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update

Trenwick doubles its capital through securities offering

WESTPORT, Conn.—Trenwick Reinsurance Group's capital exceeds $52 million, following the completion last week of a $25.2 million private offering of common securities.

The proceeds of the offering will be used to increase the capital and surplus of the group's flagship company, Trenwick America Reinsurance Corp., to more than $45 million.

The majority of the offering was

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Coverage fight rages in Hyatt hotel disaster

By DOUGLAS McLEOD

KANSAS CITY, Mo.—Four and a half years after the disastrous collapse of two skywalks at the Kansas City Hyatt Regency Hotel, insurers are still arguing over who is liable for the claims.

Excess liability insurers for Hyatt Corp. and Hallmark Cards Inc. are appealing a February state judge's order apportioning coverage for the 1981 disaster.

Jackson County Circuit Court Judge Timothy D. O'Leary ruled that insurers for Hyatt—operator of the hotel—must pay two-thirds of the losses sustained by Hyatt, Hallmark and Hallmark's subsidiary, Crown Center Redevelopment Corp., which owned the hotel.

Judge O'Leary's ruling called for Hallmark's excess liability insurers to pay the remaining one-third of the judgments, settlements and defense costs arising from the disaster, which killed 114 people and injured at least 200 others (*BI*, March 11).

Northbrook Excess & Surplus Insurance Co.—Hyatt's first excess insurer at the time of the accident—is appealing the ruling, arguing that liability should be divided equally between Hyatt's and Hallmark's insurers.

Highlands Insurance Co., another Hyatt excess insurer, is arguing that a separate trial be held to determine the relative fault of Hyatt, Hallmark and other parties for the skywalk disaster. Insurance proceeds should then be apportioned based on the outcome of the fault trial, Highlands argues.

Bolstering its argument that a fault trial would be feasible, Highlands points to a recent ruling by an administrative law judge finding two engineers involved in the design of the skywalks grossly negligent (*BI*, Nov. 25).

Highlands also asks the appeals court to reverse Judge O'Leary's order that Highlands drop down to cover defense costs in a lower excess layer where defense coverage was excluded. The insurer argues that it should not be liable for such costs until all underlying coverage is exhausted.

In contrast, three of Hallmark's excess insurers—Commercial Union Insurance Co., Republic Insurance Co. and American Insurance Co.—are arguing on appeal that all of Hallmark's insurance should be considered excess of Hyatt's.

CU, Republic and American argue that they should be allowed to "reform" an endorsement to the Hallmark coverage that added Hyatt as a named insured.

American, a unit of Fireman's Fund Insurance Cos., also contests

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New Jersey ruling limits workers' rights to sue

By STEPHEN TARNOFF

TRENTON, N.J.—A New Jersey Supreme Court ruling this month establishes strict standards governing when a worker can sue an employer for injuries.

The state high court ruled that an employee may sue his or her employer directly only if the employer's actions were "substantially certain" to cause the employee's initial injury.

In doing so, the court said that even if an employer intentionally exposes a worker to a hazardous situation or deliberately conceals information about a hazardous situation, neither is reason to permit employees to sue their employers for damages in addition to receiving workers compensation benefits.

The New Jersey decision is another in a series of state court rulings on workers' rights to sue their employers for damages for injuries. Workers are testing workers compensation laws that deny employees the right to sue employers for workplace injuries.

The issue is 'what level of risk-exposure is so egregious as to constitute an "intentional wrong,"' the court says.

Most workers compensation experts say the New Jersey ruling, while recognizing an employee's right to sue an employer, is strict enough to protect employers from a flood of liability suits filed by employees. Some experts, however, complain that the ruling weakens the exclusive remedy provisions of workers compensation law.

In its Dec. 10 ruling, the New Jersey Supreme Court points out that it is a fact that workers who contract occupational diseases and such injuries should be compensated within the workers compensation system.

The court did say, however, that if the employer fraudulently concealed information about the workers' disabilities leading to aggravation of an injury, the employee can sue the employer.

The decision in *Millison vs. E.I. du Pont de Nemours and Co.* denies workers the right to sue the company for their injuries but allows them to proceed with an action charging fraudulent concealment of employees' medical history.

The ruling was made on five consolidated cases of more than 30 present and former employees at two du Pont plants in New Jersey.

Besides collecting workers compensation for asbestos-related injuries, the workers sued du Pont and its company physicians in state court in New Jersey.

The employees, who worked in du Pont plants for at least 20 years, charged du Pont and its physicians with intentionally exposing them to asbestos in the workplace and deliberately concealing the risks of exposure.

In addition, the employees charged du Pont and the physicians with fraudulently concealing specific medical information obtained during employee physical examinations that revealed diseases already contracted by the workers.

The trial court granted summary judgment for du Pont but refused to dismiss the claims against the company physicians.

At the appellate level, not only was the decision for du Pont affirmed, but the claims against the physicians also were dismissed

The workers then appealed to the Supreme Court.

At issue in the high court was the interpretation of the state statute permitting employees to sue employers outside the workers compensation system if the employer committed an "intentional wrong."

The plaintiffs argued that du Pont's knowledge and deliberate exposure of the employees to a hazardous work environment and its fraudulent concealment of the employees' existing occupational diseases was an "intentional wrong."

Du Pont, however, relying on previous state court rulings, asserted that only conduct amounting to a "deliberate intention" to injure employees was sufficient to qualify as an "intentional wrong."

The plaintiffs' complaint failed to show that there was actual intent to injure the workers, du Pont contended.

In its decision, the Supreme Court said that in setting an appropriate standard to determine what is an "intentional wrong," it had to take into account the "unpleasant, even harsh, reality" that industry knowingly exposes workers to the risks of injury and disease.

"The essential question therefore becomes what level of risk-exposure is so egregious as to consitute an

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There was no doubt about it: The current insurance market crisis and Congress' attempt to tax benefits were the top stories of 1985, according to the *Business Insurance* Risk Management and Employee Benefits Boards. Stories on both board surveys begin on Page 3; synopses of the top benefit stories are on pages 11 to 14; and summaries of the top risk management stories are on pages 21 to 22.

Complete vote calculations for 1985's most important stories Page 3

1. *Rates rise and capacity shrinks*
2. *ISO pushes new claims-made form*
3. *EIL insurance market collapses*
4. *Best's ratings tumble for insurers*
5. *Product liability bill fizzles*

1. *Tax reform threatens benefit plans*
2. *Courts back retiree health benefits*
3. *Extending spousal benefits urged*
4. *State-mandated benefits OK'd*
5. *HHS suggests terminating FSAs*

NEWSPAPER

update

Trenwick doubles its capital

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subscribed by existing shareholders, confirmed James F. Billett Jr., chairman and chief executive officer.

Major shareholders of Trenwick include foreign investors Ivory & Sime in Edinburgh, Scotland, Fox-Pitt, Kelton in London and U.S. companies Orion Capital Corp., Business Mens' Assurance Co. of America, Conning & Co., CIGNA Corp., St. Paul Fire & Marine Insurance Co., Hartford Fire Insurance Group, TRW Corp. and USF&G Corp.

Concurrent with the completion of the offering, the group restructured, creating Trenwick Group Inc., domiciled in Delaware, as the ultimate parent company. Trenwick originally incorporated in Bermuda in 1978.

FASB issues final pension rule

STAMFORD, Conn.—Employers with underfunded pension plans will have to list their pension liabilities on their balance sheets beginning with their 1989 financial statements, under a final rule issued last week by the Financial Accounting Standards Board.

Currently, pension liabilities are listed as footnotes to a company's financial statements.

As expected, the final rule will not allow an employer with more than one plan to combine liabilities and assets on its balance sheet. For example, an employer with a $100 million surplus in a salaried employees' pension plan and a $50 million unfunded liability in an hourly employees' plan could not merge the amounts to show a $50 million surplus. Some experts expect companies with separate underfunded and overfunded plans to merge those plans before 1989 so they won't have to list a pension liability.

In addition, the FASB final rule does not require employers that base pension benefits on employees' salaries to estimate future salary increases when they calculate pension liabilities.

Instead, employers generally will have to list as pension liabilities only the difference between the market value of plan assets and accumulated vested and non-vested benefits.

Cigarette maker wins two suits

SANTA BARBARA, Calif.—In two recent decisions, a federal judge and a state court jury have found R.J. Reynolds Tobacco Co. not liable for the death of one man and injuries to another allegedly caused by smoking.

In the first trial in a new wave of litigation against the tobacco industry, a jury in Santa Barbara voted 9-3 that Reynolds was not liable for the 1982 death of John Galbraith. Mr. Galbraith, 69, smoked two to three packs of cigarettes daily for most of his life.

Plaintiffs' attorney Melvin Belli has said that certain evidence not allowed by the trial judge hurt the case. The case will be appealed.

In the other case, a federal judge in Knoxville, Tenn., dismissed a product liability lawsuit against Reynolds brought by a man claiming cigarette smoking caused circulatory problems that led to amputation of his left leg.

U.S. District Court Judge Thomas G. Hull ruled in favor of Reynolds on a summary judgment motion, saying attorneys for plaintiff Floyd Roysdon failed to show the cigarettes were defective and unreasonably dangerous. The ruling came on the fifth day of the trial in which Mr. Roysdon, 51, was seeking $55 million from Reynolds.

The suits are two of about 40 such suits nationwide.

Also, courts in the San Francisco area recently dismissed more than 300 cross-complaints brought by GAF Corp. against various tobacco companies seeking contributions to damage awards for asbestos-related diseases (*BI*, Oct. 14).

However, a GAF spokesman said the cross-claims were dismissed only on procedural grounds, and GAF plans to to file lawsuits against the tobacco manufacturers.

Howden units reach settlement

LONDON—Two Alexander Howden Group units say they have reached an agreement to settle a lawsuit filed by about 300 members of Ian Posgate's syndicates.

Under the agreement, Alexander Howden Underwriting and Alexander Howden Group Ltd., a brokerage unit, would pay members 13.4 million pounds ($19 million). Alexander Syndicate Management, the agency representing the members, says it will recommend that the names accept the offer.

The litigation stems from alleged mismanagement of Syndicates 126 and 127 by some former Howden officers and directors before Alexander & Alexander Services Inc. acquired Howden in 1982.

New York adopts MGA rules

NEW YORK—Insurers and reinsurers in New York that contract with managing general agents now must file disclosure forms with

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Mafia members tried to bilk Hall affiliate, indictment says

By DOUGLAS McLEOD

NEW YORK—The insolvent Union Indemnity Insurance Co. of New York is listed among the victims of fraud in an indictment of nine reputed Mafia members.

The 28-count federal racketeering indictment—handed up Dec. 19 in U.S. District Court for the Eastern District of New York—outlines a wide-ranging racketeering conspiracy that included schemes to defraud Union Indemnity, a union pension fund and several major corporations, including Chubb Corp., Mobil Oil Corp., General Motors Corp., Beneficial Commercial Corp., Chemical Bank and First National Bank of Chicago.

Named in the indictment is Michael Franzese, 34, a reputed member of New York's Colombo crime family. According to the indictment, Mr. Franzese operated or controlled 18 corporations through which money from the alleged racketeering activities was funneled.

Mr. Franzese has denied any connection to organized crime.

Also named are eight others identified as employees or associates of Mr. Franzese or his companies.

The indictment, charging violations of the federal Racketeer Influenced and Corrupt Organizations Act, describes a total of 21 separate acts of alleged racketeering.

One of these acts involved a scheme to defraud the state of New Jersey and Union Indemnity, a subsidiary of Frank B. Hall & Co. Inc. that is currently being liquidated by the New York Insurance Department.

According to the indictment, Mr. Franzese and two others arranged for Associated Facilities of America Inc.—an agent of Union Indemnity based in East Meadow, N.Y.—to issue a guarantee bond covering New Jersey state motor fuels tax owed by Houston Holdings Inc.

The original $60,000 amount of the bond, issued in 1983, was increased to $500,000 in 1984, according to the indictment.

As part of a scheme to defraud the state and Union Indemnity, Houston Holdings defaulted on its obligation to pay about $3.1 million in state motor fuel taxes, according to the indictment.

The indictment does not say whether Union Indemnity actually paid on the bond before entering liquidation last July (*BI*, July 22).

Officials in the U.S. Attorney's office and the New York Insurance Department could not be reached last week for comment.

(Union Indemnity also issued a $750,000 construction

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Valve implant is trigger for coverage

By STEPHEN TARNOFF

SAN FRANCISCO—A U.S. appeals court says insurance coverage for the manufacturer of a contaminated heart valve that caused injury over the course of two policy periods was triggered when the valve was implanted.

Comparing the case to asbestos coverage cases, the 9th Circuit U.S. Court of Appeals adopted the exposure theory of liability, ruling that the bodily injury took place when the valve was implanted, and not over the length of the injury.

The court specifically rejected the view that two policies should be triggered because there was a continuous injury to the victim over the course of the two policy periods.

The case involved an aortic heart valve manufactured by Hancock Laboratories Inc. of Anaheim, Calif., that was implanted into the heart of William Outlaw Jr. in December 1976.

The valve was contaminated with bacteria, forcing Mr. Outlaw to undergo another operation for removal of the valve and implantation of a replacement on June 21,

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Newest CGL changes affect five-year tail cover

By ROBERT A. FINLAYSON

NEW YORK—The most recent amendments to the commercial general liability claims-made form make it easier for policyholders to trigger the automatic five-year tail coverage.

An amendment filed by the Insurance Services Office with state regulators on Dec. 23 makes it clear that to trigger coverage under the five-year tail, the policyholder need only supply information about an occurrence that could give rise to a claim to the extent that information is available.

The amendment was prompted by discussions between ISO and state regulators, who worried that the current policy language could allow an insurer to deny coverage under the five-year tail if the policyholder could not provide detailed information about an occurrence.

Claims-made CGL policyholders automatically receive the five-year tail coverage if the retroactive date of their coverage is changed.

The tail provides coverage—subject to the aggregate limits of the policy—for claims stemming from occurrences before the retroactive date of the new policy that are reported to the insurer after that date.

However, the occurrence must be reported to the insurer within 60 days of the expiration of the prior policy to trigger the automatic five-year tail. And, the automatic tail does not apply if other insurance is in place to cover the claim.

ISO included the automatic five-year tail in its October revision of the claims-made form to allay concerns raised by risk managers and brokers that insurers would advance a CGL policyholder's retroactive date, creating a gap in coverage. The automatic tail would—to a limited extent—prevent such a gap (*BI*, Oct. 14).

"Unlimited" tail coverage—which provides an unlimited time period in which to file claims, subject to the aggregate limit of the

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Mission affects other firms' Best ratings

By JUDY GREENWALD

NEW YORK—Mission Insurance Co.'s financial problems are impacting A.M. Best Co.'s evaluation of other property/casualty insurers.

The president of Indianapolis-based Protective Insurance Co. said his company has been placed on Best's "watch list" because of reinsurance recoverables owed to Protective by Mission, which was ordered into conservation in California in October.

The results of insurers on the watch list have deteriorated since the beginning of 1985, but the decline has not been significant enough to warrant a change in alphabetical ratings, according to Best. Thus, Protective retains its A rating.

However, Best changed the rating of Integrity Insurance Co., based in Paramus, N.J., to "omit," Best's lowest, from "not assigned" partly because of reinsurance recoverables due from Mission (*BI*, Dec. 23).

In addition, Investors Insurance Co. and subsidiary Chesapeake Casualty Co. were placed on the watch list because of large recoverables due from Mission. Both insurers have A-plus ratings.

Officials of the Ramsey, N.J.-based insurers could not be reached for comment.

Besides those insurers whose ratings have been affected by Mission's financial difficulties, other property/casualty insurers that either were placed on the watch list or whose ratings were downgraded by Best as part of its nine-month insurer evaluations include:

- First Southern Insurance Co. of Tampa, Fla., whose rating was changed to "deferred" from B-plus. A deferred rating means a significant but non-recurring event since year-end affected Best's evaluation of a company. In First Southern's case, Best cited new ownership and management.

First Southern had been placed on Best's watch list last month (*BI*, Nov. 18).

