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Update

Proposal to further extend COBRA benefits introduced

WASHINGTON—A proposal to require employers to extend COBRA coverage for up to 15 years for some dependents was included in the Women's Health Equity Act introduced earlier this month.

A provision of H.R. 5397 would apply to former employees' dependents who were at least 50 years old when they became COBRA beneficiaries. Those dependents would be eligible for COBRA coverage until becoming eligible for

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Judges' attempt to consolidate asbestos suits may trigger delays

By STACY ADLER

CLEVELAND—Two recent orders from federal judges could further delay payments to asbestos injury victims, rather than expedite them as intended.

Attorneys and others actively involved in asbestos litigation say the orders—which create nationwide class-action lawsuits on behalf of asbestos victims and suggest forming a nationwide asbestos claims-handling facility—raise a morass of legal questions and are sure to trigger new litigation.

"These orders raise more questions than they answer," said Scott Gilbert, an asbestos producer attorney with Covington & Burling in Washington, D.C.

Plaintiffs' attorney Fred Baron of Baron & Budd in Dallas says the orders are likely to foster further delay in resolving the 90,000 asbestos injury claims now pending in state and federal courts.

"Our grandchildren are likely to handle the appeals of these orders," said Mr. Baron, adding that a vast majority of plaintiffs' attorneys oppose forming a nationwide asbestos class-action lawsuit.

Both plaintiffs' attorneys and some asbestos producers are expected to appeal an Aug. 10 order signed by 10 federal judges consolidating many of the asbestos cases now clogging the nation's courts into complex class-action lawsuits.

This order followed a Cleveland federal judge's proposal to form a nationwide asbestos claims-handling facility, which also is generating opposition.

The Federal Judicial Center reports that as of January 1990 there were 29,466 asbestos personal injury cases pending in federal courts and 60,000 such cases pending in state courts.

Under the complex plan outlined by the 10 federal judges on Aug. 10, parties to these cases would go before one of three federal judges, each of whom will play a different role.

U.S. District Judge Thomas D. Lambros in Cleveland and U.S. District Judge Robert M. Parker in Tyler, Texas, will oversee the consolidation of two asbestos class actions. The two class actions currently comprise about 11,000 plaintiffs, but thousands of other cases could be added.

According to the order, Judge Lambros would play the main role in settling these cases, while Judge Parker would serve as a trial

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Health plan rate hikes moderate at midyear

Indemnity premiums rise 20%

By CHRISTINE WOOLSEY

Employers are facing lower group health insurance cost increases than they did a year ago—but not by much.

And, percentage increases in premiums charged by health insurers and health maintenance organizations are not expected to fall into the single digits anytime soon.

The trend lines insurers use to project group health insurance costs are leveling off and the premiums charged by most insurers appear to have caught up with spiraling medical cost inflation.

As a result, employers that renewed their indemnity health care plans at midyear received slightly lower premium increases—with most hovering around 20%—than did employers that renewed their plans in January. However, some consultants pointed out that a few recent indemnity plan premium increases range up to 40%.

Insurers and others point out that employers that introduce managed care elements into their indemnity plans—like utilization review programs and programs to manage skyrocketing mental health care costs—are being hit with lower premium increases than employers that have not adopted managed care techniques.

Premium increases charged by many health maintenance organizations ranged between 12% and 19% at midyear.

Both the indemnity plan and the HMO premium increases are lower than a year ago, when indemnity plan premium increases ranged between 25% and 35% and HMO increases averaged 15% to 20%.

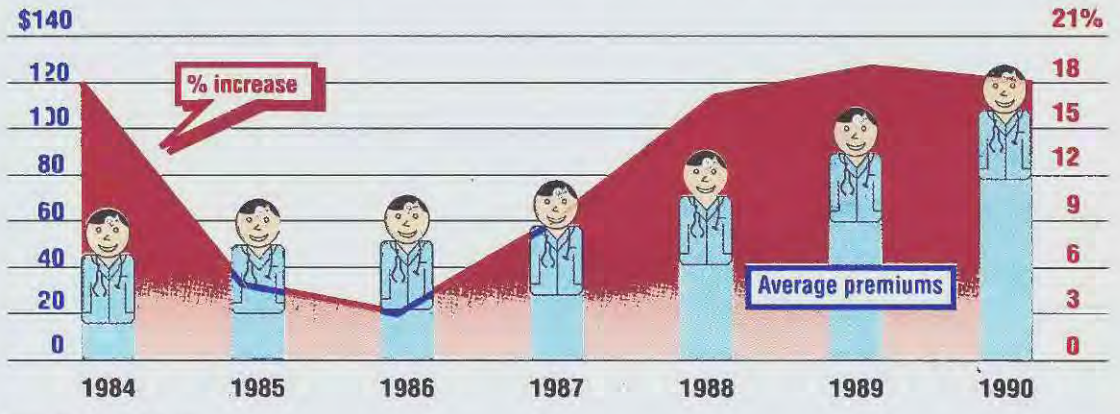
Meanwhile, employers that self-insure their group health benefits still see their costs rising 10% to 20%, about the same as a year ago.

Lawrence Leisure, a vp in the New York office of benefit consul-

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Health insurance premiums continue to zoom

Average group health insurance premium increases hit the double digits for the third consecutive year.



Source: Hay/Huggins Co. Inc.

BI/HOLLY SEGUINE

European investors to buy The Home

By LINDA J. COLLINS

NEW YORK—The proposed sale of The Home Insurance Co. by AmBase Corp. to a European investment group will benefit the insurance company's policyholders by giving it more ready access to capital, The Home's management says.

Securities analysts, however, say the sale will be disastrous for AmBase shareholders, who had expected to receive a special dividend following the Home sale.

Investors reinforced this view last week as AmBase stock plummeted.

Separately, AmBase announced last week that it posted second-quarter losses of $106 million, largely stemming from the devaluation of junk bonds held by its insurance subsidiaries. Ambase says those losses caused it to violate its loan agreements.

Under the terms of the proposed sale, which AmBase values at $905 million, investor group Vik Brothers International will pay $620 million for the insurer and its subsidiaries. The amount is to be paid either in cash or through the assumption of AmBase corporate debt or by a combination.

"The actual structure of how the $620 million comes to us has not been worked out," said AmBase Senior Vp Robert L. Woodrum.

In addition, the transaction leaves in place $285 million of The Home's $2.95 Series A cumulative preferred stock, of which AmBase now owns $124 million. Other investors own the remainder of the preferred stock.

"AmBase, at the time of the sale, plans to sell its preferred stock holdings to a third party. They will not be sold in the marketplace," stressed Mr. Woodrum, who also noted that AmBase's investment adviser is First Boston Corp.

He said that AmBase will use the cash portion of the $620 million and its anticipated $124 million in proceeds from the sale of its preferred Home stock to retire AmBase's outstanding debt, which AmBase estimated at $730 million.

The transaction is subject to completion of a due diligence audit by Vik Brothers as well as approval by AmBase shareholders and insurance regulators.

AmBase and Home executives said in interviews last week that the sale is a positive step for the insurer and its policyholders.

"The main reason we're selling The Home is that we had too much

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NEWSPAPER

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27% of employers now offer family leave programs: Study
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Update

COBRA proposals in health bill

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Medicare at age 65 or obtaining health insurance from another employer.

Federal law now requires employers to extend COBRA coverage for up to three years—regardless of a dependent's age—in the event of an employee's death, marital separation or divorce.

The proposal also would allow children of a beneficiary who was eligible for extended coverage to retain the coverage until age 23.

The Women's Health Equity Act was introduced by Rep. Patricia Schroeder, D-Colo., with 59 co-sponsors, including Reps. Barbara Kennelly, D-Conn., who drafted the COBRA provisions, and Marcy Kaptur, D-Ohio, who may later introduce those provisions as a free-standing bill (*BI*, July 30).

Waiver of 401(k) tests opposed

WASHINGTON—The Bush administration says it will oppose provisions in a pension simplification bill that would exempt employers with generous 401(k) plans from non-discrimination tests.

Thomas Terry, tax benefits counsel for the Treasury Department, says exempting some companies from the tests would erode current policies against discrimination in retirement plans. Non-discrimination tests compare salary deferrals of highly paid employees to those of lower-paid workers.

Such exemptions would remove an incentive to provide benefits beyond statutory minimums to lower-paid workers, Mr. Terry earlier this month told the Senate Subcommittee on Private Retirement Plans and Oversight of the Internal Revenue Service.

A pension bill introduced in July by Sen. David Pryor, D-Ark., and Reps. Rod Chandler, R-Wash., and William Archer, R-Texas, would exempt employers qualifying for either of two safe harbors.

Under one, an employer would have to match 100% of employee elective contributions, up to 3% of employee compensation, and 50% of employee contributions between 3% and 5% of employee compensation. To qualify for the other safe harbor, an employer would have to make contributions of at least 3% of employee compensation regardless of whether the employees actually contribute to the plan (*BI*, Aug. 13).

Cargo war risk rates altered

LONDON—Cargo war risk underwriters once again altered minimum marine war risk rates in the northern Persian Gulf last week as tensions in the Middle East continued to mount.

For the first time in recent history, the Lloyd's of London and Institute of London Underwriters' Cargo War Risk Rating Committee included Jordan in its list of nations subject to tariff minimum cargo rates. The cargo war risk rate last week was set at 0.1% of insured value for cargo being delivered by ship to Jordan.

The committee also decided to quote a minimum cargo rate of 0.5% of the insured value for the Saudi Arabian ports in the Gulf north of Dammam. The committee previously said these areas were "held cover," which means that underwriters could set their own minimum rates. However, the committee kept Persian Gulf ports in Iraq and Kuwait on a held cover basis.

Meanwhile, hull war risk underwriters did not alter rates last week. Rates had been raised on Aug. 8 (*BI*, Aug. 13).

M&M merges reinsurance units

NEW YORK—Marsh & McLennan Cos. Inc. is merging its U.S. and British reinsurance brokerage units into one operation.

Guy Carpenter & Co. Inc. of New York will head M&M's combined international reinsurance operation, although C.T. Bowring Reinsurance Ltd. of London will retain its name and identity, said a spokesman for New York-based M&M.

Richard H. Blum, currently president of Guy Carpenter, will assume the additional title of chairman. G.H.C. Wakefield, chairman of Bowring, will be deputy chairman.

The consolidation, announced last week and effective immediately, is designed to enhance customer service and to formalize the existing close relationship between the units, the spokesman said.

M&M's reinsurance brokerage operations generated $224.4 million in commissions and fees in 1989, according to M&M's annual report. The combined operations have about 2,200 employees in 25 offices worldwide, the spokesman said.

Hartford to fight N.J. auto order

HARTFORD, Conn.—ITT/Hartford Group Inc. says it will not immediately withdraw from the New Jersey private passenger auto insurance market if it must stop writing all commercial and personal property/casualty and life/health insurance in the state.

Hartford, however, says it will challenge Insurance Commissioner Samuel Fortunato's Aug. 14 order that it surrender all its licenses if it stops writing auto coverage in New Jersey.

"If it is necessary (for Hartford) to continue to write automobile insurance in New Jersey in order to keep the rest of its business, it will do so," said Donald R. Frahm, chairman and president.

Hartford subsidiary Twin City Fire Insurance Co. has been attempting to withdraw from the New Jersey auto market for several months. Twin City says a 1989 insurance reform law will make writing auto coverage unprofitable in New Jersey.

Twin City wrote private passenger auto premiums of $16.7 million in 1989, or 1.023% of the private passenger auto market. Twin City wrote commercial auto premiums of $49.6 million in 1989, or 13% of that market.

Updates continued on page 29

Errors and omissions

• David Corp.'s entry in the July 23 directory of RMIS vendors contained several errors. The company, founded in 1985, reported 24 new clients in 1989. The company's president is Alan Burns.

Insurers to pay thrifts for EPIC losses: Court

By DOUGLAS McLEOD

RICHMOND, Va.—Two mortgage insurers must honor millions of dollars in claims filed by a group of savings and loan institutions stung in the 1985 collapse of real estate syndicator Equity Programs Investment Corp., a federal appeals court has ruled.

Overturning a lower court order rescinding the insurance coverage, the 4th U.S. Circuit Court of Appeals ruled that Foremost Guaranty Corp. and United Guaranty Residential Insurance Co. of Iowa cannot deny liability for more than $8 million in losses suffered by eight S&Ls in the EPIC collapse (*BI*, Aug. 15, 1988).

The S&Ls include the defunct Silverado Banking Savings & Loan Assn. of Denver, a target of congressional scrutiny over possible improper conduct by Neil Bush, a Silverado director and son of President Bush.

Foremost and United Guaranty sought to rescind coverage of mortgage loans issued to real estate limited partnerships organized by EPIC. The insurers charged that EPIC Mortgage Inc., an EPIC unit, misrepresented the workings of the EPIC program.

However, the appellate panel found that the insurers had access to EPIC documents that accurately described the program and therefore cannot claim that oral misrepresentations by EPIC officials amounted to fraud.

Foremost—now known as General Electric Mortgage Insurance Corp. of Michigan—will ask the appeals court for a rehearing, said Irving P. Margulies, a partner with the Washington, D.C., firm of Weiner, McCaffrey, Brodsky & Kaplan, which represents the insurer.

Foremost has not decided whether to petition the Supreme Court for a review of the case if a rehearing is denied, Mr. Margulies said.

United Guaranty, facing the bulk of the mortgage claims, has not yet decided whether to seek a rehearing before the court of appeals, according to Richard L. Gray, the insurer's vp and general counsel.

Falls Church, Va.-based EPIC formed scores of real estate tax-shelter partnerships in the early 1980s. The partnerships bought houses—mainly in Texas—to hold as rental properties, expecting to

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Losses from power outage largely uninsured

Blackout hits Manhattan

By MICHAEL SCHACHNER

NEW YORK—Consolidated Edison Co. of New York Inc. has $500 million in property insurance to cover damage stemming from last Monday's massive fire at a downtown electrical substation.

The fire triggered a power outage that left a sizable portion of New York's financial district blacked out through the week.

The utility also says it has $235 million in liability coverage to cover any payments owed to customers for losses caused by the blackout. The utility's tariff with New York state stipulates that it can only be held liable for such damages if it is proven to be grossly negligent.

Businesses left without power for most of last week fear their own insurance will not cover their losses.

Con Ed said it has not altered the coverage it reported in an April 1988 audit conducted by the New York State Public Services Commission.

Industrial Risk Underwriters of Hartford, Conn., underwrites the $500 million in property coverage, which has a $1 million deductible.

Rebuilding the burned out substation will take about a year and will cost at least $25 million, according to the utility.

Officials said the cause of the blaze may not be known for months.

The 1988 audit also showed that Con Ed has $235 million in liability insurance written by: Associated Electric & Gas Insurance Services Ltd., a New Jersey-based captive owned by utilities; and X.L. Insurance Co. Ltd. and A.C.E. Insurance Ltd., both based in Bermuda.

However, it's not known how much of its liability risk Con Ed retains.

As of late last week only one lawsuit had been filed against Con Ed.

The Harbor Lights restaurant sued for $500,000, claiming Con Ed was grossly negligent for failing to provide ample backup electricity following the blackout, said Brian O'Dwyer, a partner of O'Dwyer & Bernstein, the New York law firm representing the restaurant.

In addition, Sage Realty Corp., a property manager that manages a downtown building and that claims losses exceeding $1 million, has obtained consent from Con Ed to inspect the damaged substation, said Rory Cutaia, a lawyer with Shea & Gould, a New York firm representing Sage.

The inspection will take place as part of discovery proceedings before a suit is filed, he said.

Meanwhile, blackout-related losses at local businesses, including the South Street Seaport shopping center and the Fulton Fish Market, mounted daily as repair crews worked around the clock trying to restore power to a 70-square-block area left without electricity for the remainder of the week.

By Wednesday, some businesses were able to operate on a partial basis with emergency generators supplied by Con Ed or building owners. Nevertheless, telephone service was inconsistent and elevators and air conditioning units

Continued on page 4

Environmental consultants listing debuts

Business Insurance will publish its first directory of environmental risk management consultants in the Oct. 8 issue, which will contain a spotlight report on specialty risks, focusing on environmental liability.

The directory is published as an editorial service; there is no charge for companies to be included. To be listed, companies must fill out and return a questionnaire provided by *Business Insurance*. If your company provides environmental risk management consulting services and you have not yet received a questionnaire, please request one from Sara Harty, Editorial Assistant, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611-5290; 312-280-3195.

Sept. 10 is the deadline for returning questionnaires.

Inside

✓ One editorial this week urges Congress to clarify risk purchasing group rules while another admonishes some self-insured employers for discriminatory restrictions on AIDS coverage. **PAGE 8**

✓ A British court has widened the eligibility of relatives of victims of a 1989 soccer stadium disaster to seek compensation. **PAGE 23**

✓ The West German insurance industry reported a modest rise in premiums in fiscal 1989, but was battered by heavy losses during the year. **PAGE 23**

✓ The Senate Judiciary Committee has released a product liability reform bill, but the panel's chairman says he doesn't expect a full vote on the bill. **PAGE 25**

✓ Analyst Leonard M. Wilson of Lazard Asset Management Inc. in New York says brokers are relying on strong revenues from other areas like consulting to boost second-half results. **PAGE 31**

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Lawyers discuss tort, insurance issues

When should a lawsuit be filed against a firm?

By STACY ADLER

CHICAGO—Arthur Aardvark's state-of-the-art pacemaker fails, causing him to be hospitalized for four days while a new unit is installed.

Following the surgery, Mr. Aardvark is plagued by fear that the new unit will also fail.

Should a plaintiffs' attorney accept this hypothetical case?

How would such a case be litigated?

Would punitive damages be awarded if it were shown that the manufacturer of the pacemaker, the mythical Digitalis Corp., knew the unit could fail?

These are just some of the questions a 12-member panel of plaintiffs' and defense attorneys, corporate officers, a consumer activist and a judge grappled with during an Aug. 5 roundtable discussion.

Sponsored by the Chicago-based law firm Mayer, Brown & Platt, the program, which was titled "Civil Liability: A Strategy for the 90s," was held concurrently with the annual American Bar Assn. convention.

The first question posed by moderator Arthur Miller, a Harvard Law School professor: Does Mr. Aardvark have a legitimate case against Digitalis Corp.?

Mr. Miller reminded the panelists that Mr. Aardvark had to be hospitalized for four days while a new pacemaker was implanted and that he was forced to miss a week of work.

Robert Habush, a plaintiffs' attorney with Habush, Habush & Davis in Milwaukee, said: "No law firm could afford to prosecute this case."

Mr. Aardvark simply "does not have a compelling damages case," said Mr. Habush, a former president of the Assn. of Trial Lawyers of America. In other words, Mr. Arrdvark would not recoup a lot of money if his lawsuit were successful.

Plaintiffs' attorney Philip H. Corboy of Corboy & Demetrio in Chicago agreed, noting that Mr. Aardvark's health insurer would pay his medical bills and his company probably would pay him for the missed week of work.

Plaintiffs' attorney Stanley Chesley of Waite, Schneider, Bayliss & Chesley in Cincinnati agreed, saying that at least for

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Jockeys saddled with exclusions from state workers comp laws

By MEG FLETCHER

CHICAGO—Jockeys want all states that permit thoroughbred racing to conclusively establish that jockeys suffering legitimate turf-related injuries are eligible for workers compensation benefits.

Many states currently do not require horse owners or trainers to provide such coverage and some states specifically exclude jockeys from the work comp system, said Martin Minkowitz, an attorney for the Jockeys' Guild in Lexington, Ky.

Guild representatives spoke at a meeting of the American Bar Assn.'s Tort and Insurance Practices Section during the recent ABA convention in Chicago.

Even in states that require employers to provide work comp benefits to injured jockeys, benefits are often denied or delayed because of legal questions about an employer's identity and responsibility.

"There is a morass of litigation regarding liability," Peter Rhulen, vice chairman of brokerage Markel Services Inc. in Monticello, N.Y., said in a subsequent interview.

However, amendments adopted last month to New York's racing and work comp laws can serve as a model for a workers compensation program that better protects jockeys while saving horse owners and trainers money and reducing their liability, said John Giovanni, national managing director of the 1,100-member Jockeys' Guild.



AP/Wide World Photo

Jockeys like Pat Day, shown here aboard Easy Goer, risk injury in every race in which they ride.

The guild expects to push for similar changes in

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TPAs of self-funded plans exempt from state rules

By MICHAEL BRADFORD

TALLAHASSEE, Fla.—A state law regulating third-party administrators does not apply to those handling only self-insured employee benefit plans that are governed by federal regulations, an appellate court has ruled.

Last month's ruling by a three-judge panel of the 11th U.S. Circuit Court of Appeals in Atlanta affirms a lower court opinion that state regulation of self-funded benefit plans is pre-empted by the Employee Retirement Income Security Act of 1974.

The lower court ruling came last year in a 1986 lawsuit by the Self Insurance Institute of America that challenged the Florida law (*BI*, July 3, 1989).

The appellate court judges simply affirmed the earlier ruling without offering a separate opinion.

In its suit, the SIIA challenged a 1983 law that requires a TPA to:

- File an annual statement detailing financial condition, transactions and other affairs and pay an annual filing fee of $60.
- Make a $50,000 security deposit during its first full year of operation. In subsequent years, a TPA must deposit an amount equal to at least 10% of the amount of funds handled or managed annually, up to $50,000. A fidelity bond can be filed to meet this requirement.
- Draw up and comply with written agreements with self-funded employer clients. The agreements must contain statutory requirements, stipulate that the

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Explorers, not insurers, own treasure

Finders are keepers: Court

By MARK A. HOFMANN

NORFOLK, Va.—Claiming tons of gold lost in an 1857 shipwreck is theirs because they paid claims on the loss, insurers should appeal a federal judge's award of the treasure to an Ohio exploration group, says a lawyer for the insurers.

A U.S. District Court judge in Norfolk, Va., last week declared Columbus America Discovery Group Inc. the sole owner of hundreds of millions of dollars of gold bullion and rare coins it discovered off South Carolina in 1986 (*BI*, July 9).

Insurers have until Sept. 14 to appeal.

Maritime law experts say the ruling could help to clarify how insurers can maintain rights to lost property.

Columbus America—a consortium of scientists and investors based in Columbus, Ohio—has spent more than $13 million finding the Central America wreckage and recovering the gold from its resting place more than a mile beneath the Atlantic.

Stressing that he was "guesstimating," Barry Schatz, a Columbus America project director, said the cache could be worth $450 million. A lawyer for the discovery group called it "the largest American treasure in history."

Eight U.S. and British insurers and New York's insurance superintendent, acting as receiver for several defunct companies, claimed that they or their corporate forebears collectively had paid about $1.5 million in claims stemming from the disaster.

Insurance covered about three tons of gold owned by companies, which last week was valued at about $38.6 million. However, experts disagree about what portion of the total amount of gold on board was insured.

Last week, U.S. District Court Judge Richard Kellam—who had earlier dismissed the claims of 23 insurers—ruled that the remaining insurance company claimants

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Quarter of employers offer parental leaves

By JERRY GEISEL

NEW YORK—Just more than a quarter of all employers offer parental leave programs, a percentage that is likely to increase during the next decade, according to a new survey.

In a survey of 253 employers, Buck Consultants Inc. found that 27% have parental leave programs, while 73% do not.

However, 21% of the employers without such programs said they expect to add them within 10 years, a reflection of growing employer interest in the programs.

"There is intense employer interest in parental leave programs," said Barbara Adolph, manager of work and family consulting services for Buck in Secaucus, N.J.

The survey defined parental leave as a formal policy that, at a minimum, allows employees to take paid or unpaid leave—with no loss of seniority or status—for the birth or adoption of a child.

Several factors are fueling interest in parental leave programs, according to Ms. Adolph. One is that more employers view such leave as a benefit needed to attract and retain employees.

"There is intense competition for the best employees. Parental leave programs are seen by more companies as a benefit they have to offer to help them recruit and keep employees," she said.

At the same time, companies have become more aware of demographic changes, such as the rise in two-wage earner families, that increase the need for parental leave, Ms. Adolph said.

About one-fifth—21%—of employers without parental leave programs say they will voluntarily add them within 10 years. But most—62%—say they will only add such programs if new laws force them to do so, the survey says.

Thirteen percent didn't know if such programs will be added; 4% gave other responses.

Ms. Adolph says that the high percentage of employers saying they will add parental leave programs only if forced to do so should not be interpreted as employer resistance or antipathy.

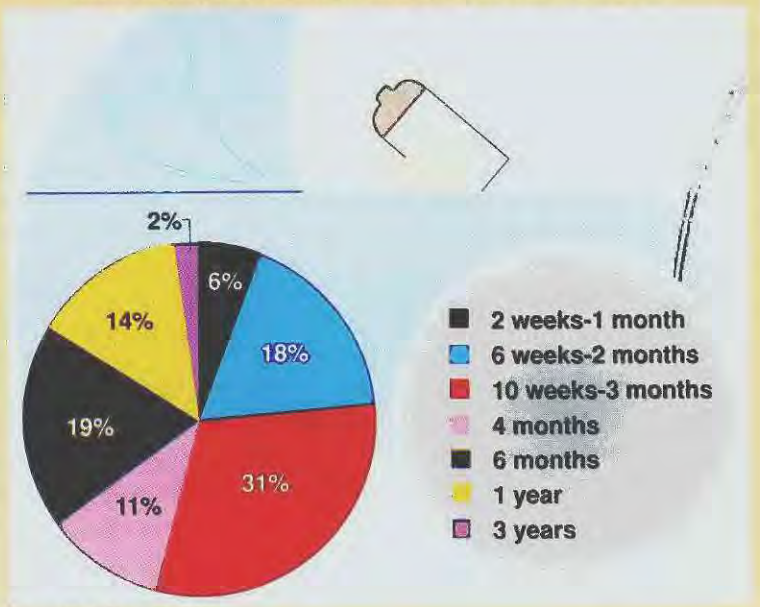
Instead, she said, it is more a reflection of employer desire to wait and see what may be legally required rather than add programs now that later may have to be changed.

"While many employers are exploring parental leave programs, they are not quite ready to jump in.

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Lengths of leaves

Of the 27% of employers that offer parental leave programs, most allow employees maximum time off of at least 12 weeks.



Source: Buck Consultants Inc.

BI/HOLLY SEGUINE

N.Y. blackout

Continued from page 2
were not operating.

Many other businesses posted signs on their front doors reading: "Closed indefinitely due to blackout."

Con Ed, as required by its 1986 tariff with the state, is providing $2,000 to commercial customers and $100 to residential customers to cover spoiled food items. The maximum aggregate amount Con Ed would have to pay for food replacement under the tariff is $1 million.

Brokers and property underwriters say it is unlikely that many businesses which suffered losses will be able to file additional business interruption claims unless they bought off-premises power failure endorsements.

Property insurance experts say it is unlikely that small business would have had such coverage.

This type of endorsement is usually only purchased by industrial risks and is ignored by most retailers and offices, said Thomas Cannon, president of the New York office of Jardine Insurance Brokers Inc.

"I guess we'll soon find out how many businesses had this, but I suspect that most didn't. Offices probably wouldn't think to buy it. It's really underutilized," he said.

Howard Miller, director of production for B.R.I. Coverage Corp., a brokerage whose offices were among those still without power late last week, also said he doubted many businesses had such an endorsement.

Businesses also could be covered if they purchased an extra-expense endorsement to property policies, Mr. Miller said, though he was uncertain how many extra-expense claims the outage might generate.

To generate such a claim, a business must prove it sustained operating losses, said David Riley, a vp and regional underwriting manager for Allendale Insurance Co. in Livingston, N.J.

Most companies with offices in the area did not experience losses, sources at those companies reported.

Mr. Miller noted that B.R.I. itself had some extra expenses—like "a couple of thousand dollars" in car service bills sending employees home after subway service was knocked out—but he said he wasn't sure a claim would be filed for these costs.

One hard-hit area was the Fulton Fish Market, an outdoor seafood market where by Thursday morning the smell of rotting fish permeated the air.

Losses could total $5 million to $6 million for all vendors there, said Frank Minio, owner of Smitty's Fillet House Inc., a wholesale fish dealer.

Mr. Minio said Smitty's stands to lose $10,000 to $50,000, depending on when power is restored. The loss will be uninsured because he didn't purchase off-premises power coverage.

"After buying liability, workers compensation and boiler and machinery coverage, another type of insurance would have been too expensive," he said. "Besides, I thought I already had a blue-ribbon policy."

Peter H. Glazier, president of Delta Dallas in the South Street Seaport, which owns and operates Gianni's restaurant and two banquet facilities, put the daily cost to Gianni's at $15,000 to $25,000 in gross receipts.

"We'll suffer, but we won't jump in head first and do anything rash. I need to see what our total losses are," Mr. Glazier said. "My insurance broker says we are covered, but I'm just playing wait and see now."

He said he was unsure how much of Gianni's $25,000 or so in perishable inventory was salvaged after the blackout

He would not comment on the restaurant's insurance.

Joe Ochs, vp and general manager of Seaport Marketplace Inc., a subsidiary of Baltimore-based Rouse Co., which owns the Seaport complex, said his company has incurred unspecified costs from bringing in two giant generators that provided enough power to about half of the 130 stores, bars and restaurants at the Seaport.

He added that the power failure caused the cancellation of a popular outdoor concert series planned for Thursday as well as millions of dollars in lost income for tenants.

"During one week last August we did in excess of $2.5 million," Mr. Ochs noted.

A spokeswoman in Baltimore would not comment on Rouse's insurance or say whether tenants would be compensated.

