability for workers compensation benefits is an exclusive remedy" for the employees' actual damages under MSAWPA's motor vehicle provisions.

The district court cited a 1987 decision by the 4th U.S. Circuit Court of Appeals in Richmond, Va., that upheld the exclusive remedy of South Carolina's workers comp law in rejecting a suit by an agricultural worker who was sprayed with pesticides while working in his employer's field.

However, the 11th U.S. Circuit Court of Appeals in March 1989 overturned the Florida district court decision, ruling that the MSAWPA pre-empted the exclusive remedy provision of Florida's work comp law. The court rejected a U.S. Department of Labor regulation that state work comp benefits are a worker's exclusive remedy.

Finally, the U.S. Supreme Court rejected the Adams Fruit appeal of that decision.

•

Adams Fruit Co. Inc. vs. Ramsford Barrett, et al.; U.S. Supreme Court No. 89-2035.

Opinions

Affordable health benefits

WE APPLAUD the efforts of legislators in Virginia and Washington state to make health insurance more affordable for small employers.

Washington's governor has signed and Virginia's governor is expected to sign recently approved measures that would exempt commercial health insurance policies sold to certain small companies from including the full scope of benefits those states now require (*BI*, March 26).

Already, insurers are responding positively to the initiatives.

For example, Blue Cross & Blue Shield of Virginia plans to offer a reduced benefit plan for small employers at about two-thirds of the average cost of current comprehensive coverage.

Backers of the Washington legislation say they have received assurances from insurers that they could offer a new streamlined health care insurance policy for smaller companies at a 40% cost savings compared with standard group health insurance products.

Both initiatives mark the beginning of a long-overdue reversal of misguided state efforts to force health insurers to offer dozens of benefits.

State laws requiring insured health care plans to cover certain types of treatment, like chiropractic care and mental health services, do not reflect any national consensus on the types of benefits that should be part of a group health care plan.

Instead, these mandates typically have been the result of lobbying by special interest provider groups eager to expand their markets.

State legislators, as reflected by the proposals in Virginia and Washington, are beginning to realize that mandated benefits are, in fact, counterproductive.

By requiring one benefit after another, state legislators over the last two decades have helped make group health insurance unaffordable for a growing number of small employers.

Legislators now are beginning to understand that mandates aren't worth the paper they are printed on if they force these small companies to drop their group health insurance programs and, thus, leave many workers bereft of even basic health insurance coverage.

By reducing the scope of mandated benefits and thereby lowering the cost of insurance, employers are much more likely to offer group coverage, reducing the number of uninsured workers.

And, cutting back state requirements also eliminates another negative consequence of mandated benefit laws by reducing the incentive for small employers to self-fund their health care programs, many of which may be unable to truly bear the risk.

Self-funded programs, under a 1985 Supreme Court decision, are exempt from state mandated benefit laws.

While the measures in Virginia and Washington are welcome, they are only a first step in what we hope becomes a national battle to eliminate ill-conceived state benefit mandates.

What should or should not be offered in a health insurance plan is something to be determined by employers and employees, rather than state legislators responding to the parochial demands of special interest groups.

Letters

N.Y. moves to reduce meritless lawsuits

To the editor: I read with interest the letter from David A. Lovitt in the Feb. 26 issue that suggests that a major component of any plan for reducing medical costs must be an effective plan for limiting medical malpractice litigation. He further suggests that "attorneys and their clients should be held responsible for the defense costs of lawsuits that are found to be without merit."

Mr. Lovitt and your readers would be interested in knowing that over the past several years New York State has taken significant steps to reduce the incidence of meritless malpractice litigation. Since 1985, the New York Legislature has instituted reforms such as penalties for frivolous lawsuits, restrictions on collections from collateral sources of coverage, declining scales of contingency fees depending on the size of the verdict and requirements for the filing of certificates of merit relating to the litigation.

It is widely believed that these measures, plus enhanced risk management procedures by hospitals, have contributed to a dramatic decrease in the number of new case filings for medical malpractice actions.

However, the value of such legislative reforms, and the attendant decrease in malpractice litigation, has not yet been realized in terms of reducing medical costs. Rather, this can be seen as only one step in a comprehensive program of health care cost containment that also must include rigorous controls over utilization and fraud, as well as a refocusing of the medical community from defensive medicine to responsible medicine. These parts, taken together, should spell success in our efforts to make health care more affordable and, ultimately, available to all who need it.

Guy J. Velella
Chairman
Committee on Insurance
New York State Senate
Albany, N.Y.

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Pepper proposal could hurt small firms

To the editor: Though the concept of mandating that employers offer health care benefits—as the Pepper Commission has proposed—has merit, the execution of this concept would create a serious problem for many small businesses. As a health insurance broker for many small businesses, I can foresee many of these problems.

First of all, assume that on average it would cost approximately $5,000 annually to cover the average family under a decent medical insurance plan. If an employee earns $100,000 per year, this represents 5% of earnings, but to an employee earning only $15,000, this represents one-third of earnings. Many small businesses could not afford to spend an additional $5,000 per year on an employee who earns $15,000 annually to cover the anticipated cost of a family medical insurance plan. In fact, many small businesses barely are making it and this burden probably would push them into bankruptcy.

If there has to be a health benefit mandate, it should be based on a percentage of earnings formula so that an employer with a high percentage of low-paid employees could afford to initiate the plan without going bankrupt. What is a well-meaning program must be realistic in its cost burden to small employers.

Richard P. Duffy
Agent
The Equitable Life Assurance Society
of the United States
Ridgefield, Conn.

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At issue

Should insurance commissioners be barred from working in the industry after leaving office?

Eben L. Jones
Group director-insurance & risk management
Rollins Inc.,
Atlanta

An opportunity for them to continue service to the industry in support services or brokering should not be limited. Some waiting period might make sense before allowing them to work inside a company actively regulated during their term, or before allowing them to establish their own company. This could minimize the "insider trading" edge.

Frank E. Locke
Administrator-risk & insurance
Oklahoma Natural Gas,
Tulsa, Okla.

No. Other elected or appointed state and federal government officials aren't prohibited from becoming lobbyists or spokespersons for the industries they once regulated. In this role, state insurance commissioners could be valuable assets in improving the public perception of the insurance industry.

Stephen W. Scammell
Director-risk management
GAF Corp.,
Wayne, N.J.

No. There is a wealth of experience gained by being an insurance commissioner that could be of value to the industry. Besides if commissioners were barred, who would ever want to become one? The benefits of having them back in private industry far outweigh the drawbacks.

Mari-Jo Hill
Senior risk analyst
SAS Institute Inc.,
Cary, N.C.

Not unless the same prohibition applies to ex-presidents who use their diplomatic and international contacts to further their personal goals. At least NAIC members have developed some specific knowledge of the workings of the industry. Using their visibility for future gain becomes more of a logical career progression.

Compiled by Christine Woolsey

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Letters

Canadian agrees medical system could be better

To the editor: In a letter in your Feb. 12 issue Mark Mitchell criticizes the Canadian health system, and in a March 5 letter Gordon Hird defends that system.

There may be many reasons, as Mr. Hird says, why Canada is a better place to live than the United States; however, a better medical system is most certainly not one of them.

My own experiences and those of others I know well demonstrate this and information in the media proves it, as well. Just one example: both the provinces of Ontario and British Columbia are currently sending a percentage of their heart patients to U.S. hospitals for lack of Canadian facilities.

There are no incentives in Canada for those in the medical profession to excel, and many—fortunately not all—of those who do leave Canada to practice in the United States. Canadian doctors are forced, by virtue of being underpaid, to jam as many patient visits as possible into a given day, thus depriving patients of the time needed to help them maintain or recover their health.

Under the Canadian system it is illegal for the doctor to charge more for his services and thus spend the time needed with the patient and the doctor is not allowed to opt out of the socialized system.

The sooner the Canadian system adopts some of the American attitudes relative to competition and freedom of choice, the sooner the system will improve for the benefit of patient and doctor alike.

Peter Shuley
Peter Shuley & Associates Inc.
Vancouver, British Columbia

Soft market cycle puzzles investor

To the editor: I must admit that I am a little puzzled.

The Top 65 or so reinsurers have a combined ratio of 108% and the insurance company industry average is said to be about 112%. Yet, for 1989, insurers' policyholder surplus is up, giving us another year of "soft" market. Since no companies are taking remedial action, I was taught that this means the combined ratio is already up at least 5 points for 1990.

I don't know whether I should buy all the insurance company stocks I can get my hands on or dump them all.

George Knight Jr.
President
George Knight & Associates Inc.
Tulsa, Oklahoma

Self-regulation by UR industry?

To the editor: In regard to several recent *Business Insurance* articles on regulating the utilization review firms, self regulation by the utilization review industry could be beneficial (*BI,* Feb. 19; Jan. 22).

However, the downside to this proposal would be creation of homogeneous utilization review organizations, distinguished only by price. Another conceivable problem: Accreditation could be perceived as a rubber stamp as more utilization review firms meet minimum standards.

The most successful utilization review firms will need to show a more timely involvement and provide new products to distinguish themselves from their competitors.

Dr. William N. Werne
Medical Director
Republic-RSB Companies Inc.
Naperville, Il

NAIC panel approves offset restrictions

By MEG FLETCHER

SALT LAKE CITY—State insurance regulators who want to make more money available to policyholders of insolvent insurers won the first round of a 2½-year battle within the National Assn. of Insurance Commissioners.

NAIC's Rehabilitators and Liquidators Task Force capped years of wrangling last month by amending a model law to limit reinsurers' ability to offset debts with insolvent insurers.

The amendments were adopted at the NAIC spring zone meeting, March 25-27 in Salt Lake City. However, to be incorporated into the existing model law, the amendments must be approved by another committee and by the full NAIC.

The amendments passed last month restrict reinsurers' ability to reduce amounts owed an insolvent insurer by the amount that insurer owes them (*BI*, June 5, 1989; Dec. 18, 1989).

The new proposals would allow reinsurers to continue offsetting reinsurance claims owed to insolvent insurers against premiums owed by insurers.

In addition, multiple reinsurance contracts written by one reinsurer could be combined for offset purposes.

Supporters of broad offsets by reinsurers predicted the amendments, which they say change centuries-old public policy concerning offsets, will reduce the availability of reinsurance, increase its cost and create trade barriers for foreign reinsurers.

On a 12-6 vote, regulators approved amendments to Section 30 of the NAIC's Insurer's Supervision, Rehabilitation and Liquidation Model Act, which was approved in 1978. The amendments were presented by Christopher Maisel of Rubinstein & Perry, an Austin, Texas-based law firm active in receiverships.

"It's a victory for policyholders and taxpayers," said Robert Deck, supervisor of receiverships for the Missouri Insurance Department.

Most state offset laws are based on the 1978 NAIC model law, which allows an insolvent insurer and "another person"—which applies corporations, associations and other entities—to offset most mutual debts and credits.

But the increasing complexity of insurance and reinsurance transactions during the past decade has created situations not contemplated by the model, including reinsurers' right to offset. While regulators and courts have applied the model law to reinsurers, interpretations of reinsurers' right to offset have varied.

Under the new amendments, an insurer that both reinsured an insolvent insurer and ceded reinsurance to the same insurer generally would be prohibited from combining both types of contracts when attempting to offset debts with the insolvent insurer.

This is known as an "assumed vs. ceded" offset.

When acting as a ceding company, the reinsurer would have to stand in line with other creditors to collect amounts owed by the insolvent insurer, even if the company seeking the offset also reinsured the insolvent insurer.

Such "assumed vs. ceded" offsets in the Mission Insurance Co. insolvency entitles reinsurers to $300 million that otherwise would be available to pay policyholders' claims, said Mr. Maisel, whose firm is assisting in Mission's liquidation.

"It's unfair for reinsurers to get to the front of the line and require guaranty funds to take on a larger burden," he said.

"We cannot give into the intense pressure of reinsurers on this issue," said California Insurance Commissioner Roxani Gillespie in a March 25 letter to other state commissioners.

However, the regulatory subgroup's amendments were modified earlier this year in the wake of criticism from reinsurers to allow "assumed vs. ceded" offsets if an insurance commissioner personally approved them to prevent or mitigate another insurer's impairment or insolvency.

Offsets still would be denied among affiliated companies.

The amendments would take effect Jan. 1, 1992, and would apply prospectively to all contracts entered into, renewed, or extended, on or after that date.

However, reinsurer representatives and some regulators—including James Schacht, chief deputy director of the Illinois Insurance Department—favor giving reinsurers broader offset rights.

NAIC

They propose allowing "assumed vs. ceded" offsets and establishing a trust fund on behalf of the insolvent insurer to collect and disburse offset payments, with the interest accruing to the insolvent insurer.

"We think what we are proposing is the existing state of affairs," Mr. Schacht said. It reflects current case law but provides necessary clarifications, he added.

At least two more rounds remain in the fight over new offset rules.

The Financial Condition Subcommittee, the task force's parent committee, is expected to consider the amendments at the NAIC summer meeting June 3-7 in Baltimore. If approved by that group, the amendments could be presented to the full NAIC at the summer meeting.

Formal adoption of restrictive offset amendments would indicate that regulators' have become more pro-consumer on public policy questions, observers say. Each state would have to adopt the changes, but a more restrictive NAIC stance would send a message to judges ruling on offset-related cases.

Voting to restrict reinsurers' ability to offset were regulators from Arizona, Arkansas, California, Kentucky, Missouri, New Jersey, New Mexico, New York, Oklahoma, Pennsylvania, Tennessee and Texas.

Following the meeting, representatives of Idaho and Florida, who mistakenly voted against the amendments, indicated their support of the amendments.

Also voting against the offset restrictions were Hawaii, Illinois, Iowa and West Virginia.

Indiana Insurance Commissioner John J. Dillon III, the chairman of the task force, did not vote and would not say whether he favored the proposal. However, the alternative proposal favored by Mr. Schacht and the reinsurers bore the letterhead of the Indiana Insurance Department. ■

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Solvency regulation improving: NAIC chief

By MEG FLETCHER

SALT LAKE CITY—State insurance regulators say they are making progress in enhancing insurer solvency regulation through activities of the National Assn. of Insurance Commissioners.

"Activities have begun in earnest," said NAIC President Earl Pomeroy at the NAIC spring zone meeting March 25-27.

A five-point plan to improve regulation of insurer solvency was adopted at the NAIC's winter meeting (*BI*, Dec. 18, 1989).

The plan's key objectives are: uniform evaluation of reinsurance-related issues; state implementation of minimum standards for financial regulation; assessment of the NAIC's current examination process; enhanced solvency support mechanisms; and review of capitalization and reserve requirements, as well as annual statement disclosures.

According to Mr. Pomeroy, who is North Dakota's insurance commissioner, the NAIC is now:

- Developing audit mechanisms to gauge state compliance with minimum standards for financial regulation.
- Developing model restrictions on insurers' use of junk bonds to meet capitalization requirements. These restrictions are expected to be ready for adoption by the NAIC in June.
- Planning five fact-finding hearings on improving financial examination of insurers.

The first such hearing was held at the Salt Lake City meeting.

- Reviewing the findings of the report on insurer solvency issued by the House Oversight and Investigation Subcommittee chaired by Rep. John D. Dingell, D-Mich. (*BI*, Feb. 26).

The subcommittee's report is the result of "substantive and fair"

NAIC

subcommittee hearings, but is "unduly apocalyptic" about state regulators' ability to control insurer solvency, Mr. Pomeroy said in an NAIC statement.

"State insurance regulators must continue to enhance their ability to regulate industry solvency if they are to avoid federal intervention," he added.

"We at the NAIC believe that solvency regulation is a challenge, not a crisis," Mr. Pomeroy said.

Solvency regulation at the state level has its problems, he admits. "The world has changed faster than we have."

State property/casualty and life/health guaranty funds paid out $2.2 billion from 1969 to 1987. In addition, more life insurance companies now are becoming insolvent than property/casualty companies, Mr. Pomeroy noted.

However, the dimensions of the insurer insolvency problem are small compared to the failure of federally regulated savings and loans, Mr. Pomeroy said. Those losses are estimated in the hundreds of billions.

In 1990, the NAIC also intends to further examine reinsurance regulation and its Insurance Regulatory Information System.

Regulators will also explore developing reserve requirements for insurers that reflect the degree of risk in their business as well as their financial condition, Mr. Pomeroy said.

Meanwhile, insurance industry representatives say state regulators' current solvency evaluation processes are basically sound, but could be improved by streamlining and speeding up the process.

Representatives of several insurer trade associations recommended ways to improve NAIC financial examinations at the first of five sessions designed to gather public comment on improving the regulation process.

The hearings were held by the NAIC's Committee on Examination Processes, chaired by Kansas Insurance Commissioner Fletcher Bell.

"The system is working and is workable," said Lenore Marema, vp-legal and regulatory affairs for the Alliance of American Insurers in Schaumburg, Ill.

However, she and other industry representatives recommended that examiners make better use of insurer audits already prepared by certified public accountants, provide more advance notice to insurers about examination scheduling and give insurers better estimates of examination costs.

All insurers in a group or pool should be examined at one time, recommended Phillip Schwartz, vp-financial reporting and associate general counsel for the American Insurance Assn. in Washington, D.C.

The Salt Lake Convention and Visitors Bureau

Salt Lake City was the site of the National Assn. of Insurance Commissioners' spring zone meeting, held March 25-27.

In addition, he agrees with regulators' previous recommendations that insurers considered to be "in sound financial condition" be exempted from periodic examinations so regulators' limited resources could be targeted toward troubled companies.

Mr. Schwartz said a survey of AIA members found that many want regulators to cut delays in issuing final examination reports.

"Several AIA member companies report that final examination reports are sometimes not issued until many years after the field examinations have been completed. Several affiliated groups noted that states have not yet released final reports for examinations of the insurers as of 1984," Mr. Schwartz said.

In addition one insurer is concerned about an unspecified state insurance department, which retained an out-of-state accounting firm with no previous experience with property/casualty audits to conduct an insurer examination, Mr. Schwartz said.

That firm and a single contract examiner have so far run up fees of $700,000 to examine the relatively small insurer, which is part of a larger insurance group whose units are domiciled in other states, he said.

Many insurer representatives said they support NAIC proposals that financial reports be audited by certified public accountants and that loss reserves be certified by independent actuaries.

However, Roy Woodall Jr., president of the National Assn. of Life Companies Inc. in Washington, D.C., said small insurers are concerned about the added cost of these requirements, plus the cost of the state examination itself.

"There is a thin line between having good regulatory processes and regulatory overkill," Mr. Woodall said.

Meanwhile, brokers are concerned about relying on financial data supplied by insurers when placing insurance and the "considerable time lag" between when the data is reviewed by regulators, said William Poland, senior vp at Jardine Insurance Brokers Inc. in San Francisco and a member of the National Assn. of Insurance Brokers board of directors.

Risk managers want "national"—not federal—regulation through "significant cooperation and standardization among states," said Howard Greene, director-governmental affairs for the Risk & Insurance Management Society Inc. in New York.

