

Business Insurance

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Texas plant explosion could be largest property loss in history

PAMPA, Texas—Property losses from a catastrophic explosion at a Hoechst Celanese Corp. chemical plant in Pampa, Texas, last month could amount to \$350 million, one of the largest single property losses in history, insurance industry sources report.

A large part of the loss will be covered by the giant property insurance pool Hopewell International Insurance Ltd. in Bermuda, of which Celanese' Bermuda-based captive insurer, Elwood In-

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Ferry victims may receive only \$7.5 million

By STACY SHAPIRO and KATHLEEN BARNES

MANILA, Philippines—Liability losses stemming from the sinking of a passenger ferry in the Philippines last week with more than 1,500 aboard—the worst-ever loss of life at sea during peacetime—may total only \$7.5 million, London underwriters predict.

Underwriters are calculating that compensation for the survivors of passengers who died when the ferry Dona Paz and a small tanker collided will amount to only \$5,000 per victim.

Philippine-based Sulpicio Lines, the owner of the ferry, has offered to pay 20,000 Philippine pesos (\$965) per victim, or a total of \$1.45 million.

Underwriters say that the Dona Paz has \$10 million in liability insurance.

The Dona Paz also has 25 million Philippine pesos (\$1.2 million) of hull and equipment insurance. That coverage is reinsured into London through Lloyd's of London broker Willis Faber P.L.C. Reports say the insurance in written in the Philippine market by Prudential Guarantee of Manila.

The death toll from last week's disaster probably will be greater than the 1,503 lives lost when the steamship Titanic sank in the North Atlantic in 1912 after ramming an iceberg, the previous worst peacetime shipping disaster.

The sinking of the Dona Paz is the second serious passenger ferry disaster this year. Some 188 people were killed when the Herald of Free Enterprise sank in Zeebrugge Harbor off Belgium in March (BI, March 16).

The Dona Paz was crowded with travelers bound for Manila from outlying islands for the Christmas holiday when it collided with a smaller tanker, the M.T. Victor, off Marinduque on Dec. 20.

The tanker, owned by Soriano Industrial Co. of the Philippines, was carrying 8,800 barrels of oil and a crew of two.

Reports say both vessels and the water around them were quickly engulfed with flames. Only 27 people are known to have survived, some with critical burns.

Survivors have said the ferry was overcrowded, with as many as four passengers assigned to a single berth. However, a spokesman for Sulpicio denied that the ferry was overcrowded.

Sulpicio manifested 1,493 passengers and 60 crew members on the 2,215-ton ship. However, even a Sulpicio spokesman admitted in the first hours after the tragedy that the ship many have carried more passengers than were listed on the manifest.

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Employers to pay PBGC variable-rate premiums

By JERRY GEISEL

WASHINGTON—Beginning this week, businesses will pay pension termination insurance premiums to the Pension Benefit Guaranty Corp. on the basis of how well their pension plans are funded.

Concluding a drive that began in earnest a year ago, Congress last week enacted and President Reagan signed legislation that creates a new variable-rate premium structure for the PBGC.

The new premium is expected to improve the finances of the PBGC, which has a \$2 billion or \$4 billion deficit, depending on the outcome of its legal battle with LTV Corp. over who is responsible for LTV's massive pension liabilities.

Effective Jan. 1, the annual PBGC premium will range from \$16 to \$50 per defined benefit pension plan participant. Currently, all employers pay an annual PBGC premium of \$8.50 per participant regardless of how well their pension plans are funded.

The legislation also closes many of the loopholes in federal law that have made it relatively easy for some companies to underfund their pension plans and shift their pension liabilities onto the PBGC at little cost.

In addition, starting Jan. 1, 1989, employers will have to fund their pension promises—both past and future—much more quickly. And, companies will find it difficult to dodge making required contributions to their pension plans by obtaining funding waivers from the Internal Revenue Service.

"The pension funding provisions are a clear signal by Congress that pension promises are going to have to be paid. The liabilities cannot be amortized into infinity," said Mark Ugoretz, executive director of the ERISA Industry Committee, a Washington-based benefits lobbying group representing large employers.

"Those who bargain for and make promises will have to be responsible for those promises," he added.

The benefit provisions in the budget reconciliation legislation passed by Congress and signed by President Reagan last week did not include one potentially costly

pension proposal.

A coalition—composed of the administration and members of the congressional tax committees—resisted efforts by some members of the House and Senate labor committees to gut the funding standards and require employers terminating overfunded plans to give a portion of the excess assets to plan participants.

"Some members of Congress thought it was more important to have well-funded pension plans than to give a gift to participants. I applaud those members," said Dick Raskin, a consultant with The Wyatt Co. in New York.

While landmark decisions were being made on pension issues, congressional conferees also were deciding other employee benefit issues, sometimes to the satisfaction of employers, sometimes not.

In the closing days of the session, a congressional conference committee:

- Killed an employer-assailed provision in House-passed budget reconciliation legislation that would have allowed states to establish employer-subsidized health care pools to provide coverage to high-risk uninsured individuals.

Employers criticized the pool provision, which also surfaced and was killed last year, as forcing companies to pay twice for health care benefits: once for their own employees and once for those not covered by group health plans.

- Rejected a provision in the House budget bill that would have crippled flexible benefit plans by placing a \$500 cap on the maximum annual pretax contributions employees could make to the plans (BI, Dec. 21).

- Did not act on legislation to establish new, more reasonable penalties for companies that violate the health care continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (BI, Dec. 14).

These legislative actions mark the end of the first half of the 100th congressional session, a session in which some employee benefit issues that had been stalled for years were decided in a matter of days.

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'The pension funding provisions are a clear signal by Congress that pension promises are going to have to be paid,' says Mark Ugoretz.

The top stories of 1987

A panel of risk managers selected the softening property/casualty insurance market as the top risk management story of 1987 over last year's No. 1 story, state-enacted tort reforms. Meanwhile, benefit managers ranked employer reaction to the harsh COBRA penalties as the year's top employee benefit story, with Sen. Edward Kennedy's bill that would mandate that employers provide health care benefits following close behind. See stories, page 3.

Complete vote tabulations for the year's top stories
Page 3

Employee benefit winners

Employers protest COBRA penalties

Health care benefits mandate proposed

Congress threatens cafeteria plan cap

Group health insurance rates surge

Post-retirement health care costs loom

Risk management winners

Property/casualty market softens

More states enact tort reform measures

Few risks written on claims-made form

Risk retention, purchasing groups grow

OSHA hazard communication standard

Update

Property loss may set record

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insurance Ltd., is a shareholder and member. Hopewell buys reinsurance from more than 250 reinsurers, including Hopewell shareholders, and most major world reinsurers are involved to some extent, said Jack Ryan, president of American Risk Management Inc., a Fort Lee, N.J.-based unit of The Reiss Organization. A Reiss unit in Bermuda, International Risk Management Ltd., manages Hopewell.

The Celanese plant was heavily damaged when a cloud of highly flammable butane gas exploded Nov. 14. Three workers were killed and 37 were injured in the blast and in another smaller explosion.

An investigation into the cause of the accident is continuing, according to a spokesman for Hoechst's Celanese Chemical Co. subsidiary, which operated the plant.

Early estimates of the damage ranged from \$200 million to \$400 million, though a more recent estimate pegged the loss at \$300 million to \$350 million, insurance sources say. These estimates include substantial business interruption losses, the actual extent of which will not be known for several months, sources note.

The plant will be able to resume production of some chemicals by next April, while production facilities for all chemicals will not be restored until the end of 1988, a Celanese spokesman said. All of the rebuilding work should be finished by the end of 1989.

Hopewell will be responsible for a major portion of the Pampa loss, Mr. Ryan confirmed.

Hopewell provides Reiss clients with unlimited property reinsurance coverage under a basic quota-share treaty with 140 participants. It also maintains excess-of-loss reinsurance in three layers between \$25 million and \$100 million per occurrence per cedant and facultative coverage above \$100 million with more than 100 other reinsurers.

Any losses that exceed the excess-of-loss and facultative coverages revert to the basic quota-share treaty participants.

Among the prominent Hopewell reinsurers are Swiss Reinsurance Co., Zurich Insurance Co. and Prudential Reinsurance Co.

Hopewell, organized in 1972, estimated its 1987 premiums at \$100 million.

Elwood, the Celanese captive, is also a member of United Insurance Co., a casualty reinsurance facility for Reiss clients.

Celanese announced earlier this month that it will rebuild the plant, which produced several commodity organic chemicals.

Argonaut terminates sale

LOS ANGELES—Argonaut Insurance Group Inc. and New York-based Gibbons, Green, van Amerongen last week terminated an agreement under which Argonaut would have been acquired in a \$620 million leveraged buy-out.

The agreement was terminated because the Oct. 19 stock market crash triggered financing difficulties, the two firms said.

Under the agreement announced Oct. 4, Gibbons a leveraged buy-out specialist, would have paid \$53 a share for Argonaut in a combination of cash and securities. Payment would have been \$45 in cash per share plus a share of a new preferred stock valued at \$8.

The termination of the agreement was not caused by any change in the insurer's financial condition, according to a joint announcement by the firms. However, because of the stock market crash, Gibbons' expense to finance the transaction would have increased significantly and would have required significant changes in the transaction. The two parties could not agree on new terms.

Argonaut reported net profits of \$41.3 million in the first half of 1987, compared with \$17.1 million for the first half of 1986.

Argonaut has authorized its board of directors to repurchase as many as 2 million of its 11.7 million shares of common stock, a company spokesman said. The stock will be purchased depending on market conditions and other considerations.

Argonaut—once owned by Los Angeles-based conglomerate Tele-dyne Inc.—became independent in October 1986. The property/casualty insurer specializes in workers compensation insurance.

The insurer is not looking for other suitors at this time.

M&M creates new unit

NEW YORK—Marsh & McLennan Cos. Inc. is realigning some of its global insurance brokerage operations by creating a new unit, Marsh & McLennan Worldwide Services Co., that will coordinate the activities of M&M's wholesale brokerage units and its specialized industry groups, including the aviation and aerospace group.

The new unit also will coordinate other M&M support services, such as risk management services, captive management, loss prevention and global insurance marketing. M&M Worldwide Services will not include M&M's reinsurance brokerage, benefits consulting or investment management operations.

Marsh & McLennan Inc. will continue to provide direct insurance brokerage services in North America, while Marsh & McLennan Bowring Ltd. will place direct coverage elsewhere.

John T. Sinnott, executive vp of M&M Inc., will serve as president of M&M Worldwide Services.

Ford seat belt ruled defective

BALTIMORE—A federal court in Baltimore has ordered Ford Motor Co. to pay \$3.3 million to a 13-year-old boy who was severely injured because of defects in the design of rear lap seat belts of a Ford Escort in which he was riding.

James Garrett suffered severe spinal and abdominal injuries in 1985 when the car he was riding in collided with a dump truck. He is now permanently paralyzed from the waist down.

A U.S. District Court jury found Detroit-based Ford liable on Dec. 17 for installing defectively designed lap seat belts and for failing to install rear seat shoulder belts.

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NYIE must be changed to survive: Chairman

By DEBORAH SHALOWITZ

NEW YORK—The New York Insurance Exchange cannot survive unless it is restructured with a "new purpose, new capital and new direction," according to NYIE Chairman David J. Sherwood.

However, recommendations on how the shuttered exchange should be restructured differed among the experts who testified last week before New York Insurance Superintendent James P. Corcoran and two of his deputy superintendents, Martin Minkowitz and Miriam Boggio.

Three of the experts called for a complete restructuring of the exchange, and two proposed encouraging the marketplace to seek capital from non-insurance sources.

The NYIE's decision to stop writing new and renewal business in November was triggered in large part by a deluge of withdrawal petitions from member syndicates, brokers and associate brokers. After the exchange board extended to Nov. 10 the deadline for syndicates to file withdrawal petitions following complaints that a \$25 million drawdown of members' security fund deposits was not announced until two days after the original deadline, 27 of the exchange's 37 solvent syndicates, as well as many broker and associate broker members, had filed to withdraw.

The drawdown was approved after the security fund's directors reviewed an actuarial report that showed six of the NYIE's eight insolvent syndicates may be broke by \$170 million (BI, Nov. 30; Nov. 23; Nov. 16).

Mr. Sherwood, former president of Prudential Insurance Co. of America, said the NYIE board believes that

"a restructured exchange could play a significant role in the market by attracting new capital from sources outside the insurance business."

New York State Sen. John R. Dunne, R-Garden City, agreed, noting that the exchange needs to attract "substantial new capital."

In response to a question, he suggested that perhaps banks should be allowed to invest in syndicates.

"Let's encourage these other financial players to come in and show how good they really are," said Sen. Dunne, chairman of the Senate's task force on the exchange.

Another "indispensable part of any plan either to re-establish the exchange or to achieve an orderly winding down of its affairs is to reduce the expenses related to the building," Mr. Sherwood said.

In an effort to cut expenses, the board is considering a possible sale of the exchange's headquarters building in lower Manhattan, though the board has not decided yet to go ahead with the sale (BI, Dec. 14).

However, the primary responsibility of the exchange now is to "help syndicates fulfill commitments to contract holders as efficiently as possible," Mr. Sherwood said.

Longer-range considerations for the exchange include making sure that it serves "those areas the rest of the insurance business in this country is not serving well, which means reinsurance and difficult-to-place risks," Mr. Sherwood said.

And, the exchange must have "big units of capital" and low overhead costs, he said.

Mr. Sherwood asserted that the exchange should be self-governing, pointing out that Lloyd's of London—

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Minimum benefit proposal advances in Massachusetts

By DONNA DiBLASE

BOSTON—Employers in Massachusetts would be required to provide health insurance for most employees by the year 1992 or be assessed a surcharge on their unemployment insurance premiums under a bill making its way through the state Legislature.

The bill, S.B. 2164, would require employers to provide minimum health care coverage to employees who are heads of households who work at least 30 hours per week after they have worked 90 days, as well as to employees who work at least 20 hours per week after they have worked six months.

Employers also would not be responsible for covering seasonal employees or employees who already have insurance through their spouse's benefit plan.

To encourage small businesses to voluntarily comply before the mandate takes effect April 1, 1992, the bill provides tax incentives. And, to make the mandate more palatable, the bill caps the cost to employers of the state's "free care/bad debt" uncompensated care pool. The pool, funded by an assessment on employers, reimburses the 104 acute care hospitals in Massachusetts for health care delivered to the indigent and uninsured.

To alleviate the problem of an oversupply of hospital beds and to promote health care cost containment, a restructured hospital financing system would distribute state revenues to hospitals based on their patient volume as well as cap overall hospital revenues. This could force the closure of some hospitals with declining patient share that had been propped up by the existing system, observers predict.

In addition, the bill would create a new state agency

to oversee the employer-provided health insurance program, assist small businesses in obtaining health insurance and study health care issues, among other things.

Employee benefit consultants and at least one large employer coalition say that most large employers favor the bill because it would spread responsibility for the uninsured more evenly.

And, they predict that legislation like this will become more common in states, noting that mandated benefits already are a major issue on the federal level.

S.B. 2164 passed the Massachusetts Senate Ways and Means Committee in a special weekend session earlier this month and last Monday passed the full Senate by a vote of 33-4. The House must act on the bill by midnight on Jan. 5.

Employer groups and employee benefit consultants said it is difficult to predict whether the bill will be enacted, given the late date of its arrival in the House and the fact that it is more than 100 pages long. Ways and Means Committee staffers did not return repeated phone calls.

The bill, sponsored by Senate Ways and Means Committee Chairwoman Patricia McGovern, D-Lawrence, was introduced as a compromise to a House initiative sponsored by Gov. Michael Dukakis.

The Dukakis proposal, H.B. 6096, was fiercely opposed by employers, mainly because it sought to force all employers to provide health insurance to all employees, including part-time and seasonal workers. The bill, which died in the House, was almost identical to the federal minimum health care coverage bill proposed by U.S. Sen. Edward Kennedy, D-Mass.

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Inside

✓ This week's editorial offers the *Business Insurance* analysis of what will be "in" and "out" in the coming year among the trendy in risk management, employee benefit management and insurance. **PAGE 8**

✓ Automobile manufacturers are enjoying protection from liability for failure to install air bags in their cars because courts are ignoring both the congressional intent of the National Traffic and Motor Vehicle Safety Act and judicial precedent, according to Richard J. Medalie, with the Washington law firm of Friedman & Medalie, in Perspectives. **PAGE 15**

✓ An agreement reached by ministers from the 12-member European Community will considerably open up the EC non-life insurance market by allowing insurance companies based in one member state to cover large risks located in other member states. **PAGE 21**

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Top employee benefit stories

Story	Number of votes					Total points*
	1st	2nd	3rd	4th	5th	
Employers protest harsh COBRA penalties	16	11	7	4	3	156
Kennedy introduces mandated health benefits bill	14	9	10	7	3	153
Congress threatens benefit cap in cafeteria plans	8	8	5	4	10	105
Group health insurance rates continue to surge	3	5	5	9	10	78
Employers worry about retiree health care costs	4	3	4	2	5	53
Congress considers state health insurance pools	2	3	5	5	2	49
Proposals would expand Medicare benefits	1	1	6	7	1	42
Employers take steps to cope with AIDS epidemic	2	1	4	5	0	36
Administration seeks risk-related PBGC premium	0	4	4	3	2	36
PBGC returns terminated pension plans to LTV	2	2	2	2	4	32

*Five points awarded for first-place votes, four points for second-place votes, etc.

Source: BI survey

COBRA's venom raises ire for second straight year

By JERRY GEISEL

F

or the second year in a row, the problems caused by COBRA's health care continuation rules are employee benefit managers' choice as the top story of the year.

In 1986, benefit managers selected the enactment of the Consolidated Omnibus Budget Reconciliation Act as the most important benefit story of the year by a six-vote margin, with the Tax Reform Reform Act of 1986 close on its heels.

This year, by an even narrower three-vote edge, benefit managers chose COBRA as the top story of 1987, edging out legislation introduced by Sen. Edward Kennedy, D-Mass., to require virtually all employers to offer a minimum group health care benefit plan to employees.

The story selected by benefit managers as the third most significant of the year was the unsuccessful drive in Congress to impose crippling new rules on flexible benefit plans.

The No. 4 story—the surge in health care costs—was also selected as one of the top stories in 1986. Last year, benefit managers chose surging health care costs as the third most significant story of the year.

Rounding out the top five stories of 1987, increased employer concern about post-employment health care costs was selected by benefit managers as the fifth most important story of the year.

Business Insurance polled members of its Employee Benefit Board to determine the top benefit stories of 1987. The benefit managers were asked to rank in order from 1 to 5 the most significant stories of the year.

When the survey was tallied, votes were given weighted values. Each story was given five votes for each first-place vote it received, four points for each second-place vote, three points for each third-place vote, two points for each fourth-place vote and one vote for each fifth-place vote.

Fifty-five members of the Employee Benefit Board responded to the survey. COBRA, the federal law that requires most employers to extend their group health care programs to former employees and employees' widowed, divorced or separated spouses, garnered 156 total points on its way to being selected as the top story of 1987.

Included in COBRA's 156-vote total were 16 first-place votes, 11 second-place votes, seven third-place votes, four fourth-place votes and three fifth-place votes.

It is not surprising that COBRA has been selected as the top story by benefit managers two years in a row.

COBRA, enacted without a single congressional hearing, has forced employers to open up their group health care programs to millions of new participants. The law has been an administrative nightmare as employers have had to extend benefits to participants lacking a direct employment relationship with them.

And the penalty for companies who fail to comply with COBRA is massive and unprecedented: Under Internal Revenue Service rules published this year, a single COBRA violation would cost a company its full tax deduction for health care expenses in a year (see synopsis, page 17).

Legislators this year did make an effort to scale back COBRA's onerous penalties, but those new reduced penalties were stripped—in the closing days of the congressional session—from a budget bill (see story, page 1). As a result, employers will continue to face massive COBRA penalties.

It is those penalties, which apply even if a violation is inadvertent and quickly corrected, that have aroused the anger of benefit managers and led

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Top risk management stories

Story	Number of votes					Total points*
	1st	2nd	3rd	4th	5th	
Property/casualty market begins to soften	23	10	4	2	1	171
More states enact tort reform measures	11	9	5	4	2	116
Few CGL risks written on claims-made form	6	7	7	3	6	91
Risk retention, purchasing groups proliferate	4	9	5	4	3	82
OSHA expands hazard communication standard	5	5	1	4	10	66
Stock market crash hits insurers' surplus	5	0	3	5	7	51
Ruling gives asbestos companies broad coverage	0	5	3	7	5	48
Corporations adopt limits on directors' liability	0	3	7	4	4	48
Superfund cleanup costs ruled 'property damage'	3	0	5	5	3	43
Westinghouse files massive coverage litigation	0	3	8	3	0	42

*Five points awarded for first-place votes, four points for second-place votes, etc.

Source: BI survey

Softening market ranks No. 1 with risk managers

By ALISON KITTRELL

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he most important risk management story of 1987 reflects the old axiom: What goes up must come down.

After several years of spiraling rate hikes, property/casualty insurance prices began to moderate in 1987, with rate decreases reported for property and some casualty risks.

The softening market was the runaway choice of the 59 members of the *Business Insurance* Risk Management Board who responded to *BI*'s annual survey on the most important events of the year. Thirty-nine of the respondents ranked the market change as among the top five stories of the year, and most of those ranked it in the first or second spot.

The risk managers gave the softening market a total of 22 first-place votes, 11 votes as the No. 2 story, four third-place votes, two fourth-place votes and one fifth-place vote.