- South Carolina Insurance Co. in Columbia, S.C., a member of the Seibels Bruce Group. The insurer was placed on the watch list but retains a B-plus rating. Change in leverage was given as the reason by Best.

An insurer's leverage is determined by looking at its exposure to pricing errors or errors of estimation in its liabilities, as well as its exposure to contingent adjustments and the security of its reinsurance.

- Dependable Insurance Co. of Jacksonville, Fla., which was placed on the watch list with an A-plus (contingent) rating. Leverage also was cited as the reason.
- Country-Wide Insurance Co. in New York was placed on the watch list because Best found problems with its profitability and leverage. It has a B rating.
- RGAF Underwriters of Ocala, Fla., which had been slated to be assigned a rating in 1986, was given an

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Top stories of 1985

Risk managers select rate hikes, ISO form

History repeated itself in 1985—at least as far as risk managers are concerned.

The stories selected by members of the *Business Insurance* Risk Management Board as the top two events of 1985 were the same subjects that ranked first and second in last year's survey.

The risk managers overwhelmingly selected as the most important story of the year the massive rate hikes and capacity shortfalls in the property/casualty insurance marketplace.

After years of purchasing insurance at cut-rate prices, commercial insurance buyers saw the first signs of a market hardening in 1984 as rates began to rise. But, those increases were mild compared with rate hikes in 1985, as insurers—attempting to recover from record losses—sometimes increased rates more than 1,000%.

Along with higher rates, insurers drastically slashed the maximum limits they offered for many types of coverage. And, risk managers found it impossible to find some types of coverage, like municipal liability, day-care center liability and liquor liability insurance (see synopsis, page 21).

Judging from insurers' and reinsurers' predictions, the hardening market may repeat as the top story of 1986. Based on these forecasts, corporations can expect available limits in 1986 to again be drastically reduced, while the coverage that is available will be much more expensive.

The story selected as the year's second most-important story was the Insurance Services Office's proposed claims-made and occurrence commercial general liability policy forms.

ISO, which released its controversial claims-made CGL form in late 1984, continued to lobby for the form's acceptance by Jan. 1, 1986, despite the vociferous opposition of risk managers and insurance regulators (see synopsis, page 22).

In addition, ISO proposed in the spring to include all defense costs within the aggregate policy limits of the new CGL form beginning July 1, 1986, but softened this stance in December.

ISO amended its CGL proposals several times during 1985 to help blunt this criticism, but as the year drew to a close, the forms were ready for implementation on the Jan. 1. target date in less than one-third of the states.

The importance that risk managers assigned to the hardening market and the CGL proposals is evidenced not only by their return to the top of the annual *BI* survey but also in the huge number of votes the two stories garnered.

The hardening insurance market captured 185 of 210 possible points. Thirty of the 42 risk managers responding to the survey ranked this story as the most important of 1985, while another seven risk managers cast second-place votes for the story.

The CGL forms attracted 148 points, including eight first-place votes and 20 second-place ballots.

The story that was ranked as the No. 3 story of 1985—the continuing collapse of the environmental impairment liability insurance market—trailed the top two stories by a huge margin, attracting only 39 points and no first-place votes.

While 40 of the 42 participating risk managers said the hardening market was one of the year's top stories and 38 voted for the CGL forms; only 15 risk

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Benefit managers tap events in Washington

For the third consecutive year, most of the top employee benefit stories were produced in Washington.

Four of the five stories that members of the *Business Insurance* Employee Benefits Board selected as the most important benefit stories of 1985 involve Washington-based developments.

The clear favorite among benefit managers as 1985's most important story was the effect of tax reform packages on employee benefit plans (see synopsis, page 11).

The story selected as the third most significant of the year was legislation now awaiting final congressional approval that would require employers to extend their group health insurance plans to employees' widowed and divorced spouses and to employees who lost their jobs (see synopsis, page 12).

A Supreme Court ruling upholding the rights of states to impose minimum benefit requirements in group health insurance policies was selected as the No. 4 story of the year (see synopsis, page 12).

And, the fifth-place story was a Department of Health and Human Services study advocating restrictions on flexible spending accounts because they undermine health care cost containment and because they cost the federal government billions of dollars in lost revenues (see synopsis, page 13).

The only non-Washington story selected as one of the top five stories of 1985 was court rulings barring employers from making unilateral cuts in retirees' health care programs. That story was voted the second most significant story of 1985 (see synopsis, page 11).

To determine the top employee benefit stories of the year, *Business Insurance* sent a list of the major stories of 1985 to members of its Employee Benefit Board. Board members 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 points 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 point for each fifth-place vote.

The hands-down choice as the top story of the year among the 46 benefit managers responding to the survey was the affect of tax reform proposals on employee benefit plans.

The tax reform story amassed 199 total points, the highest cumulative score by a wide margin. In fact, the 33 first-place votes received by the tax reform story was more than six times greater than the five first-place votes earned by the story on court rulings on post-retirement health care benefits, which generated the second highest total number of points.

Tax reform also garnered five second-place votes, three third-place votes, two fourth-place votes and one fifth-place vote.

The selection of tax reform as the most significant story in 1985 will come as little surprise to benefit managers.

No other development, inside or outside of Washington, would so negatively affect benefit plans as tax reform.

For example, the tax reform revision package passed by the House of Representatives in mid-December imposes onerous new non-discrimination rules on 401(k) salary reduction plans and drastically cuts the maximum annual salary deferral limit to a plan to $7,000 from $30,000.

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Story	Number of votes 1st	2nd	3rd	4th	5th	Total points*
Rates rise and capacity shrinks	30	7	2	0	1	185
ISO pushes new claims-made form	8	20	8	2	0	148
EIL insurance market collapses	0	3	7	1	4	39
Best's ratings tumble for insurers	0	1	5	3	5	30
Product liability bill fizzles	1	0	2	5	2	23
Executives found guilty of murder	0	2	2	3	2	22
States act to curb insurance crisis	0	1	4	2	2	22
London writes claims-made forms	0	2	1	3	4	21
Public entities lose liability cover	0	1	3	3	1	20
Buyers create own capacity	0	1	2	3	1	17

*Five points awarded for first-place votes, four points for second-place votes, etc. Source: *BI* survey

Story	Number of votes 1st	2nd	3rd	4th	5th	Total points*
Tax reform threatens benefit plans	33	5	3	2	1	199
Courts back retiree health benefits	5	7	13	4	5	105
Extending spousal benefits urged	2	8	3	7	4	69
State-mandated benefits OK'd	1	5	3	4	1	43
HHS suggests terminating FSAs	0	1	7	4	4	37
The changing health care system	3	1	2	3	4	35
Congress mulls major PBGC bills	0	1	4	4	3	27
Employers gather health care data	1	1	1	1	4	18
Employers tap rich pension plans	0	0	2	2	4	14
PBGC hit with big terminations	1	0	1	2	1	13

*Five points awarded for first-place votes, four points for second-place votes, etc. Source: *BI* survey
Charts, page design: Amy Palmer

Washington emphasis for third straight year

This is the third consecutive year that Washington-based events have dominated *Business Insurance's* survey of top employee benefit stories.

In a similar survey of the most important stories of 1984, all five top stories came out of Washington (*BI*, Jan. 7). And, many of those stories repeated as the top stories of 1985.

The top benefit story in 1984 was Internal Revenue Service rules significantly limiting the use of flexible spending accounts.

The second-most significant story in 1984 was the increased vulnerability of employee benefit plans to administration and congressional attacks in the aftermath of President Reagan's re-election.

The third-most significant story in 1984 was expected restrictions on 401(k) salary reduction plans.

The fourth-biggest story in 1984 was the introduction of "flat-tax" proposals and their effect on tax-favored employee benefit plans.

Finally, the fifth-most significant story in 1984 was congressional approval of legislation restricting the kinds of taxable benefits that can be offered by cafeteria benefit plans.

Similarly, Washington-based events dominated the top benefit stories of 1983, as four of the five top stories stemmed from Washington developments (*BI*, Jan. 2, 1984).

In 1983, the top benefit story was the Supreme Court decision in the Norris case that sex no longer can be a factor in determining retirement benefits.

The No. 2 story of 1983 was President Reagan's Social Security commission's recommendations to shore up the Social Security program. During 1983, Congress enacted most of those recommendations.

The third-most significant story of 1983 was regulations drafted by the Equal Employment Opportunity Commission requiring employers to offer workers between 65 and 69 a choice of enrolling in corporate health plans or sticking with Medicare as their primary health insurer.

The fifth-biggest story of 1983 concerned congressional proposals to tax employees on employer health insurance contributions above certain levels.

The only non-Washington story included in the top five benefit stories of 1983 was employers' efforts to control health costs, which ranked fourth.

Benefit stories

Continued from previous page

The House-approved tax bill also drastically cuts the maximum annual benefit that can be funded through a qualified defined benefit plan to $77,000 from $90,000 and the maximum annual contribution to a defined contribution plan to $25,000 from $30,000.

Other tax reform proposals would have an even more severe effect on employee benefits. For example, the Reagan administration called for the elimination of 401(k) plans and taxing employees on a portion of the value of employer-paid group health insurance premiums.

While the story on court rulings limiting the right of employers to cut post-retirement health care benefits was a distant second with 105 votes, it collected the highest number—13—of third-place votes of any story.

And, the post-retirement health care story's five first-place votes trailed only the tax reform story.

The third-place story, legislation to require employers to extend group health insurance plans to employees' divorced and widowed spouses and to employees who lose their jobs, collected 69 votes.

While the health care extension story collected only two first-place votes, it garnered eight second-place votes, the most of any story.

Health care extension also received three third-place votes, seven fourth-place votes (more than any other story) and four fifth-place votes.

The fourth-place story—the Supreme Court decision affirming the right of states to impose benefit requirements on group health insurance policies—collected 43 votes, largely due to the five second-place votes it received.

The Supreme Court story collected only one first-place vote, but it did win three third-place votes, four fourth-place votes and one fifth-place vote.

The fifth-place story—the Department of Health and Human Services study urging restrictions on flexible spending accounts—didn't win any first-place votes. But the story, which received 37 total votes, received one second-place vote, seven third-place votes and four votes each for fourth and fifth place.

Almost making it into the top five stories of 1985, with 35 votes, was the continuing transformation of the health care delivery system. That story received three first-place votes, the most of any story not included among the top five.

In 1985, the traditional fee-for service health care delivery system was rapidly displaced by alternative delivery systems, such as health maintenance organizations and preferred provider organizations, which many experts see as less costly and more efficient options for providing health care to employees (*BI*, July 22).

HMOs are prepaid health care plans in which employees receive benefits for a fixed monthly fee. Under preferred provider arrangements, employers or their insurers negotiate rates and comprehensive utilization review programs with selected hospitals and doctors. Then, the health care plan is amended to encourage employees to use these preferred providers, which generates cost savings for employers.

Today, about 92% of all health care is reimbursed under the traditional fee-for-service system, while just 7% is paid for under the HMO system and just 1% under PPOs.

But by 1995, the fee-for-service share of the market could drop to 55%, while PPOs' share will grow to 25% and HMOs' share will hit 20%, according to health care experts interviewed by *Business Insurance*.

The seventh-place story, with 27 votes, was legislation to close loopholes that make it relatively easy for companies to terminate underfunded pension plans and shift the liabilities to the Pension Benefit Guaranty Corp.

Although this story failed to receive a single first-place vote, it did receive one second-place vote and four votes each for third and fourth places. It also received three fifth-place votes.

The PBGC legislation, tacked onto a budget reconciliation bill that was near congressional approval at year-end, would make it much more difficult and expensive for employers to terminate underfunded defined benefit plans.

For example, employers would be required to fully fund vested pension benefits before they could terminate a pension plan.

By contrast, an employer now can terminate a plan anytime it wants and its maximum liability to the PBGC for unfunded benefits is

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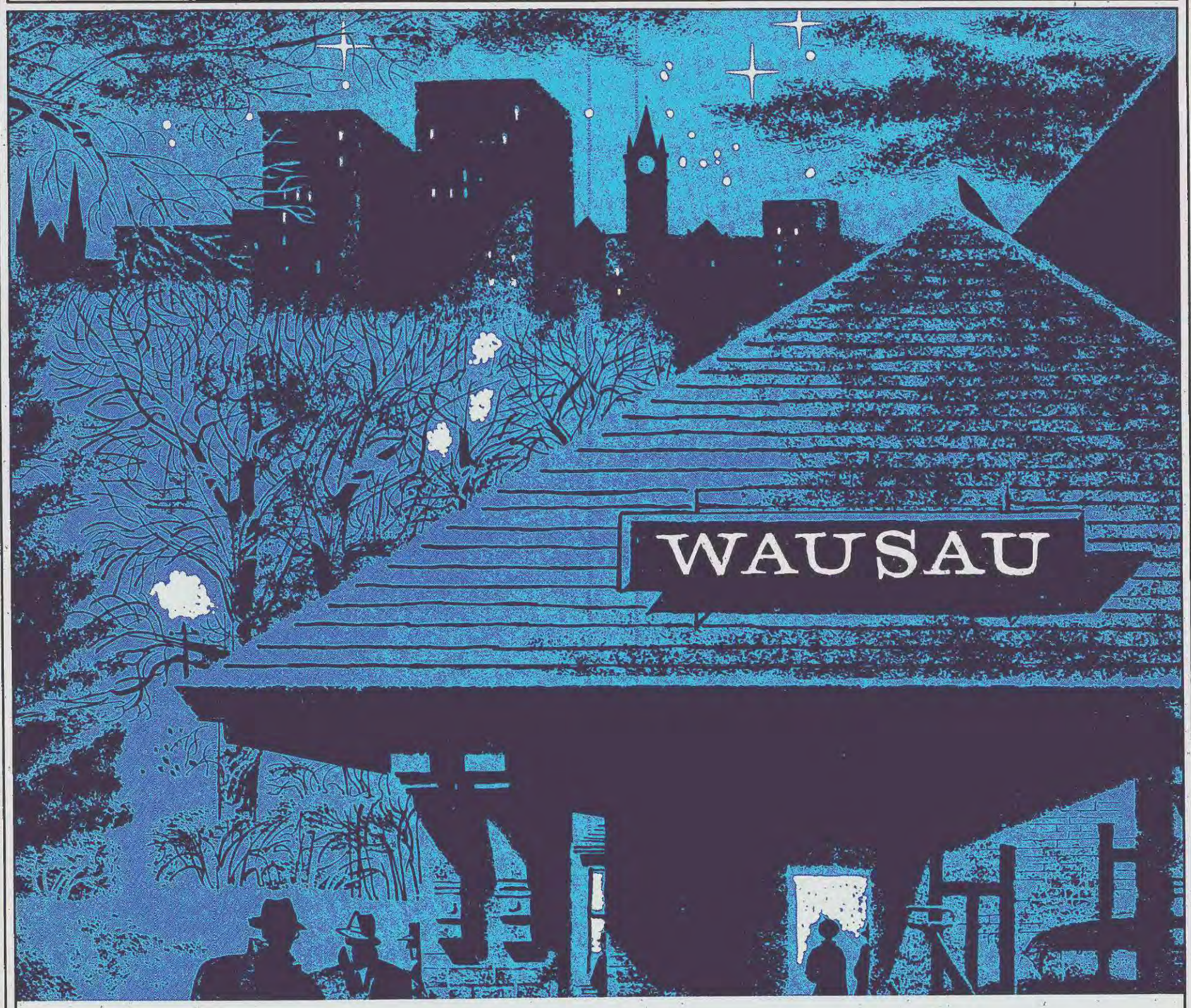

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CIGNA

Benefit stories

Continued from page 4

equal to 30% of the employer's net worth.

Companies with little net worth, like service firms with few corporate assets, may find it cheaper to terminate an underfunded plan and shift the liabilties to the PBGC than to continue operating the plan.

In addition, the legislation, which is designed to shore up the financial base of the PBGC and wipe out the agency's $1.3 billion deficit, would boost the annual premium employers with defined benefit plans pay the PBGC to $8.50 per participant from the current $2.60 (*BI*, Nov. 11; Nov. 25; Dec. 23).

The eighth-place story, which received 18 points, was employers' increased reliance on the analysis of health care data to help them control their health care costs (*BI*, March 18).