Mr. Greene also joined the NAIB in calling for regulatory prompt action against troubled insurers. Too often, regulators contribute to the size of an insolvency by delaying action to allow troubled insurers to try to write their way out of their problems, he said.

Most observers said they support raising state insurance department budgets to hire more staff to examine solvency issues.

Regulators responded by asking insurers to testify, at budget hearings in their respective states, in favor of staff expansion.

The NAIC also will hold public hearings on the examination process on April 11 in Scottsdale Ariz.; May 3 in Orlando, Fla.; June 19 in Chicago; and July 10 in Boston.

Mr. Bell's committee is scheduled to present final recommendations on the examination process to all NAIC members at the group's winter meeting Dec. 2-6 in Louisville, Ky.

Other action at the spring zone meeting included:

Rental car rules

An NAIC subgroup agreed to accept final comments on several changes to a variety of model laws designed to increase insurance regulators' authority over rental car companies.

Currently, employees do not have to be licensed by a state insurance department to provide insurance-like coverages for accidental death and dismemberment and personal effects, because they are merely enrolling a customer into a group program.

Proposed amendments to the NAIC's Agents and Brokers Licensing Model Act and its Single License Procedure Model Act would require licensing anyone offering enrollment in more than one group insurance contract as a "limited insurance representative."

No firm would be required to maintain more than one such representative per location under the proposal.

But requiring one license gives state regulators authority to review the operations of a rental car company office, said Richard Rogers, deputy director of the Illinois Insurance Department's consumer division.

In addition, proposed changes to the NAIC's Unauthorized Insurers Model Act are designed to make it illegal for a rental car company to alter, amend or void insurance coverage as part of the rental car contract.

For instance, the use of a common rental car contract agreement that voids coverage for activities like driving on a gravel road could result in fines up to $10,000 for the rental car company.

Finally, another proposed change establishes a separate unfair trade practices model act that would prohibit "the offering for sale of any policy or certificate that contains inconsistent, ambiguous or misleading clauses, or contains exceptions or conditions that will unreasonably or deceptively affect the risks that are purported to be assumed by the insurance policy or certificate."

The changes, which are proposed by the NAIC's Market Conduct and Consumer Affairs Subcommittee, could be adopted as early as the

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Continued from previous page
NAIC's summer meeting, June 3-7 in Baltimore.

Policy form changes

The Insurance Services Office Inc. informed state insurance regulators about two proposals, which will soon be filed with the states, to limit defense costs under pollution liability insurance policies.

ISO's commercial general liability policy will not be affected by the proposed changes.

ISO said an insurer voluntarily could decide whether to use the proposed endorsements with either of two ISO pollution liability policy forms: Form CG 00 39, which includes coverage for government-mandated waste cleanups, and Form CG 00 40, which excludes such cleanups from coverage.

One proposed option would include defense costs within the limits of the policy, while the other would cap insurers' defense expenses at a specific amount outside of policy limits, said Diane Eisenberg, ISO's manager of government relations and filing operations.

The endorsement providing a separate defense amount meets the needs of those risks that must comply with Environmental Protection Agency financial responsibility requirements, according to ISO.

Under both options, an insurer is obligated to notify the policyholder when its duty to defend will end and to cooperate in an orderly transfer of defense obligations.

ISO believes that the existence of these defense options may enhance the availability of pollution coverage, an ISO statement said.

However, the Independent Insurance Agents of America strongly opposes the new endorsements because it fears they "may render an insured unable to adequately finance and/or manage his defense after he has exceeded his defense limit."

In addition, ISO said it is planning to broaden coverage soon for some pollution cleanup costs under ISO's commercial automobile liability policy.

Under the proposal, coverage for certain pollution cleanup costs will be provided if the accident results in either bodily injury or property damage.

Foreign trade

State insurance regulators report they are preparing for international trade talks in Switzerland and Mexico.

The NAIC has established a committee to deal with insurance issues at a meeting of signatories to the General Agreement on Tariffs and Trade negotiations, said Mr. Pomeroy, who also is chairman of the NAIC's International Insurance Relations Task Force.

The primary issue to be raised during GATT negotiations affecting insurance regulators is access to foreign insurance markets (*BI*, Dec. 19, 1989).

The negotiations begin May 7 in Geneva, Switzerland, and are expected to be completed before the end of this year, said Linda Powers, a deputy assistant secretary with the U.S. Commerce Department.

The timetable "is like a speeding train," she said. There is "almost overwhelming political pressure for the process not to fail," she said. "We just have to do the best we can do."

Regulators were urged to contact the governor in their respective states and comment on the insurance-related portion of a survey that federal trade officials sent to each governor. The responses are due April 15.

In addition, the Mexican government's move toward privatization of the government-controlled insurance industry offers "significant opportunities" for U.S.-based insurers, said Jo Ann Howard, a member of the Texas State Board of Insurance.

Current discussions are focused on automobile-related coverages for tourists who cross the U.S.-Mexican border.

U.S. insurers interested in writing private passenger automobile coverages in Mexico were urged to contact Ms. Howard prior to meetings with Mexican officials scheduled for May.

Meeting changes

Mr. Pomeroy announced that the NAIC is slightly altering its meeting structure to allow more time for state regulators to discuss issues privately.

Mr. Pomeroy said past meetings too often appeared to be a cross between a legislative assembly and "a Shriners' convention." The frivolity, he said, may detract from serious work.

Consequently, the traditional Sunday night reception at NAIC meetings will be replaced with a commissioners-only dinner. ■

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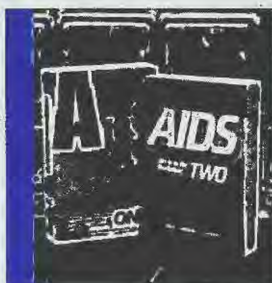

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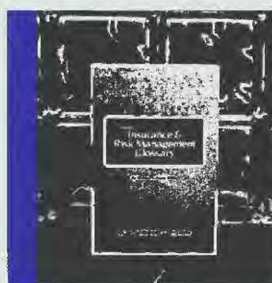

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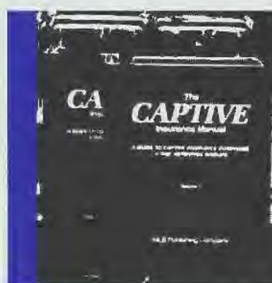

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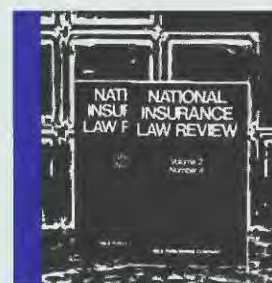

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Sedgwick E&O suit

Continued from page 2

Bland Welch and Sedgwick, "were in breach of duty in failing to inform the insurers" that the reinsurance cover was subject to a "48-month cutoff."

Under the reinsurance contracts covering the Avondale risk, coverage would be voided if the construction of the tankers took longer than 48 months. However, such an exclusion was not included in the primary insurance covering the tankers.

The judge, however, ruled that the insurers must bear some responsibility for not checking whether their reinsurance was adequate.

As a result, Justice Phillips ruled that the brokers should pay only 80% of the insurers' claim.

Sedgwick still is studying the judgment and has not yet decided whether to appeal the decision, said a Sedgwick spokeswoman.

However, Sedgwick is fully insured for the award under E&O policies covering Bland Welch and Sedgwick for the period in question, she said.

Sedgwick would not detail the E&O underwriters or the limits of the policies, but the spokeswoman confirmed that the policies are underwritten in the London market.

Some $240 million of the $300 million Avondale insurance settlement in 1980—a record claim in the marine insurance market at the time—was paid by London market underwriters and $60 million was paid by U.S. and Scandinavian insurers.

The claim was paid to El Paso Co. in Houston after three ships designed to transport liquified natural gas were deemed unusable.

Cracks in the ships' polyurethane insulation, discovered during tests on the first ship completed, made them all unusable for the explosive cargo.

The $300 million claim was paid to El Paso, rather than Avondale, because El Paso had already paid for the ships.

In his ruling last month, Justice Phillips ordered Sedgwick to pay the award to Lloyd's syndicates managed or formerly managed by Jansen Green Management Ltd.; H.G. Chester & Co. Ltd.; Secretan (Underwriting Agencies) Ltd.; Stewart & Hughman Ltd.; Roy Hill Underwriting Agencies Ltd.; and the now-defunct P.C.W. Underwriting Agencies Ltd. In addition, Sedgwick must pay The Orion Insurance Co. P.L.C. of London and Excess Insurance Co. Ltd. of Worthing, England.

From 1973, these insurers all subscribed to a building risks coverage program written for Avondale, brokered in London by Sedgwick and in New York by Frank B. Hall & Co. Inc., according to court papers.

When Avondale in the mid-1970s secured the order to build the three LNG tankers for El Paso, "Sedgwick appreciated that the values involved were likely to exceed the capacity of the London direct marine market and that it would be necessary to offer insurers excess-of-loss reinsurance if a significant proportion of the risk was to be successfully placed," the judge noted in his decision.

"Sedgwick (was a) highly specialized direct insurance broker, but had limited experience of reinsurance," the judge wrote. "In or about July 1973, (Sedgwick) invoked the assistance of brokers who specialized in reinsurance, namely Bland Welch," the ruling says.

A Bland Welch director "informed Sedgwick that the marine reinsurance market would not have the capacity to provide the cover required and that it would be necessary to tap the non-marine market. This market would not be interested in facultative reinsurance of individual hulls. It might be tempted, however, by a master excess-of-loss cover to which would attach all high-value construction risks placed in the London market," said Justice Phillips.

"And thus it was that between them Sedgwick and Bland Welch developed what came to be known as the 'Superhulls cover,' " he said.

The Superhulls reinsurance program covered some 200 superhulls—ships with a completed value of more than $60 million—that were to be built in the following three years, including the three Avondale LNG tankers. However, other insurers on the Avondale risk had their own reinsurance separate from the Superhulls program.

The reinsurance for the Superhulls program was led by former Lloyd's underwriter Leslie Dew and Lloyd's underwriter Richard Hazell. However, during placement of the reinsurance, Mr. Hazell altered the original terms to include the phrase "period of construction not exceeding 48 months," said the judge.

At various times during 1976, 1977 and 1978, the delivery dates for the three tankers were extended under the construction contracts. The extensions were approved by insurers.

Then, in July 1979, the insulation of one of the LNG tankers failed during sea trials, prompting a claim against the insurers. The insurers, in turn, gave the reinsurers notice of a possible claim in September 1979.

However, "early in December 1979, reinsurers declined liability on the ground that the cover had ceased by reason of the 48-month clause," Judge Phillips said.

The brokers—Bland Welch and Sedgwick—claimed that they "fully informed the insurers of the terms of the reinsurance that was available under the Superhulls cover and, in particular, of the existence and nature of the 48-month clause," the judge said.

However, during the trial, witnesses for the insurers "testified unanimously that they were led to believe that the reinsurance was 'as original' " meaning that they were not told of the 48-month clause, "and that they were not shown the reinsurance slip," the judge said.

And while one of the Sedgwick directors involved in placing the Avondale cover was in court during most of the trial and another was flown from the United States to be available to give evidence for the brokers, "neither went into the witness box" to deny the insurers' allegations, said Justice Phillips.

"In these circumstances, and in accordance with the unchallenged evidence of the insurers' witnesses," the judge found that:

- Sedgwick informed the insurers that excess-of-loss reinsurance coverage had been placed for the Superhulls program without mentioning that the reinsurance coverage was subject to the 48-month clause.
- Sedgwick did not show the insurers the reinsurance slip.
- It is reasonable to infer that the insurers believed that the reinsurance was 'as original.'
- The insurers were induced by the availability of the Superhulls program to write larger shares of the Avondale cover than they would otherwise have done.

As a result, the judge ruled that Sedgwick and Bland Welch breached their duties to the insurers by:

- Failing to give insurers accurate information concerning the reinsurance cover available.
- Failing to draft the contract wording with proper skill and care.
- Failing to inform the insurers that the reinsurance coverage obtained did not comply with the coverage ordered.
- Failing to take steps to procure coverage extensions once the 48-month period expired.

The judge also ruled the "insurers owed no duty to the brokers to read the insurance wording with skill and care and to draw attention to any inadequacies in the cover."

However, "it does not follow from this that the insurers were not guilty of neglect of what would be prudent in respect of their own interests," the judge said. "The result of the insurers' negligence was thus that they failed to obviate, at least in large measure, the consequences of the brokers' breach of duty."

As a result, the brokers were held 80% responsible for the consequent lack of reinsurance coverage. ■

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LaFalce proposal

Continued from page 3

crimination rules' impact on flexible benefit plans, multiemployer plans, governmental, quasi-governmental and non-profit entities, and self-insured plans.

Rep. LaFalce said he has extended the comment period on his proposals until mid-April.

"I want your input before I introduce any legislation, so nobody will be able to say that they were not given an opportunity for input before the introduction of the legislation, much less before any congressional consideration of it," he said.

Rep. LaFalce

Regarding other employee benefit issues, Rep. LaFalce told the ECFC meeting that the Pepper Commission report was of "real significance" because it can form a "starting point of debate" on the issue of health care reform (*BI*, March 5).

The Pepper Commission report, released last month, recommended that employers with more than 100 workers be required to sponsor a health insurance plan meeting minimum federal standards or pay new payroll taxes to fund a new public plan to provide coverage to the uninsured.

The wall of opposition to major reform of the nation's health care insurance system seems to be "crumbling" like the Berlin Wall, he said.

Rep. LaFalce also said he favored a bill, S. 2016, proposed by Sen. Patrick Moynihan, D-N.Y., that, among other things, would reduce the Social Security payroll tax to 7.51% from the current 7.65% of a worker's first $51,300 of wages (*BI*, Jan. 22).

Rep. LaFalce said he opposes legislation proposed by Rep. Peter J. Visclosky, D-Ind., that would require that employees be given joint control over employer-sponsored pension plan assets (*BI*, March 5; Oct. 2, 1989). Rep. LaFalce said his House Small Business Committee will be scheduling hearings in the coming weeks to discuss the impact of the legislation, H.R. 2664, on small businesses. ■

ECFC chiefs re-elected at meeting

ARLINGTON, Va.—Charles W. Rogers will serve an 11th one-year term as chairman of the Employers Council on Flexible Compensation.

Mr. Rogers, vp of compensation and benefits at Pepsico Inc. in Purchase, N.Y., was re-elected at the group's Flexcomp '90 Meeting last month.

ECFC President Donald F. Crowley, division head of compensation and benefits at Citicorp's Citibank unit in Long Island City, N.Y., was re-elected for a third term. Vp Glenn Solomon, director of benefits administration at the Cleveland Clinic Foundation in Cleveland, was re-elected for a second term.

Secretary Victor Gilla, corporate manager of employee benefits at Ball Corp. in Muncie, Ind., was re-elected for a second term, as was Treasurer Brian D. Jellison, president of Ingersoll-Rand Co. of Woodcliff Lake, N.J., who will serve his 11th term.

New board members elected were: Donald H. Edman, director of personnel programs at International Business Machines Corp.in Armonk, N.Y.; Frank P. Kellner Jr., director of benefits administration at Johns Hopkins University in Baltimore; Teri Teat, managing director of compensation and benefits at American Airlines Inc. of Fort Worth, Texas; Paul Thomson, director of compensation and benefits at United Technologies Corp. in Hartford, Conn.; and Dana Willis, director of corporate benefits at Houston Industries Inc., a Houston electric utility and coal transportation company.

A record crowd of more than 550 attended the annual meeting of ECFC, a 10-year-old non-profit association comprising major industrial companies and actuarial, insurance and accounting firms.

For more information, contact Bonnie Whyte at the Employers Council on Flexible Compensation, 927 15th St. N.W., Suite 1000, Washington, D.C. 20005; 202-659-4300.

—*By Adrienne C. Locke*

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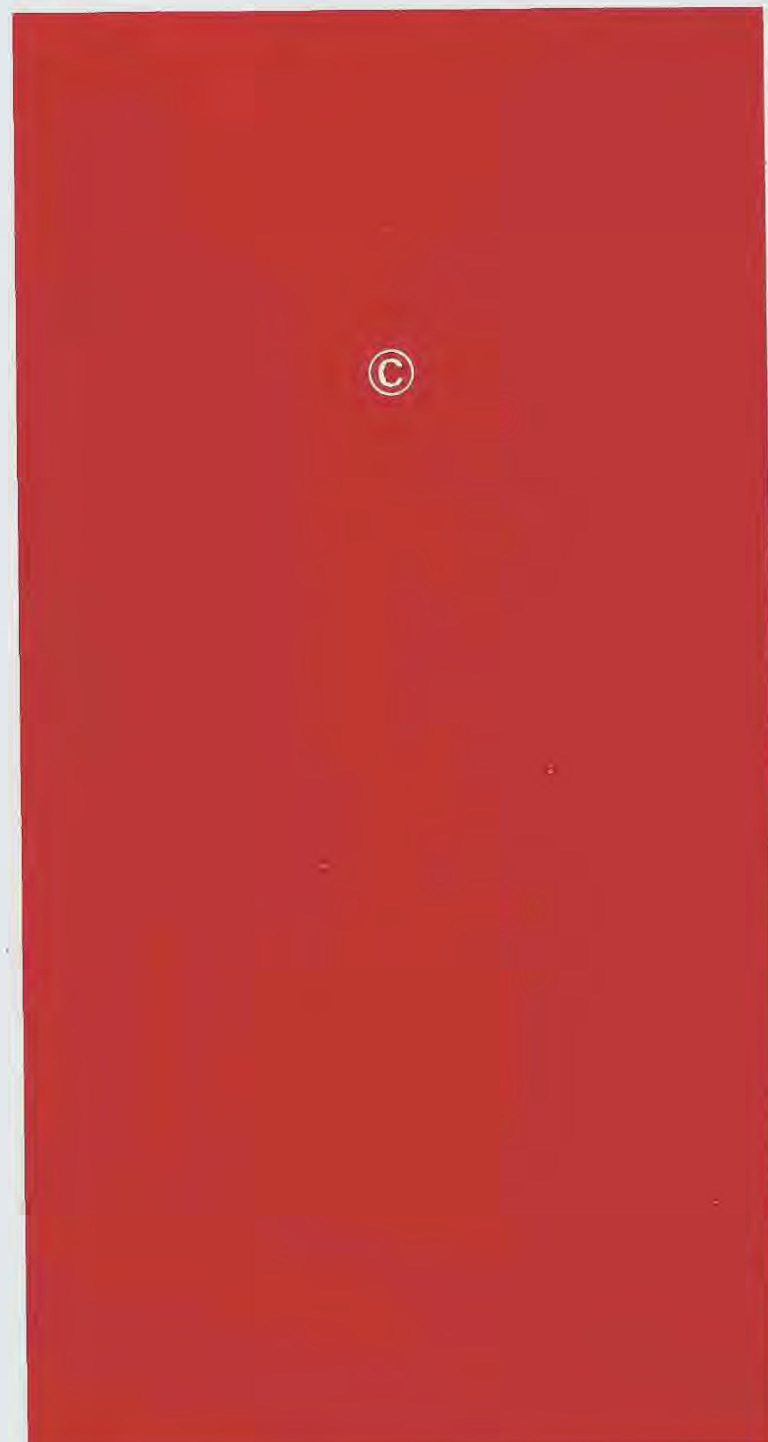

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Elder care seen as growing need

Several options available for employers

By ADRIENNE C. LOCKE

ARLINGTON, Va.—The need for elder care benefits will grow as the population ages and more working families are required to provide long-term care to elderly dependents, a benefit consultant says.