In compiling the vote totals, *BI* assigns five points for a first-place vote, four points for a second-place vote, three points for a third-place vote, two points for a fourth-place vote and one vote for a fifth-place vote.

Thus, the property/casualty insurance market, which was selected by readers in last year's poll as the No. 2 story of 1986, garnered a total of 171 points.

Three other stories that ranked among the top five stories of 1986 also were among the top five stories in this year's rankings:

- The continuing move by states to enact tort reform legislation, at least partly in response to the liability insurance problems of the mid-1980s, paced second in the 1987 poll.

This story received 11 first-place votes, nine second-place votes, five third-place votes, four fourth-place votes and two fifth-place votes, for a total of 116 points.

Tort reform efforts were ranked by readers last year as the top story of 1986.

- The failure of the comprehensive general liability claims-made policy form to be used on a widescale basis, despite the three-year push by insurers to adopt the form, was ranked as the third most important story of 1987.

The continuing saga of the claims-made form, which ranked as the fourth-place story in last year's poll, received six first-place votes, seven second-place votes, seven third-place votes, three fourth-place votes and six fifth-place votes, for a total of 91 points.

- The formation of risk retention groups and purchasing groups under the Risk Retention Act amendments passed in 1986 grabbed fourth place in this year's poll.

This story received four first-place votes, nine second-place votes, five third-place votes, four fourth-place votes and three fifth-place votes, for a total of 82 points.

The enactment of the Risk Retention Act amendments was the No. 3 story of 1986.

- The federal hazard communication standard, which goes into effect next spring and that requires all employers to inform employees of the potential dangers of any hazardous substance used in the workplace, is the only new story to crack the top five this year, capturing fifth place.

The hazard communication standard received five first-place votes, five second-place votes, one third-place vote, four fourth-place votes and 10 fifth-place votes, for a total of 66 points.

By far, though, the dominant story of 1987 according to the *BI* panel was the softening market. And what made it such an important story, most of the

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The top stories of 1987

Top stories

Continued from previous page

respondents said, was that it was in such welcome contrast to the hard market of the previous 2½ years, when property/casualty coverage was hard to find and even harder to afford (see synopsis, page 9).

"The hard market of 1985-86 created pure havoc throughout the industry, from insured to broker to insurer. This problem was a principal topic of discussion at board rooms around the world and affected both large and small corporations," said Richard E. Caines, director of risk management and insurance for Peter Kiewit Sons' Inc. in Omaha, Neb.

"Insurance costs were totally out of control in 1985 and '86. Also, coverages were restricted and in some cases unavailable. 1987 brought much-needed stability to business managers," said E.L. Bolin, manager of insurance for

Northwest Natural Gas Co. in Portland, Ore.

The softening market made life easier not just for risk managers, but for their corporations as well. The corporate risk manager for a petroleum company with \$1.3 million in annual sales commented, "Insurance costs are so important during these times of marginal operating margins."

However, despite the cheer that lower rates and broadened capacity brought to risk managers in 1987, many of the respondents expressed skepticism about how long the change would last (see story, page 6).

Richard M. Inserra, vp-risk management for Triangle Industries Inc. in New York, said: "The improved capacity and lower prices were both necessary and welcomed. However, the impending return of 'cutthroat competition' so soon after the high industry losses of 1983-85 suggests that the insurance industry's memory gets

shorter as the volatility of the cycles increases. I foresee another hard market in the early 1990s."

Despite the softening market, the movement continued among the states to pass tort reform measures, which began in 1986 in response to the extremely tight market for liability insurance in 1984-86. More than 35 states enacted tort reform measures in 1986, and the trend continued in 1987 (see synopsis, page 10). The risk managers ranked this as the No. 2 story of 1987.

The risk manager for a consumer products company with \$1.1 billion in annual sales explained, "Laws which reduce the liability exposure to more reasonable levels will benefit the consumer and corporations."

Most of the respondents agreed that tort reform will help limit liability exposures and said that, in turn, will help stabilize the insurance marketplace.

Dan Sampson, corporate con-

troller for Kinark Corp. in Tulsa, Okla., said tort reform was the most important story of 1987 because it is the story "most likely to have a positive, long-term effect on settlement of liability litigation. And, that will contribute to a more rational and stable environment for liability coverage."

"This action will help to bring back some predictability to losses," agreed Leonard J. LaCagnin, risk manager for the city of Newport News, Va. "It should help in expanding the insurance market's capacity."

Charles L. Russell, director of insurance for Amerace Corp. in Hackettstown, N.J., said, "Tort reform is vital to limiting the products liability risk to reasonable levels. This is getting at the root causes of the high cost of insurance."

And the corporate claims manager for an agricultural cooperative with \$1.8 billion in annual sales said, "Tort reform is the lar-

gest single issue in the insurance industry and requires public attention because the civil justice system is in dire straits."

The risk managers said the No. 3 story of 1987 was the inability of insurers to push through widespread use of the claims-made commercial general liability policy (see synopsis, page 10).

Despite three years of work by the Insurance Services Office Inc., most comprehensive general liability insurance policies are still being written on the occurrence forms, and the claims-made form primarily is being used only for high-hazard and long-tail risks.

Risk managers say that is good news for them. Russ Harris, director of insurance and claims for Hawaiian Electric Co. Inc. in Honolulu pointed out, "The occurrence form allows the buyer to truly buy insurance and not worry that it may go away at renewal in the event that a change of insurers is made or there is some other event to lose continuity."

The risk managers ranked the formation of risk retention groups and purchasing groups under the last year's amendments to the Risk Retention Act, the fourth-biggest story of 1987. The amendments, which were passed in 1986, allow risk retention groups to write most kinds of liability coverages or purchase these lines of insurance on a group basis (see synopsis, page 11).

Risk managers said this new flexibility gives businesses somewhere to turn for liability insurance other than to the often-prohibitive commercial market.

Robert E. Marginot, chief of risk and insurance for Loudoun County, Va., said, "Risk retention groups have begun to offer an alternative to a commercial market that has become restrictive and/or prohibitively expensive."

Keith Grand, risk manager for the city and county of San Francisco, agreed, but he offered a warning and an observation: "The amended Risk Retention Act provides the authority and impetus for business and government entities to get off the commercial insurance roller coaster in a nationwide way. It also gives them enough rope to hang themselves."

"If acted upon in a big way, the act will significantly change the future of commercial insurance in the United States. It is more proof that insurers are unable to learn and legislators are unable to resist short-term tinkering," Mr. Grand said.

The No. 5 story was the new federal ruling that employers must inform workers of hazardous materials in the workplace (see synopsis, page 11). The rule takes effect in the spring of 1988, and the Occupational Safety and Health Administration estimates that compliance will cost employers \$687.2 million in the first year.

Some of the risk manager respondents support the ruling, despite its price tag. For example, the staff assistant for risk management for a telecommunications firm with \$400 million in annual sales said, "Employees are a company's most important asset, and they have a moral right to have all information regarding potential dangers."

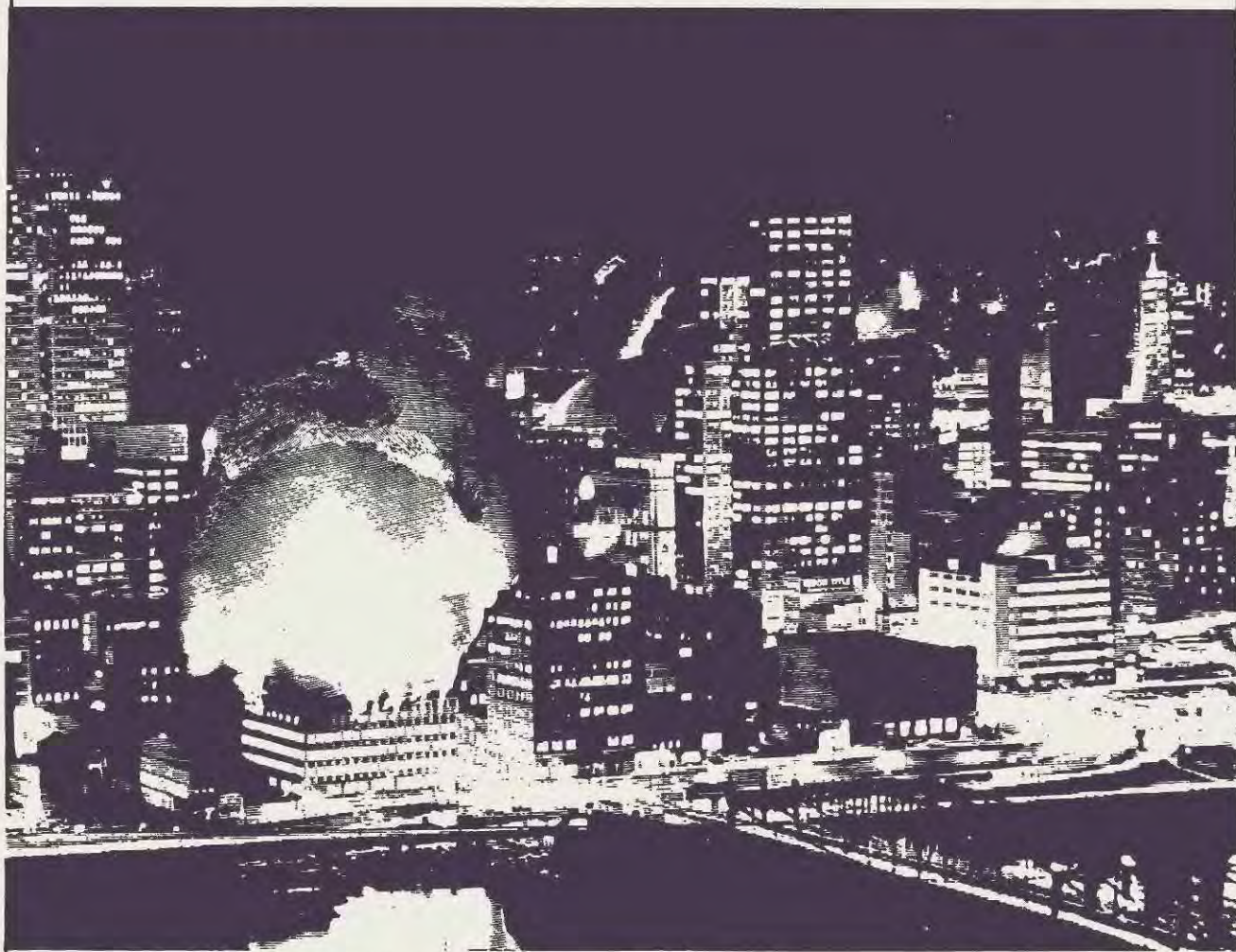
But other respondents noted that the new rule may open a Pandora's box of problems for employers.

William R. Loehr, risk manager for Onondaga County, N.Y., said, "This is a time bomb greater than the asbestos problem. Some studies indicate that at least 50% of all cancer deaths can be related to the workplace."

A related issue, the House passage of the High Risk Occupational Disease Prevention and Notification Act, which would require notification of all current and former employees exposed to hazardous substances to seek medical attention, received 28 total points.

Continued on page 6

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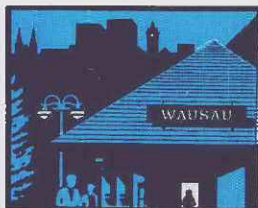
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Top risk management stories

Continued from page 4

In explaining why he chose the consideration of this legislation as the No. 1 story of 1987, Larry R. Sutton, risk manager for Crown American Corp. in Johnstown, Pa., said, "Legislators and lawyers, with well-intentioned or self-serving interests, continue to bludgeon corporate America to an economic death. While on one hand we struggle for solutions to balance our budgets and trade deficits, on the other hand we continue to make it more difficult for our businesses to compete in the world economy. At some point the power brokers must accept a balance between individual rights upon which our Constitution is based and the profit motive upon which our free-enterprise system is based."

The story ranking as the sixth most important of 1987 among the surveyed risk managers was the October stock market collapse.

Although many predict that "Black Monday," which cost the property/casualty industry about \$10 billion in surplus, is not expected to immediately affect rates and coverage availability, some observers fear it will have a psychological effect on insurers, making them restrain competition.

The stock market crash received five first-place votes, three third-place votes, five fourth-place votes and seven fifth-place votes, for a total of 51 points.

Risk managers who chose the stock market collapse as the top story of 1987 said they believe it will have an effect—both actual and psychological—on the insurance market.

John J. Altman, the insurance manager for Centimark Corp. in Bethel Park, Pa., said he is "concerned over the stock market collapse and the ripple effect it may have on all aspects of business, spending, etc., as well as the effects on insurance."

The collapse "reduces capacity, eliminates investment income to some extent from the bottom line. Insurers have a severe distaste for risk-taking," said the director of insurance for a government entity with a \$1 billion annual budget.

The collapse "will stop the 'softening' market, resulting in no reductions in property and casualty premiums and perhaps even some increases in late 1987 and in '88," predicted Orlan N. Jenkins, manager of insurance and claims for Mistletoe Express Service in Oklahoma City.

Two stories tie for seventh place.

The ruling by a California Superior Court judge that insurers that wrote liability coverage for asbestos producers from the time a person was exposed to asbestos through the time a claim was filed or the victim dies are liable for claims, was one of the seventh-place stories. This story received five second-place votes, three third-place votes, seven fourth-place votes and five fifth-place votes, for a total of 48 points.

Also receiving 48 total points was the quick action by corporations, threatened with losing outside directors because

of problems obtaining directors and officers liability insurance, to take advantage of new state laws allowing companies to limit directors' liability. This story received three second-place votes, eight third-place votes, four fourth-place votes and four fifth-place votes.

The ninth-place story was the 8th U.S. Circuit Court of Appeals ruling that cleanup costs paid by defendants in Superfund litigation can be considered "property damage" and are recoverable from insurers under general liability insurance policies. This story received three first-place votes, five third-place votes, five fourth-place votes and three fifth-place votes, for a total of 43 votes.

Explaining his choice, Raymond J. Alletto, risk manager for Nubbell Inc. in Orange, Conn., said, "Environmental impairment is the single greatest issue corporate risk management will face until the turn of the century. Judicial intervention will be necessary to keep insurers in the system."

The 10th-place story was the suit by Westinghouse Electric Corp. against all of its property and liability insurers since 1948 for defense and indemnification of massive hazardous waste and toxic substance claims. The suit, one of the largest insurance coverage suits ever filed, prompted similar actions by other policyholders. This story received three second-place votes, eight third-place votes and three fourth-place votes, for a total of 42 points.

Relieved risk managers recall 'pleasant' 1987

By ALISON KITTRELL

Risk managers are calling 1987 a pretty good year.

But, many of the 59 members of the Business Insurance Risk Management Board who responded to BI's annual year-in-review survey predicted that 1987 was the calm before the storm.

After the extremely tight property/casualty insurance market of the mid-1980s, most risk managers found smoother sailing in the softer market of 1987. In fact, the BI panel chose that softening market as the most important event of the year (see story, page 3).

Many would agree with Jack Walker, manager of taxes and insurance for Curtiss Wright Corp. of Lyndhurst, N.J., who said of 1987, "It came one year too late."

Still, the risk managers were grateful that it came at all. George M. Mills, risk manager for the New Jersey Highway Authority in Woodbridge, N.J., said market

conditions in 1987 were "much more pleasant" than the tight market of 1986.

"The softer market was a relief," agreed Anita Percaccin, risk manager for C.J. Segerstrom & Sons, a real estate developer in Costa Mesa, Calif.

"It was a year of higher visibility and opportunity for risk managers with market changes sufficient to give them control over their programs (and therefore less frustration!)," explained the senior vp for a commercial banking company with \$24 billion in assets.

Ben C. Francis, risk manager for the Santa Clara Valley Water District in San Jose, Calif., said 1987 was "quiet—everyone is waiting for someone to do something."

And, Dennis C. Doherty, risk manager for Hennepin County, Minn., said 1987 was "a period for consolidation and renewal. (There were) few catastrophic events of global risk management concern."

A few risk managers, however,

took a negative view toward 1987. For example, the insurance manager for a state university with a \$300 million annual budget called the year "Lousy! The courts are trying to destroy the industry, Congress has jumped on the bandwagon and senior (insurer) management is once again proving its total inability to learn from experience: 'Cut those rates! Let's get market share!'"

But many more risk managers said the relative calm of 1987 gave them a chance to evaluate their positions and get ready for the next round of changes.

The director of risk management for a chemical manufacturer with \$600 million in annual sales said, "It was the state of a 'period of adjustment' following the turmoil of the hard market and its consequences, e.g., claims-made policy, high premiums, restricted coverage, greater self-assumption of risk, etc. These developments are beginning to formulate the new

risk management and insurance environment."

"1987 is a year that is 'setting the stage' for more significant changes and events in the next few years," agreed Richard M. Inserra, vp-risk management for Triangle Industries Inc. in New York.

And, many of the risk managers are not optimistic about those changes. When asked to predict what will make headlines in 1988, 11 of the risk managers said they expect a new round of insurer rate-cutting, which in turn will spawn another tight market.

The risk manager for an electric utility with \$490 million in annual sales predicted, "By late 1988, the soft market underwriting cycle will return, and by mid-1989, the insurance industry will be shooting itself in the foot once more."

Joe I. Banda, risk manager for the city of McAllen, Texas, said he expects "a return to cutthroat competition. Premiums will remain the same, but coverages will improve."

And Gerald W. Raschke, vp of Associates Corp. of North America in Dallas, took a philosophical view: "I hope the insurance industry has learned a lesson—but I doubt it. They haven't done so in the 40 years I have been in the profession, so I don't expect a change now. We'll probably go back to the old 'rate wars' and a new cycle in 1991. Fortunately, I'll be retired and won't have to worry about it anymore."

Many of the risk managers expect the toll of competition on insurers to continue. Two respondents, for example, predict major insurer insolvencies during 1988.

The corporate claims manager for an agricultural cooperative with \$1.8 billion in annual sales said 1988 will see "insolvency of some large insurers."

And the risk manager for a manufacturer with \$600 million in annual sales predicted the "complete collapse of all U.S. insurance exchanges."

Despite the soft market, risk managers expect the move to non-traditional methods of financing risk to continue: Six of the respondents predicted buyers will continue to look for options beyond the traditional commercial insurance industry.

Keith Grand, risk manager for the city and county of San Francisco, predicted that 1988 will see "insurance buyers finding stable, long-range alternatives to commercial policies."

And Robert E. Marginot, chief of risk and insurance for Loudoun County, Va., expects "a further rush toward non-traditional commercial and risk-treating devices."

But, the risk managers also see potential problems with some of

those alternative funding devices, especially risk retention groups. The move by businesses to form such groups under the amended Risk Retention Act was named as the No. 4 story of the year by the BI panel, although six of the respondents said they expect problems to develop with the new groups.

The risk management coordinator for an oil and gas and investments company with more than \$200 million in annual sales said, "Risk retention groups will face financial instability because of insufficient surplus and inadequate management."

Another area in which the risk managers predict problems is hazardous waste and toxic substances: Seven respondents named that as an area of concern for 1988.

"The courts will continue to rule against insurers on coverage issues relating to hazardous waste and toxic tort exposures," predicted Raymond J. Alletto, risk manager for Hubbell Inc. in Orange, Conn.

Added Don W. LeMond, risk and insurance manager for the state of Missouri, "The whole environmental/toxic tort area will continue to be most important. Government will continue to expand its influence and control over the whole area."

"Hazardous waste and toxic substance claims will increase and product liability damages will increase, while actual property losses will be reduced from previous years," said the fire protection and safety specialist for an air cargo company with \$2 billion in annual sales.

Other areas of concern in 1988 noted by the respondents include:

- Continued efforts on tort reform, cited by three respondents.

- Workers compensation, cited by two respondents.

Edward C. Bickmore Jr., administrator/risk manager for the Central San Joaquin Valley Risk Management Authority, said, "Hopefully, we finally recognize the 'time bomb' in our midst: workers compensation. Maybe our legislatures will act before it's too late."

- Continuing problems with directors and officers liability insurance, cited by three respondents.

Dan Sampson, corporate controller of Kinark Corp. in Tulsa, Okla., said 1988 will bring "increased D&O exposure, especially failed banks and savings and loans, and in connection with shareholder actions on recent public stock offerings."

- Increasing numbers of claims related to acquired immune deficiency syndrome, cited by two respondents.