This story received one first-, second-, third- and fourth-place vote as well as four fifth-place votes.

Employers across the nation are asking more questions about what they are getting for their health care dollars and are asking for more data to analyze their health care expenditures.

In fact, employers' appetite for this new information has spurred the development of various "health care data consultants."

The ninth-place story, with 14 votes, was the increasing number of employers that have terminated overfunded defined benefit plans to recover excess assets (*BI*, Feb. 25; June 17).

This story received no first- or second-place votes; however, it did attract two third-place votes, two fourth-place votes and four fifth-place votes.

According to the PBGC, employers since 1980 have collected a total of $5.8 billion in excess assets from overfunded pension plans they have terminated.

During the year, several major property/casualty insurers, including Wausau Insurance Cos. and Fireman's Fund Insurance Cos., said they would terminate overfunded pension plans and add the excess assets to their policyholders surplus.

The record asset reversion was announced in June when United Airlines said it would terminate several plans to recover $962 million in excess assets.

In recent years, many pension plans have become overfunded because the booming stock market has boosted the value of plan assets far higher than anticipated.

On the other side of the pension spectrum, the 10th-place story was the huge claims faced by the PEGC from employers that terminated underfunded plans (*BI*, April 29; July 22; Nov. 4). This story received a total of 13 votes, including one first-place, third-place and fifth-place vote and two fourth-place votes.

During 1985, the PBGC was hit with the biggest claim in its 11-year history when Wheeling-Pittsburgh Steel Corp., a financially troubled steel producer, told the PBGC that it was terminating four large underfunded pension plans.

The PBGC estimated that the liabilities it would have to assume from the Wheeling-Pittsburgh plan terminations could total $475 million.

The Wheeling-Pittsburgh terminations shed new light on the PBGC's financial problems and may have given a push to Congress to act—after years of delay—on legislation to bail out the agency.

During the year, the PBGC also was hit with another jumbo-sized claim when Allis-Chalmers Corp., a diversified manufacturer in West Allis, Wis., said it would terminate a plan with just $5 million in assets and about $170 in unfunded vested benefits.

This story was written by Washington Editor Jerry Geisel

Washington concerns most benefit experts

By JERRY GEISEL

The constantly changing Washington legislative and regulatory scene was uppermost in the minds of employee benefit managers during 1985.

"Benefit departments can't keep up with the changes Washington... has proposed," said the benefit manager of an 8,000-employee manufacturing distributor in echoing the comments of many other benefit managers.

Indeed, during 1985 it seemed that a new and significant employee benefit development came bursting out of Washington almost every week.

It was a year of tax reform, in which legislators zeroed in on employee benefits—like 401(k) salary reduction plans, pension plans and group health insurance programs—as targets of new taxes and restrictions intended to pave the way for lower corporate and individual tax rates.

It was a year in which legislators reached agreement in setting new liability rules for companies terminating underfunded pension plans.

And, it was a year in which Congress was on the verge of passing legislation to require employers to

One benefit manager comments that 1985 was 'a year of anguish and uncertainty.'

open up their group health insurance programs to extend coverage to workers who lost their jobs and to employees' widowed or divorced spouses.

This swirl of legislative and regulatory activity aroused the anger of several benefit managers who responded to a *Business Insurance* Employee Benefit Board survey asking board members to rank the top stories of the year (see story, page 3) and to give their comments on 1985.

"There is legislative turmoil. How can we plan our work when we haven't the slightest idea of what the rules will be?" complained the director of compensation and benefits at a textile manufacturing company with 24,000 employees.

"A year of anguish and uncertainty," added the corporate benefits manager at an oil refinery with 1,000 employees.

"No consistent pension policy or tax policy—no one is looking at the big picture," said the director of compensation and benefits at a diversified manufacturing company with 6,000 employees.

Not surprisingly, several benefit managers said they had trouble keeping on top of all the Washington-related employee benefits developments.

"It was a never-catch-up year. As soon as one bill was passed, another came along," said the assistant treasurer for a basic steel manufacturer with 1,500 employees.

The year was "confusing and complex due to such things as interpreting and implementing changes from the Retirement Equity Act and following proposals on 401(k) plans," said a manager of benefits and compensation for an 800-employee company.

"The most hectic of my 25 years in benefits planning due to tax reform and the changing economic

Continued on next page

Continued from previous page
conditions in the industry," said one manager of employee benefit planning and policy administration.

Some benefit managers said the legislative uncertainty in Washington was affecting their own timetables to implement new benefit programs.

The lack of final 401(k) plan regulations from the Internal Revenue Service "is holding up implementation of a 401(k) plan in our company," said the assistant vp and benefit manager for an apparel manufacturer with 5,000 employees.

"Who wants to risk adding or expanding benefits in this type of atmosphere," commented a benefit manager at a 4,500-employee company.

And, as confusing as the Washington benefits scene has become, some benefit managers were warning that the worst may be yet to come.

1985 was "a year that a lot of smoke was generated with the potential for a large fire. Right now it is smoldering," said the benefits manager at a retail chain with 38,000 employees.

"ERISA will be a piece of cake compared to what is going to happen in the next 18 to 24 months," said the corporate benefits planning administrator at a utility with 1,400 employees.

Others described 1985 as a year of waiting for the outcome of benefit developments in Washington to be decided.

"A year of wait-and-see as legislative uncertainty continues," said the manager of corporate benefits at an aerospace and defense contractor.

"A year of unrest in the government's position on benefits," said the benefit manager of a construction materials manufacturer with 1,800 employees.

Some benefit managers predicted that when the waiting ends, the tax reform package won't contain much reform.

"Everyone was waiting for tax reform. But when the measure is passed by Congress, the bill will hardly be termed reform," said a personnel administrator for a chemical manufacturer with 9,000 employees.

Although many benefit managers worried about legislative and regulatory changes emanating from Washington, some benefit managers were more concerned about changes in their own workforces.

The benefits administrator at a rubber manufacturing company with 1,000 employees noted that his company's younger workers were much more resistant to higher health care plan deductibles and second opinion surgery programs compared with the older employees.

"This attitude (among young workers) could cause problems in 1986," the benefits administrator said.

Other managers, though, found that additional employee benefit cost sharing helped keep their costs under control.

"Our costs for benefits have been much less than expected. We installed many cost-shifting benefits in our plan, and I hope that made a difference," commented the director of human resources at a fabric manufacturing company with 200 employees.

But, the human resources director added, "Time will tell."

Other benefit managers noted that the move to alternative health care delivery programs, like preferred provider organizations and health maintenance organizations, seemed to accelerate.

"It appears a larger number of HMOs and PPOs are arriving on the scene," commented the employee benefits manager at a diversified manufacturing company with 5,000 employees.

"More employees are shifting to HMOs," added another benefit manager, but he also expressed concern about increasing HMO rates.

1985 marked "a shift from traditional to alternative benefit programs," said the corporate employee benefits director at a plastics processing company with 350 employees.

And one employee benefit manager, no doubt reflecting the feelings of many of his colleagues, was able to sum up 1985 in one word: "Hellish." ■

1985 marked 'a shift from traditional to alternative benefit programs,' one respondent says.

opinions

Some spirited predictions

IN THE HOLIDAY SPIRIT, we are suspending for one week words of counsel, criticism and complaint.

Instead, we offer some scenarios for the year ahead.

As commercial property/casualty insurance rates continue to climb and available limits shrink, we will see at the Risk & Insurance Management Society meeting in April in Toronto:

- Risk managers crying in their Canadian beer.
- Shrimp, shrimp, shrimp everywhere, as insurance brokers, rolling in big revenues, will try to outdo each other with lavish hospitality suites rivaling San Francisco-1981.
- Insurance underwriters, in short supply, eating at the best restuarants at the expense of brokers and risk managers hungry for coverage.

As the new claims-made commercial general liability form works its way into the marketplace, the acronym CGL will take on new meaning:

- For risk managers—Confusing and Greatly Lacking.
- For brokers—Chaos and Greater Liability.
- For insurers—Come and Get Less.

As a new tax bill finally emerges from Congress, we will see:

- Employee benefit lobbyists devastated, not by the contents of the bill but by their new unemployment.
- Employee benefit consultants elated, again not by the contents of the bill but by the revenue bonanza to follow in explaining the bill's provisions to employers.
- Employee benefit managers crying in their beer in Toronto.

And, following colorful characters in the insurance and risk management worlds in the year ahead, we will see:

- Former INA president, law student and now A.C.E. Insurance Co. consultant John Cox—burned out by the strain of reviewing underwriting submissions to A.C.E.—go back to school again, this time to study crowd control, only to leave again to open a cigar store in Pago Pago.
- Lloyd's of London underwriter Stephen Merrett —dejected after Lloyd's refuses his generous offer to decorate its new building with two unique sculptures that greatly resemble satellites—escape on a space shuttle flight.
- Risk manager and RIMS President P. Richard Hackenburg—after a year of perfecting his art of diplomacy, stamina for travel and style of public speaking and becoming accustomed to the title "Mr. President"—declare his candidacy for the Republican presidential nomination to make a federal issue of the new claims-made form.

letters

J. Robert Hunter deserved better treatment

To the editor: I object to both the tone and accuracy of your editorial "Tort Reform Drive Not New" (*BI*, Dec. 9). Having heard the entire testimony given before the Senate Subcommittee on Business, Trade and Tourism, I came away with an entirely different perception of J. Robert Hunter's testimony. As a public entity risk manager for the past five years, I believe you cannot dismiss Mr. Hunter as a "self-proclaimed consumer advocate."

Our civil justice system is a system by which our citizens resolve the issues of modern society, not in a perfect vacuum, but in the imperfect world we all live in.

Tort reform has been going on in this country for 200 years. Our citizens have demanded that all entities, public or private, be held accountable for their actions. And, we are better for this, even if, at times, we must handle claims that are frivolous and seemingly without merit. This is a price of our citizenship.

The insurance industry has not been isolated during the evolution of our civil justice system. When the market was soft, insurers seemed to be content to collect premiums and pay claims.

Mr. Hunter's testimony has not been refuted by the industry very well. To date, insurers have not produced any empirical data that suggests there is any link between the number of claims filed and claims paid, let alone a direct relationship between paid claims and the losses of the industry.

Mr. Hunter did refute the testimony of the insurance lobby and was prepared to demonstrate that the actual financial performance of the insurance industry was at its all-time best at Sept. 30, 1985. Insurers cannot adequately explain how this could be during what they claim is the worst loss cycle ever.

Furthermore, Jerry Geisel, reporting on the hearing in the same issue, quoted me several times, which implied that he was present when I gave my testimony or that he interviewed me (*BI*, Dec. 9). Neither was the case. Mr. Geisel apparently left before I spoke and lifted, as direct quotes, the testimony in the written statement of the Public Risk and Insurance Management Assn.

In all, it was a grave disservice to your newspaper as a source of unbiased reporting of not only the facts, but also the tone and subtleties of what transpired.

Mark Ferraro
Risk Manager
City of Dallas

Editor's note: Mr. Geisel attended the hearing. Mr. Ferraro's comments reported in Business Insurance were taken from his written testimony.

Business Insurance welcomes letters from its readers. Please keep your comments as brief as possible. We reserve the right to edit letters for clarity or space. We will not publish unsigned letters. Send your comments to Letters to the Editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611.

Aggregate limits the real problem with CGL

To the editor: I have been following much of what has been written concerning the new claims-made general liability policy about to be foisted on the American public.

Frankly, I am not sure whether I am in an "Alice in Wonderland" environment or whether I am experiencing a "forest for the trees" syndrome.

Everybody seems to be concerned about the technical aspects of "claims-made" vs. "occurrence," and much has been made by all concerned about retroactive dates, laser endorsements, etc. Frankly, all these items are mechanical, the details of which we will have to learn to live with.

What startles me is the apparent lack of concern for the one item that contains a built-in potential for absolute disaster for American business: the implementation of aggregate limits.

So far, I have attended two seminars on the subject of the new CGL policy. When I raised the question of how to monitor impairment of aggregate limits and their reinstatement, the best that I got from a major national insurer was a blank stare and a promise to "check with the home office and get back to you." The major insurer went on to point out that the program has been approved in 27 states and it is the insurer's intention to implement the program as of Feb. 1, 1986, even though there was no answer on impairment of aggregate limits!

It is not too difficult to picture a scenario wherein several outstanding claims are not adjudicated until many years after the expiration of the policy. It would appear that the first ones adjudicated get whatever is left of the pie until the aggregate is exhausted. The insured is then left with the alternative of either paying the remaining judgments or going bankrupt since reinstatement of the aggregate several years after expiration is obviously impossible.

Perhaps the solution to this dilemma would be for the Insurance Services Office to provide for *automatic* reinstatement, regardless of whether the policy has expired. The amount of coverage reinstated could be to the exact dollar required by the judgment, and the premium therefore could be proportional to the final audited premium for the original policy.

Another alternative might be for the insured to set up a series of holding companies with subsidiary operating companies with no assets. These subsidiaries could then be simply collapsed, leaving the poor claimant out in the cold.

I hope that the ISO pundits can display additional "wisdom"and come up with a solution.

Warren G. Aaronson
Executive Vp
National Coverage Corp.
Seaford, N.Y.

Let the regulators fund state guaranty funds

To the editor: Guaranty funds were originally enacted to convert the deficiencies of the insurance commissioners in regulating the solvency of insurers. An exposure is not cured by insuring it. Any good risk manager knows it is less costly to prevent a loss than to insure it.

With respect to "big guy versus little guy," where do the financial resources of the big guy come from? (*BI*, Nov. 25, Dec. 9, 16) A large portion of these resources come from the little guy who buys stock to save for retirement needs.

I know how more money could be generated for guaranty funds: Let's make the states give back that portion of the premium taxes (which, in theory are collected to pay for insurance regulation) that they stole for their insurance departments to enrich their general funds.

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Tax reform is top benefits story of 1985

The concept behind tax reform is simple: Lower basic corporate and individual tax rates and then pay for these cuts by eliminating hundreds of tax breaks.

The Reagan administration and many congressmen embraced the concept.

But as benefit managers were to discover, one of the ways the administration and legislators planned to pay for lower basic rates was to wipe out the tax-favored status of many employee benefits.

All of the tax reform packages unveiled during the year proposed sweeping changes in major employee benefit programs (*BI*, June 3, Sept. 9, Oct. 7, Nov. 11, Dec. 2, Dec. 16, Dec. 23).

For example, the bill eventually passed by the House, known as the Tax Reform Act of 1985, would make massive changes in 401(k) plans, defined benefit and defined contribution plans and health care programs.

These changes included:

- Lowering the maximum salary deferral limit in a 401(k) plan to $7,000 from $30,000; reducing employee contributions to Individual Retirement Accounts by the amount deferred to a 401(k) plan; slapping a 15% excise tax on pre-retirement "hardship" withdrawals of 401(k) funds; and imposing strict and complex non-discrimination rules on 401(k)s.
- Cutting the maximum annual benefit offered by a defined benefit plan to $77,000 from $90,000 and the maximum annual contribution to a defined contribution plan to $25,000 from $30,000.
- Setting uniform non-discrimination rules for welfare-type plans, requiring they be available to at least 90% of employees.
- Imposing a 10% excise tax on reversions from overfunded pension plans.

Benefit lobbyists in Washington had their hands full trying to keep up with the various proposals, let alone lobby against them.

For example, late last year, the Treasury Department proposed the elimination of 401(k) plans. Then, in May, the administration proposed an $8,000 limit on 401(k) deferrals and new non-discrimination rules. In August, it backtracked and again proposed eliminating the plans.

Meanwhile, in Congress, the Ways and Means Committee staff in September proposed a $5,000 deferral limit and somewhat different non-discrimination rules.

Finally, Ways and Means and the full House accepted a $7,000 annual limit on 401(k) plans and accepted elements of the non-discrimination rules proposed by staffers and the administration.

Just as benefit provisions changed constantly, so did predictions about the bill's fate. One week analysts pronounced tax reform dead, and then next week the legislation came back to life.