A variety of manageable options are available to employers that want to offer elder care in flexible benefit programs, according to Deborah J. Lewis, assistant vp of the health strategies group with Alexander & Alexander Consulting Group Inc. in Westport, Conn.

However, employers must consider several factors when choosing benefits to offer, so that the services properly meet workers' needs, she said.

"This is an issue that employers are becoming more aware of," Ms. Lewis told the Employers Council on Flexible Compensation's Flex-Comp '90 Meeting, held March 14-16 in Arlington.

Six of 10 senior executives in a 1989 survey of the 1,000 largest U.S. companies knew of at least one person working close to them who was dealing with a significant elder care problem, she said.

ecfc

In addition, 49% of the executives responding to that John Hancock Financial Services/Fortune Magazine poll had to decide how to care for an elderly dependent within the past two years, she said.

Workers with elder care responsibilities could benefit from a variety of services, she said. And because that range of services employers could offer has grown, employers considering offering elder care as a benefit should first review their program goals, said Ms. Lewis.

Elder care "is not a cookie cutter program," so careful planning, good communication with the workforce, and looking at models that are similar to the kind of program desired are important steps to developing a successful program, Ms. Lewis said.

She recommends benefits managers begin by asking themselves the five W's—who, what, when, where and why:

• What does an elder care program consist of?

It can include informational assistance and support, financial aid, corporate support of community programs, personnel policies that make allowances for employees caring for a dependent, assessment and referral, or direct care from an employer-sponsored program.

• Where would care be given?

Elder care could be provided at the worksite, near where an employee lives, or in the dependent's community.

• When would care be given?

It could be needed on an ongoing basis or only in emergencies.

• Why is elder care needed?

The median age of the general population is increasing, but it is rising most rapidly among those age 65 and older, Ms. Lewis said. This, coupled with the fact most elder care is delivered by the elderly person's family, will make elder care a sought-after employee benefit, she said.

Many current employees who care for elderly dependents say their careers have suffered, they have missed work or have left a job at one time or another to provide this care, she said.

Corporate-sponsored elder care programs offers employees with older dependents the help they need and also allows employers to keep valuable workers, she added.

Ms. Lewis also noted that the "who" in an elder care program can refer to the sponsor, care giver and elderly dependent.

Elder care differs from other forms of dependent care because of the large number of services that an elderly dependent may need regularly, she said.

Transportation, home maintenance, meals, counseling, shopping companionship, health care, legal and financial services and assistance in making appointments may all be necessary, she said.

The services that are covered under an employer-sponsored elder care program should reflect employee needs, as well as the kind of program an employer could affordably support, Ms. Lewis said.

A variety of parties—labor, management, human resources, and any outside help—should be involved in planning the benefit program, she said.

When setting up a program, employers can tap a wide range of external resources. These can include national, state and local programs, professional coalitions, consultants, other corporations that already have elder care programs, employee assistance programs, joint public and private initiatives, and vendors that sell dependent care services, she said.

Then, employers then can choose from a variety of different services the offer to employees under an elder care program, including:

• Assessment and referral. This can include assessment of the dependent's needs, identifying the resources available to assist the care giver, referrals to other agencies, and counseling and support.

• Financial assistance/benefits, including long-term insurance, elder care insurance, flexible benefits and dependent care spending accounts, and respite care, in which an assistant comes to the home of an older person needing care while that person's care giver is away for a short time.

• Direct care from the employer, including employer-sponsored elder daycare centers, respite care provided by a company's retirees who volunteer to care for elderly dependents of employees, or even daycare centers that are open to both and employee's children and elderly relatives.

• Personal policies/time programs, including flex time, part-time work options, job sharing, family leave policies or phased-in return to work.

• Information and support including seminars, support groups, newsletters, hot lines, employer-sponsored care giver fairs, books and pamphlets.

Even employers with limited resources could offer some assistance by making adjustments in company policies, using existing resources established for dependent care or just providing information to employees, Ms. Lewis said. ■

It's Our

Factory Mutual System

U.S. may follow Europe's benefit lead

By ADRIENNE C. LOCKE

ARLINGTON, Va.—U.S. employers will follow the lead of European companies and offer improved parental leave and additional time off, a trends forecaster predicts.

However, employers in Europe will begin to scale back benefits as competition among businesses increases in a single market, predicts Graham T.T. Molitor, president of Public Policy Forecasting Inc. in Potomac, Md., a research organization that tries to predict future government policy on various issues.

Mr. Molitor told the Employers Council on Flexible Compensation's FlexComp '90 Meeting, held March 14-16 in Arlington, that much can be learned from studying how change—including change in employee benefits—progresses from country to country. A slow but identifiable sequence of events can "reliably indicate future change," he said.

Employers can gain insight by recognizing and understanding the cycles and possible flow of events, Mr. Molitor said.

The United States traditionally has followed Western Europe—the Scandinavians in particular—in adding social welfare benefits, he said. In fact, it can take decades for U.S. employers and government agencies to pick up on social programs offered in Europe.

For example, Mr. Molitor pointed out that the United States adopted child labor laws about a century after they were adopted in Europe. Similarly, it took the United States 24 years to adopt workers compensation statutes, 30 years to enact mandatory unemployment insurance and 82 years to establish an old-age assistance program, he said.

"In recent years, these tiers of countries have been the first to implement almost any issue, and certainly any employee benefit or social welfare issue," Mr. Molitor said.

In addition, some European countries offer more generous benefits than U.S. employers.

U.S. workers receive 8.8 paid vacation days a year on average, while Swedish employees are offered a minimum of five weeks paid vacation, and that will increase to six weeks in 1991, Mr. Molitor said.

Generally, Sweden, Norway, Switzerland and The Netherlands are among the first to develop and adopt new government or employer-sponsored programs, he said.

These bellwethers "provide early signals that are likely to give rise to public policy change," said Mr. Molitor.

Denmark, France, Great Britain and West Germany adopt them next, followed by the United States and Canada, and, finally, Third World nations, he said.

Once these ideas reach the United States, a similar pattern of "precursor" states emerges, said Mr. Molitor.

For instance, employers and government entities in California, New York, and Massachusetts usually are the first to adopt new benefit and social welfare ideas, while rural states like Alabama, South Dakota and Mississippi usually lag behind.

Once benefit or social programs are established in the United States, it can be 10 to 20 years before Congress mandates or regulates these programs, he explained.

Mr. Molitor noted that looking to Europe can help U.S. benefit managers identify new trends in employee benefits in the United States.

For example, family management benefits, like leaves to care for newborn children and sick relatives, have been offered for years in Europe, though they are just beginning to win favor in the United States, he said (*BI*, April 2).

The benefits, which are deep-seated elsewhere, are trends that U.S. employers will find "difficult to resist," Mr. Molitor said.

For example, only 11% of private sector employers in the United States in 1987 had parental leave policies or programs in place. And most of those programs consisted of counseling and seminars, not time off, he said.

At the same time, 57% of mothers with children age 6 or younger were working, and that percentage is estimated to hit 60% during the 1990s, Mr. Molitor said.

In contrast, Europeans countries provide four to 12 months of prenatal leave and three to 29 months of leave after the birth of a child, with some countries providing up to 100% of salary during the leaves, he said.

Under Sweden's 1973 child care leave law, for example, either parent can receive 15 months of leave for the birth of a child and receive 90% of pay for the first 12 months, he said. Maximum leave may be extended to 18 months next year, he added.

In addition, parents can receive two months leave at 90% of pay to care for sick children under 12 and disabled children under 16, he said.

The Swedish social security system pays 85% of the cost of these parental leave benefits, with the remainder paid from the government's general revenues, Mr. Molitor said.

The Swedish government also pays 50% of the nation's day care costs through general revenues, while employers pay 37% and parents only 13%, he said.

Mr. Molitor noted that, in the future, U.S. employees will want not only parental leaves to care for children, but also leaves to care for aging parents and ill spouses or live-in mates.

He also notes that states are expanding the types of medical treatment that they require insured health plans to cover.

Coverage mandates for more than 700 types of care and treatment have been enacted by 38 states, he said, including coverage for the cost of acupuncture, chiropractic care, in some states, and even reimbursement for wigs if baldness has medical causes.

Massachusetts, for example, requires insured health care plans to provide coverage for in-vitro fertilization procedures which costs $5,000 and has only a 15% to 20% success rate, Mr. Molitor said.

In time, as employers voluntarily implement new employee benefits, "they set patterns that often seep into laws many years later," he explained.

Other predictions by Mr. Molitor include:

- Average life expectancy among Americans will rise to 79 years by 2050, with some people living as long as 130 to 140 years.

The average life expectancy among all Americans was 74.9 years as of 1988, according to the National Center for Health Statistics.

Increased life expectancy would put further pressure on employer- and government-sponsored retirement income and retiree health care programs.

- On-the-job exercise programs, once an executive privilege, will be extended to all employees and their families. ■

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ASK A RISK MANAGER

Light-duty programs cut work comp costs, reduce work days lost

Q **We are evaluating whether initiating a "light-duty" program would really be a cost-effective way to help reduce our workers compensation costs. Do you believe these programs are worthwhile?**

A Light-duty programs have found favor with many companies that believe rehabilitating injured employees is far more cost-effective than replacing them. They certainly have merit as part of an overall medical cost-containment program, which is a subject of great interest today.

As we explore the concept, let's briefly focus on the definition of rehabilitation before diving into the specifics of a light-duty program.

We should view rehabilitation as a combination of efforts among all those parties who can influence a person's recovery and ultimately restore his productivity. Rehabilitation, in the truest sense, centers on caring for the whole person—mind and body. In many instances, long after the body has been restored to health or made functional again, the psyche still needs nurturing. A light-duty program, as part of the occupational rehabilitation process, offers an opportunity for both mind and body to heal.

A risk management professional is keenly aware that his or her company should value employees as its most important asset. An employee's ability to perform a service for the employer, now and in the future, provides the basic reason for the company's existence. Furthermore, maintaining a high level of morale in the workplace increases productivity and profits. Experience shows us that when employees feel good about themselves and their employer they consistently perform above the expected norm.

A light-duty program provides the opportunity to bring a disabled worker back into the workforce and visibly communicates that the employer genuinely cares for its people. Who wouldn't prefer to work for a company that exhibits such concern?

An employee who is off the job for an extended period of time because of disability can begin to feel detached from the employer. He or she could easily become just a name on the monthly loss run, identified by a dollar sign and the outstanding claim reserve. It's not surprising that the disabled employee wonders if anyone knows he or she exists. The experience can be the equivalent of living in a never-never land. However, a light-duty program allows the employer and employee to stay in touch and, most importantly, provides a means of having the disabled worker remain part of the team.

Simultaneously, the employer benefits by saving dollars that would otherwise be paid under workers compensation for lost wages (indemnity) and by having jobs performed that would normally be put aside. Many employers their injured employees perform routine light-duty jobs such as counting time cards, answering phones or assisting with housekeeping chores.

The most common argument usually presented by those who do not support the light-duty concept is that money is spent needlessly to find work for injured employees. They view the process as an attempt to create busywork at the company's expense. A look at the statistics, however, reveals quite a different picture. Consider these facts:

- In 1988, workers compensation accidents cost workers and society an estimated $47.1 million.
- In 1987, American workers suffered approximately 1.8 million disabling injuries.

A sampling of data from companies that are actively involved in a light-duty program provides a strong argument in favor of the concept. Virtually all of the companies I recently evaluated were able to reduce workers compensation costs by a minimum of 28% one year after the programs were implemented. These companies also realized at least a 25% reduction in total work days lost within this same time frame. And, not surprisingly, lost-time cases were settled an average of four months earlier because of the light-duty program. This means sizable savings all the way around.

Another issue to consider when exploring the pros and cons of light-duty programs is the difficulty experienced by companies today in recruiting qualified personnel. I already briefly mentioned that the employer that places a high value on the health and well-being of its workforce attracts high caliber employees.

With the baby boom generation now hitting stride at middle age, a shrinking labor market will have an impact on the way businesses operate in the future. For example, employers—such as my own—that operate multiple locations and have historically recruited younger workers are seriously feeling the crunch. As the workforce ages, employee health issues are becoming increasingly important. Our ability to retain and, wherever possible, retrain disabled personnel will affect our ability to expand.

The successful administration of a light-duty program requires a commitment from all levels of management. Everyone involved should derive a benefit from the program. If your company understands and supports the rationale of the concept, initiating a light-duty program should provide you with positive results. ■

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

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

Ms. Werner

This month's column on risk management issues is written by Susan M. Werner, director of risk management at Hardee's Food Systems Inc. in Rocky Mount, N.C. Joseph W. Duva, director of employee benefits at Allied-Signal Inc. in Morristown, N.J., answers benefits management questions. William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions on benefits issues. And, Richard E. Sherman, a principal with Coopers & Lybrand in San Francisco, answers actuarial questions in the casualty field.

Mr. Duva's and Ms. Werner's columns appear alternately on the second Monday of each month. Mr. Miner's and Mr. Sherman's columns appear alternately on the first Monday of each month.

Ms. Werner's next column will appear in June.

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

Avoid settlement renegotiation

Monitor annuity prices in structured settlement

BELIEVE IT OR NOT, this year many personal injury cases settled in structured settlement form will have to be renegotiated because they were based on expired annuity rates.

Since the strain of renegotiating a settlement can be extreme on all parties, it is in everyone's best interest to avoid an event like this at all costs. Fortunately, you can prevent these kinds of disasters if you follow a set of simple guidelines adhered to by structured settlement consultants.

First, recognize that keeping close track of annuity prices is important. Although each structured settlement offer is made with full knowledge of its costs *at that time*, the price quotes received from life insurers that write annuity contracts are seldom valid for longer than 10 days, even though negotiations may stretch on for weeks, months or even years. In the meantime, the insurers' rates don't wait.

Since settlement annuities are priced very closely to the market and competition is stiff, when interest rates change, annuity rates follow almost immediately. Failure to acknowledge this fact can mean exceeding settlement authority or renegotiation.

Second, plan for adverse price changes. Build room in your settlement budget for potential price increases. Perhaps the easiest method is to build in a so-called "fudge factor" by reducing your settlement budget by a specific dollar amount.

In this regard, it is helpful to know that annuity rate changes tend to come in 4% to 5% doses (smaller changes in interest rates are too expensive for life insurance companies to respond to, while greater changes are too risky not to). Hence, if you are going to pad your budget, we suggest you use a maximum total settlement cost equal to 5% less than your total authority. This will protect you from at least one change in rates and will alert you to the possibility of more changes so that you can re-evaluate.

You can also protect your case during negotiations by purposefully using a mid-priced annuity company. Since early in negotiations you will have no idea which structured settlement design will settle the case or when an agreement will be reached, it is more important to protect your case than to shop for the lowest cost. Buying an annuity from a solid and predictable mid-priced company extends the "shelf life" of your settlement design, making it more useful to you in the negotiating process.

As long as you don't commit to that particular insurance company, you can always reprice the package after reaching settlement. As with using "fudge factors," be sure to ask for a company with an annuity priced approximately 5% high of your desired price so that you have ample protection and warning should rates go against you.

Using a mid-priced life insurer is often the wiser choice of the two because, early in negotiation, you can't know if any restrictions on annuity company selection are going to be forced on you by the plaintiff's

Continued on next page

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AIDS battle

Continued from page 2

For example, the administration is asking Congress to budget $3.5 billion for AIDS programs, compared with $8 million budgeted in 1982.

President Bush said those funds would be used for AIDS research, to provide grants to organizations that provide care for those with AIDS or the HIV infection and for funding local programs offering AIDS-related services.

In addition, both the Centers for Disease Control and the National Institute of Health are conducting tests on new drugs to treat people with AIDS, he noted.

These efforts have led to increased availability of experimental drugs for people with AIDS and the HIV infection, and of new therapies to treat HIV-infected people before they develop AIDS, he said.

And, the $10 billion allotted for the "war on drugs" will also help the war against AIDS and HIV infection, because one of the fastest-growing AIDS populations is intravenous drug users, President Bush said.

President Bush also voiced his commitment to educate the population about AIDS, how it is spread and what people can do to protect themselves.

"Our goal is to turn irrational fear into rational acts, and every American must learn what AIDS is and what AIDS isn't," he said.

The president said he wants to make certain that every American has access to all available information necessary to help prevent the spread of AIDS and the HIV virus.

"The ignorant may discriminate against AIDS, but AIDS won't discriminate among the ignorant," he said.

President Bush compared the AIDS epidemic to the U.S. polio epidemic during the 1930s.

Most medical experts at that time considered a cure so far in the distant future that they refused to speculate about when it might be discovered, he noted.

Decades of advances have been squeezed into 10 short years of AIDS research, speeding scientists toward a cure for this disease, though the crisis is far from over, he said. ■

South Dakota injured workers to pick doctors

SIOUX FALLS, S.D.—A controversial workers compensation bill that permits employees to choose their own physicians has been signed into law after almost three years of heated debate.

The law was passed by both houses of the South Dakota Legislature by a wide margin last month after its sponsor, Rep. Pam Nelson, D-Sioux Falls, garnered enough public support to turn the issue into a ballot initiative had the bill been defeated.

The legislation, S.B. 194, introduced by Rep. Nelson in 1987, was a response to labor union complaints that physicians contracting with some of the state's larger employers were returning employees to work before they had fully recovered from work-related disabilities like carpal tunnel syndrome.

Labor spokesmen claimed that one of the main offenders was John Morrell & Co., a meatpacker in Sioux Falls.

Morrell recently agreed to pay $1.25 million under one of the largest settlements of proposed Labor Department penalties for workplace safety violations (*BI*, March 26).

Previously under the state's workers comp law, employers had the option of allowing injured employees to seek care from their own doctors. While Rep. Nelson conceded that the majority of employers allowed their employees this privilege, "those who did not were abusing the system."

However, in hearings held on the bill, opponents argued that the new law would drive up workers compensation health care costs.

Higher workers comp costs in states that allow employees their choice of physicians "just goes with the territory," said David A. Gerdes, a Pierre, S.D., attorney who represented the Alliance of American Insurers.

The bill's backers and opponents subsequently hammered out a set of amendments to clarify the legislation before it was approved.

Those amendments, among other things, require employees to inform employers of the identity of their chosen physicians, to stay within South Dakota for care and to receive care from the physician of first choice. And, employers retain their right to obtain a second physician's opinion.

—*By Laura Mazzuca*

WHAT GIVES SWISS LIFE THE RIGHT TO TELL OTHERS SECOND BEST IS NOT ENOUGH?

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INTERNATIONAL

AP/Wide World Photo

Trafalgar Square was one of several sites in London where violent anti-tax protests erupted, causing some property damage.