Continued on page 7

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7th	Net Operating Income	\$ 5,132,000
10th	Net Written Premium to Policyholders' Surplus	1.18
12th	Combined Loss Ratio	93.50%

*(Comparison based on 1986 results)

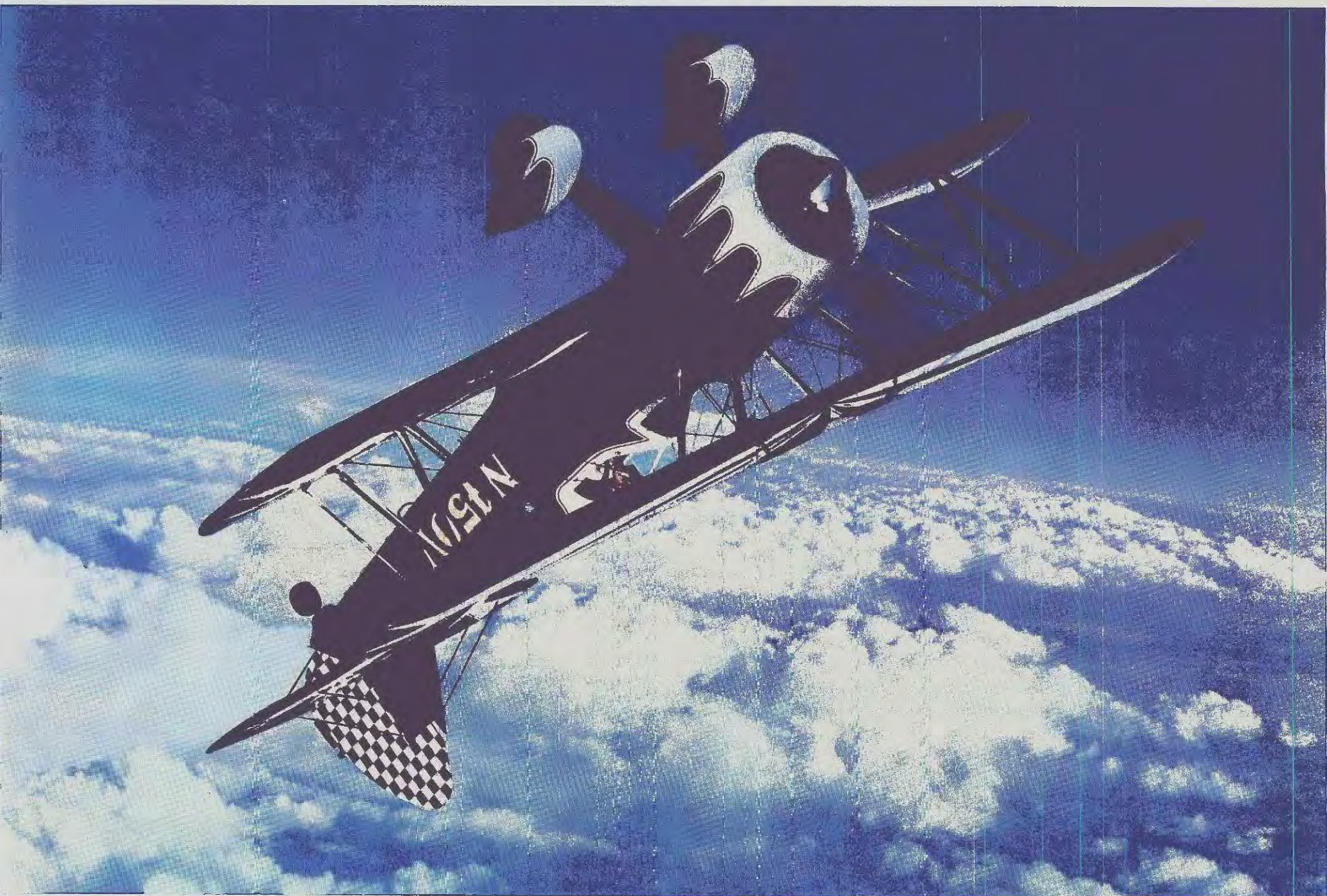


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Opinions

Dust off your hula-hoop

AS WE HEAD into 1988, herewith is the *Business Insurance* analysis of what will be "in" and "out" in the coming year among the trendy in risk management, employee benefit management and insurance.

For good or ill:
 In: Preparing to comply with OSHA's hazard communication standard.
 Out: The High Risk Occupational Disease & Notification Act.
 In: Suing every insurer that ever wrote a policy for companies involved in cleaning up Superfund sites.
 Out: Suing insurers for coverage of asbestos claims.
 In: Shopping the market for competitive quotes for property/casualty insurance.
 Out: Organizing a risk retention group.
 In: Criticizing the property/casualty insurance business for erratic pricing cycles.
 Out: Flex rating.
 In: Self-funding group health plans.
 Out: First-dollar group health coverage.
 In: Group universal life.
 Out: Supplemental term insurance.
 In: Funding for retiree health care costs.
 Out: Onerous penalties for violating COBRA.
 In: Long-term health care insurance.
 Out: Flat-rate PBGC premiums.
 In: Medicare Insured Groups.
 Out: Employer indifference to AIDS.
 In: Managed health care.
 Out: Indemnity health care plans.
 In: Preferred provider organizations.
 Out: Health maintenance organizations.
 In: Celebrating Lloyd's of London's 300th birthday.
 Out: The New York Insurance Exchange and the Insurance Exchange of the Americas.
 In: Buying more reinsurance.

Out: Large retentions by primary property/casualty insurance companies.
 In: Smoking out fraudulent deals masked by the tight market.
 Out: J. Robert Hunter.
 In: Independent and tough-minded state insurance regulators.
 Out: Expensive lunches for risk managers bought by brokers.
 In: Property/casualty insurers paying taxes.
 Out: Tax loss carryforwards.
 In: The new Insurance Services Office's occurrence commercial general liability insurance form.
 Out: The Insurance Services Office's claims-made CGL form.
 In: Insurance company executives arguing against rate-cutting.
 Out: Insurance company executives blaming reinsurers for capacity problems.
 In: Commercial insurers writing high-limit excess liability insurance.
 Out: New excess liability insurance facilities organized by insurance brokers.
 In: Proposals to amend the McCarran-Ferguson Act.
 Out: Legislatures considering tort reforms.
 In: Litigation between reinsurers and ceding companies.
 Out: Gentlemen's agreements.
 In: Underwriting satellite insurance.
 Out: Surplus lines insurance.
 In: Mergers and acquisitions.
 Out: Insurance company and insurance brokerage stocks.
 In: Creative solutions to speeding the liquidation of broke insurance companies.
 Out: Raising capital for new insurance ventures.
 In: Increasing the amount guaranty funds can assess insurers.
 Out: Barbados as a captive domicile.

Letters

Examine aggregates in new CGL form

To the editor: The article by Michael Bradford, "Critics Adapt to Constraints of New ISO Form" (*BI*, Dec. 14), did a good job of highlighting several important aspects of the new CGL form. Some of the discussions about aggregate limits bears further comment.

Whether the aggregates in the '86 form are more or less restrictive than the '73 form depends upon how each form is endorsed. For example, I would rather have the aggregate limits under the 1986 form than the aggregate limits under the 1973 form with the GL 99 16 attached. That endorsement is known as an all lines aggregate and applies to bodily injury and property damage combined for all coverages.

Also, it is important to consider modification of the 1986 aggregate limits by use of one of three endorsements: CG 25 01; CG 25 03; and CG 25 04. The CG 25 01 provides separate sets of aggregate limits for both the products-completed operations aggregate and the general aggregate at a named location or project. The CG 25 03 provides a separate general aggregate limit on a per project basis. The CG 25 04

provides a separate general aggregate limit for all owned or rented locations.

All agents and brokers should be extremely concerned about the plethora of errors and omissions exposures created by the new CGL form. While the aggregate limits and the expanded pollution exclusion are two of the more significant changes, the new definition of "mobile equipment," the lack of automobile contractual liability coverage and the concept of a "first named insured" should not be overlooked.

Dean E. Brooks
 Chairman, Independent Insurance Agents of America Inc.
 Commercial Lines Committee
 Brooks-Lussem Insurance Inc.
 Des Moines, Iowa

Risk group article was not balanced

To the editor: I have been on the lookout for a balanced critique of risk retention group developments during the past year. The article by Charles A. McAlear, "New Risks: Risk Retention Groups May Not Really Be a Panacea" (*BI*, Nov. 30), certainly wasn't it. His hypothetical company, Drunk Drivers Insurance Co., probably exists only in his mind and certainly is not representative of the types of groups that have been formed. And his assertion that all groups are looking for the domicile that will permit the lowest capitalization and premium level is simply without basis.

In short, his article trots out all the same bogeymen that were around before passage of the 1986 amendments.

Having been involved in a number of risk retention group formations—and

having seen a few proposals that we wouldn't dream of submitting to the Vermont Insurance Department—I can assure Mr. McAlear that there is at least one state chartering sound, well-conceived and well-capitalized risk retention groups.

John L. Primmer
 Primmer & Piper
 St. Johnsbury, Vt.

Did we at least spell your name correctly?

To the editor: Regarding the Nov. 23 issue, tough week for the headline proof-reader!

- "Who's Fault Is Increasing Complexity of Benefits?"
 Who is? Who has? Who was?
- "FICA Tax Rate Increases to 7.15% in 1988."
 Sign me up for that rate.

Patricia R. Sweeney
 Benefits/Insurance Coordinator
 Home Petroleum Corp.
 Denver

ICA not in contempt, Florida judge rules

To the editor: This firm represents Insurance Corp. of America. The article "Bel-Aire Settles with Regulator" (*BI*, Dec. 7) states that John Grote has been charged by the Florida Department of Insurance with selling an Insurance Corp. of America policy in violation of a Florida state court injunction prohibiting such sales.

What was not reported in the article
Continued on page 20

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1987 remembered

Continued from page 6

• Aircraft safety and liability problems, cited by two respondents.

Larry R. Sutton, risk manager for Crown American Corp. in Johnstown, Pa., explained, "Aircraft maintenance and safety is unacceptably low."

• Changes in employee benefits plans, including legislation proposed by Sen. Edward M. Kennedy, D-Mass., that would force employers to offer minimum health care benefits to employees.

Sherry Rynders, risk management director for the Collier County Board of Commissioners in Naples, Fla., predicted "new tax laws limiting advantages on benefits (and Sen.) Kennedy's repeated attempts to mandate health care coverages."

• The financial recovery of broker Frank B. Hall & Co. Inc., cited by two respondents.

A few of the respondents said they expect little change in 1988. For example, Ralph Perry, vp of Amfac Inc. in San Francisco, said, "Except for natural events that may cause insurance companies to make major rating/pricing changes, I see very little new activity."

Some respondents said it was too early to make predictions about 1988.

The corporate risk manager of a state university with an annual budget of \$800 million said, "A lot will depend on the economy and the stock market and, as usual, world events. Certainly the presidential election will give some sense of direction or lack of it."

And, Richard H. Vincent, insurance manager for M-I Drilling Fluids Co. in Houston, took a light-hearted—and realistic—approach. Asked what he predicted for 1988, Mr. Vincent replied, "If I knew that, I would go out and get a good job."

Property/casualty rates reverse their course

After two years of major rate increases and severe capacity restrictions, risk managers and brokers renewing commercial property/casualty coverages for January 1987 began to see the market turn.

Capacity began opening up for all but the most difficult property/casualty risks, and many insurers that had withdrawn from specific lines, certain geographic areas or the market as a whole in 1985 and 1986 re-entered the marketplace or expanded their writings in 1987 (BI, Jan. 5).

Unlike the two previous January renewal seasons, when many brokers burned the midnight oil to piece together whatever protection they could find for their clients and still did not complete the renewals until well into January, brokers in January 1987 generally finished their work by Jan. 1.

And, brokers began filling in what was commonly referred to as "Swiss cheese" gaps in commercial excess layers, as excess coverages became more readily available.

Excess limits were not restored to 1983-1984 levels, but buyers generally could purchase more excess coverage following two years of dramatic restrictions.

Although the reinsurance market remained tight, many insurers that viewed their business as more profitable after two years of premium hikes decided to assume higher net retentions and cede less coverage to reinsurers.

And for insurance buyers that needed higher excess limits than they could find in the conventional marketplace, alternative facilities such as A.C.E. Insurance Co. Ltd., X.L. Insurance Co. Ltd. and American Excess Insurance Assn. were available.

Buyers of commercial liability insurance began to see single-digit rather than double-or triple-digit—rate increases, stable rates or, in some cases, slight rate reductions.

Buyers began to see even some competition for their property business, with many getting rate reductions in the 10% to 15% range.

One of the most dramatic signs of market stabilization was that many liability risks were written on an occurrence form, despite the vows made by insurers throughout 1986 that almost all liability risks would be written only on a claims-made basis beginning in 1987.

When those insurers faced the prospect of losing business to other insurers that were willing to write liability risks on an occurrence basis, the claims-made furor quickly died down.

However, claims-made forms continued to be used for long-tail risks, such as product liability and professional liability risks.

Market changes in the commercial property/casualty marketplace continued as the year progressed. Competition intensified for property accounts, and rate reductions spilled over into some liability accounts as well (BI, July 13).

By midyear, many businesses without major long-tail liability exposures were seeing rate reductions in the neighborhood of 5% to 15% and less restrictive coverage terms.

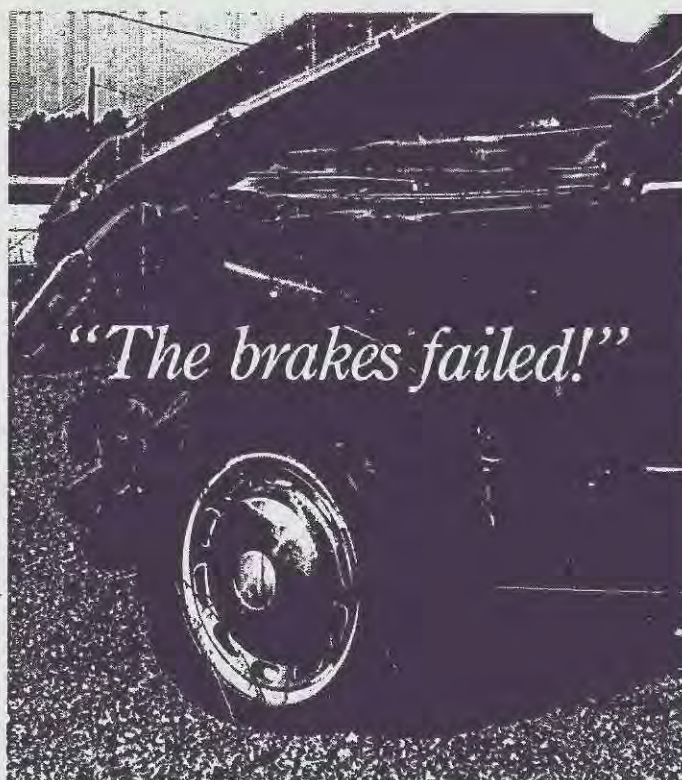
While rate reductions were not generally seen in professional liability and product liability lines, many of these buyers were able to purchase greater amounts of coverage than they could in 1985 and 1986.

And many types of coverage that were available through only the surplus lines market in 1985 and 1986 again resurfaced in the standard insurance marketplace (BI, Aug. 10).

Insurer marketing representatives also began to call on brokers and agents to renew relationships that were strained during the hard market. They asked for larger premium volume commitments from the producers and identified the types and classes of business they were interested in writing.

In fact, the stabilization and subsequent competition in the marketplace developed so quickly in 1987 that insurers, brokers and risk managers began to voice concerns at conventions, seminars and in interviews that too rapid and dramatic a market swing might put the industry in jeopardy.

—By Linda J. Collins



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Tort reform movement advances in '87

Although 1986 is considered as "the year of tort reform," there were continued—and perhaps even greater—changes in the civil justice system in 1987.

"1987 was as much—if not more—of the year of reform" than 1986 was, asserted James Coyne, president of the American Tort Reform Assn., the Washington-based group dedicated to developing and promoting civil justice reform at both the state and federal levels.

Tort reforms enacted last year generally were "more substantive" than those during the previous year, said Mr. Coyne, a former White House official and Pennsylvania Republican congressman who once again is seeking election to Congress.

For example, Wisconsin's 1986 law that capped pain and suffering awards in medical malpractice cases at \$1 million was "like telling a drunk he could only have 20 drinks a day," he said.

However, 1987 reforms—such as the package awaiting the governor's signature in New Jersey that eliminates joint and several liability for public entities, public employees and school athletic conferences and requires that recoveries by plaintiffs from certain collateral sources offset court awards in some personal injury and wrongful death cases (*BI*, Dec. 14)—could have a far-reaching effect, possibly even leading to insurance premium reductions, according to Mr. Coyne.

While "it depends on the level of reform, history would project that rates will come down in anywhere from six to 24 months," he said.

However, there would be a greater impact on the cost and availability of insurance if courts uphold the reforms, he said, noting that insurers are hesitant to move while the reforms are being challenged.

Tort reforms were enacted in 17 states during 1987, compared with 20 in 1986, according to statistics supplied by ATRA.

However, ATRA tallies only those reforms it considers significant. For example, reforms that apply only to medical malpractice cases would not be included in ATRA's total for the year.

But ATRA "believes the few states that have not yet acted will do so in 1988."

In addition, "Many states will be working to improve what they already have," Mr. Coyne predicted. "We have set in place a permanent force that watches and checks the judiciary."

Limits on punitive damages and abolition or modification of joint and several liability were the two most common tort

reforms of the year, ATRA figures show.

Altogether during 1987, 13 states capped the amount of punitive damages that could be awarded in civil suits, and 13 limited the application of joint and several liability.

States that limited punitive damages were: Alabama, California, Georgia, Idaho, Iowa, Kansas, Missouri, New Jersey, North Dakota, Ohio, Oregon, Texas and Virginia.

States that modified the application of joint and several liability were: Arizona, Georgia, Idaho, Louisiana, Missouri, Montana, Nevada, New Mexico, North Dakota, Ohio, Oregon, South Dakota and Texas.

"Joint and several liability's days are numbered across the country," Mr. Coyne predicted.

Mr. Coyne also contends that people are beginning to realize they must take responsibility for their own actions and "can't be rushing off to the courts every time they have an argument."

For example, this attitude is "clearly evident" in Alabama, where one week after the passage of tort reform legislation, the Alabama Development Office advertised nationally in *The Wall Street Journal* that the state was "open for business" (*BI*, Sept. 14).

While significant reforms were passed during 1987 limiting both awards and liability, no state imposed caps on attorneys' contingency fees, unlike 1986, when nine states passed such legislation.

"What we have learned is that the trial lawyers will fight to the death to preserve the contingency fee system," Mr. Coyne said. And, even ATRA is seeking only a sliding scale—not a specific limit—on attorneys' contingency fees.

Also during 1987:

- Three states—Idaho, Kansas and Oregon—limited non-economic damages, such as pain and suffering.

- Six states reduced compensatory awards to plaintiffs by payments received from collateral sources. Those states were: Georgia, Missouri, Montana, North Dakota, Ohio and Oregon.

- Four states either prohibited or limited the accrual of prejudgment interest on future damages. Those states were: Iowa, Louisiana, Rhode Island and Texas.

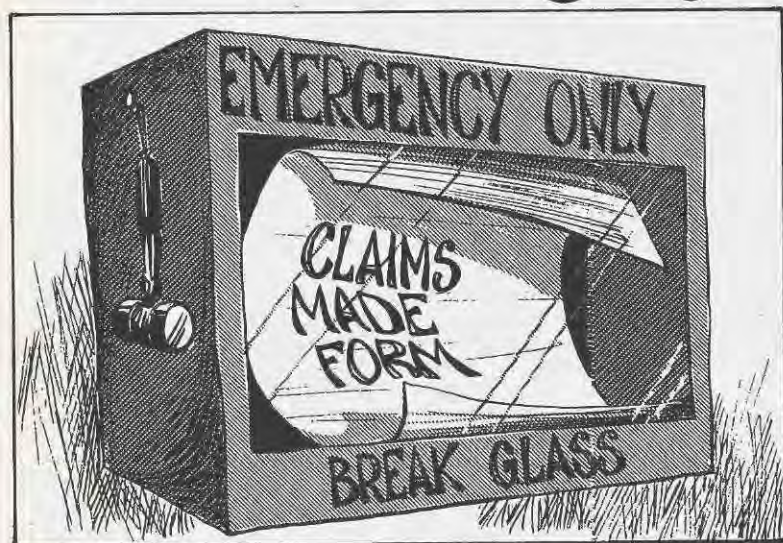
- Six states allowed periodic payments of future damages. Those states were: Alabama, Idaho, Montana, North Dakota, Ohio and Rhode Island.

- Eight states empowered the courts to impose sanctions against frivolous suits. Those states were: Alabama, Idaho, Ohio, Oklahoma, Oregon, Rhode Island, Texas and Virginia.

—By Joanne Wojcik



Insurers largely ignore claims-made form



The Insurance Services Office Inc.'s 1986 claims-made general liability policy was left on the shelf by most insurers this year, but the policy and rate-making organization's new occurrence form saw a growing acceptance among underwriters.

Insurers continued to use the controversial claims-made form for long-tail liability risks during 1987, but buyers of insurance for less hazardous commercial risks generally have been able to purchase coverage on an occurrence policy.

This year has been a quieter one than 1986 with regard to the claims-made policy.

ISO compromises with regulators, brokers and buyers led most to drop their opposition to the policy format by the beginning of this year.

While the claims-made policy was being ignored, ISO's 1986 occurrence form was gaining acceptance during 1987.

The biggest change to ISO's occurrence form was the establishment of an aggregate limit on all losses covered by the policy. The 1973 form that was prevalent until last year did not impose such a limit, except by endorsement.

In addition, the new form does not cover all sudden-and-accidental pollution as did the 1973 version.

Throughout 1987, insurers have routinely switched occurrence coverage to the new form and insurance industry observers predict that the new ISO form will soon become the standard occurrence policy (*BI*, Dec. 14).

Underwriters predicted early in 1987 that the occurrence-based policy would dominate the commercial insurance marketplace, emphasizing that the claims-made form would be used only for long-tail and high-hazard risks because of the opposition that form has faced and the increasing tendency of insurers and reinsurers to write coverage on an occurrence basis (*BI*, Feb. 9).

Some agents and brokers say that any problems created by the new occurrence form can easily be solved, while others complain that the new coverage format creates several headaches.

Some producers have expressed fears that they will be sued for errors and omissions by policyholders who do not understand the 1986 occurrence form.

