

Business Insurance

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Continental Illinois granted new trial in D&O dispute

CHICAGO—Continental Illinois Corp. will get a new trial to try to recover directors and officers liability insurance to cover a \$17.5 million settlement made in 1986 with shareholders.

Continental's shareholders had sued the company in 1984, claiming it overstated earnings in 1983 and 1984 by understating reserves for bad loans. The suit was later merged with another suit that specifically named five directors and officers that shareholders claimed

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Insurers blast NAIC profit report

By MEG FLETCHER

KANSAS CITY, Mo.—A new report on the U.S. property/casualty insurance industry's profitability is drawing cheers and jeers because it is based on insurers' total investment income.

The "Report on Profitability by Line by State, 1989," recently released by the National Assn. of Insurance Commissioners, allocates insurers' total investment income—including investment income on surplus—to all insurers' operations in each state and to 18 lines of insurance they write.

Previously, only investment income attributable to "policyholder supplied funds," like premiums, was included in the annual report on insurers' profits. Investment income on surplus was excluded.

Property/casualty insurers in 1989 reported an average profit of 4.4% of direct premiums earned before reinsurance if investment income on surplus is included, according to the report. If investment income on surplus is not included, insurers' made no profit in 1989.

However, the industry's 1989 profit leaps to 7.2% of earned premiums after reinsurance if investment income on surplus is included, compared with 2.5% if investment income on surplus is excluded.

The U.S. property/casualty insurance industry reported surplus of \$133.7 billion at year-end 1989, according to A.M. Best Co.

Insurers' profits varied widely by line of business and by state (see charts on pages 1 and 21 and story on page 21).

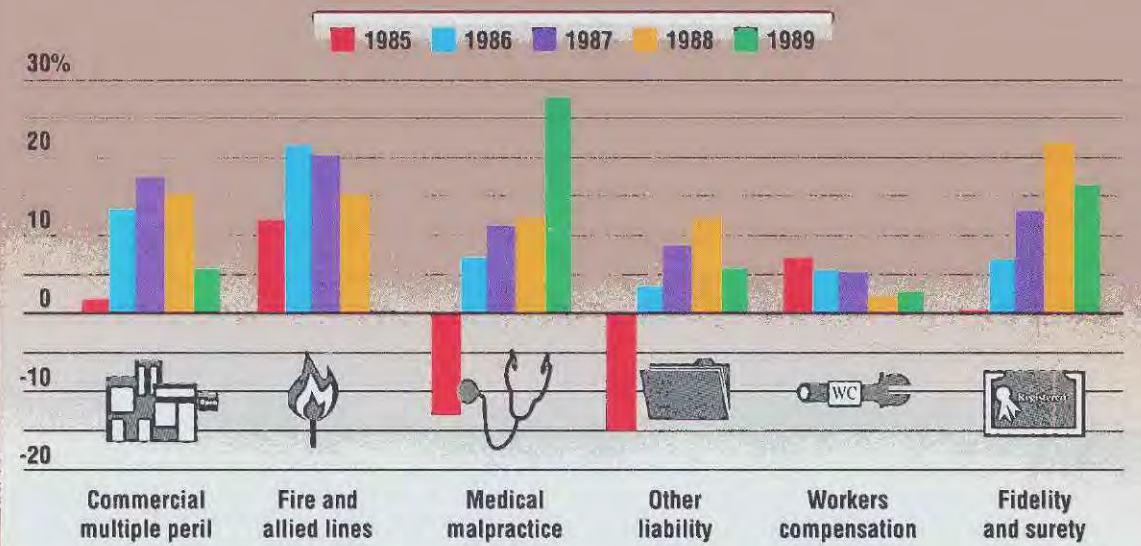
Regulators and consumer advocates enthusiastically endorse the NAIC's new method of reporting insurance industry profits, saying it is more accurate and allows a fairer comparison of insurance industry profits with those of other industries.

But, insurance industry representatives oppose the change, saying they disagree with the NAIC's concept of allocating investment income on surplus. In addition, they fear that the new data will be misunderstood and misused.

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Insurer profits tracked by line

Insurer profits for most lines of commercial insurance fell in 1989, though medical malpractice profits rose. Profits are stated as a percentage of earned premiums.



Source: National Assn. of Insurance Commissioners

GRAPHIC BY HOLLY SEGUINE

Retailers' holiday fear

Shopping surge expands exposures

By MICHAEL BRADFORD

Sloppy risk management, like the Grinch who stole Christmas, can create a very un-merry holiday.

That's especially true for department stores and other retailers, where the hustle and bustle of cheerful shoppers can quickly turn to fierce and ruthless pandemonium at the sight of a blue-light special.

Along with increased sales volumes, the holiday shopping season increases retailers' exposure to a host of risks, ranging from slip and fall claims to bomb threats to employee theft. As a result, 'tis the season when retailers' risk managers earn their stripes.

Michael P. Davan, who is new to retail risk management in his position as vp of corporate insurance at R.H. Macy & Co. Inc. in Newark, N.J., said he was geared up to handle the risk management challenges faced throughout the year on a grander scale during the

holiday season.

"All the problems retailers have in general will be magnified," Mr. Davan remarked.

"All systems get strained at this time of year," said Al Rodriguez, president of Rodriguez Consulting Group Inc. in Jacksonville, Fla.

"You want to make sure all safety and loss control methods are strictly enforced because of the high volume of customers in the store," warned Alice Weiss, president of Leonard R. Friedman Risk Management Inc., a risk management consultant in Great Neck, N.Y.

All the exposures a store faces are "maximized at this time of year," she said.

Herb Feldman, president of Herbert H. Feldman Risk Management Inc., also in Great Neck, agreed. "You should highlight and amplify risk management programs" during the gift-buying season, he said.

However, others say that if re-

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AP/Wide World Photo

Risk management experts suggest retailers stress loss control during the holidays.

Firm to appeal ban on limits for AIDS cover

By ADRIENNE C. LOCKE

INDIANAPOLIS—A Fort Wayne, Ind., employer that limits benefits for AIDS patients covered by its self-funded health care plan is appealing a state civil rights commission hearing officer's ruling that the company must provide equal coverage for AIDS patients.

Lincoln Foodservice Products Inc. contends that the ruling earlier this month by the hearing officer in Indianapolis violates the Employee Retirement Income Security Act of 1974, which preempts state laws relating to benefit plans.

The hearing officer ruled that Lincoln's policy violates the state's civil rights law and that the ERISA pre-emption provision does not apply because another federal law prohibits discriminatory benefit plans.

Benefit consultants, though, pointing to similar cases earlier this year, expect that a court will overrule the hearing officer's rul-

ing if the full seven-member commission upholds it.

At issue is Lincoln's 1988 changes to its self-funded group health care plan for salaried employees. Under the revised plan, the maximum lifetime benefit is nearly 20 times greater—\$1 million—except for covered lives with acquired immune deficiency syndrome.

Covered lives with AIDS or an AIDS-related complex have a maximum lifetime benefit of \$50,000 and an annual maximum of \$25,000 under the revised plan.

There is no annual benefit cap on other covered medical benefits.

While everyone in the plan is subject to deductibles of \$250 for individuals and \$500 for families, persons with AIDS face other benefit reductions under the revised plan.

They must pay 20% of all inpatient costs and 50% of all outpatient costs above the deductibles.

Except for AIDS patients, Lin-

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A&A, Hall resume legal fight over employees, clients
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Update

New trial ordered in D&O case

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had understated bad-loan reserves.

Continental settled the suits in 1986. But a jury in 1989 found that since Continental made the settlement to save its own reputation and not to protect its directors and officers, the settlement was not covered by Continental's D&O insurance (*BI*, Jan. 23, 1989).

However, the 7th U.S. Circuit Court of Appeals found errors in the way the case was tried and ordered a new trial, in part because the insurers appeared to have switched strategies midway through the original trial.

Harbor Insurance Co., which wrote \$15 million of primary D&O coverage for Continental, and Allstate Insurance Co., which wrote \$10 million in D&O coverage excess of \$15 million, initially argued that the company was not insured for the settlement because the officers' and directors' conduct was so egregious that indemnification would go against public policy.

But the insurers later argued that since the directors and officers had never been shown to have committed wrongdoing, the settlement was on behalf of Continental and not its directors and officers, said Judge Richard Posner.

A Harbor attorney said the insurer is considering whether to seek a rehearing of the 7th Circuit's decision.

Eagle-Picher files fraud suit

CINCINNATI—Eagle-Picher Industries Inc. is suing three asbestos plaintiffs' attorneys, charging they fraudulently tried to force the firm into bankruptcy to thwart a consolidation of asbestos injury claims.

Brooklyn U.S. District Judge Jack B. Weinstein on Dec. 11 conditionally approved a bid by Eagle-Picher for class-action certification of thousands of asbestos claims in its efforts to become the first company to consolidate such claims without filing for bankruptcy (*BI*, Dec. 17).

The day before Judge Weinstein's ruling, plaintiffs' attorneys filed a petition to force Eagle-Picher into involuntary bankruptcy. The petition, which Judge Weinstein later labeled "fraudulent on its face," was thrown out by a Cincinnati federal judge Dec. 11.

Eagle-Picher filed its lawsuit against the lawyers in federal court last week, charging that they conspired to file the bankruptcy petition to "sabotage" the class-action to preserve legal fees they would earn litigating asbestos claims individually. The suit names Ronald L. Motley, a Charleston, S.C., lawyer; and Frederick M. Baron and Brent M. Rosenthal, partners with the Dallas firm of Baron & Budd.

The suit, which seeks more than \$1 million of damages, charges Mr. Motley with racketeering and all three lawyers with malicious prosecution, abuse of process and interference with business relationships.

Mr. Baron denied that his firm was involved in the bankruptcy filing and called the Eagle-Picher charges "specious" and "outrageous." He said he plans to file a counterclaim against Eagle-Picher and seek sanctions against the company for filing the complaint.

And, Mr. Baron has filed an emergency motion asking the 2nd U.S. Circuit Court of Appeals to quash Judge Weinstein's ruling on the grounds he exceeded his authority in ordering a nationwide stay of asbestos litigation against Eagle-Picher.

Mr. Motley could not be reached.

HMO guaranty coverage at risk

PEORIA, Ill.—A bankruptcy petition filed by three hospitals against an Illinois health maintenance organization threatens to disrupt guaranty fund protection for the troubled HMO's 7,300 members.

However, the Illinois Insurance Department is preparing to file a petition with the U.S. Bankruptcy Court in Peoria to dismiss the petition by the hospitals, which are creditors of the HMO, Health Plan of Central Illinois Inc. of Peoria.

The three Peoria hospitals filed the petition on Dec. 4 after the HMO had consented to a state-controlled liquidation. The Illinois Department of Insurance has determined that the HMO had a net worth of only \$1 million, \$500,000 less than state law requires.

However, because the bankruptcy petition is a federal proceeding, it takes precedence over the state liquidation, so the liquidation cannot proceed, explained an Insurance Department spokesman.

Under Illinois insurance law, following the approval of the liquidation petition the Illinois HMO Guaranty Assn. would have been responsible for covered claims as well as for continuation of coverage under the terms of the health care contract. But, pending resolution of the bankruptcy proceeding, it is "uncertain" whether the guaranty fund will cover members' claims, the department spokesman said.

HMO members are advised to "begin an immediate search for replacement health insurance coverage," the spokesman said.

Health costs top \$600 billion

WASHINGTON—U.S. health care expenditures topped \$600 billion for the first time, rising 11% last year to \$604.1 billion from \$544 billion in 1988, the Department of Health and Human Services said.

Health care costs, as a percentage of the nation's gross national product, leaped to 11.6%, up from 11.2% in 1988.

"Steep increases in health costs are limiting access to health care and imposing a heavy burden on individuals, industries and government," said HHS Secretary Louis Sullivan.

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Errors and omissions

• Farmington Hills, Mich.-based MedView/Comp Pro was serving 3.8 million employees enrolled in its workers compensation preferred provider organization as of June 30, 1990. Its 1989 revenues were \$7.7 million. The enrollment was understated while gross revenues were overstated in the *Business Insurance Managed Care Market Report*. Med View/Comp Pro also should have been listed in the following 20 states in which it operates: Alabama, Arizona, California, Colorado, Florida, Georgia, Illinois, Indiana, Louisiana, Maryland, Massachusetts, Missouri, Michigan, New Hampshire, New Jersey, Pennsylvania, Tennessee, Texas, Virginia and Wisconsin.

A&A, Hall resume fight over employees, clients

By JUDY GREENWALD

OMAHA, Neb.—Frank B. Hall & Co. Inc. and rival brokerage Alexander & Alexander Inc. are trading charges in state and federal courts over Hall's hiring of 11 Omaha-based A&A employees in October and November.

In the latest round, Hall last week filed an antitrust suit in U.S. District Court in Omaha that, among other things, charges A&A with "intentional, wanton and malicious misconduct."

That action follows a Nebraska state court hearing that began Nov. 28 in response to a suit A&A filed against Hall protesting the hiring of the employees.

A&A attorneys contend that

Hall's antitrust action is an attempt to derail the state court proceedings.

These tangled legal proceedings are the latest in a series of law suits dating back to 1988 concerning the defection of A&A employees from the world's second-largest brokerage to join seventh-ranked Hall (*BI*, Feb. 27, 1989). Hall has hired numerous executives from A&A, including Hall Chairman Donald W. Bell, who had been senior vp and Eastern regional manager for A&A (*BI*, May 22, 1989).

The federal antitrust suit filed by Hall seeks at least \$100 million in damages in connection with the hiring of the 11 former A&A employees, seven of whom had signed non-competition agreements, ac-

cording to court papers.

Meanwhile, the state suit filed by A&A seeks a permanent injunction barring the 11 employees from soliciting business from certain A&A clients.

Judge Donald Hamilton of the state District Court of Douglas County in Omaha last month granted a temporary restraining order barring the employees from contacting these A&A customers.

A&A is now seeking to have that temporary restraining order become a temporary injunction, which would remain in effect until its suit against Hall is resolved. A hearing on this motion has been adjourned until Jan. 2.

But the state court hearing could

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Travelers, USF&G, AmBase units downgraded

Insurers' ratings down

By JUDY GREENWALD

Three insurers' solvency ratings from independent rating agencies slipped last week while another was put on a watch list.

Travelers Indemnity Corp., USF&G Corp. and AmBase Corp. received lower ratings last week from at least one independent rating agency while Crum & Forster Inc. units were placed on A.M. Best Co.'s watch list.

Standard & Poor's Corp. lowered the claims-paying ability rating of Travelers Indemnity Co., a unit of Hartford, Conn.-based Travelers Corp., and participants in the Travelers Indemnity intercompany pool to double-A from double-A+.

S&P cited Travelers' operating performance, including its \$499 million third-quarter operating loss and its 33% reduction in its quarterly dividend—triggered by Travelers' decision to add \$650 million to real estate and mortgage loan reserves—as among the factors in its decision (*BI*, Oct. 15).

Noting that S&P had put Travelers on its CreditWatch list Oct. 5, a Travelers spokesman said the move was not unexpected. "The double-A rating is considered very strong. We would point out that S&P described Travelers' outlook as 'stable' and note the strategic initiatives Travelers is implementing to improve property/casualty performance," said the spokesman.

Separately, S&P lowered the claims-paying ability rating of United States Fidelity & Guaranty Co. and its Fidelity & Guaranty Life Insurance Co. unit, both units of Baltimore-based USF&G Corp., to A from double-A.

In addition, it lowered USF&G Corp.'s senior debt rating to triple-B from single-A; its preferred stock rating to triple-B— from A—; and its commercial paper rating to A-2 from A-1. All the ratings had been on CreditWatch since November.

S&P cited capital deterioration and the "considerable" asset quality risks that capital must now support, below-expected operating

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New 404(c) rules released

By JERRY GEISEL

WASHINGTON—Proposed Labor Department rules would make it easier for employers to avoid fiduciary liability for investment decisions made by employees enrolled in defined contribution plans.

The new rules, which were sent last week to the Office of Management and Budget for review, would give employers more latitude in offering investment alternatives for defined contribution plans, like 401(k) plans, and still be relieved of fiduciary liability.

The rules will replace much-criticized Labor Department regulations proposed in 1987, but which never have gone into effect and now will be withdrawn.

The earlier rules said employers had to offer four investment alter-

natives—each of which would have to meet specific financial objectives—for employers to qualify for an exemption under Section 404(c) of the Employee Retirement Income Security Act of 1974. That section relieves employers of fiduciary liability for losses from a participant's investment decisions (*BI*, July 23).

Rather than specify an investment objective, the new rules simply would require employers to offer participants a broad range of at least three diversified investment categories, each of which has "materially different risk and return characteristics."

In addition, an investment alternative offered to participants, like an equity fund, would have to be diversified and not invested solely in one stock. Participants would have to be given the opportunity to

switch from one fund to another at least quarterly.

Employer stock also could be offered, but only as a fourth alternative and only if it is publicly traded with sufficient frequency and volume to assure liquidity. Participant shareholders also must have voting rights.

The new proposals provide "more flexibility and less rigidity," said Assistant Labor Secretary David Ball.

"Clearly, the new proposals give employers more latitude in the investment choices they must offer to plan participants," said Frank Roque, a consultant with Hewitt Associates in Lincolnshire, Ill.

Once the regulations are issued, a 60-day comment period will be offered.

Mr. Ball expects final regulations to be issued next year. ■

Inside

✓ In Perspectives, Frank W. Bonheim of Levitz Furniture Corp., details the challenges and rewards of introducing a group long-term care benefit program. **PAGE 15**

✓ R.H.M. Outhwaite (Underwriting Agencies) Ltd. contends that members of syndicates it managed are being prevented from withdrawing from litigation. **PAGE 17**

✓ The Australian government now requires all ships navigating the Great Barrier Reef to have on board a pilot familiar with the fragile waters. **PAGE 17**

✓ Myron M. Picoult and daughter Jodi Picoult van Leer take a whimsical look at insurers' efforts to reverse their problems. **PAGE 23**

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Photo by Mary Herlehy

While the market has improved, some blood banks still have problems finding adequate liability insurance.

Blood banks still have hard time obtaining liability cover

By LOUISE KERTESZ

New capacity is trickling into the liability insurance market for blood banks, but many facilities still face problems finding adequate coverage, say blood bank executives and insurance brokers.

Buoyed by so-called state "blood shield statutes" that protect blood banks from strict liability, as well as relatively few huge jury awards against the facilities in recent years, a few more insurers recently have entered the general and professional liability market for blood banks, observers explain.

And, as a result of the blood shield statutes as well as the facilities' stringent testing of their inventory for AIDS, most blood bank insurers are not insisting on excluding coverage for claims that the facilities passed along AIDS-tainted blood.

But, insurers generally will not offer a policy with a retroactive date that is earlier than the fall of 1985, when blood banks began testing their inventories for antibodies to the human immunodeficiency virus, which causes acquired immune deficiency syndrome. Most insurers writing blood bank liability coverage at that time changed to a claims-made form from an occurrence form.

In addition, insurers generally have stabilized rates, observers say. Two years ago, insurers were socking blood banks with 200% premium hikes.

However, some blood banks still complain that the market offers inadequate coverage, that coverage is too expensive and that there still are too few underwriters.

For instance, Christopher Mandel, risk manager for the American Red Cross in Alexandria, Va., asserted that "there is no coverage available of any cost benefit to anyone."