Police may pay insurers for London riot claims

By CAROLYN ALDRED

LONDON—Insurers may be able to seek compensation from the London police after paying claims to policyholders whose property was damaged during violent protests March 31, the day before an unpopular new tax was introduced.

Insurers face at least hundreds of thousands of pounds in claims following destruction caused when the demonstrations turned violent.

Shops in London's fashionable West End were looted and their windows smashed. Cars and other property were set on fire by several hundred of 40,000 or so marchers, said police, who reported making about 340 arrests.

Non-insured property owners and insurers will be able to claim compensation from the Metropolitan Police authority—which covers London and its surrounding suburbs—if police declare the incidents a riot, confirmed a police spokesman.

The Riot (Damages) Act of 1886 provides for compensation from local police "where a house, shop or building in any police district has been injured or destroyed or the property therein has been injured or stolen or destroyed by any persons riotously and tumultuously assembling together."

Such compensation already is being considered for a March 8 riot in the Hackney district of London that occurred after local authorities announced the tax, confirmed the police spokesman.

The latest round of property damage occurred as demonstrators marched to Trafalgar Square to oppose the April 1 introduction of a new tax to replace a property tax.

The new levy—described as a community charge by Prime Minister Margaret Thatcher, but widely called a poll tax—is a flat-rate charge by each local district on every member of the community over age 18.

Local taxes previously had been collected only from homeowners at rates based on property values.

Mrs. Thatcher's Conservative government says the new tax will make local officials more accountable to all voters. Opposition parties criticize the tax as regressive, saying it places disproportionate burdens on the poor.

Following the anti-tax demonstrations, 558 crimes were reported to Metropolitan Police, including damage to 200 cars and 242 other cases of property damage, the police spokesman said.

One insurer said total damages may exceed 1 million pounds ($1.64 million).

Most commercial property insurance policies in Britain include riot damage either as part of the policy or as an optional endorsement that is offered to policyholders, said an Assn. of British Insurers spokesman.

Business interruption also usually is covered by insurers if property is damaged in a riot, said Philip Ashdown, a director of Bain Clarkson Ltd.'s U.K. division in Haywards Heath, England.

Businesses also occasionally purchase additional insurance to cover loss of profits if a surrounding area loses its appeal for customers on account of riots or other factors, said Mr. Ashdown. ■

European insurers set to merge

By CAROLYN ALDRED

One of the first cross-border mergers of major European insurers is set to take place amid increasing competition in anticipation of the single European market.

Groupe A.G., Belgium's largest insurance company, and N.V. Amev, The Netherlands third-largest insurer, announced plans last week to merge their operations.

The resulting company would be among Europe's 15 largest insurers with annual premium volume of 10 billion guilders ($5.22 billion at current rates)

However, the merger "with the aim of combining the two companies' operations to form a single group" involves no equity changes.

"It is the intention that N.V. Amev and Groupe A.G. shall retain their individual corporate structure and national character," the two companies said in a statement last week. Both corporate bodies "will continue to function as before and. . .their equity structure and shareholding relationships will remain unchanged."

Amev depository receipts will still be quoted on the Amsterdam stock exchange, and Groupe A.G. shares will be traded in Brussels.

The two companies, which both write life and non-life insurance, will be "equally represented in the new group's management" and each company will have seats on the other's board, the companies said.

The combined group will "be among the largest suppliers serving the Belgian and Dutch insurance" and banking markets, the two announced. The merged companies also provide all lines of insurance and financial services in several other European countries, the United States, Australia and the Far East.

About 85% of the combined group's revenues will be generated in Belgium, The Netherlands and the United States.

Amev's U.S. property/casualty affiliates include American Security Insurance Co. of Atlanta; Standard Guaranty Insurance Co. of Atlanta; and Superior Insurance of Tampa, Fla. In addition, Amev owns Time Insurance Co. of Milwaukee and two other life insurers.

The property/casualty insurers wrote $370.8 million in net premiums in 1989, according to A.M. Best Co.

Group A.G.'s U.S. holdings include a 25% share of United Reinsurance Corp. of New York and a 4.1% share in Transatlantic Reinsurance Co.

"This will be the first full cross-border merger within the European Community in the field of insurance, banking and other financial services," the companies said.

The two "have agreed that the value of Amev's contribution exceeds that of Groupe A.G. by 1.15 billion guilders, ($600 million) for which Amev will receive compensation from Groupe A.G. totaling 575 million guilders ($300.2 million), spread over 10 years," the companies announced.

As of Dec. 31, 1989, the companies' combined workforce was about 20,000, including 4,000 in Belgium, 8,000 in The Netherlands and 5,000 in the United States.

Combined capital and surplus for year-end 1989 was about 8 billion guilders ($4.2 billion at current rates) using Dutch accounting principles and about 4.5 billion guilders ($2.35 billion) using Belgian accounting principles.

The discrepancy is primarily due to accounting for assets based on historical value in Belgium and market value in The Netherlands.

"The two companies will be examining how best to organize their financial reporting in the future," according to the statement.

Both companies will be equally represented on a new management committee, which is to be jointly chaired by the chairmen of Groupe A.G.'s and Amev's boards.

Describing why they are merging, the companies cited the emergence of large, diffuse financial services companies in Europe. "Combining size and local presence, these groups will be in a position to grasp the opportunities offered by the further integration of the European markets. At the same time, this will also mean intensified competition." ■

Sydney firm has coverage for explosion

SYDNEY, Australia—Insured losses from a natural gas plant explosion in Sydney last week could total more than $5 million Australian ($3.8 million U.S.), an insurance adjuster says.

The adjuster, who did not wish to be named, said material damage from the March 31 blast was about $3.5 million Australian ($2.7 million) and business interruption losses would be about $2 million Australian ($1.5 million).

The gas plant in St. Peters, a suburb of Sydney, is owned by Sydney-based Boral Ltd. A police arson squad is investigating the fire, but has not determined the cause.

The adjuster said a 100-metric ton tank of liquified petroleum gas exploded, and surrounding tanks caught fire. Five of seven tanks at the site were damaged. The tanks ranged in size from 100 metric tons to 45 metric tons.

Boral's property and business interruption coverage is provided under a single industrial special risks policy with limits of $100 million Australian ($76.2 million), underwritten by QBE Insurance Group Ltd. of Sydney, the adjuster said.

The policy has a per-loss deductible of $10,000 Australian ($7,620) with a $1.5 million Australian ($1.1 million) annual aggregate, he said.

Following the explosion, police and firefighters temporarily closed the Kingsford-Smith International Airport in Sydney and evacuated nearby suburbs.

The New South Wales state government is investigating the blast, and the local council is lobbying to move the plant further away from the airport and private homes.

—By Kate McIlwaine

U.K. child care benefits boosted

By CAROLYN ALDRED

LONDON—Employer-provided child care may become more widely available in the United Kingdom following a government decision to abolish a tax on employee use of workplace nurseries.

In the annual budget announced March 20, John Major, the chancellor of the exchequer, agreed to drop the six-year-old tax.

The move was hailed by Working for Childcare, a non-profit group lobbying for government and business improvements in child care.

"Removing the tax is just one step on the road to securing good quality child care in sufficient quantity for the working parents in this country," said Delyth Morgan, a director of Working for Childcare, which was set up after the nursery tax took effect.

British corporate child-care benefits still do not approach the level of benefits available in the United States, the group says.

"As long as Britain lags so far behind its major industrial competitors, we shall continue to work for the development of quality child care for working parents," said Ms. Morgan.

Child-care benefits are still very rare in the United Kingdom, though many large private companies are considering them, according to a recent survey of Britain's 150 largest companies by Working for Childcare.

"As the demographic time bomb" ticks away, employers will be forced to provide more facilities to attract and retain women employees, the group contends.

The survey found many private companies "are now giving serious consideration to some form of child care provision for parents at work," said its author, Rob Shooter.

Sixty-four of the 106 responding companies offer extra help with child care or are reviewing policies on child care, the report notes.

However, WFC estimates that there are still only about 120 worksite day-care centers in the United Kingdom, about two-thirds of which are at public hospitals and schools and other state-run facilities.

About 28% of the responding companies currently operate or are thinking of setting up a workplace nursery.

Meanwhile, some responding companies are looking at other options such as child-care vouchers, with which an employer would subsidize day care provided by outside vendors or an employee's relatives.

In a new child care voucher system set up by benefit consultant William M. Mercer Fraser Ltd. and the National Childminding Assn., employer vouchers issued to employees can be used only for care from NCA-accredited providers.

Also, some companies offer career break programs, which allow parents to return to work after taking several years off to raise children.

However, "the expected shortfall in recruitment to the workforce of the future means that industry will need to attract, train and recruit an ever-increasing number of women with children," said Mr. Shooter in the Working for Childcare survey.

Britain's international competitiveness "will depend on our ability to respond to and facilitate changes in the nature of our workforce. So far, we are lagging behind our major competitors," said Mr. Shooter. ■

Facility offers direct D&O link to Lloyd's

By CAROLYN ALDRED

LONDON—U.S. brokers soon will be able to directly place directors and officers liability risks with syndicates at Lloyd's of London via a new computerized trading facility.

Lloyd's broker Gibbs Hartley Cooper Ltd. and Lloyd's D&O underwriter John Wetherell say the new trading facility will reduce the cost of placing North American D&O insurance at Lloyd's.

The facility's efficiency will allow Lloyd's syndicates to write North American D&O insurance with premiums as low as $1,500 per risk. Currently it is uneconomical to place with Lloyd's underwriters D&O accounts generating premiums of less than $10,000, said Simon Harrap, managing director of GHC North America.

This initiative is one of several recent moves by individual Lloyd's brokers and syndicates to attract smaller business to the market (*BI*, March 12).

The facility will cater to D&O insurance for directors of companies with less than $75 million in assets or non-profit entities of any size, said Mr. Harrap.

Backed by 40 to 50 Lloyd's syndicates, the facility is led by syndicate 1145, underwritten by Mr. Wetherell.

The initial electronic link will be between GHC and syndicate 1145. However, following a pilot program with several U.S. brokers, Mr. Harrap says he expects some U.S. brokers to be linked directly to Mr. Wetherell's underwriting box by the end of the year.

GHC will remain the Lloyd's broker for all the risks placed via the facility.

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Piper Alpha reserves

Mercantile & General Reinsurance Co. P.L.C. has increased its loss reserves for claims stemming from the 1988 Piper Alpha oil platform loss to 49 million pounds ($80.2 million) from 5 million pounds last year ($8.1 million at year-end 1989 exchange rate).

The reinsurer's increased exposures arise from its involvement in the London excess-of-loss reinsurance market, where Piper Alpha claims continue to spiral.

"Reserves have also had to be strengthened on other parts of the marine account," said M&G's parent company, Prudential Corp. P.L.C., announced last month.

M&G, which would not reveal its total loss reserves, announced a pretax loss for 1989 of 28.7 million pounds ($46.2 million), compared with a 1988 pretax profit of 33.6 million pounds ($60.8 million at year-end 1988 exchange rate).

"Our exposure in North America has resulted in significant losses in the second half of the year arising from Hurricane Hugo and the San Francisco earthquake, as well as the Phillips Petroleum explosion in Texas," M&G noted.

Gross premiums for 1989 increased 12.9% to 319.3 million pounds ($514.1 million) from 282.9 million pounds ($512 million) in 1988.

Although investment income increased to 141.7 million pounds ($228.1 million) from 115 million pounds ($208.2 million), M&G's underwriting loss was 150.3 million pounds ($242 million), compared with a loss of 27.6 million pounds ($50 million) in 1988.

LUC leases offices

London' third major insurance exchange will open in two years following the recent signing of a lease on a 295,000-square-foot property in the City, London's financial district.

Currently under construction, the London Underwriting Centre's new home at 3 Minster Court is due to open in March 1992.

Market Building Ltd., a leasing and management company set up by 24 founding insurance and reinsurance companies, signed the 25-year agreement with developer Prudential Corp. P.L.C.

The "purpose-built environment will enable brokers to conduct business fast and effectively with a large number of underwriters, while maintaining the London market's special tradition of person-to-person contact," MBL said in a statement.

More than 80% of the office space has been leased to about 70 companies, according to MBL. A lottery will be held to allocate office space within the center.

Equipping the building to meet brokers' and underwriters' needs will cost up to 54 million pounds ($88.4 million), said MBL.

LUC "is certain to play a significant role in maintaining and developing the London market's preeminent position in world insurance," said the statement.

Besides the LUC, the other underwriting centers in London are Lloyd's of London and the Institute of London Underwriters.

Merrett doubles profits

Merrett Holdings P.L.C., parent company of one of Lloyd's of London's largest underwriting agencies, more than doubled its pretax profits for the last fiscal year to 9.9 million pounds from 4.4 million pounds ($16 million from $7.4 million).

The bumper profits—the company's best ever—reflect profitable syndicate results in the 1986 underwriting year, Merrett says.

Fiscal 1989 revenues totaled 23.1 million pounds ($37.2 million at Sept. 30, 1989 exchange rate), up 52.3% from 15.1 million pounds ($25.5 million at Sept. 30, 1988, exchange rate) the previous year.

Total capacity of the group's 16 syndicates this year is 632 million pounds ($1.02 billion), down 3.4% from 654 million pounds ($1.11 billion) capacity in 1989.

Meanwhile, Merrett Insurance Services Ltd., a subsidiary set up in 1987 to attract smaller, domestic U.K. commercial business to Lloyd's, is beginning to grow gradually, said Merrett's annual report.

"From a slow start, premium income is increasing with marketing links already established. Despite their initial concern over the MIS concept, we are now seeing more support from Lloyd's brokers," the report states.

Brokerage defections

Four brokers have left Lloyd's of London brokerage C.T. Bowring & Co. Ltd. to join fellow Lloyd's brokerage Nicholson Chamberlain Colls Ltd.

The team—Paddy Jago, Roland James, Mark Synnott and Adrian Allen—will form a new Nicholson Chamberlain Colls unit to handle North American non-marine reinsurance business.

Meanwhile, a team of five marine brokers has joined Bowring Marine & Energy Ltd., a subsidiary of C.T. Bowring, from Sedgwick Marine & Cargo Ltd., a subsidiary of Sedgwick Group P.L.C.

Robert Wiggins has been named a director of Bowring Marine & Energy, and Clive Dolby, Mark Banks, Jennie Rickards and William Crickmore have been appointed assistant directors.

The team "will spearhead the production of marine business in Europe working in conjunction with Marsh & McLennan's European offices," according to Bowring, a Marsh & McLennan Cos. Inc. subsidiary.

Cover for buyouts

A property/casualty insurance program for new companies formed from management buyouts is being marketed by Sedgwick James Ltd.

Sedgwick James, the retail insurance broking arm of Sedgwick Group P.L.C., says most firms have difficulty setting up their own insurance program after a management buyout, which can leave them dangerously exposed to risk.

As a result, Sedgwick James and London-based insurer Guardian Royal Exchange Assurance P.L.C. have set up a facility that gives companies instant insurance coverage for up to 60 days after a buyout.

Coverages included in the package include property damage; business interruption; public and product liability; auto; personal accident; computer; and fidelity guarantee insurance.

Sedgwick claims the policy—called Start Out—is the first such program in the United Kingdom.

Graham Miller profits

London-based Graham Miller Group Ltd. reports 1989 was a banner year for the international loss adjusting company.

Graham Miller's 1989 revenues increased 48.4% to 10.98 million pounds ($17.7 million at year-end 1989 exchange rate) from 7.4 million pounds in 1988 ($13.4 million at year-end 1988 exchange rate) and pushed up pretax profits to 1.7 million pounds ($2.7 million) from 927,676 pounds ($1.7 million).

After a December 1987 buyout, management and staff now own most of the company, which operates 54 offices in 39 countries.

It provides loss adjusting services to reinsurance companies, insurance companies and syndicates, captive insurers and self-insured corporations. It also provides claims management for insurers and captives.

The company recently formed Graham Miller Reinsurance Evaluations Ltd. to provide external audits and claims analysis for underwriters and claims managers; expert opinions on reinsurance transactions and other reinsurance advice.

Comings and goings

Former Lloyd's of London underwriter **John Pryke** has been appointed a non-executive director of Liberty Mutual Insurance Co. (Massachusetts) Ltd. Mr. Pryke will remain a non-executive director of Cuthbert Heath Holdings Ltd.; Cuthbert Heath Underwriting Ltd., and R.F. Bailey (Underwriting Agencies) Ltd.

Mark D. Absalon has joined Bain Clarkson Ltd. as a director of the broker's Marine Division. Mr. Absalon, a specialist in Far East business, joined Bain Clarkson from Leslie & Godwin Ltd.

Tony Hobrow has been named a director of English & American Underwriting Agency Ltd. and general manager of the company's marine syndicate. ■

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Surety market

Continued from page 3

the faithful performance of a construction contract and payment of all incidental material and labor bills.

Meanwhile, the fidelity bond market posted its fourth consecutive underwriting profit in 1989, though results were off from the year before. Fidelity bonds reimburse an employer for losses due to employee dishonesty.

Surety results have improved drastically over the past two years because fewer construction contractors have encountered financial troubles, explained Howard Boyle, vp-surety for Johnson & Higgins in New York.

Thus, "competition has heated up (among underwriters) for major contractors. Most big companies are trying hard to write business as long as it's on their basis. I have noticed a definite aggressiveness toward writing business, even though the underwriting criteria has remained pretty strict," Mr. Boyle said.

Mr. Stough of A&A agreed that the market is "very competitive" for "good" contractors.

Underwriters are also actively pursuing small to medium-sized contractors whose accounts can be written on a net basis.

"Government spending (on infrastructure projects) is down and so are housing starts," so new and existing surety bond markets will have to compete for premium dollars, pointed out Stewart Duke, vp-surety at Baltimore-based Fidelity & Deposit Co., one of the nation's oldest surety bond underwriters.

"The market has loosened considerably since 1986-87, when construction was booming," but the surety industry's combined ratio was poor, said Lloyd Provost, president of the Surety Assn. of America in Iselin, N.J. About 300 underwriters of contract and fidelity bonds for contractors, financial institutions, government entities public officials and other employers belong to the SAA.

Underwriting quality has "improved greatly" in those three years, he said. "It had to change or the industry would have died."

Mr. Provost credits wholesale changes in underwriting standards for the surety market's turnaround.

"Companies re-underwrote all existing accounts in 1988," Mr. Provost said.

Surety underwriters, for example, now require and more closely scrutinize a greater amount of financial information from contractors before agreeing to write bonds, he said.

In addition, underwriters have refused to issue bonds to contractors with questionable records, he said.

Mr. Stough of A&A agreed that surety underwriters have stuck to "basic underwriting policies."

"Occasionally we'll see someone go off the limb, and we're never sure quite why. But for the most part, they're checking the typical things like management and track records," Mr. Stough said. "The days of underwriters thinking they couldn't make a mistake are over. They found out the hard way," he said, referring to huge underwriting losses in the mid-1980s.

Underwriters say the construction business—which fuels the surety bond market—is noticeably better than four years ago when cost overruns were more common among contractors.