While retailers and restaurants were hit hardest, companies based in skyscrapers in the blackout zone scrambled to keep things running as close to normal as possible.

Generators in many buildings provided only enough power to run lights, said sources in those buildings.

Computers, air conditioners and elevators in all of the area's big buildings were knocked out late last week, leaving many companies operating with skeleton crews.

However, businesses whose buildings suffered power outages said they did not expect to experience large operating losses and, thus, would not be able to file business interruption claims even if they carried off-premises power riders.

"We don't expect any losses at all," said Peter Armour, executive vp with Wilcox Inc., the reinsurance brokerage arm of Johnson & Higgins, whose building was blacked out all week. If client needs "are emergencies, we are routing them to our Philadelphia office."

When power went out, Mr. Armour said, Wilcox evacuated the building and moved people to J&H's corporate headquarters several blocks away.

At American International Group Inc., whose headquarters are in the heart of the blackout area, emergency generators were running the lights by Wednesday, said a company spokesman. But AIG, which owns the building, had no other power.

"Until (Wednesday) we were using cellular phones. We have other contingency plans for business, but I'm not sure exactly what everyone has been doing. It has been pretty crazy. You can pretty much say that the afternoon Monday and all of Tuesday were lost days," he said.

B.R.I.'s operations were knocked out after the fire last Monday and its building was closed on Tuesday, Mr. Miller said. Brokers called clients to give their home phone numbers and let them know "we are alive and barely surviving," he said.

On Wednesday, some semblance of normal operations resumed when an emergency generator restored partial power.

As of Wednesday, though, B.R.I. was still functioning with only partial lighting and telephone service and with no air conditioning or elevator service. Fax machines and computer systems were still knocked out, Mr. Miller reported.

However, he doubted whether the outage damaged the firm's computer systems or records to an extent that would produce a claim on its electronic data processing policy, though he said B.R.I. had to wait for the systems to be restored to see if anything was lost.

Corroon & Black Corp.'s corporate offices were also put out of commission by the blackout, said a spokeswoman. Professional personnel were moved to its New York profit center just a few blocks away.

"We won't experience any operating losses. We have been operating with a skeleton crew, but we're coping," she said.

Similarly, Continental Corp. moved most of its employees who normally work downtown to various branch offices in New Jersey.

"We don't foresee any losses, but as we sort the situation out we'll see if there are any extra expenses and losses. We just can't tell now. It will take days to know," said a spokeswoman.

•

New York Bureau Chief Douglas McLeod contributed to this story.



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GAO studies multiemployer health plans

By ADRIENNE C. LOCKE and MICHAEL SCHACHNER

Benefit beat

WASHINGTON—Most multiemployer health plans provide retirees with health care coverage, according to the U.S. General Accounting Office.

However, a recent GAO survey also notes that multiemployer plans account for only a small portion of the estimated 5.6 million retirees with employer-sponsored health care benefits.

Multiemployer plans are benefit programs jointly sponsored by a union and two or more employers according to a collective bargaining agreement between employers and the union. For example, a carpenters union could negotiate for a multiemployer health plan to be sponsored by several employers the union holds contracts with.

Most multiemployer plans are jointly run by equal numbers of union and employee representatives.

The GAO report—requested by Rep. Edward R. Roybal, D-Calif., chairman of the House Select Committee on Aging, and Rep. J.J. Pickle, D-Texas, chairman of the House Oversight Subcomittee—found that 607, or 66.3%, of the 915 multiemployer health care plans surveyed between August 1989 and January 1990 provide health care coverage to retirees.

About 60%—or 1.7 million—of the 2.8 million employees that belong to those plans are enrolled in plans that provide retiree health care coverage, the GAO said.

However, of the estimated 5.6 million retirees that now receive employer-sponsored health care benefits, only 6%—or 337,000—are members of multiemployer health care plans, the report said.

The GAO also found that 34.4% of the retirees in these multiemployer plans are under age 65. The study noted this coverage is important for these retirees, who are not yet eligible for Medicare.

All told, multiemployer plans provide health care and retiree health care coverage to just 2% of an estimated 96 million private sector employees.

Overall, the GAO found that 32% of private sector employees receive health care and retiree health care coverage through plans that are sponsored directly by an employer; 31% are members of direct employer-sponsored plans that do not offer retiree coverage; 1% are members of multiemployer plans that do not offer retiree coverage; and 34% are not enrolled in any health care plan.

In addition, the report found that the majority of multiemployer health plans—61.8%—cover workers in the construction industry.

Because of the nature of employment patterns and cycles in the construction industry, employees are felt to have a working relationship with the industry as a whole rather than any one company, the GAO noted.

Of the other plans surveyed, 16.5% covered workers in the agricultural, mining, manufacturing, and wholesale industry; 10% covered workers in the transportation and utilities industries; 5.4% covered workers in the retail trade industry; 3.1% in covered workers who work for professional services firms; and 3.1% covered workers in the consumer services industry.

The report also found that many multiemployer health care plans require some form of cost sharing by retirees to help limit the cost of providing benefits. More than half, or 56%, of the multiemployer health plans surveyed require retirees to contribute to the cost of their health care coverage.

Copies of "Employee Benefits: Extent of Multiemployer Plan Retiree Health Coverage," can be obtained from the U.S. General Accounting Office, P.O. Box 6015, Gaithersburg, Md. 20877; 202-275-6241. The first five copies are free; additional copies are $2 each.

Dental benefit savings

A group of Pittsburgh surgeons is saving money on employee dental expenses while offering employees four times the level of benefits it offered a year ago.

University Surgical Associates, a group of 57 private practicing doctors affiliated with the University of Pittsburgh, saved about $8,000 in dental care costs in a year after implementing a self-insured, direct reimbursement dental program, according to Joseph Farrell, a consultant with Farrell Benefits Consultants in Pittsburgh.

USA accomplished the feat simply by self-insuring its plan, under which about 175 employees and family members pay for all dental care expenses out of pocket and then are subsequently reimbursed, said Mr. Farrell, who helped design and implement the program.

Under the plan, which began Aug. 1, 1989, the first $200 of expenses are covered at 100%. Eighty-five percent of the next $500 in costs are covered under the plan, and 70% of the remaining expenses up to $4,000 per year are covered.

All dental services are covered under the program. There are no coverage schedules and reimbursement is not limited to traditional services, Mr. Farrell said.

By comparison, USA's old plan, which was underwritten by Blue Shield of Western Pennsylvania at an annual premium of about $45,000, offered only a $1,000 annual limit on benefits. Coverage was limited to 80% for basic treatment and 50% for major treatment.

"With an insured program, the company is pooled with other companies and everyone pays the same rate, which isn't always representative of losses and benefits received," Mr. Farrell explained. "With this plan, you take them out of that setting and you can increase benefits and not increase costs."

The plan, which cost USA about $37,000 in benefits and administrative fees for the year, also encourages employees to become better consumers of dental services because they are required to pay first and file for reimbursement. "There's less unnecessary treatment under this program," Mr. Farrell said.

Mr. Farrell, who also acts as the plan administrator, lauds the program's simplicity. "It doesn't matter what type of dental work they receive. The employee no longer has to worry about whether it's covered or whether it's major, preventive or diagnostic." He added that the simplicity also allows for low administrative costs. ■

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Opinions

Clarify purchasing group rules

YET ANOTHER FEDERAL appellate court decision restricting use of the Risk Retention Act reinforces the need for Congress to overhaul that law.

Last month, the 11th U.S. Circuit Court of Appeals ruled that state insurance regulators can require a risk purchasing group insurer that is domiciled in another state to be licensed in their states before the insurer can do business (*BI*, Aug. 13).

Specifically, the court said the pre-emption provisions of the Risk Retention Act do not bar states from imposing licensing requirements on non-domiciliary purchasing group insurers.

This marks the second time a federal appellate court has ruled that non-domiciliary states can require purchasing group insurers to meet their own licensing requirements. In 1989, the 8th U.S. Circuit Court of Appeals came to the same conclusion (*BI*, July 24, 1989).

By now, it should be clear where courts are coming from: Unless state insurance laws and regulations, like licensing requirements for purchasing group insurers, are explicitly pre-empted by the act, courts will support regulators' attempts to apply these rules.

Given that stance, it is now up to Congress to lay out—as specifically and unambiguously as possible—exactly which state rules and requirements can be applied to purchasing group insurers.

This is no easy task and will require balancing the traditional goal of state regulation—ensuring the solvency of all insurers—with the general goal of the Risk Retention Act—facilitating the group purchase of commercial liability insurance.

These goals are not mutually exclusive.

State regulators are rightly concerned about the dangers to policyholders and the public if thinly capitalized insurers are allowed to write a huge volume of business for purchasing groups.

To allay this concern, we believe it is essential that a purchasing group insurer would have to meet new, federal minimum capital and surplus requirements.

However, the minimum capital and surplus requirement—$3 million—laid out in legislation introduced by Rep. Jim Slattery, D-Kan., strikes us as much too low to give comfort to regulators that a purchasing group insurer will, in fact, have the financial resources to meet obligations of policyholders.

An additional requirement imposed on an insurer before it could write purchasing group business might be that it would have to be licensed for a certain number of years. While this would not guarantee an insurer is sound—witness the number of commercial insurers that have failed after many years of operations—it would prevent insurers with no track record from immediately entering the purchasing group business.



• CEMENT BOOTS •

Certainly, any changes to the Risk Retention Act must stipulate that purchasing groups be controlled by buyers, not by brokers and insurers.

That requirement would avoid situations in which unscrupulous insurers organize purchasing groups, attract policyholders with rock-bottom premiums, cede much of the risk to unknowing reinsurers and then pocket ceding commissions.

In such a scenario, the fate of the purchasing group makes no difference to the insurer.

In exchange for these safeguards, regulators should accept what we believe was the intent of Congress when it passed the Risk Retention Act, even if it was not made clear: Purchasing group insurers should have to meet the licensing requirements of only one state.

If purchasing group insurers have to meet the varying licensing requirements of every state in which they write business, there would be little, if any, attraction for an insurer to write coverage for the groups.

Now's the time for Congress to fix the Risk Retention Act to meet the concerns and needs of regulators and buyers—before the commercial insurance market hardens.

Correct ruling, but bad idea

WHILE WE CONCUR with a federal court decision upholding a self-insured employer's right to cut health care benefits for employees with AIDS, we abhor such efforts to restrict AIDS coverage.

Last year, an employee sued after H&H Music Co. capped lifetime coverage for acquired immune deficiency syndrome at $5,000, while retaining a $1 million limit for other conditions. The employee charged that violated the Employee Retirement Income Security Act, which bars discrimination against plan participants.

As a self-funded plan, H&H's program was not subject to Texas law, which bars sublimits in insured plans. Under ERISA, self-funded plans are exempt from state laws that mandate policy provisions.

Last month, Judge Norman Black ruled that H&H had the right to cut the benefits. He correctly noted that nothing in the 1974 law requires a company to offer equitable AIDS benefits. At the same time, in summary plan descriptions, H&H notified employees that the company reserved the right to amend or terminate its health care plan at any time (*BI*, Aug. 6).

Judge Black's ruling—now on appeal—gives the company the legal right to provide smaller AIDS benefits. But such discrimination, legal though it may be, flies in the face of what is fair and decent.

No company would, for example, limit coverage just for premature infants or for cancer patients, even though neonatal and cancer treatment is very expensive. Why, then, single out AIDS patients?

Companies that can no longer afford the cost of catastrophic claims should lower benefit limits for all claims, rather than just for one type of illness.

And, instead of slashing benefits, the more sensible and humane approach would be to control AIDS and other catastrophic claims through case management. AIDS is an excellent example of how home or hospice treatment can cost less than hospital care.

Ultimately, employers should be aware that any health care plan discrimination against AIDS patients will, sooner or later, trigger congressional debate. As we previously have noted, that debate could expand into congressional attempts to mandate the entire scope of group health plan benefits and limits.

That debate can be forestalled if employers provide the same levels of health care coverage for AIDS as for other medical conditions.

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Parental leave

Continued from page 3

They are waiting to see what state legislators or Congress does," Ms. Adolph said.

"Companies want to wait until the legislative activity settles down," she added.

Parental leave bills have been a hot issue at both the federal and state levels.

A bill passed by Congress earlier this year would have required companies with at least 50 employees to offer up to 12 weeks of job-protected leave.

Leave could have been taken for the birth or adoption of a child; to take care of a seriously ill child, parent or spouse; and for an employee's own illness.

During the leave, an employee's health insurance would have had to continue as if he or she stayed on the job (*BI,* June 18).

Citing his opposition to benefit mandates, President Bush later vetoed the bill. A motion to override the veto failed by a wide margin.

However, Sen. Christopher Dodd, D-Conn., reintroduced the measure, S. 2973, just before Congress left this month on its summer recess.

Meanwhile, at the state level, Connecticut last year and New Jersey earlier this year enacted extensive parental leave measures. Both of these measures will go fully in effect in 1993 (*BI,* Jan. 1).

Maximum periods of leave varied in the Buck survey. Most common was a limit of 12 weeks, which was offered by 29% of employers with parental leave programs (see chart, page 3).

However, 46% of employers offered longer programs, including: 11% that offered up to four months of unpaid leave; 19% with six months; 14% with one year; and 2% with three years.

On the other hand, 26% of employers provided fewer than 12 weeks, including: two weeks of unpaid parental leave, offered by 2%; four weeks, 4%; six weeks, 5%; eight weeks, 13%; and 10 weeks, 2%.

Seventy-two percent of employers said they continued health insurance plans for employees while on parental leave. The survey did not detail what portion of the premium companies paid for employees on parental leave.

Sen. Dodd's legislation would require companies to continue health care coverages on the same terms and conditions as if the employee were still on the job. If, for example, active employees had 80% of their premiums paid, those on leave would get 80% of their premiums paid.

According to the Buck survey, large employers were most likely to continue health care coverage for employees taking parental leave.

Seventy-six percent of large companies—those with more than 5,000 workers—said they continued such coverage.

Among small employers—those with fewer than 1,000 employees—the figure was 71%, and among medium-sized companies it was 63%.

Only 38% of employers with the programs said some or all employees are eligible for salary continuation during parental leave. The remaining 62% said they do not continue salary during parental leave.

Among employers with parental leave programs, 78% offer the programs to all employees, while 22% provide the programs on a more limited basis.

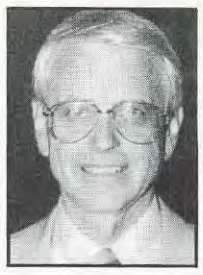
"It is an equity issue. Once an employer writes something down and puts a parental leave program in place, it recognizes that the program has to be companywide," Ms. Adolph said.

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Copies of "Parental Leave—An Employer View," are available from Carolee Martin, Manager of Marketing, Buck Consultants Inc., 500 Plaza Drive, Secaucus, N.J. 07096-1533. The cost is $50.

At issue

Were you surprised by your group health insurance renewals?



Don Theil
Assistant personnel director
University of Michigan, Ann Arbor, Mich.

The premium increase for 1991 was not as much as I thought it would be. We saw a 7% increase this year, compared to 45% last year. The increases seem to bounce all over the place. Evidently our claims have moderated a bit—the big claims weren't as high this year. And, I think the low increase is partially attributable to such a high increase last year.



Janet D. Collins
Chief-employee benefits/transactions
County of San Bernardino, San Bernardino, Calif.

Yes. We have a self-funded indemnity plan and two HMOs for our 10,000 active employees and 3,000 retirees. Unlike most groups, the indemnity plan has the lowest premium of the three plans. HMO premium increases were the highest ever—23.5% and 17.8%—while the indemnity plan had the lowest increase—2.2%.



Les Brockhurst
Vp-human resources
Arizona Public Service Co., Phoenix

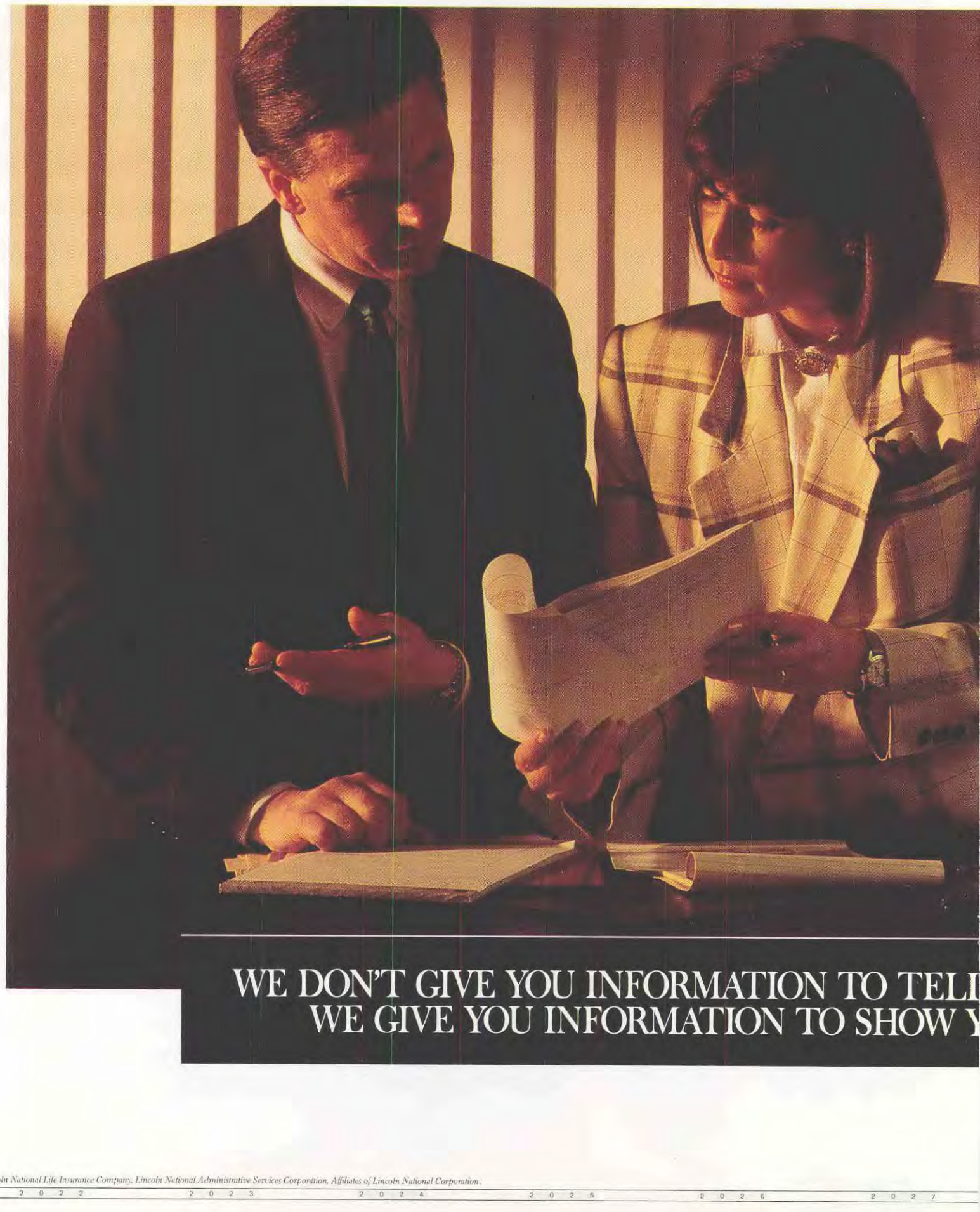
Yes. We had targeted a 15% increase in our health insurance costs and we were able to keep that to 10%. I think some of the cost containment programs we've put in—like a wellness program, employee education and utilization review—have proven effective earlier than we had anticipated.



Steve Holland
Benefits administrator
First USA Inc., Dallas

No surprises. Our research indicated that we could anticipate a 16% overall premium increase. Thus far, our overall premium increase has been about 13% and we really don't expect to go any higher.

Compiled by Christine Woolsey



EPIC ruling

Continued from page 2

sell them at a profit after four or five years.

EPIC Mortgage originated mortgage loans on the properties and then sold the loans to third parties —including S&Ls—either as whole loans or in the form of mortgage-backed securities.

As the real estate market in the Southwest soured, though, the houses could not be sold at a profit. In addition, rental income on the houses did not cover the costs of the mortgages, which then forced the partnerships into bankruptcy.

EPIC defaulted on more than $1 billion in debt related to roughly 350 partnerships, an estimated 20% to 25% of which was insured.

Several mortgage insurers have collectively paid tens of millions of dollars to settle EPIC-related claims, including Milwaukee-based MGIC Investment Corp.; Republic Mortgage Insurance Co., a unit of Chicago-based Old Republic International Corp.; U.S. Mortgage Insurance Co., formerly Pamico Mortgage Insurance Co. of Blue Bell, Pa.; and Commonwealth Mortgage Assurance Co. of Philadelphia, a unit of Reliance Group Holdings Inc. (*BI*, June 6, 1988).

The EPIC debacle is also blamed for the demise of Los Angeles-based TMIC Insurance Co., ordered into liquidation in 1988 (*BI*, Sept. 2, 1985).

Foremost and United Guaranty filed declaratory judgment actions in 1985 against several savings & loans that invested in EPIC mortgages or mortgage-backed certificates.

Those savings & loans included Dominion Federal Savings & Loan Assn. in McLean, Va., now known as Trustbank Savings; and First National Bank of Maryland in Baltimore, acting as trustee for a group of S&L certificate-holders, including Silverado.

Dominion bought whole mortgages through EPIC, insuring 25% of the face value with United Guaranty and Foremost.

The S&L group represented by First National invested in EPIC mortgage-backed certificates and also insured 25% of the face value with Foremost and United Guaranty, although the savings & loan group settled its claims with United Guaranty before trial.

The only conclusion is that 'the insurers closed their eyes to the obvious,' says the court.

The suits, consolidated in U.S. District Court in Alexandria, Va., as part of multidistrict litigation related to EPIC, sought to rescind coverage of the EPIC mortgages on the grounds that the coverage had been fraudulently procured.

The insurers charged that officials of EPIC Mortgage had claimed in meetings that the partnerships were operated independently, with each partnership's funds held in escrow, court papers say.

EPIC Mortgage officials also represented that the older partnerships' properties were being sold without problems, that new investors were continuing to buy into the limited partnerships and that EPIC was in sound financial shape, court papers say.

In fact, EPIC—unable to sell the properties of older partnerships—camouflaged the problem by "re-syndicating" the older partnerships, selling their properties to new partnerships, according to the appellate ruling.

Old partnerships were also propped up with loans from new entities, the appellate ruling says.

Despite its oral representations to the contrary, EPIC routinely withdrew money from new partnerships as soon as it came in and used it to artificially revive failing partnerships "while immediately impairing the new partnerships from which the funds were taken," the appeals panel found.

U.S. District Judge Claude M. Hilton rescinded the Foremost and United Guaranty mortgage insurance in a 1988 ruling. In that ruling, he found that EPIC had misled the insurers about its operations.

In an Aug. 6 opinion, however, the appellate panel reversed Judge Hilton's ruling.

Among other things, the appeals court noted that the insurers had reviewed an EPIC private placement memorandum that disclosed EPIC's right to borrow money from limited partners' contributions and make loans to partnerships.

Under a section headed "Conflicts of Interest," the memorandum also noted a potential conflict between EPIC and limited partners arising from EPIC's right to advance money to partnerships.

EPIC had made such loans in the past to fund the operating deficits of some partnerships, the document disclosed.

The alleged oral misrepresentations by EPIC Mortgage officials thus directly contradicted written documents to which both insurers had access, the appeals panel concluded.

"The contradictions between the written and oral statements should have at the very least prompted the insurers to uncover the truth," the court found.

"Even if the insurers did not know which of the statements were true, they could not act reasonably in relying on one over the other," according to the court.

The appellate panel also labeled as "clearly erroneous" the lower court's conclusion that the two mortgage insurers could not have discovered the alleged fraud even if they had thoroughly investigated the EPIC program.

The district court judge supported this conclusion by noting that EPIC's own auditors and Touche Ross & Co.—which reviewed the program for three other mortgage insurers—failed to detect the fraud.

The appeals court, however, found that the Touche Ross review —which Foremost and United Guaranty did not see—in fact highlighted the program's problems and "painted a grim picture of EPIC's future."

Noting that the private placement memorandum revealed EPIC's right to borrow from partnerships and that the insurers never bothered to ask whether such borrowing actually took place, the appeals court found that "no other conclusion could be drawn except that the insurers closed their eyes to the obvious."

"The indicators of fraud were not so well-hidden that they were obscure upon reasonable inquiry. Thus, the insurers may not rescind based on the misrepresentations they claim," the appeals panel wrote.

Trustbank Savings, formerly Dominion Federal, is owed $5.1 million by United Guaranty and $1.1 million by Foremost, according to William L. Stauffer Jr., a lawyer with Frank, Bernstein, Conaway & Goldman in Tysons Corner, Va., representing the S&L.

The insurers may also owe more than $1.5 million in prejudgment interest, though it is not yet clear whether the court will allow these damages, Mr. Stauffer said.

The S&L group represented by First National is owed about $1.7 million by Foremost, and prejudgment interest may push this amount to more than $2 million, according to Joseph Fanone, a lawyer with Ballard, Spahr, Andrews & Ingersoll in Washington, D.C., representing First National. ■



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Cheri Eisenberg

Harvard Law School Professor Arthur Miller, center, moderated the panel of legal experts.

Liability scenario

Continued from page 3

now, this case is not worth litigating.

Thus, the nation's leading plaintiffs' counsel are unwilling to help Mr. Aardvark, said Mr. Miller, surprised by their apparent lack of interest.

"It must be Sunday," quipped defense attorney Victor Schwartz of Crowell & Moring in Washington, D.C. "These guys are being too timid.

"It is more likely they would have an ad in the newspaper seeking out more clients (with defective pacemakers)," charged Mr. Schwartz.

And Alan B. Morrison, co-founder of Public Citizen Litigation Group, a consumer advocacy organization in Washington, D.C., expressed concern that many other people were walking around with defective pacemakers. He suggested that attorneys consider a class-action lawsuit on behalf of everyone with a Digitalis pacemaker.

Mr. Morrison urged the plaintiffs' attorneys to take steps to force Digitalis to notify everyone with a pacemaker of the defects and, perhaps, to force a recall of the product.

"My client is not a knight in shining armor," countered Mr. Corboy, noting it is not Mr. Aardvark's duty to take on massive litigation on behalf of others.

Robert H. Malott, chairman of and chief executive officer of FMC Corp., a chemical and manufacturing company based in Chicago, asked why none of the plaintiffs' attorneys considered contacting the corporation directly.

Charles B. Renfrew, general counsel for Chevron Corp. in San Francisco, agreed, contending that the corporation is likely to offer to compensate Mr. Aardvark—even if he does not file a lawsuit—if he can prove he was injured.

"We would consider compensating him in return for a general release," said Mr. Renfrew, playing the role of general counsel for Digitalis. Under a general release, the plaintiff would surrender his right to later sue the corporation.

"Why not let the plaintiff reserve his rights in case there are further problems downstream?" asked Mr. Chesley.

Why not pursue the case? 'My client is not a knight in shining armor,' says Philip Corboy.

Mr. Malott and Mr. Renfrew said use of a general release in return for compensation is standard practice.

At this stage, Mr. Miller asked the panel to make a further assumption: Digitalis' chief engineer has just informed the chief executive officer that although the pacemaker is state-of-the-art with a standard 1% to 2% failure rate, some imprecise soldering has left 25,000 units with an 8% to 10% failure rate.

Mr. Malott, playing the role of CEO of Digitalis, said he would immediately meet with the corporation's general counsel and its product liability insurer. This was the panel's only mention of insurance companies and their role in these scenarios.

Mr. Renfrew said Digitalis would most likely conduct a "cost-benefit analysis" to determine the proper course of action. Such an analysis, he said, would take into account expert medical and legal opinions.

"The best thing a company can do is seek the best advice it can," agreed Michael M. Uhlmann, a defense attorney with Pepper, Hamilton & Scheetz, a Washington, D.C. firm.

In talking to medical experts, the company learns that warning everyone with its pacemakers of the defects will cause some people to have immediate heart attacks and die.

Mr. Mallot and Mr. Renfrew said it would be difficult for Digitalis to know whether warning people was the best tactic.