Agents and brokers note that many policyholders, especially small businesses, do not fully understand all the coverage changes in the new occurrence form even

after those changes are explained to them.

The Risk & Insurance Management Society Inc., one of the most outspoken critics of the revised claims-made form, said that it could "live with the changes in the '86 occurrence form."

All that currently remains of the controversy over the new ISO general liability forms is whether defense costs should be included within policy limits.

In late 1986, the National Assn. of Insurance Commissioners rejected ISO's plan to include those costs within policy limits (*BI*, Dec. 15, 1986). Risk managers continue to contend such a move would limit their coverage while insurers argue that the measure would help them control costs.

Responding to the NAIC's recommendation that ISO develop an "outside" limit on defense costs in certain lines, ISO earlier this year proposed a non-mandatory endorsement to the general liability forms that would cap an insurer's defense costs at an amount equal to the policy's aggregate limit (*BI*, Nov. 23).

That proposal brought criticism from regulators and producers who said the endorsement does not specify to what exposures it would apply.

Regulators and producers say the proposal would mean defense possibly could be disrupted if responsibility were shifted to the policyholder or excess insurer when limits were exhausted.

Although there are concerns with the ISO proposal, some insurance industry experts have predicted that even if the endorsement becomes available soon, it will not be used because of the current softening in the commercial insurance marketplace.

—By Michael Bradford

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Risk retention, purchasing groups proliferate

While businesses, professionals and insurers flock to establish risk retention and purchasing groups under the amended Risk Retention Act, relatively few of them are actually operating.

Since the enactment of the 1986 amendments, more than 100 purchasing groups and about 25 risk retention groups have been formed by a wide range of professionals and organizations—including blood banks, architects and engineers, anesthesiologists and nurses—the U.S. Commerce Department estimates.

Under the amendments to the Risk Retention Act, signed into law Oct. 27, 1986, employers, trade groups and professional organizations with similar risks can band together to form special multiple-owner insurers, known as risk retention groups, to operate nationwide to provide member-owners with all types of commercial liability coverages except workers compensation. And, proponents contend that a risk retention group chartered in one state can operate nationwide without having to obtain prior rate and policy form approval from every state in which it does business, although state regulators disagree.

Proponents say another provision of the new law pre-empts state regulations that make it difficult or impossible for employers to band together to purchase liability insurance on a group basis.

But many of those risk purchasing groups are not yet operating or have not been licensed, the Commerce Department said in its report to Congress on the status of the act (BI, Oct. 5).

This is partly due to competition returning to many segments of the commercial insurance market.

But also hampering the operation of such groups may be some state insurance regulators who are concerned about the solvency of some groups and interpret the amendments as giving them authority to regulate non-resident purchasing groups that sell to policyholders in their states (BI, Aug. 3; June 29).

That interpretation has prompted litigation in Iowa and New York and administrative actions in Missouri (BI, Dec. 14; Dec. 7; Oct. 5).

The Commerce Department says multistate regulation would make group purchase of insurance virtually impossible and has recommended that the act be amended to make it clear that only one state has the authority to impose its insurance laws and requirements on insurers of nationwide risk purchasing groups.

In its report, the Commerce Department suggests that Congress define a purchasing group's location as the place where the group is domiciled or incorporated.

In addition, the department says Congress should make it clear that public entities are exempt from state laws that make it unlawful for them to participate in risk retention or purchasing groups.

Although the Commerce Department report criticizes state regulatory action, it shares regulators' concern that insurance buyers could lose their purchasing clout if insurers—rather than buyers—take the lead in forming purchasing groups (BI, Aug. 24).

State regulators say Congress did not intend that insurers would organize purchasing groups but, rather, that such groups be organized by buyers so they can bargain collectively for liability coverage from an insurer.

Risk Retention Act amendments are viewed differently by other segments of the insurance industry.

While professional reinsurers are not eager to add risk retention groups to their list of clients (BI, Sept. 21), risk retention groups represent a valuable business opportunity for third-party administrators who predict they will be a major contributor to the growth of their claims administration business (BI, Jan. 26).

—By Meg Fletcher



OSHA rule expands hazard notification

Employers' responsibility for notifying workers of the potential dangers of any hazardous substance used in the workplace was significantly expanded under a Labor Department rule published in 1987.

The Occupational Safety and Health Administration's hazard communication standard, which becomes fully effective May 23, 1988, requires employers in all industries to establish a hazard communication program to inform workers of the potential dangers of any hazardous substance used in the workplace (BI, Aug. 24).

Compliance with the standard, which will cover a total of 32 million workers in 3.5 million locations, will cost employers \$687.2 million in the first year, OSHA estimates.

The hazard communication program must include:

- Labeling containers of potentially hazardous materials with appropriate warnings.
- Developing material safety data sheets (MSDS) that detail the substances' properties and the nature of the hazard.
- Making the MSDS available to all employees.
- Developing written and oral training programs for employees on how to deal with potentially hazardous substances.

Manufacturers, importers and distributors of potentially hazardous substances have been required since November 1985 to prepare MSDS to accompany materials they sell to manufacturers.

As of Sept. 24, 1987, these companies had to transmit the MSDS to all "downstream" employers under the first phase of the expanded hazard communication standard.

OSHA issued the expanded hazard communication standard following a May 29 order by the 3rd U.S. Circuit Court of Appeals to do so.

The 3rd Circuit Court directed OSHA to expand the rule two years earlier, but the agency demurred,

claiming it did not have enough information on the feasibility of expanding the rule.

In March 1987, the United Steelworkers union petitioned the 3rd Circuit Court to enforce its July 1985 judgment, which the court did.

While some business groups initially complained that the timetable for implementing the new regulations was too short and that the public was not allowed to participate fully in the rulemaking process, most employers say the rule will help ensure worker safety and health.

Furthermore, the expanded hazard communication standard makes unnecessary a high-risk occupational disease notification bill that already has passed the House and is awaiting action on the Senate floor, according to some business representatives.

That legislation would, among other things, require employers to individually notify current and former workers—going back at least 30 years—who are or have been exposed to hazardous substances in the workplace that they should seek medical testing to determine whether that exposure has or is likely to result in illness or disease (BI, Oct. 19; Aug. 17; April 27).

Employers contend the legislation would cost them billions of dollars by encouraging both workers compensation and tort actions.

Employers maintain that OSHA's expanded hazard communication standard would accomplish the goal that proponents of the high-risk notification legislation seek: making employees aware of any potentially hazardous substances they may encounter on the job.

Employers also say that OSHA's hazard communication rule is a forward-looking, preventive measure, while the high-risk notification legislation concentrates on actions that have happened in the past.

—By Deborah Shalowitz



Ben Pistilli promoted at American Re

Ben Pistilli has been promoted to Vice President, Real Estate and Facilities, in American Re's Administration Division.

Mr. Pistilli will be in charge of real estate leasing, building management, and facilities at the company's proposed new headquarters in Princeton, New Jersey.



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Benefit events

Continued from page 3

them to select COBRA as the most important employee benefit story of the year.

"An administrative oversight in an otherwise efficiently managed program could cost an employer 'big bucks,'" said Jack Hargest, director of personnel benefits at the American Gas Assn. in Arlington, Va.

"In an ever-escalating legislative environment, we are hit with overwhelming penalties on rules which are just about impossible to accurately administer," said J. Kevin Gill, director of compensation and benefits at Spring Industries Inc. in Fort Mill, S.C.

In amassing 153 points, the Kennedy health care legislation—the second most significant story of the year—received 14 first-place votes, nine second-place votes, 10 third-place votes, seven fourth-place votes and three fifth-place votes.

Benefit managers who selected the Kennedy bill as the most important story of the year warned that the measure would lead to big increases in corporate health care costs (see synopsis, page 17).

"If passed, this bill could significantly change the shape of health care plans offered by employers. To comply, plans must be made richer in certain areas and coverage must be offered to a broader base of employees," said the benefits coordinator for a retail drug chain with \$4 billion in sales.

"If the Kennedy bill goes through, there will be a great number of employers going out of business because of the cost to them," predicted Dee Puccini, benefits director at Universal Hotels in Yonkers, N.Y.

"Our company's future rests with the outcome of this proposal," said the personnel manager of a agricultural wholesaler that employs many part-time seasonal employees who would be entitled to group health care coverage under the Kennedy proposal.

Other benefit managers said the Kennedy bill is a step toward socialized medicine.

"Once benefits are mandated at any level... we move toward socialized medicine very quickly, costing everybody, with no (cost) control," said an employee benefits manager at a building materials firm with 15,500 employees.

The third most important story—Congress' drive to impose a \$500 annual limit on the amount of pre-tax salary that employees in flexible benefit plans could contribute toward uncovered benefit expenses—received 105 votes, including eight first-place votes, eight second-place votes, five third-place votes, four fourth-place votes and 10 fifth-place votes.

The threat of restrictions on flexible benefit plans led hundreds of employers to write their senators and representatives in Washington in a successful effort to save the plans (see synopsis, page 18).

One benefit manager who selected the cafeteria plan cap proposal as the most important story of the year warned that enactment of the cap would have meant the end of flexible plans.

"If this legislation is final, it will destroy all flexible benefit programs... it will be a tragedy if (they are) destroyed," said a benefits administrator for a retail food chain with 25,000 employees.

Another benefit manager said he was angry that Congress again has attempted to mandate benefits.

"Benefit managers are again being asked to completely revise their benefit plans that were installed at most companies at great expense," said Dennis Spalding, human resources director at Die-makers Inc. in Monroe City, Mo.

The 78 votes tallied by the fourth-place story—the rise in health care costs—included three

first-place votes, five second-place votes, five third-place votes, nine fourth-place votes and 10 fifth-place votes.

After paying up to 15% premium increases for 1987, some employers may pay premium hikes of up to 40% for their group health insurance plans in 1988 as health care inflation continues (see synopsis, page 19). This renewed surge in health care inflation—after some respite in the mid-1980s—is evidence that companies have yet to tame health care costs.

"Most companies who have introduced health care cost containment have felt that they've 'fixed' the problem. It is apparent that new initiatives are needed to control costs," said Jeanne Kardos, director of employee benefits at Southern New England Telecommunications Inc. in New Haven, Conn.

The fifth most important story—employer concern about the cost and liabilities of post-employment

health care programs received 53 votes: four first-place votes, three second-place votes, four third-place votes, two fourth-place votes and five fifth-place votes.

Benefit managers who selected post-retirement health care as the most important story of the year noted that retiree health costs and liabilities eventually will cause big problems for companies.

"Eventually, it is going to cause the most problems for most companies. It will have a dramatic effect on the financial markets," said the vp of human resources at a communications firm with 12,000 employees.

"With the great unfunded liabilities for retiree benefits, employers have to be given some leeway for change. If not, some mature companies may be forced out of business," said an employee benefits supervisor for a manufacturer with 1,250 employees.

The No. 6 story of the year—legislation to allow states to set up

employer subsidized pools to provide health care coverage for high-risk uninsured individuals—received 49 votes including two first-place votes, three second-place votes, five third-place votes, five fourth-place votes and two fifth-place votes.

Under the plan, strongly opposed by employers, individuals could receive comprehensive health care coverage through state pools (BI, July 20, Aug. 17). However, if premiums paid by participants are insufficient to cover pool costs, as would be almost certain, employers with more than 20 employees would be assessed to make up the difference.

Employers refusing to pay the assessments would be liable for a special excise tax equal to 5% of gross wages.

Employers with health care plans assailed the pool proposal, arguing they would be forced to pay for health care coverage twice: once for their own employees and

once for pool members.

That employer opposition prevailed. The pool proposal, which had become part of a House-approved budget reconciliation bill, was killed this month by a congressional conference committee.

The No. 7 story—legislation to expand the federal Medicare program to give the elderly more protection from catastrophic health care expenses—received 42 votes, including one first-place vote, one second-place vote, six third-place votes, seven fourth-place votes and one fifth-place vote.

At year end, both the House and Senate had passed Medicare expansion legislation. While there are differences in the two measures, they both would limit the maximum annual out-of-pocket expense for a beneficiary for acute care services to less than \$2,000. Currently, beneficiaries could be liable for tens of thousands of dollars in expenses during a year.

Continued on next page



WHEN A REINSURER PLAYS FOLLOW THE LEADER,

Continued from previous page

The Senate measure includes an amendment that would require employers to pass cost savings to retirees when post-employment health care programs are reduced to eliminate benefits that duplicate the expanded Medicare program (BI, Nov. 16).

Two stories tied for the No. 8 spot with 36 votes:

- Employers introducing employee AIDS educational programs to help fight the disease (BI, Sept. 7).

- Legislation proposed by the Reagan administration and approved last week by Congress to establish a variable-rate premium structure for the Pension Benefit Guaranty Corp. (see story, page 1).

The AIDS story received two first-place votes, one second-place vote, four third-place votes, five fourth-place vote and no fifth-place votes.

Employers expanded their use of case management to hold down the cost of treating AIDS patients. And some employers began educational programs about acquired immune deficiency syndrome.

"The AIDS disease is a very frightening and unknown factor in many of our lives but can have serious ramifications to everyone at home and at work," said Linda Wright Manuel, corporate employee benefits director at Kurz-Kasch Inc. in Dayton, Ohio, who selected the AIDS story as the top benefits story.

The PBGC variable-rate premium issue collected four second-place votes, four third-place votes, three

fourth-place votes and two fifth-place votes.

Under the legislation, the annual PBGC premium per plan participant will range from \$16—for employers with fully funded plans—to as much as \$50 for the most poorly funded plans. Currently all employers pay an \$8.50 premium per participant.

The No. 10 story of the year—the PBGC's move to return three massively underfunded pension plans to financially ailing LTV Corp.—received 32 votes, including two votes each for first through fourth places and four fifth-place votes.

The PBGC terminated several LTV plans with more than \$2 billion in unfunded liabilities after LTV said it no longer could afford the plans.

Later LTV, a financially troubled Dallas-based steel and aerospace manufacturer, started a new low-cost pension program to replace some benefits LTV retirees lost when the PBGC took over the plans.

In September, though, the PBGC returned the terminated plans to LTV arguing that the new plans are in effect an illegal continuation of the old plans (BI, Sept. 28).

Pension observers said that if LTV were allowed to proceed, other companies would imitate LTV. Ultimately, such actions could result in the collapse of the PBGC, some said.

At year-end, the controversy was being reviewed by a federal court.

New laws, regulations challenge benefit execs

By JERRY GEISEL

1987 was such an action-filled year for employee benefit managers that many say they struggled just to keep up with all the legislative changes.

"Frightening! So many issues to demand your attention that it is difficult to plan for the future," said a compensation and benefits manager for a general merchandising retailer with sales of \$165 million who responded to a *Business Insurance* Employee Benefit Board survey on the most important benefit events of 1987.

"Hectic! We barely addressed one change when the next came along," said J. Kevin Gill, compensation and benefits director at

Spring Industries Inc. in Fort Mill, S.C.

"No period of calm with new laws and regulations continuously appearing," said the assistant vice chancellor at an educational institution with 4,000 employees.

"The year of legislation and regulation," remarked Hugh E. Becker, director of human resources at Robbins & Myers in Dayton, Ohio.

"Legislation is increasing in the area of welfare plans at an alarming rate," said the benefits manager at a computer systems company with sales of \$500 million.

"Another year of chaos from Congress on the heels of a chaotic 1986, 1985 and 1984," said a manager of pensions and employee benefits for a manufacturer with \$1 billion in sales.

Indeed, things were hopping in Washington.

1987 was the year in which the Internal Revenue Service published rules to aid employers in complying with the health care continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985.

Those rules said that even if the COBRA violation involved just one employee and was quickly corrected, an employer would lose its tax deduction for health care expenses for a full year. In addition, all highly compensated employees of the company would have the cost of their employer-provided health care coverage added to their taxable income.

The COBRA rules triggered a wave of employer complaints, which led Capitol Hill staffers to draft new, less onerous COBRA rules. However, the drive to enact those rules fell short.

In 1987, Senate Labor and Human Resources Committee Chairman Edward Kennedy, D-Mass., proposed legislation to require virtually all employers to offer a group health benefits program to employees.

While Sen. Kennedy said he only wanted employers to offer a "minimum plan," surveys found that virtually all employers would have to overhaul their health care plans if the Kennedy measure were enacted into law.

This also was the year in which Congress attempted to impose crippling new restrictions on flexible benefit plans, a move stopped at the very last moment by a massive employer-led lobbying effort.

And, 1987 was a year in which Congress was on the edge of passing legislation to expand the federal Medicare program to give retirees more protection from catastrophic acute care medical expenses.

At the last moment, legislators killed a proposal to allow states to set up employer-subsidized pools to provide coverage for high-risk uninsured individuals.

But in the last legislative days of the 1987 session of Congress, legislators did approve an entire new set of pension rules, including a new variable-rate pension termination insurance premium structure for the Pension Benefit Guaranty Corp. and new, tougher pension funding rules.

With all this going on in Washington, it is little surprise that benefit managers had difficulty keeping up with this breakneck legislative pace.

But of all the benefit issues swirling in Washington, benefit managers expressed the most concern—at times anger—over the COBRA rules and Sen. Kennedy's mandatory health insurance legislation.

Continued on next page



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Benefit woes

Continued from previous page

"I'm not pleased with the government forcing enforcement burdens onto the employer, such as COBRA," said the personnel manager for an agricultural wholesaler with sales of \$20 million.

The COBRA penalties are "worrisome," said a benefit planning manager at a manufacturing firm with \$9 billion in sales. "Business cannot stand the risk nor avoid it."

"A year in which the feds made great inroads in passing social programs off onto employers. Because of a lack of resistance, we can expect more," warned Eddie James, personnel manager at Red Dot Corp. in Seattle.

"The beginning of a strong government trend toward social health insurance sponsored by employers," commented a supervisor of corporate benefits at a manufacturer with sales of \$128 million.

The "federal government want-

ing to legislate health care changes and wanting private industry to pay," said the administrative manager for a convenience food manufacturer with 460 employees.

Some benefit managers said they were angry at the damage Congress inflicted on benefit plans with the Tax Reform Act of 1986.

"A year in which the Tax Reform Act of 1986 wreaked havoc... especially on 401(k) plans," said the benefits manager of a Houston telecommunications firm.

Among other things, the 1986 tax law, which took effect this year, set new non-discrimination rules for 401(k) plans and lowered the maximum annual salary deferral to \$7,000 per employee from \$30,000.

"Confused. Still trying to catch up with the Tax Reform Act of 1986," said an employee benefits manager for a pharmaceutical manufacturer with 10,000 employees.

With so much going on in Washington, some benefit managers said they were forced to assume new roles.

"Benefit managers now have to be lawyers, financial analysts and politicians all rolled into one," said a benefits administrator for a retail food chain with 25,000 employees.

Beyond Washington, though, many benefit managers expressed concern about a new round of health care inflation.

"Hospital and medical costs escalated at a far greater rate than anticipated... a major concern," said a vp of human resources at an automotive supplier with \$100 million in sales.

"1987 was a trend-setting year, a year of portent. It began the return of high health care cost inflation," said Joseph G. Charles, group director of employee benefits at Ryder Systems Inc. in Miami.

Some said rising health care costs were forcing companies to consider either cutting benefits or pick up more of the costs.

"With the high cost of medical insurance, companies have no choice but to cut some benefits or have to pay for the extras themselves," said Dee Puccini, director of benefits at Universal Hotels in Yonkers, N.Y.

Others said employers were taking more action this year to try to control rising health care costs.

1987 was a year of "intense employer focus on containing the cost of health benefits for both active employees and retirees," remarked the benefits coordinator for a drug chain with \$4 billion in sales.

Some benefit managers described the year as one in which new efforts were made to develop managed health care programs.

"A year of evolution. Major carriers developing their own HMO networks and triple-option programs," said a Pennsylvania benefit consultant.

And, a benefit manager for a manufacturer with 4,000 employees offered a tongue-in-cheek analysis of 1987: "Other than COBRA and the Oct. 19 market dive, not too bad."

Benefit managers also predicted that legislative issues coming out of Washington also are likely to make headlines in the coming year.

For example, 16 benefit managers said the Kennedy health care legislation and the general issue of mandated health care will make headlines in 1988.

In addition, 13 benefit managers predicted that post-employment health care issues will make news next year, while 12 benefit managers said new congressional efforts to limit the attractiveness of flexible benefit plans will make headlines.

Eight benefit managers predicted issues relating to acquired immune deficiency syndrome as among the most important events of 1988, while seven predict that COBRA will continue to be in the news. ■

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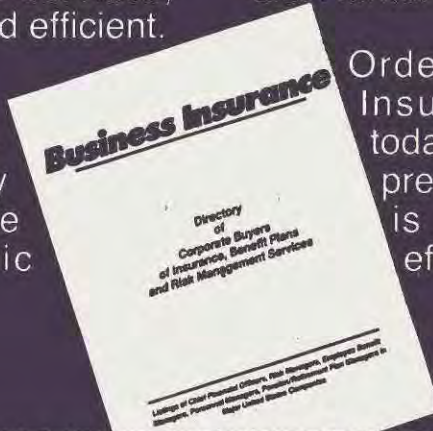
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BID 12/28

SAFETY STANDARDS

Courts help automakers avoid liability for not installing air bags

By Richard J. Medalie

AUTOMOBILE manufacturers are enjoying protection from liability for failure to install air bags because courts are ignoring both the congressional intent of the National Traffic and Motor Vehicle Safety Act and judicial precedent.