In the end, with some last-minute personal lobbying by President Reagan, the package cleared the House and was sent to the Senate Finance Committee, where a new round of battles awaits next year. ■

Courts defend retiree benefits

No one knows exactly how much in post-retirement health care benefits employers have promised but not funded. But, everyone agrees these liabilities are huge—and are growing.

Employers in 1985 worried that they would not be able to afford what they have promised and contemplated taking steps to cut costs, such as requiring retiree cost sharing.

But, courts consistently have refused to let employers make unilateral cuts in retirement programs, even when plan documents explicitly give companies the right to make changes.

In the latest such decision, U.S. District Court Judge Thomas Wiseman Jr. in Nashville, Tenn., ruled that retirees have a contractual right to promised post-retirement benefits and employers cannot unilaterally cut those benefits.

The promise to provide post-retirement health care is not a "mere gratuity," but a contract, the judge said (*BI*, Oct. 28).

Judge Wiseman rejected arguments by American General Corp., a Houston-based insurer, that "termination/modification clauses" in plan documents give employers the unilateral right to amend post-retirement health care plans.

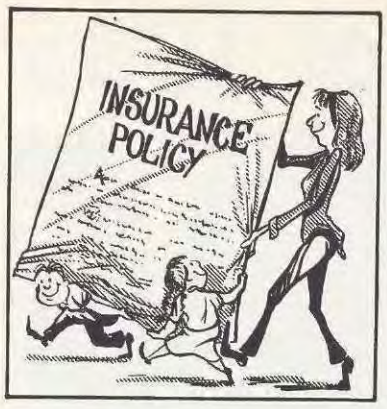
Judge Wiseman's ruling was only a preliminary injunction certifying a retirees' suit as a class action and barring American General from making any further cuts in benefits provided to the retirees—former employees of NLT Corp., a Nashville company bought by American General in 1982.

While the American General case has yet to be ultimately decided, it added to employers' fears that they may well be stuck with huge post-retirement liabilities.

Those fears began in 1984 when federal judges ruled that Bethlehem Steel Corp. (*BI*, Oct. 1, 1984) and White Farm Equipment Co. (*BI*, Oct. 29, 1984) could not unilaterally cut benefits.

Bethlehem Steel later agreed to a compromise (*BI*, March 18). The White Farm decision is on appeal. ■

The editorial cartoons appearing on pages 11, 12, 13, 21 and 22 were done by Roger Schillerstrom, a Chicago-based free-lance cartoonist.



Supreme Court rules states can mandate benefits

Employers and insurers in 1985 lost a decade-long battle to overturn state laws that require group insurance policies to offer certain employee benefits.

For years, employers and insurers joined forces to argue that a pre-emption provision in the Employee Retirement Income Security Act of 1974 bars states from regulating benefit plans covered by ERISA.

However, that battle was lost when the U.S. Supreme Court in June ruled that states do have the power to mandate benefit requirements in group insurance policies (*BI*, June 10).

In a case involving a 1975 Massachusetts law requiring all group health insurance policies to offer minimum mental health benefits, the Supreme Court justices said the scope of the pre-emption provision was explicitly limited by another provision in ERISA known as the "savings clause." That clause preserves any state law regulating insurance.

That 8-0 Supreme Court decision was a blow to group health insurers and their policyholders who had fought to escape the costly burden of designing policies to meet the varying requirements of different states.

Insurers said the administrative cost of complying with varying state laws—a cost that is passed on to employers—equals at least 10% of the policy premium.

Those laws, found in at least 26 states, usually require policies to offer coverage for mental illness, drug abuse and alcoholism.

With the Supreme Court giving its blessing, states are expected to add more benefit mandates, further increasing administrative complexity and costs for employers who operate nationwide.

The cost of complying with more state benefit requirements could force employers to drop other, more popular benefits, insurers warned.

The Supreme Court decision, though, gave employers added incentive to self-fund their health benefits.

The court made it clear that ERISA does pre-empt states from imposing benefit requirements on

Continued on next page

Budget bill may extend health plans

At year-end, Congress was on the brink of passing legislation to require most employers to amend their health care programs to extend coverage to millions of people.

Tacked onto a budget reconciliation bill, H.R. 3128 was a far-reaching proposal to require employers to extend their group health insurance programs to employees' widowed and divorced spouses as well as to employees who lose their jobs.

The bill would require employers to extend their group health care programs for three years to a former spouse and for 18 months to employees who lose their jobs.

If an employer does not meet these two provisions, the company would lose its federal tax deduction for health care coverage expenses.

However, employers would be allowed to charge spouses and former employees a premium of up to 102% of the cost of coverage.

For most employers, this extension of coverage would have to begin by July 1, 1986.

However, employers with 20 full-time employees or less would not have to extend health care coverage.

This new benefit mandate will cause administrative problems for employers who will have to track, try to collect premiums from and process claims for people who have no employment relationship with a company, experts warned.

In addition, benefit consultants said that only those who expect to use health care services would opt for continued coverage, creating adverse risk selection.

The health care extension proposal got its start in legislation introduced in January by Rep. Fortney (Pete) Stark, D-Calif. His bill, H.R. 21, would have required employers to extend group health care programs for five years to spouses and dependents after an employee's marital status changed (*BI*, Jan. 14).

His proposal was later tacked onto a House budget reconciliation bill, while a somewhat different health care extension proposal approved by the Senate Finance Committee was added to the Senate's budget reconciliation bill.

House and Senate conferees in December then ironed out differences in the bills—chiefly in how long coverage should be extended to spouses.

Aside from causing massive administrative problems for employers, benefit experts warned that the health care extension legislation might be the forerunner of more congressional interference with the shape and content of employee benefit plans.

Congress could—by removing the tax-deductible status of other health care-related benefits—try to require employers to offer benefits it deems "socially desirable," experts said.

If that becomes the case, Congress—and not employers and unions—would determine the shape of group health insurance plans, they warn. ■

Continued from previous page
self-funded or uninsured group health plans.

"We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation, while the latter are not," the court said.

"By so doing, we merely gave life to a distinction Congress is aware of and one it has chosen not to alter," the court said.

The Supreme Court decision involved a Massachusetts law that requires insured employee benefit plans to offer at least $500 of coverage annually for outpatient mental health care.

In addition, the Massachusetts law requires benefit plans to provide coverage for at least 60 days of inpatient mental health care annually.

In 1979, Massachusetts asked a state Superior Court to declare that the mental health care law applies to insurance policies sold to employers.

The state also asked that Travelers Insurance Co. and Metropolitan Life Insurance Co. be ordered to comply with the law.

The Superior Court and later the Massachusetts Supreme Judicial Court ordered the insurers to comply with the law. The insurers then appealed those rulings to the U.S. Supreme Court

The insurers argued that the savings provision in ERISA was meant to exempt from pre-emption "traditional" state insurance laws, like reserve and solvency requirements, and not "innovative" laws that set benefit requirements.

But the Supreme Court said there was nothing in ERISA to distinguish between different types of insurance laws.

"The presumption is against preemption, and we are not inclined to read limitations into federal statutes in order to enlarge their preemptive scope.

"Further, there is no indication in the legislative history that Congress had such a distinction in mind," according to the court's decision. ■

FSAs survive HHS attack

Flexible spending accounts, so far, have survived a scathing attack from the U.S. Department of Health and Human Services.

In a highly controversial study, the department said FSAs should be prohibited because they actually undermine health care cost containment and reduce federal tax revenues (*BI*, May 27).

"The natural, sound policy response to these arrangements is to prohibit them," the department concluded in its "Study of Cafeteria Plans and Flexible Spending Accounts."

The agency's attack on FSAs stunned employers and benefit consultants, who for years had said the popular and rapidly growing funding arrangements enhanced cost containmemt.

Under a typical FSA, employees agree to reduce their pretax salary by a certain amount.

Funds generated through salary reduction are placed into an account, known as an FSA, and then can be used to pay expenses not covered under a group health insurance plan, such as deductibles and coinsurance, vision and dental care costs, dependent care and legal expenses.

As a sweetener, employers sometimes add their own contributions.

At the end of the year, the employee typically could cash out the balance remaining in an FSA and pay tax on that amount or roll over the balances into a savings plan.

Since July 1, though, employees have had to forfeit balances in the FSA at the end of the year under the "use it or lose it" rule of the Internal Revenue Service.

Employers had championed FSAs as a cost-containment weapon. They said allowing employees to pay for uncovered health care expenses with pretax dollars makes it easier for companies to convince workers to accept cost-containment features like higher deductibles and coinsurance levels.

But the Department of Health and Human Services came to the opposite conclusion.

In its study, the agency said FSAs boost health care expenditures and reduce federal revenues because they inflate the demand for health care services and allow uncovered benefit expenses to be paid with pretax instead of aftertax dollars.

The study was based on a complex model set up by researchers and drew heavily upon a study by the Rand Corp. that found that use of health care services decreases if employees pay more of the costs.

Using pretax dollars is a change "equivalent to a price decrease," the study said.

Aside from inflating the demand for health care, FSAs cost the government billions of dollars in lost revenues because out-of-pocket benefit expenses that had been paid by employees with aftertax dollars would be paid with pretax dollars, lowering employees' taxable income, the report said.

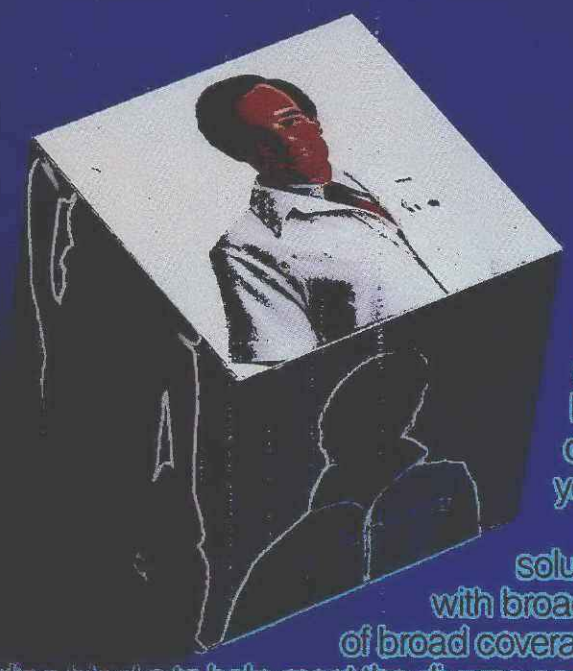
But consultants said the study missed a key point: When employers establish an FSA, they also change their health care plan to require more employee cost sharing.

When employees pay a greater share of health care costs, health plan use decreases, experts said.

And, as utilization decreases, employers' health care expenses can be cut and their health insurance premiums lowered. ■

THE EMPLOYEE BENEFITS PUZZLE

The Unionmutual solution



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. . . and in Flexible Benefits.

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*Employee Benefit Plan Review, April 1985

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The 12 Days of Underwriting

On the first day of January
My underwriter said to me:
I'll give you the business for free.

On the first day of February
My underwriter said to me:
Capacity is yours, and
I'll give you the business for free.

On the coldest day of March
My underwriter said to me:
Throw in the quake,
Capacity is yours, and
I'll give you the business for free.

On the first day of April
My underwriter said to me:
J&H's form,
Throw in the quake,
Capacity is yours, and
I'll give you the business for free.

On the finest day of May
My underwriter said to me:
Let's do a deal,
J&H's form,
Throw in the quake,
Capacity is yours, and
I'll give you the business for free.

On a summer's day in June
My underwriter said to me:
Raise the commission,
Let's do a deal,
J&H's form,
Throw in the quake,
Capacity is yours, and
I'll give you the business for free.

On July 27th
My underwriter said to me:
Penny DIC,
Raise the commission,
Let's do a deal,
J&H's form,
Throw in the quake,
Capacity is yours, and
I'll give you the business for free.

On a dog day in August
My underwriter said to me:
I'll take the lead,
Penny DIC,
Raise the commission,
Let's do a deal,
J&H's form,
Throw in the quake,
Capacity is yours, and
I'll give you the business for free.

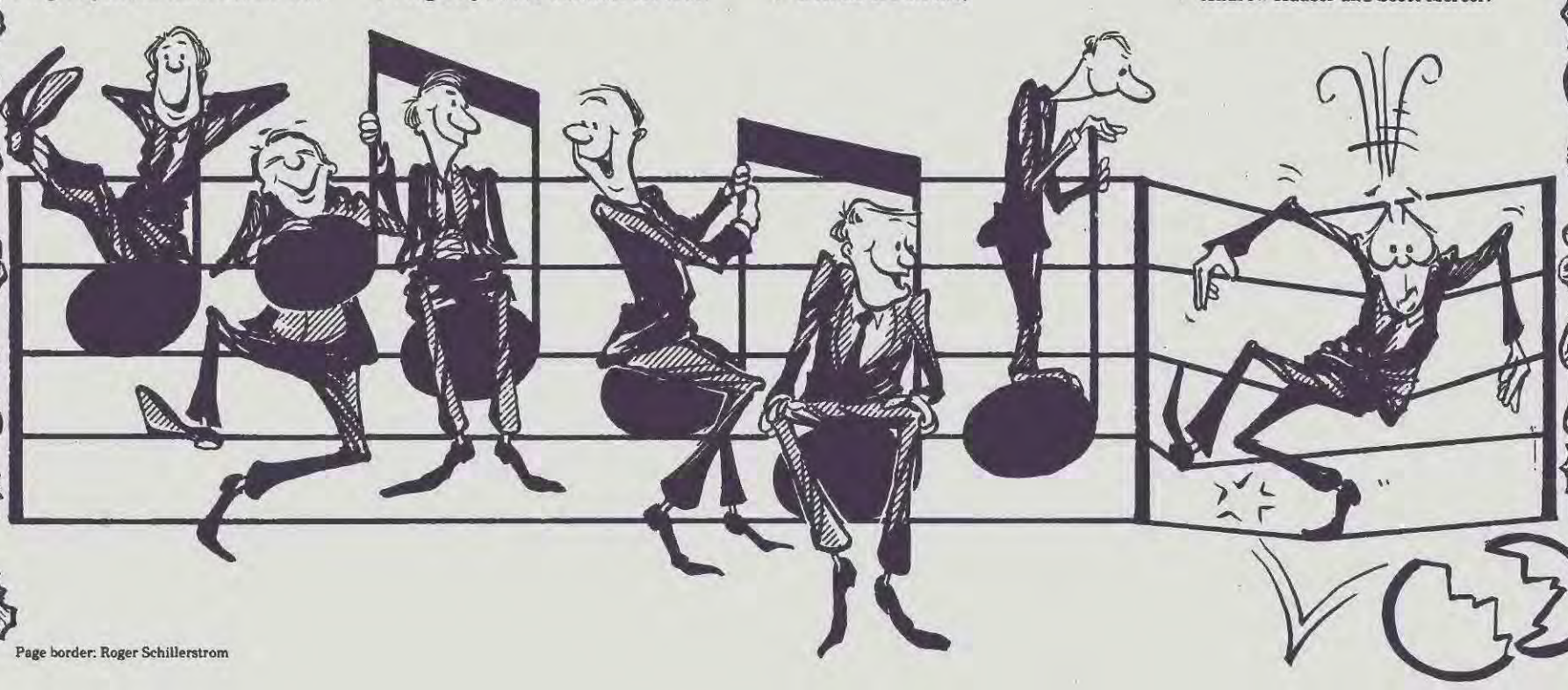
On a cool day in September
My underwriter said to me:
Declare ACV,
I'll take the lead,
Penny DIC,
Raise the commission,
Let's do a deal,
J&H's form,
Throw in the quake,
Capacity is yours, and
I'll give you the business for free.

On a brisk day in October
My underwriter said to me:
Drinks are on me,
Declare ACV,
I'll take the lead,
Penny DIC,
Raise the commission,
Let's do a deal,
J&H's form,
Throw in the quake,
Capacity is yours, and
I'll give you the business for free.

On a Monday in November
My underwriter said to me:
I'll come to you,
Drinks are on me,
Declare ACV,
I'll take the lead,
Penny DIC,
Raise the commission,
Let's do a deal,
J&H's form,
Throw in the quake,
Capacity is yours, and
I'll give you the business for free.