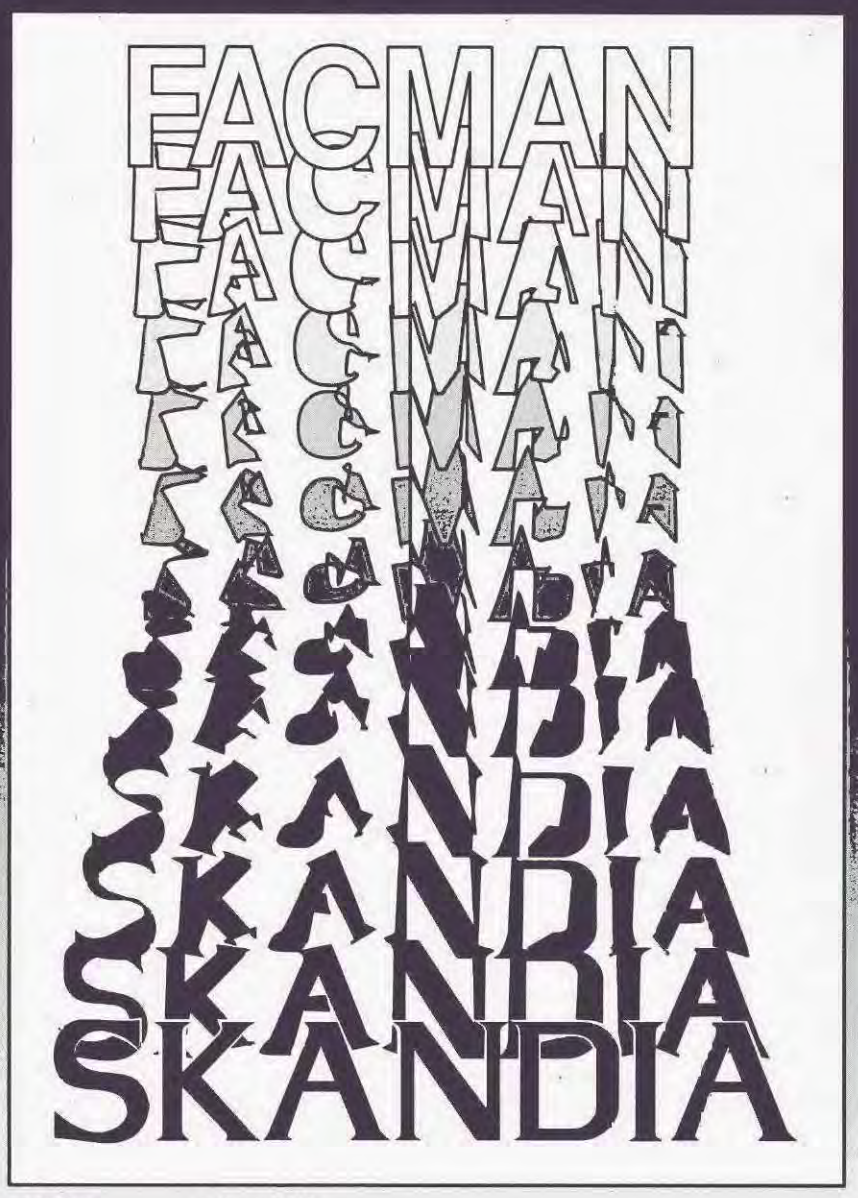
Defense attorney James F. Neal of Neal & Harwell in Nashville, Tenn., agreed: "Just getting the word out will cause more deaths."

"A 10% failure rate and you are not going to warn people?" asked a dismayed Mr. Chesley.

The plaintiffs' attorneys suggested that whether or not the

Continued on next page

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Continued from previous page
warnings will cause more deaths, the manufacturer had a legal duty to issue them.

Mr. Renfrew said Digitalis was now in a Catch-22 situation: If it warns people it may cause more deaths, and if it fails to warn people it faces serious litigation.

"I am concerned about a class-action lawsuit seeking punitive damages," said Mr. Renfrew.

"Failure to warn is an overt act that could lead to punitive damages," said Mr. Chesley, who appeared to show more interest in the litigation.

The mention of punitive damages sent defense attorney Mr. Neal reeling.

"If you do away with punitive damages, you will see companies acting more responsibly," he charged. "I totally disagree with private punitive damages."

But Mr. Chesley maintained that punitive damages deter corporate wrongdoing.

The panel was also asked to consider the viability of filing a class-action lawsuit.

Mr. Miller told the panel that Mr. Chesley has three clients with Digitalis pacemakers, Mr. Habush has one client and Mr. Corboy has one client.

The attorneys, however, say there is still not enough interest to warrant filing a class-action suit.

"The procedural labyrinth of personal injury litigation does not lend itself to class-action status," said Mr. Corboy.

However, the attorneys did concede that they would work together in the litigation of their five cases.

At this point all of the plaintiffs' attorneys agreed that they would file lawsuits to begin discovering documents at Digitalis.

However, Mr. Renfrew, acting as general counsel for Digitalis, said his company might be willing to

'You cannot ignore the costs of trying cases vs. settling these cases,' says Mr. Renfrew.

disclose documents without a lawsuit.

Mr. Corboy was shocked: "I can't imagine Corporate America supplying that information."

What about settling the case? asked Mr. Miller.

Mr. Renfrew said Digitalis "would think seriously about settling."

He said whether or not the company thinks Mr. Aardvark has a legitimate claim, Digitalis must consider the economic benefits of an early settlement.

Mr. Malott agreed. He said FMC Corp. "settles half of the product liability actions where there are no damages."

"We have to defend lawsuits even if they are frivolous," he explained.

Mr. Corboy asked Mr. Malott how he determines whether a lawsuit is frivolous. "If it's lost, is it frivolous?" he asked.

Peter Huber, a fellow of the Manhattan Institute, a conservative think tank, countered: "If it's won, does it have merit?"

Mr. Renfrew disclosed that Chevron Corp. currently is facing 3,200 lawsuits. "Managing a wide variety of cases, you cannot ignore the costs of trying cases vs. settling these cases," he said.

As a result, companies often settle cases they view as frivolous, said Mr. Renfrew.

This infuriated the plaintiffs' attorneys.

"They shouldn't settle" if they really believe the claim is worthless, said Mr. Chesley.

"I have no sympathy for a corporation that buys off people that easily!" roared Mr. Corboy.

Seeing that faces were flush and tempers were rising, Mr. Miller appealed to Judge Pamela M. Rymer of the 9th U.S. Circuit Court of Appeal.

The judge said the debate filled her with the sense that money is the overriding factor in making decisions in these scenarios.

"We need to remember our professional responsibility to think seriously about litigation and how it is conducted," said Judge Rymer in a plea for rational thinking.

But Mr. Miller questioned whether the nature of an adversarial system of justice discourages just that sort of thinking: "If everyone has a client and is taught to be an advocate, an adversary, isn't it unrealistic to hope that the lambs and the sheep will ever lie down together?" ■

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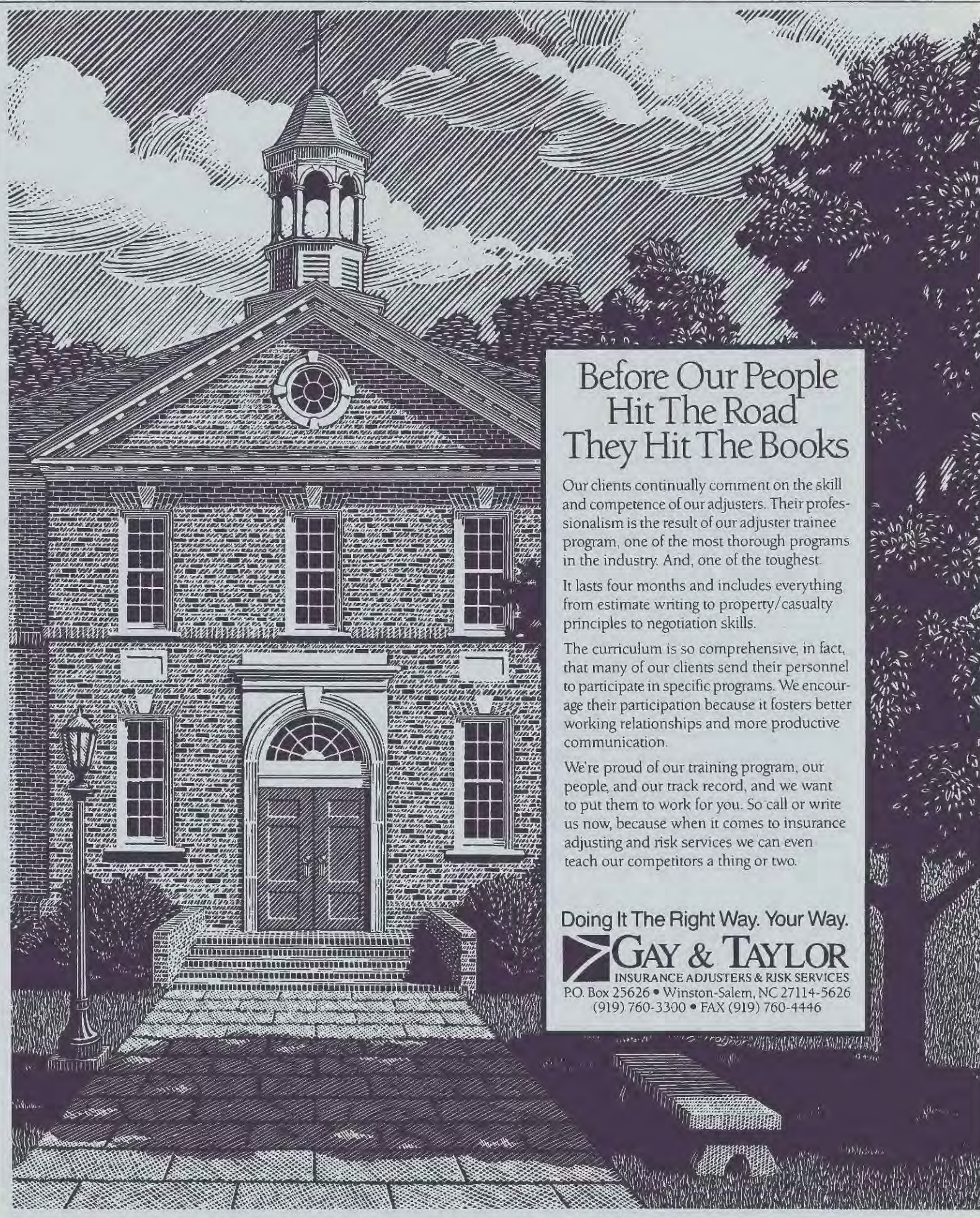
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Oversight of insurers 'weak': Gillespie

By STACY ADLER

CHICAGO—Legislative and regulatory oversight of the insurance industry now is "very weak" and will likely "get worse before it gets better," according to California Insurance Commissioner Roxani Gillespie.

"The trend in government in the last 10 years has been paralysis," she said.

Despite "a lot of fire and brimstone" from regulators and elected officials, there has been very little real action in terms of insurance regulation, charged Ms. Gillespie.

The commissioner criticized current insurance regulatory practices as well as California's Proposition 103 during a program at the American Bar Assn. convention earlier this month in Chicago. The meeting was co-sponsored by the Tort and Insurance Practice Section and the Public Regulation Committee of the ABA.

"The expectations of the public and the ability of government to deliver are poles apart," Ms. Gillespie noted.


Ms. Gillespie

People want all their injuries insured but they "don't want to pay the tab," explained Ms. Gillespie, referring to voter-approved Proposition 103, which among other things called for property/casualty insurers in California to roll back insurance "charges" 20% from October 1987 levels. However, this and other provisions of Proposition 103 are still tied up in litigation.

The pervasiveness of insurance makes it very similar to taxes, said Ms. Gillespie.

And like taxes, insurance regulation is becoming a hot issue for politicians, she said.

Politicians today say things like: "Read my lips—no increases in auto insurance," quipped Ms. Gillespie.

By making the California insurance commissioner's post elected, rather than appointed, Proposition 103 only exacerbated the problem, she said.

California state Sen. John Garamendi, D-Walnut Grove, and Wes Bannister, a Republican from Huntington Beach, are vying for the insurance commissioner's post in the November election.

Neither of the candidates in California is going to have a significant impact on insurance industry regulation, said Ms. Gillespie.

"What happens when the market hardens in three years and the elected official is running for governor?" she asked. "I don't think politics is the answer at all."

Ms. Gillespie concedes that there are also problems when a state insurance commissioner is appointed.

Too often regulators are "too close to their licensees," charged Ms. Gillespie.

She noted that insurance company employees often leave their jobs to become regulators and later leave those posts to go back to work for insurance companies.

In addition, regulators are not in office long enough to make concrete changes, she said.

"Our legislative system of insurance in this country is very weak," concluded Ms. Gillespie.

And she predicts that it will not get any stronger. "Regulation in the '90s will not be much different. Government cannot respond if it is paralyzed."

In fact, the situation is likely to get "worse before it gets better," she said.

"What we will do the '90s is reap what we have sowed in the '80s," she said.

In California, that means learning to live with an insurance reform law—Proposition 103—that "doesn't work."

For consumers, putting such a flawed law in place was "Alice in Wonderland," Ms. Gillespie said.

She predicts that "the courts are where problems with Prop 103 will eventually be resolved," but warns that that system "does not come cheap."

"It is not an efficient way to create public policy," Ms. Gillespie adds.

On another issue confronting insurance regulators, Ms. Gillespie warned that state regulators nationwide will be forced to struggle with the issue of reinsurance offsets in the 1990s.

Ms. Gillespie, who as California insurance commissioner is liquidator of Mission Insurance Co., has taken a strong position that reinsurers should not be entitled to offset amounts they owe to the estate of an insolvent insurer by amounts the insolvent company owes them.

"We must go after all the businesses who built the house of cards," she said. "If a reinsurer who helped a company go under knows they will not be entitled to offsets, they will be more careful next time around."

Finally, the world of insurers is becoming much smaller, said Ms. Gillespie, referring to the proposed $1.1 billion acquisition of Fireman's Fund Insurance Co. by West German insurer Allianz A.G. Holding (*BI*, Aug. 6).

"These pressures from abroad necessarily bring change" in the regulatory environment, Ms. Gillespie said.

As more complex financial institutions take over control of insurers, regulation will become "much more difficult," explained Ms. Gillespie. ■

THE HOM



OLD PROS ON

Don't litigate D&O disputes, lawyers say

By STACY ADLER

CHICAGO—Corporate officers and their insurers must make more of an effort to settle directors and officers insurance coverage disputes without litigation, according to a panel of attorneys.

"There is plenty of room in the D&O form to find resolution of threshold issues," said Stuart Philip Ross of Ross, Dixon & Musbach in Washington, D.C. "My recommendation is to talk first, don't run to court," urged Mr. Ross.

By filing a pre-emptive lawsuit, policyholders and their insurers can "poison the atmosphere" that would allow them to settle their differences, he said.

Mr. Ross made his comments during a panel discussion at the annual American Bar Assn. convention in Chicago earlier this month. The panel, titled "D&O Policies: Current Issues of Concern to Insurers and Insureds," was sponsored by the ABA Section on Litigation and co-sponsored by the Section on Insurance Coverage and the Corporate Counsel Committee.

Seeing well-publicized court cases involving D&O insurance gives the impression that D&O claims are routinely litigated, said Mr. Ross. However, he said, they are not.

More often than not, policyholders and their D&O insurers can resolve their coverage disputes outside a courthouse, he said.

The key to avoiding litigation, he said, is a spirit of cooperation. "When cooperation breaks down, the legal bills run up."

The duty of cooperation and the duty of good faith "run both ways," stressed Nancy E. Barton, an insurer attorney with Weil, Gotshal & Manges in New York and another member of the panel.

She predicted that when policyholders take coverage positions that are "beyond the pale," more and more insurers will bring bad-faith lawsuits against their policyholders.

The duty of good faith "is a reciprocal obligation," she said.

Because the issues in a D&O claim vary widely from one case to another, there is no "static model" on how these cases should be settled, said Kenneth A. Sagat, an attorney with D'Amato & Lynch in New York.

"Insurance companies are probably settlement-neutral," Mr. Sagat said.

"They seek to resist blackmail. On the other hand, they are sometimes more pragmatic than management in seeking out settlements."

One issue that often complicates the settlement of a D&O claim occurs when one of several directors named in an underlying lawsuit seeks to settle his or her portion of the underlying claim and wants indemnification from the D&O insurer.

If the insurer believes the single director's settlement of the underlying claim is fair, it will go ahead and settle with that defendant, said Mr. Ross.

'My recommendation is to talk first, don't run to court,' says Stuart Ross of Ross, Dixon & Musbach.

"However, that settlement will diminish the funds available for the remaining directors and officers," he said.

"There can be real tension and real conflicts with regard to how to divide the pie," agreed Mr. Sagat.

The challenge for policyholders and insurers when one director wants to settle is to find the appropriate level of indemnification, said Ms. Barton.

Policyholders and insurers "must determine what is a fair use of policy proceeds," she said.

Disputes over exclusions in the D&O policy can be difficult to settle and often lead to litigation, according to attorneys on the panel.

The insured vs. insured exclusion and the regulatory exclusion are the "most hotly contested exclusions" in a D&O policy, said Joseph F. Johnston Jr. of Drinker, Biddle & Reath in Washington, D.C.

The insured vs. insured exclusion bars coverage for claims against a director or officer by another director or officer of the same corporation, or by the corporation itself.

"The D&O policy was never designed to provide for this type of first-party coverage," said Mr. Johnston.

The regulatory exclusion bars coverage for claims brought against a director or officer by regulatory agencies, such as the Federal Deposit Insurance Corp.

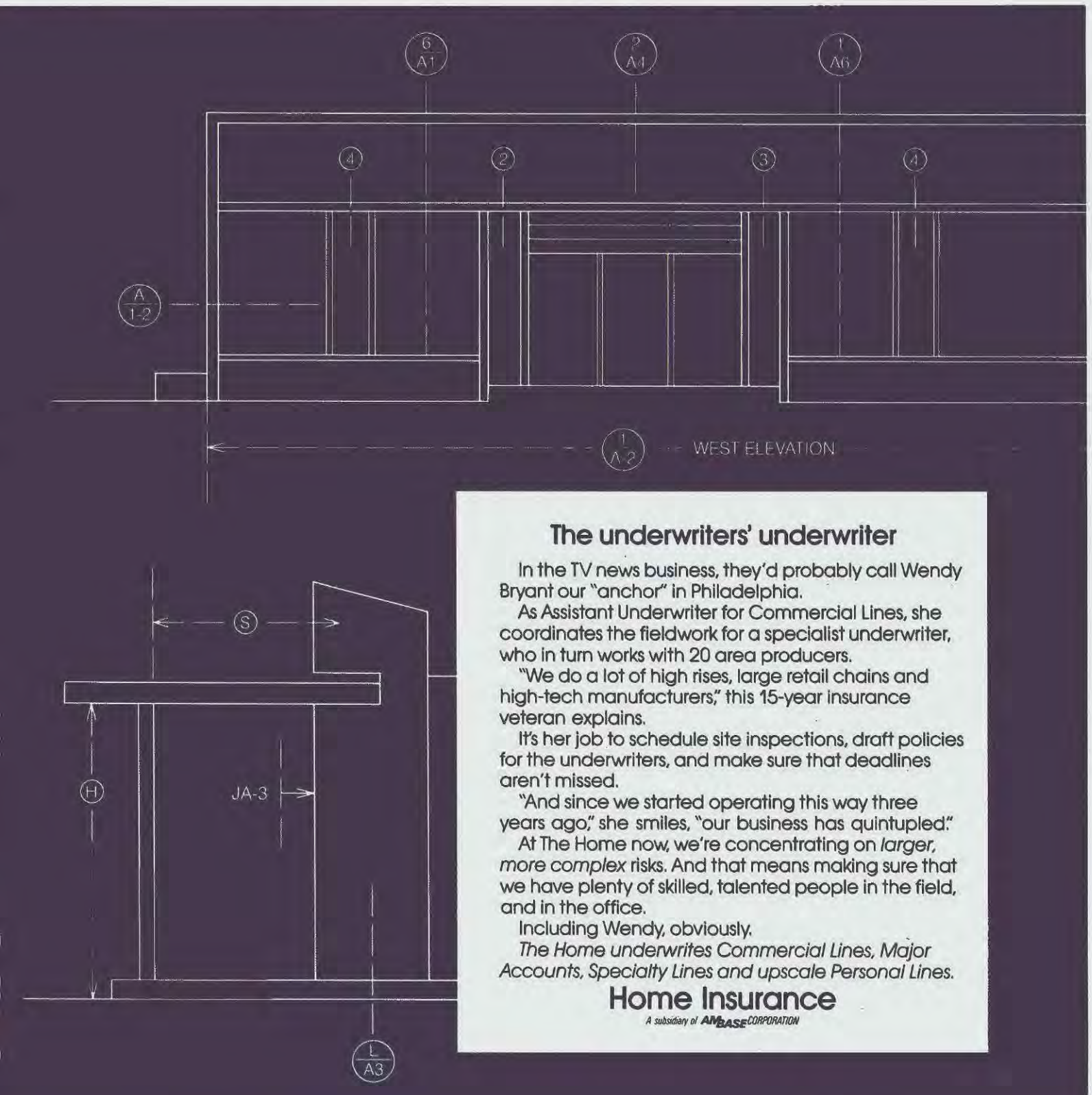
"Some courts have held this exclusion to be against public policy," said Mr. Johnston.

For example, the Maryland Special Court of Appeals in May upheld a lower court ruling striking down both the regulatory exclusion and the insured vs. insured exclusion in D&O policies for financial institutions (*BI*, May 14).

"If the (regulatory) exclusion is struck down, insurers will be reluctant to write coverage for marginal banks," he predicts. "Only the best banks will be able to purchase D&O coverage."

Also speaking at the program were Dennis J. Block of Weil, Gotshal & Manges in New York and Carolyn H. Rosenberg of Sachnoff & Weaver in Chicago. ■

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Jockey injuries

Continued from page 3

nearly all 40 states with thoroughbred racetracks; a handful have already adopted "acceptable" laws or administrative rules, Mr. Giovanni said.

Workers comp benefits can be very important to jockeys, who face a constant risk of injury while on the job.

Despite the popular image—"a little guy with a tall blonde on his arm and a long limo"—relatively few jockeys can afford grand lifestyles, Mr. Giovanni said.

On average, they gross about $25,000 a year before taxes and expenses. That doesn't provide much of a cushion when a jockey is injured and benefits are delayed or denied, he said.

And jockeys are frequently hurt.

"It's a dangerous profession," acknowledged Pat Day, an Eclipse Award-winning jockey who has won 4,500 races.

Some 3,000 licensed jockeys and exercise riders in the thoroughbred racing industry sustain about 2,500 injuries annually, Mr. Giovanni said. Racing-related injuries kill an average of two riders a year.

A videotape shown at the ABA meeting showed the havoc that occurs when a thoroughbred—weighing more than 1,000 pounds and traveling 40 mph—collapses or collides with other horses.

Jockeys have only their skill and a helmet to protect them. Mr. Day, for example, has broken bones, cracked his skull and sprained his neck in accidents.

Mr. Day also has endured several near-misses: On a recent Friday the 13th, his mount broke a foreleg. The momentum of the fall catapulted him over his horse's head and into the path of an oncoming horse—which jumped over him.

Legal disputes resulting in delayed or denied workers compensation benefits stem from the fact that some states laws historically have treated some professional athletes—like jockeys—differently because they voluntarily engage in risky occupations, said Mr. Minkowitz of Stroock & Stroock & Lavan, a law firm in New York.

Also, a jockey is usually hired on a race-by-race basis, making him a "freelance rider" rather than an employee.

The image—'a little guy with a tall blonde and a limo'—is exaggerated, says John Giovanni.

Courts have shown an "increasing" tendency to deny workers compensation coverage to freelance jockeys, considering them independent contractors, who are excluded from the coverage, rather than employees, Mr. Minkowitz said.

Another problem is that a popular jockey can ride several different owners' horses in a single day, making liability difficult to determine for ailments like back sprains or other cumulative trauma disorders, Mr. Minkowitz said.

However, if an owner or trainer hires a jockey and requires him to ride whichever horse the owner or trainer designates, he is considered a "contract rider." There is usually no question that he is an employee and therefore eligible for workers compensation coverage, Mr. Minkowitz said.

All licensed racetrack personnel —including jockeys and exercise riders—are covered by a basic health and disability policy provided by racetracks through the Thoroughbred Racing Assn. of America. It provides up to $50,000 in medical benefits as well as up to $100 per week in indemnity benefits for approximately two years.

Those benefits are smaller than those payable under many state workers compensation laws and can be inadequate when, for example, an accident leaves a jockey paralyzed, Mr. Giovanni said.

"Our goal is to achieve workers compensation coverage for jockeys in all jurisdictions where they ride," Mr. Minkowitz said.

The Jockeys' Guild strongly endorses the New York amendments signed into law last month. Horse owners and trainers also supported the measures.

The new amendments state that jockeys, apprentice jockeys and exercise persons are "conclusively presumed" to be employees of a new, non-profit fund as well as employees of owners and trainers who are licensed to race horses in the state.

That "effectively removes any issue as to whether a jockey has been engaged as an independent contractor," Mr. Minkowitz said.

Owners and trainers will be required to contribute each year to the New York Jockey Injury Compensation Fund Inc., which will buy insurance for jockeys and other racing employees.

Owners and trainers also will benefit from the amendments, added Mr. Giovanni. Their projected cost for the group-purchased coverage—$150 to $175 a year—is "substantially" less than the approximately $350 that many now pay for individually purchased coverage.

Exclusive remedy provisions of the state work comp law also will protect horse owners and trainers from most lawsuits by injured jockeys.

Amendments to New York's law also require that one jockey representative join horsemen on the fund's seven-member board of directors as well as on a special track inspection team. That team's goal is to report the need for health and safety improvements to state racing officials while they are considering a racetrack's capital improvement plan to ensure that money is allocated for the improvements.

For example, the guild wants racetracks to install a cushioned inside rail—called a "Fontana rail"—to prevent a jockey who has been thrown from a horse from being impaled on rail slats.

Although it considers the New York law ideal, the guild says work comp programs in other states—like Maryland, New Jersey, California and Montana—are "acceptable," Mr. Giovanni said in an interview.

A fund in Maryland, for example, covers only jockeys, not apprentices or exercise riders.

The guild will encourage most states to adopt a New York-style law to better protect jockeys and save owners and trainers money, he said.

Once broad-based but economical workers compensation coverage for jockeys is established nationwide, the guild hopes that racetracks will replace their basic accident policy with a catastrophic plan that will provide high limits of coverage.

In return, jockeys have indicated a willingness to sign waivers that would prevent them from suing a racetrack in connection with injuries, Mr. Giovanni said.

For instance, Ron Turcotte, the jockey who rode Secretariat to the Triple Crown, sued the New York Racing Assn., owner of three New York tracks, for damages after he was paralyzed in a 1977 racing accident. That suit was dismissed on appeal (*BI*, Dec. 8, 1986).

Racetracks would benefit from such an arrangement because they would no longer face lawsuits for operating an unsafe worksite and would probably pay less for catastrophic health and disability coverage than they now pay for the basic coverage, Mr. Rhulen said. ■

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InsurerTopics

A special editorial section sent exclusively to insurers and reinsurers

Education's day in the sun

Insurers pay tuition, bonuses for school-bound employees

By MARK A. HOFMANN

Insurers are doing more with less.

As fewer new workers enter an increasingly complex and competitive marketplace, both property/casualty and life insurers are aggressively encouraging employees to hone their professional skills.

Companies still promote in-house education, but are turning increasingly to outside sources. Rewards for employees include tuition aid—in some cases prepaid—and sizable bonuses.

This year, for example, 5,829 Hartford Insurance Group employees have taken the Insurance Institute of America's Introduction to Property and Liability Insurance course, said Frank Scanlon, a Hartford assistant vp.

Of those, 5,160—or 88.5%—passed the exam. Non-executive-level personnel who pass the exam receive a $100 bonus; when executives pass, $100 is donated to the charity of their choice, he said.

The Hartford, Conn.-based insurer has long encouraged continuing education, but has "significantly" increased the rewards only this year, says Mr. Scanlon. A heigtened emphasis on education is part of an "Excellence at Work Initiative" designed to make employees more customer-oriented.

State Farm Group has always encouraged education, said William Grogg, the Bloomington, Ill.-based insurer's manager of education and training. "What we've got going for us is tradition."

As scrutiny and criticism of the industry increase, this commitment becomes more important, Mr. Grogg said. Companies need knowledgeable spokespeople in both official and unofficial capacities. An example of the latter, he said, would be answering a neighbor's question about an industry practice. "We want to be as articulate as we can be on all the issues."

A heightened interest in employee education shows up in the surge of examination essays the IIA is grading, said President Norman Baglini. About 65,000 CPCU and IIA essay exams were administered in 1985; that figure doubled by 1990.

Much of the dramatic growth has occurred in the most basic courses. Of the approximately 55,000 introductory course exams that have been graded since the program began in 1985, 15,000 were graded during the just-ended fiscal year, he said.

A "majority" of those taking the exams are insurance company employees, said Mr. Baglini, though he was uncertain of the breakdown among employees of insurers, agencies, brokerages, trade associations and other enterprises that might encourage their personnel to take the course.

Insurers have two major goals in using the course, he said.

First, companies want to provide professional and technical personnel with greater knowledge of the workings of the insurance business early in their careers. Insurers also want data processors and other support staffers who do not need detailed knowledge to have a basic understanding of the industry.

According to Mr. Baglini, three other programs are of special interest to insurers.

Technical experts who need broader business knowledge to move into administrative positions favor the Chartered Property and Casualty Underwriter program. And general insurance and the Associate in Risk Management courses also have been growing in popularity.

Companies most heavily promote the CPCU designation, human resources officials say.

"CPCU is by far and away our flagship," said Larry Weidemier, a manager of employee training in the commercial insurance division of Aetna Life & Casualty Co.

Since 1988, the number of commercial division employees achieving the CPCU designation had jumped to about 90—depending on the latest exam results—from 35. Mr. Weidemier would not say how large a financial incentive the Hartford, Conn.-based company offered, calling it "proprietary information."

One tactic Aetna uses to attract people to the CPCU and other IIA courses is prepayment. Employees "don't have to front the money," he said. "It makes it so much easier."

Mr. Weidemier added that when he began working toward the designation more than 20 years ago, prepayment had not yet become a widespread industry practice.

Mike Schlosser, vp-training and development for the commercial units of Crum & Forster Inc., agreed on the allure of the CPCU.

Annual bonuses of $1,000 are given to employees for three years after they achieve the designation. In addition, said Mr. Schlosser, the Basking Ridge, N.J.-based insurer awards the employees expense-paid trips for two to the Society of CPCU annual convention to receive their designations. "We found that many of the people receive additional support at home."