In addition, a shakeout in the construction industry has led to better results for surety underwriters, Mr. Provost said.

"When underwriting results were poor, there were too many contractors," Mr. Provost said. Double-digit inflation in construction costs caused contractors to underestimate costs, which increased contract bond losses, he said.

"Construction is on a level plane, with the exception of California, the Pacific Northwest and Florida, where construction is progressing, and New England, where its on the decline by about 10%," said CIGNA Bond Services' Mr. Perler.

Despite its apparent recovery, surety underwriters are not giving the construction industry a completely clean bill of health.

As a result, "We have established some controls, which if adhered to, will protect the (surety) industry's well-being," Mr. Perler said.

For example, CIGNA Bond Services, which targets contractors with $25 million to $200 million in annual revenues, examines a contractor's in-progress work before issuing a bond, he said. CIGNA Bond Services wrote $59 million in surety bond premiums in 1989, $50 million of which was contract bond business, about the same as in 1988.

However, "In our view, construction is still sick," said George Holbrook, president of Reliance Surety Co., the bond writing unit of Reliance Group Holdings Inc. of Philadelphia. "Things are better now. . .industrywide, but there are still losses out there that are very big.

"The market turned for the better only because insurers began charging better rates for bonds" and because underwriters cut broker and agent commissions, he said.

Mr. Holbrook said Reliance wrote about $100 million in surety bond premiums last year—$85 million of which was attributable to contract bonds, down 5.5% from about $90 million in contract bond premiums in 1988.

'Occasionally we'll see someone go off the limb, and we're never sure why. . .the days of underwriters thinking they couldn't make a mistake are over. They found out the hard way,' says John Stough of Alexander & Alexander.

Reliance specializes in smaller contractors with annual revenues of $5 million to $20 million, he said.

Baltimore-based United States Fidelity & Guaranty Co. also is placing more emphasis on scrutinizing the risks it underwrites, according to John Huss, assistant vp-fidelity and surety.

"I think the market and USF&G have done a lot of corrective things to take care of the problems that surfaced in 1984 through 1986. We realize that qualifying the risk is vital. We always thought we made sure of it. Now we are making sure of it," Mr. Huss said.

USF&G wrote $104 million in contract bond premiums in 1989, up 8.3% from $96 million in 1989.

Mr. Huss noted that the 20% loss ratio on USF&G's contract bond book of business last year was better than the insurer's 1988 loss ratio.

"We make certain contractors have experience and have been profitable in the type of project they are seeking bonding. We also want the contractor to be familiar with the geographic region," Mr. Huss said.

Fidelity & Deposit also had a profitable year last year, according to Mr. Duke.

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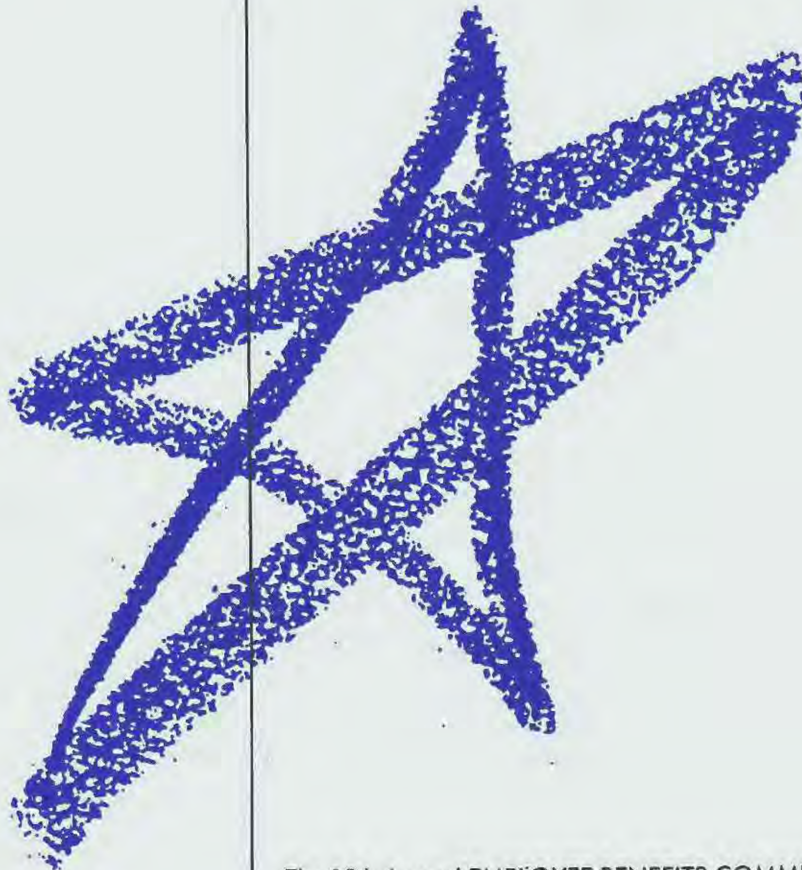

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For Competition rules and entry forms, or for details and reservations for the Awards Luncheon, write to the EBC Registrar at the address below, or call (212)-210-0780.

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Surety market

Continued from previous page

The underwriter wrote $103 million in contract bond premiums last year, up 6% from $97 million in 1988.

Mr. Duke said the combined ratio for all of the insurer's commercial book of business—including both surety and property/casualty insurance business—was "just over 100%" in 1989 and "just under 100%" in 1988.

The insurer wrote about $172 million in gross property and casualty insurance premiums, Mr. Duke said.

Some observers predict the market will remain stable, at least for the short term.

Mr. Stough said the contract bond market should be good for underwriters for at least two years.

"I think the need to rebuild the country's infrastructure will create opportunities for contractors and surety bond writers," Mr. Stough said.

Mr. Huss of USF&G predicts a stable surety market through 1990.

"There's no slam dunk coming in surety. I don't foresee any major increase in premium dollars or profits," Mr. Huss said.

Despite the "good shape" the market is in now, though, underwriters must still be aware that "contractors are operating with thin profit margins and it doesn't take much to send a contractor over the edge," warned J. Martin Huber, executive vp of the National Assn. of Surety Bond Producers, a group of 684 agents based in Washington, D.C.

Timothy Kenneally, executive vp of the financial products division of New York-based broker Sedgwick James Inc., said the softness of the surety market is "a disturbing trend because more contractors will become qualified than should be," which could lead to underwriting losses.

"I have also sensed a renewed pressure on softer pricing, which will have a negative impact on the industry. It's evident by the number of regional and second-tier companies aggressively entering the surety market," he said.

Only in environmental contracting has competition not heated up, according to Mr. Kenneally. High failure rates and dangerous conditions make underwriters reticent to write bonds for asbestos abatement and hazardous waste cleanup contractors, he said.

However, the NASBP's Mr. Huber said "a lot of people want to bond this, but there's no clear language today in the Superfund laws stating when a job is done. There is a problem with technology constantly advancing, and contractors don't want to be told down the line that they didn't use the right equipment" to clean up a site.

"The surety doesn't want to be perceived as the liability insurer of last resort," he explained.

Meanwhile, the $1 billion fidelity market posted an underwriting profit for the fourth consecutive year in 1989, but the market was not as profitable for underwriters as it was in 1988.

In 1988, the fidelity bond industry's combined ratio was 70%, the same as in 1987.

"Fidelity was not as good last year" Mr. Provost said.

"The profit rate was about 30% (in 1988), and I know it won't be near that for 1989," he said, blaming last year's lower profits on a softer market.

"Fidelity is a commercial line, and all commercial lines markets saw lower rates in 1989," he said.

USF&G wrote $18.5 million in miscellaneous bonds last year, including fidelity bonds, down slightly from $19 million in 1988.

Its fidelity bond business for the past two years has been "acceptably profitable," Mr. Huss said.

CIGNA Bond Services last year wrote $9 million in miscellaneous bonds, including fidelity, down 35.7% from $14 million in 1988, Mr. Perler said.

Fidelity & Deposit wrote $32 million in miscellaneous bonds in 1989, including fidelity bonds, up 3.2% from the $31 million it wrote two years ago.

Reliance in 1989 wrote about $15 million in miscellaneous bonds, including fidelity, up 11.1% from $13.5 million in 1988, according to Mr. Holbrook.

But, Sedgwick James' Mr. Kenneally said that fidelity bond underwriters should exercise more "caution" in underwriting bonds for financial institutions. ■

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Category	Count
Administrative:	
CEO's Presidents, and Owners	3,291
Vice-Presidents, General Managers and Other Administrative Personnel	3,847
Financial:	
Chief Financial Officers and Vice-presidents of Finance	2,382
Secretaries, Treasurers, contollers and other Financial Personnel	3,562
Risk/Employee Benefits:	
Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations	11,566
Sub-total	**24,648**
Associations	539
Government, Unions and Educational Institutions	1,389
Commercial Consumers Sub-total	**26,576**
Insurance Agents and Brokers	10,223
Insurance Companies	7,713
Accountants, Actuaries, Attorneys & Consultants	3,353
Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers	1,115
Others Allied to the Field	2,149
TOTAL	**51,129**

* Source Business/Occupational breakdown of qualified circulation, November 27, 1989 issue, as submitted to BPA for December 1989 BPA Publisher's Statement.

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LEGAL NOTICES

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IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS COUNTY DEPARTMENT, CHANCERY DIVISION

IN THE MATTER OF THE LIQUIDATION OF THE PATRIOT LIFE INSURANCE COMPANY NO.89 CH 9456

NOTICE OF CLAIMS DATE AND PROCEDURES

PLEASE TAKE NOTICE that on August 23, 1989 an Order of Liquidation With a Finding of Insolvency was entered against Patriot Life Insurance Company ("Patriot") by the Circuit Court of Cook County, Illinois. Zack Stamp, Director of Insurance of the State of Illinois is the statutory and court affirmed Liquidator of Patriot.

TAKE FURTHER NOTICE that pursuant to the Order, all rights and liabilities of Patriot and its creditors, policyholders and all other persons interested in its assets are fixed as of August 23, 1989, unless otherwise provided in a subsequent order of the Court.

TAKE FURTHER NOTICE that on September 13, 1989 the Circuit Court of Cook County, Illinois entered an Order Fixing the time and procedure for the filing of claims. Pursuant to the terms of that order, any and all persons, partnerships, corporations, associations, estates, trusts and governmental units having or claiming to have any accounts, debts, claims or demands against Patriot, or claiming any right, title or interest in or to any funds or property of Patriot in the possession of the Liquidator are required to file a Proof of Claim with Liquidator, or the Florida Ancillary Receiver, on or before 4:30 p.m. Chicago Time, August 24, 1990.

TAKE FURTHER NOTICE that the form and required content of all proofs of claim are described in the Illinois Revised Statutes, 1987, Chapter 73, Paragraph 821. Proofs of claim, together with supporting documents, if any, are to be filed with, and may be secured from, the Special Deputy Liquidator, Patriot Life Insurance Company, in Liquidation, 446 East Ontario Street, Suite 700, Chicago, Illinois 60611 or the Florida Department of Insurance, Ancillary Receiver of Patriot life Insurance Company, Post Office Box 110, Tallahassee, Florida 32302. Filing shall occur upon receipt of Proof of Claim by the Liquidator or the Ancillary Receiver. The Liquidator reserves the right to require such additional information with respect to any claim as he may deem necessary. The Liquidator further reserves all rights to any and all defenses of Patriot concerning such claim(s). All Proofs of Claim must be duly sworn to before an officer authorized to take oaths.

THE LAST DATE FOR THE FILING OF PROOFS OF CLAIMS WITH THE LIQUIDATOR OR THE ANCILLARY RECEIVER AT THE ABOVE MENTIONED OFFICES IS AUGUST 24, 1990 AT 4:30 P.M., CHICAGO TIME. NO ONE HAVING OR CLAIMING TO HAVE ANY CLAIMS AGAINST PATRIOT LIFE INSURANCE COMPANY SHALL PARTICIPATE IN ANY DISTRIBUTION OF THE ASSETS OF PATRIOT UNLESS SUCH CLAIMS ARE FILED WITH THE LIQUIDATOR OR THE ANCILLARY RECEIVER ON OR BEFORE AUGUST 24, 1990 AT 4:30 P.M.

James W. Schacht, Special Deputy Liquidator

Medicare fees

Continued from page 1

care physicians, like internists and family practitioners.

As a result of the new reimbursement system, physicians who will be paid less by Medicare will attempt to recoup lost Medicare income by increasing fees charged and services provided to privately insured patients, benefits experts expect.

In addition, physicians who will be paid more by Medicare are expected to increase fees paid by the private sector, experts say.

"The reason we are worried about this is because providers are saying that they cannot afford to provide (to Medicare) their services at this price, and so they have to look elsewhere to make up the difference. And that place is the private sector," said William Lane, vp and actuary at Mutual of Omaha Insurance Co. in Omaha, Neb.

"Once a doctor gets to a certain standard of living, he will do what he can to maintain it," said John Varda, group insurance manager at Caterpillar Inc. in Peoria, Ill.

"Most physicians have an excellent standard of living and want to maintain it," said Richard Finni, director of managed care services at Buck Consultants Inc. in Secaucus, N.J.

To protect themselves from cost shifting, most insurers will move to a fee schedule like the Medicare physician reimbursement system, observers say.

"We expect that most insurers will adopt it," Mr. Finni said.

Robert Larson, president of Park Ridge, Ill.-based Insurance Administration Center Inc., the claims administrator for the insurance programs offered by the National Assn. of Wholesaler-Distributors, also believes insurers will not hesitate to adopt such a fee schedule.

"I think most of them will try to ride the wave of what they perceive as a cost-control measure," he said.

William Mayer, a medical consultant in the Washington office of The Wyatt Co., agreed.

"It is easy for an insurance company that has a preferred provider organization network to implement RBRVS within the program," he said, referring to the new Medicare "resource-based relative value schedule" for reimbursing physicians.

Several insurers say they are beginning to examine the feasibility of adopting a similar physician fee reimbursement schedule.

"We are looking at the schedule," said Mr. Lane of Mutual of Omaha.

"We feel adoption of a fee schedule is favorable" if it is a better way to limit costs for employers and the insurer, said David Mooney, associate vp for group operations at Nationwide Life Insurance Co. of Columbus, Ohio.

"There's a trend toward putting in a schedule of fees in contracts," said Joseph Moran, vp and actuary at New York Life Insurance Co. of New York.

The increasing gap between the fees paid by PPOs and those paid by plans without managed care measures is fueling that trend, Mr. Moran said.

But some insurers say it is too soon to speculate on whether moving to the new fee schedule is prudent.

For example, Aetna Life Insurance Co. in Hartford, Conn., has reservations about moving too fast, though it is investigating using an RBRVS.

"But, we need more time to look at this," said a spokesman, noting that Aetna is "very concerned" about the possibility of cost shifting from health care providers.

Many Blue Cross and Blue Shield plans are considering using an RBRVS, but they want to evaluate the new Medicare reimbursement system first, said Carron Maxwell, director of provider and cost management strategies with the Chicago-based Blue Cross/Blue Shield Assn.

The Health Insurance Assn. of America does not have an official policy on the new Medicare physician fee reimbursement system. It is waiting "to see if there will be some kind of cost shift" from Medicare, a spokesman said.

The National Assn. of Manufacturers in Washington, D.C., supports the new reimbursement schedule, even though NAM recognizes there may be some cost shifting to the private sector, said Sharon Canner, assistant vp and director of employee benefits.

Meanwhile, if employers do offer indemnity health care plans featuring an RBRVS, employees and dependents could be left holding the bag for costs that exceed the fee schedule, Mr. Lane of Mutual of Omaha said.

Employers with indemnity plans underwritten by insurers that have implemented an RBRVS will have no choice but to shift costs to employees, agreed Larry Townley, second vp of health economics at John Hancock Mutual Life Insurance Co. in Boston.

Kenneth Sperling, a consultant in the Rowayton, Conn., office of Hewitt Associates, said insurers will try to duplicate the Medicare physician reimbursement system in indemnity plans, but these plans will result only in a shifting of costs to employees, not an actual reduction in costs.

> **'We feel adoption of a fee schedule is favorable,' says Mr. Mooney of Nationwide.**

But many employers feel they can no longer pass along additional health care costs to workers, noted Mr. Mayer of Wyatt.

"Many employers have already gone into a period of cost shifting onto employees. Any further cost shifting will not be well-received," he said.

Many experts say that a managed care program, like an HMO or PPO, would offer the best protection from physician cost shifting.

"You're in better shape to deal with the cost shift if you are in managed care than if you are in an operation that is open-ended like a major medical program, where you have no control over the provider," Mr. Moran of New York Life said.

Any health insurance product that offers a managed care feature "will see an increase" in interest from employers, predicted Dan Dragalin, vp of group medical services at Prudential Insurance Co. of America in Newark, N.J.

However, because managed care plans restrict access to physicians as well as services in some instances, some employees may not agree to participate in such plans, said Mr. Lane of Mutual of Omaha.

"Some people value that freedom of choice," he said.

Nancy Buckman, director of managed health care at John Hancock in Boston, agreed.

"Many employees want complete coverage and complete freedom of choice and are not willing" to move to a more restrictive health plan.

Employers that negotiate health care benefits with labor unions may find it particularly difficult to move from an indemnity plan to a managed care plan, observed Robert Hertenstein, medical director of group insurance at Caterpillar.

Persuading labor to accept a managed care plan that reduces covered services or access to health care providers is not easy, he said.

While Caterpillar offers health maintenance organization options to employees, workers are not penalized if they do not use the HMO. The company's self-insured indemnity plan does not contain managed care features.

And, Mr. Moran of New York Life noted that "there are communities where doctors have much more of a capacity to dig in their heels, and those doctors can be more independent than those who feel there aren't enough patients to go around."

But, for employers that do not move into managed care programs and do not have indemnity plans featuring an RBRVS, "their costs are going to be outrageous" Mr. Lane said.

Although the Medicare program will not begin phasing in the RBRVS until 1992, most experts believe that employers should begin preparing to respond to the expected physician cost shifting immediately.

"It is not too soon to begin analyzing the current fees they have been paying. . .to see where the potential for shift lies," said Mr. Martingale of TPF&C.

For instance, employers should already begin considering switching to a managed care program now, he said.

"With costs rising the way they are and the pressure within companies to keep it under control, short of managed care, there really is not much you can do," Mr. Martingale said.

Mr. Finni from Buck agrees.

"The only way that employers can protect themselves from the cost shift that will come about once RBRVS is fully implemented is through managed care" he said.

Wyatt's Mr. Mayer urged employers that want to negotiate any changes in contracts with providers to do so before the Medicare physician fee reimbursement system is implemented.

"Once the squeeze is on, it will be increasingly difficult to negotiate these changes," because doctors will resist further fee setting from payers, he said.

Others do not feel such a sense of urgency.

"Practically speaking, I think there is a good lead time. I don't think there is going to be any real push toward trying to adjust until the fee schedule in marginally implemented," said Mercer's Ms. Pflaum.

In the meantime, the U.S. Chamber of Commerce in Washington, D.C., is engaging in talks with members about employers' options.