"That's why we don't look to the traditional market" for coverage, he said.

The Red Cross in 1988 set up a captive to underwrite the first \$1 million of general liability and association liability coverage and reinsure some of the Red Cross' workers compensation, auto liability and property risks (BI, April 18, 1988).

And, the limited marketplace and the high cost of coverage compared with the current risk have convinced the American Assn. of Blood Banks, which has 130 members, and the Council of Community Blood Centers, an association of 38 blood banks, to consider forming their own joint industry captive.

The two organizations are currently working with The Wyatt

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Using work comp claims to screen workers blasted

By MEG FLETCHER

Labor representatives and some state workers compensation administrators are trying to temper employers' increasing use of workers comp claims history information to weed out undesirable job applicants.

Employers may be denying jobs to capable applicants based on superficial or possibly incorrect information about the applicants' past workers compensation claims, they say.

And critics of using workers comp claims history to screen prospective employees say they support programs implemented in Michigan and Oklahoma that limit employers' access to work comp claims information.

Employers, though, say they need such data to screen out appli-

cants with a history of repeated claims, which may indicate applicants' ineptness or possibly fraudulent behavior during previous employment.

In addition, employers say they use the information to do a better job of placing applicants in appropriate jobs.

For example, an employer may not want to place an applicant who has sustained a back injury and is susceptible to reinjury in a job that requires heavy lifting.

The issue of whether employers should have access to applicants' workers comp claims history "is always a dilemma," said Michael R. Clingman, administrator of the Oklahoma Workers' Compensation Court in Oklahoma City.

"I think there is always a tension in this field of right to privacy between those who want to know—

and those who have a right to hide," agreed Douglas F. Stevenson, a workers comp defense attorney with Stevenson, Rusin & Friedman Ltd. in Chicago.

But, the growth of credit reporting agencies and non-profit employer-funded groups that will provide employers with applicants' workers comp claims histories has fueled the debate over employers' use of such information.

Labor and consumer groups say employers' easy access to workers comp claims information from state workers comp bureaus makes it easy to "blacklist" applicants.

Workers should be protected from data searches, especially those that may reveal incomplete or inaccurate information, labor representatives and consumer

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Rising benefit costs

Increases are biggest worry of executives

By DEBORAH SHALOWITZ

The rising cost of medical benefits and the burden of government legislation and regulation are the most pressing among a host of problems facing corporate America, according to a recent survey of senior executives.

More than three-fifths of the 1,729 senior executives surveyed by The Wyatt Co. cited rising health benefits costs as "very important," far outweighing responses on other issues.

The rising cost of health benefits is "of extreme importance" to executives, said Sylvester Schieber, director of Wyatt's Research & Information Center in Washington, D.C., and one of the survey's authors. "This is one of the major issues of concern that (executives) are focusing on."

Of the different types of executives surveyed, human resources personnel were the most sensitive to the health benefits issue, with some 66% rating the rising cost of medical benefits as very important,

Medical costs top execs' list

Executives rate the soaring costs of medical benefits as by far the most important of several issues their companies face.

How important are the following issues facing your company today? (% responding "very important")	Top executive	Finance	Human resources	Misc.
Medical benefits cost increases	64	61	66	60
Government legislation and regulation	46	41	44	51
Worker productivity	43	38	40	42
Environmental issues	37	29	25	35
Lack of qualified workers	22	14	20	20
Foreign competition	13	13	14	12

Source: The Wyatt Co.

GRAPHIC BY CYNTHIA WATSON

compared with 64% of top executives, 61% of finance executives and 60% of other executives.

The second biggest concern was government legislation and regulation, with between 41% and 51% of the different groups of executives rating this issue as very important.

Other issues rated very important by the executives surveyed included worker productivity, cited by between 38% to 43% of the executives polled; environmental and

ecological issues, 25% to 37%; a lack of qualified workers, 14% to 22%; and foreign competition, 12% to 14%.

This is the first year that Wyatt has conducted the "Leading a Changing Work Force" survey. The responses of health care executives will be tabulated in a separate study.

The most effective way to manage employers' health benefits

Continued on page 14

Fireman's Fund recoups excessive attorney fees

By STACY ADLER

SAN FRANCISCO—Fireman's Fund Insurance Co. will be able to recoup hundreds of thousands of dollars of excessive legal fees from two California law firms under an arbitration award and a tentative settlement.

The insurer can recoup more than \$250,000 in "excessive" legal fees charged by the San Francisco law firm Kahn & Fasano for defending policyholders under an arbitrator's decision affirmed last week by a California state court.

The law firm—which was hired by the policyholders rather than Fireman's Fund—must pay back \$148,611 in "excessive legal fees" it billed the insurer and cannot bill the insurer for \$119,000 more in legal fees, according to the arbitra-

tor's Nov. 7 decision.

In addition, Fireman's Fund says the Los Angeles law firm of Rucker & Clarkson has agreed to pay the insurer and Allstate Insurance Co. a total of \$400,000 under a tentative settlement over the firm's involvement in a network of California attorneys known as the "Alliance" that allegedly bilked the insurers out of more than \$200 million.

The Alliance attorneys are accused of controlling both sides of disputes and of paying policyholders to be clients (BI, April 2).

In the Kahn & Fasano case, a state court in San Francisco last week affirmed the Nov. 7 arbitration decision by Judge Daniel Weinstein that the \$148,611 in fees the law firm charged Fireman's Fund was for services that were

"unnecessary, unreasonable and wholly disproportionate to the services performed."

The arbitrator also refused to allow the law firm's claim against Fireman's Fund for \$119,000 in unpaid fees.

In total, the arbitrator awarded Fireman's Fund \$267,611 in legal fees billed over a 24-month period.

Judge Weinstein noted in his arbitration decision that although an insurer must "rely in large part on the integrity and professionalism of" the attorneys it hires to represent policyholders, an insurer does not "become an instant milking cow subject to unbridled billing practices in the utter disregard of common sense, as was done in this case."

Fraudulent attorney billings of

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Indiana AIDS case

Continued from page 1

coln picks up either 100% of the cost of covered procedures or 80% of the first \$5,000 of claims, depending on the procedures.

In March 1989, Lincoln employee Kenneth Westhoven, who was diagnosed with AIDS in December 1988, filed a civil rights complaint against Lincoln, charging that the company's health plan discriminates against employees with AIDS in violation of a state civil rights law.

Indiana State Civil Rights Commission hearing officer Paul A. De Prez on Dec. 3 found the plan discriminatory, ruling that the state's civil rights law applies in the case for several reasons.

First, Mr. De Prez ruled that the state civil rights law merely clarifies an existing federal law that he says prohibits benefit plans like Lincoln's.

And, while ERISA does pre-empt state laws that relate to benefits, ERISA also says that it should not be construed to "alter, amend, modify, invalidate, impair or supersede any law of the United States... or any rule or regulation issued under such law," he said.

Therefore, if there is a federal law that prohibits the practices undertaken by an ERISA benefit plan, the same prohibition made by state law would not be pre-empted by ERISA, he ruled.

Mr. De Prez noted that the federal Rehabilitation Act of 1973 prohibits benefit discrimination on the basis of a handicap.

He acknowledged that the federal law applies only to companies that have federal contracts or receive assistance from the federal government and that Lincoln does not fall into either category.

But, Mr. De Prez, interpreting the intent of Congress in drafting ERISA and the Rehabilitation Act, said the company still cannot reduce benefits for employees with AIDS.

"One might think that Lincoln could maintain an ERISA benefit plan that violates the Rehabilitation Act's prohibited discriminatory practices while all other employers subject to the jurisdiction of the Rehabilitation Act would be required to maintain plans that do not so discriminate. This would be contrary to ERISA's basic goal of uniformity of benefit plans to the extent of precluding discrimination," he said.

In addition, Mr. De Prez noted that the U.S. Supreme Court in a 1983 case recognized that its interpretation of ERISA's pre-emption clause "may cause certain practical problems" and that state courts and agencies will have to review certain employment practices.

That case involved a provision of the New York human rights law that prohibited employers from limiting benefits for female plan participants who are pregnant.

However, in that case, the court upheld the ERISA pre-emption.

The Supreme Court during that same 1983 case also noted that Congress had expressed concerns about benefit discrimination, Mr. De Prez said.

But, "after being assured that non-discrimination in benefit plans was fully required under federal law," Congress did not amend ERISA to prevent such benefit discrimination, he said.

"Lincoln's contention from the filing of the civil rights complaint has been and continues to be that the Indiana Civil Rights Commission has absolutely no jurisdiction over this matter," the company said.

Lincoln also claims that ERISA does not prevent self-funded plans from restricting benefits for certain illness, said attorney Thomas Kimbrough of Barrett & McNaghy in Fort Wayne.

Mr. Kimbrough said the commission's position in this case is just a "strained attempt to justify its jurisdiction."

Mr. Kimbrough also says he does not understand the hearing officer's argument, because while Mr. De Prez says he is concerned about ERISA's goal of maintaining uniform regulation of benefit plans, he also applies state law to self-funded plans.

Lincoln's principal reason for amending the plan has been to cut health care costs, Mr. Kimbrough explained.

Lincoln's 1988 health care costs were 49% greater than in 1987, and its 1989 health care costs were 107% greater than two years earlier, the company says.

The plan changes were made after Lincoln's third-party administrator suggested, among other things, reducing benefits for covered lives with AIDS to cut benefit costs, Mr. Kimbrough said.

Lincoln's TPA is Automated Group Administration in Fort Wayne. The TPA confirmed it advised Lincoln to limit benefits for covered lives with AIDS as a cost-containment measure.

In addition, Lincoln at the same time capped lifetime substance abuse and mental illness benefits at \$25,000. Covered lives receiving those benefits also are subject to the same copayments as covered lives with AIDS-related illnesses.

"Lincoln has constantly struggled with providing maximum benefits to as many employees as financially possible, while at the same time being fiscally responsible," the company said.

"Lincoln is in no manner unique in its application of cap on certain illnesses," it added.

But, Mr. De Prez dismissed Lincoln's financial reasons for the change in policy because the company increased the benefits for many other employees while reducing benefits for employees with AIDS and ARC.

"The dire picture painted by Lincoln of no health insurance being provided by most employers if they were prohibited from discriminating against the instant handicap is an exaggeration," he said.

The case is expected to head to the courts.

"It is very rare for the commission to overturn" an initial ruling, noted Karen Freeman, the commission's director.

However, benefit consultants expect Lincoln to fare better in court.

"I think this ruling will follow the same track as other ERISA cases like this questioning federal pre-emption of state law," said John Hoos, national practice leader for the legal group at Hewitt Associates in Lincolnshire, Ill. "We'll see it turned around."

colnshire, Ill. "We'll see it turned around."

"Right now, there's nothing on the books that clearly prohibits" a plan like Lincoln's, he said.

Frederick Rumack, director of tax and legal services in the New York office of Buck Consultants Inc., agreed.

"There isn't a provision under ERISA to prohibit this type of behavior at this time," he said.

Federal courts so far have ruled that ERISA does not require employers to offer equitable benefits to employees with AIDS.

Most recently, the U.S. Supreme Court ruled in late November that ERISA's pre-emption clause exempts self-funded plans from state rules that apply to policies sold by commercial insurers.

Earlier this year, in what is believed to be the first ruling on this issue, a federal court in Texas upheld the right of Houston-based music equipment distributor H&H Music Co. to limit benefits for employees with AIDS (BI, Aug. 6).

The decision is being appealed.

H&H Music was sued by an employee who claims the company and its health care insurer, General American Life Insurance Co. of St. Louis, conspired to deny him close to \$1 million of health care benefits by switching from an insured plan to a self-funded plan administered by the insurer.

The new self-funded plan limits lifetime medical benefits for AIDS-related illnesses to \$5,000, while the lifetime benefit for other medical conditions is capped at \$1 million. Texas law prohibits such limitations in insurance plans.

In its June 26 ruling, the federal court said that "ERISA does not mandate that employers provide any particular benefits and does not itself proscribe discrimination in the provision of employee benefits."

However, Galaxy Carpet Mill Inc., a Chatsworth, Ga.-based company, withdrew its policy of capping the lifetime health benefits of covered lives who have "voluntarily" contracted AIDS after strong protest from AIDS activist groups (BI, Feb. 19).

Insurer ratings

Continued from page 2

performance and restructuring uncertainties caused by senior management changes at USF&G as among the factors in its move.

In addition, A.M. Best changed to an A-contingent from an A its ratings on United States Fidelity & Guaranty Co., Fidelity & Guaranty Insurance Underwriters Inc. and Fidelity & Guaranty Insurance Co., citing changes in profitability and leverage since its December 1989 report.

In a letter to its agents, USF&G said it is now taking steps to strengthen the company.

In addition, Moody's Investors Service downgraded the credit ratings of New York-based AmBase Corp. and its subsidiaries and said it will continue to review these ratings for possible further downgrading.

The rating of the financial strength of The Home Insurance Co., intercompany pool members was lowered to Ba2 from Ba1, while the rating on its cumulative preferred stock was lowered to b1 from ba3.

Also, the rating on AmBase Corp.'s 11.75% sinking fund debentures, due 2008, was lowered to B2 from B1, and the rating on its 14.875% senior subordinated notes, due 1998, was lowered to Caa from B2.

The rating on Home Group Funding Corp.'s 14.875% senior subordinated notes, due 1998, was also lowered to Caa from B2.

Separately, AmBase said it had been advised by TVH Acquisition Corp. that it had received a commitment letter from a bank group for the debt financing necessary to consummate TVH's purchase of The Home Insurance Co. (BI, Oct. 8). It did not reveal the amount involved.

Meanwhile, the Home Insurance intercompany pool, which has a triple-B+ claims paying ability rating from S&P, and The Home Insurance Co.'s preferred stock, which has a B-plus rating, remains on S&P's CreditWatch, where it has been since February.

The rating implication has been changed from developing to negative, however, because of decreased financial flexibility and liquidity at AmBase, as well as lower statutory surplus at The Home since the beginning of the year, according to S&P.

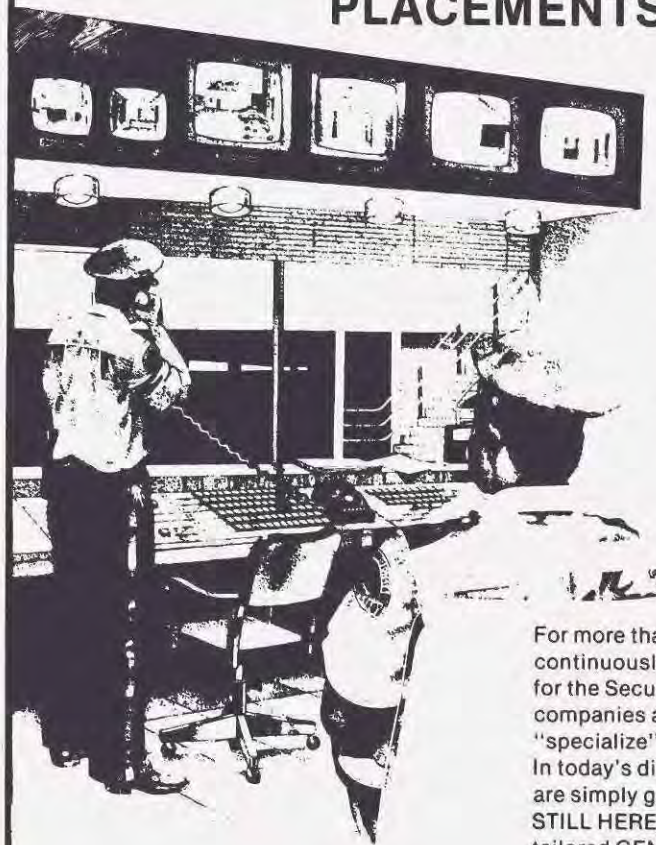
S&P said both ratings will be lowered if the TVH acquisition is not completed. S&P said they may also be lowered if the acquisition is completed to reflect the final terms of the transaction, the impact of TVH's debt-servicing requirements on The Home and the insurer's prospects in the insurance market.

Meanwhile, Best put Crum & Forster units, all of which have been rated A-, on its watch list, citing profitability and leverage concerns. C&F policyholder surplus fell 41% to \$1 billion on Sept. 30 compared with a year earlier (BI, Dec. 3).

A spokeswoman for Basking Ridge, N.J.-based C&F said the insurer was "obviously disappointed by Best's decision. However, it is important to note that another generally accepted industry measure of financial stability is the risk ratio and by that standard C&F's premium-to-surplus ratio... was an acceptable 2.4-to-1 as of Sept. 30, 1990."

The primary reasons for the surplus decline were a decline in the market value of C&F's equity portfolio, additional provisions for reinsurance recoverable and new statutory reporting requirements, she said.

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WAUSAU INSURANCE

State agency advised to drop HMOs

By MICHAEL SCHACHNER
and JOANNE WOJCIC

Benefit beat

The California Public Employee Retirement System will not immediately follow the recommendation of an employee benefit consultant to drop seven of the 19 health maintenance organizations offered to employees and retirees.

The PERS Health Benefits Committee voted earlier this month not to use the A. Foster Higgins & Co. Inc. study as the sole criterion for deciding to reduce its HMO roster, said Bob Walton, assistant executive officer for the Sacramento-based agency.

Action to reduce the number of HMOs offered also was postponed because the board does not have adequate time to implement a new benefit program by its February meeting, which is when it usually makes health benefit-related decisions, he explained.

PERS' contracts with its HMOs renew at the end of July, Mr. Walton said.

"The board sees the report as only the first step," he said.

PERS plans to work with the consultant to re-evaluate the HMOs because many of the HMOs complained that "human errors," such as mistakes by clerical workers who provided information for the study, caused them to receive low rankings, Mr. Walton said.

"We're going to give them a second shot. We don't want to dump any HMOs just because they didn't fill out the questionnaire cor-

rectly," he said.

PERS contracted with the Los Angeles office of Foster Higgins in February 1990 to develop criteria for evaluating the quality of HMOs participating in the PERS health benefits program.

The HMOs were evaluated based on their responses to a questionnaire on their service area and the size of their provider networks.

Based on the results of the evaluation process, the consultant recommended that PERS discontinue contracting with seven of the HMOs and limit the service areas of five of the remaining 12 HMOs.

Foster Higgins recommended that PERS discontinue contracting with: Maxicare Health Plans Inc., Lincoln National Health Plan of California, FHP Health Care, Travelers Health Network, Bay Pacific Health Plan, Physician Corp. of America and Health Plan of the Redwoods.

The HMOs that the consultant recommended PERS continue contracting with were: Kaiser Foundation Health Plan Inc.-Northern California Region; Kaiser Foundation Health Plan Inc.-Southern California Region; Health Net; Foundation Health Plan; CIGNA Healthplan of California Inc.; PARTNERS National Health Plans; Valucare; TakeCare Health Plan; HEALS; Lifeguard; Bridgeway Plan for Health; and The

Health Plan of America.

However, the consultant recommended that PERS limit the geographic service areas of Foundation, Lifeguard, CIGNA, TakeCare and Bridgeway.

The study said that 20,371 PERS employees and retirees are enrolled in the HMOs that would be eliminated or whose service areas would be restricted.

However, due to the duplication of physician networks, the proposed HMO cuts might actually affect only 6,894 employees and retirees, the consultant said.