Bonuses at Hartford this year are considerably more lucrative.

Employees receive $400 for each of the 10 CPCU sections completed plus a one-time bonus of $2,000 upon passing the 10th examination, said Hartford's Mr. Scanlon.

This compensation represents a "significantly enhanced" incentive over that offered previously, said Mr. Scanlon, who would not close the size of previous bonuses.

Charles Edinger, executive vp of the New York-based College of Insurance, offered two possible reasons for the interest in the CPCU program.

Recognition is the first. "Clients seem to recognize that the CPCU designates a certain level of expertise," he said.

The other reason has less to do with the technical aspects of the designation than with the persistence and interest required to achieve it. People willing to put in the time and effort to pass 10 examinations demonstrate "the kinds of qualities that are looked for in any organization," he said.

Crum & Forster's Mr. Schlosser also reported interest in the ARM courses cited by Mr. Baglini. "We feel that the ARM gives employees a good view of the insurance industry without getting too detailed in underwriting," he said.

At the Insurance Educational Assn. of San Francisco, "we see a lot of growth in the whole area of risk management," particularly in pursuit of the ARM, said Roger Smith, president of the industry-supported, non-profit group.

Among State Farm employees, general insurance courses—completion of which does not lead to professional designations—were probably the most popular offerings, Mr. Grogg said.

Aetna's Mr. Weidemier said the general insurance courses attract technical and administrative personnel rather than management. "A lot of people will take these as an entree to CPCU," he said.

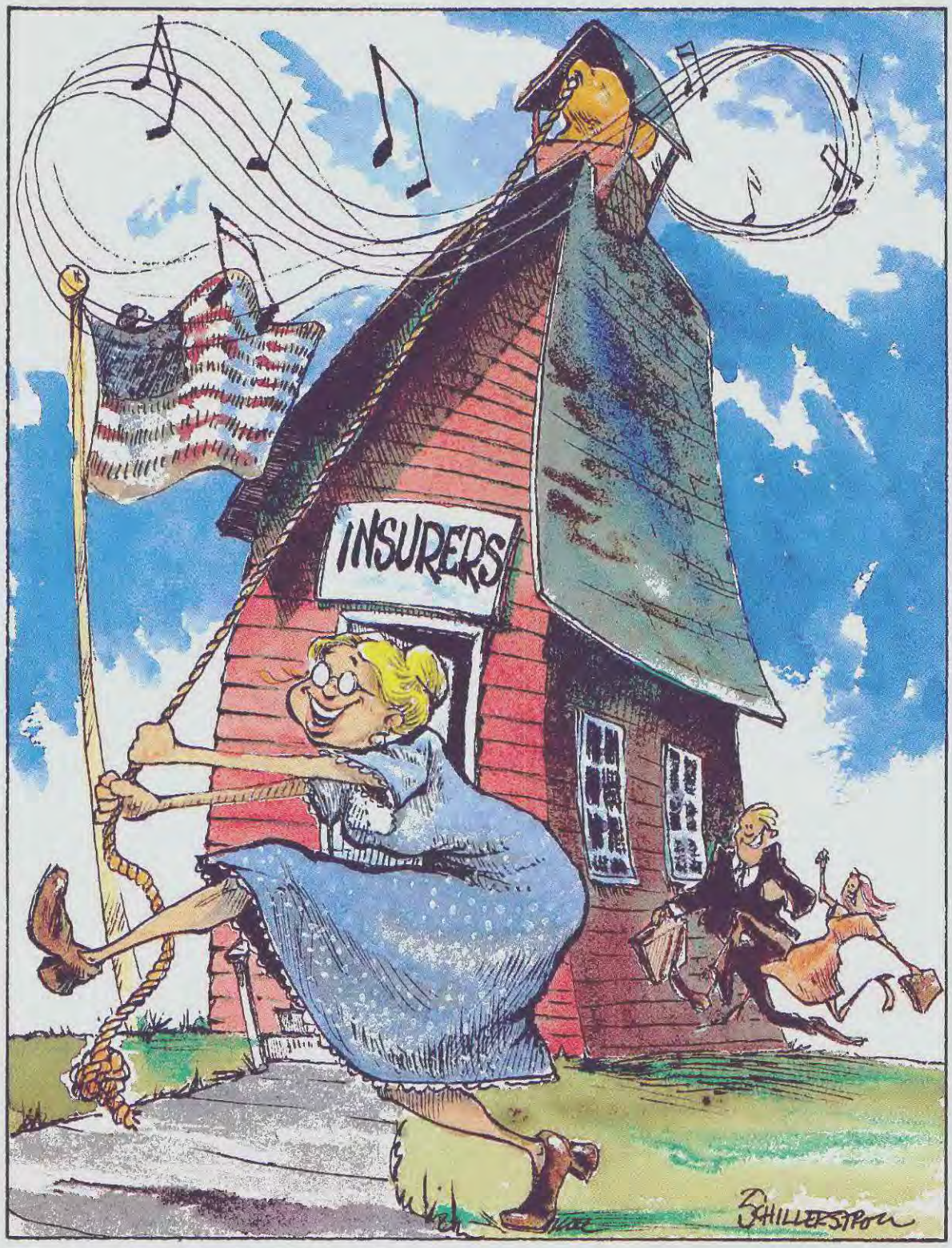
Other courses cited as particularly useful by insurers lead to such specialty-oriented designations as associate in claims and associate in underwriting.

Aetna's Mr. Weidemier noted, however, that even the Certified Insurance Counselor designation, traditionally of interest mostly to agents, is gaining popularity among Aetna marketing professionals.

Cost-effectiveness is a key reason insurers like professional designation-related courses, said Hartford's Mr. Scanlon. Much of the work is done on employees' own time, allowing them to maintain regular work schedules.

And the costs are low. For example, each CPCU course, including study materials and an exam, is

Continued on next page



Insurer Topics

Education efforts

Continued from previous page

about $150 including an exam and a one-time matriculation fee, according to the IIA. Other designations cost less to pursue.

Supporting IIA programs has not overshadowed in-house educational efforts, insurers say.

The St. Paul Cos. Inc. follows a "train the trainers" strategy in promoting its own programs, said Mickey Mulcahy, employee development officer with the St. Paul, Minn.-based company.

As an example, she cites negotiation programs for claims handlers and underwriters. Human resources personnel identified "a core group" of line managers from offices across the country who came to St. Paul's headquarters to participate.

Sending those managers back to their offices to teach subordinates "enables us to provide more training more readily at a lower cost," Ms. Mulcahy said.

Several initiatives begun since 1987 are designed to improve customer service.

An orientation program called "Directions" relies heavily on video to impress upon newly hired workers "the impact of customer service on St. Paul," she said. A "service management" lecture program seeks to give teams of managers the skills they need to motivate their subordinates effectively; and a third program—called "Service Plus"—presents situations tailored to St. Paul's products and services and instructs employees on how to handle them.

One of the more popular in-house programs Aetna offers culminates in the award of a data processor certificate. The program, aimed at both automation employees and users of electronic data processing systems, provides an overview of automated systems Aetna uses, Mr. Weidemier said.

At Kemper Group's national property/casualty companies, employees receive "career development guides" that promote education needed to advance in a given area such as underwriting, said Barbara Brooks, director of corporate education for the Long Grove, Ill.-based insurer. Ms. Brooks said the guides are a "package of information and strategies."

Career progression charts show employees how to move from one job to another within the company, Ms. Brooks said.

Core development plans define by each job title the desirable "training and development activities required for a position," including IIA courses, in-house seminars and programs at nearby colleges, she said.

Although life insurers have their own lore to impart, their educational efforts follow much the same path as their property/casualty counterparts. Financial incentives and tuition reimbursement encourage employees to pursue professional education that leads to widely recognized designations.

However, instead of having one facility preparing curricula and grading examinations leading to professional designations, the life insurance industry has two—the American College of Bryn Mawr, Pa., and the Life Office Management Assn. in Atlanta, better known as LOMA.

The American College administers the Chartered Life Underwriter and Chartered Financial Consultant designations. LOMA administers the Fellow, Life Management Institute program. LOMA also offers an Associate, Customer Services program and offers the Associate in Research and Planning in conjunction with the Insurance Institute of America.

The FLMI program is "company-based," said William Rabel, LOMA's senior vp-education and training. The CLU program, on the other hand, has been favored traditionally by agents, said John Grimes, the American College's director of company relations. Both say the programs, rather than being competitors, complement one another.

Mr. Grimes said, however, that he has "seen an increase of interest at the home office" in the CLU designation during recent years. Company administrators "need to be talking the same language" as their agents, he said.

Mr. Grimes said that three main groups of home office personnel appear to be interested in the CLU: agency support employees such as marketing personnel and trainers; advanced sales personnel, many of whom are certified public accountants; and advanced underwriters.

Like property/casualty insurers, life companies offer incentives to employees taking the courses.

"We have a specific incentive program, which is currently under review," said Ginger Ward, a human resources manager for UNUM Life Insurance Co. Ms. Ward said that in addition to reimbursing employees for the costs of pursuing professional designations, the Portland, Maine-based insurer currently pays successful CLU candidates $1,500.

"Over the past three years, I've seen a marked increase" in employees' interest in professional education, said Ms. Ward. A major reason for the increase is a realization by executives that they and their subordinates must be "constantly learning" to stay competitive, she said.

At State Farm, Mr. Grogg said, 241 employees earned the CLU designation last year. About half were agents and half company people, he estimated. By contrast, the 199 CPCU designees and 33 FLMI designees were almost all company people, he noted.

Not all employees who begin the LOMA courses complete the series, however.

Many stop after passing the exams for "Principles of Life and Health Insurance" and "Life and Health Insurance Company Operations," said Lorna Simon, managing consultant in the human resources development and training department at Metropolitan Life Insurance Co. of New York.

Those passing the two courses, designated Level I, receive a LOMA certificate.

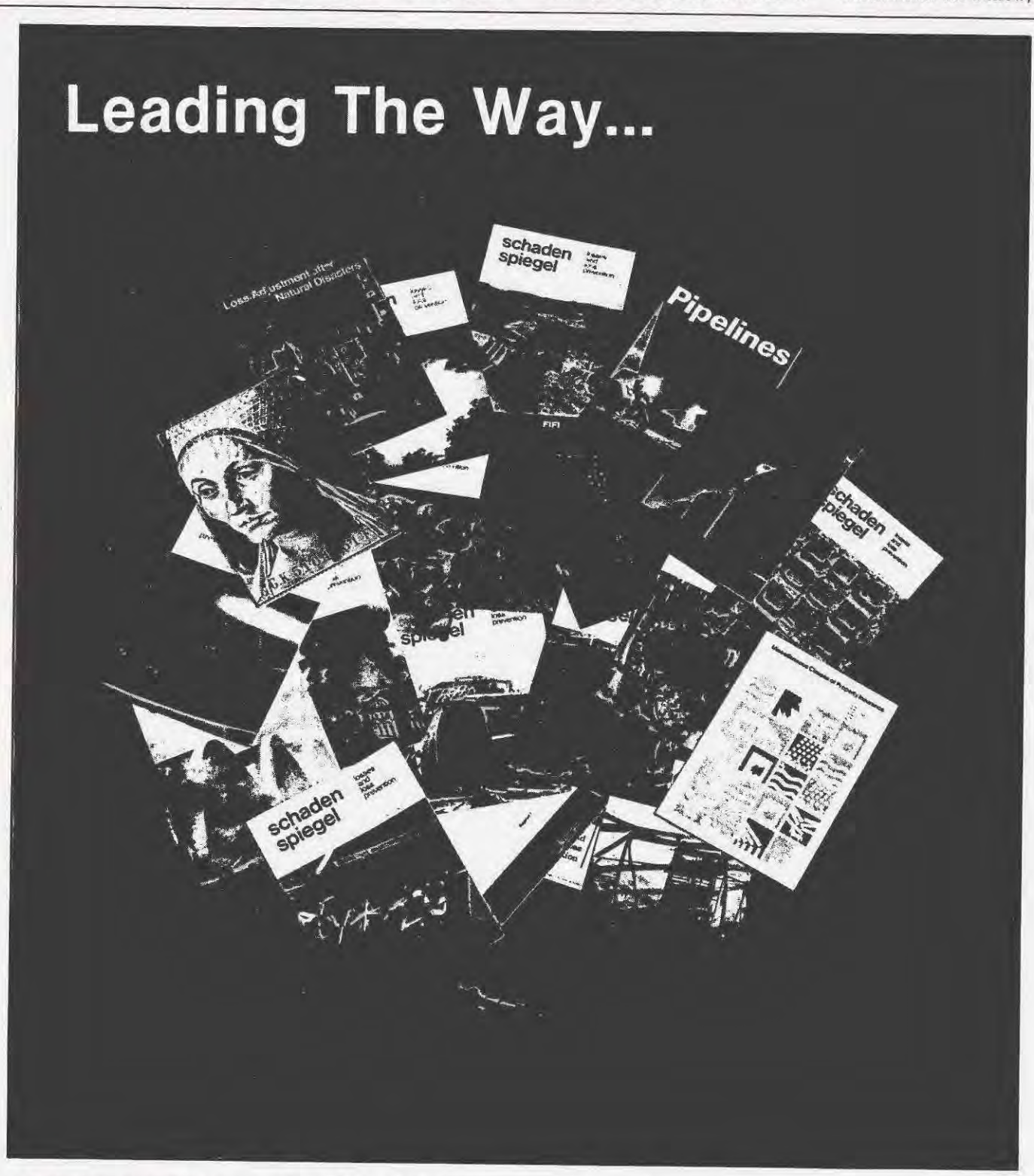
Increased competition among life insurers may be having an ironic impact on employee education, said LOMA's Mr. Rabel.

"Our experience suggests that companies are interested" in promoting professional education and have grown "more generous" in their support of it, he said. However, because of reductions in the size of workforces among life insurers, the professionals who remain simply don't have as much time to devote to education, he said.

Samuel Weese, president of the American College, agreed that there may be fewer life insurance agents and home office personnel in the future. "The numbers may not be as great in the future, but there will be a higher percentage with advanced education," he said.

Mr. Rabel noted that companies of all kinds will have fewer people to pick from when staffing. He estimated that 85% of the workforce of the year 2000 is already on the job. "The way you're going to be profitable is to have smart people make good decisions for you. They're here now."

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Insurer Topics

Education efforts

Continued from page 16B

"The only way to get people up to speed is through continuing education and professional development," he added.

The concerns of property/casualty insurers are much the same. Kemper's Ms. Brooks said that in general, employee skills become obsolete in about five years regardless of the industry. The constant obsolescence "necessitates that we be involved in ongoing education. It's just a fact of life nowadays," she said.

"There's going to be a shortage of knowledge workers in the next decade and beyond," said the IIA's Mr. Baglini. "The demographic influence has impacted us and I expect it will continue to do so," agreed St. Paul's Ms. Mulcahy.

Crum & Forster's Mr. Schlosser said one of the biggest problems insurers face is convincing employees just how complex the business is. "If we don't have our people involved in professional education, we think we're being remiss as we look to the future," he said.

Education programs can help companies compete for employees as well as for customers, experts say.

When the most able and enthusiastic employees sign on, "the opportunity to continue their development is what they're looking for," Mr. Schlosser said. If they don't find this opportunity with one company, they'll move to another, he said.

State Farm's Mr. Grogg added that once a company makes a commitment to continuing education, it can't tie the strength of that commitment to the ups and downs of the market cycle.

The fluctuations of the market have not shaken State Farm's resolve on employee education, he said. ■

Many designation programs offered to insurer employees

The most widely recognized professional designations and professional education programs in the property/casualty insurance industry are administered by the Malvern, Pa.-based American Institute for Property and Liability Underwriters and the Insurance Institute of America, collectively known as the Insurance Institutes of America.

The life insurance industry has two widely recognized organizations granting educational and professional designations: the Bryn Mawr, Pa.-based American College and the Atlanta-based Life Office Management Assn.

A list of the major programs offered by each institution follows:

The Insurance Institutes of America

• Chartered Property Casualty Underwriter: This program—leading to the CPCU designation—is designed for experienced insurance professionals. Candidates must pass national essay examinations that test their knowledge of 10 areas of insurance. The 10 CPCU courses are: CPCU 1, "Principles of Risk Management and Insurance"; CPCU 2, "Personal Risk Management and Insurance"; CPCU 3, "Commercial Property Risk Management and Insurance"; CPCU 4, "Commercial Liability Risk Management and Insurance"; CPCU 5, "Insurance Company Operations"; CPCU 6, "Legal Environment of Insurance"; CPCU 7, "Management"; CPCU 8, "Accounting and Finance"; CPCU 9, "Economics"; and CPCU 10, "Insurance Issues and Professional Ethics."

In addition, a successful candidate must have at least three years' industry experience and agree to abide by the American Institute for Property & Casualty Underwriters' code of professional ethics.

• Associate in Claims: The four-course AIC program, which was developed with the Des Plaines, Ill.-based National Assn. of Independent Insurers, is aimed primarily at experienced claims adjusters, supervisors and examiners. Candidates must pass an essay examination dealing with each of four courses, which include: AIC 33, "The Claims Person and the Public"; AIC 34, "Principles of Property and Liability Claims Adjusting"; AIC 35, "Property Loss Adjusting"; and AIC 36, "Liability Insurance Adjusting."

• Associate in Underwriting: Another four-course program, the AU designation is aimed at both insurance company underwriters and managers and agency underwriters. The four essay examinations that must be passed to achieve the designation are drawn from: AU 61, "Principles of Property and Liability Underwriting"; AU 62, "Personal Lines Underwriting"; AU 63, "Commercial Liability Underwriting"; and AU 64, "Commercial Property and Multiple Lines Underwriting."

• Associate in Risk Management The ARM program is a three-course program developed in conjunction with the New York-based Risk & Insurance Management Society. Its target audience includes corporate risk managers, agents, insurance company commercial lines specialists and safety personnel. The examinations that must be passed are drawn from information contained in ARM 54, "Essentials of the Risk Management Process"; ARM 55, "Essentials of Risk Control"; and ARM 56, "Essentials of Risk Financing."

• Associate in Loss Control Management: Achieving the ALCM designation requires passing five examinations, two of which are drawn from CPCU courses. The designation is designed for insurer loss control professionals, corporate loss-control officials and agency, consulting or brokerage personnel involved in loss control. The ALCM courses are ALCM 74, "Accident Prevention"; ALCM 75, "Property Protection"; and ALCM 76, "Industrial and Environmental Hygiene." The candidate must also pass the examinations given in two of three CPCU courses: CPCU 1, CPCU 5 and CPCU 7.

• Associate in Premium Auditing: This designation, developed with the assistance of the National Society of Insurance Premium Auditors for premium auditors, requires passing six examinations. Coursework includes APA 91, "Principles of Premium Auditing," and APA 92, "Premium Auditing Applications," as well as CPCU 1, CPCU 3, CPCU 4 and CPCU 8.

• Associate in Reinsurance (ARe): The newest designation, for which classes begin next month, targets reinsurance professionals.

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Courses

Continued from page 16D

To earn the ARe designation, which was developed with support from the Society of CPCU's Reinsurance Section and the Brokers & Reinsurance Markets Assn., candidates must pass examinations based on ARe 141, "Principles of Reinsurance," and ARe 142, "Reinsurance Practices," as well as CPCU 5 and CPCU 8.

• Associate in Marine Insurance Management: This AMIM program, developed with the American Institute of Marine Underwriters and the Inland Marine Underwriters Assn., is designed for underwriters, agents, adjusters and others involved in marine insurance. Candidates must pass six exams based on six courses: AMIM 121, "Ocean Marine Insurance" and AMIM 122, "Inland Marine Insurance," as well as CPCU 1, CPCU 5, CPCU 6 and CPCU 7.

• Associate in Management: The AIM program is aimed at technical experts who need to understand insurance management. Candidates must pass four exams to achieve the AIM designation. Coursework is composed of AIM 41, "Process of Management"; AIM 42, "Management and Human Resources"; AIM 43, "Managerial Decision-making"; and AIM 44, "Management in a Changing World." The AIM designation waives the CPCU 7 exam.

• Associate in Automation Management: The AAM designation is designed for anyone in insurance whose job involves working with computers. The automation designation, which was developed in conjunction with the National Assn. of Insurance Women, requires passing three exams that draw upon information provided by AAM 131, "Essentials of Automation"; AAM 132, "Automation in Insurance"; and AAM 133, "Managing Automated Activities."

• Associate in Insurance Accounting and Finance: The AIAF designation is aimed at insurance company accountants, statisticians and financial experts. Four exams must be passed: AIAF 111, "Statutory Accounting for Property and Liability Insurers"; AIAF 112, "Insurance Information Systems"; AIAF 113, "Insurance Company Finance"; and CPCU 5.

• Associate in Research and Planning: The six-course ARP program was designed in cooperation with the Society of Insurance Research. It is targeted at planning, research, forecasting and issues management personnel. Candidates must pass exams based on ARP 101, "Business Research Methods," and ARP 102, "Strategic Planning for Insurers," as well as CPCU 1, CPCU 5, CPCU 9 and CPCU 10.

• Accredited Advisor in Insurance: The AAI program, designed for agents and brokers, requires passing three exams: AAI 81, "Principles of Insurance Production"; AAI 82, "Multiple Lines Insurance Production"; and AAI 83, "Agency Operations and Sales Management."

• Introduction to Property and Liability Insurance: This program is designed to give anyone in the insurance industry a basic understanding of how insurance works. Successful candidates in the 11-week program receive a certificate of completion.

• Introduction to Claims: A seven-week course aimed at people who need a basic knowledge of claims-handling terms and practices, Introduction to Claims requires passing an examination to receive a certificate of completion.

• Program in Supervisory Management: This program was designed for insurance company and agency supervisors who oversee technical work, clerical work or other activities. It consists of two courses: SM 18, "Essentials of Supervision," and SM 19, "Supervisory Skills." Successful candidates receive a certificate of completion.

• Program in General Insurance: This three-course program is aimed at people in the insurance industry who have technical jobs and desire an overview of insurance principles. The three courses are INS 21, "Property and Liability Insurance Principles"; INS 22, "Personal Insurance"; and INS 23, "Commercial Insurance." Those who pass the examinations receive a certificate of completion.

American College

• The Chartered Life Underwriter designation can be earned with specializations in either life insurance or personal insurance. Each concentration requires passing six required courses and four electives.

The courses required for the CLU life insurance specialization are: HS 323, "Individual Insurance"; HS 324, "Life Insurance Law"; HS 325, "Group Benefits"; HS 320 "Introduction to Financial Planning"; HS 321, "Income Taxation"; and HS 328, "Investments." The electives are HS 322, "The Financial System in the Economy"; HS 326, "Planning for Retirement Needs"; HS 330, "Fundamentals of Estate Planning I"; HS 331, "Planning for Business Owners and Professionals"; and HS 334, "Fundamentals of Estate Planning II."

The courses required for the CLU personal insurance specialization are: HS 315, "Personal Risk Management and Insurance I"; HS 316, "Personal Risk Management and Insurance II"; HS 317, "Multiline Insurance Law and Operations"; HS 320; HS 321 and HS 328. Personal insurance specialists can pick from the same list of electives plus HS 325.

• The Chartered Financial Consultant or ChFC designation requires completion of HS 332, "Financial Planning Applications plus HS 320, HS 321, HS 323, HS 328 and HS 330. In addition, the candidate must pass four electives from a slate of seven: HS 329, "Wealth Accumulation Planning"; HS 336, "Decision-making at Retirement"; HS 337, "Business Taxation and Planning"; HS 339, "Computerizing a Financial Planning Practice" HS 327, "Employee Benefits"; and HS 331 and HS 332.

Life Office Management Assn.

To achieve the Fellow, Life Management Institute designation requires passing nine required courses and one elective. The required courses are: "Principles of Life and Health Insurance"; "Life and Health Insurance Company Operations"; "Legal Aspects of Life and Health Insurance"; "Marketing Life and Health Insurance"; "Management of Organizations and Human Resources"; "Information Management in Insurance Companies"; "Accounting in Life and Health Insurance Companies"; "Economics and Investments"; and "Mathematics of Life and Health Insurance." The elective can be chosen from a list of 10 courses: "Life and Health Insurance Claims"; "Financial Management"; "Financial Services"; "Group Insurance"; "Human Resources Administration"; "Information Systems"; "Managerial Accounting"; "Management Science"; "Pension Planning"; and "Selection of Risks." ■

September

Conferences & Exhibits

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Issue: September 17
Ad Closing: September 5

October

Claims Automation & CPCU Report

Today's technology provides claims departments with more than statistics ... now qualitative information — programs that offer value judgements — are also available. From the detection of insurance fraud to artificial intelligence, BI editors will report on how insurers are using advanced automation systems to improve their operations. Also in this section — a report on the Chartered Property & Casualty Underwriters conference.

Issue: October 15
Ad Closing: October 3

November

Reinsurance Issues & Relations With Intermediaries

BI editors will report on how insurance companies select reinsurance intermediaries — what they look for and what they expect. In addition, this section will reveal how direct writers — reinsurers not marketing their coverage through an intermediary — approach insurance companies as well as how insurers interact with direct writers.

Issue: November 19
Ad Closing: November 6

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Insurer Topics

Insurer Topics

Teacher education program slowly expands

By MARK A. HOFMANN

INDIANAPOLIS—The Insurance Education Foundation says it is stressing quality rather than quantity in expanding its continuing education and public relations program for high school teachers.

"We want to adhere to strict standards," said Larry Forrester, president of the National Assn. of Mutual Insurance Companies, an Indianapolis-based trade group that founded IEF in 1988. Mr. Forrester says his organization is "extremely pleased" with the results of the teacher workshops.

The Indianapolis-based foundation is supported by donations from NAMIC members, other companies, agent associations and others. "It really does have some broad industry support," he said.

The IEF raised about $482,000 during the fiscal year ended Aug. 1, 1990, said IEF Chairman James Osborne, chairman of McMinnville, Ore-based Oregon Mutual Insurance Co.

Mr. Osborne said the group's initial projection of raising $1 million in its first year of operation "may have been a little naive" (*BI*, Aug. 21, 1989). He noted, however, that IEF still hopes to attract annual contributions of $1 million within the next few years. The money is used to pay for the annual workshops, which Mr. Osborne estimated cost about $50,000 each, and for the distribution of "Choice-Chance-Control" teaching kits that explain basic insurance terms and practices to high school students.

Amy Geffen, vp-professional programs for The College of Insurance in New York, also considers the program a success. "I think it's extremely successful. The participants learn a great deal about insurance and have abundant opportunities to share ideas with their fellow teachers," she said.

To participate, teachers must apply to either site of the workshops—The College of Insurance or the Insurance Center at Drake University in Des Moines, Iowa. Incentives for doing so are high: Those who complete the two-week course receive three hours of graduate credit. And all tuition, books, room and board are provided by IEF grants.

Each teacher receives a copy of "Choice-Chance-Control," a 20-minute IEF video designed to explain insurance basics in a humorous way. Travel and incidentals are participants' only out-of-pocket expenses.

Participating teachers "really appreciate" the low costs, said Linda Hanson, manager of professional insurance education and conferences at Drake's insurance center. "They don't often get many things for free."

At The College of Insurance, enrollment in teacher workshops has grown to 41 this year from 23 in 1989, the first year the workshops were offered.

The College of Insurance encourages participation by minority teachers. About a quarter of this year's participants were members of minority groups and others teaching in inner-city schools, said Ms. Geffen.

At Drake, 38 teachers have enrolled in each of the three years workshops have been offered. Students come primarily from the Midwest and generally teach business or consumer education, said Ms. Hanson. This year, only one participating teacher at Drake was a minority group member.

Ms. Hanson pointed out that the curriculum used at the workshops draws upon one created more than a decade ago for an insurance education workshop developed for Des Moines-area teachers. "The curriculum has stayed pretty much the same," she said.

During the two-week workshops, students at both campuses receive instruction in the basics of property and casualty insurance. The instructors, faculty members from the colleges, give special attention to personal automobile and homeowners insurance, life insurance, workers compensation and insurance company operations.

"This not only helps them as teachers, but as consumers, too," said Drake's Ms. Hanson.

Students at workshops also meet with industry experts, like insurance executives and state regulators. For example, participants at the New York workshop visited The Home Insurance Co.

Ms. Geffen said the workshops have a public relations as well as an educational impact. "The participants learned more about insurance, but also some who came in with a negative view of the insurance industry went away with a more positive view," she said.

NAMIC's Mr. Forrester said that although the IEF initially intended to add a campus to the program each year until a workshop took place in every region of the country, the group is more concerned about maintaining program standards than expanding for the sake of expanding.

Earlier this summer, Mr. Osborne said, a state-level educational organization called the Oregon Insurance Education Foundation used its own funds to initiate a teacher workshop at Oregon State University at Corvallis, Ore. Twenty-five teachers attended the workshop, which used IEF materials.

"Different states will set up different programs," he said.

As IEF fund-raising picks up, the number of programs funded by the national foundation will increase, said Mr. Osborne. He said that to assure that the programs are "independent and objective," IEF will limit possible workshop sites to colleges and universities that offer an insurance curriculum. About 70 institutions currently offer insurance courses, although in some cases the offerings are very limited and would eliminate a school from the list of possible sites.

Some simple arithmetic, Mr. Forrester said, puts the programs' impact in perspective. If each of the 40 high school teachers that participate each year teaches three classes of about 30 students, "it becomes very impressive on how many young people we reach."