Twenty-one years ago, Congress enacted the National Traffic and Motor Vehicle Safety Act. Responding to the "soaring rate of death and debilitation on the nation's highways," Congress declared that the purpose of the act was "to reduce traffic accidents and deaths and injuries to persons resulting from traffic accidents." To this end, Congress required the secretary of transportation to "establish by order appropriate federal motor vehicle safety standards, defined as 'minimum' standards for motor vehicle performance. . . which . . . meet. . . the need for motor vehicle safety."

In passing the law, Congress explicitly addressed what it did and did not intend to pre-empt in two separate provisions: a pre-emption clause in Section 103(d) and a savings clause in Section 108(c).

The Section 103(d) clause stated the pre-emptive effect that Congress had intended the federal motor vehicle safety standards to have on state and local safety standards:

"Whenever a federal motor vehicle safety standard. . . is in effect, no state or political subdivision of a state shall have the authority either to establish or to continue in effect, with respect to any motor vehicle or. . . equipment, any safety standard applicable to the same aspect or performance of such vehicle or. . . equipment which is not identical to the federal standard" (emphasis added).

The Section 108(c) savings clause set forth the non-pre-emptive effect that Congress intended the federal standards to have on common law claims:

"Compliance with any federal motor vehicle safety standard issued under this subchapter does not exempt any person from any liability under common law."

For 20 years following passage of the Safety Act, every appellate court, including eight federal courts of appeal, five state supreme courts and five intermediate appellate courts, that considered the question of pre-emption of common law liability by the Safety Act and the federal motor vehicle safety standards rejected pre-emption out of hand. The first appellate court to confront the issue—the 8th Circuit in *Larsen vs. General Motors Corp.*—emphasized in 1968 that Section 108(c) ". . . expressly

negatives any intention of Congress to acquire jurisdiction in this field and leaves the common law liability intact."

Observing that the Safety Act provided only for "minimum safety standards," the court in *Larsen* concluded that the Safety Act was "intended to be supplementary of and in addition to the common law of negligence and product liability."

The National Highway Transportation Safety Administration—the federal agency presently responsible for administration of the Safety Act—also rejected pre-emption of common law claims, differentiating the Section 103(d) pre-emption clause from the Section 108(c) savings clause: "Section 103(d) is limited to the effect of federal standards on state regulations covering the same aspects of performance. Section 108(c) of the act governs the effect of federal standards on product liability suits," the then-chief counsel of the NHTSA wrote in 1981.

Last year, the pre-emption issue began to be raised in the context of common law claims against automobile manufacturers for defective occupant restraint systems lacking air bags or other adequate occupant restraints. Three federal and four state trial courts, following the precedent set in *Larsen* and its progeny, have ruled against pre-emption and have denied summary judgment for the automobile manufacturers. Eight federal and four state trial courts, however, have ignored the 21 years of judicial precedent and have actually granted judgment on the pleadings or summary judgment on the ground that the common law air bag

or occupant restraint claims were expressly and/or impliedly pre-empted by the Safety Act and federal motor vehicle safety standards. In so holding, these courts have paid scant attention to the prior case law, have dealt cursorily with the express language of the Safety Act's savings and pre-emption clauses and have all but ignored the Safety Act's legislative history. More important, these courts have failed to recognize the basic presumption against pre-emption, which may only be rebutted by a clear and manifest intent of Congress—especially if common law claims are involved.

Despite the plain words of Section 108(c), these courts have maintained that the savings clause only preserves common law claims when the plaintiff alleges either that a design defect is not specifically addressed by a federal motor vehicle safety standard or that the manufacturer has failed to comply or has violated a federal safety

standard. Indeed, the courts insisted that "the clear meaning of the (savings) clause is that compliance with the federal standards does not protect an automobile manufacturer from liability. . . in connection with matters not covered by the federal standards" (emphasis added).

But if there is no federal standard covering a particular matter, how can there be compliance with a

standard? If there is no such standard, how can it have been "issued?" If non-exemption from common law liability only occurs in the absence of an applicable standard, why does the savings clause speak in terms of non-exemption from common law liability in the context of "compliance" with a relevant, issued federal motor vehicle safety standard?

With respect to the pre-emption clause, the recent decisions have asserted that "there is nothing in the language of the Safety Act. . . to suggest that the term 'safety standard' (as used in Section 103(d)) is intended to

encompass only standards adopted by a regulatory body." The presumption against pre-emption of common law tort claims, however, clearly suggests the opposite conclusion. Such pre-emption cannot be inferred from the lack of language, especially when a savings clause preserves all common law liability.

In refusing to abide by the basic principles of pre-emption and statutory construction, these courts have also either failed to discuss the legislative history at all, or, although invoking the talisman of congressional intent and purpose, have failed to analyze that history. At most, they have relied on selective quotation and have drawn unwarranted conclusions. The original version of the Senate bill, S. 3005, contained a provision similar to what ultimately became the Section 103(d) pre-emption clause. It made clear that a state safety standard was considered as being established by a "law, regulation or ordinance," and not by court judgment or jury verdict.

In contrast, the Senate bill contained no savings clause or any other provision relating to the effect of federal safety standards on common law claims. Nevertheless, the Senate in its report confirmed that "the federal minimum safety standards need not be interpreted as restricting state common law standards of care. Compliance with such standards would thus not necessarily shield any person from product liability at common law."

Following passage of the Senate bill, the House version of the bill, H.R. 13228, was amended to contain the precise language of the savings clause now contained in Section 108(c). In

commenting upon the effect of the provision, Rep. John D. Dingell, D-Mich., stated that the House had "preserved every single common-law remedy that exists against a manufacturer for the benefit of a motor vehicle purchaser. This means that all of the warranties and all of the other devices of common law that are afforded to the purchaser, remain in the buyer, and they can be exercised against the manufacturer."

Because the House bill contained an express savings clause with respect to common law liability, the tentative quality of the Senate report gave way to the unequivocal statement of congressional intention in the House report: "It is intended, and this subsection specifically establishes, that compliance with safety standards is not to be a defense or otherwise to affect the rights of parties under common law, particularly those

relating to warranty, contract, and tort liability." The same House report made clear that the proposed Section 103(d) pre-emption clause was intended to apply to state safety standards.

The House-Senate conference reported that "the House version contains a provision that specifically provides that compliance with federal motor vehicle safety standards does not exempt any person from any liability under common law. The Senate version had no comparable version." The Senate managers specifically accepted the House amendment that added the savings clause. Sen. Warren Magnuson, D-Wash., explained to the Senate that the "provision makes explicit, in the bill, a principle developed in the Senate report." The House and Senate managers also agreed on the "safety standard" language in the pre-emption clause. The pre-emption and savings clauses were thereafter enacted into law as Sections 103(d) and 108(c) of the Safety Act.

Thus, the legislative history of the Safety Act confirms that Congress intended by the savings clause to preserve common law liability in the courts even if an injury arose out of conduct encompassed by the federal safety standards. In contrast, Congress intended by the pre-emption clause to prohibit states from passing legislation or promulgating regulations purporting to establish safety standards not identical to, but

Continued on next page

Speaking out

Congress intended by the savings clause of the Safety Act to preserve common law liability in the courts.

Courts have paid scant attention to the prior case law and have ignored the act's legislative history.

Richard J. Medalie is a partner with the Washington, D.C., law firm of Friedman & Medalie P.C., specializing in corporate and commercial litigation and arbitration.



8-year-old covered by work comp

The Supreme Court of North Carolina ruled that an 8-year-old son of a store's cashier, who performed odd jobs at the direction of the store manager and was paid a dollar by the manager, was an employee of the store for workers compensation purposes, even if his employment as a minor was illegal.

In December 1982, Shane Tucker slipped on a sidewalk of Williams Oil Co. and fell, cutting his hand. Prior to the incident, Shane was hired by Williams' store manager to perform duties at the service station's convenience store where his mother was a cashier. He stocked cigarettes, bottles in the cooler, picked up trash and did other odd jobs from time to time, usually receiving a dollar for his services. Shane and his mother filed a personal injury suit against Williams. The lower courts dismissed the suit concluding that Shane had to pursue his claim through workers compensation.

The appellate court believed the evidence supported the lower court's findings that the manager had hired Shane to do odd jobs, as needed. The court said that at the time of the accident, Shane was engaged in doing those tasks. Thus, the court said that Shane was Williams' employee at the time of the accident and had to pursue his claim through workers compensation law. *Lemmerman vs. A.T. Williams Oil Co.*, Supreme Court of North Carolina, Nov. 18, 1986 (BI/05/Sept.—\$10).

Heart failure compensable

Congestive heart failure was a compensable injury where a pre-existing pathology was coupled with unusual and extraordinary conditions of employment, a South Carolina appellate court ruled.

James R. Cline worked as a food service manager for a restaurant that was open only during the tourist season. However, his was a full-time year-round position. He managed the day-time operations, supervised the cooks, ordered, inspected and inventoried food and shopped for food and utensils. In April 1982 he also became manager of a new restaurant opened by his company with an entirely different menu. Mr. Cline had to work with 10 new food suppliers. Each restaurant had separate inventory, facilities, personnel and books. The two restaurants

Legal briefs

were 150 feet apart, requiring Mr. Cline to continuously go back and forth.

Mr. Cline had a pre-existing condition of congestive heart failure for which he took medication. His employer was aware of this condition. In August 1982 he became ill at work and was admitted to the hospital where he was diagnosed as having suffered a heart attack. Mr. Cline claimed workers compensation based on his heart attack. The commissioner awarded benefits, which was upheld by the trial court.

On appeal, the employer claimed that no accidental injury was proven since there was a lack of evidence of a sudden unusual exertion or strain related to Mr. Cline's employment. However, the court said that where heart problems have resulted from extraordinary duties and an increase in hours worked over a period of time, a heart injury is compensable. The court was satisfied that Mr. Cline had demonstrated sufficient evidence of unusual and extraordinary work conditions to sustain an award of compensation. *Cline vs. Nosredna Corp. Inc.*, Court of Appeals of South Carolina, Oct. 15, 1986 (BI/01/Sept.—\$10).

Chemical dependency

A Louisiana appellate court concluded that chemical dependency suffered by a policyholder was a "sickness" and not a "mental illness" covered under a group health insurance policy.

Donald Hayden and his dependents were covered under a group health insurance policy issued by The Guardian Life Insurance Co. of America. In 1982, Mr. Hayden's daughter underwent treatment for what was diagnosed as alcohol and drug abuse. The policy covered "sickness or injury," defined as "a sickness or disease" suffered by a covered person. Coverage for mental and emotional illness was significantly limited.

Mr. Hayden submitted claims for treatment totaling nearly \$10,000. Guardian Life tendered a check for about \$880 for a portion of the charges under the "mental or emotional illness" clause but denied further

payment. Mr. Hayden sued Guardian Life and won in trial court.

The appellate court affirmed, concluding that chemical dependence, such as suffered by Mr. Hayden's daughter, was a "sickness." *Hayden vs. Guardian Life Insurance Co. of America*, Court of Appeals of Louisiana, Dec. 23, 1986 (BI/04/Sept.—\$10).

Settlement by insurer

At issue in a case of first impression in Illinois was whether an insurer has a duty to consider the interests of its policyholder when settling a claim that fell fully within the deductible portion of a policy. An Illinois appellate court ruled that the insurer had no duty to consider the policyholder's interests where the insurer had a right under the policy to settle a claim within the policy limits without the policyholder's consent.

Casualty Insurance Co. issued to Town & Country Pre-School Nursery Inc. a liability insurance policy with a \$2,000 deductible per claim. Michael West, a minor, sustained an injury upon the premises. A claim was filed on his behalf. After an investigation, Casualty settled the claim for \$1,800. It then requested reimbursement from T&C for the full amount. T&C refused. Casualty sued and was awarded a summary judgment by the trial court.

On appeal, T&C argued that a settlement fully within the deductible portion fell outside the policy limits. However, the court rejected this contention as without merit. The court noted that under the terms of the policy, which it declared was clear and enforceable, Casualty had the right to settle the case within the policy limits and its duty of good faith, therefore, was not a material factual issue.

Casualty Insurance Co. vs. Town & Country Pre-School Nursery Inc., Appellate Court of Illinois, Aug. 27, 1986 (BI/04/June—\$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.

Automobile safety

Continued from previous page
nevertheless applicable to the same aspect of performance as the federal safety standards. The congressional intention was to rely solely on federal expertise to set safety standards, and to rely on the state courts and juries to remedy whatever injury took place pursuant to common law tort liability. To be sure, implicit in the scheme was a tension between the conclusion that safety regulation was to be the exclusive concern of federal law and the conclusion that a state could nevertheless permit the award of damages based on its own common law liability.

This was not the first time that Congress established this dual federal-state system and had accepted the tension it created. Congress had previously established a comparable dual system under the Atomic Energy Act. Congress was willing to live with the tension under that act because, as the Supreme Court noted in *Silkwood vs. Kerr-McGee Corp.* in 1984, Congress did not believe that it was inconsistent to vest the Nuclear Regulatory Commission with "exclusive regulatory authority over the safety aspects of nuclear development, while at the same time allowing plaintiffs like *Silkwood* to recover for injuries caused by nuclear hazards."

Similarly, in the Safety Act,

Congress did not believe it was inconsistent to vest NHSTA with exclusive regulatory authority over the safety aspects of motor vehicle performance while at the same time allowing automobile accident victims to recover for injuries caused by defective motor vehicle design. Thus, the legislative history of the savings and pre-emption clauses confirms their clear language that Congress never intended to pre-empt common law liability by the passage of the Safety Act.

Although several of the courts that have granted summary judgment have agreed that the Safety Act expressly precludes federal pre-emption of common law liability, they have nevertheless interpreted the statute as impliedly pre-empting state common law product liability claims. In so holding, these courts have completely misconceived of their function in resolving pre-emption issues.

The appropriate method of pre-emption analysis was recently provided by the Supreme Court in *California Federal Savings & Loan Assn. vs. Guerra*—the pregnancy leave case. In *Guerra*, the court examined what Justice Antonin Scalia termed the "anti-pre-emption provisions" of a federal enactment. The court held that, in these provisions, "Congress has explicitly disclaimed any interest categorically to pre-empt state law or

'occupy the field.' " Because the statutory provisions were a "reliable indicium of congressional intent with respect to state (regulatory) authority," the court found "no need to infer congressional intent to pre-empt state laws from the substantive provisions" of the federal act. Justice Scalia observed that, once the court determines that a specific statutory provision precludes pre-emption, that should be the end of the analysis; no further inquiry is needed, nor indeed permitted.

The import of *Guerra* is clear. It is one thing for the courts to try to divine congressional intent as to implied pre-emption from the overall operation of a statute and its legislative history when Congress has been silent. It is quite another thing to do so, when Congress has included express anti-pre-emption provisions in the statute. Since the issue of pre-emption is always one of congressional intent, there can be no better reliable indication of what Congress wanted to pre-empt or not to pre-empt on a given subject than what it expressly did pre-empt or did not pre-empt in the specific language of the statute.

When Congress directly expresses its anti-pre-emption intention in the specific language of a statute, the courts may not go beyond that language to search for a different

pre-emption balance. Thus, once an explicit pre-emption clause does not include state common law claims within its scope, or once an explicit savings clause expressly preserves state common law claims, there can be no basis for courts to look for implied pre-emption in other parts of the act. Since Sections 103(d) and 108(c) of the Safety Act deal expressly with pre-emption—or, more appropriately, with non-pre-emption of common law liability—the pre-emption analysis should begin and end with those provisions.

For over 20 years, the federal and state appellate courts have implicitly followed the *Guerra* mode of analysis in their rejection of federal pre-emption of state common law under the Safety Act. Unfortunately, recent federal and state trial court decisions upholding federal pre-emption of air bag and other occupant restraints product liability claims have ignored this long line of precedent. When the pre-emption issue finally comes before the appellate courts again, one can only hope that these courts recognize, as the Supreme Court in *Guerra* stated, that their "sole task is to ascertain the intent of Congress," as well as to follow the judicial precedent that they originally established in rejecting federal pre-emption of common law liability under the Safety Act.

Drive to limit COBRA's bite falls short

It came down to the wire, but an employer-led drive to convince Congress to overhaul COBRA's onerous penalties fell just short of success, a victim of the politics of deficit-reduction legislation.

That drive began in June when the Internal Revenue Service published regulations to aid employers in complying with the health care continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (BI, June 22).

Those rules said that even if the COBRA violation involved just one employee and was quickly corrected, an employer would lose its tax deduction for health care expenses for a full year.

In addition, all highly compensated employees of the company would have the cost of their employer-provided health care coverage added to their taxable income if the company was found to have violated COBRA.

And, in the case of collectively

bargained multiemployer welfare plans, the rules said that if just one plan member, or the plan administrator, did not comply with COBRA, all the employers contributing to the plan would lose their tax deductions for health care expenses.

Those regulations to implement COBRA, the federal law that requires most employers to extend their group health care programs to former employees and employees' widowed, divorced or separated spouses and dependents, ignited an unprecedented storm of employer protest.

Employers said it was outrageous to impose such massive penalties for a violation that may have lasted just one day and involved just one employee.

And, companies were incensed that a tax deduction for health care expenses—which could amount to tens of millions of dollars for a large employer—would be taken away for a single inadvertent COBRA violation.

tent COBRA violation.

More than 1,000 employers wrote to the IRS, demanding new penalties that would be tied more closely to the length and severity of the violation (BI, Aug. 24).

Those COBRA letters got the attention and eventually the support of Reagan administration officials.

In October, administration officials began to send signals to Congress that the penalties were out of line, but that only Congress had the power to enact a legislative remedy (BI, Oct. 12).

Legislators read those signals. House Ways and Means Committee staffers drafted new, far less painful COBRA penalties (BI, Nov. 2).

Under those proposed penalties, an employer generally would pay an excise tax of \$100 for each day it failed to extend coverage to a COBRA beneficiary.

And, if the violation were inadvertent and corrected within 30 days, there generally would be no penalty at all.



In some situations, though, such as the IRS uncovering an uncorrected COBRA violation during a plan audit, the employer could be slapped with an excise tax of at least \$18,000 for each person to whom the employer failed to extend coverage.

While some thought the Ways and Means Committee penalties still were a bit stiff, they were welcomed as a vast improvement over the IRS penalty for one COBRA violation.

Eventually, the Ways and Means Committee's proposed COBRA penalties were passed by the full House as part of a budget reconciliation bill's technical corrections section.

Since no congressional opposition to the new penalties had emerged, employers had expected the penalties to be accepted as part of a uniform reconciliation bill hammered out by a conference committee.

However, those hopes were dashed when congressional leaders

and administration officials, as part of a so-called summit pact to reduce the federal deficit, agreed that most of the technical correction provisions should be stripped from the budget bill (BI, Dec. 14).

Some of those technical provisions would have cost the government revenue and, thus, increase the federal deficit.

Legislators and staff said virtually the entire technical corrections section had to be dropped because there was not enough time to separate the revenue-neutral provisions—like the COBRA penalties—from the revenue-losing provisions.

While that decision killed any chance that new, reduced COBRA penalties could be enacted this year, business lobbyists are optimistic that a new effort will be made in 1988 to enact COBRA changes, either as part of a technical corrections bill or another piece of legislation.

—By Jerry Geisel

Kennedy fails to rally support for group health plan mandate

At year-end, Senate Labor and Human Resources Committee Chairman Edward M. Kennedy was looking for new ways to drum up more congressional and business support for his legislation to require employers to offer group health care coverage.

At first, everything seemed to be going Sen. Kennedy's way when in May he introduced his proposal, S. 1265, mandating that virtually every employer provide a health care plan with at least prescribed minimum benefits to employees and their dependents (BI, May 25).

Business groups praised Sen. Kennedy and his staff for consulting with them in drawing up the legislation, which was in sharp contrast to the traditional go-it-alone Kennedy approach to legislation.

And, business groups noted that the minimum plan advocated by Sen. Kennedy was a far cry from the "womb to tomb" coverage the Massachusetts Democrat had once backed.

For example, under the measure, annual health care deductibles for health care services could not exceed \$250 per person or \$500 for family coverage—limits higher than those found in many employer plans.

The proposal also set a \$3,000 annual out-of-pocket employee expense limit, which most plans would be able to meet.

In June, at the first hearing on the bill, Sen. Kennedy won support from such major employers as Chrysler Corp. and American Airlines Inc. They argued that their health care costs are inflated because hospitals are shifting the costs of the uninsured to them in the form of higher charges to insured patients (BI, June 29).

If all employers were required to offer a health care plan to employees, as Sen. Kennedy wants, the problem of cost-shifting would ease, proponents of the Kennedy measure said.

But support for the Kennedy bill soon began to erode.

While Sen. Kennedy said he was not proposing a "Cadillac" plan, researchers found that enactment of the bill would force virtually every employer to overhaul its plan.

For example, New York-based TPF&C, the benefit consulting division of Towers, Perrin, Forster & Crosby Inc., found that not one



of the health plans offered by 74 employers it surveyed provided all the benefits mandated by the Kennedy bill (BI, Aug. 31).

For example, close to three-fourths of the employers surveyed by TPF&C failed to offer health care coverage—as would be required under the bill—to part-time employees working as few as 17.5 hours a week.

In addition, some two-thirds of surveyed employers did not pay the entire health insurance premium for workers earning less than 125% of the federal minimum wage, as the bill requires.

And, a majority of surveyed employers required employees to pay more than 20% of the premium for family coverage. The Kennedy bill limits employee contributions for family coverage to 20% of the premium.

A later survey by William M. Mercer-Meidinger-Hansen Inc. in New York found that Sen. Kennedy had made few inroads in capturing business support.