As of June 30, PERS was providing health care coverage to 315,000 public entity employees and retirees and 423,500 dependents through the 19 HMOs; one self-funded indemnity plan with a preferred provider option administered by Blue Shield of California; and four association plans for local safety officers, firefighters, correctional officers and California Highway Patrol officers, according to Mr. Walton.

In addition, PERS offers a prescription drug program that includes a mail-order component and varied copayments to encourage the use of generic drugs.

Most employees and retirees make no contribution to their health care premiums, and retirees receive the same level of benefits as active employees, he said.

Odd-hour child care

About 1,500 autoworkers at New

United Motor Manufacturing Inc.'s Fremont, Calif., assembly plant now can drop their children off at a nearby child care center as early as 5:15 a.m. under a special arrangement between the automaker and Tri-City Children's Center.

The employee-funded daycare arrangement allows workers to report on time for the plant's morning shift, which starts at 6 a.m. and ends at 2:30 p.m., said Sharon Sarris, manager of community relations for NUMMI, which is a joint venture between Detroit-based General Motors Corp. and Torrance, Calif.-based Toyota Motor Corp. U.S.A.

Tri-City Children's Center, a non-profit organization, charges parents about \$85 per week for child care, which is below the going rate in the San Francisco area, Ms. Sarris said.

In addition, NUMMI is in the process of coordinating an arrangement with Tri-City under which the company would pick up a significant portion of the center's added costs to stay open until 1:30 a.m. so the company's 1,400 second-shift workers also could use the facility, Ms. Sarris said.

The second-shift schedule is 4:30 p.m. to 1 a.m.

The child care facility also is available to 100 maintenance workers, whose schedules overlap portions of the first and second shifts.

For Tri-City to stay open after midnight, the facility would need beds for young children and improved parking lot lighting.

"This would come at a significant cost, but the company is committed to helping employees with their child care needs," Ms. Sarris said.

NUMMI will pick up the entire cost of upgrading the facility, she said. Those costs have not been determined yet.

In addition, if Tri-City stays open until 1:30 a.m., it would need to enroll at least 20 children to break even, Ms. Sarris said. She said NUMMI would be willing to pay the difference between the number of children that are enrolled and the break-even number.

A NUMMI employee survey showed that at least 200 employees were experiencing difficulty in arranging child care because of their shift schedules.

In addition, NUMMI employees beginning Jan. 1 will be able to set aside up to \$5,000 per year in a pretax dependent care spending account to pay for child care and other expenses.

Annuity purchase

McDonnell Douglas Corp. will save more than \$700,000 next year in PBGC premiums by purchasing annuity contracts from two insurers to cover pension obligations to nearly 37,000 participants in the company's defined benefit pension plan.

In addition, the annuity purchases are allowing the St. Louis-based aerospace contractor to boost earnings in the final two quarters of 1990 by accelerating the rate of amortization of unrecognized net assets in its overfunded pension plan.

McDonnell Douglas in the fourth quarter purchased an annuity from the Prudential Insurance Co. of America of Roseland, N.J., to cover pension benefits for 21,600 retired hourly employees and 1,100 retired salaried employees.

"Retirees will have their pension benefits guaranteed by a large, financially secure company and McDonnell Douglas can increase its ratio of pension plan assets to liabilities," a spokeswoman said.

McDonnell Douglas in the third quarter purchased an annuity from

Metropolitan Life Insurance Co. of New York to cover pension obligations to 14,200 retirees.

McDonnell Douglas will continue to administer the pension plan for retirees whose benefits will now be paid by the insurers.

The plan had assets of \$5.9 billion at year-end 1989 and prior to the annuity purchases had 184,500 participants, 45,000 of whom were retired. The pension plan is overfunded by "more than \$2 billion," the spokeswoman said.

Because McDonnell Douglas' pension plan is overfunded, the company is subject to PBGC premiums of \$19 per plan participant effective Jan. 1. With insurers guaranteeing pension benefits to 36,900 plan participants, the company will save more than \$700,000 in PBGC premiums next year, pointed out Larry Wiltse, a consulting actuary with Buck Consultants in Secaucus, N.J.

Mr. Wiltse added that McDonnell Douglas' move significantly strengthens quarterly earnings and improves the company's assets-to-liabilities ratio.

The purchase of the Prudential annuity is contributing to McDonnell Douglas' \$136 million gain in the fourth quarter, or \$3.55 per share. The annuity purchase in the third quarter contributed to a \$234 million gain, or \$6.11 per share.

Growth in flex plans

More than 40% of U.S. employers offer flexible benefits plans to their employees, and more than one-third of the companies that do not offer flex plans are considering implementing one, reports a recent survey conducted by Buck Consultants Inc.

The New York-based benefits consultant's survey, "Flexible Benefits-An Alternate Design," found that 159 employers, or 41% of 387 firms that responded to the survey, offer flexible benefit plans.

The survey found that employers have three primary goals when implementing such programs:

- Sixty-one percent of the respondents said they implemented flex plans to help workers meet their changing needs.

- Fifty-four percent said they implemented flex plans to improve benefit plans with little or no additional cost to the employer.

- Forty-five percent said they implemented flex plans to help contain health care costs.

"Flex is often the single best way to address changing employee needs while controlling benefit costs in general, and medical costs in particular," said John Haslinger, Buck's director of flexible benefit consulting services.

The survey also found that the most frequently offered core benefits within flex plans are group life insurance, group medical coverage and long- and short-term disability coverage. Sixty-nine percent of respondents said their flex plans provide group life insurance as a fixed benefit; 57% offer traditional medical coverage as a core benefit; and 56% offer long- and short-term disability as core benefits.

The survey found that the benefit employers most often offer as an elective is health care coverage through a health maintenance organization. Sixty-three percent of the respondents said they offer HMOs.

In addition, 61% of the respondents offer dependent care coverage as an elective benefit, according to the survey.

A copy of the study "Flexible Benefits-An Alternate Design" can be obtained for \$100 from Carolee Martin, manager of marketing, Buck Consultants Inc., 500 Plaza Drive, Secaucus, N.J. 07096; 201-902-2555.

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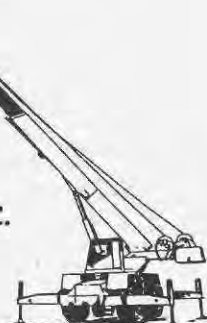
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THAT HARD MARKETS MAY BE NEAR.

AS THE COST OF WORK COMP
AND GROUP HEALTH PLANS RISE,
DARE WE HOPE FOR RELIEF
TO WIPE TEARS FROM OUR EYES?

WE'VE WATCHED AND WE'VE LISTENED
AT EACH DINGELL SESSION
HOW ALL IS NOT WELL
WITH STATE REGULATION.

THE WINDSTORMS OF EUROPE
MUST HAVE BLOWN O'ER THE SEAS,
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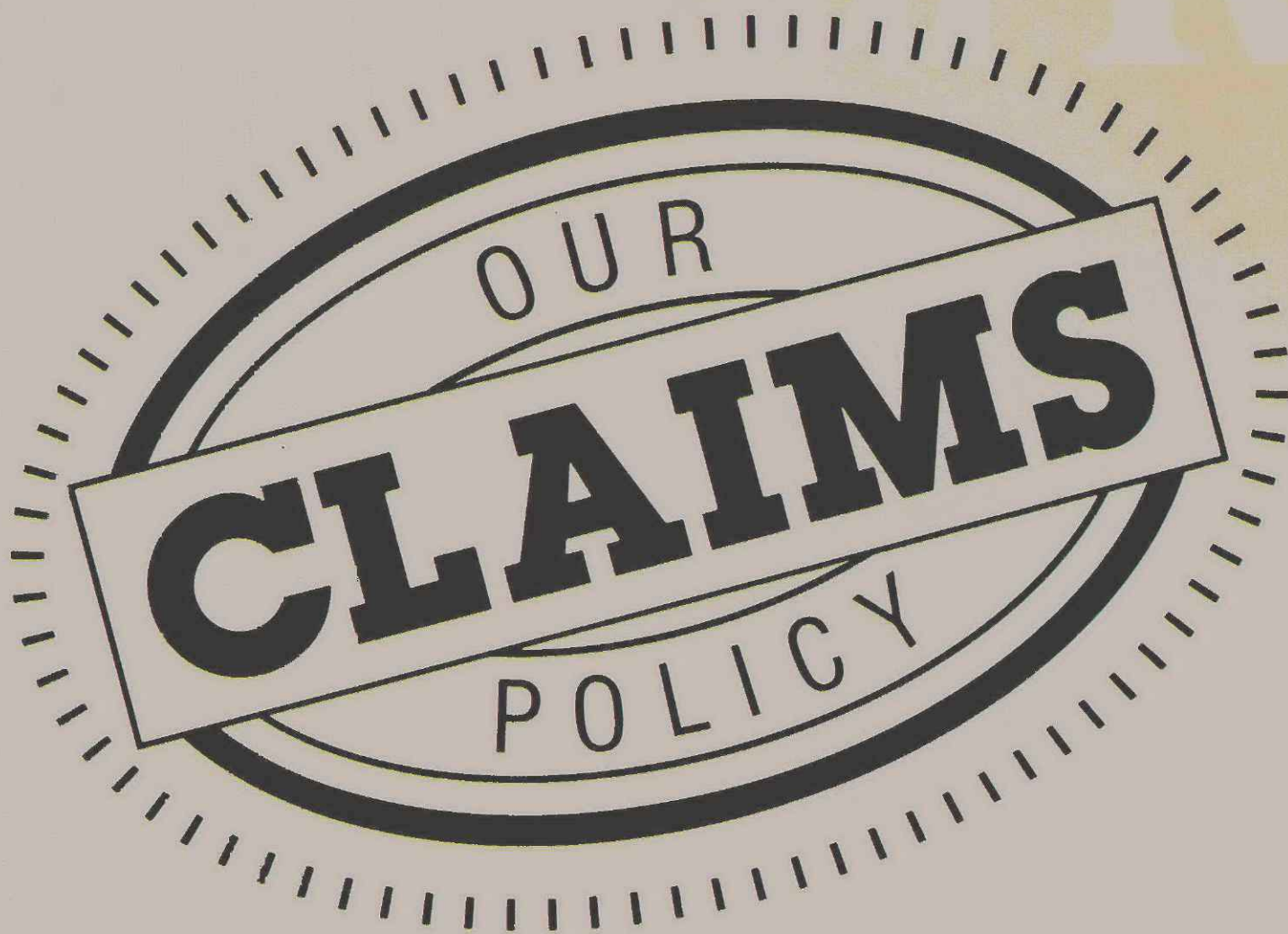
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Blood bank risks

Continued from page 3
Co., but it is "too early" to discuss plans, said James MacPherson, executive director of the Washington, D.C.-based Blood Council.

The AABB's earlier plans to form a risk retention group on its own were unsuccessful because of a lack of capital (BI, Jan. 25, 1988; Sept. 28, 1987).

Blood banks in general currently can obtain claims-made coverage in the commercial marketplace with limits of \$1.1 million to \$1.3 million per claim and a \$3 million aggregate, said Karen Logue, deputy chairman of Johnson & Higgins' Health Group in New York.

But Mr. MacPherson said most facilities typically find claims-made limits of \$2 million per claim and aggregate.

And, an American International Group Inc. surplus lines unit has written up to \$5 million in per claim limits, noted John Haskell, a vp with Alexander & Alexander Services Inc. in Pittsburgh.

Self-insured retentions and deductibles generally range from \$25,000 to \$50,000.

Some insurers offer limits excess of SIRs rather than deductibles so policyholders must assume claims-handling responsibilities. But, the SIRs do not count as part of policy limits, as deductibles do.

Two years ago, blood banks generally could not find more than \$1 million of coverage, Mr. MacPherson pointed out.

However, before the AIDS epidemic, "it was not unusual to find \$10 million in coverage," he said.

And, blood banks are now paying four to five times in premium what insurers must pay in claims or place in reserves, he said. Rates generally run from as little as \$1.25 per unit of blood collected to as much as \$5 per unit.

However, "in general, there's less of a problem" in finding coverage, said Michael O'Brien, senior vp of Johnson & Higgins in Los Angeles. The situation "is not as hysterical as a few years ago."

Two years ago when a blood bank's liability insurance program expired, "it took a lot of doing to get someone else to come in and fill the void," said Dan Connor, president of LifeSource in Glenview, Ill., one of Illinois' largest blood banks.

"Currently, there are about six or seven programs" available from insurers, said Mr. Connor, who is also chairman of the AABB's insurance committee.

Some AABB members are also American National Red Cross centers, he said. The 54 Red Cross centers supply half of the nation's blood needs. Other members of the AABB and members of the Blood Council supply the other half.

"In general, the insurance companies are feeling more comfortable" about insuring blood banks, said Dr. Herbert Perkins, executive director of Irwin Memorial Blood Bank in Oakland, Calif.

"The blood bank outlook has improved since two years ago, and we just hope that will continue," said Barbara Barnett, assistant underwriting manager of Medical Insurance Exchange of California in Oakland, a physician-owned facility that insures 10 blood banks in California, including Irwin Memorial, and one in Alaska.

The market is slightly improving in part because blood banks have tested their inventories since 1985 for HIV, said the Blood Council's Mr. MacPherson.

As a result, "there are few cases of post-transfusion AIDS anymore," he said.

Therefore, blood bank insurers generally are not insisting on excluding coverage for claims that the facilities passed along AIDS-tainted blood.

There have been only two periods during which significant

claims were filed against blood banks, according to Michael J. Gallagher, president of Nova Insurance Services of Houston, a producer for the Classic Syndicate on the Illinois Insurance Exchange, which insures blood banks.

Those periods were before the test for hepatitis was developed in the early 1970s and before the test for HIV was developed, he said.

But, most states have enacted blood shield statutes or laws requiring plaintiffs in product liability cases against blood banks to prove negligence to collect damages.

New Jersey is now the only state without a blood-shield statute, but case law in that state "performs

the same function," said Robert Rigney, an AABB attorney.

In addition, the California Supreme Court last summer let stand a lower court ruling that a state law limiting non-economic damages in medical malpractice cases to \$250,000 applies to blood banks.

And, juries generally are returning "more realistic" verdicts in the cases that come to trial, Mr. O'Brien said. "They realize that available technology is not foolproof."

Because there have been relatively few big jury awards against blood banks since 1985, insurers are realizing "they ought to get back into this market because there's good profit to be made,"

Mr. MacPherson said. "Our experience is predictable and isn't that bad."

Nevertheless, blood banks "can't be overconfident," because "juries are unpredictable," cautioned Irwin Memorial's Dr. Perkins.

LifeSource's Mr. Connor agrees that "with one well-publicized negative case, (the market) could change very quickly" and become as hard as it was two years ago.

Still, the market remains much tighter than it was before the outbreak of AIDS, observers noted.

"It's still a very selective, limited market, not an open market as such," agreed LifeSource's Mr. Connor.

"Even in the best of times," not

many insurers were interested in writing coverage for blood banks because it was not profitable, said J&H's Mr. O'Brien.

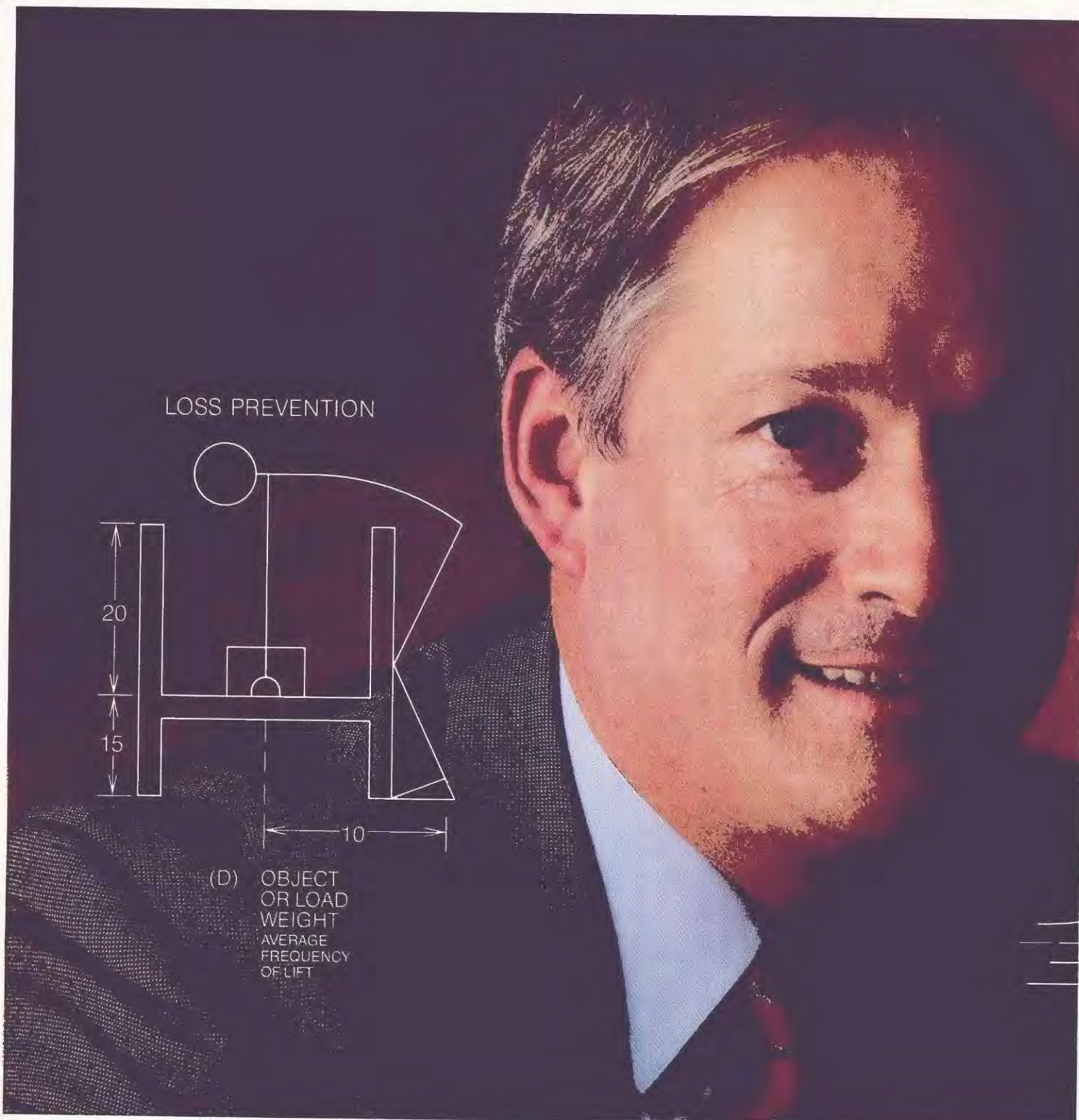
"It's still a scare. I don't see (the market) opening up," agreed John Gross, managing director of Marsh & McLennan Inc. of New York.

Large blood banks like Irwin Memorial would like to find claims-made coverage with a retroactive date prior to 1985 but cannot, said Irwin Memorial attorney Duncan Barr of O'Connor, Kohn, Dillon & Barr in San Francisco.

The situation is frustrating because Irwin Memorial has won some recent product liability cases,

Continued on next page

THE H O M



OLD PROS ON

Continued from previous page
Mr. Barr said.

Irwin Memorial's Dr. Perkins said that the blood bank's liability insurer, MIEC, recently offered the facility higher coverage limits. But, neither he nor Mr. Barr would provide details of the blood bank's coverage.