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Insurer Topics

To bolster its image, insurer adopts classroom tactics

By MARK A. HOFMANN

CHICAGO—A Chicago insurer is betting on an innovative high-school education program to help improve the industry's dismal image and draw talented young people into its ranks.

Other insurers have participated in the Chicago public school system's 9-year-old "Adopt-a-School" program by donating computer equipment to schools. But Interstate National Corp. this year became the first to provide the materials and support for a course in insurance, which was taken for credit by 25 students.

And the Fireman's Fund Insurance Co. unit intends to repeat the series of hour-long classes at Hirsch Metro High School in Chicago, says Patrick S. O'Flynn, its chief executive officer.

Interstate, said Mr. O'Flynn, is willing to help other Chicago-area insurers that want to start a similar effort at other city schools through the Adopt-a-School program.

"Like a lot of people in the insurance industry, we share the frustration at our inability to improve our relations," he said.

The curriculum used at Hirsch drew upon "Choice-Chance-Control," a program the Insurance Education Foundation developed to teach insurance principles to high school teachers (*IT*, Aug. 21, 1989).

Christopher R. Pett, Interstate's education and communication specialist, said the Hirsch program "related everything to personal auto" insurance as a means of piquing students' interest.

For example, to answer questions like "How come kids have to pay such high rates for auto insurance?" the course explained how rating works, Mr. Pett said. Later lessons on underwriting principles had students examine what constituted acceptable and unacceptable risks among teenage drivers, he said.

Most of the 25 students in the weekly, hour-long classes were in Hirsch's computer science program, Mr. Pett said. Classes ran from February to June, although holidays and vacations held the number of sessions to 12.

The course, offered an elective, was taught by Interstate employees primarily from the underwriting and claims departments, said Mr. Pett. Because the students had technical backgrounds, the course was promoted in part as a chance to learn more about an industry that relies on computers, he said.

Students were skeptical. "The first questions were: 'Why are rates so high?' and 'Are you regulated?' " said Carole Newman, Interstate's general counsel and human resources vp.

What students appeared to enjoy the most was having Interstate employees speak about their careers and daily challenges, said Mr. Pett. "It was a great opportunity to use our in-house talent."

Participating in the program also generated pride among Interstate employees. "It's not often that we get to talk about our own interests," Mr. O'Flynn said.

As their final project, the students wrote and shot videotapes illustrating what they'd learned about insurance. They also visited Interstate's Chicago headquarters.

The program ended with a June 6 career day at Hirsch, where Interstate representatives discussed career opportunities. A few weeks later, six Hirsch students began eight-week internships at Interstate.

Interns worked on special projects in a half-dozen areas: underwriting, claims, government affairs, corporate services, human resources and finance, Mr. Pett said.

Mr. O'Flynn noted that when students began the insurance program at Hirsch, they had the usual perceptions about insurance—"the negative ones."

Sonia Johnigan, one of the six student interns, said that before taking the course, "the only knowledge of insurance I had was paying the premium."

Max Reed, an intern in the finance area who is working on a reinsurance project, said that the information presented in the program "was all new" when he first sat down in class but that his interest picked up as the program progressed.

Although Mr. Reed said that he is not certain that he will pursue an insurance career, he found the course of interest in his pursuit of a career in accounting and finance.

Mr. O'Flynn called the change in students' perception and knowledge of the insurance industry wrought by the program "remarkable."

Mr. Pett said that Interstate spent less than $1,000 on its program, declining to be more specific.

Implementing the program probably took more time and effort than originally expected, Mr. O'Flynn said, leaving no doubt that he considered the extra work worthwhile.

Noting that the program involved teachers as well as students, Mr. O'Flynn predicted that the teachers would pass on some of their new insurance knowledge to other students in business classes.

"If each company, agency and brokerage had a similar approach, the result would be remarkable," Mr. O'Flynn said. ■

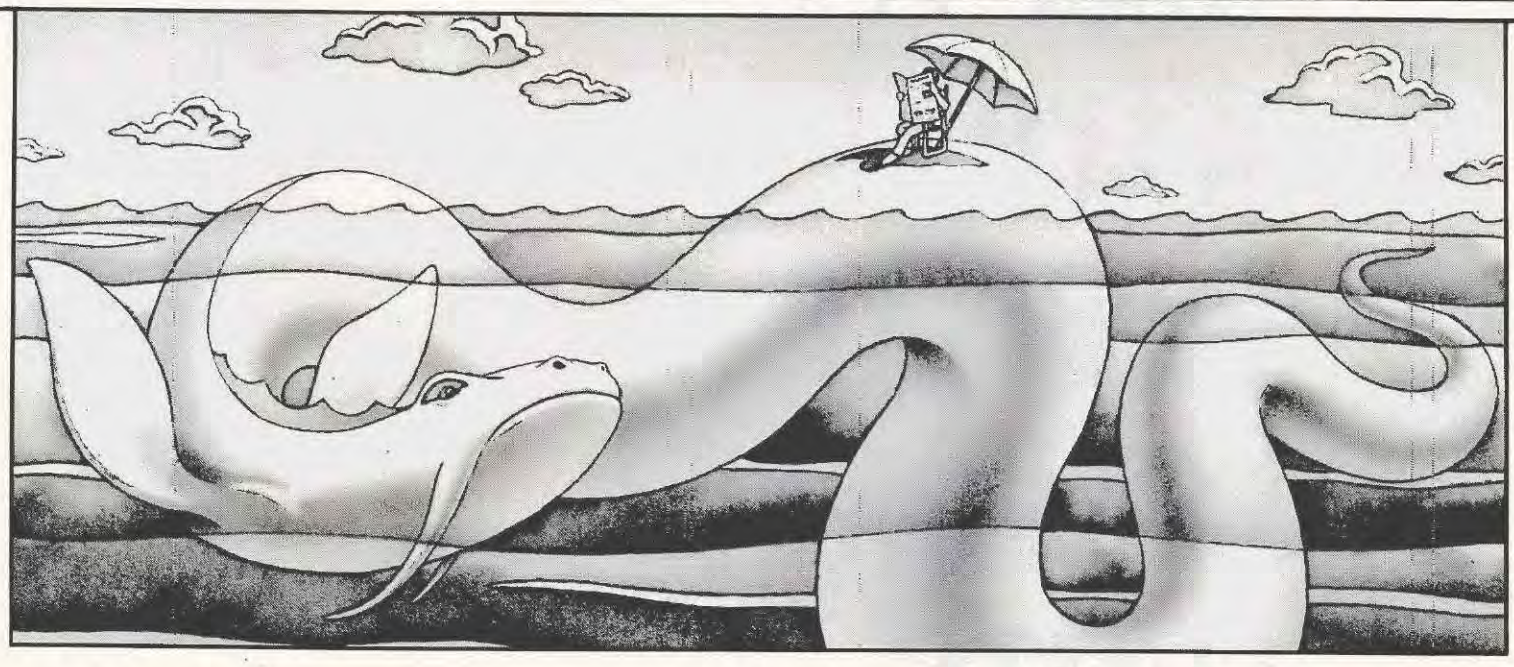
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Datebook

AUGUST

AUG. 27-30. Product Safety and Liability Prevention course in Madison, Wis., sponsored by the University of Wisconsin-Madison Extension; $995. The Wisconsin Center, 702 Langdon St., Madison, Wis. 53706; 608-263-4712 or 608-263-3370.

SEPTEMBER

SEPT. 5. Arbitration Forum Seminar Program in Philadelphia, sponsored by Arbitration Forums Inc.; $95; $75 each for three or more attendees from the same organization. **Also Sept. 6** in Baltimore. Arbitration Forums Inc., 200 White Plains Road, P.O. Box 66, Tarrytown, N.Y. 10591-0066; 914-332-4770.

SEPT. 5. Workers Compensation Seminar in Rockford, Ill., sponsored by the Illinois State Chamber of Commerce; $120 for ISCC members; $180 for non-members. **Also Sept. 6** in Peoria, Ill.; **Sept. 11** in Springfield, Ill.; and **Sept. 13** in Chicago. Illinois State Chamber of Commerce, 20 N. Wacker Drive, Chicago, Ill. 60606-3083; 312-372-7373.

SEPT. 5-7. Techniques of Risk Management course in Vancouver, B.C., sponsored by the Risk & Insurance Management Society Inc.; $540 for RIMS members; $640 for non-members. **Also Dec. 5-7** in New York City. Risk & Insurance Management Society Inc., Education Department, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

SEPT. 5-7. An Introduction to International Employee Benefits conference in Chicago, sponsored by International Benefits Information Service and Charles D. Spencer & Associates Inc.; $780. International Benefits Information Service, 250 S. Wacker Drive, Suite 600, Chicago, Ill. 60606-5834; 312-993-7900.

SEPT. 6. Information Strategies to Manage Your Health Care Costs seminar in Chicago, sponsored by the National Assn. of Health Data Organizations; fee for NAHDO public associate and supporting members; $125 for NAHDO individual members and non-members. National Assn. of Health Data Organizations, 316 Pennsylvania Ave. S.E., Suite 202, Washington, D.C. 20003; 202-546-5881.

SEPT. 9-10. Evaluating Case Mix, Severity of Illness and Health Status in HMOs conference in Washington, sponsored by Group Health Assn. of America; $315 for GHAA members; $425 for non-members. **Also Dec. 2-3** in Los Angeles. Group Health Assn. of America, Dept. 0612, Washington, DC 20073-0612; 202-778-3230.

SEPT. 9-11. Annual American Assn. of Preferred Provider Organizations Conference in New Orleans; $425 for AAPPO members; $525 for non-members. American Assn. of Preferred Provider Organizations, 111 E. Wacker Drive, Suite 600, Chicago, Ill. 60601; 312-644-6610, Ext. 3270.

SEPT. 10-11. 1990 Casualty Loss Reserve Seminar in Dallas, cosponsored by the American Academy of Actuaries, the Casualty Actuarial Society and the Conference of Actuaries in Public Practice; $375 for members of the three sponsoring organizations; $450 for non-members. American Academy of Actuaries, 1720 I St., N.W., Seventh Floor, Washington, D.C. 20006; 202-223-8196.

SEPT. 10-11. Insurance Investigative Accounting and Auditing Conference in New York City, sponsored by Executive Enterprises Inc.; $1,045. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

SEPT. 10-12. Insurance Accounting and Statutory Statement Preparation Conference in New York City, sponsored by Executive Enterprises Inc.; $1,045. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

SEPT. 10-12. Fundamentals of Insurance course in Chicago, sponsored by the Risk & Insurance Management Society Inc.; $495 for RIMS members; $595 for non-members. **Also Dec. 3-5** in New York City. Risk & Insurance Management Society Inc., Education Department, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

SEPT. 10-14. Fundamentals of Employee Benefits Management course in Brookfield, Wis., sponsored by the International Foundation of Employee Benefit Plans; $1,000 for IFEBP members; $1,125 for non-members. **Also Oct. 22-26** in Brookfield, Wis. IFEBP, Registration Department, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

SEPT. 10-14. Certificate in Environmental Health & Safety Law program in Las Vegas, Nev., sponsored by the Institute for Applied Management & Law Inc.; $1,475. Institute for Applied Management & Law Inc., 610 Newport Center Drive, Suite 1060, Newport Beach, Calif. 92660; 714-760-1700.

SEPT. 12-13. Product Safety and Liability Prevention course in Madison, Wis., sponsored by the University of Wisconsin-Madison Extension; $720. The Wisconsin Center, 702 Langdon St., Madison, Wis. 53706; 608-263-4712.

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Gerald D. Stephens, CPCU
President & CEO, RLI Corp.

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I think the answer to both of these questions boils down to one word: *service*. It's service, or the lack of it, that causes consumers to be disillusioned and it's service that can change that disillusionment into satisfaction.

When I take off my hat as "insurance company president" and put on my "insurance consumer" hat, I'm appalled by what I see. I buy a commercial policy and it takes three or four months to get it. When I get it, my college education isn't enough for me to wade through the confusing verbiage. It's about time we started doing something about consumers' problems. It's time we started to demonstrate our care and compassion through our service. At RLI, that's just what we're doing. And we begin with fast service. There's no reason policy turnaround should be as high as 90 days. Our underwriters consistently succeed in making that figure fifteen days. Why can't other insurance companies do the same?

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ASK A RISK MANAGER

Opportunities presented through acquisitions

Q **I understand your company has grown over the years through acquisitions. What are some of the main activities a risk manager should engage in when his or her employer acquires another company?**

A Your question is especially timely since I now find myself in the process of managing the exposures and modifying our present risk management program following an acquisition a few months ago. Over the course of my 17 years with Hardee's Food Systems Inc., I have been directly involved with the many "opportunities" associated with two major acquisitions. This sudden growth has increased our fast-service-restaurant base by several hundred locations throughout the country.

Those of you who are familiar with the Associate in Risk Management program offered by the Insurance Institute of America will recognize the various steps in the risk management decision-making process that I will mention here:

- Step I: Identify exposures.
- Step II: Evaluate the various risk management techniques for handling these exposures.
- Step III: Select the appropriate techniques.
- Step IV: Implement the appropriate techniques.
- Step V: Monitor the results.

In real-life situations, I have found that applying these steps provides for a workable action plan, especially amid the frenzied atmosphere of a major acquisition. It literally provides a means of wrapping your arms around this deal that suddenly changes the complexion of an entire risk management program.

Step I, exposure identification, is the most critical to the acquiring company. The process works best when the risk manager is tapped as one of the key players on the acquisition team and, therefore, becomes involved in the game. Senior management that overlooks the importance of a risk manager's involvement in assessing risks can face significant unexpected exposures after finding out that what initially looked great on paper is in fact a bad investment from an operational perspective.

The exposure identification process involves answering the fundamental question: "What are the exposures associated with this purchase and what impact will they have on the acquiring company?" A few specific areas to address are:

✔ Environmental exposures such as pollution, chemical hazards and the existence of underground storage tanks. The risk manager should be familiar with regulatory requirements associated with these exposures and coordinate the development of an appropriate compliance program. Failure to comply with existing regulations can result in huge penalties to the organization or criminal charges brought against executive management.

✔ Geographical exposures associated with the location of the facilities to be acquired. Are they subject to loss by flood, hurricane, tornado or earthquake? Is there an ample water supply for fire protection purposes? A thorough evaluation of these exposures can make a difference in management's decision whether to proceed with the purchase. If the locations are susceptible to any of these perils, a crisis management plan should be developed to address the particular hazards.

✔ Physical exposures are those that affect the physical condition of the locations. Are the physical properties in good repair and structurally sound? Any deficiencies in key areas such as electrical wiring should be identified and corrected. It's better to understand and provide for the cost of upgrading the facilities before the acquisition rather than face a huge cash outlay after the fact.

✔ Operational exposures are those that create an occupational injury or disease exposure to employees or a bodily injury exposure to third parties. The risk manager should ask the following questions: Are employees subject to excessive noise levels because of a production process? Do mechanical processes exist that could result in repetitive motion injuries? Are employees exposed to hazardous chemicals?

Also to be considered are material handling practices and sustained exposure to temperature extremes. The list of potential operational exposures goes on and on.

As for hazards to third parties, the risk manager should determine if the public is subjected to injury by frequenting the premises or purchasing one of its products. Yet another important operational issue deals with security. Is the business located in a high crime area or involved in a process that makes it more susceptible to robbery, theft or arson?

✔ Underwriting exposures center on the evaluation of historical loss data and comprehending the spread of risk by reviewing such items as a schedule of locations and vehicles. The risk manager should obtain, as soon as possible, a detailed list of casualty and property losses, preferably covering a 10-year period. By analyzing this loss data, the risk manager can determine the adequacy of current retention levels and coverage limits. An actuarial review of prior casualty losses is very important if acquiring outstanding liabilities is possibly a part of the purchase agreement.

The current schedule of locations should also provide the insurable values for each property. This same schedule provides additional insights such as workers compensation exposures in monopolistic states or operations that are subject to state-mandated disability plans. The need for certain specialty coverages such as professional liability or aviation should also be considered.

To properly initiate the exposure identification process, the risk manager should personally conduct on-site surveys of an adequate number of facilities (if the acquisition involves several properties) so that he or she has a sampling of reliable data to evaluate. If the purchase involves one or only a few locations, the risk manager's job is a bit easier from the survey standpoint but essential nonetheless.

The second step of our acquisition action plan involves evaluating the many alternatives available to control these exposures. This is an opportune time to decide if outside consultants are needed to help manage specific hazards related to the environment or chemical handling. This is also the time to inform the broker and other providers of the pending acquisition to allow for a smooth transition of the additional risk into the existing program. Or, perhaps, consideration should be given to re-marketing the insurance programs since the exposure base will change significantly.

The risk manager should determine if the present loss prevention program is suited to meet the exposures of the business to be acquired. I also suggest a careful review of the program used by the business to be acquired since the goal is to blend the best aspects of both programs to achieve the ultimate in loss prevention. Other procedures should be evaluated with this same purpose in mind.

Our recent acquisition provided us the opportunity to completely revise our accident reporting procedures simply because the company we acquired has a more efficient program. Implementing the new program into our existing operations was a benefit to the entire organization.

Step III in the five-step process is selecting the appropriate risk management techniques. The risk manager should recommend the most effective coverage mechanisms, then designate and arrange for the various risk management services required to accommodate the demands created by the acquisition. This step marks the stage when adjustments are made to the loss prevention program. You will find that if Step I and Step II have been properly performed, this third step is a natural progression in the sequence of events.

Step IV provides for implementing the entire action plan. Everyone associated with the administration of the risk management program is functioning as a team, assuring that it's "all systems go" on the acquisition date. I find this phase both exhilarating and frightening at the same time!

Since our acquisitions have involved the purchase of many locations over a sizable geographic spread, a main objective of mine has been to have each restaurant manager understand our program and what is expected of him or her. And, when that first accident occurs or the first safety inspection is performed, everyone does what is expected. As for brokers, underwriters and the claims administrator, they are well prepared at this point to provide whatever services are required.

The final step, monitoring the results, is an ongoing process and provides the risk manager with a report card of how well the program is performing. Feedback from individuals at all levels within the organization and from outside service providers is essential. The goals of the program should be flexible since the acquisition will bring major changes in the organization's environment. And, above all, these goals should be realistic and obtainable.

Employee education relating to accident prevention should be a continuous process. As losses occur and develop to an ultimate cost, the risk manager must assess their impact on the coverage program previously selected. Some questions to ask are: Is the retention level appropriate? Should self-insurance be considered for a certain line of coverage?

The monitoring phase never really ends. Outside influences will call for adjustments and enhancements in the most sophisticated of programs. The risk manager should keep management informed of the success of the overall program and make recommendations on ways to improve performance levels.

One final bit of advice: Keep a sense of humor and be patient. Acquisitions are meant to "grow the business" and provide opportunities. They certainly provide the latter to folks in our profession, so make the most of them! ■

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.

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. 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.



Ms. Werner

Ms. Werner's column appears 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.

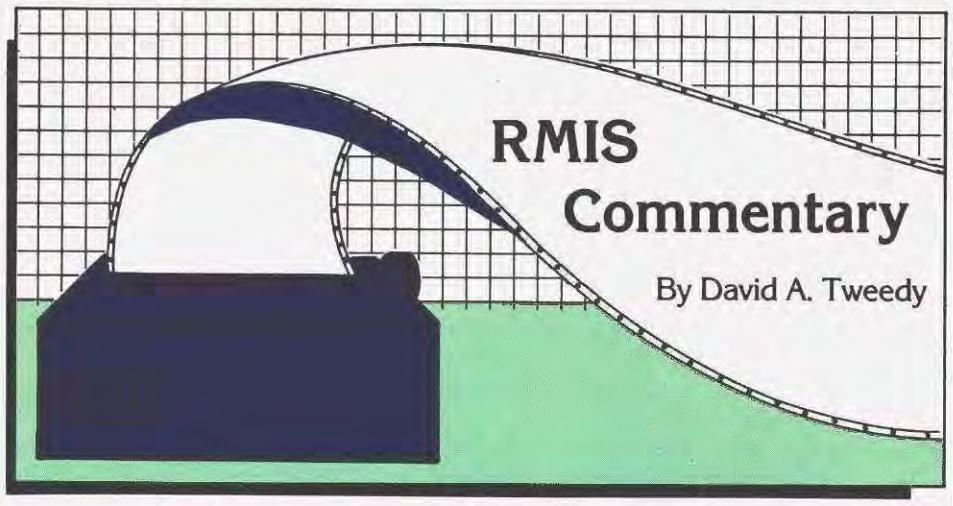
Ms. Werner's next column will appear in October.

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.

Specs needed for RMIS

Needs determination essential basis for system

By David A. Tweedy



FOR THE PAST TWO months, we have seen that the design of a responsive risk management information system requires thoughtful planning. A careful needs determination study is the foundation for developing the ultimate system specifications for both hardware and software. It identifies the data sources and flows, the participants involved and the desired end results. The cost benefit analysis quantifies the tangible and intangible expenses and savings—or increased efficiencies—to justify the creation of the RMIS, especially to the company's senior management. With the advent of medical case management/bill review software, the cost justification has been made more definable.

What is the next step? Before detailed proposals can be sought from prospective vendors, the quantified needs as determined by the needs analysis now must be translated into system specifications. This is often the most difficult and time-consuming part of the design of a comprehensive RMIS. But, a slack effort by the risk manager and the RMIS committee at this point can be fatal. The time well-spent in the needs identification process in quantifying the organization's information flows and needs is now carried out in detailed system specifications.

Quite simply, specifications define the activities and functions you want the RMIS and the vendor support system to perform.

The first step has been done. The needs identification process sets the parameters of the ultimate RMIS through the many interviews conducted with key personnel within the organization, as well as with important outside sources, such as brokers, third-party administrators, insurers, attorneys, etc. The risk manager had the key responsibility for organizing and directing the needs identification process. But, unless he or she has an extensive systems background, the actual design of the specifications should be left to the consultant, in-house expert or system vendor. A risk management information system is a complete combination of hardware, software and human elements.

Nevertheless, the risk manager should be an active participant in the translation of the layman's terminology into the technical system specifications to ensure that the system ultimately does what the risk manager desires. As is the case when designing any set of specifications, the objectives are completeness, logical flow and clarity of intent.

For vendors and/or in-house data processing departments to correctly interpret needs and develop a responsive RMIS, their set of instructions must have several elements. In a bidding situation, whether it is for property insurance or a sophisticated risk management information system, the specifications must have sufficient depth to respond to the needs already defined, and they must be clear and logical to enable the bidding vendors to more easily prepare a responsive quote.

Careful attention to the specifications will help the risk manager select from among the three to five proposals he or she may receive in the bidding process. Ambiguities in vendor proposals usually result from unclear specifications or documentation. What exactly should the specifications contain?

First of all, a current description of the organization is necessary. A general description of the firm's risk management department and its functions will help describe the situation to the potential vendor. For example, what is the current claims procedure for the organization? How are the costs allocated among divisions? Is any improvement needed? What importance is placed on loss development and/or loss forecasting? What type of hardware, if any, exists within the organization? Is a link-up with the firm's current mainframe anticipated, or will the RMIS be a totally separate entity? Who in the department will be using the system, and what kind of training do they have in systems? Is it necessary that reports be generated on location, or can they be sent by an outside vendor upon request? How customized will the reports and analytical functions need to be?

The risk manager has the key responsibility for organizing and directing the RMIS needs identification process. But, unless he or she has an extensive systems background, the actual design of the specifications should be left to the consultant, in-house expert or system vendor.

The information in the next several areas clearly identify to the vendor the type of system desired. The key areas are:

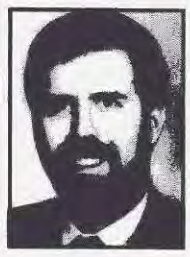
- **Data base construction.** Identify the information you want to be included within the RMIS master data base. The most common elements are incidents, claims, policies, locations and properties, and organizational information.
- **Data access requirements.** Next, include specific instructions on how the data can be accessed once it is introduced into the data base. For instance, how many data elements do you wish the system to contain to search for information, such as date of accident, claim number, social security number, location, claimant name, etc.? What information on the screens do you wish to capture?
- **Reporting requirements.** There is a differential between standard reports—such as monthly loss runs, loss developments, losses by division, etc.—and "ad hoc" reports. Ad hoc, or "what if," reports are essential to allow maximum flexibility and, therefore, good decision-making. They allow the user to define a set of parameters to ask questions of the database to get specific information. For example, a risk manager may want to know how many back injuries have occurred at a certain location since implementation of certain loss-prevention activities. The ad hoc report function would allow the risk manager to deviate from the standard reporting formation to get that answer. The risk manager should attempt to identify as many ad hoc reports as possible beforehand, in the specifications stage, in order to prevent costly modifications once the system has been implemented.
- **Analytical capabilities.** What types of analytical functions are desired? For example, does the risk manager want a cost-of-risk allocation system, loss-forecasting system, cash flow evaluation of proposals, captive insurance company model-building segments, etc.?

If so, the desired output from these analytical functions must be clearly delineated. How often will the analysis be required? What kinds of insurance proposals will be evaluated? How will the premiums be allocated among the divisions? Will it be by personnel, actual loss experience, sales volume?

- **Conversion.** This can be an expensive and time-consuming process. Changing claims service providers usually requires conversion of the existing database to be easily accessed and used by the new system. The specifications package should include information pertaining to the volume and format of data to be converted.
- **Interface.** The needs analysis may have identified other internal systems or data bases with which to communicate. These need to be identified for the vendors, especially if any customized "bridge" software routines must be developed to allow this communication.
- **Training and backup support.** The specifications must clearly identify the training process involved (who, where, when) and account personnel to service the account.
- **Customization.** Systems rarely are installed "off-the-shelf" with no modification. The specifications must clearly explain to vendors that they must both identify and quantify time and costs associated with any changes.
- **Other.** This catchall section covers such questions as: What kind of security system is anticipated? Will there be a need for passwords for a certain level of management? What kind of internal data editing features will be included? How will new data be entered—by magnetic tape, telecommunications, floppy disk?

I have touched the surface of a very detailed and complex process. The design of accurate, logical and clear system specifications is critical in developing the desired risk management information system. Proper time should be taken in developing the specifications and refining them to the utmost degree before submitting them to interested bidders. Sloppily prepared specifications will cause the risk manager more problems in the long run, and it is much better to invest the time up front than to try to correct the problems after the system has been implemented. ■

David A. Tweedy is a senior consultant for Betterley Risk Consultants Inc. in Worcester, Mass. He is the editor of Betterley Risk Management Commentary and the author of RMIS Update, a yearly publication analyzing major risk management information systems and vendors. Mr. Tweedy's column on risk management information systems appears the third Monday of the month.



Sunken treasure

Continued from page 3

lacked sufficient documentary evidence that they had insured and paid claims on commercial shipments of gold carried by the Central America.

Judge Kellam found that 19th century newspaper accounts of claims payments were insufficient proof that insurers had not abandoned their claim to the gold. In fact, by not maintaining proof of a continued interest in the ship, insurers demonstrated that they had abandoned the ship and its cargo, the ruling said.

Insurers said they paid banks and other businesses, primarily in New York, that were awaiting shipment of the California gold on the Central America.

After being shipped from San Francisco to Panama and taken across the isthmus by mule train and railroad, the gold was transferred to the Central America, which stopped in Havana before sinking in September 1857 in a hurricane off the coast of South Carolina while en route to New York. More than 400 of the 575 people aboard the ship were killed.

The insurers that claim they had continued to stake a claim to the gold are: Atlantic Mutual Insurance Co. of Murray Hill, N.J.; Insurance Co. of North America, a CIGNA Corp. unit in Philadelphia; units of Sun Alliance & London Insurance P.L.C. of London; Guardian Royal Insurance Exchange Assurance P.L.C. and Indemnity Marine Assurance Co., both of London; and the Salvage Assn., which represents Lloyd's of London underwriters.

In addition, the New York superintendent of insurance, acting as receiver on behalf of eight New York insurers that went out of business in the 19th century, also claimed a portion of the gold.

Judge Kellam specifically rejected the insurers' contention that they never abandoned claim to the gold, which the insurers claimed was theirs by subrogation.

"How could one better demonstrate their intention to abandon a claim to or interest in property than to intentionally destroy every evidence of its claim, right or title thereto?" he asked.

"It seems more than unusual that some 11 or more companies that have proof of what they say is an asset—or claim—and which they say was never abandoned, each destroyed all documents which established their right to the claim," the ruling said. "None say they accidentally destroyed or lost the documents. They deliberately destroyed every document that would in any way show they had an interest in such a claim and had any intention to pursue it."

A lawyer for the insurers disagreed.

"Over a period of time, documents get lost," said Douglas A. Jacobsen, a partner with Bigham Englar Jones & Houston, a New York firm.

"We believe there's no evidence that the underwriters abandoned the Central America. The owners don't lose title by mere passage of time," he said.

> **'Over a period of time, documents get lost,' says Douglas A. Jacobsen, a lawyer for the insurers.**

"Based on what we've reviewed so far, our feeling is we'll recommend that our clients appeal," said Mr. Jacobsen.

A lawyer for Columbus America —Richard T. Robol of Hunton & Williams in Norfolk—said any appeal would be dealt with "step-by-step."

Mr. Robol, a member of the American Assn. of Defense Trial Attorneys who often represents insurers, said the message in Judge Kellam's ruling is simple: "Insurance companies need to look carefully and review with their counsel exactly what they need to do and what they need to maintain" to protect their interests.

According to Michael S. Cessna, a maritime law expert not involved in the case, "This decision illustrates very vividly the dilemma that an underwriter faces in protecting its subrogated interest in property that has been lost at sea.