On a bleak day in December,
My underwriter said to me:
Market's gone hard,
You come to me,
Drinks are on you,
Declare RCV,
Excess of lead,
Nickel DIC,
Cut the commission,
FOR-GET THE DEAL,
ISO form,
Throw out the quake,
No capacity, and
We'll take all your business risk-free.

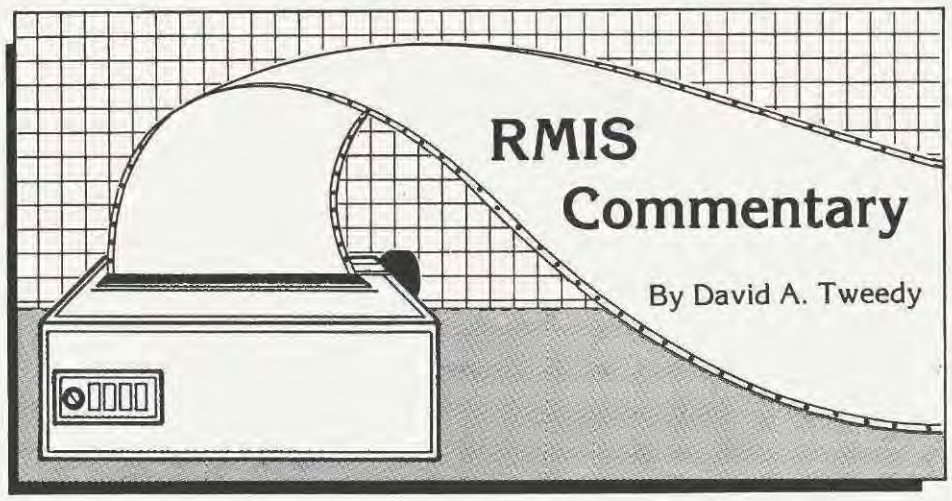
This holiday effort was prepared by Jerome Karter, vp and manager of the New York International Department of Johnson & Higgins, and his colleagues, Andrew Haaser and Scott Mercer.



Page border: Roger Schillerstrom

perspective

Hard market fuels demand for RMIS



WITH THE hardened insurance market wreaking havoc on the risk management community, it should not come as a surprise that there is an impact on the demand for risk management information systems.

But, the questions are, "What type of impact?" and "What is the scope of the impact?" And, answers to those questions may surprise many.

Generally, RMIS vendors believe that the hard market is good for business. The reason: Risk managers are finding that data from an RMIS are more acceptable to underwriters. Also, advanced modeling capabilities give the user a better gauge for comparing insurance and non-insurance options.

Yet, there is a dilemma: With soaring premium increases, how can a risk manager afford to buy or lease a sophisticated RMIS to help during the current crisis?

At the beginning of the difficult insurance market in early 1985, a major broker—using a well-known RMIS provider system—ran an advertisement that roughly said, "Now that the competitive cycle has ended and there is a requirement for good, solid exposure and loss information, do you have it?"

In other words, he was asking, had the risk manager invested in an RMIS?

But, it is easy to have such 20/20 hindsight. One of the problems facing the risk manager trying to convince management to invest in an RMIS during the soft, competitive cycle was senior executives' perception of the management value of an RMIS.

After all, it seemed that rate reductions of 25% to 50% occurred every year, so what was the need for a sophisticated, expensive information system?

Now, with rates increasing at sometimes phenomenal levels, management may be reluctant to spend additional money for an RMIS. So, the risk manager is in a classic Catch-22 situation.

Another problem facing potential buyers—then and now—is the proliferation of systems and vendors.

Even with some computer background, it is difficult to choose the correct software and vendor to handle the RMIS needs of a company. And, this confusion understandably causes caution on the part of buyers.

And, another problem is the time a risk manager must invest installing and implementing the RMIS.

No matter how "user friendly" the system is, there is an initial commitment of time that must be made before the RMIS is of any real value.

Despite these problems, however, the demand for risk management information systems continues to rise as the market hardens.

There are several reasons, including:

- Increased fear among buyers that insufficient information will result in less-desirable quotes from insurance companies.

With the return of underwriting as a decision-making force in renewals, there is an increased demand for solid exposure data presented in a well-documented fashion. Underwriters have come to expect not only more supporting exposure data, but also better-presented data before they will issue quotes.

So, fear on the part of buyers that they will get poor quotes—or no quotes at all—has increased the demand for an RMIS with good data summary and analysis capabilities.

As we have discussed earlier in this column, a well-designed RMIS can generate this information from its data base. The accuracy and speed of data analysis and presentation are far better with an RMIS than with a manual operation.

Many underwriters assert that receiving data from a risk management information system usually results in their issuing a better quote than they would have had they received manual information.

Therefore, more risk managers are turning to risk management information systems to prepare that information and maintain it. And, this is a trend that should continue throughout the remainder of the hard cycle.

- Better quantitative analysis of insurance vs. non-insurance options. When insurance becomes either too expensive or unavailable—because of disappearing capacity or the unwillingness of insurers to write coverage—it becomes necessary to explore other risk-financing options.

Captives, rent-a-captives, self-insurance, trust agreements, etc., are some options that should be explored and compared in terms of the best dollar return on investment.

And, a well-designed RMIS with the correct analytical features can be a very useful tool in helping the risk manager sift through many different proposals.

And, again, the RMIS can perform these analyses much more quickly and accurately than they could be done manually.

Also, an RMIS-generated financial analysis adds to the credibility of the recommendations the risk manager ultimately makes to senior management.

- Increasing management confidence in personal computers. More and more, senior management is amenable to, and even encouraging, increased use of PCs by their middle management.

For example, I have talked to many risk managers who just received IBM or Apple personal computers in their offices and were told to "do something with it."

Because many risk management information system vendors now are gearing up to produce off-the-shelf software to be used by these more common personal computers, this adds to the demand for the RMIS.

- Risk management professionalism. Risk management information systems more and more are becoming an integral part of the risk management professional's daily life. There is increasing acceptance of the value of an RMIS in record keeping, report production and analyses.

And, this is being translated into increasing willingness on the part of senior management to approve at least stand-alone systems, the cost of which does not exceed $15,000.

And, with staggering premium increases that more than double the risk manager's insurance budget in a given year, that investment on a one-time basis does not seem like much, if it can help the risk manager get a better handle on the situation.

- Data control. Another dilemma of the current hard market is that, while insurers are demanding better data from buyers before quoting, they are not very responsive in providing detailed and timely loss and premium information.

A well-designed RMIS has captured this data, and it is readily available to the risk management professional.

This type of data control is a very desirable feature of the RMIS, especially in the current difficult market.

These are some of the major reasons the demand for risk management information systems has not been affected adversely by the hard market.

The demand for stand-alone systems has increased dramatically, as might be expected because of their lower cost. But, even mainframe vendors and support providers are experiencing growth.

At the very least, we can say there is one good thing—from the buyer's viewpoint—that comes out of the hard insurance cycle: The increasing acceptance and use of the RMIS will help the risk management professional do a better job.

And, in these difficult days, that help is welcome. ■

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

Worker's refusal of treatment not unreasonable

legal briefs

New Mexico appellate court ruled that a worker's refusal to submit to recommended treatment was not unreasonable, since there was no proof that the disability would have been reduced even if the treatment was successful. Betty Brooks hurt her back in February 1979 while working as a school cook. Her employer's insurance company voluntarily paid her workers compensation benefits.

Thereafter, the employer petitioned the court to terminate Ms. Brooks' benefits for refusing to submit to medical and surgical treatments. The trial court ordered that her benefits be brought current, but also ordered that Ms. Brooks submit to a myleogram and other necessary care by a doctor.

A probable herniated disc was revealed and surgery was recommended by the physician. However, Ms. Brooks refused to undergo the surgery.

A second physician offered chemonucleolysis, another form of treatment, but, again, Ms. Brooks refused.

The employer then moved to terminate her workers compensation benefits. The trial court reduced her benefits by 50%.

On the appeal, the New Mexico appellate court said that unless an employee's refusal to submit to medical treatment was arbitrary and unreasonable, compensation cannot be denied.

According to the court, a major factor in evaluating whether an employee acted reasonably in refusing treatment is weighing the probability that the treatment would reduce the worker's disability by a significant amount against the possible risks associated with the treatment.

The appellate court said that, in this case, even if the risks connected with the medical treatment were minimal, the evidence failed to support a finding of any medical benefit that would reduce Ms. Brooks' disability.

Thus, according to the court, Ms. Brooks' refusal to submit to treatment was not unreasonable. *Brooks vs. Hobbs Municipal School*, Court of Appeals of New Mexico, Aug. 16, 1984 (*BI*/03/Au.-$5). ■

These abstracts were prepared by Cases Unlimited Inc. A copy of an entire decision may be obtained by sending a check for $5 made out to Cases Unlimited to Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. List the number for each opinion.

Rates, capacity top risk management story

Risk managers' jobs got tougher in 1985 as the tightening of property/casualty insurance markets that began in 1984 grew worse.

Reinsurance and direct insurance rates continued their upward spiral, while capacity dwindled.

The situation became so bad for some—including small businesses and municipalities—that state regulators stepped in to try to limit the damage to some policyholders.

Meanwhile, larger insurance buyers that were particularly hard-hit by capacity shortfalls—notably chemical, pharmaceutical and oil companies and banks—started looking at alternatives to commercial insurance, including forming new insurance companies.

And, the worst of times may be yet to come: Reinsurance and direct insurance buyers are expecting more of the same as 1986 renewals approach.

Insurance buyers are being hit with rate hikes ranging from mere double digits to as much as 1,000% for a broad range of property and casualty coverages.

Rates for directors and officers liability insurance rose by 50% to 500% this year (*BI*, July 19), while rates for bank fidelity bond coverage jumped by as much as 300% (*BI*, March 18). And, agents and brokers errors and omissions rates rose by 100% to 500% (*BI*, Feb. 18).

Municipalities, among the hardest-hit by the hard market, are paying up to 1,000% more for less coverage than they've had in previous years (*BI*, July 8).

Aviation reinsurance is expected to cost ceding companies up to 700% more (*BI*, Dec. 9).

Capacity, meanwhile, declined for many risks and became almost non-existent for some.

The environmental impairment liability market was shaken early in the year when several prominent EIL insurers pulled out (see story, page 22).

Excess umbrella capacity available from commercial insurers has been cut in half for many policyholders, while D&O capacity dropped from $200 million to as little as $30 million; fidelity insurance capacity from $300 million to $100 million; and E&O capacity from $250 million to $150 million or less.

For some risks, no capacity existed: RCA Corp. was forced to self-insure the launch of one of its satellites because insurance for the risk was unavailable (*BI*, Nov. 18).

A withdrawal of reinsurance support helped produce the shortfall of capacity for direct insurance buyers.

Several reinsurers stopped accepting business this year, including GRE Re Corp., American Mutual Reinsurance Co., Ohio Reinsurance Corp., National Excess Insurance Co. and several syndicates on the New York Insurance Exchange.

The capacity problem also was aggravated by a number of insurance company insolvencies.

Companies placed in liquidation since the beginning of the year include Ideal Mutual Insurance Co. and Union Indemnity Insurance Co. of New York, both by order of New York courts; Transit Casualty Co., by order of a Missouri court; Iowa National Mutual Insurance Co., by order of an Iowa court; and Mentor Insurance Ltd., which is being liquidated by Bermuda authorities.

Other insurers were placed in rehabilitation or conservatorship, including Delta America Re Insurance Co., which is being rehabilitated by the Kentucky Insurance Department; and several units of Mission Insurance Group Inc. that have been placed in conservatorship by the California Insurance Department and other state regulators.

Insurance buyers are being hit with rate hikes ranging from mere double digits to as much as 1,000% for a broad range of property and casualty coverages. . . .Capacity, meanwhile, has declined for many risks.

Coverage for such risks as municipalities and day-care centers became so scarce that insurance commissioners in several states—including New Jersey, South Carolina, California, Colorado, Tennessee and North Dakota—took various steps to protect policyholders.

These steps included:

- Issuing emergency rules to restrict insurers' rights to cancel or not renew property/casualty policies or impose midterm premium increases.
- Developing market assistance plans for municipalities and day-care facilities.
- Investigating the possibility of self-insurance pools or joint underwriting associations for municipalities.
- Launching studies of the extent of the commercial insurance crunch in various states.

Larger insurance buyers, including many Fortune 500 chemical, pharmaceutical and oil companies, acted to ease their capacity problems by contributing to the formation of new insurance companies to insure their risks.

Among these is A.C.E. Insurance Co. Ltd., a Cayman Islands-domiciled excess insurer developed by broker Marsh & McLennan and boasting more than 20 corporate sponsors.

Other such companies include:

- CASEX, a Bermuda-based mutual insurer being formed to provide liability limits excess of $50 million to its approximately 15 chemical company sponsors.
- Tortuga Casualty Co., an excess casualty facility developed by the Reiss Organization. ■

Risk managers force ISO to alter claims-made form

Risk managers and brokers went on the offensive in 1985 in an effort to force the Insurance Services Office to modify its proposed claims-made commercial general liability policy form—and they scored several impressive victories.

Early in the year, ISO took a hard line against critics of the claims-made CGL form, but by midyear the insurer trade group was forced to make major concessions on the proposal in its bid to gain the support of state insurance regulators.

Despite these concessions, only 14 states have approved the revised claims-made policy form, and it appears that several key commissioners will seek additional concessions from ISO.

The National Assn. of Insurance Brokers fired the first salvo in the battle against the claims-made CGL when in February it asked state insurance regulators to hold hearings on the proposed policy form (*BI*, March 25). By May, the Risk & Insurance Management Society had joined the fight (*BI*, June 10).

Meanwhile, ISO staffers and officials from several major U.S. property and casualty insurance companies met July 27 in Chicago with insurance regulators from 18 states. The insurers were hoping to convince the regulators of the need for the claims-made CGL (*BI*, Aug. 5).

But, the regulators had other ideas. Having been lobbied heavily by risk managers, agents and brokers, regulators spent nearly two hours grilling the ISO staffers and insurance industry officials on the claims-made policy.

That meeting proved to be a turning point in the battle over the claims-made form, as ISO apparently was convinced major changes would be needed to win the regulators' approval of the form.

And in mid-September, ISO announced that it was withdrawing two highly controversial endorsements to the claims-made policy form: one that would have limited the length of time that the extended reporting period or "tail" coverage would be in effect for an individual policy and another that would have removed an insurer's obligation to provide any tail coverage (*BI*, Sept. 16).

Although insurers said the two endorsements were intended for limited use, risk managers and brokers feared they would be used by insurers to routinely deny tail coverage under claims-made policies.

But the changes announced by ISO in September were not enough to gain the support of risk managers or brokers. They managed to keep the heat on ISO by convincing regulators that additional changes were needed in the claims-made policy form.

On Oct. 4, ISO announced it was refiling the claims-made policy form with five major changes. Those revisions established a five-year, automatic extended claims reporting period for known occurrences; changed the trigger of coverage to include claims made verbally to the policyholder or insurer rather than only claims made in writing; limited when an insurer can advance the retroactive date of a policy; provided for the reinstatement of the aggregate limits of the policy for tail coverage; and withdrew endorsements that limited the availability of unlimited tail coverage (*BI*, Oct. 7; Oct, 14).

Still, RIMS officials and regulators from several states said they wanted additional revisions in the claims-made policy form. But ISO officials countered that there could be no more changes in the form until after their proposed Jan. 1, 1986, implementation date.

Meanwhile, ISO's June 27 announcement that it would file an amendment to both the claims-made and occurrence CGL forms to include defense costs within policy limits met with a chorus of criticisms from buyers, brokers and regulators (*BI*, July 8).

In December, ISO announced a major revision to its original plan that would give policyholders 50% of their aggregate limits toward defense costs before those costs would begin to eat away at indemnity limits. And, ISO said it would delay the filing of that amendment until at least Feb. 15 while insurance commissioners studied the proposal (*BI*, Dec. 22).

EIL market crunch forces search for options

The environmental impairment liability insurance market continued to contract in 1985, forcing risk managers and brokers to look for alternatives to commercial insurance for their pollution exposures.