In general, though, "because blood banks are still in a period of difficulty," MIEC has reduced aggregate limits in its policies to blood banks, said Ms. Barnett.

MIEC will write claims-made coverage of \$1 million per claim with a \$1 million aggregate, half of the \$2 million aggregate it offered two years ago, and \$2 million per claim with a \$2 million aggregate,

or two-thirds of the \$3 million aggregate offered in 1988.

MIEC's rates per unit of blood collected annually are "no more than \$5," Ms. Barnett said.

She also noted that the insurer may offer improved coverage after 1991 if blood banks' recent good loss experience continues.

"We're not looking for any great changes in the next year, but after that if things continue as they are now, you'll see a lot of softening as far as that coverage being available and the cost of the coverage," she said.

A new entrant in the blood bank liability insurance market is AIG unit American International Surplus Lines Insurance Co. of Jersey

City, N.J., which will write up to \$5 million of per claim limits. Generally, it writes \$1 million per claim/\$1 million aggregate or \$2 million/\$2 million of coverage, according to an AIG spokesman.

Deductibles range from \$5,000 to \$10,000, and SIRs generally range from \$25,000 to more than \$50,000.

The minimum premium is \$25,000 for \$1 million in limits, he said.

Coverage for AIDS claims is available, but each risk is evaluated individually. And AIG will underwrite risks in California more stringently, he said.

Another recent market entry is Reliance Insurance Co. of Illinois, a unit of Reliance Group Holdings

Inc. of Philadelphia.

Reliance writes \$1 million/\$1 million and \$2 million/\$2 million of claims-made coverage on a non-admitted basis.

Premiums, which depend on units of blood collected and the deductible, range from \$5,000 to \$200,000, said Robert Dowden, senior underwriter at Reliance National Risk Specialists, which underwrites on behalf of Reliance units.

Deductibles range from \$1,000 to \$10,000, he said.

Reliance, which began writing policies for blood banks in May 1988, insures 35 centers nationwide, except in Massachusetts, he said.

Classic Syndicate Inc. on the Illinois Insurance Exchange is offering \$1 million per claim/\$1 million aggregate limits, said Vp Art Torrington.

And, the syndicate has removed the \$250,000 sublimit for AIDS claims it had imposed two years ago, Mr. Gallagher of producer Nova Insurance Services noted.

An endorsement offers two guaranteed renewal periods with limited exceptions, Mr. Torrington said.

In addition, excess coverage "might be available" from other syndicates on the Illinois exchange, he said, though he could not estimate the total coverage available.

The premium charged by Classic for most blood banks is \$1.25 per unit of blood collected.

But the premium for blood banks in San Francisco is as much as \$4.50 per unit, said Mr. Gallagher.

The minimum premium is \$5,000.

Classic offered blood bank coverage two years ago but "got few takers," according to Mr. Gallagher. Classic now insures 20 blood banks nationwide, and four applications are pending, he said.

St. Paul Fire & Marine Insurance Co., a unit of The St. Paul Cos. Inc. of St. Paul, Minn., is writing renewals for blood banks as it has since 1986 but is not seeking new blood bank accounts, said Jack Coderre, vp of the Medical Services Division.

And, most of the blood banks insured by St. Paul Fire & Marine are affiliated with hospitals that also are insured by St. Paul, he said, describing the insurer as a minor player in the blood bank market.

St. Paul insures about 30 hospital-affiliated blood banks and about 15 to 20 independently operated blood banks, he said.

Mr. Coderre explained that the insurer is not seeking new blood bank business because, while the facilities "have become very conscientious" and are "utilizing the proper tests" to prevent transfusion-related AIDS, "nevertheless, there is a significant potential of high claims alleging negligence."

As a result, St. Paul is "renewing on a more limited basis... in some cases with reduced limits," he said.

The insurer now offers \$1 million/\$1 million of claims-made coverage.

Retentions, which "vary by the size of the blood bank and the nature of the risk," start at \$50,000, Mr. Coderre said. However, "many hospitals have retentions higher than that already," he noted.

The St. Paul policy does not have an AIDS exclusion, but a blood bank must maintain its AABB accreditation without any contingencies.

Mr. Coderre declined to provide information about premiums but agreed that premiums "have certainly stabilized since the late 1980s."

"A handful" of blood banks in Florida are insured by the Florida Medical Malpractice Joint Underwriting Assn., said Preston Cowie, general manager of the JUA.

The JUA, which was established in 1975, insures 650 risks, including nurses, doctors, dentists and hospitals, he said.

The blood banks insured by the JUA customarily have not been able to find coverage in the voluntary market, Mr. Cowie said.

The state JUA writes occurrence-based policies with limits of \$250,000 per occurrence and \$750,000 aggregate, he said. Premiums range from 91 cents to \$1.24 per unit of blood collected.

State law calls for refunds to JUA policyholders if the JUA makes a profit and policyholder assessments if the JUA has a deficit. While the JUA has issued refunds, it has never levied an assessment, Mr. Cowie said. ■

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A NEW TEAM

Holiday retail risk

Continued from page 1

tailers' risk management programs have been especially good the rest of the year and kept stores a safe and worry-free haven for shoppers, chances are Santa won't drop any unpleasant surprises into their stockings this holiday season.

"Increased traffic shouldn't contribute to more accidents if you keep the store a safe place to shop at all times," says Carl Seaholm, manager of corporate risk management in the Pittsburgh office of Dallas-based J.C. Penney Co. Inc.

He urged using common sense and emphasizing standard loss prevention—"keeping the aisles clear and the floors free of debris so customers don't injure themselves by tripping and falling."

Wesley Rowe, senior vp at Kevin F. Donoghue & Associates, a risk management consulting firm in Boston, agrees that retail stores "shouldn't be doing anything different now" in terms of new risk management techniques. "People slip and fall all during the year."

But, he said, it helps to emphasize some of the risk management procedures in place year-round.

"Keep employees well-educated," he advised. "Teach them that if they see something on the floor, don't leave it there. Basically it's just good loss control and education of employees."

Such extra emphasis is important, because many retailers increase their hours during the holiday shopping season and therefore increase their exposure, said Mr. Rodriguez. The possibilities of "all the normal things that could happen are extended," he said.

Mr. Feldman said careful risk management is important for retailers, "particularly in the Snow Belt," where water and slush tracked into stores increases the potential for slips and falls.

While J.C. Penney's Mr. Seaholm doesn't see slips and falls as a major problem during the Christmas rush, shoppers at other stores are falling all over themselves.

"Our five highest-accident days are always between Thanksgiving and Christmas," said Carolyn Pare, risk manager of the department store division of Dayton-Hudson Corp. in Minneapolis, whose stores include Dayton's in Minneapolis, Hudson's in Detroit and Marshall Field & Co. in Chicago.

"Sales volume is up, and there is a correlation with the frequency of accidents," she said. Along with the increased foot traffic, inclement weather at this time of year plays a part, she said.

And, she said, some accidents are unrelated to the snow and ice outside. Many shoppers are injured simply by blundering into displays or permanent store fixtures.

Dayton-Hudson begins its risk management defense in October against problems caused from the holiday shopping onslaught by publishing warnings and advice to employees in a newsletter.

Darrell Glubka, risk manager at the Atlanta-based Rich's department store chain, a division of Federated Department Stores Inc., said slips and falls "almost double in some locations" during the holiday shopping season.

"We have a lot of older customers at that time of year," he said, including some with failing eyesight who are prone to trip and fall or stumble into a display or wall.

And, he said, in some cases it's fancy footwork, more than slippery sidewalks, that accounts for the rise in accidents among shoppers. "Down here, it's not so much weather conditions. We have a lot of fraud cases this time of year."

No amount of risk management can prevent attempted fraudulent injury claims, he said, adding that daily inspections and stringent housekeeping measures help re-

duce legitimate claims.

If Rich's starts getting three or four accidents of the same type at a location, risk management takes an on-site look at the problem and gets it fixed, Mr. Glubka said.

Mr. Rodriguez pointed out that there is a greater chance of fraudulent claims during the holidays because "people feel like they need more money at this time of year" with the pressure of buying gifts. "You've got more opportunity for the bogus types of falls."

Big crowds can mean big problems in emergencies, risk managers and consultants agree.

Russell Sykes, president of risk management consultant Aditex Inc. in Vancouver, British Colum-

bia, said bomb threats are a particular problem during the holidays.

The number of such threats usually rises during the Christmas season, a time when some people lack the money to buy presents and blame retailers for the high cost of merchandise, Mr. Sykes explained.

Retailers should maintain close relationships with local police and fire departments that would respond to a bomb threat, he said.

Deciding whether to evacuate a store when a bomb threat is received can be a tough decision, he said. But, if a store is not evacuated and a bomb explodes, the result could be death and injury and lawsuits from customers and employees, Mr. Sykes said.

Bomb threats aside, heavy crowds should spur risk managers to an increased concern for public safety, Mr. Feldman said.

He advised retailers to check fire doors frequently to make sure they are operating and aren't blocked.

"Beef up security to ensure the orderly flow of traffic in the event of an emergency," he added.

In addition, he said store managers should be on the lookout for loose rugs and slippery floors that could booby-trap exit paths.

Retailers are quick to point, though, that decorations displayed during the holidays don't pose a significant fire threat.

"Most material has to comply with local fire codes," said Mr.

Seaholm of J.C. Penney.

Mr. Glubka of Rich's said guidelines are so strict that "we don't have any problems at all" with the risk of fire from decorations.

A fire risk is more likely to exist in a back room, said Tom Briggan, a risk management consultant with The Wyatt Co. in San Francisco. "I've seen stock rooms loaded down with boxes, ribbons and wrapping paper."

Temporary employees hired during the season should be trained to eliminate such a fire hazard, Mr. Briggan emphasized, and must be knowledgeable about procedures for leading crowds out of a store if a fire does threaten shoppers'.

Continued on next page

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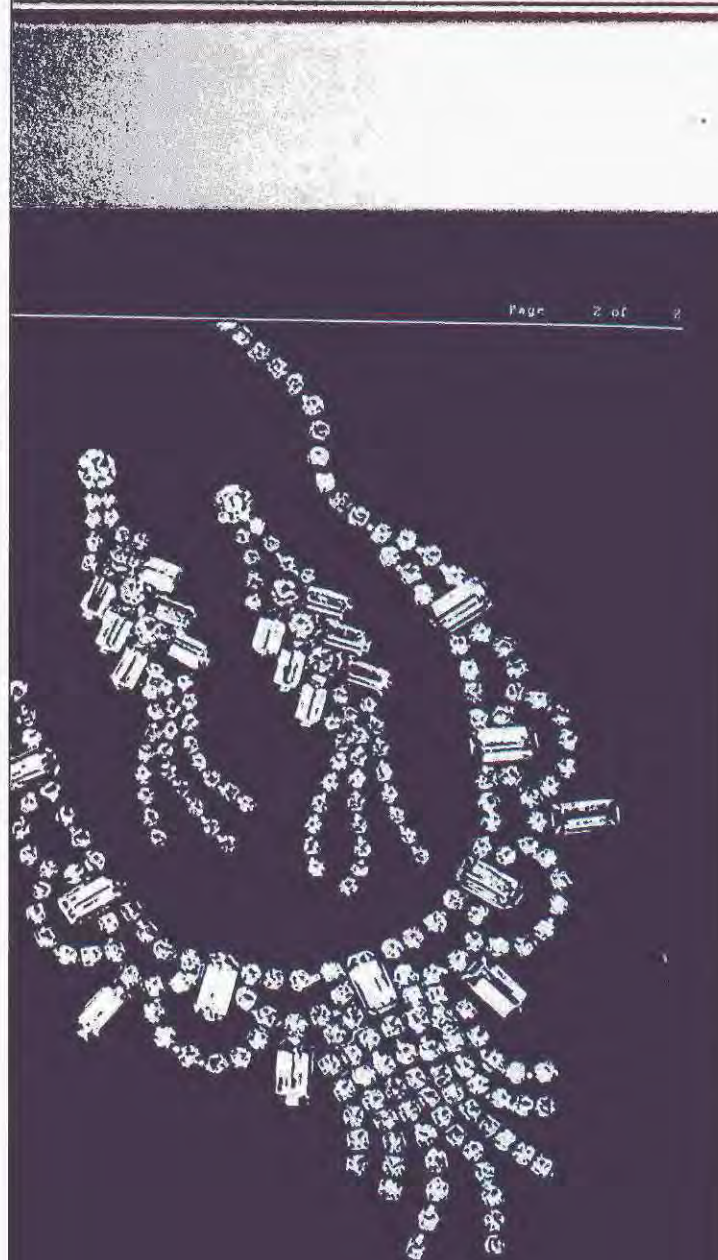
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Continued from previous page safety.

Risk managers and consultants also point out that big crowds have sticky fingers, and not just in the candy department.

Shoplifting may be worse this year because of the slackening economy, Mr. Rodriguez said, and risk managers and consultants agree that the only way to keep shoplifters at bay is to increase security.

"It's so bad during the year, I don't see how it can get much worse," said Mr. Glubka.

One solution is to beef up security. "Sometimes just the appearance of increased security can help cut back on that type of thing,"

said Mr. Rowe of Donoghue & Associates.

According to a study recently released by Ernst & Young, retailers should also teach security personnel to keep an eye on store employees.

Retailers that participated in the study reported that customers made up 93% of the shoplifting apprehensions in 1989, while only 7% were employees. However, the average recovery per customer apprehension was \$196, while the average for each employee caught was \$1,350.

Shoplifting and employee theft, known in the retailing business as "shrinkage," is at an all-time high, said Richard Hersh, president of

the Washington, D.C.-based International Mass Retail Assn., which co-sponsored the study.

The study indicated that department stores spend a greater percentage of sales to fight shrinkage than other types of retail outlets. Department stores in the survey averaged \$3.7 million per store in loss prevention expenses—or 0.54% of sales—more than twice as much as drugstore chains and supermarkets.

Peter Gilmartin, manager of Ernst & Young's national retail service office in New York, said the entire group of 160 retailers surveyed indicated that electronic inventory tags—those plastic tags that set off alarms at a store's exit

—are the most effective weapon in combatting theft. Guards and detectives are next on the list.

Mr. Briggan of The Wyatt Co. said temporary help hired during the holidays is sometimes responsible for employee theft.

"Depending on the retailer, there may or may not be a rigorous examination regarding temporary employees' backgrounds," he noted.

And, Mr. Briggan warned, when checking out temporary help, retailers should not forget to inquire as to the background of that fat guy in the red suit. "The concern is that you could get a bad apple." Even if a store's Santas come from agencies, risk managers should

make sure St. Nick's background has been checked, he said.

Ms. Weiss of Friedman Risk Management said risk managers also should keep in mind that additional security may be needed to safeguard the large amounts of money that retailers collect at this time of year.

She suggested stores make small, frequent bank deposits to minimize the risk of being caught with large amounts of money on hand or en route to the bank.

Security also should extend to the parking lot if the lot is the retailer's responsibility.

Stores that dish out Christmas cheer on a plate have to concern themselves with the risk of food poisoning, said Aditex's Mr. Sykes.

"Some department stores feed 5,000 a day" during the holiday season, said Mr. Sykes, and retailers with food concessions have to be particularly careful that food is not contaminated.

Most department stores are "really very careful" about inspecting and preparing food to be served to customers, he said.

On the insurance side, coverage for business interruption and inventory rank as top considerations for retailers during the season.

"Business interruption can be a particular problem," said Leonard Silver, president of First Risk Management Co. in Feasterville, Pa. "Many retailers depend on Christmas sales to make their year."

If disaster strikes and a retailer finds itself without business interruption coverage, the store could sustain heavy losses, he said.

Mr. Feldman agreed that because the Christmas season can produce more profits than "half a year of slow months," business interruption coverage should be a top priority.

"The business interruption formulas and values need to be reviewed and adjusted for seasonal variations," Mr. Feldman noted.

Most retailers aren't adequately covered for business interruption exposures, according to Mr. Silver. "I've known of stores that have been destroyed before Christmas, and they've been clobbered because a large percentage of their sales comes during the holiday season."

He said risk managers should make sure business interruption policies also cover losses the retailer might sustain if a supplier is destroyed and unable to deliver its products.

And, Ms. Weiss noted that although business interruption insurance should be purchased long before the Christmas selling season, slack economic times may mean retailers should adjust their coverage. "Limits might be overstated."

Experts agree that property coverage should account for increased inventory during the holidays, and not just for the stock in the store. Mr. Feldman said risk managers have to consider off-premises locations where additional inventory is stored. If temporary facilities, like trailers in a back parking lot, are used to store inventory, manufactured coverages may be necessary, he said.

A store's inventory should be valued at its selling price and not its cost, Mr. Silver said. That way, the retailer can recoup lost profits in the event of a catastrophe.

Retailers' workers compensation exposures also are greater during the holidays because "you don't always know what you're buying when you get temporary employees," Mr. Briggan said.

Thorough background checks may not be performed, and a retailer could hire someone looking to collect workers comp payments, he added.

Mr. Glubka said Rich's had some new employees "work a day and go out with back strain."

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Group long-term care plans

Furniture retailer helps workers plan for lingering illness

By Frank W. Bonheim

INTRODUCING ANY NEW EMPLOYEE benefit is a major challenge for benefits managers. But few are more challenging than group long-term care, which provides coverage for nursing home and home health care services.

To do so, benefit managers must take into account varying levels of employee awareness of the need for coverage. In addition, they must communicate a fairly complex and little-known form of insurance.

Last year, Boca Raton, Fla.-based Levitz Furniture Corp. faced these challenges and introduced GLTC as a contributory benefit during our annual open enrollment period. Employee response—nearly 18% enrollment—suggests that offering GLTC is a win-win situation for employers and employees alike.

As employers, we have an opportunity to address the growing concern among many employees over gaps in their medical coverage. Employees can take an affordable step toward planning for future health care needs.

A comment from a Levitz manager who led one of the enrollment meetings says it all.

"This was one of the most talked-about benefits in a long time," the manager said. Employees "are ready to take more responsibility for their future."

Levitz is not saying its approach is right for every

employer. However, this case study should provide insight for other benefits managers who are considering GLTC.

Levitz is the nation's largest retail furniture distributor with more than 115 locations throughout the United States. Of about 6,700 total employees, some 4,700 are full-time and insurance-eligible.

In 1988, Levitz switched to a flexible benefit program. The major benefits are:

- Three levels of health care coverage plus a health maintenance organization option.
- Dental.
- Four levels of life insurance coverage.

Levitz is not saying its approach is right for every employer. But this case study should provide insight for other benefits managers considering long-term care insurance programs.

- Long-term disability through salary continuation or weekly indemnity.
- Personal accident.
- Medical and dependent care reimbursement accounts.
- Contact lens discount.

To support these benefits, Levitz conducts an ongoing communications program including videos, articles in company publications, a toll-free telephone help line and various booklets and correspondence.

Levitz first considered adding GLTC in June 1989, when an employee survey showed that GLTC was the top choice among possible new benefits. We decided to respond quickly and introduce it during

our next enrollment period in October.

Our first step was to put together a "wish list" of all the features we wanted to see in the GLTC coverage, in our benefit communications and in service by the insurer. Among the major wishes on our list were:

- An insurer with a strong record of financial stability.
- An insurer with expertise in successful employee solicitation and communication.
- A product with adequate benefit levels, reasonable exclusions and simple application procedures.
- A product flexible enough to suit the varied needs of our associates.
- Excellent administration and claim service.