"This teaches them a number of lessons," said Mr. Cessna, who is with O'Neill, Eichen, Miller & Breckenridge, a New Orleans firm.

The ruling could be used as a precedent in other cases, observers note.

"It has opened up a whole new field of human endeavor, deep-ocean discovery. It has opened a new field of law that corresponds to that endeavor: the law of deep-ocean discovery. It makes it clear that under that law, individuals have the freedom to explore the deep ocean and to enjoy the benefits of their exploration," said Mr. Robol.

But the decision, said Mr. Schatz, will "ultimately be very good for the insurance companies" because it spells out what insurers must do to protect their rights to lost property.

In his ruling, Judge Kellam faulted insurers for doing too little to protect their claims. Atlantic Mutual paid $150,000, more than any other U.S. insurer, he noted, but that amount was much more significant in 1857 than today.

"It is difficult to believe that a company claiming an asset or property worth $150,000 in the 1800s or even the early 1900s would destroy all evidence of its claim if it had any intention to pursue it, or any hope of recovery," he wrote.

Insurers, the judge said, abandoned the ship because they neither knew where it was nor how to recover the gold in such deep waters.

"Their actions speak clearly," he wrote. "They had no hope or idea they could locate the Central America, and even if they located it, they had no hope they could recover anything from it. They destroyed the documents and intended thereby to abandon any claim they might have. Such action was guided by the decision that location of the wreck was next to impossible."

Even if the wreck could be located, recovery would have been impossible until the 1960s, the ruling said.

Nevertheless, the scientific means to locate deep ocean ship

Continued on next page

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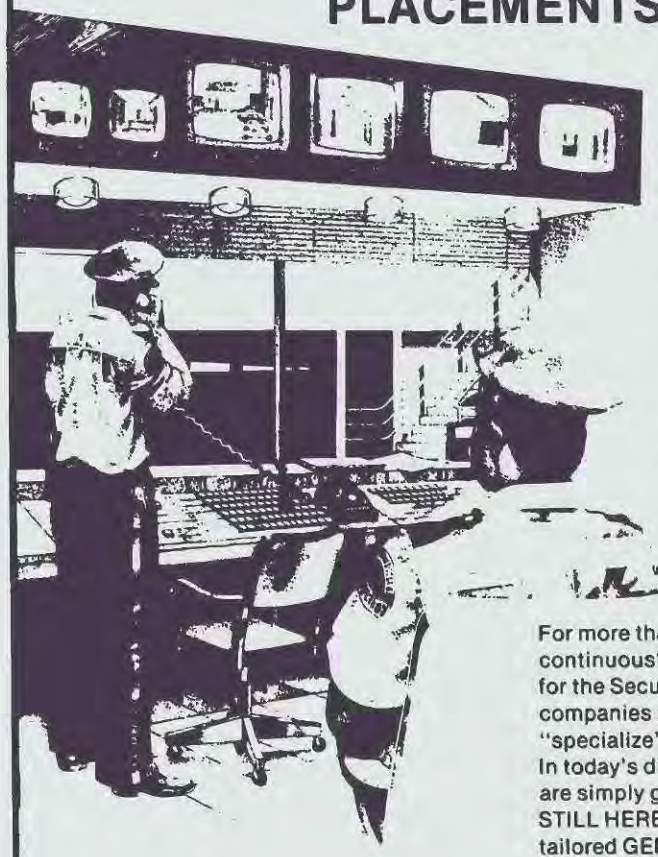
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Treasure dispute

Continued from previous page

wrecks and possibly recover the contents in deep water had been available for 20 years before the Columbus group began its efforts, according to the ruling.

"Still, not one of the insurance companies undertook to locate or recover the Central America. The inaction did not stop there. The record is devoid of any evidence that even up to this day any one of the insurance companies ever sought to locate or have a discovery company or group undertake to locate and recover the Central America" he wrote.

Judge Kellam noted that in 1858 two of the insurers discussed a possible recovery with Brutus Villeroi, a French salvor. But that operation was predicated on Mr. Villeroi inventing a submarine without any financial assistance from the insurers. No record exists of such an expedition.

The ruling, said Mr. Cessna, should further impress upon underwriters that they have to make reasonable efforts to recover lost treasure.

Insurers, the court further noted, would have no claim on what all parties agree were "substantial quantities of gold" that private passengers were carrying in addition to the ship's cargo of bullion. Gold was carried in money belts, carpet bags or trunks; some was deposited with the ship's bursar.

Estimates on the 1857 value of the gold range up to $1 million, but the actual value for the coins far outweighs their face value.

Among the ones already recovered are very rare, privately minted coins, including two of a variety of which only two were previously known to exist, said Mr. Schatz of Columbus America.

Twenty-dollar double eagle gold pieces struck at the San Francisco mint also have been recovered. Collectors pay more than $500 apiece for the very popular coins, depending on their condition, he said.

•

Columbus America Discovery Group Inc. vs. the unidentified, wrecked and abandoned sailing vessel, its engines, tackle, apparel, appurtenances, cargo, etc., located within a box defined by the following coordinates: northern boundary—31 degrees 37 minutes north latitude; southern boundary—31 degrees 33 minutes north latitude; western boundary—77 degrees 2 minutes west longitude; eastern boundary—76 degrees 57 minutes west longitude (believed to be the S.S. Central America), United States District Court for the Eastern District of Virginia, Norfolk Division, No. 87-363-N.

TPA ruling

Continued from page 3

TPA is responsible for maintaining adequate books and records for five years after the contract with the employer, and make clear that the TPA's compensation is not contingent on the plan's claims experience.

The statute gives the Insurance Department the authority to suspend or revoke the license of a TPA administering an employee benefit plan.

In its original complaint against then-Florida Insurance Commissioner Bill Gunter, the SIIA, whose membership includes third-party administrators, argued that "because the Florida statute 'relates to' and purports to regulate directly and indirectly any ERISA 'employee welfare benefit plan' that covers Florida residents, the Florida statute is pre-empted by and in conflict with ERISA."

Under ERISA, an employee benefit plan is not considered an insurer or engaged in the business of insurance for the purposes of state laws designed to regulate insurance or contracts.

But the state argued that the state statute regulates insurance and therefore is not subject to the pre-emption under the law's "savings clause."

That clause "saves" state law from ERISA pre-emption and says the pre-emption does not apply to any state law that regulates insurance.

The state's position was that companies administering ERISA-governed employee benefit plans were in the business of insuring benefits and therefore could be regulated.

However, U.S. Magistrate William C. Sherrill Jr. of U.S. District Court in Tallahassee wrote in the original ruling that the Florida statutes "relate to" ERISA plans and therefore are pre-empted by the federal law.

The savings clause does not apply, he decided, because the Florida statute does not regulate the business of insurance.

Only a small portion of the TPAs operating in Florida were exempted from regulation by that ruling, according to Peter Ostreich, senior attorney with the state Insurance Department.

He called the ruling "very narrow," saying "at least 98%" of the TPAs in Florida provide administrative services for both ERISA plans and other plans that are not regulated by the federal law. Those TPAs continue to fall under regulations set down in the 1983 state law, he pointed out, because the court ruled that the Florida law is pre-empted "only to the extent that such statutes are applied to employer/plan sponsors or contract administrators with respect to their activities, functions and responsibilities performed on behalf of self-funded ERISA employee benefit plans."

Mr. Ostreich said the department does not know how many TPAs in the state provide services only for plans that would be regulated by ERISA.

However, the SIIA is calling the ruling a victory for the self-insurance community.

"We don't view it as a TPA issue, but as an ERISA issue," declared SIIA Executive Vp James Kinder. The trade group's point in suing, he said, was to show that the pre-emption clause is strong enough to override any attempted state regulation of employee benefit plans.

Mr. Kinder said the group has "always believed ERISA is the governing law for employee benefit plans and state laws are pre-empted even if they try to regulate an employee benefit plan indirectly as the state of Florida attempted to do."

If state laws regulating self-insured benefit plans were not pre-empted by ERISA, the cost of providing the plans would increase substantially, simply as a result of license fees states could impose on TPAs and plan sponsors, according to Mr. Kinder. "ERISA provides for uniform regulation which is in the best interest of employers, beneficiaries, plans sponsors and service providers such as contract administrators."

At least one TPA still regulated by the Florida law does not find the rules particularly onerous.

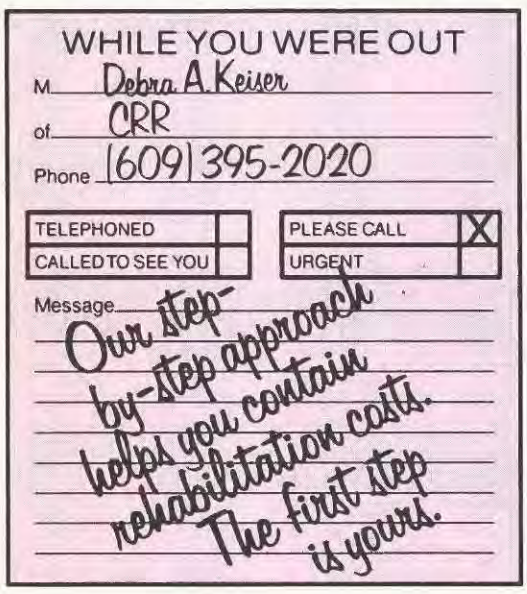
"Even though we are regulated at the state level, what is being asked of us is not a problem," said Robert F. McBurney, president of Bankers Risk Management Services in St. Petersburg.

Mr. McBurney said state regulation "helps our industry maintain its credibility."

The appellate ruling will likely have little effect on day-to-day operations because "the number of TPAs doing strictly self-funded business is quite limited," he added. ■

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INTERNATIONAL

German insurers' premiums grow 7.5%



BI/JOHN SMITHER

By DON LEWIS KIRK

BONN, West Germany—West Germany's tightly knit insurance industry managed to produce moderate growth in premiums in fiscal 1989, though they were strained by several large losses, including the string of windstorms that hit Europe earlier this year.

For the year ending June 30, 1990, the West German insurance industry recorded a 7.5% increase in premium volume to 125.6 billion deutsche marks ($75.6 billion at the appropriate exchange rate), up from 116.8 billion deutsche marks ($59.9 billion at the appropriate exchange rate) for the year ending June 30, 1989, according to George Buchner, president of the West German Insurance Assn. in Cologne.

The year was marked by heavy property losses in Germany and around the world. However, it also was a year of opportunities for insurers as the border between East and West Germany was removed.

Last year saw "terrible" conditions in commercial lines for West German insurers because of heavy industrial losses, Mr. Buchner said. Most companies, he noted, relied on strong performance in personal lines operations to buoy their overall results.

Among the larger losses to hit insurers were the windstorms that buffeted Europe in January and February, causing an estimated $8.8 billion in damages (*BI*, April 30). Although the brunt of the storm damage was felt in the United Kingdom, damage in West Germany has been estimated to exceed $1.8 billion (*BI*, March 5).

The performance of five of West Germany's largest insurance groups that recently released their 1989 results are indicative of how the market fared.

Allianz A.G. Holding, by far the largest insurer in West Germany, also posted one of the largest jumps in premium volume among leading insurers for the year ending June 30.

Allianz recorded an 8.9% jump in premium volume to 31.8 billion deutsche marks ($19.1 billion) for the year ending June 30, up from 29.2 billion deutsche marks ($15 billion) for the year ending June 30, 1989.

Part of the Munich-based insurer's premium growth came from an increase in premiums attributable to foreign business. Foreign business comprised 44% of premiums in fiscal 1989, up from 40% in

Continued on next page

LONDON

Storm losses wrack U.K. insurer profits

By STACY SHAPIRO and CAROLYN ALDRED

LONDON—Losses from European storms early this year are damaging half-year profits for some of the largest U.K. insurers.

General Accident P.L.C. of Perth, Scotland, reported a massive pretax loss of 66.2 million pounds ($124.4 million) for the six months ending June 30, compared with a profit of 122 million pounds ($196.4 million) in the comparable period of 1989.

Premium revenues totaled 1.6 billion pounds ($3 billion) for the first half of 1990, a rise of 3.2% compared with 1.55 billion pounds ($2.5 billion) for the same period in 1989.

"Our results at the half year are dominated by the severity of weather-related losses incurred largely during the first quarter and while a small pretax profit has been achieved in the second quarter, underwriting deterioration in most of our major markets has continued," the chief general manager, Nelson Robertson, said in a statement.

"To counter this trend, specific rating and other remedial action has been taken with a view to the restoration of an acceptable level of profitability as our major and urgent objective," he added.

Results were worst in the United Kingdom, where General Accident premiums in the first half totaled 565.9 million pounds ($1.06 billion) and its underwriting losses were 94.5 million pounds ($177.7 million). In the United States, General Accident's second-largest market, premiums for the first six months of 1990 totaled 462.4 million pounds ($869.4 million) and underwriting losses hit 48.6 million pounds ($91.4 million).

Meanwhile, at Commercial Union P.L.C. of London, profits were down by 82.3% to 16 million pounds ($30.1 million) for the first half, compared with 90.2 million pounds ($145.2 million) in the first half of 1989.

First-half premium revenues increased 5.5% to 1.9 billion pounds ($3.57 billion) in 1990 from 1.8 billion pounds ($2.9 billion) in the first six months of 1989.

Storms in the first quarter cost the insurer a "total of 55 million pounds ($103.4 million), including the cost of 22 million pounds ($41.4 million) to reinstate our reinsurance premium," said Commercial Union Chief Executive Tony Brend.

Tiny risks

Business is moving at a snail's pace at Lloyd's of London brokerage Sedgwick Non-Marine Ltd.

The brokerage is the first to place livestock all-risks mortality insurance for a snail farm.

According to Sedgwick's in-house magazine last month, Frangua S.A. was established in 1986 in Guatemala, "where the humid climate is ideal for breeding 'petite gris,' the smallest and most popular edible snail."

In France, "les escargots" are a delicacy. Frangua S.A. aims to capture 5% of the French market and its target for 1990 is to export about nine tons of frozen snail meat each month, according to Sedgwick.

To reach its target, the snail farm must accommodate 18 million snails at different stages of growth. An average Frangua snail grows to 1-inch long and weighs 0.35 ounces.

Sedgwick Non-Marine's international property broker David James earlier this year obtained livestock coverage for Frangua based on the number and weight of snails over a 12-month period for Frangua.

The coverage was placed in Lloyd's of London for an undisclosed limit.

The policy, designed to pay losses in a catastrophic situation, is written on a "livestock all-risk mortality basis, which includes cover against animal predators but, because the death rate among young snails is fairly high, excludes mortality among snails" less than 0.4 inches long.

In the event of a catastrophe, the young snails could be excluded from coverage by working out a weight ratio to the number of snails to determine the age of the snails, Mr. James said.

However, he said, "We hope we'll never pick up a loss."

Mr. James added, "To say the livestock/bloodstock underwriters with whom we placed the business were surprised is an understatement. But they could see from the technical details that this was

Continued on next page

Contract coverage shunned

LONDON—A leading Lloyd's of London's political risk underwriter stopped writing contract frustration insurance just before the Iraqi invasion of Kuwait.

Merrett Underwriting Agency Management Ltd.'s syndicate 418 decided to stop underwriting the coverage worldwide—not just in the Persian Gulf—"because we were not getting adequate returns," said the syndicate's political risk underwriter, Deborah MacDonald.

Besides, she added, "it's a very volatile business. Witness what's just happened."

Ms. MacDonald, however, continues to underwrite contract frustration reinsurance and other classes of political risk insurance, such as confiscation risks. Political risk business accounted for 3%, or 7.2 million pounds ($11.5 million), of the syndicate's total allocated capacity of 238.7 million pounds ($384.3 million) in 1989, according to MUAM's 1989 underwriting accounts.

—By Stacy Shapiro

Claim by victims' relatives allowed

By CAROLYN ALDRED

LONDON—Relatives of victims of an April 1989 British soccer stadium disaster can seek additional damages if they suffered psychiatric disorders after watching the tragedy unfold on live television, says a British judge in a precedent-setting ruling.

Relatives of 95 people who were crushed to death or suffocated and 170 others who were injured when thousands of soccer fans attempted to pack into a sold-out tournament at Hillsborough Stadium in Sheffield are suing the South Yorkshire Police Department for unspecified damages.

The police department already has admitted liability (*BI*, April 24, 1989).

Because the event was an important match on Britain's soccer calendar, the tournament and subsequent tragedy were shown live on television.

High Court Justice Hidden in Liverpool broke legal ground last month by ruling in a test case that watching the disaster broadcast live was sufficient to allow the 16 plaintiffs to seek compensation.

In the July 31 decision, the judge also extended existing British law by ruling that brothers and sisters could claim damages for nervous shock after watching a sibling involved in the tragedy. Previously, British law allowed only parents and spouses to make such claims.

However, Justice Hidden denied a request by relatives of the 95 victims who died in the disaster for additional damages for the victims' pre-death pain and suffering. The judge noted that unconsciousness occurs very quickly, almost instantaneously, in cases of suffocation.

The plaintiffs and the South Yorkshire Police Authority have 12 weeks to appeal the decision. Lawyers for both sides said it is too early to comment on whether they will appeal.

No monetary awards were made by the judge, as the decision was a test case involving a point of law.

Negotiations now will begin between the 13 plaintiffs who suffered "post-traumatic stress disorder" after watching the disaster on TV and the police authority's insurer, Municipal Mutual Insurance Ltd., on the level of damages to be awarded, said Peter Metcalf, a partner of Hammond Suddards, a Bradford-based law firm representing the police.

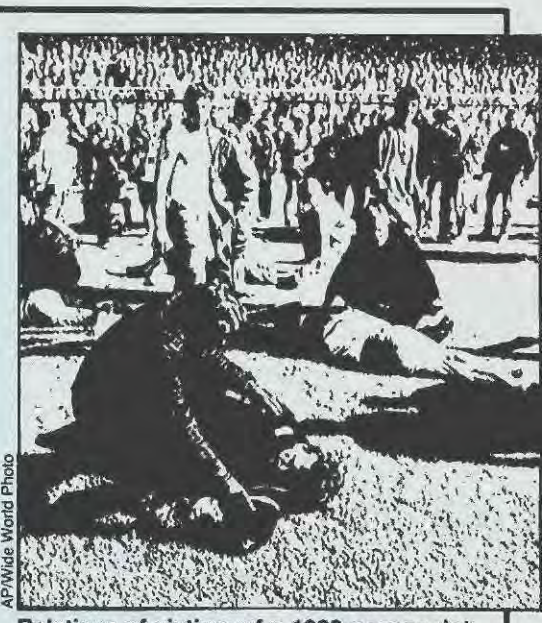
If an agreement cannot be reached, the case will proceed to court to determine the amount of any compensation, he added.

The ruling allows an additional 134 relatives who suffered post-traumatic stress disorder by viewing the soccer disaster—but were not included in the test case—to seek damages from the police department, said Nicola Harrison, a partner of Liverpool law firm Mace & Jones, and spokeswoman for the Hillsborough Steering Committee of lawyers representing the plaintiffs.

Awarding post-traumatic stress disorder compensation to victims' parents who watched the incident on television as well as to brothers and sisters of the victims "breaks new ground," said Alan Fisher, a partner in Davies Arnold & Cooper, a defense firm in London.

"It extends the category of payments for shock" and "opens up a new class of claimants," Mr. Fisher said.

Continued on next page



AP/Wide World Photo

Relatives of victims of a 1989 soccer riot who watched on TV can seek damages.

INTERNATIONAL

German insurers

Continued from previous page
fiscal 1988, Allianz reported.

And, foreign expansion for the company continued last month with its planned acquisition of Fireman's Fund Insurance Co. of Novato, Calif. (*BI*, Aug. 6).

That acquisition follows Allianz's hotly contested purchase earlier this year of East Germany's monopolistic insurer Staatliche Versicherungs der DDR (*BI*, April 16; March 19).

Chief Executive Officer Wolfgang Schieren projected Allianz's growth in premium volume will exceed 10% in fiscal 1990, rising to more than 36 billion deutsche marks ($23 billion at current exchange rates).

Munich Reinsurance Co., the world's largest reinsurer and one of Germany's largest companies, posted a 1.6% increase in premium volume to 12.6 billion deutsche marks ($7.6 billion) in 1989 from 12.4 billion deutsche marks ($6.4 billion) in 1988 (*BI*, Aug. 13). Munich Re has crossholding shares in several other West German insurers, including a 25% stake in Allianz.

Forty-five percent of the Munich-based reinsurer's premium volume came from foreign business last year, about the same level as in 1988, said a spokesman for the reinsurer.

Munich Re reports that its foreign results were "severely" hurt by Hurricane Hugo, which struck portions of the Caribbean and Southeastern United States (*BI*, Oct. 2, 1989; Sept. 26, 1989).

And, Munich Re's 1989 domestic results were affected by two major industrial fire losses last year, the spokesman said:

- The explosion and fire of a Bayer A.G. factory in Uerdingen Feb. 14, 1989. The total insured property loss reached $60.1 million and business interruption losses totaled $83 million (*BI*, April 30).
- An explosion March 7, 1989, in an ethylene oxide plant owned by BASF A.G. in Antwerp, Belgium, that cost insurers $88 million in property damage and $294 million in business interruption losses (*BI*, April 10, 1989).

Munich Re would not reveal how much of each risk it had assumed. Coverage for both companies was led by Gerling-Konzern Versicherungs-Beteiligungs A.G. of Cologne (*BI*, April 10, 1989).

Fiscal 1989 was not an easy one for the Gerling group, Germany's largest industrial insurer, because of a price war in fire insurance risks, which has dampened Gerling's revenues.

Gerling's loss ratio on fire insurance business climbed to 141.2% last year, up from 90.3% in 1988, the company reported. Inadequate rates for this business and an increase in losses are responsible for the deteriorating results, Gerling said.

Nevertheless, citing a strong increase in domestic automobile insurance premiums, Gerling reported a 2.7% increase in premium volume to an estimated 7.7 billion deutsche marks ($4.6 billion) in 1989 from 7.5 billion deutsche marks ($3.8 billion) in 1988.

Gerling reported foreign business dropped to 16.1% of premiums in 1989, from 16.5% of premiums in 1988, blaming the decrease on unfavorable exchange rates.

Gerling had led an unsuccessful effort to outbid Allianz for East Germany's Staatliche earlier this year (*BI*, June 18), a move that could have led to a sizable increase in foreign premiums for the firm.

But that hasn't slowed the company's activity across the border. Gerling already has established a risk management consultant, a reinsurance company and a marketing office in East Germany. In addition, the insurer reports that it has opened offices in most of the major cities in East Germany.

Gerling expects continued competition in fiscal 1990 over insurance prices and contract conditions, following the July removal of trading barriers in the European Community for most industrial and commercial insurance risks, said a spokesman for the insurer.

Another of Germany's largest insurers, Aachener & Munchener Group, counted on distribution agreements with banks to help boost its premium volume last year.

The Aachen-based insurer's annual report cites a cooperative venture with Bank fur Gemeinwirtshaft, in which it has a controlling interest, for helping boost premium volume to 5.4 billion deutsche marks ($3.3 billion), up 5.9% from 5.1 billion deutsche marks ($2.6 billion) in 1988.

In addition, the insurer cites restructuring of Volksfursorge Group, a Hamburg-based multiline insurer, as a measure that will boost premiums. A&M subsidiary Central Krankenversicherungs A.G., a Cologne-based health insurer, acquired a 50% stake in Volksfursorge this month, the company reported.

Under the restructuring, Volksfursorge agents are now selling the insurance products of A&M subsidiaries Central Kranken and Badenia Bausparkasse GmbH in addition to their own products, according to A&M Chief Executive Officer Helmut Gies.

Mr. Gies said A&M also is looking to enhance distribution of its products in East Germany.

"After all legal hurdles are taken, our corporation will move from the conceptual to the actual distribution" of insurance in East Germany, he said.

Victoria Group of Dusseldorf also is blazing a trail into East Germany. Chief Executive Edgar Janott says that while most West German insurers have been placed in an "awkward position" by Allianz's takeover of Staatliche, Victoria is building its own presence in East Germany, having established a new, central office in Berlin.

Mr. Janott says that Victoria will concentrate on writing commercial lines in East Germany, focusing on risks that are free of any responsibility for polluted property.

One way it plans to do this is by avoiding writing coverage for older, established East German industries and structures, he said.

"We won't insure industry or businesses that exist already," Mr. Janott said. "Most buildings are in (poor) conditions where they cannot be insured."

Mr. Janott recently announced the creation of Victoria Holding A.G. in Berlin to consolidate the insurance group's 14 domestic and 11 foreign insurance subsidiaries.

Last year, Victoria Group reported premium volume of 4.8 billion deutsche marks ($2.9 billion), up 9.1% from 4.4 billion deutsche marks ($2.3 billion) in 1988. ■

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LONDON

Continued from previous page
a serious risk and they were keen to support such an innovative venture."

Earthquake risks

A new booklet available from the Reinsurance Offices Assn. outlines theoretical techniques for assessing earthquake risks and the likely damage earthquakes would cause to different geographical locations.

The 40-page booklet—"Principles of Earthquake Risk Assessment for Reinsurance Purposes"—was written by P. Andrews and J.C. Doornkamp.

Copies of the booklet are available for three pounds, which includes postage, from the ROA, Aldermary House, Queen St., London EC4N 1ST. Payment in British pounds sterling should accompany all orders. ■

Soccer disaster ruling

Continued from previous page
However, the ruling also limits the payments "in an artificial way, leaving room for further development in the law," Mr. Fisher said, referring to the ruling's restriction that plaintiffs are entitled to damages only if they witnessed the disaster on live television, not if they read about it or saw or heard about it by watching subsequent, taped broadcasts.

Compensation for psychiatric disorders is a "very dynamic area of the law," Mr. Fisher added.

Other British lawyers agree that the parameters of liability in this area of tort law could still be extended.

"There is a moving boundary at the moment in this area of law and it hasn't stopped moving yet," said Andrew Tucker, a partner with Pannone Napier, a law firm that represents plaintiffs.

Pannone Napier is representing relatives and victims of people who died or were injured when a British ferry capsized in the English Channel in March 1987, killing more than 130 people (*BI*, March 16, 1987).

The law firm is seeking damages on behalf of about 50 relatives of people on the ferry who watched news reports of the disaster immediately after the ferry capsized, Mr. Tucker said. The case is likely to come to court next year, he noted. ■

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Business Insurance

Judiciary Committee to release product bill

By ADRIENNE C. LOCKE

WASHINGTON—The chairman of the Senate Judiciary Committee does not expect that federal product liability reform legislation will come up for debate on the Senate floor.

Because of that doubt, committee Chairman Joseph R. Biden Jr., D-Del., says he will discharge the bill, S. 1400, from his committee this week without taking any action.

Sen. Biden said that the "controversial nature" of the bill indicated that this issue needed "further debate and study to resolve," but thought there was "insufficient time remaining in this Congress to do so."

"Because I do not believe the Senate will vote on this bill this Congress, I chose not to place the bill on the committee's agenda," Sen. Biden said in a statement.

However, supporters of S. 1400 should look on the lack of action by the Judiciary Committee as an "encouraging sign" that the business community is gaining support for the legislation, said Tom A. O'Day, associate vp at the Alliance of American Insurers in Washington, D.C.

"Sen. Biden was not sure of his votes and was not sure of his committee" in returning an unfavorable recommendation, he said, explaining that the senator did not call a committee vote on the bill because of that uncertainty.

By releasing his statement, Sen. Biden "is just protecting his position on the bill and his jurisdiction," Mr. O'Day said.

Following earlier Senate Commerce Committee approval of the bill, the Judiciary Committee's action and the amount of pressure building up from the business community for a full Senate debate on S. 1400, the Senate leadership "would be hard-pressed not to give supporters their time on the floor," Mr. O'Day said (*BI*, June 4).

Meanwhile, some legislators continue to question whether the product liability reform bill, introduced by Sen. Robert Kasten, R-Wis., will improve competitiveness for U.S. firms abroad and create a more predictable legal environment for product liability risks.

Supporters of a uniform federal liability law say superseding state tort laws is a minor "intrusion" on states' rights that is necessary to help businesses compete abroad.

Opponents, however, claim the Kasten bill would not improve competitiveness, but would begin a never-ending process of asking Congress to further restrict the rights of those injured by defective products.

Several Judiciary Committee members voiced concerns about changing existing laws without assurances that changes would bring about the desired effects.

"Before we take away the rights of the states to determine their own liability standards, careful thought and consideration must be undertaken to assure that such intervention in the affairs of individual states and their respective legislative bodies is appropriate," said Sen. Strom Thurmond, R-S.C.

"I am certainly sympathetic to S. 1400. At the same time, however, I have some real questions about this particular legislation," said Sen. Herbert H. Kohl, D-Wis.

Continued on page 27

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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
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NOTICES

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, CHANCERY DIVISION
IN THE MATTER OF THE LIQUIDATION OF)
ASSOCIATED LIFE INSURANCE COMPANY) NO. 88 CH 6942

NOTICE

PLEASE TAKE NOTICE, that on March 3, 1989 an Order of liquidation with a Finding of Insolvency was entered against Associated Life Insurance Company ("Associated") by the Honorable Harold A. Seigan, Judge of 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 Associated.

TAKE FURTHER NOTICE that pursuant to said Order, all rights and liabilities of Associated and its creditors, policyholders and all other persons interested in its assets are fixed as of March 3, 1989, unless otherwise provided by such further Order of the Court.