By year's end, only American International Group Inc. and the Pollution Liability Insurance Assn. were writing EIL coverage, brokers report. Two other insurers that had been willing to write EIL coverage in early 1985—Hartford Insurance Group and Travelers Indemnity Co.—dropped out of the market by the middle of the year (BI, Sept. 9).

And, brokers say, pricing for EIL coverage is up substantially over 1984 and is expected to continue to climb.

Limits remained steady through the year, with AIG offering up to $10 million per occurrence and $10 million annual aggregate, while PLIA has limits of $6 million and $9.5 million.

On top of the difficulties associated with the EIL market, which provides coverage for gradual pollution exposures, risk managers faced a new wrinkle in 1985 in their efforts to insure their pollution exposures.

Coverage for sudden and accidental pollution risks, once available to nearly every commercial general liability policyholder, began drying up.

Dogged by a string of court decisions that seem to fly in the face of policy language limiting pollution coverage in the standard CGL policy to sudden and accidental incidents, insurers decided in late 1984 that they could no longer afford to give courts the opportunity to broadly construe what they believed to be very limited pollution coverage (*BI*, Oct. 29, 1984).

Working through the Insurance Services Office, insurers moved to cut their pollution losses by agreeing to a total exclusion of pollution liablities in ISO's proposed new CGL policy forms. And, most insurers—including the London market—began earlier in the year to exclude sudden and accidental pollution coverage for larger risks insured under manuscript forms.

With virtually no pollution coverage available from the commercial insurance market, risk managers and brokers began revising some of the pooling concepts and group captive arrangements that had been discussed in 1978, before EIL insurance was widely available (*BI*, Sept. 9).

To date, such efforts have met with only limited success. Several groups of Fortune 500 companies are working separately to put together group captives for EIL coverage, but none has yet proved successful. Problems with capitalization, lack of reinsurance support and development of policy language are the major stumbling blocks, according to consultants.

Meanwhile, the Environmental Protection Agency reported in December that at least 47 companies were forced to close their hazardous-waste management facilities because they could not obtain EIL coverage needed to meet the agency's financial responsibility requirments. The vast majority of companies that met the requirements did so by passing a financial test designed to determine whether a company has the financial strength to self-insure its pollution exposures, the EPA said (*BI*, Dec. 16). ■

Best rating changes draw ire of insurers

A.M. Best Co. changed the ratings of more property/casualty insurers in 1985 than it has in at least a decade.

Drawing the ire of many insurers and reinsurers, Best also changed some of its evaluation criteria, no longer giving credit for an underwriter's reinsurance if the reinsurance is ceded to non-U.S. companies and secured with a letter of credit (*BI*, Nov. 11).

But the big news concerning Best in 1985 was the poor ratings given to many large commercial insurers.

Of the 1,775 property/casualty insurers rated by Best in 1985, 331 received lower ratings, compared with only 183 last year.

An omitted rating was given to 118 companies in 1985, up from only 38 in 1984 (*BI*, July 15). Some ratings also were deferred.

The companies whose ratings were omitted or deferred in 1985 included units of Mission Insurance Group Inc., Transit Casualty Co. and Wausau Insurance Cos. (*BI*, July 1).

Mission Insurance Co. and several other Mission units were later placed in conservation, Transit Casualty was liquidated and Wausau joined Nationwide Insurance Group in exchange for a capital infusion.

Other insurers whose ratings were omitted or not assigned specifically because they secure a significant amount of non-U.S. reinsurance through letters of credit include International Surplus Lines Insurance Co., Mead Reinsurance Corp., Constellation Reinsurance Co., Integrity Insurance Co., RLI Insurance Co. and Mutual Fire, Marine & Inland Insurance Co.

But, most of these underwriters say brokers, looking for capacity in a tightening market, will pay less attention to Best's rating than they might have a year ago.

In contrast to the great numbers that saw their rating lowered, only 25 companies received a higher rating from Best in 1985, down from 100 in 1984.

The only leading commercial property/casualty company whose rating was upgraded by Best was Liberty Mutual Insurance Co., up to A-plus from A.

Later in the year, Best announced that it would review insurers' ratings quarterly and establish a "watch list" of companies whose results have deteriorated but do not yet warrant a change in ratings.

Best has downgraded the ratings of several insurers based on their nine-month 1985 performance, including American Centennial Insurance Co., Great Global Insurance Co., Lumbermens Mutual Insurance Co., Missouri Professional Liability Insurance Assn., Atlanta International Insurance Co., Integrity Insurance Co. and Pine Top Insurance Co. And, it placed several insurers on its watch list (BI, Nov. 18; Dec. 23 and story, page 2). ■

Federal product liability reform stumbles

Employers are reeling this year from a serious setback in their four-year battle to persuade Congress to pass a federal product liability reform law.

After approving similiar bills in previous sessions, the Senate Commerce Committee in May declined to report out and send to the Senate floor comprehensive federal product liability legislation, S. 100, introduced by Sen. Robert Kasten, R-Wis. (*BI*, May 27).

That dealt a grave blow to manufacturers' hopes for a product liability bill during 1985.

Also, after the Commerce Committee vote, Commerce Committee Chairman John Danforth, R-Mo., directed committee staffers to draft a new product liability bill that included a no-fault mechanism to ensure speedy compensation to accident victims who waived their right to sue product manufacturers.

Sen. Danforth attributed the defeat of the Kasten bill to its lack of a no-fault provision (*BI*, June 24).

But manufacturers and insurers had misgivings about a no-fault compensation system that would allow accident victims either to file a lawsuit or to waive the right to sue in exchange for prompt payment of economic losses.

But, complex no-fault compensation provisions were included in draft bills Commerce Committee staff unveiled in July and December (*BI*, Dec. 9).

Aside from establishing an optional no-fault system, the December staff draft made new changes in the "tort reform" provisions.

For example, it made it clear that tobacco products and alcoholic beverages would remain covered by state product liability statutes and not by the federal law.

Other changes in the new draft included giving the Commerce Department power to draft insurance coverage requirements for certain foreign manufacturers and require two trials for punitive damages.

Other provisions in the December draft were unchanged from earlier proposals.

To date, no hearings on the second draft have been held, but manufacturers hope growing awareness of problems with the justice system will renew interest. ■

New Jersey ruling

Continued from page 1

'intentional wrong,'" the court said.

The court's answer was that there will be "intent" under the statute only if it is substantially certain" that harm will occur from the employer's conduct.

"The dividing line between negligent or reckless conduct on the one hand and intentional wrong on the other must be drawn with caution, so that the statutory framework of the Act is not circumvented simply because a known risk later blossoms into reality," the court said.

"We must demand a virtual certainty."

The court added that courts must examine not only the conduct of the employer but also the context in which that conduct takes place in determining if there is an "intentional wrong."

"May the resulting injury or disease, and the circumstances in which it is inflicted on the worker, fairly be viewed as a fact of life of industrial employment, or is it rather plainly beyond anything the legislature could have contemplated as entitling the employee to recover only under the Compensation Act?" the court asked.

The court said the employees' attempts to sue in tort outside workers compensation for their initial asbestos injuries did not meet the "substantial certainty" standard.

"Although defendants' conduct in knowingly exposing plaintiffs to asbestos clearly amounts to deliberately taking risks with employees' health, as we have observed heretofore the mere knowledge and appreciation of a risk—even the strong probability of a risk—will come up short of the 'substantial certainty' needed to find an intentional wrong," the court said.

"In the face of the legislature's awareness of occupational diseases as a fact of industrial employment, we are constrained to conclude that plaintiffs-employees' initial resulting occupational diseases must be considered the type of hazard of employment that the legislature anticipated would be compensable under the terms of the Compensation Act and not actionable in an additional civil suit."

However, the court did rule that the employees were entitled to sue du Pont for its alleged aggravation of the initial occupational diseases due to its alleged fraudulent concealment of the employees' injuries.

These allegations included that du Pont's medical staff provided employees with physical chest X-rays that indicated asbestos-related injuries but that the doctors did not inform the plaintiffs of their illnesses.

Instead, the doctors told the employees that their health was fine and sent them back to work in the same hazardous conditions, according to the allegations.

"These allegations go well beyond failing to warn of potentially dangerous conditions or intentionally exposing workers to the risks of disease," the court said.

"There is a difference between, on the one hand, tolerating in the workplace conditions that will result in a certain number of injuries or illnesses, and, on the other, actively misleading the employees who have already fallen victim to those risks of the workplace.

"An employer's fraudulent concealment of diseases already developed is not one of the risks an employee should have to assume. Such intentionally deceitful action goes beyond the bargain struck by the Compensation Act," the court added.

"The legislature, in passing the Compensation Act, could not have intended to insulate such conduct from tort liabilty.

"We, therefore, conclude that plaintiffs' allegations that defendants fraudulently concealed knowledge of already contracted diseases are sufficient to state a cause of act for aggravation of plaintiffs' illnesses, as distinct from any claim for the existence of the initial disease, which is cognizable only under the Compensation Act."

The court added that its decision should not discourage companies from engaging in medical programs to discover occupational illnesses. "Corporate medical departments will remain immune from liability at common law for all conduct short of intentional wrongs," the court said.

"Under our holding, all degrees of negligence continue to be subject to the 'exclusive remedy' bar of compensation. Thus, these plaintiffs now face the unenviable burden of proving a deliberate corporate strategy to conceal plaintiffs' asbestos-related diseases that were discovered by defendants-doctors in corporate physical examinations."

As a final point, the court ruled that employees can pursue both workers compensation benefits and a tort remedy. However, if the employees win their lawsuit, they should not be entitled to both tort and workers compensation recoveries, and the company or its liability insurer can offset compensation benefits previously paid, the court said.

Attorneys and workers compensation specialists differ on the implications the New Jersey high court decision will have for employers.

Many say the standards of proof set up by the court and the language in the opinion are strong enough to protect employers from substantial litigation.

The decision is a "far more restrictive view" and more employer-oriented than has been the experience in other states, like Illinois, said William Krucks with the Chicago firm of Freeborn & Peters. "I think it is a very conservative opinion."

Mr. Krucks also said there appears to be "nothing new" in the New Jersey Supreme Court's ruling permitting suits to proceed against employers who fraudulently conceal the fact that an employee has an occupational disease. In other states, workers compensation has not been the exclusive remedy in suits against employers where fraud is alleged.

Workers compensation attorney Merton E. Marks agrees that the opinion takes a "fairly pro-employer point of view."

"It appears the court is construing intentional act fairly conservatively," says Mr. Marks of the Phoenix firm of Lewis and Roca.

"When you lay this decision side-by-side with the Blankenship decision in Ohio, it is a much more conservative definition of an intentional act."

In *Blankenship vs. Cincinnati Milacron*, the Ohio Supreme Court held employees can sue their employers for "willfully disregarding known health hazards." Prior to this 1982 ruling, employees only could file workers compensation claims against their employers for injuries (*BI*, April 3, 1983; April 26, 1982; Nov. 8, 1982).

The New Jersey decision is "part of a gradual erosion of the exclusive remedy of workers compensation that is taking place," Mr. Marks said.

But, he added, "I don't really see this decision as spawning litigation against employers on the theory that they failed to disclose the harmful nature of work substances."

Charles Coakley, senior counsel with the American Insurance Assn., also said the case "seems to draw tight restrictions" on when suits can be brought against employers by employees.

"The decision seems to set down tight parameters which ought to stick," and if they do, it should not cause problems to employers, he says.

"If courts don't go beyond the parameters of this case, I don't think employers will have a problem in New Jersey."

Mr. Coakley said that plaintiffs attorneys will probably bring cases to test the boundaries of the decision, and the courts' rulings in those cases will determine the decision's ultimate impact.

Others are concerned that the New Jersey ruling will result in more suits and greater liability for employers as plaintiff attorneys test the limits of the decision. The "substantial certainty" test runs the risk of being interpreted more liberally in future decisions, permitting more suits against employers, some say.

It's a "dangerous doctrine," said Professor Arthur Larson, a leading workers compensation legal scholar. He points out that the decision leaves "an awful lot of elbow room."

"In the hands of a careless court, it can get completely out of hand," he said. Some jurisdictions, for example, have "started with substantial certainty tests and for all practical purposes destroyed the concept of intention," he said.

Professor Larson also fears that permitting suits for an employer's fraudulent concealment from an employee of existing diseases could be abused. But, he adds, it is "a defensible doctrine."

The adoption of the "substantial certainty" test rather than the "deliberate intention" test erodes the exclusive remedy clause, contends Nancy Schroeder, senior counsel for workers compensation for the Alliance of American Insurers, a trade association of insurers.

"The Alliance feels it is inappropriate to use the "substantial certainty" test in the workers compensation area," she said.

Even though the court ruled partially in du Pont's favor, Ms. Schroeder says "the decision is very significant."

The decision is "another arrow in the quiver for plaintiffs' attorneys," said plaintiffs' attorney Alan Darnell.

Although stringent proof is required to prove "fraudulent concealment" of a worker's injury, even this opportunity was not available before, he said.

"It is a victory for plaintiffs," said Mr. Darnell of the Woodbridge, N.J., firm of Wilentz, Goldman & Spitzer. "It is another avenue of redress for injured plaintiffs."

Glenn Paulsen, director of the New Jersey Division of Workers Compensation, predicts a significant increase in litigation as a result of the du Pont decision.

The decision could in the future lead to increased costs for employers under the employers' liability portion of the standard workers compensation policy, said Robert Heckman, New Jersey special deputy commissioner of insurance and chairman of the state's Compensation, Rating and Inspection Bureau.

"I don't think there is any doubt the decision has slightly eroded the exclusive remedy concept," Mr. Heckman said. "It opens the door a crack."

The Supreme Court ruling goes far beyond asbestos and could affect any suits stemming from injuries from toxic substances, said Michael Perlin, a professor at New York Law School who was special counsel to the New Jersey Commission of the Public Advocate. The commission filed an amicus curiae brief in the case. However, much will depend on the evidence that is developed about particular toxic substances and a company's knowledge of them to determine what the impact will be, he added.

But, Professor Perlin does not consider the du Pont ruling an erosion of the exclusive remedy doctrine.

"I see it as the Supreme Court applying relatively common sense and reasonable principles to a set of facts never looked at before," he said.

In a statement, du Pont said it believes it will not be held liable on grounds that its corporate strategy was to conceal existing diseases in the workers.

"We feel vindicated as we are confident that no such evidence exists," the statement said.

The decision also will not affect the company's extensive screening program for employees, said Robert A. Shinn, plant manager at du Pont's Chambers Works, where one of the plaintiffs worked.

"At du Pont, we plan to continue to keep employees and pensioners fully apprised of any findings based on our use of this most advanced medical examination techniques," said Mr. Shinn in a prepared statement.

"Although lawsuits may result, it is our obligation to keep employees informed." ■

Safety officer sentenced for lying to OSHA

SYRACUSE, N.Y.—The former health and safety director for a GTE Corp. subsidiary in Troy, Mich., has been sentenced to three months in jail and fined $10,000 for lying to an Occupational Safety & Health Administration inspector.

Carl MacPetrie, who pleaded guilty to the charge, was sentenced last month by a federal district judge for the Northern District of New York.

A spokesman for GTE Corp. noted that Mr. MacPetrie's guilty plea was a personal matter and that the federal government did not implicate the GTE subsidiary in the case.

The case stems from three 1981 OSHA inspections of GTE Valeron Corp.'s plant in the Syracuse area. GTE Valeron is a subsidiary in GTE Corp.'s precision materials group.

According to Assistant U.S. Attorney Craig Benedict, Mr. MacPetrie told an OSHA inspector that a rough-cut saw that cuts materials to make tools, generating cobalt dust during the process, was down for repairs.

But Mr. MacPetrie admitted in court that the equipment had been disabled at his direction.

If the saw had been operational, the OSHA inspector would have measured how much of the harmful dust it emitted, Mr. Benedict explained.

The $10,000 fine is the maximum under the law, and the three-month jail sentence is half the maximum, Mr. Benedict said. He also noted that the law does not provide for either time off for good behavior or parole.

"This is a very stiff penalty," Mr. Benedict said.

Mr. MacPetrie was unavailable for comment.