In July, we discussed our list with an insurance broker and, by the end of August, we had signed a contract with CNA Financial Corp. Our plan would offer three optional benefit levels and would be available to employees, spouses and parents of employees, where state law permits.

In early October, we held "Train the Trainer" sessions. These sessions, as the cornerstone of our benefits communications, trained our assistant branch managers to conduct the enrollment sessions at their locations. The insurer provided a complete training package, including a videotape, presentation script and all the enrollment materials that would be available to employees.

Our open enrollment period ran for just over three weeks in late October and early November. The centerpiece of GLTC communications was a two-part videotape provided by the insurer. Part one was a segment from a network news broadcast on the difficulties many Americans face in paying for nursing home care. Part two explained the

Continued on next page

Determining safety measure's value

By The Insurance Institute of America

The following question and answer are drawn from the curriculum for the Associate in Risk Management designation awarded by the Insurance Institute of America. They represent the type of question asked—and the possible answers—in one of the three examinations for the A.R.M. designation.

This month's question and answer, drawn from a recent national examination in ARM 54—Risk Financing—deals with how the reasonableness of the premium savings an organization receives from its commercial insurer for adopting a proven safety measure is likely to affect that organization's decision whether to remain with its current insurer or to seek alternative financing.

Q: The risk management professional for a clothing manufacturer, whose operations involve many employees working long hours with sewing machines, has determined that the aggregate number of hand injuries that these employees suffer is related to the total number of employee hours worked each year by the equation:

$$N = 3 + 0.3H$$

In this equation, N is the number of annual hand injuries and H is the

A.R.M. exercises

number of employee hours in millions each year.

This clothing manufacturer is considering purchasing some safety equipment that its vendor claims will improve safety so that the number of hand injuries for employees working with the new equipment will be:

$$N = 7 + 0.15H$$

On average, each hand injury costs \$2,000 in workers comp benefits.

• The clothing manufacturer's workers compensation program uses a traditionally insured guaranteed cost policy. The manufacturer's workers compensation insurer has agreed to reduce the manufacturer's annual premium by \$30,000 if it purchases and uses this safety equipment.

Assume that this manufacturer's employees continue to work a total of 500 million employee hours annually and that the vendor's forecast of the hand injury rate using the safety equipment proves correct. Is the \$30,000 reduction that the insurer has offered reasonable from the manufacturer's standpoint? Support your answer with appropriate calculations.

• Suppose that this clothing manufacturer decides that the workers compensation premium reduction is not sufficient and that, in response,

the manufacturer's risk management professional recommends that the manufacturer join an existing association workers compensation captive. Identify and briefly describe five factors—other than its current workers compensation insurance costs—that this manufacturer should consider in deciding whether to join this association captive.

A: • Without the new safety equipment, the manufacturer whose employees are working 500 million hours a year can expect the annual number of hand injuries to be 153, computed as:

$$\begin{aligned} N &= 3 + (0.3)(500) \\ &= 3 + 150 \\ &= 153 \end{aligned}$$

With the safety equipment, the same number of employee hours each year can be expected to generate 82 annual hand injuries, computed as:

$$\begin{aligned} N &= 7 + (0.15)(500) \\ &= 7 + 75 \\ &= 82 \end{aligned}$$

Thus, the safety equipment should prevent an average of 71 hand injuries per year ($153 - 82$), saving the insurer \$142,000 in workers compensation payments, computed as $71 \times \$2,000$. In light of these savings, the \$30,000 premium reduction offered to the manufacturer appears to be inadequate.

- Five possible factors the

manufacturer should consider in deciding whether to join the association captive are:

- ✓ The premiums the captive would charge; in other words, the manufacturer's cost of risk financing through this captive.
- ✓ Whether the captive offers a loss-responsive rating plan so that the manufacturer's workers compensation costs can be reduced as its safety record improves.
- ✓ The capitalization requirements of the captive, which determine most of the manufacturer's initial cost of joining.
- ✓ The conditions under which the manufacturer would be allowed to withdraw from the captive if it wished to re-enter the commercial insurance market in the future.
- ✓ The extent of the manufacturer's likely influence over the captive's operating procedures and management decisions—determining how much the manufacturer would be able to tailor the captive's activities to its particular needs.

The sample questions and answers used in this column are taken from the Associate in Risk Management designation curriculum of the IIA. For more information on the content of the A.R.M. program, write Dr. G.L. Head, Vp, Insurance Institute of America, P.O. Box 314, Malvern, Pa. 19355.

Group long-term care

Continued from previous page
long-term care plan.

The insurer also provided each employee with a package of information, including enrollment and question-and-answer booklets, a rate sheet and a request card for a parents' information package. In addition, the program's insurer, CNA Financial Corp., offered our employees a toll-free GLTC information hot line.

The entire presentation was a strong one. We made it even stronger by introducing a brochure titled "Sharing Responsibility for Today and Tomorrow" during the same meeting.

Levitz produced the brochure to educate employees about the reasons for rising health insurance and benefits costs, how rising costs affect Levitz and its employees and what should be done to slow the trend. The overall message of the brochure stressed the need for employees, Levitz and the government to share responsibility for paying for and controlling health care costs.

Our message struck home. By the end of the year, 819—nearly 18%—of our employees had enrolled in the plan, as did 330 spouses.

It was gratifying, of course, to get this kind of response. Not only did it validate our decision to add GLTC, but it also showed that more and more

employees welcome the opportunity to plan ahead and share responsibility for their future health care needs.

For benefits managers considering GLTC, here are some guidelines based on our experience:

- Educate yourself on long-term care.

Before talking to any insurers, learn as much as you can about how the coverage works, what employees want and what your industry is doing in the area of long-term care.

- Evaluate the insurer.

Financial stability is a must, because your employees will be depending on the insurer to be there many years down the road. Also vital is a track record of successful group long-term care enrollment by the insurer.

- Know the product.

GLTC is a complex product, and each insurer offers a different combination of features. Among the most important features to employees are adequate benefit levels, reasonable exclusion clauses, no minimum or maximum age for enrollment and excellence in administration and claims service.

Other important features include lifetime guaranteed renewability, reasonable institutional care requirements prior to payment of benefits, no requirements for proof of insurability or physician's statements and inflation-adjustable benefits.

Benefits managers should also be aware that certain states do not permit companies to offer GLTC coverage to parents of employees. Check with your broker or insurer on these legal considerations.

- Keep your perspective.

Persuasive sales presentations by insurers makes it easy to lose your objectivity. Instead, develop a written wish list of all the features you expect of the coverage and the insurer.

- Communicate carefully.

It's essential that your employees understand exactly what GLTC does and does not cover.

- Diversify your communications.

GLTC is a complex subject best communicated through a variety of media. Benefits managers should consider using videos, printed material, oral presentations and telephone hot lines.

- Look at the big picture.

While some employees are well aware of the need to plan ahead, others assume that Medicare represents a complete retirement health plan. As a result, benefits managers need to provide a context for GLTC by educating employees on the need to share responsibility for their own health care needs.

Frank W. Bonheim is vp-human resources of Levitz Furniture Corp. in Boca Raton, Fla.

Managing non-medical disability costs

"Return to Work by Design: Managing the Human and Financial Costs of Disability"

By Gene Dent

Published by Martin-Dennison Press, 3633 Stone River Circle, Stockton, Calif. 95219-3146 \$28 (includes shipping).

By Paul D. Winston

The human and financial costs of disability to both employer and employee can be enormous, writes Gene Dent in "Return to Work by Design." But, he adds, so can the savings generated by an effective disability management program.

Mr. Dent, who is disability manager for the University of California's Lawrence Livermore Laboratory, contends that the complexity of disability is routinely unappreciated and underestimated by employers.

Non-medical problems surrounding an ill or injured employee are often lumped in with attempts to treat the medical aspects of the disability, he says. While medical factors are central to how soon an injured or ill employee returns to work, it isn't the sole consideration, according to Mr. Dent.

"Physicians see daily that the speed with which someone returns to work has little to do with the speed at which human tissue heals itself and more to do with the patient's personal circumstances, the relationship between employer and employee, the availability of light-duty work, etc.," he writes.

"Return to Work by Design" offers a thorough

Books & ideas

look at how employers can effectively manage these non-medical aspects of workers' disabilities and their costs.

Among numerous other areas, the book's 13 chapters cover in depth such topics as:

- Forces that delay or prevent an employee's return to work.

An employee's pre-injury state of mind, reaction to the accident that caused injury, and personal and emotional problems are all factors that can "sabotage" a return to work, Mr. Dent writes.

- Guidelines for "reasonable accommodation" of disabled workers who have returned to work.

Mr. Dent reviews several recent court decisions that have attempted to define "reasonable accommodation" for employers, noting that most state and federal statutes governing disability are ambiguous about how this condition should be met. How an employer provides reasonable accommodation takes on even more significance as a result of its inclusion in the Americans With Physical Disabilities Act of 1990, he says.

- Designing a return to work program.

One of the first issues to consider in designing such a program is what department within the company should oversee the program, according to Mr. Dent. He explains why an in-house medical department, employee benefits manager, safety department or risk manager all may be feasible

choices.

- Back injury problems and potential solutions.

Mr. Dent reviews a host of treatments for back injuries, which he says account for about one-third of all workplace injuries, and he reviews which treatments are effective and which are not.

"Although back pain is a familiar complaint, medicine's history of treating it is dismal," he notes.

- Psychological stress cases.

"Psychological stress claims are an exciting phenomenon on the workers compensation scene—exciting in the sense that a raccoon becomes excited when caught on the interstate in the headlights of an 18-wheeler," Mr. Dent writes.

He reviews the types of stress claims, causes in the workplace for such claims and, ultimately, possible treatment.

"Return to Work by Design" covers a host of other issues surrounding the non-medical aspects of disability. In addition to its 13 chapters, the book contains appendices with sample forms used in return-to-work planning and a guide to adaptive devices and computer resources.

"The experience of some of this country's largest and most successful corporations indicates that thoughtful planning coupled with specific actions can promote prompt return to work," Mr. Dent stresses. "Return-to-work programs acknowledge that the employer, while not having absolute control over the process, can influence the outcome of injury/illness/disability for everyone's benefit. It's a case of nothing ventured, something lost."

Retiree cannot seek time loss benefits: Court

Can a voluntarily retired worker, who is collecting retirement benefits, simultaneously qualify for time loss payments for an industrial injury sustained prior to retirement?

Not according to a recent decision of the Court of Appeals of Washington.

On Feb. 2, 1983, Gene Overdorff, then age 55, suffered a hernia while shoveling coke for his employer, Kaiser Aluminum & Chemical Corp. He filed a workers compensation claim, which was accepted by the Department of Labor and Industries. However, despite the injury, Mr. Overdorff continued to work until

Legal briefs

he voluntarily retired on Feb. 28, 1983.

His hernia condition progressed to a point where surgical repair became necessary. Two years and nine months after his industrial injury, Mr. Overdorff underwent the operation.

The Department of Labor and Industries authorized payment for his medical treatment and closed his claim.

However, Mr. Overdorff sought reconsideration, asserting a right to

time loss compensation.

This was denied by the department, but an administrative law judge awarded him benefits. This was affirmed by the trial court.

The appellate court concluded that, under the facts of this case, an individual who voluntarily withdrew from the workforce for nearly three years and who interrupts his retirement to undergo corrective surgery should not be entitled to time loss benefits.

The appellate court's ruling emphasized that Mr. Overdorff's claim lacked the requisite adverse impact—lost wages or income—to

warrant an award of time loss benefits.

The trial court decision awarding benefits was overturned.

Kaiser Aluminum & Chemical Corp. vs. Overdorff, Court of Appeals of Washington, March 30, 1990 (BI/02/Jan.-\$10).

These abstracts were prepared by Cases Unlimited Inc. Copies of these decisions are available by sending a \$10 check payable to Cases Unlimited to Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590. List the number for each opinion.

INTERNATIONAL

Australia approves reef pilot standard

SYDNEY, Australia—Australia's federal government is stepping in to make it compulsory for ships negotiating the fragile waters of the Great Barrier Reef to have a pilot familiar with the waters on board.

An Australian marine underwriter earlier this year unsuccessfully lobbied the International Maritime Organization and other marine insurance underwriters to adopt such a requirement (*BI*, May 21).

Geoffrey G. Gauci, managing director of Sydney-based underwriter Marine & Aviation Management Services Ltd., a wholly owned subsidiary of Norwich Winterthur (Australia) Ltd., said he

welcomes the announcement.

"It's a great step forward for this country and for an area of the world that's unique," he said. Mr. Gauci is Australia's sole representative on the marine hull committee of the IMO, which is a United Nations agency that establishes standards for maritime safety and the prevention of pollution from ships.

Ros Kelly, Australia's minister of the environment, tourism and territories, who announced the planned requirement, said the Great Barrier Reef is a world heri-

tage area and "a unique area requiring the highest possible level of environmental protection."

The government is also concerned about the cost to the nation's tourism industry, as well as cleanup costs, if there is an oil spill on the reef, she said.

The government will amend its Great Barrier Reef Marine Park Act to require all ships of 70 meters (77 yards) or more in length and all loaded oil tankers, chemical carriers and liquefied gas carriers, regardless of size, to take pilots on board when navigating

the north section of the inner reef, as well as Hydrographer's Passage, a route through the reef off the Queensland coast near the city of Mackay.

The reef is the world's largest collection of coral reefs, a 1,250-mile-long maze of islands, shoals and reefs along the northeast coast of Australia.

The IMO had recommended in 1986 that pilots be used in the waters around the entire stretch of the reef, but shipowners and charterers had ignored the recommendation, Mr. Gauci said.

He said underwriters had not been prepared to load premiums or endorse policies requiring a pilot because the insurance market was

so soft and because a minimal amount of marine business was written in the Australian market.

Ms. Kelly said the Australian government had received international endorsement of its proposal at a meeting of the IMO's marine environment protection committee in London last month.

The Great Barrier Reef area was classified as a "particularly sensitive area," and governments represented on the committee agreed to instruct ships flying their flags that they must act in accordance with Australia's requirement for pilots.

The Great Barrier Reef is the first area in the world to receive
Continued on next page

Iran may renew relations with foreign underwriters

By MARIA KIELMAS

LONDON—Iran may soon thaw its chilly relations with foreign insurers, some observers say.

But companies that insure property risks in Iran may be hit with huge losses in the earthquake-prone country because of an outdated national building code.

Insurers think there is room for international cooperation in the Iranian market, especially after European Community sanctions against Iran were dropped in October and diplomatic ties with Britain were recently re-established.

"It really depends on the Iranian government," said Bill Hazeldon, assistant group overseas manager at Commercial Union

Assurance Co. P.L.C. in London.

Mr. Hazeldon regards Iran as a country with long-term prospects for foreign insurers, particularly since insurance has been deregulated in neighboring countries like Turkey and Pakistan to encourage foreign investment.

And, Iranian authorities have demonstrated renewed interest in minimizing their earthquake risk by inviting foreign experts to attend a conference on earthquake seismology in Tehran next spring.

This conference could signal the first Iranian interest in earthquake risk since the 1978 revolution, said Herbert Tiedeman, engineering consultant to Swiss Reinsurance Co. in Zurich, Switzerland.

Swiss Re had been active in the

Iranian market since 1961 but pulled out two years before the 1978 revolution because of escalating fire and motor losses, said Mr. Tiedeman. He added that at the time, Iran had been developing expertise in earthquake seismology and engineering.

However, Iran's density of earthquake coverage historically has been very low, with only about 5% coverage in Tehran and probably none at all in the major provincial centers like Mashhad in the Northeast and Tabriz in the West.

The Iranian insurance industry, including both domestic and foreign-owned companies, was nationalized in the early 1980s.

Iran has one state-owned reinsurer.
Continued on next page



AP/Wide World Photo

Insurers in Iran face sizeable losses in the earthquake-prone country.

ACE Ltd. announces dramatic decline in underwriting profit

HAMILTON, Bermuda—ACE Ltd. last week announced an underwriting profit of \$6.2 million for the year ending Sept. 30, down sharply from \$133.8 million in 1989.

ACE Chief Executive Walter A. Scott conceded the underwriting result was "by far the lowest" since the policyholder-owned high excess liability insurer began operations five years ago.

ACE Ltd. underwrites through two insurance subsidiaries: A.C.E. Insurance Co. Ltd., which is incorporated in the Cayman Islands; and A.C.E. Insurance Co. (Bermuda) Ltd. (*BI*, April 30).

Earned premiums in 1990 rose 1.7% to \$216.4 million, of which \$150 million came from excess liability business, while directors and officers liability accounted for \$71 million. In 1989, earned premiums totaled \$212.7 million, of which \$145.9 million was excess liability business and \$69.8 million was D&O business. Reinsurance ceded rose to \$4.8 million in 1990 vs. \$3.1 million in 1989.

Mr. Scott blamed the lower underwriting profits on a \$177 million provision for paid and outstanding losses and loss expenses, which was more than three times the \$46.5 million set aside in 1989.

"You have to remember that our underwriting profit of over \$133 million last year on premiums of \$213 million was artificially high," Mr. Scott pointed out. "This year's \$6.2 million underwriting profit represents a combined ratio of about 97%, which most people in the property/casualty industry would kill to have right now."

Although he would not identify claims for which ACE is reserving funds, Mr. Scott revealed that ACE had begun payments this year on its first claim, which was related to the loss of an oil platform in the Gulf of Mexico.

"We had expected to begin paying out on a school bus traffic accident first, but this one got ahead of it," he said.

Mr. Scott said that ACE had paid out \$26 million so far and expected to make "further payments before the end of the year."

ACE's total provision for losses and loss expenses now stands at \$202.6 million, a figure which Mr. Scott said was a cumulative al-

Continued on next page

BERMUDA BRIEFS

LONDON

Some names quit Outhwaite suit

By CAROLYN ALDRED and STACY SHAPIRO

LONDON—A minor battle is brewing over whether the members of syndicates managed by R.H.M. Outhwaite (Underwriting Agencies) Ltd. can withdraw from litigation filed last year against 81 Lloyd's of London members' agencies.

A year ago, 814 members belonging to the Outhwaite 1982 Names Assn. filed a lawsuit in London's High Court to recover millions of dollars in losses they face from runoff reinsurance policies underwritten by Richard Outhwaite (*BI*, Dec. 25, 1989). In order to pursue damages, members must sue the members' agent that placed them on the syndicates. The leading defendant named in the litigation is the Outhwaite agency, which placed 31 of the plaintiffs on the syndicates.

Altogether, there are now 880 to 890 Lloyd's members named as plaintiffs in the action.

However, Outhwaite earlier this month lodged a formal protest with the members' association's law firm, Richards Butler, "on evidence that members wishing to resign from the association and withdraw from pending litigation are being prevented from doing so," according to a press release from the agency.

The Outhwaite agency has distributed a letter from the associa-

tion's chairman, Peter Nutting, to a member who wants to withdraw from the litigation as proof of the difficulty members have if they decide to opt out of the suit.

Mr. Nutting's letter states that eight members were allowed to withdraw earlier this year "on agreed terms including certain indemnities." More recently, another 13 individuals were allowed to leave on a "costs amnesty" basis, whereby the defendants agreed to pay for their share of the legal costs so far incurred on behalf of the members. The amnesty deadline was Nov. 21.