The Mercer survey of more than 5,000 employers found that more than 80% were opposed to the legislation (BI, Dec. 7).

Employers told Mercer that enactment of the bill would lead to higher costs. Companies also said they didn't want the federal government to mandate the shape of their benefit programs.

On two occasions, Sen. Kennedy canceled Labor and Human Resources Committee votes on the bill, a sign that he had not lined up sufficient political support.

Business lobbyists said committee Democrats, who were supposed

to be a bedrock of support for the bill, were concerned about the cost of the legislation. By some estimates, the Kennedy measure could increase businesses' annual health care costs by \$100 billion; Sen. Kennedy offered a much lower estimate of \$12.5 billion.

While the bill is stalled, new efforts are expected to revive it next year. Indeed, at a time when at least 35 million Americans lack health insurance, Congress will continue to explore ways to reduce the number of uninsureds.

—By Jerry Geisel

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Employers repel attack on flexible benefits

Employers, at the 11th hour, were able to stave off a congressional assault on flexible benefit plans, but few doubt that the battle is over.

After a furious employer-led lobbying campaign, congressional conferees agreed this month to kill a provision in a House-passed budget bill that many said would have crippled flexible benefit plans (BI, Dec. 21).

The battle began in October when the House Ways and Means Committee passed budget reconciliation legislation with a provision that would have placed a \$500 annual cap on the amount of pretax salary that employees in flexible benefit plans could contribute toward uncovered benefit expenses.

In addition, employees covered by flexible benefit plans that offer a choice between non-taxable benefits and cash would have been taxed on the amount of cash they could have possibly received from the plan over a \$500 threshold, even if they rejected the cash and selected additional tax-free benefits (BI, Nov. 9; Oct. 19).

After the full House in late October passed the budget bill—with the \$500 flex cap—employers by the hundreds wrote to their congressmen urging defeat of the cap.

Employers, in their letters, warned the proposal's Jan. 1 effective date would create administrative nightmares. They explained that companies with flexible benefit plans would have had less than two months to inform their employees of the changes and to allow employees to reconsider their benefit choices for 1988.

Employers and others warned that the \$500 cap on pretax salary contributions to flex plans would kill tax-effective employee funding for expensive dependent care costs, such as day-care center tuition, that an employer could not afford to fund on its own.

And, employers said, the \$500 cap on pretax salary contributions to flexible spending accounts would be too little to allow employees to pay the higher health insurance premiums and unreimbursed health care costs that have been shifted to them under cost containment programs.

With such a limitation on tax-effective funding of benefit costs, it would become much more difficult for employers to convince employees to pick up a greater share of health care costs through higher deductibles and coinsurance charges,

many said.

At the same time, the provision would have had a dramatic effect on plans that give employees a choice of either non-taxable benefits or cash.

Typically, employees in such plans are given "flex dollars" or "flex credits" to buy different benefit options, which are assigned a monetary value. The balance of flex dollars not used for benefits may be collected in cash.

By placing a \$500 cap on "cashable" benefit credits, the ability of flexible benefit plans to provide a wide assortment of benefits to a diverse workforce would have been blunted, many said.

For example, employees who used all their flex dollars to pay for needed benefits, would, in effect, have been taxed on a portion of their employee benefits.

And, if employers had limited available cash to \$500 so that employees would not be liable for additional taxes, employees no longer would have such a powerful financial incentive—the ability to get a lot of cash—for selecting low-cost benefit options.

These and other arguments were contained in the hundreds of letters that employers fired off to Capitol Hill.

The fate of the \$500 cap on flexible benefit plans was decided during the week of Dec. 13 when members of a congressional conference committee met to iron out differences between the House and Senate-approved budget bills. The Senate measure did not contain any comparable restrictions on flexible benefit plans.

At first, the House conferees insisted on the \$500 cap. Senate members refused to accept it. The House came back with a counteroffer: a \$5,000 cap for dependent care expenses and a separate \$750 for all other benefit expenses.

Senate conferees rejected the House's revised offer. With the Senate conferees refusing to budge, the House conferees, led by Ways and Means Committee Chairman Daniel Rostenkowski, D-Ill., at last agreed to strip the flexible benefit provision from the budget bill.

While employers were ecstatic over their victory, their joy was tempered by the sober recognition that in an era of huge federal budget deficits, new attacks on flexible benefit plans to gain revenue are a virtual certainty.

—By Jerry Geisel



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Commercial Consumers
Administrative:
CEO's Presidents and Owners 2,570
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Financial:
Chief Financial Officers and Vice-presidents of Finance 2,787
Secretaries, Treasurers, controllers and other Financial Personnel 5,600
Risk/Employee Benefits:
Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations 9,701
Sub-total 23,868
Associations 500
Government, Unions and Educational Institutions 914
Commercial Consumers
Sub-total 25,282
Insurance Agents and Brokers 10,858
Insurance Companies 7,140
Financial Institutions 989
Actuaries, Attorneys, Adjusters, Appraisers and Consultants 4,617
Others Allied to the Field 1,792
TOTAL 49,689
* Source: Business/Occupational breakdown of qualified circulation, May 25, 1987 issue, as submitted to BPA for June 1987 BPA Publisher's Statement.

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Group health care costs continue climb

Unabated increases in group health insurance costs continued to sting employers throughout 1987.

Despite cost containment and managed care efforts, rates for traditional indemnity plans jumped an average of between 15% and 20% in 1987. Rates for health maintenance organizations increased between 2% and 7% (BI, Dec. 21).

And, insurers and HMOs predict even higher increases in 1988. Indemnity premiums will jump as much as 40%, while HMO premiums will increase as much as 15%.

Health care inflation, as well as an increase in the overall inflation rate, are primarily to blame, say insurers and HMOs.

In addition, underpriced health insurance and increased utilization of health care services have contributed to high premium increases.

Benefits experts warn employers to step up their cost-containment efforts and to more directly involve employees in the purchase and payment of health care.

Some insurers admit that the steep premium increases charged in 1987 and planned for 1988 could be partly attributable to underpriced health insurance over the last few years. They say that, in some cases, premium increases in recent years have not kept pace with the rate of health care inflation and

may have even masked inflation.

Consequently, employers may have felt they really had control of health care costs and therefore may have become lax in their cost-containment efforts.

In the past few years, the increase in the overall inflation rate has been considerably lower than the increase in the medical care inflation rate. For example, the overall Consumer Price Index increased at an annual rate of 3.6% in 1985 and 1.4% in 1986, compared with the 6.2% increase in the CPI's medical care component in 1985 and the 7.7% increase in medical care inflation in 1986.

And, while the CPI rose at an annual rate of 2.1% for the first six months of 1987, the medical care component rose at an annual rate of 6.3% (BI, Aug. 17).

But, the gap between the rate of increase in the overall CPI and the medical care component is closing: The CPI rose at a rate of 4.8% for the first 10 months of the year, while medical care prices increased at a rate of 6.1% for the same period.

Benefits experts also attribute rate increases to an increase in the utilization of health care services, particularly outpatient services.

Despite the emphasis on moving the delivery of some services to a more cost-efficient

outpatient setting from a hospital setting, the overall cost of care may have increased. This has occurred because while the individual cost of a service may be lower in an outpatient center, the actual number of units of service delivered may have increased as providers attempt to regain lost profits, the experts explain.

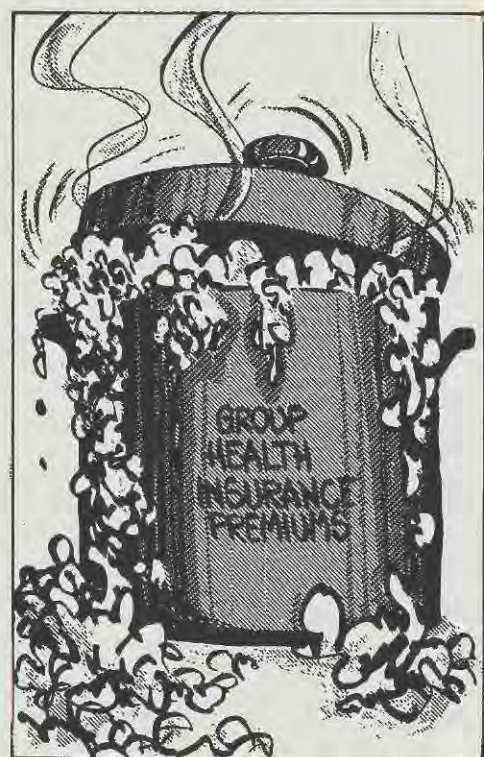
Employee benefit consultants and insurers advise employers to continue using many of the same cost-containment techniques—such as utilization review and managed care plans—but they also urge employers to become more aggressive and involved in their employees' health care.

For example, employers must keep employees informed of the increasing cost of health care and require some cost-sharing by employees. Employees then will be more likely to shop for the most cost-efficient health care, benefits experts say.

In addition, employers must keep track of their own health care plan data so they can determine exactly what cost-containment programs they need to best manage costs.

This data also will help employers identify the most efficient, highest quality providers in their region and to then negotiate preferred provider agreements with those physicians or hospitals, benefits experts say.

—By Donna DiBlase



Firms fret about retiree health care liabilities

The cost and liabilities of employer-provided retiree health care plans became an increased concern during 1987 to employers, the Reagan administration and Congress.

Only a few years ago, retiree health care plans were a largely forgotten, low-cost benefit. Many companies had little idea of the plans' liabilities and not much attention went into plan design.

There was little reason for employers to be much concerned about the plans. Often, the number of retirees was small—relative to a company's active workforce—and the cost of the plans was low.

But, several events have increased the visibility of and problems associated with retiree health care plans.

As the workforce has aged, the number of retirees has shot up, sharply increasing the cost of post-employment health care programs.

And, several federal court decisions in the last few years have increased uncertainty about the ability of employers to unilaterally cut health care benefits promised to their retirees.

While retiree health care plans may once have aroused little corporate concern, clearly that is no longer the case.

For example, 47% of employee benefit managers surveyed earlier this year by Equicor predicted that their companies' retiree health care costs will become a major problem within the next 10 years (BI, Feb. 2).

However, few benefit managers reported that their companies prefunded retiree health care benefits—and for a good reason. In 1984, Congress took away any employer tax incentives to prefund retiree health care benefits.



But this year, legislators and the administration took several steps—so far unsuccessful—to increase funding of retiree health care benefits.

For example, in February, the Reagan administration asked Congress to allow employers to transfer excess assets from their overfunded defined benefit pension plans on a tax-free basis to finance health benefits for current retirees (BI, Feb. 23).

Under the proposal, pension assets exceeding 125% of plan liabilities transferred to a special Voluntary Employee Beneficiary Assn. formed to fund current retirees' health care

benefits would be exempt from federal excise or income taxes. In addition, assets in the VEBA would earn tax-free interest.

While this proposal, which the administration wanted included as part of a pension funding bill, was defeated in the House Ways and Means Committee, observers regard the asset transfer proposal as a first step toward increasing congressional interest in funding of retiree health care. And some congressmen came up with their own proposals to give employers new tax incentives to fund the growing mountain of retiree health care plan liabilities.

For example, Rep. Rod Chandler, R-Wash., in June introduced legislation, H.R. 2860, to allow employers to make tax-deductible annual contributions of between \$1,500 and \$2,250 per employee to fund retiree health plan accounts. Funds in the accounts would accumulate tax-free interest until withdrawn to pay for health care expenses when an employee retires (BI, July 6).

While Congress had not acted on the Chandler proposal by year-end, experts say new efforts will be made next year to drum up congressional support.

And, the Employee Benefit Research Institute, a Washington-based benefits think tank, provided yet another reminder of the magnitude of post-retirement health care liabilities.

A study conducted for EBRI by Milliman & Robertson Inc. found that if employers had to recognize retiree health care expenses on corporate balance sheets, as they currently do pension expenses, some companies' reported net incomes could decline 30% to 60% (BI, Nov. 23).

—By Jerry Geisel

New York Insurance Exchange

Continued from page 2

"the world model"—is self-governing, and the idea of self-regulation in reinsurance and surplus lines remains valid.

"The fact that this attempt at an exchange has not worked as well as we had hoped does not mean that the idea should be abandoned," Mr. Sherwood concluded.

Two experts addressed some of the same issues contained in a report released in November that was prepared by New York-based Stewart Economics Inc. (BI, Nov. 23).

Among the the report's recommendations were that:

- The exchange go forward with fewer, more highly capitalized syndicates.
- The security fund be eliminated.
- That exchange back-office services be cut back.

Walter Groden, president of David C. White Agency Inc., a charter broker member of the NYIE, also said that syndicates should be more highly capitalized. But he called for the dissolution of the current exchange and the creation of a totally new insurance exchange.

"I do not believe that the New

York Insurance Exchange Inc. should ever reopen," he declared. "It should be operated economically until all liabilities are disposed of."

A new insurance exchange should be formed that would write direct and reinsurance risks without a guaranty or insolvency fund, he said.

Minimum capitalization requirements in the new exchange should be \$25 million for a reinsurance syndicate and \$10 million or more for a direct syndicate, according to Mr. Groden.

Furthermore, underwriting members of the new exchange should be required to obtain state licenses, Mr. Groden said.

In addition, a lead/follow system, like that used by Lloyd's underwriters, should be compulsory at the new exchange, he continued. This will serve to promote "a true sense of caring what the other guy is doing," he said.

A central processing facility should handle administrative and claims processing functions, he said.

Mr. Groden also proposed that the new New York insurance exchange be permitted to write direct risks in the state "free of rate and

form" in the same manner that Free Trade Zone-licensed insurers are able to operate. The Free Trade Zone, an alternative to the surplus lines insurance market in New York, was created in 1978 to permit specially licensed insurers to write business without rate or form approval.

Peter Bickford, an attorney with Calinoff & Katz who has represented many NYIE participants, disagreed with many of the Stewart report's recommendations. Mr. Bickford, who served for five years as the first general counsel of the NYIE, objected to the report's recommendation that syndicates must have a minimum capitalization of \$25 million.

This recommendation "constitutes nothing more than a pooling of companies," Mr. Bickford claimed. "At \$25 million minimum capital, these entities are large enough to become licensed insurers with a minimum of hassle—even in New York—and gain significant market recognition without an exchange."

The security fund should not be eliminated, Mr. Bickford added.

A security or guaranty fund that provides participants in the market with a stake in the conduct of

all other participants "is an essential element of an insurance exchange," Mr. Bickford said. "If you delete the fund, you do not have an insurance exchange."

Addressing the administrative operations of the exchange, Mr. Bickford said the NYIE management has two conflicting roles: that of regulator and that of promoter of the facility.

He suggested that an autonomous audit function be created that would report directly to the NYIE's audit committee. "This would effectively free the exchange management to concentrate on managing the facility for the writing of business," he maintained.

Mr. Bickford, in response to a question from Mr. Corcoran, said that private non-insurance companies, along with smaller, foreign and captive insurance companies, probably would be interested in the formation of a new insurance exchange if it were operated differently.

Later in an interview, Mr. Bickford called for more involvement by the members of the exchange in its operation. He suggested "letting the brokers and underwriters dictate how the exchange is going to

grow and develop."

Sen. Dunne called on New York Gov. Mario Cuomo to immediately appoint an independent commission to re-examine the concept of the insurance exchange and evaluate its chances for long-term survival.

The commission should be headed by Economic Development Commissioner Vincent Tese and composed of representatives of brokers, reinsurance intermediaries, underwriters and risk managers, Sen. Dunne suggested.

The commission also could include an actuary, an insurance company executive, an investment broker, an economist and a former insurance regulator, the senator said.

Sen. Dunne stated that an independent commission is needed to study the viability of the NYIE because "many of the fundamental issues facing the exchange at this crossroad involve the interrelationship between" the Insurance Department and the exchange.

He suggested that it might be difficult for both Insurance Department and exchange officials to be objective in "identifying the breakdowns" that "led to the current crisis."

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~~Dec 14~~	~~Dec 2~~
~~Dec 21~~	~~Dec 8~~
~~Dec 28~~	~~Dec 16~~
1988	
Jan 4	~~Dec 23~~
Jan 11	Dec 29
Jan 18	Jan 6
Jan 25	Jan 12
Feb 1	Jan 20
Feb 8	Jan 27
Feb 15	Feb 2
Feb 22	Feb 9
Feb 29	Feb 17
Mar 7	Feb 23
Mar 14	Mar 2
Mar 21	Mar 9
Mar 28	Mar 16
Apr 4	Mar 23
Apr 11	Mar 29
Apr 18	Apr 5
Apr 25	Apr 12
May 2	Apr 19
May 9	Apr 27
May 16	May 4
May 23	May 11

Executives purchase Graham Miller

London

LONDON—The management of the Graham Miller Group of Companies, an international loss adjusting operation, has acquired its worldwide operations, excluding U.S. operations, from its parent company, Inchcape P.L.C.

Graham Miller's management completed the buyout following Inchcape's decision to concentrate on insurance brokerage and other non-adjusting operations, said Miller Chairman William Bolton.

Graham Miller Group has 35 offices around the world, including locations in Europe, the Middle East, Africa, the Far East, the Caribbean and South America.

The group's eight-office U.S. network was sold independently in August to Abaco Investments P.L.C.

However, Graham Miller has formed an association with two loss adjusters in New York, said Mr. Bolton: Lee McAndrews Inc., which specializes in property/casualty and marine cargo business, and European & International Adjusters Inc., which specializes in jewelers bloc, fine art and contingency surplus lines business.

Graham Miller will start rebuilding a network of offices throughout the United States by the end of next year, said Mr. Bolton.

Mr. Bolton refused to reveal financial details of the management buyout.

ness being reinsured.

- Monitoring results and investigating deviations from expected results.
- Evaluating procedures for reporting losses.
- Evaluating estimation procedures and methods of calculating incurred-but-not-reported losses.
- Assessing the use of lawyers, actuaries and other professionals.
- Evaluating settlement practices.

"The greatest demand for our services usually arises from the need to conduct a reactive audit because a problem has arisen and it is necessary to assemble the information for a solution. However, a comfort audit, on a regular basis, can reassure both parties to the treaty that the contract is operating correctly," the company says.

For more information, contact Peter Smith, Reinsurance Evaluation & Analysis Services Ltd., 20 Lime St., London EC3M 7HN, England; 01-623-6317.

Risk consultant

British accounting firm Peat, Marwick, McLintock & Co. has formed a risk management consulting unit within its management consulting operation.

The unit is headed by Gordon Sanders, a former director of Lloyd's broker Stewart Wrightson Ltd., and Clive Thursby, who had been an executive with Lloyd's broker C.E. Heath P.L.C.

"While there is a growing need from industry for help in assessing risks, there is a limited amount of independent advice available in the U.K.," said Mr. Sanders.

For more information, contact Gordon Sanders, Peat Marwick, McLintock, 1 Puddle Dock, Blackfriars, London EC4V 3PD, England; 01-236-8000.

Minet scholarship

Minet Insurance Brokers, a subsidiary of Minet Holdings P.L.C., will award an annual risk management scholarship for students taking the new Institute of Risk Management examinations in June.

The Minet Scholarship for Risk Management Student Achievement, worth up to 5,000 pounds (\$9,200), will be awarded annually in conjunction with the Institute of Risk Management, which was established in 1986 for the promotion of education and professionalism in risk management.

"The successful student will be able to spend up to four weeks in any country of his or her choice and attend a major risk management conference," said Roger Miller, chairman of the institute's board of governors.

New office

Pan Atlantic Insurance Co. Ltd., the U.K. subsidiary of Pan Atlantic Re. Inc., has moved offices to 40 Lime St., London EC3M 5BS. Its telephone number remains 01-621-1975.

Comings & goings

Maralyn Fichte has been appointed a director of E.W. Payne (North America) Ltd. and managing director of the Reinsurance Management Division.

David Lewis has been appointed deputy facultative accident underwriter for the international non-marine department of St. Katherine Insurance Co. P.L.C. He previously was U.K. accident underwriter with Assitalia (U.K.), the U.K. branch of Le Assicurazione D'Italia S.p.A.

Simon Barnes, Charles Cantlay, Alan Cranfield, Robert Curzeyand and Alastair Macdonald have been appointed to the executive committee of Alexander Howden Reinsurance Brokers Ltd.

Info

• "Insurance Agents' and Brokers' Liability for Insurer Insolvencies" is a 66-page monograph by Ronald C. Horn, a professor of insurance studies at Baylor University in Waco, Texas. In the wake of widespread insurer insolvencies and in light of the limits of state guaranty funds, Dr. Horn examines the errors and omissions claims against insurance agents, brokers and consultants. The article includes topics such as unresolved legal issues, the reliability of insurer rating services, ethical implications, and the need to address public policy questions with legislation. Copies of the monograph are \$24 including postage and handling. Pennsylvania residents must add 6% sales tax. To order, contact the Society of Chartered Property & Casualty Underwriters, Harry J. Loman Foundation, Kahler Hall, 720 Providence Road (CB 19), Malvern, Pa. 19355-0709; 215-251-2728.

• A free brochure on **business credit insurance coverage**, which is a guarantee to firms that they will not suffer excessive credit losses on sales to other businesses, is now available. The brochure outlines the coverage available and how it works. Copies are available from American Credit Indemnity Co., 300 St. Paul Place, Baltimore, Md. 21202-2183; 800-624-4969.

• A new curriculum for the **Associate in Claims program** has been introduced by the Insurance Institute of America. There is one new course, "The Claims Person and the Public," among the four now required for the professional designation. The other courses are a restructured "Principles of Property and Liability Claims Adjusting"; "Advanced Property Adjusting"; and "Advanced Liability Adjusting." Details about the restructured program are available by writing the Institute's Field Services Department, 720 Providence Road, Malvern, Pa. 19355-0770; 215-644-2100.