However, the GTE spokesman said Mr. MacPetrie was still employed by GTE Valeron and has been assigned to an "administrative position."

The Syracuse GTE Valeron plant was closed in early 1982 for economic reasons.

Meanwhile, several civil suits charging that employees have been exposed to toxic materials are pending against that plant and other GTE Valeron plants around the country, the GTE spokesman said.

Some 70 such civil cases are pending in the Syracuse area alone. Federal prosecutors believe that Mr. MacPetrie's criminal case, including his guilty plea, may have some bearing on those pending civil suits. ■

Mission affects ratings

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omitted rating because of difficulties with profitability and leverage.

Protective was placed on the watch list because of the $4 million it is owed by Mission, said Protective President Gary W. Miller.

"We don't feel in any way this impairs our solvency," said Mr. Miller, who added that he is taking several steps to strengthen the company.

In addition to the reinsurance recoverables owed by Mission, Best also cited an increase in leverage as a reason for placing Protective on the watch list, Mr. Miller explained.

According to Mr. Miller, Protective, which specializes in trucking insurance, had maintained a low premium volume during the competitive market. But as the market hardened and demand for Protective's products increased, the company expanded its premium writings "very rapidly."

The company, which wrote $24.7 million in net premiums in 1984, has almost tripled that volume in 1985, said Mr. Miller.

The company will, however, be writing at a premium-to-surplus ratio of less than 3-to-1 by year-end, said Mr. Miller. Policyholder surplus as of Dec. 31, 1984, stood at $26.7 million.

Calvin W. Carter, chairman of First Southern, whose rating was deferred, said he was told by Best that a company is usually given a deferred rating for one to three years when there is a change in ownership and management.

Mr. Carter, who moved First Southern's headquarters from Mobile, Ala., to Tampa after he acquired the insurer from Morrison Inc. late last year, said 85% of the company's line staff are new employees. The company, which solely writes commercial lines, also changed its product mix so that workers compensation now accounts for only 35% of its net premiums written, down from 55% in 1984, Mr. Carter said.

First Southern will write net premiums of about $15 million this year, he said.

A deferred Best's rating "just gives us the opportunity to make our own rating," Mr. Carter explained.

South Carolina Insurance Co. was added to the watch list along with two subsidiaries: Consolidated American Insurance Co. in Columbia, S.C., which has a B rating, and the Kentucky Insurance Co. in Louisville, Ky., which—like its parent—has a B-plus rating.

Sterling E. Beale, financial vp for South Carolina Insurance, said the companies were put on the list because their aggregate policyholder surplus dropped from to $74 million as of Dec. 30 from $130 million at year-end 1984.

The decline was primarily because of two factors, according to Mr. Beale. The first was a $27 million decrease in the value of a stock investment, which parent Seibels Bruce subsequently sold. The second was a $25 million loss on the insurers' West Coast operation, which also has since been sold.

Mr. Beale said he hopes the companies will be taken off the watch list next quarter.

Protective was placed on the watch list because of the $4 million it is owed by Mission, says Mr. Miller, adding, "We don't feel in any way this impairs our solvency."

J.L. West Jr., executive vp and treasurer of Dependable Insurance Co., said his firm was placed on the watch list because its gross leverage ratio—the ratio of its liabilities and direct written premium to its surplus—was about 11-to-1, compared with an industry norm of about 6.1-to-1.

The insurer reported gross written premiums of $123.9 million as of Sept. 30, compared with $49.5 million for the comparable period of 1984, Mr. West said. Policyholders surplus totaled $24.1 million as of Sept. 30, compared with $16.8 million on Sept. 30, 1984.

Dependable's ratio of net written premiums to surplus, however, was just more than 3-to-1, he noted.

Mr. West said the reason for the unusually high gross leverage ratio is that most of Dependable's business is credit insurance on the financing of vehicles, which has been a "boom" business over the past 18 months.

William Menza, Country-Wide's controller, said the insurer was placed on the watch list because its policyholder surplus dropped to $3.1 million as of Sept. 30, compared with $4.4 million in December 1984.

Mr. Menza said the company since has learned from the New York Insurance Department that it can carry another $300,000 in computer hardware as an asset, which will bolster its overall financial position.

Wayne McDonald, president of RGAF Underwriters, which was given an omitted rating, said the company probably will be liquidated because of problems it has had with past poor management, reinsurance and surplus. RGAF is operated by the Retail Grocers Assn. of Florida.

The company, which was formed in 1981 and has written business only for RGAF members, reported $3.2 million in net premiums written in 1984 with a policyholder surplus of $1.9 million.

Also named in Best's quarterly report were Peninsular Fire Insurance Co. in Jacksonville, Fla., and The Commercial Credit Group.

Peninsular Fire was downgraded to a deferred rating from a B. Best cited changes in profitability and leverage as reasons for the change.

The Commercial Credit Group of companies—including Atlantic Insurance Co., Gulf Group Lloyds, the Gulf Insurance Co., the Insurance Company of the Pacific Coast and the Select Insurance Co.—were placed on the watch list. Profitability and leverage were cited for all five Dallas-based companies, which have A ratings.

Spokesmen for these companies could not be reached for comment. ■

Georgia to rule soon on malpractice hike

By ANN WEAD KIMBROUGH

ATLANTA—Georgia Insurance Commissioner Warren D. Evans is expected to rule soon on whether three insurer units of the St. Paul Cos. Inc. should be granted a basic 55.5% rate increase for physician malpractice coverage in the state.

The insurers also have requested an additional hike for clients whose policies exceed St. Paul's usual medical malpractice coverage limits—typically $300,000. With the surcharge, the total hike for policyholders with higher limits would average 62.6%.

The rate request was filed on behalf of St. Paul Mercury Insurance Co., St. Paul Fire & Casualty Insurance Co. and St. Paul Fire & Marine Insurance Co. to take effect Jan. 1. The three insurers provide malpractice coverage for almost 60% of the physicians and surgeons in Georgia.

Georgia is a "file and use" state, meaning that insurers ordinarily do not need regulatory approval to increase rates.

However, state law allows the insurance commissioner to deny an insurer's proposed rate increase.

Commissioner Evans ordered hearings earlier this month to review what he termed "excessive" and "unfairly discriminatory" increases requested by St. Paul.

If Mr. Evans disallows the increase, St. Paul can challenge that decision in Georgia's Superior Court.

During the hearing, Jim Mohl, senior actuarial officer in the St. Paul Medical Services Division, testified that the insurer needs such a substantial rate increase because medical malpractice claims in Georgia are significantly higher than in other parts of the country.

For example, he said, in 1980 St. Paul paid more than $5.6 million for medical malpractice claims in Georgia. By the end of 1984, that tripled to more than $19.3 million.

In addition, the average size of a claim in Georgia grew 171% from 1980 to 1984—to about $92,000 from $33,735, Mr. Mohl said. By comparison, he said, average paid claims nationwide grew to $56,734 in 1984 from $28,059 in 1980.

Mr. Mohl also said much of St. Paul's poor experience in Georgia is the result of several very large claims. For example, he said St. Paul has made six medical malpractice settlements of more than $1 million each since the beginning of 1984.

Before the hearing, Commissioner Evans said he was "well aware that many companies that sell liability insurance are having to pay out more and have larger liability claims than ever before and, as a result, many companies have suffered huge losses."

But, he said, he feels St. Paul is partly to blame for its financial predicament.

"During the late 1970s and early 1980s, when insurance companies were able to invest premium income at record high interest rates, they sold insurance at huge discounts with expectations that their investment income would cover their insurance losses," Mr. Evans said.

"Now, it appears that some of the companies are trying to cure their financial problems overnight with large premium increases," the commissioner said.

"I just don't think it's right for the companies to offer the public huge premium discounts one year and then come up with a drastic premium increase a year or two later."he said. ■

Heart valve case

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1977.

Mr. Outlaw sued Hancock, seeking $2 million in damages. The case later was settled for $150,000.

As a result of the appellate court decision, Admiral Insurance Co. of Cherry Hill, N.J., which insured Hancock at the time the valve was implanted, will have to pay Mutual Fire, Marine & Inland Insurance Co. of Philadelphia more than $650,000 in defense and indemnification costs plus interest stemming from the suit, says Roy Weatherup, an attorney for Mutual Fire.

Mutual Fire insured Hancock at the time the valve was replaced.

Admiral had refused to defend Hancock in the case, contending that because there was injury over two policy periods, both it and Mutual Fire should respond.

At the time the valve was implanted, Hancock was insured by Admiral under a general liability policy with a combined single limit of liability for $300,000. The policy ran from April 10, 1976, until April 10, 1977.

At the time the contaminated valve was removed, however, Mutual Fire insured Hancock for a limit of $500,000 for bodily injury and property damage. Mutual's policy ran from April 10, 1977 until April 10, 1978.

Hancock first requested that Admiral defend it in the lawsuit brought by Mr. Outlaw, but Admiral refused. Hancock then tendered the defense to Mutual, which accepted it under a reservation of rights.

Prior to Hancock's settlement with Mr. Outlaw, a suit was filed by Hancock to determine which insurer should respond.

The District Court ruled that implantation of the contaminated heart valve triggered only Admiral's liability to defend Hancock and not Mutual's.

It ordered Admiral to reimburse Mutual for the $150,000 settlement, $264,000 in defense costs and attorneys fees, and interest.

Admiral then appealed to the 9th Circuit.

The issue in the case was when bodily injury occurred to Mr. Outlaw for purposes of triggering Hancock's coverage.

The court noted that in most injury cases, the occurrence and the injury take place simultaneously or so close to each other that there is no difficulty determining when coverage is triggered.

But, the court said that in this case, the victim was infected before the existence of the disease was revealed, and his condition continually deteriorated because of the presence of the contaminated valve.

The 9th Circuit said it had to decide whether coverage was triggered by exposure—in this case, the implantation of the contaminated valve—or whether it also was triggered by the continuous growth of bacteria throughout both insurance policy periods.

In its analysis, the court discussed three different theories handed down by courts in asbestos insurance coverage cases.

Under the exposure theory, the court said, bodily injury occurs when an exposure causing tissue damage takes place and not when physical symptoms caused by the disease manifest themselves.

In the Hancock case, Mutual contended the court should adopt the exposure theory, which would have triggered only Admiral's policy.

Under the continuous exposure or triple-trigger theory first handed down by U.S. Court of Appeals for the District of Columbia in Keene Corp. vs. Insurance Co. of North America, coverage is triggered by exposure to asbestos products or by manifestation of an asbestos-related disease or by an intermittent latency period.

Admiral contended that the continuous exposure theory should be adopted, which would mean it and Mutual should share in the coverage.

And under the manifestation theory, coverage is triggered by a claim that an asbestos disease has manifested itself during the policy period.

In the Hancock case, the court noted the disease process resulting from the contaminated heart valve was similar to asbestos cases in that just as exposure to asbestos sets in motion related diseases, the exposure to the contaminated valve set in motion the growth of bacteria.

But, the court said that, unlike in asbestos cases, where the injured party usually is exposed to asbestos more than once, in this case Mr. Outlaw was exposed to only one injury-causing agent, implantation of the contaminated heart valve.

Agreeing with the 6th U.S. Court of Appeals in *Insurance Co. of North America vs. Forty-Eight Insulations*, the court said: "We prefer to apply the exposure theory in determining when bodily injury occurs.

"Insurance liability policies should be interpreted to promote coverage and to fulfill the dominant purpose of providing indemnification," the court said.

"The exposure theory provides coverage and enables the insurance companies to determine their liabilities. As in this case, it will not be difficult to determine when an injured person was exposed to the particular agent which caused the bodily injury."

The court also rejected the continuous exposure theory adopted in Keene.

"The basis for the reasoning in Keene was a perceived difficulty in determining medically how or when the injury occurs in an asbestos inhalation," the court said.

"However, this seems to ignore the pragmatic concerns of a court. A court should have no difficulty in determining when an exposure to any injury causing agent occurred."

The court also rejected the manifestation theory, saying coverage can become illusory when the manufacturer of a product is faced with an increasing rate of injured persons.

"At a certain point, the manufacturer will be unable to secure any insurance coverage. Thus, when some of the injured persons manifest their injury, there will be no insurance."

Mr. Weatherup, representing Mutual Fire, said the case could be significant in asbestos coverage cases and other progressive disease cases.

Mr. Weatherup, with the Santa Monica, Calif., firm of Haight, Dickson, Brown & Bonesteel, said that because of the limited amount of existing case law in the area of insurance coverage for progressive disease, "I think the case will be of significance."

But, Loyal Pulley, an attorney for Admiral with the Los Angeles firm of Hillfinger & Costanzo, said it was uncertain if this case would have any impact on asbestos cases. He pointed out that the court distinguished the facts of this case from cases involving asbestos. ■

Latest CGL changes

Continued from page 2

policy—is also available to claims-made policyholders for a charge of up to 200% of the original policy premium. The insurer may or may not reinstate a percentage of the aggregate limit when the "unlimited" tail coverage is purchased.

In another move—one that will probably rankle insurance regulators—ISO's board decided not to file a mandatory endorsement to the claims-made form that would have obligated insurers to provide claims information to policyholders seeking replacement coverage.

"No one disagrees that the policyholder is entitled to certain claim information," said Fred R. Marcon, ISO's senior executive vp and chief executive officer. "But outstanding questions remain about the scope and detail of the information insurers can be reasonably asked to provide.

"Also, insurers are concerned—from an operational standpoint—about how quickly they can assemble and provide such information," he added.

This announcement comes on the heels of last month's decision by the National Assn. of Insurance Commissioners to approve model CGL policy language that would require insurers to provide detailed information about open and closed claims and notices of occurrences within 30 days of a policyholder's request or a notice of cancellation or non-renewal (*BI*, Dec. 23).

ISO has filed several other changes to the claims-made form, including:

- A requirement that an insurer—before it can advance the retroactive date of a claims-made CGL policy—must obtain a written acknowledgement from the policyholder that it is aware the retroactive date is being changed and has been advised of its right to buy tail coverage.
- A requirement that both the claims-made and occurrence CGL policy forms contain a 30-day notice of non-renewal. The proposed policy forms already provide for a 30-day notice of cancellation.

Further, ISO announced that it will work with the NAIC's commercial lines committee to identify and resolve any problems that may arise after the proposed CGL policy forms are implemented.

The forms have been approved or are available for use in 14 states, for implementation on Jan. 1.

The insurer trade group also said it will consult with state regulators before it makes any major changes in its policy forms. ■

Labor Department sues the trustees of profit-sharing plan

Trustees of a Southern California profit-sharing plan improperly used plan assets, the Labor Department charges in a lawsuit.

The suit, filed in U.S. District Court in Los Angeles, alleges that the trustees of Blaisdell Manufacturing Inc.'s profit-sharing plan approved $132,000 in improper loans from plan assets.

Named in the suit are Homer and Lois Blaisdell, Vance Blaisdell and Jay Blaisdell. Homer and Lois Blaisdell are owners of plan sponsor Blaisdell Manufacturing Inc. of Brea, Calif.

Homer, Vance and Jay Blaisdell allegedly approved loans that were not in the interest of plan participants, the suit says.

The Labor Department says the three men also improperly approved loans totaling $123,000 from the plan to themselves.

The suit charges that Lois Blaisdell violated her fiduciary duties by failing to correct fiduciary breaches of her fellow trustees.

The Labor Department is seeking a court order requiring the trustees to rescind the loans and repay the plan for all losses resulting from the improper loans.

The department also wants the court to remove the defendants as plan trustees, appoint a new trustee and bar the defendants from serving as fiduciaries of any employee benefit plan for 10 years. ■

update

New York adopts MGA rules

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the Insurance Department.

Under a new regulation signed by Superintendent James P. Corcoran, insurers and reinsurers must file the forms on each MGA they currently use and any they contract within the future.

The forms ask for details on the MGA's operations, including names of principals, classes of business written and the manager's underwriting authority.

According to a department spokesman, the requirement is intended to reduce possible fraud and to more closely monitor the financial solvency of an insurer or reinsurer.

The regulation also clearly states that all MGAs in the state must be licensed agents, a requirement that the department has held for some time but which was challenged by others.