However, with the expiration of the amnesty agreement, the members association "has now taken the opportunity of re-examining the position of those who decided that they would like to withdraw," Mr. Nutting said in the letter.

After taking into consideration other Outhwaite members, the association has decided "that we will not facilitate your withdrawal from the action," he said to the member in the letter.

Any member who now withdraws from litigation will have to pay for a share of the legal costs already incurred plus a share of the defendants' court costs should the members lose their action, Mr. Nutting said.

The Outhwaite agency "believes this action, which effectively locks members into the litigation process against their inclination, is both

wrong and contrary to public policy," the agency said in its press release.

"I was astonished when I heard of this development," said Edward Bloxham, chief executive of the Outhwaite agency.

Although the amnesty deadline has technically expired, the defendants will "for the present" be prepared to look "sympathetically" to the costs of members who still wish to withdraw from litigation, said Mr. Bloxham.

However, Mr. Nutting said in an interview that the "brouhaha is totally artificial."

"What I said was that we weren't able to 'facilitate' people leaving," because the association was not designed for people to resign from litigation, he said. "What I meant was that it isn't easy" to withdraw from the litigation, he said.

Members can withdraw from the litigation, but they must bear the expense of applying to the court and having their names withdrawn by a judge, Mr. Nutting explained. And, the members are liable for their portions of the court costs that have so far been incurred and for a portion of the defendants' costs should the decision go against the members.

"But, of course, we'll let people go if they want," he said.

The conflict arises from four members who want to withdraw from the litigation, Mr. Nutting
Continued on next page

INTERNATIONAL

Iranian insurance

Continued from previous page
surer and four state-owned insurance companies. The insurance companies—Bimeh Iran, Bimeh Asia, Bimeh Alborz and Bimeh Melli—by law must cede 25% of their reinsurance to the state-owned reinsurer, Markazi.

But, in 1986 Iranian business returned to the international market for coverage. The state oil company, the National Iranian Oil Corp., was among the first firms to approach the London market. Industry sources say the NIOC directly approached the London market because domestic insurers were charging from 15% to 20% in commissions. Now, about 80% of NIOC's insurance is placed on the

international market.

Iran now has one state-owned reinsurer, to which Iran's four state-owned insurance companies must by law cede 25% of all reinsurance.

Iranian insurers currently cede a small amount of catastrophe cover on the international market.

But, if this were to increase in the event of renewed international cooperation, Mr. Tiedeman said foreign insurers would find that potential insured earthquake losses in major Iranian cities would be incalculable due to the low standard of construction techniques used over the last few decades.

"The common type of high-rise construction in Iran is a flexible steel frame building with a brittle brick

infill," he said. When this type of structure is shaken by an earthquake, the steel frame flexes and the bricks drop out. A concrete frame with brick infill, which is more appropriate for earthquake-prone areas, is rare in Iran, he added.

Iran revised its national building code in 1988, based on the United States' 1971 universal building code. But the Iranian code makes no provision for compatibility of materials, a stipulation which would remove the dangerous steel/brick combination.

Mr. Tiedeman thinks the Iranian building code is outmoded and urgently needs revision. "It's a Paleolithic code," he said.

And, no matter what improvements may be made to a building

code, the insurer still has to cover older buildings, he said.

Iran, like other countries, also has no provision in its building code for the earthquake-resistant design of oil, gas and petrochemical industry plants, a major Iranian industrial risk, Mr. Tiedeman said. "That is left to the operator of the plant."

Mr. Tiedeman said Iran's area of highest risk in the event of a quake includes Tehran and its suburbs, citing the high population density, poor construction and soft subsoil.

Iran suffered a devastating quake earlier this year centered on the city of Manjil in Gilan province, which borders the Caspian Sea (BI, July 9; June 25). The quake killed more than 50,000 people and left some half a

million homeless, according to official Iranian reports at the time. The shock also caused slight damage to the Igat-1 gas pipeline, which transports Iranian gas to the Soviet Union, but this was quickly repaired.

And a Nov. 6 earthquake that hit western Iran left 101 dead, three villages wiped out and 14 damaged, though the official government estimates are regarded as incomplete. There have been no reports of damage to a gas processing plant being built at Kangan, about 10 miles from the epicenter of the November quake.

And, as recently as last Monday, an earthquake reportedly hit the Persian Gulf coast of Iran, although no reports of damage were received at press time. ■

BERMUDA BRIEFS

Continued from previous page
lowance for 12 claims.

Mr. Scott said that in the past five years ACE had benefited from a "substantial amount of good luck and the immaturity of our book of business."

Total assets in 1990 topped \$1.4 billion, while shareholders equity dropped slightly as a result of redemptions, but remained in excess of \$1 billion. However, ACE's net income tumbled 72.2% to \$61.6 million this year from \$221.9 million in 1989.

In a prepared statement, ACE said that its profitability was not helped by a decline in the return on its investment portfolio, which now includes \$1.24 billion in bonds, \$97.2 million in equities and \$14.3 million in cash and deposits.

Although investment income rose 8.5% to \$107.8 million from \$99.4 million, ACE suffered a \$43 million realized loss on the sale of securities. Mr. Scott explained that this loss occurred after ACE changed investment managers and had disposed of certain securities in the process.

"We increased our exposure to equity securities in 1990, which were hit by the Mideast crisis, and the bond market also had a bad year," he said.

Mr. Scott predicted that the company will improve its underwriting profit next year.

"We'd hope to be somewhere between our 1989 and our 1990 results next year, and we should be able to improve on our investment income," he said.

No dividend was included in the latest results. But, effective Jan. 28, ACE Ltd. will be redeeming 33.3% of its outstanding callable shares at a redemption price of

\$100 per share. ACE said the redemption will return \$98 million to the company's shareholders.

In a review of the past 12 months, ACE said that it had continued to make a number of marketing and underwriting changes designed to keep the company in the forefront of its industry.

"Early in the year, the reserve premium requirement was dropped, resulting in the return of \$28 million of reserve premiums to policyholders. The company also eliminated the need to purchase an excess liability policy before accessing ACE's D&O coverage. Of greatest significance, however, was the increase in the company's excess liability limits by \$50 million to \$200 million," Mr. Scott said.

—By Roger Scotton

OIL cuts excess limits

Oil Insurance Ltd., the giant Bermuda-based oil and gas industry mutual insurer, is reducing the excess liability insurance limits available to its participants to \$50 million from \$150 million, effective Jan. 1.

The facility's underlying \$150 million in primary liability limits remains unaffected by the decision.

OIL Senior Vp Mr. Massey said that the change was made because the company "had a great deal of limits exposed on a single occurrence" and because OIL wanted to offer its members a broader range of coverages.

OIL, which currently has 48 participants, raised its rates earlier this year after suffering operating losses of \$237.8 million in 1989 and \$514.3 million in 1988 (BI, April 30).

—By Mark A. Hofmann

Continued from previous page

said. But, he added, there are four more members who want to join the litigation, which is expected to go to trial next October.

Meanwhile, Mr. Nutting is among several newly elected members joining the Council of Lloyd's next month.

Mr. Nutting will serve as one of two external members, along with Lady Rona Delves Broughton.

The new working members elected to the council are: Simon Arnold, chairman and chief executive of Bain Clarkson Ltd.; Alan Jackson, deputy chairman of Wren Underwriting Agencies Ltd., who also will be Lloyd's senior deputy chairman; and Robert Keville, chairman of Willis Faber & Dumas Ltd.

As a council member, Mr. Nutting said that he welcomes the proposed runoff reinsurance company that Lloyd's announced earlier this month to help close open syndicates' accounts (BI, Dec. 3).

The proposed facility will be

chaired by Robin A.G. Jackson, retired underwriter of Lloyd's syndicate 799, managed by Merrett Underwriting Agency Management Ltd., as well as a former chairman of the London Asbestos Working Party.

Lloyd's has not yet announced details about the runoff reinsurance company, although Lloyd's officials have said that the reinsurer will target syndicates with open years that, unlike the Outhwaite syndicates, are no longer underwriting.

However, Mr. Nutting said "it's a pity (the facility) isn't bigger. It's not big enough to do anything about Outhwaite" and the open syndicate accounts that pertain to the Outhwaite situation.

"But it is a beginning," Mr. Nutting said.

Mr. Nutting also said there will be a "heck of a lot of work to do" on the Council of Lloyd's next year. "It is terribly important that the capital base—i.e., the non-working members—are made happier than they are at the moment,"

he said.

Mr. Nutting said he would like to see Lloyd's do several things while he is a member of the council, including:

- Reduce overhead costs so syndicates can become more profitable.

- Review syndicate reserves in light of the "crazy decisions from the American courts" to make sure reserves are adequate.

- Devise "modified" arbitration procedures to allow internal disputes in the market—whether between member and agent or agent and agent—to be resolved without having to spend millions on legal fees.

- Review the need for unlimited liability on behalf of Lloyd's members.

"Unlimited liability needs looking at again in the widest possible context," according to Mr. Nutting.

"Until that's resolved, Lloyd's won't attract people as members that it needs, namely those who are rich." ■

LONDON

GLOBAL BRIEFS

Continued from previous page
the PSA classification, Ms. Kelly said.

—By Kate McIlwaine

Sicilian earthquake

TRIESTE, Italy—Less than 1% of the total losses incurred during a major earthquake in Sicily earlier this month are insured, Italy's leading insurer believes.

There will be few if any losses covered by insurance since any earthquake risk is usually excluded

from Italian insurance policies, said Benito Pagnanelli, a director of Assicurazioni Generali S.p.A. in Trieste, Italy.

"Normally, earthquake is not covered by Italian policies," he said. "This time we (in the insurance business) are lucky."

At least 19 people died and more than 200 were injured when the tremor, measuring 5.1 on the Richter scale, struck the eastern part of Sicily.

The quake was felt all along the island's east coast, although the town

of Carlentini was hardest hit.

Reports suggest that total damage is estimated to be around \$450 million.

Earthquakes are frequent in Italy, especially in the north, said Mr. Pagnanelli. As a result, earthquakes have not been covered for many years.

The Italian government has considered a national catastrophe insurance program similar to that offered by the French government, but it is still only being discussed, Mr. Pagnanelli said.

—By Stacy Shapiro

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Workers comp

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groups say.

"Workers compensation is supposed to be a no-fault system, but the fault now is lying with the injured worker who has filed a claim," said David Czernik, director of the Louisiana Consumer League in Baton Rouge, La.

Reporting information about a job applicant's prior workers comp claim is like creating "a rap sheet for injured workers, which precludes them from finding future employment," Mr. Czernik said.

He plans to work on developing a law to make workers comp claims data confidential in Louisiana.

An employer "has every right" to ask a person applying for a job about previous injuries and whether an injury can prevent him from engaging in this particular kind of work, concedes James Ellenberger, assistant director for the AFL-CIO's department of occupational health and safety in Washington, D.C.

However, screening employees who have filed workers comp claims is a "pathetic and scurrilous" practice, added Thomas R. Donahue, secretary/treasurer of the national AFL-CIO (BI, Sept. 24).

Employer representatives, though, defend the practice of screening applicants based on prior workers comp claim activity.

"It is legitimate for an employer to want to weed out the professional claimant who is milking the system," said Fred Krebs, manager of labor and human resources for the U.S. Chamber of Commerce in Washington, D.C., though he agrees that a job applicant should not be penalized if he previously has filed a legitimate workers comp claim.

Critics of easy employer access to workers comp claims data say the information can be unfairly detrimental to job applicants in several ways.

For example, the agencies may

provide information on a different individual with the same name.

In addition, the claims history information may not show that the claims were uncontested.

And, the claims history may show the applicant was involved in a workplace accident but not show that he or she never filed a claim, sources say. They explained that an applicant's previous employer may file an accident report with a workers comp insurer immediately after an employee is injured. That information could eventually be recorded with the state agency, even if the employee never filed a claim or never received any workers comp benefits.

Many labor and consumer groups support limiting employers' access to workers comp claim histories as provided under a Michigan law that made uncontested workers comp claims confidential.

Michigan's law, which went into effect in June 1989, stemmed from the fact that the state Bureau of Workers' Disability Compensation had "lots" of problems with cursory telephone inquiries about whether particular individuals were listed on the bureau's computers as having filed workers comp claims, said Edward M. Welch, the bureau's director.

By 1989, the bureau was receiving 500 such telephone calls weekly. Bureau staff members felt obliged, under the state's Freedom of Information Act, to report a listing to a caller, Mr. Welch explained.

However, many of those callers almost never checked further with the bureau about details of the claim. Consequently, the caller may not have learned that the claim was filed by a different individual with the same name—which requires Social Security number checks to pinpoint—or that the claim was uncontested.

"My assumption is an awful lot of individuals' lost job opportunities because the bureau's computer contained their names, Mr. Welch said.

There was broad-based support in the Michigan workers comp community for making uncontested workers comp claim records confidential.

One reason that employers supported the law was because it prohibited rehabilitation and medical service providers from soliciting injured employees, which could interfere with the injured worker's medical care.

For example, a vocational rehabilitation provider in Michigan used the bureau's records to identify potential candidates for rehabilitation and solicit business from them.

In addition, the law offered a carrot for employers that self-insured their workers comp risks by also guaranteeing that the financial information they filed to the state to prove they had the financial wherewithal to self-insure would be kept confidential.

Opponents of the Michigan law included journalists and other supporters of disclosures under a state's Freedom of Information Act.

The Oklahoma workers comp administrator also has implemented procedures to protect job applicants from the disclosure of inaccurate or incomplete workers comp claims data.

The Oklahoma Workers' Compensation Court this summer began providing information on an individual's workers comp claim history only if a written request is made. The court responds by postcard to such requests and uses a claimant's Social Security number to reduce the possibility that two claimants with the same name could be mistaken for each other.

In addition, the Oklahoma court will provide claims information if an employer or a reporting service representative visits one of two offices to personally check computerized information using the applicant's Social Security number.

Staff members have been instructed to encourage those seeking workers comp claim informa-

tion to obtain complete details about a claim, said Mr. Clingman, the court administrator.

Before the court implemented the change, it was receiving about 80 calls an hour for information about whether an individual had a history of workers comp claims, according to Mr. Clingman.

The court is now sending out about 80 to 90 postcards daily, he said.

In addition to state laws and regulations limiting disclosure of workers comp claims information, the federal Americans with Physical Disabilities Act, which goes into effect in 1992, may limit employers' ability to check an applicant's prior work comp claims history.

The act prohibits most employers from discriminating against "a qualified individual with a disability" because of the disability.

Instead, the law requires an employer to make a "reasonable accommodation" for a disabled person, unless it would cause the employer "undue hardship," though critics point out those terms are not defined clearly.

In addition, the law may limit an employer's ability to check a prospective employee's workers comp claims history, said Nancy Fulco, a human resources attorney with the U.S. Chamber.

For example, the law restricts an employer's ability to inquire about a job applicant's medical history or require that the applicant submit to a medical examination, at least until an offer of employment is made.

However, many employers do not want their access to job applicants' workers comp claims histories curbed.

"Employees eager to get a job are not always totally honest about these things," noted Mr. Stevenson, the workers comp defense attorney.

"Fraud is not an isolated incident in the system," said Mike DeWitt, director of marketing for AVERT Inc. of Fort Collins, Colo.,

which says it carefully obtains and sells employees' prior workers comp claims information to employers.

For example, Mr. DeWitt questions the validity of the four or more workers comp claims filed by nearly 18,000 individuals in Colorado between 1981 and 1988. Each of these claims resulted in four or more lost workdays, he said.

Ideally, the best solution would be for both the employer and applicant to be honest and trusting, but that is not the nature of the relationship, he said.

State workers comp administrators and others who call for the confidentiality of workers comp records are making "a very bad mistake," because their position is based more on emotion than fact, Mr. DeWitt said.

And, from a typical employer's point of view, a job applicant gives up his right to privacy when he signs a job application form that allows an employer to make background checks relevant to the position he is seeking.

For example, depending on state laws and the position for which a job applicant is applying, such checks can even extend beyond prior workers comp claims to include an applicant's history in connection with prior employment, consumer credit, motor vehicle violations and criminal convictions.

An employer that decides not to hire a job applicant because of adverse background information supplied by a consumer reporting agency must identify the consumer reporting agency making the report, in keeping with requirements of the federal Fair Credit Reporting Act of 1970.

That provision gives an applicant an opportunity to challenge inaccurate information the agency may be reporting.

Many job applications also state that an applicant who is hired can be dismissed later if an employer learns that he lied as part of his application.

Michigan Mutual taps Wortman as CEO

J. John Wortman has been elected chief executive officer of Michigan Mutual Insurance Co. and its affiliates, succeeding E.L. Cox, who is retiring as of Jan. 1.

Mr. Wortman, who joined the Detroit-based insurance group as president and chief operating officer in 1989, previously served as president of American Mutual Insurance Cos. of Wakefield, Mass.

Michigan Mutual is the parent company of Amerisure Insurance Co., Amerisure Inc., Amerisure Intermediaries Inc., Amerisure Re (Bermuda) Ltd. and Amerisure Texas Inc.

In other insurer changes:

Zurich-American Insurance Group, a Zurich Insurance Co. unit in Schaumburg, Ill., announced these promotions:

Loren J. Alter to executive vp of finance and administration; David A. Bowers to executive vp of corporate law; H. Donald Hanson to executive vp in the actuarial, reinsurance and internal audit department; Richard Manetta to executive vp of insurance services;

Stuart L. Olin to executive vp of investment; and Victor E. Vogel to executive vp of corporate development. And at Zurich-American's Atlas General Agency unit in Hollywood, Fla., Donald V. Tarrence appointed president and chief operating officer. He had been a senior vp at Swett & Crawford.

Michael R. Hoy, president of Kemper National Insurance Cos.,



Mr. Wortman

Comings & goings: industry

Western division commercial lines office in Folsom, Calif., elected vp of Kemper National.

Russell E. Leatherby, the president and chief operating officer of UniCARE Financial Corp. of Irvine, Calif., assumed the additional titles of chairman and chief executive officer. He will also become chairman and chief executive of UniCARE Insurance Co., its principal subsidiary. Mr. Leatherby is replacing Ralph W. Leatherby, who became chairman emeritus.

Roderic J. Wildish, who had been Canadian regional manager in Toronto of the Marine Office of America Corp., named executive vp of MOAC, a Continental Corp. unit in Cranbury, N.J. Replacing him in Toronto is Richard J. Yeo, who had been vp and manager of Asia-Pacific operations in Hong Kong.

Foremost Insurance Co. in Grand Rapids, Mich., announced these changes: Mark T. Cusack, who had been Southwest regional vp, named regional vp of the Eastern region; Cindy McLane Glaub named vp; and Rebecca Wolfe Spratlin named vp of Foremost and Foremost Property & Casualty Insurance Co.

William C. Scott Jr. named president and chief operating officer of Winston-Salem, N.C.-based Universal Insurance Co., a unit of the Innovative Co., a holding company in Birmingham, Ala.

Kathleen Wilson promoted to senior vp-operations for Connecticut Specialty Insurance Co., an

Orion Capital Cos. subsidiary in Farmington, Conn. She had been vp of administration.