Consultants also point out that the new Medicare physician reimbursement system could actually cause employers problems in their efforts to control retiree health care costs by forcing some health maintenance organizations to drop their Medicare risk contracts.

Under such a contract, an HMO agrees to provide treatment to Medicare recipients in return for a fixed payment from the Medicare program.

As primary care physicians seek higher fees that the Medicare physician reimbursement system is expected to allow and specialty physicians resist the lower fees to be paid under the new system, HMOs will find it tougher to maintain a profit margin on their Medicare patients, said Brenda Ballard Pflaum, a consultant in the Chicago office of William M. Mercer Meidinger Hansen Inc.

Medicare's new physician reimbursement schedule "will not make it easier for HMOs" to maintain a profit margin, Hewitt's Mr. Sperling agreed.

But, HMOs may find it difficult to leave the retiree market because of added "pressures from employers" who will only enroll their active employees in an HMO "if they can also enroll their retirees," Mr. Sperling said. ■

Some doctor fees to be increased by Medicare scale

By ADRIENNE C. LOCKE

Physician fees for surgical specialties will decrease about 11% overall while fees for medical specialties will increase about 20% under the new Medicare physician reimbursement system, according to the Physicians Pay Review Commission in Washington, D.C.

For example, the fee paid for a total hip replacement would be reduced 17.4% to $1,985 from the customary prevailing fee of $2,404, according to the 13-member commission consisting of representatives of the medical and business communities, academics and a representative of the American Assn. of Retired Persons.

Congress established the commission to advise lawmakers on reforming fees paid to physicians who treat Medicare recipients.

The commission also estimates that reimbursement for a coronary artery bypass would be trimmed 27.4% to $2,828 from $3,894 and reimbursement for cataract surgery would be cut 19.5% to $1,227 from $1,524.

However, reimbursement for physician office visits would be hiked 24% to approximately $28 from about $23, the PPRC estimates.

In addition, the commission expects reimbursement for a comprehensive consultation would be increased 11.8% to $104 from $93.

However, the Health Care Financing Administration is still developing the new physician fee reimbursement schedule.

The new reimbursement system is expected to be completed by the fall of 1991, but a model system is scheduled to be presented to Congress this fall.

The reimbursement system will use a "resource-based relative value scale" based on a Harvard University study developed by medical economist William C. Hsiao and internist Peter Braun (*BI*, Sept. 18, 1989).

Under the schedule, appropriate fees for various physician services would be determined by first establishing a numerical value for each type of service based on the actual work of the physician, the expenses related to his or her practice, and medical malpractice insurance costs.

The monetary value of the services would be determined by multiplying the numerical factor by a dollar conversion factor that Congress will determine every year.

Congress could modify the dollar conversion figure annually to reflect inflation and changes in the Medicare population.

Another multiplier will be included in the formula to adjust the reimbursement of physicians in urban and rural areas to account for such factors as community size—and therefore the number of patients a physician has the opportunity to treat—and the cost of repairing equipment.

The physician reimbursement system is accurate and objective because it takes into account some of the expense involved in providing medical care, said Richard Finni, director of managed care services at Buck Consultants Inc. in Secaucus, N.J.

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Weavers' years of worry, doubt

LONDON—H.S. Weavers (Underwriting) Agencies Ltd., formed in 1962, is not a Lloyd's of London underwriting agency, though it has often been mistaken for one.

Weavers, owned by London United Investments P.L.C., specializes in writing U.S. casualty business on behalf of members of its underwriting slip, which now include Walbrook Insurance Co. Ltd. and Anglo American Insurance Co. Ltd.

Here is a chronology of events affecting Weavers and LUI during the 1980s:

1983-1985. LUI raised 12.2 million pounds in additional capital for Walbrook, an LUI subsidiary. By the end of 1985, total capital and surplus was 19.3 million pounds.

November 1985. Weavers introduces a controversial claims-made form that is less strict than the new Lloyd's claims-made policy (*BI*, Nov. 25, 1985).

April 1986. Some brokers worry that Weavers' decision to stop writing new casualty business from April 1 to July 1 was prompted by financial problems. Insurance Solvency International Ltd. of London said the "big concern is if their reserves are adequate." But Weavers Managing Director Peter Wilson said the moratorium was prompted solely by a glut of business it could not handle (*BI*, April 7, 1986).

July 1986. The moratorium on new U.S. excess liability business is lifted. LUI raises 23.4 million pounds in additional capital for Walbrook. By year-end, Walbrook's capital and surplus equals 54.4 million pounds (*BI*, July 21, 1986).

April 1987. CalFed Inc. announced activation of a new London market excess insurer, Anglo-American Insurance Co. Ltd., with $80 million in capital and surplus. Its policies would be underwritten by Weavers in London (*BI*, April 13, 1987).

August 1987. For 9 million pounds ($14.4 million at the time), LUI—Weavers' parent—purchases El Paso Insurance Co. Ltd., which insures 6.5% of the Weavers line slip. (*BI*, Aug. 3, 1987).

January 1988. Two insurers are removed from the Weavers slip and two reduce their participation after Marsh & McLennan Cos. Inc. raised concerns about the discounting of loss reserves by five of the line slip's eight insurers.

Removed are: Ludgate Insurance Co. in London, whose ultimate parent is Chicago Multi-Hospital Services, which wrote 3.58% of the slip; and Louisville Insurance Co. Ltd. in London, owned by Humana Corp. of Louisville, Ky., with 3.74%.

Kraft Insurance Co. Ltd. in London, a subsidiary of Glenview, Ill.-based Kraft Inc., and El Paso reduce their participation. Walbrook's participation is increased to 41.9% of the slip from 36.14%; and Anglo-American's participation is increased to 39.75% from 33.42% (*BI*, Jan. 11, 1988).

April 1988. Four more insurers are dropped from the Weavers slip following market concerns about the slip's security: Kraft, which wrote 5% of each risk; El Paso, which wrote 5.5%; The Mutual Reinsurance Co. of Bermuda, whose ultimate parent was the American Newspaper Publishers Assn. and which wrote 5.2%; and Compagnie Europeene D'Assurance Industrielle in Belgium, a unit of Petrofina of Italy, which wrote 2.65% (*BI*, April 18, 1988).

May 1988. Walbrook reports an aftertax loss of 2.4 million pounds for 1987 ($4.5 million at appropriate exchange rates) compared with a 1.4 million pounds profit for 1986 ($2.0 million). An exceptional claims provision of 8.5 million pounds ($16.1 million) accounted for part of the loss. (*BI*, May 23, 1988).

September 1988. LUI acquires Louisville, Kraft and Mutual Reinsurance for 150,000 pounds ($252,000). LUI Chairman Ronnie Driver says the companies were acquired to ensure an orderly runoff of their business (*BI*, Sept. 26, 1988).

January 1989. LUI announces it will acquire the CalFed Insurance Syndicate Inc. on the Illinois Insurance Exchange for $12.7 million (*BI*, Jan. 9., 1989).

April 1989. In letters to former, current and potential Weavers clients, Alexander & Alexander Inc. casts doubt on the financial strength of Walbrook (*BI*, April 24, 1989). LUI's stock price drops sharply, and Walbrook announces that it expects an increase in loss reserves at year-end 1988 will be endorsed by Tillinghast (*BI*, May 1, 1989).

May 1989. Loss and unearned premium reserves for Walbrook are within a range considered "reasonable," says Tillinghast in a qualified endorsement (*BI*, May 8, 1989).

Later in May, Walbrook reports reserves for outstanding claims at year-end 1988 of 231 million pounds ($418 million), up 57% from 147 million pounds ($276 million) at year-end 1987.

Meanwhile, LUI reports that two directors and a former director have transferred to LUI their previously undisclosed shareholdings in Michigan-based underwriting agency Russell Reinsurance Services Inc. without taking any payment (*BI*, May 22, 1989).

July 1989. Transit Casualty Co.'s receivers and Weavers say they will work together to determine Weavers' liabilities as a Transit reinsurer after a London newspaper reports that Weavers faces $300 million in losses from reinsurance ceded by Transit Casualty. Weavers said those losses do not exceed $60 million (*BI*, July 10, 1989).

October 1989. Head Insurance Investors (Bermuda) Ltd. announces the purchase of Anglo American from CalFed Inc. for 64.5 million pounds ($105.8 million) (*BI*, Oct. 16, 1989). It was approved in February by the British government.

March 1990. John Head, chairman of Head Insurance Investors, says "for the time being, we are completely supportive of Weavers" (*BI*, March 12).

Meanwhile, Transit's receiver charges that LUI officials helped sink Transit through a joint investment with Transit in two managing general agencies that produced loss-riddled business for the insurer (*BI*, March 19).

March 26. LUI announces that Walbrook suspended its underwriting, though it will continue to pay claims. However, other LUI insurance units that are in runoff have suspended their payment of claims until further notice. LUI also announces it has suspended trading of its stock on the London Stock Exchange (*BI*, April 2).

Meanwhile, Head looks for additional capital to help with the runoff of the Weavers line slip and the establishment of a restored facility to write U.S. casualty business.

—By Stacy Shapiro

Amid the smoke, some brokers saw 'fire'

By LAURA MAZZUCA

While some brokers say they saw it coming a mile away, others concede the suspension of underwriting at Walbrook Insurance Co. Ltd. late last month caught them off guard.

"I was absolutely surprised," said Randall Goss, president of U.S. Risk Insurance Agency Inc., a Dallas wholesaler.

London-based Walbrook, which until last month had written 55% of the U.S. casualty line slip managed by H.S. Weavers (Underwriting) Agencies Ltd., had "always offered a consistent and loyal market," Mr. Goss added.

Weavers was characterized by "a high degree of professionalism and integrity, and better claims payment patterns than we've experienced from others."

Other wholesale and retail brokers say they were aware of doubts about the security behind the Weavers slip that were raised by brokers Alexander & Alexander Services Inc. last spring and by Marsh & McLennan Cos. Inc. in late 1987 (*BI*, April 24, 1989; *BI*, Jan. 11, 1988). But many say they thought any reserve deficiencies at Walbrook or other underwriters on the slip had been shored up.

'I always felt there was a problem' with the Weavers slip, says Andrew H. Marks.

At Thomas F. Sheehan Inc., a wholesale brokerage in Schaumburg, Ill., officials who had reviewed Walbrook audit statements and actuarial reports for 1988 and beyond believed the Weavers slip was financially sound, said President Thomas F. Sheehan.

Because "we did not see any mass exodus" from Weavers, the underwriting suspension came as a complete surprise, said Marcus Payne, executive vp and chief operating officer of Crump E&S Group in Dallas, the nation's fourth-largest wholesale brokerage based on 1988 premium volume.

Having been a London market fixture for many years, the Weavers slip had an aura of invulnerability, said one retail broker who asked not to be named.

"They've been around for a number of years and were there in the past when we needed them," he said, noting that he was "shocked" at the underwriting suspension.

Some agents and brokers were more surprised than others.

In Florida, the state chapter of the National Assn. of Professional Insurance Agents was setting up an association errors and omissions insurance program for more than 500 member agents. Fifty-five percent of the coverage was to have been written by the Weavers slip.

Underwriters had assured the agents—who were aware of A&A's warnings on Walbrook last year—that there were no problems, said chapter President Gerry Park.

"The financials seemed fine. We went through everything," said Mr. Park, who is also president of Park & Associates, a Boca Raton, Fla., agency. "It was a good concept, it gave them (agents) what they needed."

PIA members approved the plan, but the paperwork was delayed by association attorneys and the coverage was never bound, he said.

Walbrook's problems did not come as a surprise to some brokers.

"We don't have one line here with Weavers because about a year ago we figured, 'Where there's smoke, there's fire,' " said Andrew H. Marks, president and chief executive officer of MLW Services Inc., a specialty and mid-market broker in New York.

"I always felt there was a problem," said Mr. Marks, who moved all business brokered by MLW Services business to other insurers by late last year.

But even before questions concerning Walbrook's security surfaced, MLW considered the Weavers slip a "court of last resort," useful only for volatile business.

At most, MLW had placed only $400,000 to $500,000 in premium volume for long-tail professional and product liability risks with the Weavers slip, he said.

Among those insurers that picked up business that MLW previously placed with Weavers were American International Group Inc. and The Home Insurance Co. of New York; Zurich American Insurance Co. of Schaumburg, Ill.; and The St. Paul Cos. Inc. of St. Paul, Minn.

The rates charged by these insurers were "a little bit higher, but you get what you pay for," Mr. Marks said. ■

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The Chubb Group of Insurance Companies
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CHUBB
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Business Insurance

Walbrook's future

Continued from page 1
needed to win back client and broker confidence."

Head Insurance Investors and Anglo American are continuing to negotiate with other companies to reinsure Anglo American to allow it to increase its capacity.

In another development, the estate of defunct Transit Casualty Co. is exploring the possibility of pursuing a court-supervised runoff of Walbrook (see story, page 31).

Walbrook, which writes 55% of the Weavers line slip, suspended underwriting late last month pending finalization of an actuarial report on Walbrook's and six LUI companies' reserves by the Tillinghast division of Towers, Perrin, Forster & Crosby Inc. (*BI*, April 2).

Those six LUI insurers have stopped paying claims.

Mr. Wilson said last month that Walbrook may have to post additional reserves for unrecoverable reinsurance if the six LUI insurance companies, which at one time reinsured Walbrook, are found to be insolvent. However, Mr. Wilson said Walbrook would still have a surplus even if additional reserves are needed.

Although Tillinghast has given preliminary actuarial figures to both Walbrook and the British Department of Trade and Industry, Tillinghast's final report is not expected to be completed before Easter, sources say.

Anglo American's financial well-being has not been questioned.

Mr. Wilson said last week he still hopes that Walbrook will start underwriting again and that the Weavers underwriting slip will be revived.

However, Mr. Wilson confirmed that a capital injection will be required before Walbrook can resume underwriting. He would not discuss where that capital could be found.

"It is in the interests of the whole market for the group to get itself together. . .if we can just have a breathing space and no speculation," he said.

Mr. Wilson and brokers note that so far most policyholders are being supportive of Weavers and are monitoring the situation carefully rather than panicking.

"We have had very few midterm cancellations," said Mr. Wilson.

"Clients actually are staying very cool and calm and are watching the situation," said one broker.

However, policyholders "expect some early comment and (Walbrook) may be testing them too much" if an announcement about Walbrook's future is not made shortly, the broker added.

Meanwhile, Anglo American and Head have been negotiating with a number of other companies to write quota-share or excess-of-loss reinsurance for Anglo American to allow the insurer to boost its capacity, Mr. Head said.

"The net lines (to Anglo American) would be the same, but the gross lines would be higher," he said. "We've been in discussions with more than one person."

Head Insurance Investors has also offered to buy the assets of Weavers for an undisclosed price, said Mr. Head, adding, "I haven't heard a response." The assets would include the "books, chairs, pens, paper, records" of the company and the leasehold on Weavers' offices.

However, the purchase would not include Walbrook or the other LUI insurers.

Mr. Wilson could not be reached late Friday to comment on Mr. Head's proposal.

By buying Weavers' operations, Head Insurance Investors could "deal with the orderly administration" of the runoff of the Weavers line slip, said Mr. Head, who admitted that he would have to negotiate with former members of the line slip for the runoff of their companies.

"Brokers are concerned about the orderly administration (of claims)," he said. "We have to make sure that the claims are paid in an orderly manner."

Mr. Head said that new business written by Anglo American would not be written by the same team of Weavers staffers. "We won't take the same team which brought you major problems."

While selected Weavers employees might be chosen to help administer new business, "that's up to John Cumming," the new chairman of Anglo American, according to Mr. Head.

In another development, the DTI has appointed London-based accounting firm Binder Hamlyn to audit Walbrook's accounts, confirmed Mr. Wilson.

While Mr. Wilson contends that the LUI board made the decision to halt underwriting at Walbrook, the DTI maintains that it ordered Walbrook to stop writing.

The DTI warned Walbrook as early as last fall that an underwriting slowdown could be necessary, John Redwood, Britain's minister for corporate affairs, revealed last week.

The department told LUI in October that it "needed to discuss a substantial reduction in the new business taken on by Walbrook," Mr. Redwood said.

'Clients are staying very cool and calm and are watching the situation,' says one broker.

"The Department required an actuarial report into Walbrook and its subsidiaries in January 1989," Mr. Redwood said in response to questions from David Shaw, a member of Parliament, about the DTI's actions in the Walbrook case. This report, prepared by Tillinghast, was received in June 1989, he noted.

"The department, after consulting the Government Actuary's Department, put various questions to LUI in August and September 1989. In October the DTI told LUI that it would require a further actuarial report covering all the (LUI) U.K. insurance subsidiaries and that the department needed to discuss a substantial reduction in the new business taken on by Walbrook," Mr. Redwood said.

"None of the other U.K. insurance companies in the group were authorized to take on new insurance business," Mr. Redwood added.

"The regulatory action to stop new business being taken on by Walbrook, announced at 8.30 a.m. on March 26, was on the basis of Tillinghast's preliminary work which Schroders, the recently appointed merchant bank advisers to LUI, reported to the department" on March 24, Mr. Redwood said.

Although LUI believes that Walbrook's reserves are adequate, Walbrook was forced to stop underwriting because of concerns over the adequacy of the reserves of six insurers owned by LUI and now in runoff.

Some of these insurers formerly participated on the Weavers' slip, though all had been removed from the slip by April 1988 because of concerns over the small capitalization of some participants on the Weavers slip (see story, page 28).

However, at least one of the insurers removed from the slip continued to reinsure Walbrook in 1988 and four other LUI subsidiaries also were major reinsurers of Walbrook, according to Walbrook's 1988 returns filed with the DTI. Walbrook's 1989 returns have not yet been filed.

Munich Reinsurance Co. of Munich, West Germany, is Walbrook's leading reinsurer, according to the DTI returns. Walbrook paid Munich 33.3 million pounds ($62.9 million at year-end 1988 exchange rates) in reinsurance premiums in 1988.

Walbrook also paid 3.3 million pounds ($6.2 million) in reinsurance premiums to Lloyd's of London underwriters in 1988, according to the returns.

However, Walbrook paid 8.1 million pounds ($15.3 million) in reinsurance premiums in 1988 to El Paso Insurance Co. Ltd. of London, an LUI subsidiary and a former participant on the Weavers slip; Desert Insurance Co. Ltd. of Bermuda, a subsidiary of El Paso; and London United Reinsurance Co. (Bermuda) Ltd., another LUI subsidiary.

El Paso, Desert and London United Re are among the six LUI subsidiaries that have stopped paying claims.

In addition, Walbrook ceded almost 1.1 million pounds ($2.1 million) in reinsurance premiums to LUI subsidiaries LUI Insurance Syndicate Inc. on the Illinois Insurance Exchange and The First Reinsurance Co. of Hartford, Conn., which were not affected by last month's announcement.

Until details of the Tillinghast actuarial review are released, it is difficult to assess what impact a potential insolvency among some of LUI's smaller insurance companies would have on Walbrook, observers say.