• **Computer Applications for Employee Benefit Plans**, published by the International Foundation of Employee Benefit Plans, includes discussions of benefit plan administration, keeping pace with automation and claims processing and the future of automation. Copies are available for \$10 for foundation members and \$18 for non-members by sending payment to the Publications Department, IFEBP, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

• "Better Safe than Sorry: Your Guide to Protecting Yourself from Accidents" is available to employers to help them **reduce worksite accidents** and keep employees on the job. The motivational brochure is one of Fax Communications' Health is Wealth series that includes illustrated, easy-to-understand safety tips. It includes tips on recognizing hazards, following safety

rules, preventing slips, trips and falls, safe lifting techniques and fire safety. For a sample copy, write to Fax Communications, Inc., Dept. BI, 3279 20th St., San Francisco, Calif. 94110; 415-641-7422.

• A review of **how to evaluate captives and risk retention groups** has been published in the latest issue of Betterley Risk Management Commentary by Betterley Risk Management Consultants Inc. of Worcester, Mass. Discussions include economics, coverage, fronting, underwriting, domiciles, regulatory and tax issues, as well as the necessary management issues comprising the evaluation criteria. Copies are available for \$25 each by writing Betterley Risk Consultants Inc., Department EC, 446 Main St./Worcester Plaza; Worcester, Mass. 01608; 617-754-1704.

• A **General Guide to Tort Reform** is available from American Re-Insurance Co. to give claims technicians and underwriters an overview of recent and pending tort reforms across the nation. The free brochure is available by writing George Cavell, Corporate Communications & Advertising Department, American Re-Insurance Co., 1 Liberty Plaza, New York, N.Y. 10006; 212-513-4942.

• A manual for **loss prevention and control** designed for evaluation by corporate management and implementation by plant management is available from Industrial Risk Insurers. The program was developed based on a three-year analysis of 1,169 losses totaling \$172 million, which showed that 97.9% of these losses were related in some degree to human failure. Included are topics such as smoking regulations, maintenance, employee training, new construction, hazardous materials evaluation and fire protection and security surveillance. Copies of the OVERVIEW manual are available for \$10 from Ms. P.A. Sasso, Industrial Risk Insurers, 85 Woodland St., Hartford, Conn. 06102; 203-520-7412.

• More than 200 **cassettes and videotapes on employee benefits topics** are available from the International Foundation of Employee Benefit Plans. Topics include corporate benefits management, association benefits, public employee plans, drug and alcohol rehabilitation and health care cost management. For a free copy of the cassette and videotape catalog, contact Audiovisual Services, IFEBP, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

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Letters

Continued from page 8
was the fact that the Florida Department of Insurance asked the Florida state court that entered the injunction to hold Insurance Corp. of America in contempt for violation of the injunction based, in part, upon Mr. Grote's sale of the policy. After an evidentiary hearing was held on the department's request, the Florida state court denied the request, *in toto*, and refused to find that either Mr. Grote or Insurance Corp. of America had violated the injunction.

Thomas D. Daiello
Marchbanks & Feaman P.A.
Boca Raton, Fla.

Construction risks better covered by new ISO form

To the editor: This is in response to the article in your Dec. 14 issue: "Critics Adapt to Constraints of New ISO Form."

Within that article, Dan Knise relays the message from many underwriters who have told him that "the 1973 form is still a possibility if not a reality" for construction risks.

If one were to make a comparison of the old and new occurrence forms strictly for construction risks, the latest form would be the clear winner.

The single most important disadvantage of the new ISO policy form concerns the aggregate limits, which can be improved upon by adding a per project aggregate to the policy.

But unless there is coverage in the first place, the buyer need not worry about the application of limits.

Donald S. Malecki
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EC nations to lift restrictions on non-life insurance market

By DENISE CLAVELOUX

BRUSSELS, Belgium—An agreement reached by the ministers from the 12-member European Community will considerably open up the EC non-life insurance market by allowing insurance companies based in one member state to cover large risks located in other member states.

As much as 70% to 80% of all premiums currently written in EC member states could be affected by the agreement on the terms of a new directive, reached Dec. 18 in Brussels after 12 years of consideration, estimates an EC official. However, the official could not estimate the number of policies that may be affected.

The agreement was reached about one year after the European Court of Justice ruled that regulations in West Germany, France, Denmark and Ireland that blocked the cross-border placement of insurance were illegal under the European Economic Community Treaty, known as the Treaty of Rome (*BI*, Dec. 15, 1986; Dec. 8, 1986). The EC had delayed work on the directive for three years awaiting the court's ruling.

Only the United Kingdom and the Netherlands currently allow cross-border insurance placement, while other European countries require risks to be insured by domestic insurers. The risks then can be reinsured on an international basis.

Although the 12 EC ministers have agreed in principle to the terms of the directive, they still must agree to a final text, which is expected to be available within the next six months.

Under the agreement, insurers in an EC state can cover large risks based in another EC state. Those risks are defined as all transportation, credit and surety risks.

An insurer in one EC state also can cover other risks

of an insurance buyer in another EC state when the buyer meets at least two of three criteria. And, the criteria are to be eased automatically on Jan. 1, 1993. Under those requirements, the buyer must:

- Employ 500 people; 250 people beginning in 1993.
- Generate annual revenue of 24 million ECU (\$30.4 million at the current exchange rate); 12.8 million ECU (\$16.2 million) in 1993.
- Report a balance sheet of 12.4 million ECU (\$15.7 million); 6.2 million ECU (\$7.8 million) in 1993.

However, several EC states will be allowed to apply the higher thresholds for several more years because of their smaller national insurance markets. Spain will be allowed to apply the higher limits until 1996, and Greece, Ireland and Portugal can apply the higher limits until 1998.

The thresholds agreed to by the Council of Ministers are higher than those advocated by the EC's Employers' Federation, which represents the EC's industrial and commercial policyholders. However, the EC believes the agreement will allow free access to an EC-wide insurance market for those policyholders that do not need the close and detailed protection of their own national law in dealing with insurers.

The agreement on the new directive also lays down the extent to which insurers must quote rates in local currencies. However, the agreement on the directive allows insurers greater freedom in selecting the currency in which they quote rates for transportation risks because those risks often travel through more than one EC member state.

British Undersecretary for Trade Francis Maude called the agreement "very satisfactory. It's not as perfect a regime as we could have hoped for, as we wanted a complete liberalization," he said.

"But it's much better than it might have been. British companies in particular will benefit by this decision," he said.

Massachusetts health care bill

Continued from page 2

A spokesman for Gov. Dukakis said that the governor had not issued a comment on the compromise bill because he was out campaigning for the Democratic nomination for the presidency.

In a statement issued earlier this month, Sen. McGovern noted that "we unveil a package which for the first time in our history will guarantee every Massachusetts citizen the basic right to health security. Our package is bold, yet sensible. It breaks ground by making our state the first in the nation to address this crucial need. At the same time, the plan represents our best effort to address the concerns of the large and small business and the hospitals."

Hawaii currently is the only state that requires employers to provide health insurance to most employees, according to employee benefit consultants.

Under a 1974 law, employers in Hawaii must provide minimum health care coverage to all employees who work more than 20 hours per week for four continuous weeks at the earliest available enrollment period. The coverage must be through either a health maintenance organization or through the employer's state-approved benefit plan, according to a spokesman for the state's Department of Labor.

If it becomes law, the Massachusetts bill would:

- Require employers to provide either health insurance coverage valued at \$1,680 per employee per year or contribute \$1,680 to a state fund to provide basic health coverage for employees. The employee could choose between the two.

This is different from the Dukakis proposal, which mandated provisions of group health plans. For example, the Dukakis plan capped deductibles at \$250 per individual and \$500 for a family with a maximum annual out-of-pocket expense of \$3,000.

- Impose penalties on employers not in compliance after April 1, 1992.

Employers would be assessed a per employee surcharge on their state unemployment insurance

equal to 12% of the first \$14,000 of payroll, or \$1,680 per employee.

The revenue generated by these penalties would go into a Health Insurance Hardship Trust Fund, which would be used partly to subsidize coverage for part-time employees. The fund also would assist employers whose penalties exceed 5% of their gross revenues.

- Establish temporary tax incentives to encourage small employers—those with five or fewer employees—to begin providing health insurance for their employees on a voluntary basis.

- Create the Department of Health Security.

This agency would apply the temporary tax credits to small employers who comply before the program becomes mandatory on Jan. 1, 1992, and assess penalties against those who do not comply when the mandate takes effect.

It also would broker health insurance for small employers that often have difficulty finding or affording coverage. The DHS also would create a pool for employers with five or fewer employees and administer the Health Insurance Hardship Trust.

- Cap employers' contributions to the "free care/bad debt" pool.

The aggregate assessment on employers to fund the pool would be capped at \$325 million in fiscal years 1989, 1990 and 1991. After that, the cost to the employer community would be capped at 115% of the total cost of the pool in the prior year. To ensure that the pool is maintained, the state would pick up 50% of any costs in excess of employers' share, with hospitals responsible for any remainder.

- Establish a new hospital financing system that would cap future total charges to the private sector.

Total hospital charges to the private sector would be capped at \$289 million in 1988; \$262 million in 1989; and \$195 million in 1990 and 1991.

In addition, hospitals with declining patient share would be ineligible to collect additional revenues for treating Medicaid and Medicare patients or aid from the

state, forcing some to close. There would be special provisions to protect needed specialty hospitals.

And, the state would pay up to \$50 million in Medicare losses to hospitals. This would help to eliminate the cost shift by hospitals to employers.

Employers generally support the bill, according to observers.

"This has broader support from the business community than any other piece of health care legislation in three or four years in Massachusetts," said John Crosier, president of the Massachusetts Business Roundtable. The coalition includes 55 of the largest employers in the state.

"This will let us deal gradually with health care pools and the chronic and understandable complaint of small businesses not being able to afford health insurance," he added.

But, "first of all, everyone is welcoming some relief from the original Dukakis proposal," noted Charles Ginsberg, a vp and managing director of the research and development practice of the Alexander Consulting Group Inc. in Newburyport, Mass.

"Employers were upset with that proposal because it asked for an exception from ERISA (which would require employers to cover all employees). The Senate proposal makes the program voluntary, phasing it in over a few years," he added.

"Some large employers think this will be to their benefit because it seems to them that they are carrying the load," said Alan Breiman, a principal in the Boston office of William M. Mercer-Meindinger-Hansen Inc.

"However, smaller employers—such as retailers—are concerned because this could significantly increase their costs and impact on their profit margins," he said.

The issue of mandated benefits is here to stay, said Mr. Ginsberg.

"All of these things are leading to universal health insurance and I don't think it's going to stop. Once the government gets involved in mandated health insurance, where does it stop?" he asked.

Update

Ford seat belt ruled defective

Continued from page 2

The verdict is one of the first returned in cases alleging defective seat belt design. But the number of these types of cases probably will increase, said the boy's attorney, Harold A. Sakayan, with the Washington, D.C., firm of Margolis, Sakayan & Holtz.

Ford said in a statement that the jury "completely ignored the clear, factual evidence showing there was no defect in the rear-seat restraint system and returned the verdict out of sympathy for the plaintiff and his family." The company may file a motion asking the judge to set aside the verdict and, if necessary, will appeal.

A Ford spokesman declined to discuss insurance matters.

However, Ford in the late 1970s maintained a \$2 million self-insured retention for product liability risks involving autos and had \$100 million of excess liability insurance. Ford disclosed in financial documents for 1985 it had "little or no liability insurance for incidents that might occur in 1986 because of the limited availability of such insurance at reasonable premiums" (*BI*, May 19, 1986).

South Carolina liquidates HMO

SPARTANBURG, S.C.—Patient's Choice H.M.O., a physician-owned health maintenance organization in Spartanburg, S.C., with approximately 8,500 enrollees, is being liquidated.

The for-profit HMO, established in 1986, was ordered liquidated earlier this month when it could not comply with a law requiring HMOs to maintain a net worth of \$600,000. Patient's Choice's net worth is "around zero," said an Insurance Department spokesman.

Patient's Choice was owned by between 300 and 400 doctors, he said. The independent practice association-model HMO served only employee groups in 12 counties and was not federally qualified.

The HMO ran into trouble for several reasons, the spokesman said. "They priced their product too low, benefits were too extensive, over-utilization... the usual reasons."

Most of the HMO members can obtain coverage with other plans sponsored by their employers, and those who do not can purchase a "conversion policy" from the HMO's reinsurer, Minneapolis-based North American Life & Casualty Co., the spokesman said.

However, the conversion policy costs four to five times the HMO membership and offers fewer benefits, the spokesman noted.

Equipment blamed for mine fire

PROVO, Utah—Utah Power & Light Co. and its property insurers are suing nine equipment and component manufacturers to recover more than \$86 million in property and liability claims they have paid in connection with a 1984 mine fire that killed 27 miners.

The subrogation action, filed Dec. 18 in Utah County District Court, charges that equipment and parts were defectively designed and manufactured, carried inadequate warnings and had been inadequately inspected and tested by the manufacturers.

The fire occurred at the Wilberg Mine in Emery County, Utah, on Dec. 19, 1984. Utah Power owned the mine and Emery Mining Corp. was the operator (*BI*, Jan. 7, 1985).

The defendants named in the suit are Emery; Ingersoll-Rand Co.; Kaiser Aluminum & Chemical Co.; National Mine Service Co.; Draegerwerk AG; National Draeger Inc.; Deltrol Corp.; Texas-Birmingham Bolt Co., currently doing business as Alabama Birmingham Bolt Co.; and E.I. du Pont de Nemours & Co.

These companies made the air compressor, blow-down valve, aluminum overcasts, roof bolts and emergency breathing devices used by many of the deceased miners.

The property insurers for Utah Power indemnified the utility for \$64.5 million out of an adjusted loss of \$66.9 million, with the difference representing, in part, deductibles and coinsurance, said Robert N. Schiff of the San Francisco law firm Fisher & Hurst, which represents the property insurers. The insurers are seeking recovery for property damages from five defendants: Ingersoll, Kaiser, Deltrol, Texas-Birmingham and Du Pont.

Damage sustained by Utah Power included damage to or destruction of coal; mining equipment; materials and supplies; fire fighting, rescue and recovery equipment; production capacity of the Wilberg Mine and another mine; increased insurance premiums; increased corporate costs; and loss of use of generating facilities.

Utah Power and the property insurers also seek to recover unspecified "loss of use" damages against Emery because the utility had to obtain more expensive coal from other sources.

Utah Power also seeks to recover from all of the defendants, except Emery, their share of liability in the \$22 million in settlements the utility has reached with the heirs of the mine victims.

Insurers bringing the suit include Federal Insurance Co.; Century Indemnity Co.; National Union Fire Insurance Co. of Pittsburgh, Pa.; Integrity Insurance Co.; Fireman's Fund Insurance Cos.; National Fire Insurance Co. of Hartford; First State Insurance Co.; and Christiania General Insurance Corp.

Premium collection block lifted

ALBANY, N.Y.—A State Supreme Court justice lifted a temporary restraining order preventing insurers from collecting a median 60% increase in state employees' health insurance premiums effective Jan. 1 (*BI*, Dec. 21).

However, Justice Harold Hughes noted that should he later rule the increases are not permissible, subsequent adjustments could be made to the rates, according to Henry Sobota, deputy counsel for labor relations at the New York State School Boards Assn.

Justice Hughes said he expects to rule quickly on the challenge by several state employee groups seeking to block the rate hikes.

Metropolitan Life Insurance Co. and Empire Blue Cross/Blue Shield, two of the plan's insurers, as well as several state agencies and officials were named in lawsuits filed by the employee groups.

Justice Hughes also permitted 13 unions under the umbrella of the New York State AFL-CIO to join a suit filed in November by 17 Long Island school districts to block the premium hikes.

Datebook

JAN. 7-8. Seventh Annual Occupational Health Nursing Principles and Certification Review Course in New Orleans, sponsored by the Occupational Health Consulting division of Fireman's Fund Risk Management Services Inc.; \$275. Also Feb. 4-5 in Torrance, Calif.; Feb. 18-19 in Schaumburg, Ill.; March 3-4 in Arlington, Va.; and March 17-18 in Cambridge, Mass. Annette B. Haag, Director, Occupational Health Consulting, Fireman's Fund Risk Management Services Inc., 4040 Civic Center Drive, Rafael, Calif. 94912; 415-492-4708.

JAN. 12-15. The Second Annual National Conference on Industrial Loss Prevention and Control in Orlando, Fla., sponsored by the International Society of Fire Service Instructors; \$785 for ISFSI members and sponsors; \$875 for all others. International Society of Fire Service Instructors, 20 Main St., Ashland, Mass. 01721; 617-881-5800.

JAN. 13. New ISO Commercial Property and Commercial General Liability Forms seminar in Briarcliff Manor, N.Y., sponsored by the Westchester Chapter of the Society of Chartered Property & Casualty Underwriters; \$25. Jerome Trupin, 170 Hamilton Ave., White Plains, N.Y. 10601; 914-949-4810.

JAN. 13. Customer Service for Insurance course in New York City, sponsored by The College of Insurance; \$195 for college sponsors; \$245 for non-sponsors. Professional Development Programs, The College of Insurance, 1 Insurance Plaza, 101 Murray St., New York, N.Y. 10007; 212-962-4111.

JAN. 14-15. Insurance, Excess and Reinsurance Coverage Disputes seminar in New York City, sponsored by Practising Law Institute; \$450; \$45 for course handbook only. Also Jan. 28-29 in San Francisco. Practising Law Institute, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700.

JAN. 20. Managing and Controlling Asbestos Contamination/Exposure course in Los Angeles, sponsored by the University of Southern California's Institute of Safety and Systems Management; \$160. University of California, Institute of Safety and Systems Management, Office of Extension and In-service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 213-743-6523.

JAN. 20. Health Care in the '80 and '90s: What Employers Want workshop in New York City, sponsored by the Health Research Institute; \$495. The workshop will also be held March 21 in Atlanta and May 18 in Chicago. Workshop coordinator, Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

JAN. 20-21. Second Annual Legislative Conference in Washington, D.C., sponsored by the Self-Insurance Institute of America Inc.; \$125 for ISIA members; \$175 for non-members. Kevin Shein, Self-Insurance Institute of America Inc., P.O. Box 15466, Santa Ana, Calif. 92705; 714-261-2553.

JAN. 21-22. Transportation of Hazardous Materials/Waste course in Los Angeles, sponsored by the University of Southern California's Institute of Safety and Systems Management; \$265. University of California, Institute of Safety and Systems Management, Office of Extension and In-service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 213-743-6523.

JAN. 20-21. Pension and Welfare Benefits in Bankruptcy seminar in New York City, sponsored by the Practising Law Institute; \$425; \$45 for Pension and Welfare Benefits in Bankruptcy course handbook only. Practising Law Institute, Department 8A-105, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700, extension 271.

JAN. 25-26. Hawaii-The U.S. Offshore Alternative conference, sponsored by the state of Hawaii, organized by Tillinghast, a division of Towers, Perrin, Forster & Crosby; \$50 for Jan. 25 captives briefing; \$300 for entire conference. Conference Director, Tillinghast, 722 Post Road,

Darien, Conn. 06820; 714-553-1277.

JAN. 25-29. Hazardous Materials: Handling and Disposal course in Los Angeles, sponsored by the University of Southern California's Institute of Safety and Systems Management; \$735. University of California, Institute of Safety and Systems Management, Office of Extension and In-service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 213-743-6523.

JAN. 27. Health in the 100th Congress: The Second Session conference in Washington, co-sponsored by the Washington Business Group on Health and the National Assn. of Manufacturers in conjunction with the Women in Government Relations Health Task Force; \$40 for WBGH, NAM or WGR members; \$50 for non-members. Sherri Farris, Washington Business Group on Health, 229½ Pennsylvania Ave. S.E., Washington, D.C. 20003; 202-547-6644.

JAN. 27-28. The Risk Retention Act of 1986: Opportunity or Anarchy? symposium in Rosemont, Ill., co-sponsored by the Society of Chartered Property & Casualty Underwriters Excess/Surplus/Specialty Lines Section and the National Assn. of Professional Surplus Lines Offices; \$200 for Society of CPCU members; \$250 for non-members. Mari Jennings, Professional Services Coordinator, Society of Chartered Property & Casualty Underwriters, Kahler Hall, 720 Providence Road, CB#9, Malvern, Pa. 19355; 215-251-2741.

JAN. 27-28. Persuasive Selling Skills for New Agents and Brokers course in New York City, sponsored by the College of Insurance; \$395 for college sponsors; \$445 for non-sponsors. Professional Development Programs, The College of Insurance, 1 Insurance Plaza, 101 Murray St., New York, N.Y. 10007; 212-962-4111.

JAN. 27-29. Fifth Annual Atlanta Risk Management Educational Conference sponsored by the Atlanta chapter of the Risk & Insurance Management Society; before Jan. 13: \$100 for RIMS members, \$115 for non-members, \$25 for students; after Jan. 13: \$125 for RIMS members, \$140 for non-members, \$25 for students. George Netherton, The Coca-Cola Co., P.O. Drawer 1734, Atlanta, Ga. 30301; 404-676-7032.

JAN. 27-29. Health Agenda 1988 conference in Washington, D.C., co-sponsored by the Washington Business Group on Health and the National Assn. of Manufacturers; \$475 for WBGH/NAM members; \$575 for non-members. Ellen Menton, Washington Business Group on Health, 229½ Pennsylvania Ave. S.E., Washington, D.C. 20003; 202-547-6644.