Maria L. Rodriguez-Scott appointed vp finance, chief financial officer and treasurer for Skandia Direct Operations Corp. in Miami, whose ultimate parent is Skandia Group. At another subsidiary, Southern Underwriters Inc. of Miami, R.C. Chaffin named president and W.V. Santore named vp-underwriting. Mr. Chaffin had been president and chief executive officer of Georgia Casualty & Surety Co.

Reinsurance

Ernest C. Frohboese joins General Reinsurance Corp. of Stamford, Conn., as senior vp and chief investment officer.

In addition, Michael J. Mugglebee appointed vp in Los Angeles with General Star Management Co., a General Re unit.

Zurich Reinsurance Co., a Zurich Insurance Co. unit in Stamford, Conn., announced two appointments. Stephen Muehlbauer, who had been a vp and associate counsel at Christiana General Insurance Co., joined as vp of claims and general counsel. And Barry W. Roop, who had been a manager of treaty underwriting at Philadelphia Reinsurance Corp., joined as vp of treaty underwriting.

John D. Dunn Jr. elected executive vp at Mercantile & General Reinsurance Co. of America in Morristown, N.J.

Joseph K. Ram named senior vp and Bruce Saxon Wise named executive vp at United Republic Reinsurance Co. in Houston. Mr. Ram had been vp of treaty underwriting and Mr. Wise had been president of Atlantic Management Services Inc. in San Antonio.

Agents/brokers

Marie A. Haddix, who had been marketing manager, appointed

managing vp of the Omaha, Neb., office of Alexander & Alexander Inc.

Richard Q. Ford appointed managing director of the national benefits division in Seattle with Corroon & Black Corp., a Willis Corroon P.L.C. unit. He had been vp of the national benefits division. Also at the C&B unit, Johnny Thompson named chief administrative officer of the construction industry division.

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Legal fees

Continued from page 3

insurers in California is facilitated in part by a state law that allows policyholders to pick their own counsel, known as Cumis counsel,

vs. Cumis Insurance Society Inc.—a California appellate court found that when an insurer defends a policyholder with a reservation of rights, an insurer-appointed attorney could have a conflict of interest. The attorney

A state court in San Francisco affirmed that the \$148,611 in fees that Kahn & Fasamo charged Fireman's Fund was for services that were 'unnecessary, unreasonable and wholly disproportionate to the services performed.'

in third-party litigation in which insurers have agreed to defend policyholders under a reservation of rights.

Normally, policyholders are defended by insurer-appointed attorneys.

However, in a 1984 case—*San Diego Navy Federal Credit Union*

works for the insurer that is contesting coverage but represents the policyholder that contends it is covered.

Some defense attorneys allegedly have taken advantage of this ruling by charging insurers grossly excessive legal fees when representing policyholders.

The most notorious Cumis counsel scheme allegedly was perpetrated by attorneys who are members of the Alliance.

Under Rucker & Clarkson's tentative settlement with Fireman's Fund and Allstate over the firm's involvement in the Alliance, the law firm also agreed to cooperate with Fireman's Fund and Allstate in their fraud suit against other attorneys who were allegedly involved in the scheme.

The law firm did not return phone calls.

The Fireman's Fund and Allstate fraud suit charges a total of 25 defendants with violations of the Racketeer Influenced and Corrupt Organizations act.

The insurers' suit seeks a total of \$6.3 million in compensatory damages.

If Fireman's Fund and Allstate are successful, they may recover three times their compensatory damages under RICO.

The Fireman's Fund and Allstate lawsuit also seeks unspecified punitive damages and equitable relief, including dissolution of the Alliance.

In October, Fireman's Fund and Allstate accepted settlements from three other attorneys named in the lawsuit.

Terms of the October settlement require the three defendants to pay to Fireman's Fund and Allstate an undisclosed sum of money and also to cooperate with the insurers in their fraud suit against other attorneys who are members of the Alliance.

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NAIC report

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Some insurer representatives especially are concerned that the new statistics could be used to support demands for rate rollbacks and allegations of windfall profits.

Insurers' concerns are heightened by the fact that the NAIC plans to take next year's report one step farther: Insurers' 1990 profits will be presented as a percentage of surplus—which will yield a rate of return on net worth or equity—rather than merely as a percentage of premiums earned, said Robert Klein, NAIC director of research.

The net worth calculation will make it easier for regulators and others to compare the insurance industry's profitability with that of other industries, he said.

Insurers have long contended that the risks of underwriting insurance make comparisons of their profits with those of other businesses, like manufacturers, unfair.

Regulators and insurers almost unanimously agree that the data in the new NAIC report should not be used directly for rate making because it does not provide the prospective data that ratemaking requires. However, it does provide a historical view of the adequacy of prior rates, they say.

The format of the NAIC's profitability report was expanded because

most regulators now believe that all investment income earned by insurers should be reflected in measuring their profitability, Mr. Klein said (BI, July 23).

Virginia Insurance Commissioner Steven T. Foster said the change is "long overdue" because he was tired of apologizing for the omission of investment income on surplus from the report.

The approach also is consistent with general economic theory as well as the "total return" reporting concept the NAIC endorsed in 1984, Mr. Klein said (BI, June 18, 1984).

"I think we have come leaps and bounds toward making it better," said Martin M. Simons, chief casualty actuary and director of the property/casualty division of the South Carolina Insurance Department.

"Before, the report excluded some investment income that made comparisons with other industries inaccurate," he said.

"I find it embarrassing to the NAIC to always have to explain to legislators and others that the NAIC report is useless for comparing to other industries for normal notions of profit," said J. Robert Hunter, president of the National Insurance Consumer Organization in Alexandria, Va., in a letter to the NAIC this summer.

The changes made in the latest NAIC report are "very good" and are a step "in the right direction,"

Auto insurance profits skid

Insurers' profits from underwriting auto insurance hit the skids in 1989. Profits are expressed as a percent of direct premiums earned.



Source: National Assn. of Insurance Commissioners

GRAPHIC BY CYNTHIA WATSON

Mr. Hunter said last week.

"We've gone from a system that is precisely wrong to one that is approximately right," Mr. Simons said, noting there still are differences in opinion over whether it is appropriate to allocate insurer surplus by line and by state and how to do it.

Another factor contributing to the change was insurers used the old version of the report to support contentions that certain lines of insurance were not very profitable, forcing regulators to explain that the NAIC report excluded investment income earned on surplus.

The insurance industry's reaction to the change has been "fairly intense," Mr. Simons said. "They care so much because now the report shows more income to the industry."

The industry argued "very strenuously" to keep the report the way it was, said Phillip Schwartz, vp-financial reporting and associate general counsel for the American Insurance Assn. in Washington, D.C.

"In terms of allocation of investment income, the National Assn. of Independent Insurers still doesn't think (the report) is correct or proper," said Tom Ward, director of financial reporting for the NAI in Des Plaines, Ill.

"The NAIC, by trying to absurdly refine the information, is being misleading," said Judy Mintel, associate general counsel for State Farm Mutual Automobile Insurance Co. in Bloomington, Ill.

Officials of the AIA, NAI and the Alliance of American Insurers say they are relieved that the new report also continues to report profits by-line and by-state without including investment income on capital and surplus. However, that "doesn't solve the problem," Ms. Mintel said.

Insurers generally argue that investment income on surplus should not be included in the profitability report because insurers' performance in a given state or line of business should be evaluated only on the income derived from that business.

"By allocating (investment income on) surplus by line and by state, it decreases the value of the report and increases the potential for misinterpretation and misuse," Ms. Mintel said.

"It can distort the true picture of what is happening in various states," said the NAI's Mr. Ward. A particular line of insurance in a particular state may show a profit due to the NAIC's allocation of investment in-

come on surplus even though insurers may have pulled out of that market because of high loss ratios, he said.

In addition, insurer trade associations point out that including investment income on surplus by line and by state requires insurers to provide profit information in greater detail than other industries.

The NAIC's Mr. Klein counters that it is important to establish a benchmark or standard for determining whether profits are reasonable that reflects the risk and cost associated with supplying capital to that particular state or line of business.

In addition, the report takes a conservative approach in that it "shows underwriting profit (excluding realized capital gains and losses) and total profit (including realized capital gains and losses) but does not include unrealized capital gains and losses," the report's introduction said.

Insurers also criticize the new format of the report by pointing to the difficulty in determining how to allocate investment income on surplus.

Allocating investment income on surplus by line could conflict with laws in several states like New York, which prohibit cross-state rate subsidies, Ms. Mintel said.

"There is no perfect way" to allocate investment income on surplus, Mr. Klein said. The NAIC took a "middle ground" approach by using a formula that allocates surplus on the basis of the sum of earned premiums, unearned premium reserves, and loss and loss expense reserves.

NICO's Mr. Hunter, an actuary, views that approach as an acceptable compromise.

Insurers also argue that the changes in the NAIC profit report undermine regulators' efforts to enhance the solvency of insurers.

Ms. Mintel alleged the NAIC formula could allocate negative surplus for some lines in some states, which would imply that the insurance industry is weaker than it is.

Mr. Klein disagrees, emphasizing that "complete and accurate measurement of profitability is consistent with strong solvency regulation."

While the NAIC says that the information in the report should not be used for ratemaking, insurers are concerned that the new statistics could be cited to support inappropriate public policy decisions, including demands for rate rollbacks and allegations of excessive profits.

For example, allocation of too much investment income on surplus

to New Jersey would mask the problems caused by state policies that depress profits in that state, Ms. Mintel said. According to the report, insurers produced a profit of 8.1% of earned premiums before reinsurance in New Jersey if investment income on surplus is taken into account, but only 2.4% if it is not.

"It is possible that the report would have some value in analyzing issues" like proposed rollbacks and excessive profits, said David Eley, director of insurance for the Texas State Board of Insurance, noting that he has not yet confronted these issues.

However, insurers point out that state-specific factors must be considered—including catastrophe losses, costs of doing business, claims expenses and actions by insurers to bolster reserves—before the data could be used for these purposes.

In addition to devising a method to report the industry's rate of return on net worth next year, the NAIC next year also will decide whether to continue providing data on insurer results that exclude investment income on surplus.

The NAIC's plan to move quickly with these changes is in sharp contrast to the deliberate pace of the past several years.

Most regulators declined to comment about why it took the NAIC so long to adopt the "total return" concept endorsed six years ago.

Mr. Hunter charged the NAIC did not act sooner because "the insurance industry did not want it."

"The NAIC advisory committee, made up of insurance company representatives or their consultants, has resisted change for years to be able to have reports that make them look like they are losing money when they are not," he said.

The new profit report is due, in part, to "a lot of pressure put on them through Dingell and we are concerned they may be acting too quickly on numerous issues—including this report—because of outside pressure," said the NAI's Mr. Ward, referring to the report by a House subcommittee chaired by Rep. John Dingell, D-Mich., that was highly critical of state regulation (BI, March 5; Feb. 26).

Copies of the NAIC's "Report on Profitability By Line By State, 1989" are available for \$100 by calling the NAIC's Publication Department at 816-374-7259.

Study details P/C profitability

Property/casualty insurers reported profits equal to 4.4% of earned premiums including investment income on surplus but before reinsurance, according to the National Assn. of Insurance Commissioners' "Report on Profitability by Line by State, 1989."

If investment income on surplus is not included, the insurance industry made no profit before reinsurance, the report says.

However, on a net of reinsurance basis, the insurance industry produced profits of 7.2% of earned premiums when investment income on surplus is considered and 2.5% when it is not.

The industry's 4.4% profit—before

reinsurance but including investment income on surplus—was barely half of the 8.5% profit recorded in 1988, and 9.6% in 1987. The industry recorded an 8.0% profit in 1986, up from 3.3% profit in 1985, the beginning of the last hard market.

On a by-line basis, insurers recorded the greatest profit in 1989 on financial guarantee business, in which profits totaled 59.8% of earned premiums before reinsurance but including investment on surplus. Insurers lost 17.6% of earned premium of financial guarantees in 1988.

The least profitable line of coverage in 1989 was homeowners coverage, in which insurers reported a loss of 4% of earned premium, com-

pared with a 9.4% profit the previous year.

Auto insurance profitability hit the skids in 1989, according to the report (see chart). For instance, profits on private passenger liability insurance were cut in half to 0.8% of earned premiums in 1989 from 1.7% in 1988.

Insurers' profits also varied widely by state (see chart). For example, profits including investment income on surplus but before reinsurance totaled 19.4% in Guam, but insurers lost an amount equal to 1,764.4% of earned premium in the U.S. Virgin Islands and 84.1% of earned premium in South Carolina. Both jurisdictions suffered heavy losses from Hurricane Hugo in September 1989.

1989 profitability results

State	Premiums earned (millions of \$)	Profit excluding income on capital and surplus	Total profit as a % of premiums earned
Guam	\$18	16.7	19.4
Alaska	607	11.6	15.0
District of Columbia	751	10.8	14.8
Idaho	635	10.0	13.3
Iowa	2,013	10.5	13.1
Montana	556	8.4	11.9
Minnesota	3,869	6.9	11.6
Michigan	7,994	5.3	11.5
New York	17,142	3.7	10.7
American Samoa	0.6	2.3	10.7
Hawaii	1,061	6.9	10.1
New Hampshire	1,175	5.5	9.9
Virginia	4,545	6.0	9.5
Oregon	2,501	5.0	9.4
Tennessee	3,410	6.2	9.4
Wisconsin	3,632	6.3	9.4
Connecticut	4,428	4.2	9.0
Wyoming	284	6.0	9.0
Illinois	9,901	4.0	8.9
Missouri	3,923	5.4	8.9
Nevada	906	5.7	8.9
Vermont	522	5.3	8.9
Kentucky	2,329	4.0	8.8
Washington	3,161	4.9	8.7
Maryland	4,142	4.7	8.6
Mississippi	1,616	5.2	8.5
California	32,930	3.9	8.1
New Jersey	7,413	2.4	8.1
Kansas	1,805	4.3	7.3
Georgia	5,457	3.0	5.9
South Dakota	487	2.8	5.9
Florida	11,026	1.3	5.7
Colorado	2,671	2.0	5.5
Oklahoma	2,072	2.3	5.5
West Virginia	990	1.8	5.5
Massachusetts	7,024	0.3	5.2
Pennsylvania	11,381	-1.0	5.0
Arizona	2,977	0.8	4.8
Ohio	8,705	1.0	4.5
Rhode Island	1,048	-1.5	4.5
Delaware	706	-1.3	4.0
Arkansas	1,550	0.8	3.4
Alabama	2,739	-0.2	3.1
Indiana	4,695	0.0	2.6
Nebraska	1,183	-1.8	1.2
Utah	859	-3.4	.2
Maine	1,196	-6.7	-1.5
North Dakota	461	-4.4	-1.8
Louisiana	3,155	-11.1	-4.7
North Carolina	4,289	-7.7	-5.1
New Mexico	1,021	-9.4	-5.5
Texas	14,025	-15.3	-11.7
Puerto Rico	568	-79.4	-73.0
South Carolina	2,536	-88.1	-84.1
U.S. Virgin Islands	28	-1802.9	-1,764.4
Countrywide	216,119	0.0	4.4

Source: National Assn. of Insurance Commissioners

A&A-Hall battle

Continued from page 2

become moot if Hall is successful in transferring A&A's suit to the federal court.

Hall last week had the state suit moved to federal court in Omaha.

However, A&A has responded with a motion to return the case to the state court.

U.S. District Court Judge Lyle Strom in Omaha was scheduled to decide last Friday whether the case should be heard in state or federal court, or whether an evidentiary hearing should first be held.

Attorneys for A&A said that if Hall succeeds in keeping the case in federal court, Judge Strom would have to decide whether to consider the testimony that already has been heard in state court or whether to start from scratch.

The Omaha suits are the latest in a series of suits filed by both brokers over Hall's hiring of A&A employees. Since 1988, A&A has brought suit against Hall in five separate cases—two in Colorado courts and one each in Connecticut, Texas and Oklahoma courts.

However, in May, the two brokers reached a confidential settlement in all five of these cases.

Hall states that in addition to settling the suits, the agreement also provided for negotiations of any future disputes between the two brokers. It also provided that if those negotiations are unsuccessful, any resulting litigation would be filed in New York.

Hall has now asked Judge Alfred Arraj of the U.S. District Court in Denver, who approved the settlement, to enjoin A&A from violating the agreement in any state, including Nebraska, said Blair Fensterstock, Hall senior vp and general counsel. A hearing on this motion is scheduled this week.

However, A&A contends that the current dispute does not fall within the parameters of the earlier agreement. It also says that Judge Hamilton, who is hearing the Nebraska state court action, ruled that the agreement is not applicable.

The focus of the latest dispute in state and federal courts is Hall's efforts to become a presence in the Omaha market.

Among other things, Hall's suit accuses A&A of disparaging Hall—which opened its Omaha office in October—to clients, insurers, the press and the public.

Hall states in its suit that before it opened its Omaha office, A&A controlled a dominant share of the Omaha market. In addition, it also had significant shares of the Lincoln, Neb., and nearby Des Moines, Iowa, metropolitan markets, according to court papers.

A&A's presence in these markets along with the Omaha market has given A&A monopoly power in the region, Hall's suit charges. "A&A has acted knowingly and intentionally to threaten competition

Hall's antitrust suit is 'an attempt to take the focus off of Hall's conduct,' says Mr. Schwab.

and to exclude competitors from the relevant geographic market."

Hall's suit also charges that A&A "has filed suit against Hall's employees, seeking to enforce illegal covenants not to compete, concealed the existence of both the settlement agreement and Hall as a competitor, and disparaged Hall to clients, insurance companies, the press and the public in general in an effort to impede the ability of Hall to enter these markets and compete with A&A."

The suit states that among those contacted by A&A were The St. Paul Cos. Inc., Travelers Corp., Hartford Insurance Group, Chubb Corp., Crum & Forster Inc., the Independent Insurance Agents of America and Emerald Coast Cartage, a Hall client.

These companies and groups either refused to comment or could not be reached.

Hall's suit, which charges that A&A has irreparably damaged Hall's reputation, seeks a permanent injunction barring A&A from "any further attempts to monopolize" the market; prohibiting A&A from "interfering with the con-

tractual relationships" between Hall, its underwriters, customers and employees; and prohibiting A&A from making "further false and disparaging statements" about Hall or its employees.

The roughly \$100 million that Hall seeks in compensatory and punitive damages from A&A includes \$75 million in treble damages for A&A's alleged violation of the Sherman Antitrust Act.

"We are not going to allow A&A's predatory conduct to restrict the rights of our clients to have available the quality of service for which Frank B. Hall is known," said Mr. Fensterstock. "We will use all of our resources to enhance competition in Nebraska, throughout the country and throughout the world."

In its brief seeking the return of the case to the state court, A&A charges that Hall waited until the 25th and final witness had taken the stand in the state court proceedings before moving to have the case sent to the federal court "in gross disregard of the state court."

A&A's brief states that during the hearing on A&A's request for a restraining order, evidence "established breaches of contractual, fiduciary and common law duties, wrongful removal and diversion of A&A property and information, private meetings, \$100,000 to \$150,000 signing bonuses, secret flights, destruction of A&A documents and more."

Michael Gallagher, senior attorney with A&A in Owings Mill, Md., said evidence presented at the hearing has established there was contact between Richard Coffey, former managing vp of A&A's Omaha office, and Hall officials beginning in August, though Mr. Coffey did not resign from A&A to join Hall until Oct. 29.