However, observers fear that if Walbrook fails to resume underwriting, it may quickly become insolvent because of a lack of new premium volume, even though Walbrook says its current reserves are adequate.

"A long-tail casualty underwriter cannot afford to stop underwriting. It's the lack of cash flow which will kill it," noted one broker.

A liquidation of any of the LUI insurers would have a devastating impact on the reputation of the London market, others contend.

There have been relatively few insurer or reinsurer liquidations in the London market, and most of these liquidations have been very small, noted an accountant in the liquidation department of one of London's major accounting firms.

Even if one of the small LUI subsidiaries should prove to be insolvent and is liquidated, it would be more calamitous than the bulk of the 40 or so insurer liquidations that have occurred in the London market over the last 40 years, he predicted.

One stock analyst, meanwhile, suggests that London brokers should organize a market rescue of Walbrook and Weavers.

"Given the embarrassment to the London market as a whole and to the brokers in particular which the possible insolvency of Walbrook or any of its subsidiaries would cause, it is in their interests that some sort of effective rescue package is created should it become necessary," Julianne Jessup, an analyst with Barclays de Zoete Wedd, wrote in an analyst report.

"We do not believe that the major brokers themselves would be major participants in funding such a (plan)—they lack the capital to do so," she wrote, adding, however, that the brokers "are best positioned to organize some kind of rescue."

"There may not appear to be much direct incentive for London market underwriters to participate in such a package, but the insolvency of LUI would almost certainly cause a serious loss of confidence in the London market as a whole at a time when competitive pressure from other markets is increasing," she noted. ■

Update

Federal quake cover proposed

Continued from page 2
quake insurers under the bill, introduced by Reps. George Brown, D-Calif, and Sherwood Boehlert, R-N.Y.

A spokeswoman for Rep. Brown said a Senate version of the bill is expected to be introduced within a few weeks.

Refurbished satellite insured

LONDON—The first Western satellite to be launched in China had no trouble finding launch insurance in London, despite the $245 million loss of two Japanese satellites in February.

Asiasat 1, which was to be launched Saturday by a Chinese Long March rocket, has $120 million of coverage from state-owned People's Insurance Co. of China.

But 80% of the coverage is reinsured in the London market, said Martin Hedley, managing director-aviation division of Willis Faber & Dumas Ltd., the Lloyd's of London broker that placed the coverage. Lloyd's Ariel syndicate leads the reinsurance.

The coverage covers the value of the refurbished satellite, plus the cost of a relaunch, as well as 12 months of successful operation.

The satellite is owned by Asia Satellite Telecommunications, a Hong Kong unit of Cable & Wireless P.L.C. of London; China International Trust & Investment Corp. in Beijing; and Hutchison Whampoa Ltd., a Hong Kong importing and distributing firm.

Reinsurance rates quoted the day after the loss of two Japanese communication satellites were lower than expected, Mr. Hedley noted (*BI*, March 5; Feb. 26). The insurance "was oversubscribed and well received" by underwriters, he added.

This is the second time this satellite has been insured in London. Asiasat 1 is the refurbished Westar VI satellite formerly owned by Western Union Corp. that failed to reach geostationary orbit in 1984 (*BI*, Feb. 13, 1984).

Underwriters paid Western Union $105 million for the loss, then launched a $10.5 million salvage effort in November 1984. Astronauts on the space shuttle Discovery recovered it and another satellite, both of which underwriters later sold.

Conoco self-insured for pact

PONCA CITY, Okla.—Conoco Inc. says its self-insurance program would cover a proposed $23 million settlement of a class-action suit by 400 families who claim a Conoco refinery contaminated groundwater with toxic chemicals.

Under the settlement—one of the largest of its kind—Houston-based Conoco would pay about $18 million to buy the families' homes in Ponca City, Okla.

Claims from others who lived near the contaminated water would be paid from a $5 million fund Conoco has established.

Under the settlement, which is subject to approval by a federal judge, Conoco, a subsidiary of E.I. du Pont de Nemours & Co., would not admit liability.

Housing benefit bill approved

WASHINGTON—A new employee benefit—financial assistance to meet housing costs—could be negotiated in collective bargaining agreements under a bill President Bush is expected to sign.

The House last week passed H.R. 4073, introduced by Rep. William Clay, D-Mo., that would amend the Taft-Hartley Act of 1947 to allow employers to create trusts designed to help workers pay for housing costs.

The Senate passed its version of the bill, S. 1949, introduced by Sen. Edward M. Kennedy, D-Mass., in November 1989.

Arbitration award challenged

LOS ANGELES—Canadian Reinsurance Co. is trying to vacate an arbitration ruling against a company it reinsured, claiming a lawyer for the winning party and the umpire had a "personal relationship."

The allegations echo similar charges leveled in January against the same umpire and attorney in another case. Six reinsurers in the Pacific Reinsurance Management Corp. pool had sought to have a $94.5 million arbitration award against them overturned on the same grounds (*BI*, Jan. 22; Jan. 15).

In a complaint filed in Los Angeles Superior Court, Canadian Re labeled as "corrupt and biased" a December 1989 arbitration decision ordering North American Reinsurance Corp. to pay $1.4 million to Canadian Insurance Co. of California. The arbitration involved a dispute over coverage of Canadian Insurance claims. Toronto-based Canadian Re reinsured North American for 100% of the business, court papers say.

Canadian Re, which was not directly involved in the arbitration but is acting as a "party in interest," charges that arbitration umpire William C. McIlwaine Jr. had an undisclosed personal relationship with Canadian Insurance lawyer Linda M. Lasley and a business relationship with Ms. Lasley's firm, Buchalter, Nemer, Fields & Younger of Los Angeles.

Canadian Insurance has not answered the complaint but will seek to have it thrown out, said Cliff Meyer, a partner with Buchalter, Nemer.

Briefly noted

Passengers of **Pan American World Airways** claim in a lawsuit seeking class-action status the airline fraudulently collected $18 million from a $5 per-ticket service fee for security measures that they claim the airline never provided. . . .More than 300 Lloyd's of London members last week sued **Pulbrook Underwriting Management Ltd.**, a Merrett Holdings P.L.C. unit, and seven Lloyd's members' agencies over huge losses from U.S. liability business. Pulbrook had warned members on the still-open 1982 underwriting year for syndicate 90 of a 1990 cash call of 28.7 million pounds ($46.8 million) (*BI*, Feb. 12). . . .Benefit consultant William M. Mercer Meidinger Hansen Inc. is shortening its name to **William M. Mercer Inc.**

Replacement cover

Continued from page 1

pended claims payments pending completion of the actuarial study. LUI's chief executive concedes that these six companies, four of which at one time participated on the Weavers slip and all of which have reinsured Walbrook, may be insolvent.

The financial stability of Anglo American Insurance Co. Ltd. of London, which wrote the other 45% of the Weavers line slip, has not been questioned, and Anglo American's new owner said he hopes to resurrect some form of line slip similar to the Weavers slip.

Brokers report they have been able to find replacement markets for clients whose coverage was to renew April 1 with Weavers, which had been the largest market in London for U.S. liability insurance.

An array of U.S. insurers—including American International Group Inc., Reliance Group Holdings Inc., Berkshire Hathaway Inc., The St. Paul Cos. Inc., CNA Financial Corp. and Zurich-American Insurance Group—say they will consider accounts previously written by Weavers.

In addition, underwriters at Lloyd's of London and other London underwriters say they are willing to write the coverage.

And, last week, Bermuda-based X.L. Insurance Co. Ltd., the policyholder-owned excess liability insurance facility, said it would drop its attachment point to $15 million from $25 million for existing policyholders that had purchased coverage from Weavers.

Generally, brokers last week were quick to praise the responsiveness of both domestic and foreign insurers in providing coverage —at prices characterized as reasonable—to policyholders left stranded by Weavers shortly before April 1 renewals.

Policyholders with good risks are sometimes purchasing occurrence-based coverage to replace the Weavers coverage, while tougher risks continue to be written on claims-made forms, brokers say.

"It looked like the end of the world a week ago, but with insurers willing to come in and fill some of the gaps" the picture is no longer quite so grim, said Renwick Severance, vp-special services for Boston-based Republic Hogg Robinson Inc.

However, Mr. Severance observed that "I don't see a lot of (insurers) stepping up to fill a void" in capacity for professional liability insurance—like accountants errors and omissions coverage—that was written by Weavers either on a direct or a reinsurance basis.

"Our immediate concern was the April 1 coverages and we've been able to find alternative capacity for that," said Charles L. Ruoff, senior vp of Sedgwick James Inc. in New York.

Sedgwick James has been providing its clients with information about Weavers as it becomes available and suggesting that they reassess Weavers' participation in their insurance programs.

"Markets in London and the U.S. have been pretty receptive to coming in and picking up those commitments that Weavers had for April 1," Mr. Ruoff said, adding that those placements "went much more smoothly than we had anticipated."

"In some cases where Weavers was just a participant, other participants were willing to gross up their participation to fill the void. New business was more difficult to work out in such a short time frame, but the response (from insurers) has been very satisfactory," Mr. Ruoff explained.

Occurrence coverage is available for some risks that had been insured by Weavers, said Sedgwick James vp Michael Hammer, adding that Weavers policyholders are "more likely to get occurrence coverage from U.S. underwriters."

"In some cases carriers are offering occurrence coverage and in some cases claims-made coverage. It goes account by account, depending on the risk," agreed Richard A. Maxwell, senior vp and director of marketing and professional standards for Corroon & Black Corp. in New York.

"Everybody is surprised at the speed with which insurers have responded" to Weavers policyholders left without coverage on April 1, said Richard M. Grayson, senior vp of Johnson & Higgins of Georgia in Atlanta.

"We almost get the feeling that insurers had been waiting for an opportunity to have a chance at some of Weavers' book. It is viewed as good business," Mr. Grayson observed.

In addition, "the terms do not appear predatory, which indicates that there is a competitive marketplace for most of Weavers' business," he said.

Lloyd's of London underwriters are filling the gap left by Weavers for trucking clients of Financial Guardian Group Inc. in Kansas City, Mo., said FG Chairman and Chief Executive Officer Donald R. Weber. FG's surplus lines brokerage subsidiary, FG Special Risk in Houston, previously had offered two truck physical damage programs—one through Weavers and one through Lloyd's.

While "Walbrook was a little more competitive" and most of FG's clients had chosen to use that market, Lloyd's underwriters are accepting the business previously written by Weavers at rates that are not significantly higher, Mr. Weber said.

However, London observers noted that the Lloyd's policies may require higher retentions and are written on more restrictive policy forms.

One London broker noted that, overall, the London market by itself "has the capabilities of picking up most of the capacity" lost when Walbrook stopped underwriting.

In fact, with the new markets that have begun writing U.S. casualty business since Walbrook stopped underwriting, "the London market ironically probably has more capacity for a North American account today than two weeks ago," he said.

In addition, "the international and U.S. markets also are showing more interest" in writing U.S. casualty coverage, the broker said.

However, brokers say they are advising their offices to proceed cautiously, especially for clients whose coverage with Weavers has not yet expired.

"Our instructions to our people are to seek alternatives and carefully analyze those alternatives against existing coverages to determine what the potential ramifications might be before taking any action," said Corroon & Black's Mr. Maxwell.

"We're trying to sort through each individual case and we're waiting to hear what is going to happen with Walbrook and Anglo American," Mr. Maxwell added.

"We want to find out a whole lot more before we make any recommendations to our clients," although those clients have been apprised of the situation, said Bruce C. Dunbar, chairman, chief executive officer and president of McGriff, Seibels & Williams Inc. in Birmingham, Ala.

Mr. Dunbar added that most of his clients have also elected to wait for further information from London before making any decisions about moving their business midterm.

"Most people have chosen to adopt a wait-and-see attitude. Their thought process is that it may be a week to 10 days too early to see how this will sift out," said J&H's Mr. Grayson.

"We have given our clients information as to Weavers' situation and suggested a reassessment of the Weavers participation in their programs," Mr. Ruoff noted.

Since excess liability coverage for U.S. policyholders was written by Walbrook and the other line slip underwriters on Weavers' claims-made form since the end of 1985, policyholders and brokers must take special precautions when negotiating replacement coverage, brokers point out.

Mr. Ruoff noted that "we need to give our clients the full spectrum of options that may be available, including the possible downsides of early termination."

One of the downsides of a midterm cancellation is the possible affect that would have on the extended reporting clause—also known as the extended discovery or "tail coverage" clause—in Weavers' claims-made form.

'It looked like the end of the world a week ago, but with insurers willing to come in and fill some of the gaps' the picture is no longer quite so grim, says Renwick Severance, vp-special services for Boston-based Republic Hogg Robinson Inc.

Policyholders can negotiate a seven-year extended reporting period if Weavers terminates or fails to renew the claims-made coverage, Mr. Ruoff said (*BI*, July 13, 1987). This gives policyholders seven years after the policy period to report claims related to events during the policy period, as long as Weavers had been notified of the events from which the claims arise.

Even though Walbrook has suspended writing new business and other underwriters formerly on the Weavers line slip have suspended claims payments, the seven-year extended reporting clause could be voided if a policyholder terminates its coverage midterm, Mr. Ruoff said.

The seven-year extended reporting period is activated only if Weavers cancels or fails to renew a policy. Policyholders that cancel their Weavers coverage can purchase a 12-month reporting period for a hefty additional premium, London brokers report.

Even if Walbrook is later found to be insolvent, Anglo American still would be committed to pay 45% of a policyholder's claims that fall under the seven-year extended reporting period for policy years commencing after Ango American joined the Weavers slip in April 1987, Mr. Ruoff noted.

However, he also pointed out that since the British Department of Trade & Industry says it required Walbrook to cease underwriting, it could be argued that constitutes non-renewal by Weavers, even though the DTI's requirement was placed at the request of Walbrook.

A Lloyd's broker confirmed that clients canceling Weavers coverage midterm risk losing the Weavers extended reporting period.

However, the broker pointed out that U.S. underwriters that are writing occurrence coverage in place of Weavers' claims-made coverage are offering new policyholders seven years of tail coverage to replace the Weavers extended reporting period.

A Lloyd's underwriter confirmed that he was willing to provide a replacement extended reporting period for some risks.

"If the risk obviously is a horror story I just wouldn't write it at all," the underwriter said, explaining that the issue of an extended reporting period by itself is not a major problem.

In addition to worries about the extended reporting period, policyholders must be sure that the retroactive date of a replacement claims-made policy is the same as the retroactive date of the Weavers coverage to ensure there are no coverage gaps.

The retroactive date in a claims-made policy bars coverage for any events that occur before that date. In most Weavers policies, the retroactive date is the date of the inception of the first claims-made policy purchased by the policyholder.

Richard D. Turner, vp of J&H of Georgia, said that "most of the markets we have seen that are coming up with (claims-made) alternatives to Weavers' coverage midterm are offering the same terms and conditions and retro date" that Weavers had in place.

"If they do, then the policyholder is OK. But, if you don't get a concurrent retro date from the new carrier, then you have a problem," Mr. Turner added.

He also pointed out that most insurers that are replacing coverage written by the Weavers line slip are excluding known events that might later result in a claim.

"If it is a significant situation, obviously the new carrier is going to want to exclude it," he said.

If the policyholder has reported an event to Weavers that has not yet resulted in a claim, the broker "has to make provisions for extended discovery in the event that those situations turn into claims down the road," he said.

In addition, if a policyholder cancels one or more layers of a multiple-layer liability insurance program during midterm, it would reduce the amount of total coverage available to the client, brokers point out.

Replacement coverage must be arranged in such a way "that the client does not dilute his coverage inadvertently," Mr. Ruoff said.

He noted that brokers already are searching the marketplace for retroactive coverage that would protect current and former Weavers policyholders if Walbrook and/or former insurers on the Weavers line slip cannot pay claims.

But, "those coverages are not easily obtained," he said, conceding he is unaware of an insurer that would write such coverage.

"I haven't heard anything about anyone offering retro coverage at this point, although brokers are certainly thinking about it," agreed Republic Hogg Robinson's Mr. Severance.

"We haven't had any success in placing retro coverage," acknowledged McGriff, Seibels & Williams' Mr. Dunbar.

Meanwhile, Bermuda-based X.L. announced last week that it has reduced its minimum policy attachment point for current Weavers policyholders to $15 million from $25 million in the wake of Walbrook's underwriting suspension.

X.L. currently writes up to $100 million in liability coverage excess of $25 million.

X.L. President Brian O'Hara explained the new attachment point was intended to help X.L.'s policyholders fill gaps in lower layers of coverage caused by Walbrook's problems. Only about 100 X.L. excess liability policyholders that had bought coverage from Weavers are now eligible for this new $10 million excess of $15 million layer, which will be written on a separate policy.

According to an X.L. statement, "underwriting will be on a selective basis and conditions may be more specific than conditions currently existent on coverage in excess of the $25 million attachment."

On placements above $25 million, X.L. typically offers full prior acts coverage. However, for placements from $15 million to $25 million, it is limiting prior acts coverage to events occurring on or after Jan. 1, 1986.

"We are not out to make market share off this," Mr. O'Hara stressed. "We knew there could be four or five April 1 renewals coming up which could be in difficulties, so we are just doing this to help out our policyholders."

J&H's Mr. Turner, who was one of the architects of PRIMEX Ltd., a Barbados policyholder-owned liability insurance facility for chemical manufacturers, says J&H is arranging replacement coverage for PRIMEX members that had purchased excess coverage through Weavers.

Of PRIMEX's 19 members, 16 elected to purchase $20 million in coverage primarily written by Weavers excess of PRIMEX's own $5 million layer.

According to Mr. Turner, the first $5 million of the $20 million layer was written exclusively by the Weavers line slip. The coverage was written on Weavers' claims-made form rather than on PRIMEX's claims-made form.

In addition, 87.5% of the next $15 million was written by Weavers, with the remaining 12.5% retained by or placed at the discretion of PRIMEX policyholders.

PRIMEX policyholders could then buy coverage excess of $25 million from X.L.

Although X.L. has agreed to drop down to $15 million for its existing policyholders, "that still leaves a gap from $5 million to $15 million" for those 16 PRIMEX policyholder members, Mr. Turner said. However, "we now have in place what amounts to a full replacement layer to the extent that people choose to replace the Weavers line slip," Mr. Turner said, explaining that policyholders have "a number of options" through a combination of domestic and foreign markets.

"No decision has been made, to the best of our knowledge, among people in the PRIMEX/Weavers line slip to make a move before we renew on July 1," Mr. Turner said, adding that "it's left up to individual members to decide what they want to do."

Also, last week, A.C.E. Insurance Co. Ltd., the other huge Bermuda-based excess liability insurance facility, told brokers that in light of Weavers' problems, A.C.E. was willing to approve directors and officers liability insurance applications within 48 hours, said William J. Loschert, executive vp-underwriting for A.C.E.

A.C.E. offers D&O limits of $50 million excess of $25 million.

In addition, another Bermuda facility, Corporate Officers & Directors Assurance Ltd., which is managed by A.C.E., writes $25 million in primary D&O coverage.