TAKE FURTHER NOTICE that any and all persons, partnerships, corporations, associations, estates, trusts and governmental units having or claiming to have any accounts, debts, claims or demands against Associated or claiming any right, title or interest in or to any funds or property of Associated in the possession of the Liquidator are required to file a Proof of Claim with the Liquidator on or before 4:30 p.m. Chicago Time, December 31, 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, Associated Life Insurance Company, In Liquidation, 446 East Ontario Street, Suite 700, Chicago, Illinois, 60611. Filing shall occur upon the receipt of Proof of Claim by the Liquidator. The Liquidator reserves the right to require such additional information with respect to any claims as he may deem necessary. The Liquidator further reserves all rights to any and all defenses of Associated concerning such claim. 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 AT HIS ABOVE MENTIONED OFFICE IS DECEMBER 31, 1990 AT 4:30 P.M., CHICAGO TIME. NO PERSON HAVING OR CLAIMING TO HAVE ANY CLAIMS AGAINST ASSOCIATED LIFE INSURANCE COMPANY, SHALL PARTICIPATE IN ANY DISTRIBUTION OF THE ASSETS OF THE COMPANY UNLESS SUCH CLAIMS ARE FILED WITH THE LIQUIDATOR ON OR BEFORE DECEMBER 31, 1990 AT 4:30 P.M.

James W. Schacht, Special Deputy Liquidator, Office of the Special Deputy, 446 East Ontario, Suite 700, Chicago, Illinois 60611, (312) 915-4700.

NOTICES

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, CHANCERY DIVISION
IN THE MATTER OF THE LIQUIDATION OF)
UNITED FIRE INSURANCE COMPANY) NO. 88 CH 6942

NOTICE

PLEASE TAKE NOTICE, that on March 3, 1989 an Order of Liquidation with a finding of Insolvency was entered against United fire Insurance Company ("United Fire") by the Honorable Harold A. Siegan, Judge of 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 United Fire.

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Product liability

Continued from page 25

"I'm not quite sure that this bill alone will do the trick."

Stuart Gerson, assistant attorney general in the civil division at the Department of Justice, contends that S. 1400 is necessary to help improve competitiveness.

"Our current system serves more as a deterrent to commercial development, domestic production, and employment than it does to promote the manufacturing of safer products," he said. "If you view the competitive entity as the United States of America, it is very clear that our product liability laws have a pronounced effect on our national competitiveness."

Those arguments rile trial lawyers, consumer advocates and others.

Robert Habush, chairman of the public affairs committee of 'the Assn. of Trial Lawyers of America, argued that reduced competitiveness is the newest "crisis" to justify a uniform federal liability law that would erode plaintiffs' rights.

Blaming a lack of innovation by U.S. firms on the tort system or on trial lawyers "is a very appealing argument," he said. "But there is no truth to it."

He noted that product liability reform was not included in recommendations made recently by the Office of Technology Assessment to improve the position of American business in foreign markets.

OTA representatives testified at a previous Senate Consumer Subcommittee hearing in April about the report (*BI*, April 16).

Another critic of the Kasten bill said U.S. budget deficits were more to blame for a lack of competitiveness than was fear of liability suits.

The bill "does little to enhance the competitive posture of the U.S. in the global industry," said Michael Box, chairman of the committee on law and justice for the National Conference of State Legislators in Washington, D.C.

Meanwhile, Sen. Patrick J. Leahy, D-Vt. expressed more specific concerns about the bill's effect on liability insurance costs.

"If we did this, are insurance premiums going to come down, or will the insurance companies end up with the best of all possible worlds—the shield from liability and still. . .able to charge outrageous premiums?" he asked.

Mr. Gerson from the Justice Department says that S. 1400 should help to reduce litigation-related insurance costs, particularly those associated with non-economic damages.

"My own experience suggests that this is the area where insurance companies have the most problem in predicting likely outcomes and setting reasonable rates for insurance," he said. "The change from joint and several to several liability" ought to reduce costs for areas of "insurance where there has been a lot of increases."

Under joint and several liability, any party named in a suit could be held liable for any or all damages involved in the suit, regardless of his degree of responsibility. Under several liability, a party would only be held liable for his degree of responsibility.

However, Mr. Habush dismissed as a "myth" the claim that current tort laws make insurance less available and more costly.

Several reports, including the 1989 U.S. General Accounting Office report on product liability litigation, found that litigation costs associated with product liability actions accounted for a small percentage of business expenses (*BI*, Dec.4, 1989).

Supporters of federal product liability legislation shake off those and similar conclusions "like a dog shaking off rain water," charged the trial lawyer.

Mr. Gerson rejects the premise of the GAO report, saying that it excluded many things from consideration, such as looking at geographical areas where liability is a problem.

If a federal liability law is enacted are 'premiums going to come down, or will the (insurers) end up with the best of all possible worlds—the shield from liability and still. . .able to charge outrageous premiums?' asks Sen. Patrick J. Leahy.

But Andrew F. Popper, a law professor and academic dean at American University in Washington, D.C., said the existing product liability system has not increased litigation.

He opposes eliminating joint and several liability from non-economic damages. Affixing a dollar amount to pain and suffering may be difficult, he said, but such damages cannot be fully covered in a reimbursement for medical expenses.

"The mere fact that pain and suffering is difficult to quantify should not mean that plaintiffs are somehow not entitled to joint and several liability, an entitlement that plaintiffs have for all other aspects of damages," Mr. Popper said.

If S. 1400 is approved, then those plaintiffs with the most "devastating" injuries would be forced to pursue each party who was in some way responsible for these injuries, even though they have proven the liability of defendants, he said.

Mr. Habush also opposed the Kasten bill's 25-year time limit provision, which would generally bar product liability suits involving products that are more than 25 years old.

He argues that time limits are unneeded since arguments over mechanical defects are based on the level of technology existing when the product in question was manufactured, and not current standards.

Asked by Sen. Charles E. Grassley, R-Iowa, if a 100- or 200-year time limit would be acceptable, Mr. Habush replied, "no."

Opponents of S. 1400 say no matter how harmless the bill may appear, if it is passed advocates of federal product liability laws will return to Congress each session seeking more liability defenses.

"While this bill does not contain all of the proposals that have been desired by pre-emptionists," it supersedes some state tort law and suggests more federal product liability laws to come, Mr. Box said.

Mr. Popper agreed.

"If you pass this bill, in future quiet sessions that attract nowhere near this level of attention, the federalization of tort law and the disassembling of consumer protection will become an annual function of this committee and others in Congress," he said.

However, Victor Schwartz, counsel for the Product Liability Alliance, a business-supported lobbying group in Washington, D.C., said, "We will not be coming back to Congress with a laundry list of defenses."

However, he does concede that he may seek modifications and fine-turning of the legislation if it is passed. ■

Asbestos cases

Continued from page 1

judge for parties unwilling to settle.

A hearing on the consolidation of the class-action lawsuits is scheduled for Sept. 14 in Cleveland.

In addition, U.S. District Judge Jack B. Weinstein of Brooklyn will oversee a separate class action against asbestos defendants that are shown to have severely limited resources.

Currently, only Eagle-Picher Industries Inc. of Cincinnati is slated to be a defendant in this class action. However, the order provides that five other unidentified companies could be included.

Judge Weinstein also said that he expects the Manville Personal Injury Trust—which was set up to pay asbestos injury victims as part of the Manville Corp. reorganization—to be part of this litigation.

Last week he appointed Marvin E. Frankel, a former federal judge, to conduct hearings to determine which asbestos producers have severely limited funds.

For now, the judges' Aug. 10 order does not force parties into any class action and allows current litigation to continue.

But the order said, "The need for a multi-court cooperative effort to dispose of these cases is compelling.

"The various case management techniques utilized by the federal court over the last 10 years have proved to be ineffective," the judges said. "The transaction costs are unacceptable."

Judges and attorneys estimate that as much as two-thirds of the money spent to resolve asbestos cases goes for attorneys' fees and other legal expenses.

Further, "thousands of claimants die before they can get the cases resolved," the judges explained.

The 10 judges concluded that "the asbestos litigation has become a classic example of civil cases that cost too much and take too long."

In addition to Judge Lambros, Judge Parker and Judge Weinstein, other judges who signed the order are: Walter J. Gex III of Mississippi; Alan H. Nevas of Connecticut; Richard A. Schell of Texas; Charles Schwartz Jr. of Louisiana; Charles P. Sifton of New York; Charles W. Wolle of Iowa; and Rya W. Zobel of Massachusetts.

Insurer representatives, asbestos producers and plaintiffs' attorneys say the judges' order raises a myriad of legal questions and is certain to be appealed.

'Thousands of claimants die before the cases are resolved,' say 10 federal judges.

"There are an awful lot of unanswered questions" in the order, said John F. Shea Jr., vp and claims counsel for Aetna Life & Casualty Co. in Hartford, Conn.

"I don't know if anyone has had a chance to analyze what this all means," agreed Chris Mansfield, general counsel for Liberty Mutual Insurance Co. in Boston.

Meanwhile, asbestos producers appear divided over the order consolidating cases.

"Historically, asbestos producers have had different views to the efficacy of class actions," said producer attorney Mr. Gilbert. "Today they still have differing views.

"Whether the producer industry will speak with one voice remains to be seen," he said.

What is clear is that "given the panoply of interests and issues involved, it is unlikely that these orders will be implemented in their present form," Mr. Gilbert said.

Appeals courts have reversed previous attempts to form huge asbestos class actions. In fact, just seven months ago, a federal appellate court in Texas overturned an order by Judge Parker creating a class action composed of some 3,000 asbestos cases.

The courts usually find that there are too many differences among plaintiffs in asbestos cases —some of whom are dying and some of whom have not yet manifested any injury—to make them suitable for class-action litigation.

Supporters of class-action litigation maintain that consolidated litigation saves tremendous amounts of money and time, allowing common liability issues to be resolved in one trial rather than thousands.

Plaintiffs' attorneys, for their part, largely oppose the consolidation of asbestos cases.

In class-action litigation, the judge overseeing the case sets attorneys' fees that are usually significantly lower than attorneys would receive by trying individual cases.

"To solve this problem we cannot blindly rush to a solution," urged plaintiffs' attorney Paul Gillenwater of Gillenwater, Nichol & Ames in Knoxville, Tenn.

"The time has come for an orderly resolution to the asbestos litigation," he said. "But it is not as critical a problem as it would appear. The courts can handle this litigation."

Plaintiffs' attorney Mr. Baron agreed: "Most asbestos litigation runs smoothly. The court system is working for asbestos cases as it works for all other torts."

Mr. Gillenwater and Mr. Baron attended a meeting two weeks ago of some 110 asbestos plaintiffs' attorneys from around the country to discuss the solutions being proposed by judges.

"No clear-cut agreement was reached" Mr. Gillenwater reported.

Continued on next page

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Asbestos cases

Continued from previous page

However, Mr. Baron reported that "90% to 95% of the plaintiffs' lawyers expressed their belief that class-action litigation was not the appropriate way to handle asbestos litigation.

"There will never be a majority of the plaintiffs' bar that consents to this," he said, adding that a consensual class-action is the only type that can survive.

Because there is certain to be a legal battle over the judges' order, most observers predict that the order will further delay—rather than expedite—awards and settlements to asbestos injury victims.

"There will be skirmishing that will cause delay," said Mr. Gilbert.

"There is a desire on the part of plaintiffs and defendants to sit down and reach a consensual solution," said James J. Restivo Jr., an asbestos producer attorney with Reed, Smith, Shaw & McClay in Pittsburgh. "These orders tend to complicate that process."

The class-action order came on the heels of an earlier order by Judge Lambros suggesting that the Manville Personal Injury Trust be combined with the Center For Claims Resolution, an asbestos injury claims-handling facility composed of 21 former asbestos producers, to form a single nationwide claims handling facility.

Judge Lambros also suggested including all other asbestos producers and their insurers in the new claims-handling facility.

It appears to be a good idea in principle, but implementation could be onerous, according to representatives of the Manville Personal Injury Trust, the Center for Claims Resolution and plaintiffs' and defense attorneys.

Putting judges in charge 'would be an invitation to chaos,' says Donald Blinken, a Manville trustee.

Creating a single claims-handling facility would "minimize transaction costs" and achieve "economies of scale," said Judge Lambros in his Aug. 7 order.

However, the judge failed to realize the difficult hurdles that would have to be conquered before such a nationwide claims-handling facility could be formed.

At the outset, it is highly unlikely that all U.S. asbestos producers would want to participate, observers point out.

Historically, their settlement strategies have varied widely. Some asbestos producers favor grouping together similar claims and settling them expeditiously and others want to evaluate each case individually. These differences in opinion led to the dissolution of the original Asbestos Claims Facility, which was formed amid much hoopla in the mid-1980s (*BI*, May 30, 1988).

Plaintiffs' attorney Mr. Gillenwater also noted that creating a nationwide claims-handling facility could hurt victims by making settling more difficult.

Asbestos victims now can settle with some asbestos producers and litigate with others. However, if all producers are joined together in one claims-handling facility plaintiffs will have fewer settlement options, he said.

In addition, the Manville Corp. reorganization plan prohibits the Manville Personal Injury Trust from merging right now with any other claims-handling facility, explained Marianna Smith, executive director of the trust. However, that restriction will expire this winter, Ms. Smith added.

"In principle," forming a single claims-handling facility "is a good idea" said Donald Blinken, a trustee of the Manville trust. "Economies of scale might be achieved."

Trustees of the Manville trust, however, oppose Judge Lambros' suggestion that the new claims handling facility be supervised by judges, Mr. Blinken said.

"That would be an invitation to chaos," he added.

In addition, any merger involving the Center for Claims Resolution—which was formed after the original Asbestos Claims Facility folded—would have to be approved by "a substantial majority" of the 21 asbestos producers that are members of the CCR and the insurers that support the facility, explained Lawrence Fitzpatrick, president and chief executive officer of the CCR in Princeton, N.J. This may not be easy to achieve.

"Until the Manville trust's current financial problems are resolved or alleviated I cannot imagine any producer group wanting to merge with them," said an executive, who asked not to be named.

The recent skirmishing over asbestos litigation was prompted, in part, by the Manville trust's announcement that severe cash flow problems would leave it unable to pay thousands of victims for 10 to 20 years (*BI*, Jan. 22).

However, Mr. Blinken said creating a nationwide class action or a nationwide claims handling facility will not solve the problems plaguing the Manville trust.

According to Mr. Blinken, among the likely solutions being discussed are increasing the amount of money that Manville Corp. gives the trust, expediting payments from Manville, making some trust assets more liquid and modifying the payment structure so that more severe claims are paid first.

To give the trust time to solve its financial woes, Judge Weinstein has extended until Sept. 6 an order preventing the trust from paying any settlements or judgments.

A group of 1,100 asbestos victims appealed Judge Weinstein's authority to stay payments by the trust, but the 2nd U.S. Circuit Court of Appeals last week affirmed the judge's order. ■

SET YOUR DATES

issue:	August 20
closing:	August 8
demographic section:	Insurer Topics: Employee Development & Education
issue:	August 27
closing:	August 15
issue:	September 3 — Bonus Distribution: Monte Carlo Rendez-Vous de Septembre
closing:	August 21
editorial feature:	Reinsurance: Int'l Markets/Lloyd's Report — Directory: Leading Reinsurers Worldwide
demographic section:	Agent/Broker Topics: Most Productive Agencies/Automation
issue:	September 10 — Reader Service — Bonus Distribution: IIAA; IAIABC
closing:	August 28
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WORKERS COMP

In today's workplace, major cumulative trauma disorders — serious ailments caused by repetitive motions — are afflicting employees, and affecting employers and insurers.

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Health insurance

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tant Towers, Perrin, Forster & Crosby Inc., said that overall medical plan premium increases are "moderating somewhat" at midyear.

Group health insurance premium increases have "plateaued and are a little bit lower than six months ago," agreed Jay Catlin, a benefit consultant with Secaucus, N.J.-based Buck Consultants Inc.

Allan Maltz, a vp and actuary at Aetna Life & Casualty Co. in Hartford, Conn., said many employers renewing at midyear are faring better than employers that renewed at year-end, "especially if they've moved to a managed care environment." And, even employers that stayed with the same type of plan are seeing a "modest improvement" in terms of premium increases, he said.

However, while employers are enjoying a moderation in premium increases in 1990—a trend that may continue through 1991—consultants and insurers say employers should not expect any dramatic change in future premium increases.

"For the next several months on up to a year, my expectation would be (the rate of increase) would only fluctuate a percentage point or two," predicted Dennis Whimpey, senior vp of finance at CIGNA Corp. in Bloomfield, Conn.

"Insurers have been slow to lower trend assumptions, but competitive pressures will force them down over the next several months," observed Richard Johnson, managing director of consultant William M. Mercer Inc. in Chicago.

Dr. William McGuire, president and chief operating officer at HMO operator United HealthCare Corp. in Minnetonka, Minn., said he expects overall group health insurance premium increases to drop by a percentage point or two over the next six to 12 months. However, he said, "whether it'll occur because of health care cost control or because of increased competition" among insurance companies and HMOs is uncertain.

"We don't see an aggressive pricing cycle as has been there in the past," he added.

And, no one is expressing optimism that indemnity plan premium increases will drop much lower than 10% in the near future.

"We don't anticipate rate increases will drop to single digits since they are a function not only of health care costs but administrative costs," said Joe Maginnis, vp of group underwriting at Prudential Insurance Co. of America in Roseland, N.J.

One reason premium increases are stabilizing is because insurance companies in general are no longer playing catch-up with health care cost inflation.

"It doesn't look like insurers are playing catch-up as much as a year ago," said Arthur Drechsler, a vp and national practice leader for group health benefits in the New York office of consultant Martin E. Segal & Co.

"In insured business, accounts are in the break-even position," observed Robert H. Shannon, a principal at consultant A. Foster Higgins & Co. Inc. in New York.

Mr. McGuire of United HealthCare said, "rates have caught up with the underlying expenses and premium rate increases are paralleling" health care cost trends.

In general, CIGNA has caught up with health care cost inflation, Mr. Whimpey said. However, he said some smaller accounts, particularly those with fewer than 200 employees, are still a little behind. "That block should catch up by the end of this year," he predicted.

Ray McCaskey, executive vp of planning and finance for Blue Cross & Blue Shield of Illinois, said for the most part insurers have caught up with inflation. "For our organization, we had the last little bit of catching up in January," he said. And, "there are some" insurers "that have overshot the mark and will probably back off."

TPF&C's Mr. Leisure said insurers in the past "were raising rates faster than costs were rising." But, mid-1990 insurance premiums "are more reflective of actual experience than a year ago."

John Wylde, a principal in Mercer's Tampa, Fla., office, said, "health care inflation is still going up, but it seems to have slowed somewhat. Insurance company trend factors are down 2% to 3% from a year ago."

Insurers and HMOs use those trend factors to project premium increases. Trend lines take into account factors including projected increases in overall health care costs, increased utilization and technological advances.

These trends are combined with an employer's claims experience to determine a premium.

Segal's Mr. Drechsler said in the last 12 months, the medical care cost trend reached a high of 33% and a low of 11%, with an average of 21% nationally.

Technological advances in medical care are a key—and somewhat uncontrollable—component driving the cost trend upward, experts say.

"We as a society have a love affair with health care technology. And as long as our society exercises an infinite demand for technology, there are people out there who will provide it—at a significant cost," said Leonard Wood, senior vp of marketing for HMO-USA, a national HMO network operated by the Chicago-based Blue Cross & Blue Shield Assn.

'It doesn't look like insurers are playing catch-up as much as a year ago,' says Segal's Mr. Drechsler.

BC&BS of Illinois' Mr. McCaskey also pointed out that "utilization is still a major factor" behind rising health care costs.

"We get trapped sometimes when we talk about unit prices relating to inflation increases," he said. For example, while technology and new procedures do contribute to inflation, they probably only account for 10 percentage points of a 20% premium increase, he explained, with increased utilization comprising the remainder.

William Caulfield, a senior vp at John Hancock Mutual Life Insurance Co. in Boston, said the reason premium increases have come down this year is because more employers and insurers "are beginning to understand the need to control utilization."

Annually, medical care costs are still rising at a rate approximately two times that of overall inflation, as they have in the past several years.

According to the U.S. Bureau of Labor Statistics, the medical care component of the Consumer Price Index rose at an annual rate of 9.2% for the six months ended June 30, 1990. By comparison, the overall CPI rose at an annual rate of 5.9% during the same period.

Most employers renewing indemnity plans on July 1 or Aug. 1 saw trend lines translate into 20% to 25% premium increases.

Anthony Trani, vp of group marketing at Metropolitan Life Insurance Co. in New York, said, "we're seeing trend increases of about 22% on straight indemnity cases."

Kevin Hickey, senior vp at Fort Wayne, Ind.-based Lincoln National Corp., said indemnity plan increases are falling between 21% and 23%, depending on the region of the country.

BC&BS of Illinois' premium increases for general comprehensive major medical plans are "hovering around the 20% level," Mr. McCaskey said. "That is slightly down from what it was at year-end."

Prudential's Mr. Maginnis said for employers with more than 500 employees, premium increases are in the range of 15% to 20%. "Most are clustered around 15% and some are as low as 13%," he said.

However, other consultants note some employers with indemnity plans are being hit with much higher increases.

Robert Bodor, a principal with Alexander Consulting Group Inc. in Lyndhurst, N.J., said average premium increases have come down, but he still has seen increases of up to 40%.

Foster Higgins' Mr. Shannon said the top range for indemnity plan premium increases is around 35% to 40% this year, compared with the high of 40% to 45% last year.

Employers that self-insure their indemnity plans say that claims costs are increasing this year by between 10% and 20%.

Mr. McCaskey said in general that self-insured employers' cost increases are reflecting trends and are "close to 20%."

"Now that we've caught up with inflation on the indemnity side, we're seeing fairly the same increases for insured and self-insured" employers, he said.

Gary Silverman, director of compensation and benefits for LTV Corp. in Dallas, said his company expects to see a 20% increase in group health insurance costs for 1990.

LTV, an aerospace and steel manufacturer, offers a self-insured indemnity plan along with about 15 different HMOs to its employees nationwide. Approximately 80,000 active employees out of a total workforce of 120,000 are covered by the indemnity plan.

Arthur Young, benefits manager for electronics manufacturer Hewlett-Packard Co. in Palo Alto, Calif., said he expects to see a 10% to 20% increase in the company's 1990 self-insured indemnity plan costs. However, he noted the increase will "probably be closer to the lower end."

Mr. Leisure said some of TPF&C's larger clients, specifically those with more than 20,000 employees, are seeing cost increases for self-insured indemnity plans in the mid-teens.

One reason cost increases for self-insured indemnity plans are typically lower than increases for insured plans is because "we can afford to be less conservative," Mr. Silverman said, adding that insurers must build a profit margin into their rates.

Segal's Mr. Drechsler noted that cost increases for self-insurers "depend a lot on the particular group and the kind of year they are having."

Meanwhile, most HMOs are increasing premiums between 10% and 20%, with the majority of premium increases falling in the mid-teens.

Dr. Robert Weinstein, president and chief executive officer of Chicago-based HMO-America Inc., said, "on average most of our renewal quotes were in the 10% to 20% range."

Kaiser Foundation Health Plans is increasing premiums "19% program-wide," said Dick Anderson, vp of medical economics for the Oakland, Calif.-based managed care giant.

The 19% rate increase is being applied uniformly to Kaiser accounts, which in the last several years have been charged increases averaging only 6.6%, Mr. Anderson said.

Kaiser, which has had "unparalleled growth in membership" over the last three years, needs to increase its capital, Mr. Anderson said.

Preliminary data released by Interstudy, a managed care research organization based in Excelsior, Minn., indicates that the average HMO premium increase for fiscal 1990 is 16.8%, down from a 17.2% average increase in fiscal 1989.

TPF&C's Mr. Leisure said, "the HMOs are clearly coming down from around 18% in 1989 to the mid-teens in '90 and will go down even further," probably to about 12% in 1991.

Some HMOs are already reporting premium increases in the low teens.

CIGNA Healthplans Inc. premium increases range from 12% to 15%, according to Mr. Whimpey. "That's a broad average and we have several plans across the country that won't see any increase."

Met Life is charging increases of 12% for its managed care plans, compared with about 16% last year, Mr. Trani said.

Bill Murin, vp of human resources for Telecredit Inc. in Los Angeles, said his company expected a 14% increase in HMO premiums for its Aug. 1 renewal. However, CIGNA Healthplans increased HMO premiums for the 1,200-worker computerized payment authorization company by only 12%.

Mr. Young said premium increases charged by the 86 HMOs that cover approximately 87,000 Hewlett-Packard employees nationwide "range from 8% to 25%, with an average of about 15%."

Consultants said HMOs are able to offer more reasonable premium increases because they are in better financial health than a year or two ago.

"In 1991, (HMO premium increases) will probably be around 10% to 12%, primarily because most of the plans are doing quite well financially," said Brent Greenwood, a principal in the Minneapolis office of Tillinghast, a division of Towers, Perrin, Forster & Crosby Inc.

Some employers with managed care plans experienced only single-digit premium increases during midyear renewals.

For example, premium increases for the managed care plan offered by the city of Phoenix, Ariz., was "one-third to one-half of what others are experiencing," said Philip Kundin, deputy personnel director for the city.

CIGNA underwrites the group health care coverage for Phoenix's 11,000 active and 1,500 retired municipal employees. The city's plan consists of a triple-option point of

Continued on next page

Update

Appeal seen in Boy Scout suit

CHICAGO—The Boy Scouts of America will likely appeal a $12.8 million award against a scout leader's estate, its attorney says.

A Cook County Circuit Court jury last week awarded $14.2 million to a 13-year-old boy who was seriously injured en route to a Boy Scout jamboree in 1988 when his troop leader's car was struck by a van. The leader—determined by the jury to be 90% at fault for the accident—and another scout died from their injuries. The driver of the van, found to be 10% at fault, is responsible for the remaining $1.4 million.

While jurors absolved the Boy Scouts of liability, the organization carries liability coverage to protect volunteers sued in the performance of their duties, said Kenneth Walters, director of support services. He said about 10 insurers are involved.

C. Barry Montgomery, a partner of Williams & Montgomery in Chicago and attorney for the Irving, Texas-based Boy Scouts of America, said "there is no question that the boy was badly injured, but I think the award was excessive." He contends that by allowing separate awards for each count of economic and non-economic loss, the judge "basically forced the jury to overcompensate" the boy.

St. Paul Fire & Marine Insurance Co. is the primary liability insurer—above a self-insured retention—and Reliance Insurance Co. is its first layer excess insurer, Mr. Montgomery said. He added that, to his knowledge, no other layers would be tapped.

Coastal officers face fraud suit

LOS ANGELES—Former officers, directors and shareholders of insolvent Coastal Insurance Co. are charged with racketeering, fraud and mismanagement in a suit filed Aug. 10 in Superior Court here by Insurance Commissioner Roxani Gillespie.

The civil suit, which seeks general damages of $66 million and an unspecified amount of punitive damages, also asks that damages be tripled for violations of the Racketeer Influenced and Corrupt Organizations act.

The Insurance Department seized Van Nuys-based Coastal in February 1989 (*BI*, March 6, 1989). The department found the insurer, which sold substandard private passenger auto policies and medical malpractice and general liability coverages, was insolvent by more than $40 million.

Defendants are charged with diverting funds from Coastal through various schemes, misrepresentations and kickbacks.

Briefly noted

The Bush administration is considering options to reduce the exposure of the **Pension Benefit Guaranty Corp.** to big pension claims as well as to increase the PBGC's premium income. One of the options, according to Pensions & Investments, a sister publication of *Business Insurance*, would raise PBGC premiums for employers whose pension plans have unfunded liabilities exceeding $50 million. . . .Legislation, S. 2988, introduced by Sen. Daniel P. Moynihan, D-N.Y., would make permanent Section 127 of the Internal Revenue Code, which allows an employee to receive up to $5,250 annually in tax-free **tuition reimbursement benefits** from an employer. Section 127 is now scheduled to expire on Sept. 30. . . .The criminal trial of **Chicago Magnet Wire Corp.** and several officers began last week in Cook County Circuit Court. Defendants are charged with conspiracy and multiple counts of aggravated battery and reckless conduct for exposing unprotected workers to hazardous chemicals. The trial follows a five-year legal battle over whether state or federal safety laws should apply in the case (*BI*, Feb. 5; Oct. 9, 1989). . . .Rep. Peter J. Visclosky, D-Ind., introduced H.R. 5542, which would raise the excise tax on **reversions from defined benefit pension plans** to 30% from 15%.

Health insurance

Continued from previous page
service program in which Phoenix employees can choose among a staff model, an individual practice association HMO or an indemnity plan.

"Our plan design seems to be working very effectively and as a result we had an 8.4% increase overall," Mr. Kundin said.

Mr. Leisure pointed out that group and staff model HMOs generally charged lower increases at midyear than IPA models. He said clients with staff and group models are seeing 9% to 10% premium increases, while IPA increases are closer to 15% to 17%.

In a group model HMO, a group of physicians that contracts with an HMO delivers care. In a staff model HMO, care is delivered by physicians who are employees of the HMO. In an IPA, the HMO contracts with independent physicians who deliver care from their offices.

Mr. McCaskey of BC&BS of Illinois said, "from what we've seen, we suspect the IPA situation has contributed more to the cost increases than the group models."

Lower premium increases for group model HMOs may be due in part to the risk-sharing relationship they establish with employers, experts say.

"Where physicians are at risk there are little efficiencies that can be wrung out of the system," Prudential's Mr. Maginnis said.

Most observers point out that employers with managed care programs, whether they be HMOs or indemnity plans that incorporate managed care techniques, are seeing smaller premium increases.