"I believe the antitrust complaint is a defense tactic by the defendants," said Arthur J. Schwab, a partner with law firm Buchanan Ingersoll in Pittsburgh, who also represents A&A. "Hall only filed the antitrust complaint after 11 days of very damaging testimony. It's an attempt to take the focus off of Hall's conduct, which is being revealed at this trial in Nebraska state court," he said.

Update

Risk group targeted by states

TALLAHASSEE, Fla.—Physicians National Risk Retention Group Inc. has agreed to stop writing all new and renewal business in Florida.

The Florida Insurance Department had sought to bar the Louisiana-domiciled risk retention group from the state after finding that it was discounting its loss reserves for medical malpractice business, a practice the Florida department prohibits.

Under a Dec. 7 consent order, Physicians National is free to form a new company to assume its Florida business, provided the new entity complies with Florida law.

Meanwhile, the Louisiana Insurance Department is conducting hearings on a recently completed audit of Physicians National.

Auditors concluded that the risk retention group had a policyholders surplus deficit of about \$7 million as of June 30, 1989, if its loss reserves are calculated on an undiscounted basis, according to Johnny Moore, a partner with the Baton Rouge, La. law firm of Moore & Brown, which represents the Insurance Department.

A key issue in the hearings is whether Physicians National will be allowed to discount its reserves. The insurer claims it was specifically authorized to do so under a July 1987 letter from then-Louisiana Insurance Commissioner Sherman Bernard, Mr. Moore said. The Louisiana department argues that discounting should not be allowed, he said.

The hearings, held last week, are scheduled to resume Jan. 14. Officials of Physicians National could not be reached.

Aon subsidiaries tap Washburn

CHICAGO—Illinois Deputy Gov. John E. Washburn will become a senior vp at several insurance subsidiaries of Aon Corp.

Mr. Washburn, who was Illinois director of insurance from 1983 until he became deputy governor in September 1989, will be a senior vp of four Chicago-based Aon units: Virginia Surety Co. Inc., Dearborn Insurance Co., Globe Life Insurance Co. and Ryan Insurance Group Inc., said Thomas E. Sullivan, chairman and chief executive officer of Virginia Surety.

"We are certainly pleased that he has selected to come work here," he said. Mr. Washburn will start his new duties around Feb. 1.

Mr. Washburn also served as president of the National Assn. of Insurance Commissioners from December 1987 to December 1988.

United Security award disputed

ATLANTA—Attorneys are asking a judge to reconsider a \$1 million jury award to a life insurance intermediary controlled by Atlanta Mayor Maynard Jackson and two associates.

The mayor and two others charged in a suit originally filed in 1986 that three defendants denied their company, United Security Employee Programs, sales commissions on coverage sold to fund the executive retirement plan at Atlanta-based Coca-Cola Co.

A Fulton County Superior Court jury in November ruled the three defendants must pay United Security \$509,000 in commissions on the coverage sold to Coca-Cola and \$502,000 in attorneys' fees.

Defendants in the case are Management Compensation Group/Southeast Inc. and Tax & Corporate Planning Group Inc., both of Atlanta, and Compensation Systems Inc. of Dallas.

The three defendants and United Security formed a partnership in 1984 to seek business from Coca-Cola. However, plaintiffs' attorney Darryl Love of the Atlanta firm Love & Willingham said the defendants failed to tender proper commissions to Mr. Jackson's firm for work done in soliciting the business.

Defense attorney Emmet J. Bondurant of the Atlanta law firm Bondurant, Mixson & Elmore referred to a 1989 decision by the Georgia Court of Appeals in a separate case that ruled Mr. Jackson's firm illegally solicited life insurance business from Coca-Cola.

Mr. Bondurant said motions filed with the court to reconsider the verdict are based in part on the 1989 decision.

N.Y. court OKs AIDS testing

ALBANY, N.Y.—Health insurers may consider the results of AIDS tests when reviewing coverage applications under small group health plans in New York, the state Court of Appeals has ruled.

The state's highest court last week affirmed lower court rulings striking down a New York Insurance Department regulation that would have barred insurers from requiring AIDS testing or from considering the results of such tests in determining applicants' eligibility under small group plans.

Implementation of the 1987 Insurance Department regulation had been stayed while the lawsuit brought by several insurers was decided.

Briefly noted

USX Corp. will pay a record \$3.25 million of fines for 2,153 alleged violations of federal workplace safety regulations at the steel manufacturer's Fairless Hills and Clairton, Pa., plants, under an agreement with the U.S. Labor Department. USX also will correct all alleged violations. . . . The San Francisco Board of Supervisors approved a video display terminal safety law by a 7-4 vote last week (BI, Dec. 17). It now awaits the mayor's signature. . . . Bermuda's chief Supreme Court justice has ordered the liquidation of troubled Focus Insurance Co. Ltd. removed from the control of its shareholder-appointed liquidator and placed under the supervision of court-appointed liquidators (BI, Dec. 3). . . . The Financial Accounting Standards Board has unanimously approved its final rule—FASB 106—detailing how employers must recognize retiree health care liabilities on their financial statements. Employers will have to recognize, starting in 1993, liabilities as they are accrued rather than on a pay-as-you go basis (BI, Dec. 17). . . . Virtually all Corroon & Black Corp. shareholders who asserted share appraisal rights in an effort to block the broker's merger with Willis Faber P.L.C. have now withdrawn their demands, said a Willis Corroon P.L.C. spokesman (BI, Oct. 15). . . . Arkansas Deputy Insurance Commissioner Lee Douglass has been named insurance commissioner, following the resignation of Insurance Commissioner Ron Taylor at Gov. Bill Clinton's request. Mr. Taylor said he was having personal tax problems, said the governor's press secretary.

How the Pinch bought the system

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chimney!
"And now," grinned the Pinch, "they'll get what they deserve!"

While he grabbed estimates of internal reserves. He took these reports and he started to stuff When he heard a small cough, like a grumbled "Haruff!"

A CEO stood there that the Pinch had forgot: Almost Donothing, the worst of the lot. The Pinch had been caught, since Donothing came back

To see if estimated operating returns were on track. He stared at the Pinch and said, "Santa Claus, why?"

"Why are you taking these estimates, why?" But you know, that old Pinch was so smart and so slick,

He thought up a lie, and he thought it up quick. "My dear CEO," the Pinch said, full of grace,

"I'm moving these reports to a much safer place. In wrong hands, these numbers could be a disgrace!" And the Pinch left Donothing with a smile on his face.

He climbed up the chimney, enthralled with this caper.

In the room he left only their desks and some paper. Then he did the same thing at the other skyscrapers, Leaving nothing but desks and some trivial papers!

At a quarter past dawn he packed up his sled While those CEOs snuggled warm in their beds.

Three thousand feet up, the Pinch quickly rose then, Planning to take all those firms and expose them.

"Ho, ho, ho, CEOs," was his mean Pinch-ish sneer. "They're finding out now there is no Christmas cheer!"

"They're just waking up, and surely and slow Their mouths will hang open and each CEO

"Who lives in P/C-ville will then cry, 'Oh, no!' That's a noise," grinned the Pinch, "that I simply must hear!"

Then he shook—what he saw was a shocking surprise. Every CEO below, the tall and the small, Was singing! Without any coverage at all! He hadn't stopped firms from making false claims!

Somehow or other they did just the same! And the Pinch, with his Pinch-feet ice cold in the snow,

Stood puzzling and puzzling: "How could it be so?" "It came without mortgages, or private placements!" "Without options and straddles and commercial paper!"

He puzzled three hours, completely distraught. Then the Pinch realized something he never had sought:

This industry had more resilience than he thought! No matter what papers he stole on the sly, These foolish CEOs believed they'd squeeze by!

In the past, things self-corrected—they had no doubt That this year, once again, things would work out.

And what happened then? Well, the CEOs say, That the Pinch gained 10 tons of hope on that day.

(But we analysts know that this isn't the case. A firm's past standing can't secure its future place. And we've reason to believe that the CEOs agreed There's a book on restructuring they've started to read!)

Still, whatever the reasons—we've tried hard to list 'em—

The Pinch suddenly bought into the system. And the minute he felt a bit less pessimistic He whizzed with his load to the financial district.

And he buried those papers and secured those locks On Almost Donothing's safe deposit box.

We then saw the Pinch come to the company feast And there were tears in his eyes as he served that roast beast.

Myron M. Picoult is senior vp and senior insurance analyst with Oppenheimer & Co. in New York. He is the past president of the Assn. of Insurance & Financial Analysts and a member of the New York Society of Security Analysts.

How the Pinch bought the system

By MYRON M. PICOULT
with JODI PICOULT van LEER

Special to Business Insurance

IN PAST YEARS, in tune with the season, we have conveyed our year-end thoughts on the property/casualty insurance industry through verse. This year, once again, with the help of an elf I sired 24 years ago, the following emerged. This time, we have chosen to parody Dr. Seuss' "How the Grinch Stole Christmas."

There are some subtle signs that managements have become more aware of the magnitude of their problems. However, the ability to quickly reverse a four-year decline in pricing and address various balance sheet strains may be more difficult than industry observers would like to believe. The property/casualty industry in the 1990s will likely be marked by consolidation and some shifting of the hierarchy. In short, the strong will get stronger and the weak will get weaker.

CEOs in P/C-ville found business first-rate. But the Pinch knew the cycle was truly not great. The Pinch hated business! He knew that the firms were skillfully covering a big can of worms. Those chairmen were smiling and saying, "So be it!"

And the Pinch was the one single soul who could see it.

Now, please don't ask why—no one quite knows the reason. That the casualty industry was committing this treason.

Nor why the Pinch, far removed from this sham, was the one to deduce their success was a scam.

It could be his head wasn't screwed on just right. It could be, perhaps, that his shoes were too tight.

But I think that the reason the Pinch came to mope was because he had too small a portion of hope.

But whatever the reason, from his head to his toes, He stared at their 10-Qs, hating CEOs. The Pinch peered from his cave with a sour, Pinchy frown.

At the plush corner offices below in the town. For he knew CEOs were waving magic wands—Writing off recoverables and junky junk bonds.

"And their pricing is lousy!" he wheezed in desperation.

"This broad optimism—it has no foundation!" Then he growled and his Pinchy eyes started to pop:

"I must find a way to make this lying stop!" For right now, he knew, each underwriter and actuary Was smiling and acting so blatantly merry!

"They say they're holding their own! Oh, it's nothing but noise!"

That's the one thing he hated, the NOISE! NOISE! NOISE! NOISE!

Then employees, young and old, would proudly pronounce

The proof of success (so they said). All accounts Of operating earnings CEOs had projected Were better than anyone—even they—had expected!

They would gloat over this at a big Christmas feast

Of Property Pudding and Casualty Roast Beast. And they'd feast! And they'd feast! And they'd FEAST! FEAST! FEAST! FEAST!

Which was something the Pinch couldn't stand in the least!

And then they'd do something he liked least of all:

Every CEO in P/C-ville, the tall and the small, Would stand close together and, singing their praises,

They'd wave their last paychecks and give themselves raises!

They'd sing and they'd sing and they'd SING! SING! SING! SING!

And the more the Pinch thought of this CEO-sing

The more the Pinch thought, "I must stop this whole thing!"

Why, since 1986 I've put up with it, now I must stop this farce right this minute—but how?"

Then he got an idea, an awful idea!

THE PINCH GOT A WONDERFUL, AWFUL IDEA!

"I know just what to do!" The Pinch laughed in his throat.

And he made a quick Santa Claus hat and a coat.

In a get-up like this he could easily crash That wonderful, terrible company bash!

And the Pinch chuckled low: "What a great Pinchy trick!"

"With this coat and this hat, I look just like St. Nick!"

"I'll sneak into their party, and I'll make them learn!"

"I'll steal each false number and inflated return!"

"I'll change misrepresentations into pure fact—"

"Why as Claus I can cause them to clean up their act!"

"All I need is a witness. . ." the Pinch looked around,

But since witnesses are scarce, there was none to be found.

Did that stop the old Pinch? No! The Pinch simply said,

"If I can't find a witness, I'll make one instead."

So he called his dog Max and tucked him away

Under old empty sacks on a ramshackle sleigh. And, for background, he made Max read an old 10-K.

Then the Pinch said "Giddyap!" and the sleigh's speed increased

Toward P/C-ville where CEOs were leaving their feast.

All their windows were dark. Quiet snow filled the air.

All the CEOs were dreaming of price hikes without care.

Then he came to the first skyscraper on the square.

"This is stop No. 1," the old Pinchy Claus hissed,

And he climbed in the board room, empty bags in his fist.

He slid down the chimney—a fit rather tight But if Santa could do it, the Pinch would get it right.

He got stuck only once, for a moment or two, Then he stuck his head out of the fireplace flue

Where their stock certificates all hung in a row.

"These stocks," he grinned, "are the first things to go!"

Then he slithered and slunk in a variety of facets

Around the whole room, stealing studies and assets.

Bond certificates, severity trends, auditors' letters,

Consultants' reports that could have been better,

Risk adjustment premium trends, Cash-flow projections that were dead-ends,

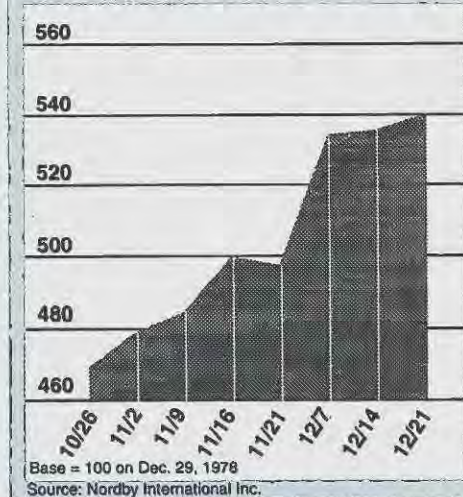
Reinsurance agreements and SEC requests, Papers proving retentions were truly a mess.

He stuffed them in bags. Then the Pinch, very nimbly,

Stuffed all the bags, one by one, up the

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BI Insurance Index



Insurance industry stocks rose last week as the *Business Insurance Index* went up 3.9 points to 540.1 on Dec. 21, from 536.2 on Dec. 14. Advancing issues for the week were led by Belvedere Corp., up 17.7%; United Medical Corp., up 13.8%; and Protective Life Corp., up 10.3%. Declining issues for the week followed AmBase Corp., down 15.3%; Provident Life, down 9.6%; and Washington National, down 7.9%. The most active issue for the week was USF&G Corp., with 6.9 million shares traded. The *BI Index* was up 0.7%; The Standard & Poor's 500 climbed 1.5%; the Dow Jones 30 Industrials were up 1.5%; and the New York Stock Exchange Composite was up 1.2%.

British Issues

Dec. 20 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence
Comm'l Union	480	22.0	28.7	6.0	490—480
Gen'l Accident	496	14.9	33.4	6.7	496—483
Gdn Royal Exch	190	16.6	15.3	8.0	190—186
Royal	402	21.4	34.0	8.5	411—402
Sun Alliance	339	12.2	16.7	4.9	339—325
Brokers					
Bradstock	256	14.5	12.0	4.7	257—255
CE Heath	466	13.6	34.5	7.4	470—464
Hogg Group	164	17.4	9.7	5.9	166—164
Lloyd Thompson	300	20.0	10.0	3.3	306—300
PWS Holdings	90	13.6	3.3	3.7	90—90
Sedgwick Grp	231	17.3	16.0	6.9	234—227
Steel Br'l Jones	266	15.8	14.7	5.5	266—266
Willis Corroon	260	19.3	16.0	6.1	269—255

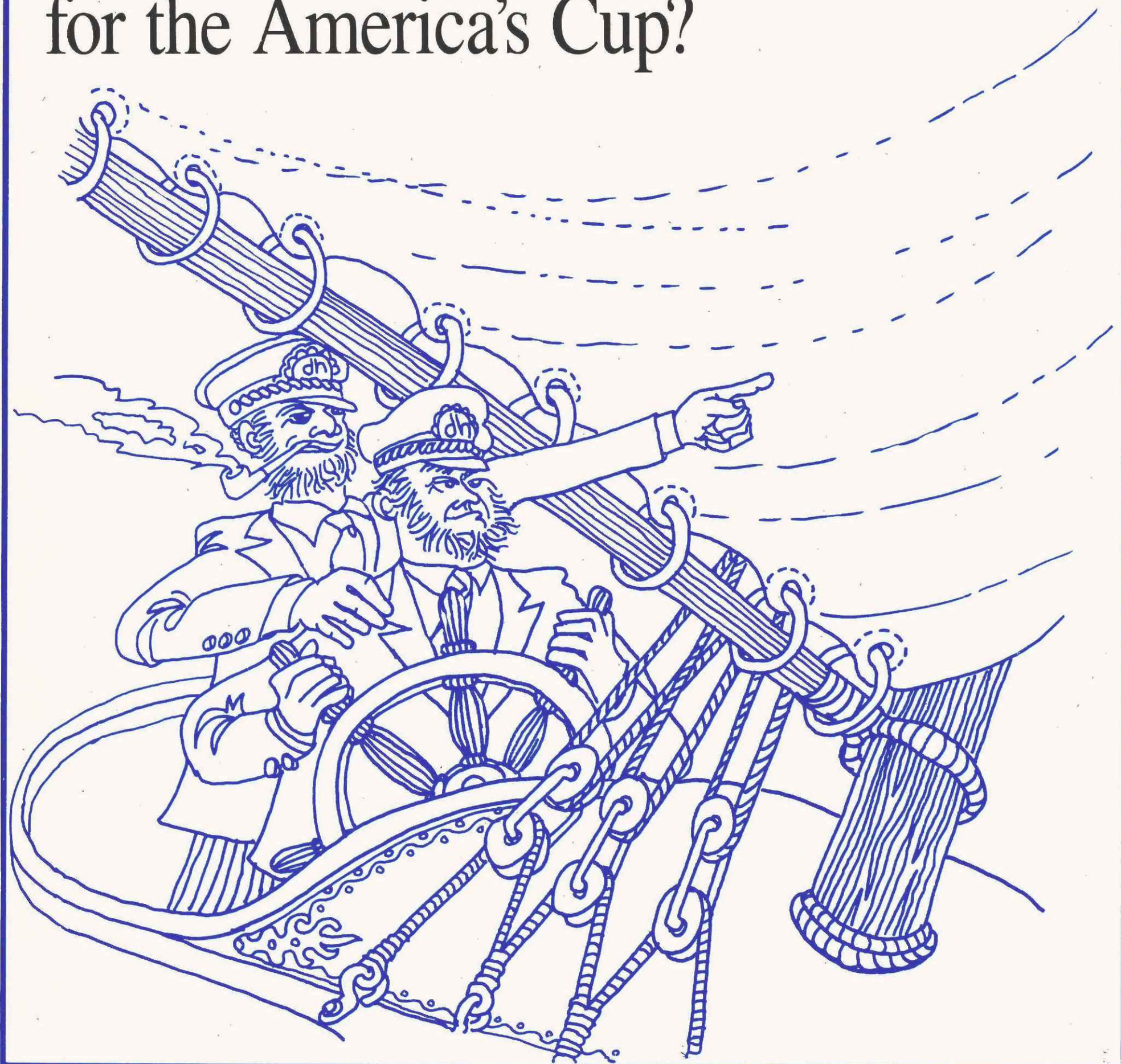
Source: Philip Olsen, Insurance Industry Analyst
London

BI Industry Stock Report

DECEMBER 17, 1990 THROUGH DECEMBER 21, 1990

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