But, A.C.E. will refuse to pay any claims below its attachment point not paid by insurers on the Weavers slip that wrote below A.C.E.'s excess liability layers, Mr. Loschert said last week at the annual meeting of the Assn. of Insurance & Risk Managers in Industry & Commerce held in Cambridge, England.

"We are not going to drop down because of problems at Weavers," said Mr. Loschert.

A.C.E. currently offers $200 million in liability limits excess of $100 million.

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Correspondent Roger Scotton in Bermuda and Associate Editor Carolyn Aldred and International Editor Stacy Shapiro in London contributed to this story.

Transit explores Walbrook runoff

By DOUGLAS McLEOD

LOS ANGELES—The estate of defunct Transit Casualty Co. is exploring the possibility of pursuing a court-supervised runoff of Walbrook Insurance Co. Ltd.

Transit, a major Walbrook policyholder, has hired Clifford Chance, a London law firm, to assess support among other Walbrook policyholders for a "scheme of arrangement," or court-ordered runoff, that would require the agreement of a majority of Walbrook's creditors, Transit lawyers say.

Transit, estimated to be insolvent by $3 billion to $4 billion, ceded a large volume of reinsurance business to Walbrook and other companies on the line slip managed by H.S. Weavers (Underwriting) Agencies Ltd.

Transit has instructed Clifford Chance to "explore all options in order to minimize the adverse impact of the Walbrook situation," a lawyer with Clifford Chance said in a statement. "If the Weavers pool can be refloated, then Transit will be happy. If not, Transit Casualty wishes to cooperate in an economical and constructive solution."

From 1980 to 1985, Transit acted as a fronting insurer for excess liability business produced by National Underwriting Agency of Chicago and ceded to numerous reinsurers, including the Weavers slip. London-based Weavers and Transit each owned a 37.5% stake in NUA.

Transit receivership officials have said they hope to eventually recover $500 million to $800 million in Transit assets, mainly in reinsurance proceeds, of which about $100 million to $300 million is allegedly owed by the Weavers slip (*BI*, July 10, 1989).

Weavers has maintained its obligations to Transit will not exceed $60 million.

Paul E. Dissenko, director of insurance operations for Transit, said he was "very alarmed" at the announcement last month that Walbrook had suspended underwriting and that six other insurance units of London United Investments P.L.C.—the parent of Walbrook and Weavers—had temporarily stopped paying claims pending the outcome of an actuarial report on the LUI subsidiaries (*BI*, April 2).

Transit asked a law firm to 'explore all options in order to minimize the adverse impact of the Walbrook situation,' a lawyer says.

Mr. Dissenko said he and other receivership officials met in London with LUI Chief Executive Peter Wilson after the announcement. Mr. Wilson told receivership officials that Walbrook is solvent and confirmed that the major concern is the condition of the six other LUI insurance units that reinsured Walbrook, according to Mr. Dissenko.

"I don't think anyone in London, including Peter Wilson, is extremely sanguine about collecting from the six reinsurers at this point," Mr. Dissenko said.

Like others concerned about the fate of the line slip's insurers, Mr. Dissenko said he is waiting to receive a summary of the actuarial report prepared by the Tillinghast division of Towers, Perrin, Forster & Crosby Inc.

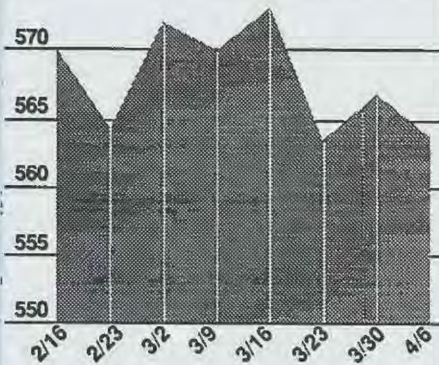
In their meeting in London, Mr. Wilson did not provide any financial information on LUI units that may be included in the Tillinghast report, Mr. Dissenko said.

Efforts should be focused on keeping Walbrook in business or ensuring an orderly runoff of its book, he said.

Transit receivership officials had said before the Weavers announcement that they are collecting loss information in hopes of negotiating commutations with Weavers. This effort is continuing, according to Mr. Dissenko, who maintained that the announcement has not produced any greater sense of urgency to the commutation plans.

"I cannot imagine putting a greater sense of urgency on a commutation with Weavers than I have put on it since I joined Transit," Mr. Dissenko said. ■

BI Insurance Index



Base = 100 on Dec. 29, 1978
Source: Nordby International Inc.

Insurance industry stocks reversed direction last week, as the *Business Insurance Index* fell 3.0 points to 566.8 on March 30, from 566.8 on April 6. Advancing issues were led by Tokio Marine & Fire Insurance Ltd., up 10.0%; Nobel Insurance Ltd., up 8.3%; and Re Capital Corp., up 6.7%; Declining issues followed SCOR U.S. Corp., down 7.5%; and Phoenix Re Corp., down 7.0%; Pacificare Health Systems, down 6.9%. The most active issue during the period was American General Corp., 4.7 million shares traded. The *BI* Index lost 0.5% for the period; the Dow Jones 30 Industrials dropped 0.4%; and the The Standard & Poor's 500 and the New York Stock Exchange Composite each lost 0.04%.

Texas awards

Continued from page 3

Even Mr. Black says he recommended that the offer be accepted.

But National Union rejected the offer, say attorneys for both sides.

"Why they didn't settle in this case remains a mystery," said Ray Marchan, the plaintiffs' co-counsel with the Brownsville firm of Warren L. Eddington.

He pointed out that the company settled for $600,000 a suit over the 1973 deaths of two shrimpers who inhaled sulphur dioxide gas emitted by the same product. The company also settled a 1981 suit that blamed a shrimper's death on its product, he said.

Defense attorney Mr. Black attributed last month's verdict to a sympathetic jury and said General Chemical plans to appeal.

There was no proof the shrimpers had read a warning label that "tells you how to use the product correctly," he said.

The label warned that the product contained sulphur dioxide, may cause eye and throat irritation and should be used in a ventilated space, said Mr. Allison. However, a layperson would not necessarily understand that using a product containing sulphur dioxide could cause death, he said.

Mr. Black said that if the award is upheld on appeal, a "subsequent suit would be brought" against National Union for the uninsured portion of the award.

In the nursing home case, a jury awarded $40.6 million to the family of an 84-year-old woman who died while held in a vest restraint without the consent of her physician or family for three consecutive nights, said plaintiffs' attorney Anthony F. Montgomery of Hornbuckle & Montgomery in Houston.

Jennie Zetterbaum had been a resident of Seven Acres for less than a month when she was found strangled with the vest restraint wrapped underneath her arms and neck in 1984, he said.

Jurors awarded the damages because "there was conscious indifference to this woman's safety," Mr. Montgomery said.

The award included $4.4 million in actual damages, $35 million in punitive damages and $1.2 million in prejudgment interest.

"We offered to settle even before discovery" and later proposed settling "well within the policy limits," Mr. Montgomery said.

He would not disclose limits of the nursing home's coverage, written by Guaranty National Insurance Co. of Englewood, Colo., a unit of Orion Capital Corp.

Mark Wham, a defense attorney on the case, said the large award was the result of pretrial publicity.

Seven Acres is appealing the decision, said Mr. Wham of Kain & Reedy in Houston. ■

British Issues

April 5 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence pence
Comml Union	462	21.3	28.7	6.2	462—450
Genl Accident	1077	16.5	66.7	6.2	1084—1075
Gdn Royal Exch	232	20.4	15.3	6.6	232—222
Royal	470	25.3	34.0	7.2	474—470
Sun Alliance	312	11.4	16.7	5.3	312—288
Brokers					
Bradstock	249	17.5	10.0	4.0	252—249
CE Heath	523	14.7	34.5	6.6	523—513
Hogg Group	149	8.8	9.7	7.2	155—149
Lloyd Thompson	285	17.8	9.7	3.4	285—285
PWS Holdings	63	9.8	3.3	5.3	63—58
Sedgwick Grp	248	16.0	16.0	7.0	249—247
Steel Brrl Jones	287	15.1	14.7	5.8	287—286
Willis Faber	260	13.7	16.0	6.9	265—256

Source: Philip Olsen/Paul Hodges, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

BI Industry Stock Report

APRIL 2, 1990 THROUGH APRIL 6, 1990

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander	NYS	26.88	0.47	-14.68	34.00	24.00	219	1.00	3.72	19	9.18	2.93
Corroon & Black	NYS	32.13	0.39	-16.01	41.00	31.63	237	1.36	4.23	15	12.73	2.52
Gallagher Arthur J. & Co.	NYS	23.13	-0.54	-6.57	26.50	18.25	40	0.60	2.59	16	5.33	4.34
Frank B. Hall	NYS	4.13	3.13	37.50	4.50	2.50	259	0.00	0.00	-2	-2.80	-1.47
Hilb, Rogal & Hamilton	OTC	15.00	0.00	-19.46	20.63	11.25	33	0.28	1.87	20	4.60	3.26
Marsh & McLennan	NYS	73.75	3.33	-5.45	89.75	59.25	584	2.48	3.36	18	10.56	6.98
Poe & Associates	OTC	12.75	-1.92	-3.77	13.00	8.00	2	0.40	3.14	16	1.89	6.75
BROKERS	AVERAGE		0.7	-4.1					2.7	15		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	39.25	3.97	-5.71	46.50	30.13	138	0.44	1.12	8	25.06	1.57
Berkshire Hathaway Inc.	NYS	6825.00	1.49	-20.87	8900.00	4900.00	1	0.00	0.00	26	2869.00	2.38
ITT (Hartford Group)	NYS	53.88	0.70	-10.02	64.50	51.88	899	1.60	2.97	8	56.33	0.96
Sears (Allstate)	NYS	38.00	-3.49	-1.94	48.13	36.50	2358	2.00	5.26	9	37.75	1.01
CONGLOMERATES	AVERAGE		0.7	-9.6					2.3	13		
INSURERS/REINSURERS												
Aetna Life & Casualty	NYS	50.00	0.00	-13.79	62.50	48.38	597	2.76	5.52	9	58.11	0.86
Ambase Corp.	NYS	7.00	-1.75	-44.55	16.38	5.75	410	0.20	2.86	2	29.08	0.24
American General	NYS	37.50	-2.91	14.50	40.25	28.13	4715	1.56	4.16	12	34.68	1.08
American Heritage	NYS	22.75	-0.55	-20.18	24.63	19.50	2	0.92	4.04	12	22.60	1.01
American Indemnity/Fin'l	OTC	6.50	4.00	-18.75	13.00	5.75	16	0.56	8.62	-2	17.38	0.37
American International	NYS	92.63	-0.40	-12.20	112.00	78.25	1092	0.48	0.52	11	41.92	2.21
Aon Corp.	NYS	36.75	-2.00	-13.27	43.25	31.00	414	1.52	4.14	10	19.62	1.87
Argonaut Group	OTC	69.50	-1.42	0.91	71.50	52.50	107	1.60	2.30	8	36.83	1.89
AVEMCO Corp.	NYS	24.00	0.52	-1.54	27.50	20.38	4	0.40	1.67	16	9.52	2.52
Baldwin & Lyons Inc.	OTC	20.50	-1.20	-4.65	24.00	15.88	22	0.28	1.37	7	20.80	0.99
Belvedere Corp.	ASE	4.38	-2.78	-20.45	6.13	4.25	16	0.04	0.91	-6	8.03	0.54
Chandler Insurance	OTC	9.25	0.00	-21.28	13.25	7.00	15	0.00	0.00	5	9.53	0.97
Chubb Corp.	NYS	92.63	-1.07	-3.39	102.75	64.00	1259	2.64	2.85	9	55.49	1.67
CIGNA Corp	NYS	50.50	-0.25	-16.18	66.75	45.25	854	3.04	6.02	11	66.64	0.76
CNA Financial Corp.	NYS	73.25	-2.17	-26.75	108.75	62.38	156	0.00	0.00	8	54.87	1.33
Continental Corp.	NYS	29.63	-2.47	-5.58	38.63	25.75	707	2.60	8.78	11	41.36	0.72
Durham Corp.	OTC	32.00	6.22	4.07	34.75	29.00	11	0.92	2.88	16	26.32	1.22
Fireman's Fund	NYS	32.00	-0.39	-9.22	40.75	30.00	602	0.68	2.13	47	32.74	0.98
Fremont General Corp.	OTC	17.63	-3.42	-12.42	22.50	14.38	256	0.80	4.54	8	19.09	0.92
Frontier Insurance Group	NYS	20.25	0.00	9.46	21.75	12.50	72	0.00	0.00	9	7.29	2.78
General RE Corp.	NYS	84.00	-1.32	-6.67	96.25	62.25	862	1.52	1.81	13	29.04	2.89
Hanover Insurance Co.	OTC	27.00	-6.90	-11.48	33.00	25.75	32	0.44	1.63	7	32.03	0.84
Harleysville Group	OTC	23.25	-2.62	-15.45	28.75	19.50	18	0.60	2.58	8	18.94	1.23
Hartford Steam Boiler	OTC	58.75	-2.49	8.29	60.25	38.50	175	1.60	2.72	16	18.94	3.10
Kansas City Life Ins.	OTC	35.75	0.00	-0.35	36.00	33.25	1	1.12	3.13	10	39.22	0.91
Kemper Corp.	NYS	39.00	2.63	-17.46	51.88	32.75	165	0.92	2.36	9	29.97	1.30
Lawrence Insurance Group	ASE	7.88	-1.56	10.53	9.13	6.50	0	0.36	4.57	15	3.29	2.39
Liberty Corp.	NYS	47.50	1.88	11.76	48.00	32.50	15	0.92	1.94	18	31.82	1.49
Lincoln National	NYS	52.00	-6.31	-14.75	62.88	46.75	225	2.60	5.00	9	49.19	1.06
NAC Re Corp.	OTC	33.50	-0.74	-7.59	41.00	23.88	208	0.20	0.60	14	22.81	1.47
Navigators Group	OTC	30.50	0.00	10.91	31.50	22.00	7	0.00	0.00	11	15.22	2.00
Nobel Insurance LTD.	OTC	3.25	8.33	62.50	3.38	1.50	40	0.00	0.00	-	7.76	0.42
NWNL Companies	OTC	30.75	1.23	-22.15	44.13	26.50	701	1.20	3.90	6	37.50	0.82
Ohio Casualty Corp.	OTC	42.50	-6.59	-10.99	52.50	34.75	482	2.32	5.46	9	33.30	1.28
Old Republic Int'l	OTC	23.88	3.80	-6.83	30.38	22.13	199	0.76	3.18	5	30.70	0.78
Orion Capital Corp.	NYS	20.00	1.27	-13.98	28.50	18.50	65	0.84	4.20	6	19.72	1.01
Phoenix RE Corp.	OTC	10.00	-6.98	-23.08	15.50	8.75	306	0.20	2.00	77	12.99	0.77
Protective Life Corp.	OTC	14.00	0.90	-1.75	16.25	10.88	129	0.68	4.86	9	14.54	0.96
Provident Life	OTC	21.63	-2.26	-16.43	30.13	20.25	533	0.80	3.70	7	23.24	0.93
Re Capital Corp.	ASE	13.88	6.73	-4.31	15.25	9.75	3	0.00	0.00	12	12.60	1.10
RLI Insurance Corp.	NYS	10.00	0.00	12.68	10.38	6.88	76	0.40	4.00	7	10.71	0.93
St. Paul Companies	OTC	59.75	0.84	-0.42	63.50	47.50	271	2.40	4.02	7	43.47	1.37
SAFECO Corp.	OTC	36.13	-1.70	-9.12	42.38	25.63	939	1.20	3.32	8	24.87	1.45
SCOR U.S. Corp.	NYS	10.88	-7.45	-23.68	14.50	8.25	27	0.20	1.84	14	10.61	1.02
Seibels Bruce Group	OTC	10.50	0.00	-3.45	13.63	8.75	19	0.80	7.62	-2	13.75	0.76
Selective Ins. Group	OTC	16.75	-2.90	-12.42	20.25	15.50	89	0.96	5.73	5	15.72	1.07
Statesman Group Inc.	OTC	2.38	-5.00	-13.64	3.63	1.88	262	0.16	6.74	4	4.19	0.57
Tokio Marine & Fire	OTC	48.00	10.03	-36.32	78.13	40.88	87	1.00	2.08	-	70.93	0.68
Torchmark Corp.	NYS	46.50	2.76	-18.78	58.75	32.63	511	1.40	3.01	12	13.23	3.51
Transamerica	NYS	36.88	-2.96	-17.37	48.00	33.13	562	1.92	5.21	9	34.63	1.06
Travelers Corp.	NYS	33.38	3.09	-9.49	45.00	32.00	1152	2.40	7.19	5	44.85	-
Trenwick Group Inc.	OTC	20.25	3.85	-16.92	26.88	14.50	43	0.36	1.78	15	16.91	1.20
United Fire & Casualty	OTC	30.50	-0.81	-7.58	34.50	29.25	4	1.20	3.93	9	22.56	1.35
USF&G Corp.	NYS	28.63	-1.29	-3.38	34.00	26.88	854	2.92	10.20	37	22.87	1.25
UNUM Corp.	NYS	44.25	-1.94	-7.33	51.38	31.00	207	0.60	1.36	10	31.20	1.42
USLIFE Corp.	NYS	37.63	-0.66	-16.85	48.13	36.88	190	1.48	3.93	5	54.34	0.69
Washington National	NYS	22.13	1.72	-21.68	29.13	21.00	49	1.08	4.88	25	32.90	0.67
USLICO Corp.	NYS	22.25	-2.20	-6.32	25.38	21.00	14	1.00	4.49	6	27.73	0.80
Zenith National Ins.	NYS	17.75	-2.07	-5.33	21.50	14.00	15	0.84	4.73	-	13.81	1.29
INSURERS/REINSURERS	AVERAGE		-0.5	-8.8					3.6	11.		2
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	15.25	-3.17	-28.24	26.38	11.25	1271	0.00	0.00	5	3.54	4.31
HMO America Inc.	OTC	5.75	-2.13	-25.81	10.63	2.00	89	0.00	0.00	21	1.12	5.13
Pacificare Health Sys.	OTC	20.13	-6.94	-22.60	30.38	11.38	94	0.00	0.00	6	6.35	3.17
Safeguard Health Enter.	OTC	6.88	-1.79	-19.12	12.50	5.13	167	0.00	0.00	12	2.99	2.30
Sierra Health Services	ASE	7.75	-6.06	-12.68	9.63	2.63	35	0.00	0.00	22	0.62	12.50
United Healthcare Corp.	OTC	10.38	6.41	-15.31	12.63	6.88	453	0.00	0.00	13	0.34	30.51
United Medical Corp.	ASE	7.88	1.61	31.25	8.25	5.38	9	0.00	0.00	23	5.70	1.38
U.S. Healthcare	OTC	11.50	-3.16	-19.30	15.50	9.25	0	0.28	2.43		3.07	3.75
HMOs	AVERAGE		-1.9	-14.0					0.3	13		
ALL COMPANIES	AVERAGE		-0.5	-9.0					3.0	11.6		

System design: Nordby International Inc.

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