Mr. McCaskey said, "we've seen some fairly marked differences between the indemnity, HMO and PPO plans and they reflect the extent to which controls are applied in each of the settings."

CIGNA's Mr. Whimpey noted that "the strongest strategy an employer can take is to implement utilization review and managed care."

MetLife's Mr. Trani agreed that managed care savings can be significant. "In indemnity plan clients, we'd see 19% to 32% higher costs" if they had not implemented managed care programs like selective provider networks, healthy pregnancy programs and utilization review.

In addition, "on the six major groups we've studied, we've seen an average of 26% less utilization than if" those groups would have "stayed in a traditional indemnity environment," Mr. Trani said.

Many employers, especially those with traditional indemnity plans in place, are "really thinking seriously about ambulatory (care) utilization review," TPF&C's Mr. Leisure said. UR can "stem abuses in the outpatient sector and ferret out" some of the physician tricks like upcoding and unbundling surgical procedures, he said.

Stringent UR also can save employers money in their mental health benefits, where jumbo claims and high utilization are costing employers big money and driving overall health plan costs skyward.

BC&BS of Illinois' Mr. McCaskey said, "We've had some plans in recent months where over 25% of our inpatient admissions were related to psych and substance abuse."

However, whether employers can reduce renewal costs if they implement managed care programs "varies an awful lot," Segal's Mr. Drechsler said. "It can have a positive effect, but if you look at it on average, the results are less impressive.

"There is a lot of 'me-tooing' going on," he said, explaining that many employers simply copy strategies used by other companies. However, employers must look at their own experience and plan design and then plot their own strategy, Mr. Drechsler advised.

'I think the indemnity plan is basically obsolete now,' says United HealthCare's Mr. McGuire.

Mr. Leisure said employers adopting a managed care network must evaluate whether the network's combination of discounts and efficiency will pay off.

"The real question is, is that network going to deliver discounts and lower utilization. Discounting arrangements without risk sharing and significant patient flow to the provider won't survive," he said.

Benefits experts are undecided about the ultimate future of the traditional indemnity plan.

While "it's probably an overstatement to say there will be no indemnity plans" in the future, "the managed care plan will emerge as the dominant" plan, Mr. McCaskey said.

"I think the indemnity plan is basically obsolete now. Using it without any controls or managed care components is pretty foolish in our opinion," said United HealthCare's Mr. McGuire.

CIGNA's Mr. Whimpey said, "some forms of indemnity will persist in the long run. But some managed care techniques will be injected into them to moderate" premium increases.

The difference in cost increases for indemnity and HMO plans is beginning to narrow, some consultants say.

Foster Higgins' Mr. Shannon said, "as corporations start to do a better job of evaluating risks, HMOs' and indemnity plans' increases will be the same."

However, others disagree. Lincoln National's Mr. Hickey said, "I don't think indemnity increases will ever go down to HMO increases." In fact, he said, "there will be pressure to bring HMO increases up to indemnity levels."

CIGNA's Mr. Whimpey said, "the 8% to 10% difference" in indemnity plan and HMO premium increases "is holding steady. I don't see them coming together."

Meanwhile, consultants say employers are still interested in shifting health care costs to employees through increased deductibles and out-of-pocket limits, but employers generally have recognized that cost shifting is not a long-term solution.

"There will be continuing cost shifting to employees," predicted Mercer's Mr. Wylde. Rising health care costs have "eaten into earnings per share so much that it receives and continues to receive attention from senior management."

But Mr. Wylde pointed out that employers now understand that a benefit change, like an increased deductible, made two years ago will not keep producing savings because of the constant increases in the cost of services and higher utilization.

As a result, some employers are showing an interest in indexing deductibles to salaries.

"This should grow to some degree," Mr. Wylde said. The practice "would eliminate the need for the employer to increase the deductible every year or so. This method is self-adjusting, so you don't have to communicate increases to employees."

Alexander's Mr. Bodor said, "more employers are talking about this. The larger the employer, the more flexibility and willingness to try this."

However, Hancock's Mr. Caulfield pointed out that indexing deductibles to salaries poses an "administrative nightmare" to human resource departments that will have to provide salary information to claims administrators. "It sounds good in theory, but very few people have been willing to put it into practice," he said.

Mr. Drechsler said employers also are showing a greater interest in linking deductibles and co-payments to individual employee risk characteristics. For example, employees who smoke may pay a higher deductible than nonsmokers. ■

Home acquisition

Continued from page 1
debt to commit the capital to make the company grow. I think under a new owner (The Home) would continue to improve," said Mr. Woodrum.

The Home's statutory surplus stood at $770 million on June 30, down from $830.8 million as of Dec. 31, according to A.M. Best Co.

Home President James J. Meenaghan said Vik Brothers representatives have assured him they have no intentions of making any significant operational or management changes.

Vik Brothers officials "have made repeated statements that they are impressed with the improvement in our company, the direction in which it is headed and our current business strategies," Mr. Meenaghan said.

Stock analysts are not impressed.

Udayan Ghose, senior vp at Lehman Brothers in New York, called the sale "a disaster" for shareholders.

The proposed sale "has devastated shareholders of AmBase," agreed James L. Bellessa Jr., vp-research for D.A. Davidson & Co., a securities firm in Great Falls, Mont.

Their comments are confirmed by the performance of AmBase's stock immediately following the announcement of the proposed acquisition late Tuesday. AmBase noted that "the expected proceeds make it unlikely that AmBase will distribute a special cash dividend to its stockholders." The company promised such a dividend earlier this year (*BI*, Feb. 26).

AmBase common shares dropped $4.75 Wednesday to $2.75 from $7.50. More than 1.9 million shares were traded, making it the second most-active issue on the New York Stock Exchange.

On Thursday, AmBase stock fell an additional 62 cents to $1.88 per share. Some 1.6 million shares traded hands, making it the fifth most-active NYSE stock that day.

Mr. Ghose said he "basically told people to sell actively" last week.

"Anybody who held the stock yesterday at $7.50 is going to get killed," said Mr. Ghose. He estimates that after the Home sale, Ambase shares will actually be worth less than than $2.

One shareholder sued Ambase last week, charging the company disseminated false information to inflate its stock price when it said it would issue the special dividend following the sale of The Home, according to press reports. The suit, filed in federal court in New York, seeks class action status. It does not specify damages.

Following the sale of The Home, AmBase—which is the sole common shareholder of The Home—would retain only its Morristown, N.J., thrift subsidiary Carteret Bancorp, which has about $6 billion in assets. But, because of "enormous problems with its loan portfolio," Mr. Ghose estimated Carteret's value at $25 million to $30 million.

In addition to The Home, Vik Brothers would acquire its various insurance subsidiaries, including U.S. International Re Inc. and Commonwealth Insurance Co. of Canada, as well as New York-based stockbroker Gruntal Financial Corp. and Sterling Forest Corp., which holds a large parcel of land north of New York City.

Mr. Meenaghan pointed out that "we had announced earlier that Commonwealth and U.S. International Re were for sale separately." The Home still plans to sell these units, even if it is acquired by Vik Brothers. "The proceeds would stay in The Home," he said.

Mr. Ghose estimated the combined value of Commonwealth and U.S. International Re at "somewhere between $150 million and $175 million."

AmBase intends to sell The Home to Vik Brothers even though the investment group's offer was not the highest received.

Business Insurance reported earlier this month that Sequoia Associates, an investment firm in Menlo Park, Calif., offered AmBase $955 million for The Home in a confidential July 30 letter (*BI*, Aug. 13).

AmBase apparently turned down the offer, which had an Aug. 3 deadline.

"The offers from other investors," including Sequoia, "weren't comparable. There were lots of differences in the structure," said Mr. Meenaghan.

"There are all sorts of moving pieces" in a transaction of this nature and the "purchase price doesn't tell the whole story," Mr. Meenaghan said, though he would not be more specific.

Mr. Ghose speculated that the Vik Brothers transaction "was the deal with the highest cash component to pay down AmBase's debt with creditors."

Robert M. Solitro, chief examiner with the New Hampshire Insurance Department, said that he could not comment on whether the transaction would be in the best interests of The Home's policyholders until his department and regulators of other states in which Home subsidiaries are domiciled analyzed filings by Vik Brothers.

Mr. Ghose of Lehman Brothers calls the sale 'a disaster' for AmBase's shareholders.

The Home Insurance Co. is domiciled in New Hampshire.

At this point, the New Hampshire Insurance Department has "very limited information" on the investment group, he added.

AmBase's Mr. Woodrum said that if the two parties reach an agreement in principle, AmBase expects to seek shareholder approval this year "and hopefully, we could close the deal before the end of the year."

AmBase's banking agreements require it to sign a definitive agreement with a buyer by Sept. 28 or face substantial penalties, Mr. Woodrum said. He added that "it will take at least four weeks of negotiations before we come to a definitive agreement."

"With AmBase, the real question right now is if this deal will go through," Mr. Ghose said, though he stressed that "there don't seem to be many alternatives."

Mr. Bellessa agreed. "Financial-service companies are built on confidence and credibility. AmBase has lost this confidence and credibility and it's conceivable that the whole transaction could unravel."

Gloria Vogel, associate director at Bear, Stearns & Co. in New York, noted that the sale "requires shareholder and regulatory approval, so there can always be question marks."

AmBase last week reported a $106 million net loss in the second quarter, compared with $30 million in net income in the second quarter of 1989. For the first six months of 1990, AmBase reported a consolidated net loss of $148 million.

AmBase attributed the loss to "losses realized in the high-yield portion of the investment portfolio of the company's insurance subsidiaries;" unfavorable property/casualty, retail securities and banking market conditions; and restructuring costs.

Losses stemming from its securities portfolio totaled $44 million in the second quarter and $86 million in the first half, the company said.

"The 1990 results reflect losses arising from a decision to reduce the level of non-investment grade bonds in The Home's portfolio and continued deterioration in the financial condition of certain issuers of high-yield securities. Approximately 70% of the difference between the cost and current market value of the high-yield bond portfolio has either been reserved or written down at June 30, 1990," the company stated.

AmBase also noted that it had "signed an amendment to its current bank credit agreement which provides for adjustments to certain financial covenants, additional contingent fees and accelerated repayment schedules."

In addition, Mr. Solitro said that in a report issued earlier this year New Hampshire regulators said they believed The Home to have been underreserved by $289.4 million at the end of 1987. The insurer did not agree with the report, he said.

However, Mr. Solitro added that The Home has "added some to its loss reserves over the last two years," but he would not be more specific.

Home officials could not be reached for comment on the New Hampshire report.

Little is known about Vik Brothers International or the sources of its funding. Calls to its U.S. general counsel were not returned.

However, Vik Brothers Insurance Inc., a unit of Vik Brothers International, owns two small U.S. insurers and once owned a syndicate on the now-defunct New York Insurance Exchange.

Vik Brothers Insurance Inc. purchased Indianapolis-based American Professionals Insurance Co., a former Baldwin-United Corp. unit, in June 1986. The company primarily writes automobile insurance, though Best's Insurance Reports notes that it also has written specialty lines like asbestos abatement liability coverage. The company wrote $5.7 million in net premiums last year, according to Best's.

In November 1989, Vik Brothers Insurance purchased Raleigh, N.C.-based State Capital Insurance Co. from Durham Insurance Group, a company spokeswoman confirmed. The company, which wrote $40.1 million in net premiums last year, primarily writes homeowners insurance, Best's reports.

In addition, Vik Brothers Insurance formed the Vik Re Syndicate Inc. on the NYIE in January 1987 from the shell of the former Chubb Syndicate Inc. (*BI*, Jan. 12, 1987). All syndicates on the exchange stopped writing in November 1987 (*BI*, Nov. 16, 1987). ●

Associate Editor Mark A. Hofmann in Chicago contributed to this story.

Relief from brokers' doldrums unlikely in bottoming market

By LEONARD M. WILSON

Special to Business Insurance

THE MID-SUMMER DOLDRUMS have overtaken insurance brokerage. Changes in insurance markets are glacial and pessimism about the timing of a turn has increased. Late in 1989, many observers were anticipating a firming in rates by the middle of 1990. Now, the consensus calls for a hardening in the second half of 1991. The gloomier forecasts push a turn out to 1992.



Mr. Wilson

Second-quarter brokerage results provided little ammunition for a more optimistic viewpoint. Results generally ran to the disappointing side, although not drastically. Analysts typically found it necessary to shave estimates for the full year.

The public brokers remain in the cautious camp with respect to premium rates. Perceptions of the market range from getting worse after a lull in competition to a possible bottoming.

Commissions on domestic business rose 2% to 5%, depending upon the broker. The state of insurance markets is evident in the slender gains. We estimate that premium rates declined across the board somewhere between 4% and 9%, extrapolating from second-quarter commission growth.

Mix changes also influenced comparisons. One broker cited the significant growth in workers compensation premiums and the countervailing drop in competitive general liability. This shifting mix has adverse effects on commissions, since workers compensation carries much lower commission rates than other liability lines.

Reinsurance brokerage strengthened distinctly in the second quarter for those brokers where the sector is important. Marsh & McLennan Cos. Inc. posted an increase of about 15% in reinsurance brokerage, for example.

Indications point to a reinsurance market that is bottoming in the United States and evincing a firmer tone in London. Nevertheless, no one is suggesting that the primary companies are ready to cut their retentions. The mixed status of reinsurance at a time of rising combined ratios in primary lines is a barometer of the ample capital currently available for commercial lines.

International insurance brokerage on the primary side largely mirrored U.S. conditions: plenty of capacity and generally easier pricing. The impact of the dollar's weakness worked its way through income statements in diverse ways. On pure foreign business, dollar-denominated revenues, expenses and profits benefited. On volume originating in North America but serviced in London, profit margins were squeezed by the currency shifts.

Growth in employee benefit consulting shows no signs of abating. Brokers typically recorded gains of 15% or better in this segment. The strong growth of benefits consulting has persisted now for about five years. During the past three years, insurance brokerage revenues have stagnated. In the case of Marsh & McLennan, this disparate performance, along with a few acquisitions, has allowed consulting revenues to approach domestic insurance brokerage. Other brokers can now claim meaningful volumes of consulting billings.

Gains in self-insurance fees can be gauged principally through Gallagher-Bassett Services, Arthur J. Gallagher & Co.'s subsidiary. Fee income advanced 19% in the quarter. Emphasis on production accounted for the rise, with innovative marketing an important stimulus to activity. Soft markets traditionally have diminished the appeal of self-insurance, but this could be changing due to more sophisticated techniques of self-funding that are not susceptible to cyclical fluctuations in premium cost.

Investment income rose about 5% for most brokers. Money market rates have remained fairly stable on a year-over-year basis, with any impetus to the category emanating from modest expansion of the float.

New business was generally robust but, as in the first quarter, we detect a slightly diminished pace of growth for net new business. This is defined as total new business less lost business for the quarter. Competitive markets equate with shopping the risk and greater account turnover. Public brokers have instituted programs explicitly aimed at dampening account turnover—with success, we believe. It is possible that new business in dollars, as contrasted with units, suffers from the continued easing in prices.

Costs remained under tight control. Most brokers kept the increase well within the single-digit range year over year. Headcounts seem to be steady. It is interesting that headcount growth in the industry has not risen very much since the soft market began. This discipline suggests that the public brokers have found the means to improve productivity at a time when units of business have continued to grow.

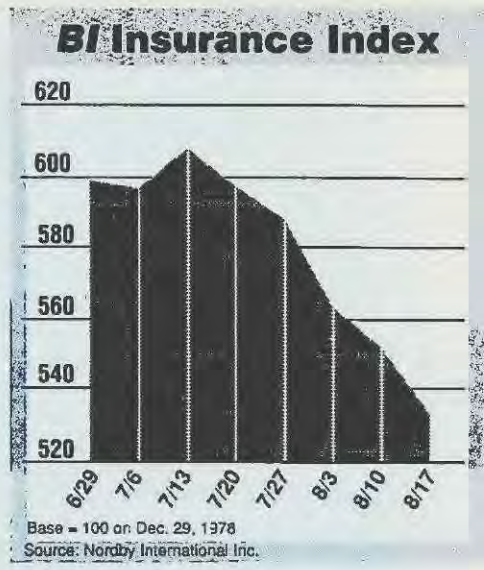
In addition, cost control enjoys much greater acceptance within organizations compared with the situation during earlier soft markets.

Profit margins continued under pressure despite attention to costs. As long as revenues advance in the low to middle single-digit range, leverage in brokerage will tend to work in the wrong direction. Earnings leverage on the upside awaits stronger growth in the top line.

Rising earning power is the driving force behind increasing stock prices. Since the euphoria late last year after a hurricane and an earthquake, earnings estimates have dropped steadily, and brokerage stocks have declined. As long as expectations for a turn in premium rates are pushed out in time, brokerage stocks will have difficulty making real headway.

Second-half performance is likely to resemble that of the first half of the year, a kind of ho-hum environment in which strong new business and tight cost control are neutralized on the income statement by a soft but bottoming insurance market. ■

Leonard M. Wilson is a senior vp with Lazard Asset Management Inc. He is a member of the New York Society of Security Analysts.



Insurance industry stocks continued to drop last week , as the *Business Insurance* Index fell 18.5 points to 533.5 on Aug. 17, from 552.0 on Aug. 10. Advancing issues were led by American Indemnity Financial Corp., up 11.1%; Travelers Corp., 6.3%; and Statesman Group Inc., up 4.0%. Declining issues followed Ambase Corp., down 71.2%; Fremont General Corp., down 14.3%; and Pacificare Health Systems, down 13.6%. The most active issue during the week was Sears, Roebuck & Co. (Allstate), 4.1 million shares traded. The *BI* Index lost 3.4% for the week; The Standard & Poor's 500 fell 2.4%; the Dow Jones 30 Industrials dropped 2.6%; and the New York Stock Exchange Composite lost 2.2%.

British Issues

August 16 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High	1 Week Low
Commil Union	487	22.5	28.7	5.9	500	487
Genl Accident	497	15.1	33.4	6.7	505	497
Gdn Royal Exch	207	18.0	15.3	7.4	211	206
Royal	433	23.2	34.0	7.8	452	433
Sun Alliance	298	13.8	16.7	5.6	306	298
Brokers						
Bradstock	232	16.2	10.0	4.3	232	232
CE Heath	462	13.6	34.5	7.5	465	462
Hogg Group	146	9.6	9.7	6.6	146	146
Lloyd Thompson	318	19.8	9.7	3.0	318	315
PWS Holdings	75	11.8	3.3	4.4	76	75
Sedgwick Grp	198	14.9	16.0	8.1	213	198
Steel Brrl Jones	261	15.8	14.7	5.6	261	260
Willis Faber	231	14.5	16.0	6.9	235	226

Source: Philip Olsen, Insurance Industry Specialist London

BI Industry Stock Report

AUGUST 13, 1990 THROUGH AUGUST 17, 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	21.38	-2.29	-32.14	34.00	21.38	325	1.00	4.68	20	9.18	2.33
Corroon & Black	NYS	30.00	2.13	-21.57	41.00	28.50	328	1.36	4.53	15	12.73	2.36
Gallagher Arthur J. & Co	NYS	21.63	-2.26	-12.63	26.50	21.00	26	0.60	2.77	17	5.33	4.06
Frank B. Hall	NYS	2.88	-4.17	-4.17	4.25	2.50	69	0.00	0.00	-2	-2.80	-1.03
Hilb, Rogal & Hamilton	OTC	14.13	-5.83	-24.16	20.63	12.50	63	0.28	1.98	19	4.60	3.07
Marsh & McLennan	NYS	67.00	-4.46	-14.10	89.75	67.00	774	2.60	3.88	16	10.56	6.34
Poe & Associates	OTC	11.25	0.00	-15.09	13.00	8.00	25	0.40	3.56	14	1.93	5.83
BROKERS	AVERAGE		-2.4	-17.7					3.1	14		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W R. Corp	OTC	33.50	-6.29	-19.52	46.50	33.75	156	0.44	1.31	7	25.06	1.34
Berkshire Hathaway Inc	NYS	6675.00	-1.48	-22.61	8900.00	5675.00	0	0.00	0.00	-22	2869.00	2.33
ITT (Hartford Group)	NYS	52.88	-3.64	-11.69	64.50	50.75	2110	1.60	3.03	6	56.33	0.94
Sears (Allstate)	NYS	28.88	-6.10	-25.48	46.38	29.00	4096	2.00	6.93	8	37.75	0.76
CONGLOMERATES	AVERAGE		-4.4	-19.8					2.8	0		
INSURERS/REINSURERS												
Aetna Life & Casualty	NYS	46.00	-4.17	-20.69	62.50	45.25	814	2.76	6.00	8	58.11	0.79
Ambase Corp	NYS	2.13	-71.19	-83.17	16.38	1.88	815	0.00	0.00	3	29.08	0.07
American General	NYS	42.25	-4.25	29.01	50.63	28.13	2150	3.20	7.57	10	34.68	1.22
American Heritage	NYS	20.63	-1.79	-27.63	24.63	19.88	21	1.00	4.85	10	22.60	0.91
American Indemnity/Fin'l	OTC	3.75	11.11	-53.13	10.75	3.38	5	0.08	2.13	-1	17.38	0.22
American International	NYS	67.13	-4.28	-20.47	89.63	66.00	2180	0.44	0.66	10	41.92	1.60
Aon Corp	NYS	32.00	-0.39	-24.48	43.25	31.50	431	1.52	4.75	9	19.62	1.63
Argonaut Group	OTC	71.00	-1.39	3.09	78.00	63.25	341	1.60	2.25	8	36.83	1.93
AVEMCO Corp	NYS	23.38	-3.61	-4.10	30.13	20.38	21	0.44	1.88	17	9.52	2.46
Baldwin & Lyons Inc.	OTC	20.50	-2.38	-4.65	24.00	19.25	0	0.28	1.37	7	20.80	0.99
Belvedere Corp	ASE	3.63	-3.33	-34.09	5.63	3.38	0	0.04	1.10	-4	8.03	0.45
Chandler Insurance	OTC	6.50	-3.70	-44.68	13.25	6.50	32	0.00	0.00	3	9.53	0.68
Chubb Corp (s)	NYS	42.25	-1.74	-55.93	51.38	36.88	878	1.32	3.12	8	55.49	0.76
CIGNA Corp	NYS	43.63	-3.59	-27.59	66.75	43.50	1153	3.04	6.97	11	66.64	0.65
CNA Financial Corp	NYS	71.38	0.00	-28.63	108.75	68.25	76	0.00	0.00	11	54.87	1.30
Continental Corp	NYS	23.88	-4.98	-23.90	37.63	23.00	926	2.60	10.89	18	41.36	0.58
Durham Corp	OTC	25.00	-7.41	-18.70	34.75	25.00	27	0.92	3.68	12	26.32	0.95
Fund American Corp	NYS	49.50	0.76	40.43	51.88	29.50	3595	0.68	1.37	110	32.74	1.51
Fremont General Corp.	OTC	13.50	-14.29	-32.92	22.50	13.25	197	0.80	5.93	3	19.09	0.71
Frontier Insurance Group	NYS	21.00	-4.55	13.51	33.00	14.13	92	0.00	0.00	9	7.29	2.88
General RE Corp	NYS	73.88	-3.59	-17.92	96.25	73.75	1198	1.52	2.06	11	29.04	2.54
Hanover Insurance Co	OTC	24.25	1.04	-20.49	33.00	22.75	67	0.44	1.81	8	32.03	0.76
Harleysville Group	OTC	24.00	-2.54	-12.73	28.75	21.00	13	0.60	2.50	7	18.94	1.27
Hartford Steam Boiler	NYS	50.00	-5.66	-7.83	62.13	48.25	85	1.80	3.60	13	18.94	2.64
Kansas City Life Ins	OTC	35.88	0.00	0.00	36.25	34.50	1	1.12	3.12	9	39.22	0.91
Kemper Corp	NYS	36.00	-3.03	-23.81	51.88	34.00	445	0.92	2.56	55	29.97	1.20
Lawrence Insurance Group	ASE	6.63	-13.11	-7.02	9.13	6.50	7	0.36	5.43	12	4.40	1.51
Liberty Corp	NYS	46.00	-2.90	8.24	50.25	35.00	9	1.92	2.30	11	31.82	1.45
Lincoln National	NYS	45.88	-6.38	-24.80	62.88	45.25	266	2.60	5.57	8	49.19	0.93
NAC Re Corp.	OTC	28.50	-5.79	-21.38	41.00	27.50	40	0.20	0.70	13	22.81	1.25
Navigators Group	OTC	33.00	-2.22	20.00	33.75	25.25	21	0.00	0.00	12	15.22	2.17
Nobel Insurance LTD	OTC	3.00	0.00	50.00	3.75	1.50	5	0.00	0.00	-8	7.76	0.39
NWNL Companies	OTC	22.00	-7.37	-44.30	44.13	21.50	342	1.32	6.00	4	37.50	0.59
Ohio Casually Corp	OTC	42.00	0.60	-12.04	52.50	34.75	31	2.32	5.52	13	33.30	1.26
Old Republic Int'l	OTC	23.75	1.60	-7.32	29.00	21.13	259	0.72	3.03	5	30.70	0.77
Orion Capital Corp	NYS	18.88	-5.63	-18.82	28.50	18.38	30	0.92	4.87	6	19.72	0.96
Phoenix RE Corp	OTC	9.00	-5.26	-30.77	15.50	8.75	51	0.20	2.22	-10	12.99	0.69
Protective Life Corp	OTC	12.75	0.00	-10.53	15.75	10.88	18	0.76	5.96	7	14.54	0.88
Provident Life	OTC	20.00	2.56	-22.71	30.13	17.00	157	0.60	4.00	6	23.24	0.86
Re Capital Corp	ASE	13.50	-2.70	-6.90	15.25	11.25	18	0.00	0.00	11	14.43	0.94
RLI Insurance Corp	NYS	11.75	-2.08	32.39	14.75	6.88	12	0.44	3.74	6	12.42	0.95
St. Paul Companies	OTC	55.25	-4.74	-7.92	63.50	53.00	825	2.40	4.34	7	43.47	1.27
SAFECO Corp	OTC	30.50	-5.06	-23.27	42.38	30.50	1071	1.36	4.46	7	24.87	1.23
SCOR U.S. Corp	NYS	8.88	1.43	-37.72	14.50	8.50	49	0.20	2.25	11	10.61	0.84
Seibels Bruce Group	OTC	7.00	3.70	-35.63	12.25	5.75	123	0.80	1.43	-1	13.75	0.51
Selective Ins. Group	OTC	15.50	-0.80	-18.95	20.25	15.25	61	1.04	6.71	6	15.72	0.99
Statesman Group Inc.	OTC	1.63	3.97	-40.91	3.31	1.25	73	0.04	2.46	3	4.19	0.39
Tokio Marine & Fire	OTC	38.13	-0.33	-49.42	78.13	36.00	4	0.25	0.68	-	70.93	0.54
Torchmark Corp.	NYS	46.75	-1.32	-18.34	58.75	42.75	441	1.40	2.99	11	13.23	3.53
Transamerica	NYS	35.25	-0.35	-21.01	48.00	33.75	452	1.92	5.45	9	34.63	1.02
Travelers Corp.	NYS	25.50	6.25	-30.85	43.38	23.75	1404	2.40	9.41	7	44.85	-
Trenwick Group Inc	OTC	19.75	-1.25	-18.97	26.88	17.25	115	0.43	2.43	9	16.91	1.17
United Fire & Casualty	OTC	34.50	0.73	4.55	35.00	30.50	4	1.20	3.48	9	22.56	1.53
USF&G Corp	NYS	22.25	-5.82	-24.89	32.50	21.13	1356	2.92	13.12	16	22.87	0.97
UNUM Corp	NYS	51.50	2.74	7.65	57.13	36.75	410	0.80	1.55	11	31.20	1.65
USLIFE Corp	NYS	34.13	0.00	-24.59	47.88	33.75	73	1.48	4.34	8	54.34	0.63
Washington National	NYS	18.88	0.00	-33.19	28.75	18.25	13	1.00	5.72	21	32.90	0.57
USLICO Corp.	NYS	20.25	-5.26	-14.74	25.00	20.25	23	1.00	4.94	8	27.73	0.73
Zenith National Ins.	NYS	14.13	0.00	-24.67	21.50	13.50	23	0.88	5.23	8	13.81	1.02
INSURERS/REINSURERS	AVERAGE		-3.4	-17.7					3.3	10.7		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	14.50	-3.33	-31.76	26.38	13.75	180	0.00	0.00	12	3.54	4.10
HMO America Inc.	OTC	5.63	-4.26	-27.42	9.75	4.38	123	0.00	0.00	7	1.12	5.02
Pacificare Health Sys.	OTC	14.25	-13.64	-45.19	30.38	14.75	232	0.00	0.00	11	6.35	2.24
Safeguard Health Enter.	OTC	5.50	-4.35	-35.29	12.50	5.13	32	0.00	0.00	9	2.99	1.84
Sierra Health Services	ASE	6.63	-10.17	-25.35	9.63	5.50	47	0.00	0.00	-18	0.62	10.69
United Healthcare Corp.	OTC	17.75	1.43	44.90	20.13	7.88	720	0.12	0.68	18	0.34	52.21
United Medical Corp.	ASE	8.63	-6.76	43.75	11.38	5.75	11	0.20	2.32	12	5.70	1.51
U.S. Healthcare	OTC	18.13	-2.03	27.19	22.25	9.63	0	0.36	99	20	3.07	5.90
HMOs	AVERAGE		-5.4	-6.1					0.6	9		
ALL COMPANIES	AVERAGE		-3.5	-16.2					3.3	10		

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