JAN. 28-29. 'Preventive Defense' and the Product Liability Case seminar in Phoenix, Ariz., sponsored by the Defense Research Institute Inc.; \$395 for DRI members; \$415 for non-members. Defense Research Institute Inc., 750 N. Lake Shore Drive, Suite 500, Chicago, Ill. 60611; 312-944-0575.

FEB. 1. Human Factors in Loss Control course in New York City, sponsored by The College of Insurance; \$195 for college sponsors; \$245 for non-sponsors. Professional Development Programs, The College of Insurance, 1 Insurance Plaza, 101 Murray St., New York, N.Y. 10007; 212-962-4111.

FEB. 1-2. Hazardous Waste Management of Small Generators course in Los Angeles, sponsored by the Institute of Safety and Systems Management, University of Southern California; \$160. Institute of Safety and Systems Management, University of Southern California, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 213-743-6523.

The Datebook is compiled from notices sent to Business Insurance. Notices should be sent at least eight weeks in advance to Datebook, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590. Please include the price, if any, of the meeting and information on registration for interested readers. Business Insurance reserves the right to select meetings of most interest to its readers and cannot guarantee that notices will be printed.

Variable-rate PBGC premium

Continued from page 1

"I have never seen so many issues come down to and be decided at the wire," said Mr. Ugoretz.

"Things have been kind of frantic in Washington," said Frederick Rumack, director of taxes and consulting services for Buck Consultants Inc. in New York.

"Benefits became one of the hottest legislative topics around," added Edward J. Davey, a vp with Johnson & Higgins in New York.

The pace is likely to continue next year. When legislators return to Washington next month they will be ready to dig into other benefit issues.

"It could be a very busy session," observed Frank McArdle, education and communications director for the Employee Benefit Research Institute, a Washington-based benefits think tank.

A conference committee, for example, is expected to be organized soon to settle differences in House- and Senate-passed legislation to expand the federal Medicare program to give the elderly more protection from catastrophic health care expenses.

In addition, new efforts will be made to enact revised COBRA penalties—probably as part of a technical corrections bill to correct drafting errors in the Tax Reform Act of 1986—while the health care pool proposal is certain to re-emerge.

At the same time, the \$500 flexible benefit plan cap, or some similar proposal, is expected to surface as Congress continues to look at benefit plans as a source of revenue to reduce the budget deficit.

"As long as there is a significant budget deficit, the non-taxability of all benefits will be examined," said Lance Tane, manager of The Wyatt Co.'s flexible compensation team in Washington.

"We will have to keep our guard up," added Ken Feltman, executive director of the Employers Council on Flexible Compensation in Washington.

For now, employers will have their hands full digesting the PBGC/pension decisions made last week.

Perhaps the most significant decision is the move away from the current flat-rate PBGC premium to a variable-rate premium structure.

While the concept had been discussed for years, a variable-rate PBGC premium only began to receive serious congressional consideration after the Reagan administration earlier this year drafted and actively supported a variable-rate proposal.

Even with support from the Reagan administration and business groups like the ERISA Industry Committee, the Assn. of Private Pension & Welfare Plans, the National Assn. of Manufacturers and the Risk & Insurance Management Society, the drive to pass a variable-rate premium had to overcome many hurdles.

The concept was denounced by labor organizations, while two congressional committees—the Senate Labor and Human Resources Committee and the House Education and Labor Committee—voted to simply hike the current flat-rate \$8.50 premium to \$19 or \$20.

But the administration and members of the Senate Finance and House Ways and Means committees resisted that effort and won.

Under the variable-rate premium, the PBGC premium will range from a base of \$16 per plan participant to a maximum of \$50.

Plans that are 100% funded will pay the \$16 premium. Plans that are less than 100% funded will pay, in addition to the base premium, a funding charge of \$6 per \$1,000 of underfunding. An employer's overall premium will be capped at \$50 per participant.

However, plans with fewer than 100 participants will pay only the \$16 premium. In addition, the new variable-rate premium does not affect multiemployer plans, which have a separate flat-rate structure laid down by a 1980 federal law.

Enactment of the variable-rate premium was saluted by administration officials.

"Congress has rationalized the pension insurance termination insurance structure. What a triumph! It is like slam dunk in basketball. The political system really has worked," exclaimed PBGC Executive Director Kathleen P. Utgoff, the key architect of the variable-rate premium.

"A variable-rate premium says if you are responsible, you will pay less. If you don't fund promised benefits, you should and will pay more. That is a more

equitable way to distribute the PBGC premium burden," said David Walker, assistant secretary at the U.S. Department of Labor.

Benefit experts outside government agree.

"This is a good compromise. It is not too Draconian, but it gives employers a new financial incentive to improve plan funding," said Wyatt's Mr. Raskin.

To improve plan funding, the legislation establishes a new amortization schedule to pay off liabilities more rapidly than the 30 years that companies generally now have to amortize pension liabilities.

Old liabilities—those established before Oct. 17, 1987—will have to be amortized over 18 years.

While complete details were not available late last week, new liabilities also will have to be funded much more quickly. For example, severely underfunded plans will, in some cases, have about three years to amortize liabilities, benefit experts said.

The new amortization schedules do not affect fully funded or overfunded pension plans.

And, employers whose plans are less than 60% funded generally will have to post a security like a surety bond before they could increase retirement benefits.

Also, under the new law, required funding contributions are due in quarterly installments. Employers now have to make annual contributions.

In addition, an employer and all its affiliates will be jointly and severally liable for funding shortfalls in each unit's pension plan. Joint and several pension funding liability will be triggered when the unit sponsoring the plan fails to make minimum contributions.

By contrast, under the old law, members of a corporate family—known as a controlled group—only are liable for each other's pension liabilities when a plan terminates.

This new joint and several liability for funding contributions could interfere with some companies' ability to compete, benefit experts have said.

For example, a corporate unit that wants to expand to meet competition might have to scrap those plans because its resources could be drained by forced contributions to another unit's underfunded pension plan.

"A corporate unit now has to be concerned about its 'brothers and sisters' within the controlled group," said Henry Saveth, a vp with Johnson & Higgins in New York.

In addition, the new law makes it more difficult for an employer to win a waiver from the Internal Revenue Service allowing an employer not to make a minimum contribution to a pension plan.

An employer now will have to prove that its financial difficulty is of a temporary, rather than long-standing, nature to obtain a waiver.

Under current law, a company seeking a waiver only has to prove that making a minimum contribution would impose a substantial business hardship.

The legislation also will require an employer to prove that making the contribution would impose a hardship on all members of the controlled group. For example, if a corporation had a healthy oil unit and a financially ailing steel unit, it would be unlikely to win a funding waiver for the steel unit.

"The screws really are being tightened on funding waivers," said Gerald Uslander, a principal in the Louisville, Ky., office of William M. Mercer-Meindinger-Hansen Inc.

Aside from being tougher to obtain, employers will not be able to receive as many waivers under the new law. The maximum number of funding waivers permissible over a 15-year period will be reduced to three from five. And, the amortization period for waivers will be reduced to five years from 15 years.

In addition, financially distressed companies will have more difficulty terminating underfunded plans.

For example, employers will find it more difficult to use a Chapter 11 reorganization as a means to shed pension liabilities.

To terminate a plan, an employer in Chapter 11 will have to prove that it would face liquidation if it did not terminate the plan.

"Pension plans can't be terminated as a first resort in a bankruptcy. Termination becomes a last resort," said the Labor Department's Mr. Walker.

Finally, the legislation makes a financially distressed employer that does terminate its pension plan liable to the PBGC for all unfunded guaranteed benefits, up from 75% under the old law.

Bill spares Lloyd's from tax status change

LONDON—Lloyd's of London is relieved that congressional conferees rejected proposals that would have drastically changed Lloyd's tax status in the United States.

"It's obviously a satisfactory and sensible outcome," said a Lloyd's spokesman.

Conferees dropped two provisions that would have imposed new, tough tax rules on Lloyd's of London syndicates, and instead agreed to have the Treasury Department study the issue. The Treasury study is due on April 1 (BI, Dec. 21).

Under one provision approved by the House last month but rejected by Senate conferees, syndicates first would have been taxed as corporations. Then, U.S. Lloyd's members would have been taxed individually on the share of profits they received from their syndicates (BI, Nov. 9).

Currently, U.S. Lloyd's members are taxed only on

their profit distributions from syndicates. Syndicates are not taxed directly.

In addition, conferees dropped a provision that would have required taxes to be paid immediately after an underwriting year rather than three years later, when profits are calculated. That measure would have forced Lloyd's to discard its traditional three-year accounting system.

Both provisions were in only the House version.

While the conferees defeated all tax provisions applying to Lloyd's, the issue may be resurrected. Once the Treasury Department completes its study next year, congressional tax committees almost certainly will take another look at how Lloyd's is taxed in the United States, congressional sources say.

The Lloyd's spokesman said Lloyd's "would be willing to enter into discussions at any time" if the tax issue re-emerges. "We await developments."

Insurance services guide

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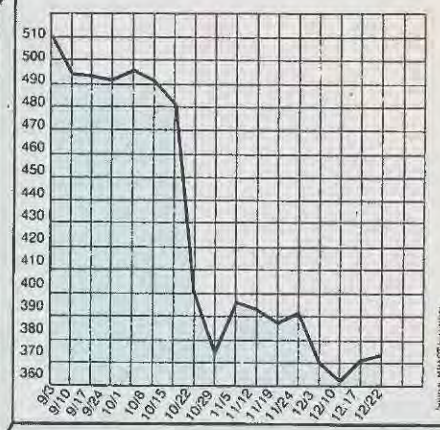
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BI Insurance Index



Insurance industry stocks posted a second week of gains last week, as the *Business Insurance* stock index rose 3 points to 374.2 on Dec. 22, up from 371.2 on Dec. 17. Advancing issues during the period were led by: Provident Life & Accident Insurance Co., up 11.7%; Aon Corp., up 9.2%; Transamerica Corp., up 9.1%; Old Republic International Corp., up 7.2%; and Orion Capital Corp., 7.0%. Declining issues were led by: Argonaut Group, down 12.2%; Frank B. Hall & Co., down 11.2%; Phoenix Re Corp., down 6.7%; Fremont General Corp., down 5.5%; and American Heritage Life Investment Corp. Conglomerates and holding company stocks monitored by *BI* posted the best performance for the period, up 2.8%; insurer stocks saw a 0.9% rise during the period, and brokerage stocks saw a 0.2% decline. Issues showing the most activity during the period were: Sears Roebuck & Co. (Allstate), 25.7 million shares traded; ITT (Hartford Group), 14.2 million shares traded; and Travelers Corp., 13.7 million shares traded. The *Business Insurance* index grew a slight 0.8% for the period, trailing the leading market indicators: The Standard & Poor's 500 grew 2.9%; the Dow Jones 30 Industrials climbed 2.8%; and the NYSE Composite gained 2.6%.

British Issues

Dec. 22 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	
Comm Union	360	13.8	17.8	4.9	364—355	
Genl Accident	855	10.2	38.3	4.5	860—851	
Gdn Royal Exch	885	12.0	46.6	5.3	888—838	
Royal	403	7.5	21.2	5.3	406—389	
Sun Alliance	870	13.0	32.2	3.7	883—836	

Brokers

CE Heath	408	13.6	34.5	8.4	408—392
Hogg Robinson	148	11.4	9.6	6.5	250—141
JH Minet	442	16.1	12.9	3.3	457—442
Sedg Grp	220	13.8	16.4	7.5	225—220
Willis Faber	247	11.2	14.8	6.0	248—223

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

BI Industry Stock Report

DEC. 22, 1987

12/18/87 THRU 12/22/87

Weekly Price % change Year to Date % change Annual High Low Vol.(000) \$ Div. % Yield P/E Book value Mkt/Bk. value

BROKERS

Alexander & Alexander Svcs	NYSE	17.63	2.9	-33.5	32.00	15.88	913	1.00	5.7	12.3	2.98	5.92
Baldwin & Lyons Inc.	OTC	12.00	0.0	-45.5	27.00	12.00	0	0.20	1.7	4.6	13.40	0.73
Corroon & Black Corp.	NYSE	28.63	2.3	-12.3	37.50	22.00	93	0.84	2.9	13.4	3.31	4.54
Gallagher Arthur J. & Co.	OTC	16.00	0.0	-39.0	31.00	15.00	0	0.40	2.5	10.6	4.81	3.33
Hall Frank B. & Co.	NYSE	3.00	-11.2	-79.3	19.00	2.50	249	6.00	0.0	10.6	0.00	N/A
Marsh & McLennan Cos. Inc.	NYSE	47.38	4.7	-22.0	72.00	43.75	840	2.40	5.1	11.8	3.14	9.22
Poe & Assoc. Inc.	OTC	7.50	0.0	-37.5	13.25	7.50	0	0.40	5.3	7.3	3.57	13.16
BROKERS AVERAGE			-0.2	-38.4					3.3	10.0		

CONGLOMERATES & HOLDING COMPANIES

Berkley W.R. Corp.	OTC	23.25	2.2	-11.4	37.00	18.75	173	0.28	1.2	5.8	13.72	1.69
Berkshire Hathaway Inc.	OTC	3000.00	0.0	6.4	-3792.00	2510.00	83	0.00	0.0	18.8	62.52	3.12
CIGNA Corp.	NYSE	45.13	-0.8	-17.9	69.50	41.25	753	2.80	6.2	5.6	42.01	1.07
CNA Fin'l Corp.	NYSE	57.00	3.6	6.0	66.50	47.00	170	0.00	0.0	10.2	42.71	1.33
General Re Corp.	NYSE	54.00	2.4	-2.7	68.88	46.00	561	1.00	1.9	12.2	23.47	2.30
ITT (Hartford Group)	NYSE	46.25	3.6	-13.4	66.38	41.88	1415	1.25	2.7	9.0	44.02	1.05
Sears Roebuck & Co. (Allstate)	NYSE	34.00	2.3	-14.5	59.50	29.75	2565	2.00	5.9	7.9	32.94	1.03
Transamerica Corp.	NYSE	30.00	9.1	-8.1	51.38	22.63	1368	1.84	6.1	5.7	26.94	1.11
CONGLOMERATES AVERAGE			2.8	-7.0					3.0	5.4		

INSURERS

Aetna Life & Cas. Co.	NYSE	45.00	0.3	-20.5	68.13	43.75	853	2.76	6.1	6.1	44.75	1.01
American General Corp.	NYSE	31.25	5.9	-15.3	44.75	27.25	841	1.25	4.0	6.3	27.12	1.15
Amer Heritage Life Inv'l	NYSE	24.00	-3.0	-6.5	34.00	23.00	12	0.96	4.0	11.5	20.37	1.18
Amer Indly Fin'l Corp.	OTC	8.88	-1.3	-50.7	19.00	7.75	4	0.56	6.3	11.5	20.40	0.44
American Int'l Group Inc.	NYSE	61.00	2.5	-0.2	83.75	53.50	922	0.30	0.5	11.4	29.02	2.10
Aneco Reins Ltd.	OTC	3.38	0.0	58.7	4.38	2.13	6	0.00	0.0	11.4	1.92	1.75
Aon Corp.	NYSE	23.75	9.2	-10.0	29.88	20.50	460	0.20	5.1	6.4	15.23	1.56
Argonaut Group	OTC	30.50	-12.2	45.2	52.13	21.00	222	0.00	0.0	6.3	14.60	2.09
AVEMCO Corp.	NYSE	19.13	2.0	-27.1	25.25	13.25	29	0.28	1.5	11.4	6.92	2.76
Belvedere Corp.	AMEX	4.75	0.0	-45.0	9.13	4.00	7	0.04	0.8	56.4	6.7	0.71
Business Mens Assur. Co.	OTC	28.88	-2.9	11.6	48.25	25.25	65	0.10	3.8	40.7	22.15	1.30
Chubb Corp.	NYSE	53.25	-0.7	-10.1	73.50	50.88	362	0.88	3.5	7.0	59.52	1.35

Philippine President Corazon Aquino ordered an investigation of the incident, which she called "a tragedy of harrowing proportions." The Philippine coast guard and navy and both houses of the Philippine Congress will participate in the inquiry.

President Aquino said "all parties at fault" must be punished. She further directed that all shipping safety regulations must be strictly enforced to prevent similar accidents.

An obviously infuriated Sen. John Osmena, calling for a thorough investigation and a shifting of responsibilities for overseeing shipping in the Philippines, charged that excess passengers and cargo are not listed in manifests and that fees are divided between the coast guard and shipping company personnel.

"We will never know how many actually perished in that accident," Mr. Osmena said. "So long as this racket of overloading exists, there will be more tragic accidents."

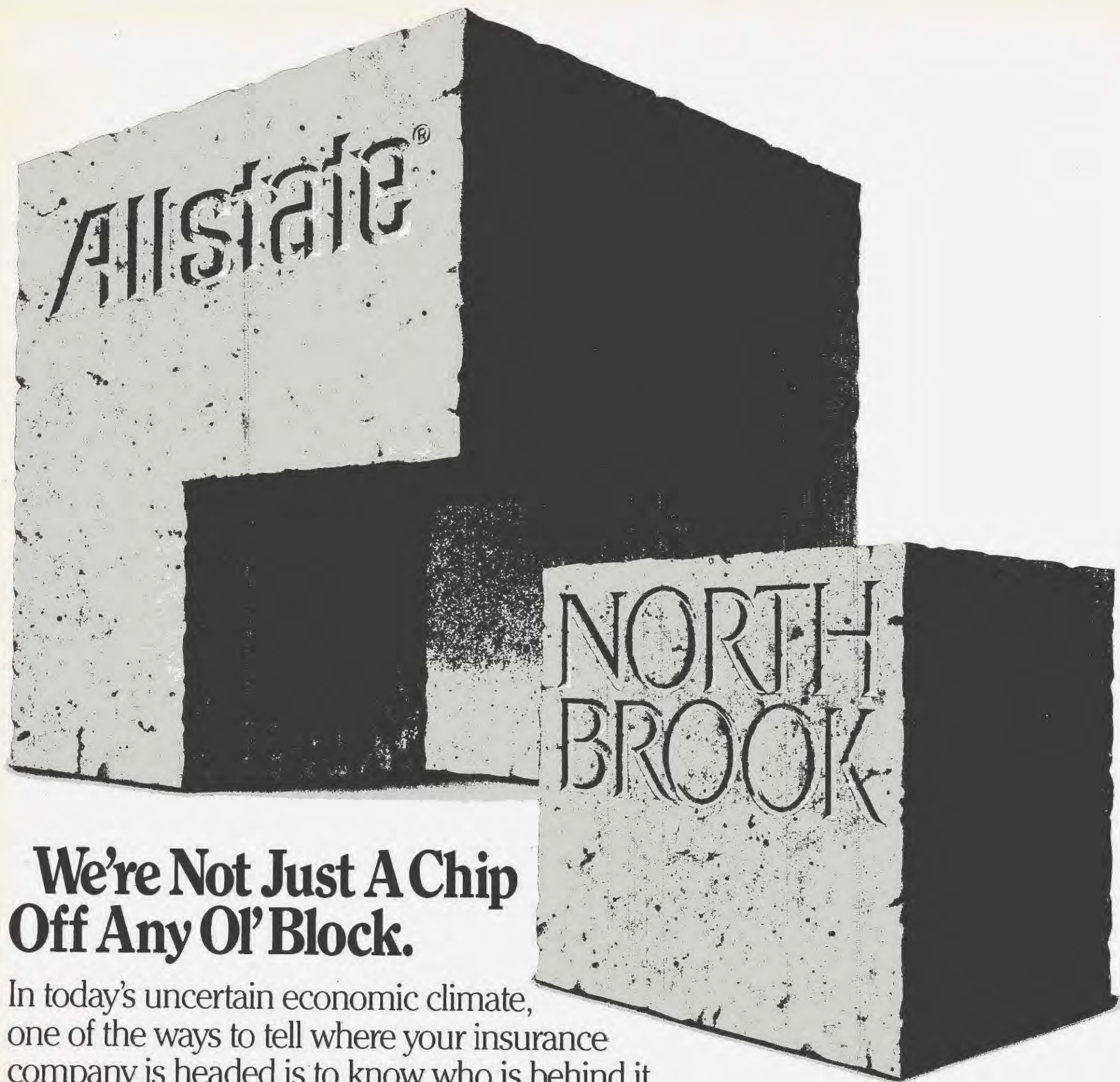
ance program. A Steamship Mutual spokesman would not comment.

One Lloyd's of London broker who did not wish to be named said that the Dona Paz, built in 1963, had been called a "constructive total loss" at least once before. A constructive total loss means that a ship was severely damaged without sinking and that insurers have indemnified the owner as if the vessel were a total loss.

The Dona Paz was built in 1963 for the Ryukyo Kaiun Kaisha of Naha in Okinawa. It was licensed to carry 608 passengers when it operated in Japanese waters as the Star Lily. The ferry was sold to Sulpicio in 1975 and subsequently remodeled and renamed Dona Paz. The ferry traveled a regular route of about 400 miles between Tacloban, Leyte and Manila.

There are no insurance details on the tanker Victor because the ship is so small that it is not named in Lloyd's shipping lists, which underwriters use to identify vessels.

Photo: AP/Wide World



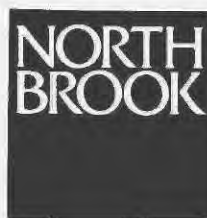
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