PBGC sues to terminate plan

NEW HAVEN, Conn.—The Pension Benefit Guaranty Corp. filed suit in U.S. District Court in New Haven seeking a court order to force the termination of an underfunded pension plan sponsored by Century Brass Products Inc. of Waterbury, Conn.

According to the PBGC, the suit was filed earlier this month to prevent further financial deterioration of the plan and to prevent any further accrual of benefits that the agency would have to guarantee to participants. The plan, which covers about 3,000 former and current United Auto Workers union members, has unfunded vested benefits of $32 million, the PBGC said.

Century Brass, which did not make at least $13 million in required plan contributions since 1980, filed for reorganization earlier this year, the PBGC said.

Searle suit ends in mistrial

BALTIMORE—A suit against G.D. Searle & Co. by 17 women claiming injuries from the Copper-7 intrauterine contraceptive that ended in a mistrial is expected to be retried. No new date has been set.

U.S. District Court Judge Joseph Young declared the mistrial earlier this month when the jury could not agree that injuries alleged by the women were caused by the Copper-7.

The Copper-7 was introduced in 1974 by Searle, now a unit of Monsanto Co. Searle faces several hundred similar lawsuits. So far it has won five of eight cases tried and has settled others.

A spokesman for Searle, based in Skokie, Ill., said the company "is prepared and intent upon defending any future challenge to be brought by the plaintiffs."

Judge stalls asbestos suit

MARTINEZ, Calif.—A state court judge has ruled that three counts in a class-action lawsuit brought by California homeowners that seek to recover the costs of removing asbestos from their homes are insufficent for the case to proceed.

An attorney for the plaintiffs said an amended complaint was filed Dec. 23.

In the original ruling, Contra Costa Superior Court Judge Richard Patsey ruled earlier this month that counts of strict liability, negligence and nuisance in the class action could not be sustained.

"California law requires the pleading of an actual, existing physical injury to persons or property, other than the allegedly defective property in question, in order to plead a cause of action for either negligence or strict liability," the court said.

"The pleading of the presence of asbestos fibers in one's home or its potential for harm is insufficient to state a cause of action in tort. Some discernible present damage must be alleged," the judge said.

The suit was filed last February against more than 40 asbestos producers (*BI*, Feb. 25). The class, which has not been certified, includes all people owning homes in California built between 1912 and 1978 containing friable or flaking asbetos sold or distributed by the defendants.

Appeal of OSHA pre-emption

CHICAGO—The Cook County, Ill., state's attorney office will appeal a recent Circuit Court ruling that federal Occupational Safety & Health Administration law pre-empts state criminal law.

In a case involving dozens of employees who allegedly were injured through repeated exposure to toxic chemicals, Cook County Circuit Court Judge Earl Strayhorn on Dec. 13 dismissed the more than 400 counts of aggravated battery, conspiracy and reckless conduct against five top officers of Chicago Magnet Wire Corp., an Elk Grove Village, Ill.-based subsidiary of North American Philips Corp. in New York.

The suburban Chicago electrical wire manufacturer and the five officers, including its president, were named in indictments handed up by a Cook County grand jury Sept. 25, 1984 (*BI*, Oct. 1, 1984).

The plant processes electrical wire by coating it with liquid enamels or polyvinyl chlorides and then baking the material onto the wire. This process can cause toxic fumes to be released into the workplace, charged the state's attorney's office in the criminal case.

The ruling is the first of its kind, allowing federal law to pre-empt state criminal statutes, said Glenn Sechen, assistant state's attorney.

"It's a federal question. It's very substantial. . . .So we're looking at a U.S. Supreme Court case," he surmised, noting that the case first must work its way through the appeals process.

Chicago Magnet Wire's attorney Robert Stephenson of Chicago said he believes that, if appealed, the judge's decision will stand.

Chicago Magnet Wire and the same officers also were named Oct. 10, 1984, in a civil suit brought by 49 employees who alleged the company and its officials willfully failed to disclose and intentionally concealed from them that they were exposed to poisonous and toxic substances. That suit is pending (*BI*, Oct. 15, 1984).

Hyatt coverage

Continued from page 1

Judge O'Leary's finding that it has a duty to defend Hyatt and Hallmark in the underlying skywalk injury claims.

The excess insurers—which filed their appeals with the Missouri Court of Appeals for the Western District in November and December—are expected to file additional briefs early next year.

The appeals court may not decide the case until next fall, according to Anthony P. Katauskas, a lawyer with Williams & Montgomery in Chicago, representing Highlands.

At the time of the skywalk collapse, Hyatt had $201 million in liability insurance through 23 insurers, including a $1 million primary policy with Occidental Fire & Casualty Co. of North Carolina; a $25 million first excess policy written by Northbrook; another $25 million excess layer divided among Pine Top Insurance Co., Centaur Insurance Co. and Insco Ltd., all represented by underwriting manager Baccala & Shoop; a $25 million excess layer written by Columbia Casualty Co.; and another $25 million layer divided among Pine Top, Federal Insurance Co. and Highlands. Another $100 million excess of $100 million was provided by 11 excess insurers.

Hallmark had $101 million in coverage, with a $1 million primary policy and a $10 million first excess policy written by Commercial Union; a $50 million excess layer written by American; and a $40 million excess layer divided between Continental Insurance Co. and Republic.

Judgments and settlements totaling more than $100 million already have been paid by Hyatt and Hallmark insurers, generally following the apportionment order.

The insurance coverage litigation started in 1981, when Hyatt filed suit asking a state court to decide which insurers should indemnify it and in what order they should pay.

In a Feb. 28 ruling that made final—and appealable—an earlier 1982 memorandum opinion, Judge O'Leary ordered the two-thirds/one-third apportionment of excess coverage based on the total available limits of the Hyatt and Hallmark lines.

Coverage on the primary level, where the limits of the Occidental and CU policies were the same, was to be split 50/50.

CU had argued that its policies issued to Hallmark were intended to cover "ongoing construction" at the Kansas City Hyatt, and that since the accident occurred during operation of the hotel, its policies should be considered excess of all of Hyatt's coverage.

Hyatt's primary insurer, Occidental, countered that since the accident resulted from a defect in the design of the skywalks, Hallmark's CU policies should be considered primary and the Hyatt line excess.

Judge O'Leary found that "overlapping coverages provided in these two broad-form comprehensive policies and the duty of each insurer to respond in good faith to each of their several insureds . . . leaves only one rational choice fair to the insurers, the insureds and the victims. That is, that we treat the two lines as concurrent insurers—both responsible for settling and defending."

Judge O'Leary specifically rejected the 50/50 apportionment proposal of Hyatt's first excess insurer, Northbrook, and the request from Hallmark's CU and American for reformation of the endorsement naming Hyatt as an additional insured on the Hallmark coverage.

On defense cost issues, Judge O'Leary ruled that exhaustion of policy limits relieved Northbrook and CU of their defense obligations and that Hallmark's American must pay its share of defense costs in the skywalk cases.

The judge also ruled that Pine Top, Federal and Highlands in the Hyatt line must drop down to cover defense costs while Columbia Casualty makes indemnity payments. The Columbia Casualty policy specifically excluded defense cost coverage.

Judge O'Leary modified this portion of the opinion last March, ruling that Pine Top and Federal have no defense obligation. Highlands, however, was still required to cover defense costs in Columbia Casualty's layer.

Nearly all of Judge O'Leary's findings are the subject of appeals by one excess insurer or another.

In its appeal brief, Hyatt's Northbrook argues that Judge O'Leary was incorrect in deciding that "other insurance" clauses in the various excess policies were mutually repugnant, allowing for pro-rata apportionment by limits.

The "other insurance" clauses provided that the policy in question would be considered excess of other collectable insurance.

Northbrook argues in its appeal that none of the excess policies in the Hyatt or Hallmark lines makes any provision for pro-rata apportionment by limits. Therefore, Northbrook claims, any apportionment should follow the 50/50 proration followed by the primary insurers.

"If there is any intent expressed by the parties, it is the intent expressed by the primary insurers," Northbrook's appeal brief reads.

Northbrook also argues that proration by policy limits runs against the trend in insurance law —which is toward proration by equal shares—and that it is based on a faulty premise that policy limits are a reflection of the amount of premium collected by a given insurer.

Meanwhile, CU, Republic and American argue in their appeals that Judge O'Leary wrongly denied them the chance to present evidence for reformation of their policies issued to Hallmark to make them excess over the entire Hyatt line.

These Hallmark insurers argue that an endorsement adding Hyatt as a named insured was ambiguous, did not express the true intent of the parties and should now be rewritten.

Hyatt and Hallmark had agreed as early as 1980 that the permanent liability insurance covering the Kansas City hotel's operations was to be Hyatt's responsibility, and that Hallmark would provide liability insurance only for ongoing construction risks, according to a joint appeal brief filed by CU and Republic.

Construction work at the hotel had ended before the July 17, 1981, skywalk collapse, the brief says.

The parties' intent was indicated by the fact that between July 1980 and July 17, 1981, all hotel-related liability claims were presented to Hyatt insurers only and not to Hallmark insurers, the CU/Republic brief adds.

Letters sent to CU after the accident by Hyatt's risk manager, Robert Duty, also indicated that Hyatt understood the Hallmark line to be excess of Hyatt's coverage, Hallmark's insurers claim.

In addition, CU never received any premium for adding Hyatt as a named insured, another indication that it did not intend to assume the risk that it has been ordered to bear, CU argues.

Judge O'Leary—who barred the admission of such "extrinsic" evidence—incorrectly ruled that the lines of insurance purchased by Hallmark and Hyatt were concurrent after concluding that the policies' other insurance clauses were mutually repugnant, the CU/Republic brief argues.

"Rather than permitting the parties to present substantial evidence that they intended the Commercial Union line to provide insurance excess over the Occidental line, the Court chose to embark on a 'clause matching' excursion. In doing so, it reached a conclusion diametrically opposed to the clear intent of the contracting parties, as manifested by their conduct prior to the skywalk collapse," the CU/Republic brief says.

CU and Republic also argue that Judge O'Leary should have enforced the other insurance clause that was part of the endorsement naming Hyatt as an insured under the Hallmark line. Enforcing this clause would have made all of the Hallmark coverage excess over Hyatt's.

Meanwhile, American—which provided the largest limit of any insurer in the Hallmark line—argues that it should not have to pay any defense costs associated with the skywalk collapse.

In his 1982 memorandum opinion, Judge O'Leary found that American had no duty to defend. This decision was based on one clause in the American policy. However, Judge O'Leary reversed himself in his final order last February, finding that American did have a defense obligation under a second clause in the policy.

In its appeal, American now argues that based on a third clause, defense costs are covered at the option of the insurer, but that American has no obligation to pay these costs or to participate in the policyholders' defense.

Hyatt insurers—including Columbia Casualty—had argued that American consented to cover defense costs by approving settlements and by acquiescing to the continued defense of its policyholders by their original defense counsel.

However, American now argues that Columbia did not present sufficient evidence to support Judge O'Leary's ruling that American has a defense obligation.

Highlands, one of Hyatt's excess insurers, argues on appeal for a more sweeping reversal of Judge O'Leary's two-thirds/one-third allocation order.

Highlands argues that Judge O'Leary was incorrect in concluding that the Hyatt and Hallmark primary CGL policies afforded the same broad coverage of all hazards and that a fault trial would be impossible.

The Hyatt and Hallmark lines were intended to cover different operations of their respective policyholders, and insurance proceeds should be allocated between the two lines only after a trial is held to determine the cause of the skywalk collapse and the responsibility of the various parties involved, Highlands maintains.

"If one accepts the premise that allocation of the fault for the skywalk collapse was impossible, then it may not have been altogether irrational to apportion the total loss as a common, indivisible liability.

"However, we know today that such a factual determination of causation and fault is not impossible," Highlands' brief reads.

Highlands then points to the recent administrative decision finding two engineers grossly negligent in their design of the system of rods and connectors used to suspend the skywalks in the Kansas City Hyatt's atrium lobby.

"The trial court did not have the benefit of this administrative finding; it erroneously believed that the cause of the collapse could never be determined. That erroneous assumption caused the trial court to treat the loss as a unified risk for purposes of allocation," Highlands argues.

Highlands also disputes Judge O'Leary's ruling that it must drop down to cover defense costs in Columbia Casualty's layer, arguing that the " 'gap' in defense coverage here results not from the failure of an insurer to live up to its bargain; rather, it obtains only because Hyatt never bothered to put such coverage in place. And because it did not purchase any such defense coverage, it itself must bear the expense."

Defense costs, Highlands further argues, should be allocated between the Hyatt and Hallmark lines on a layer-by-layer basis, depending on the limits available in each layer. ■

Franzese indictment

Continued from page 2

bond to Flexo Contracting Corp., one of the 18 companies allegedly controlled by Mr. Franzese. Apple Bank, a New York bank that had loaned money to Flexo, later sued to recover under the bond after Flexo defaulted on a construction job. However, this bond is not the subject of any allegations in the indictment.)

In a series of five other alleged racketeering acts, Mr. Franzese and three co-defendants are accused of receiving more than $400,000 in kickbacks from Leo Bloom, president of Dome Insurance Co. of the Virgin Islands, in return for investing assets of a union pension fund in Dome certificates of deposit.

Mr. Franzese and the three co-defendants acted as counsel to or were employees of the Allied Security Health and Welfare Fund, a pension fund for a union representing security guards.

The kickbacks, paid between 1982 and January 1984, included cash for a down payment on a home, a home mortgage and an expense-paid trip to St. Croix in the Virgin Islands, the indictment charges.

Dome was placed in receivership in April 1984.

The indictment also alleges that Mr. Franzese and other defendants conspired to defraud:

- Beneficial Commercial on loans to finance the sale of new automobiles by two auto dealerships controlled by the defendants.
- Chemical Bank, First National of Chicago, Bank One of Columbus, Ohio, and other banks through the use of counterfeit VISA and MasterCard credit cards.
- Chubb & Son Inc., by filing a fraudulent $24,000 claim against a pleasure boat insurance policy.
- Mobil Oil, by failing to pay for petroleum products delivered to a New York gas station controlled by one of the defendants.

All of the defendants have pleaded not guilty. ■

Lloyd's makes PCW transcripts available to prosecutor

LONDON—Lloyd's of London says the British director of public prosecution is free to examine the 300 boxes of transcripts of the Lloyd's disciplinary proceedings against former executives of PCW Underwriting Agencies Ltd.

So far, Lloyd's has passed to the director of public prosecution all the evidence in its possession—except the boxes of transcripts—concerning alleged misappropriation of millions of pounds belonging to the PCW syndicates, according to Lloyd's Chief Executive Ian Davison.

Mr. Davison said the evidence was made available to the prosecutor to help in any criminal prosecution. Based on this evidence, Lloyd's expelled two former PCW executives—Peter Dixon and Alan Sampson—and disciplined four others, he said.

But, to date, the DPP has filed no criminal charges against anyone in connection with the PCW scandal.

Until recently, Lloyd's had refused to hand over the transcripts of its disciplinary proceedings on the PCW affair.

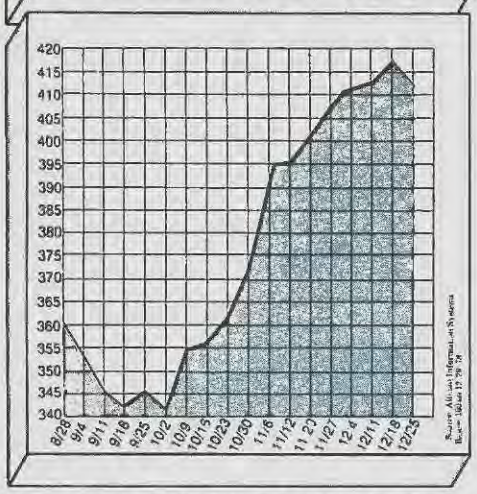
But, Mr. Davison stressed that the refusal was "not to protect fraudsters," but to protect the privacy of others who testified before the committee but who were not found guilty of any wrongdoing.

However, now Lloyd's has changed its mind, Mr. Davison explained.

The DPP "is welcome to go through" the transcripts, Mr. Davison said earlier this month. The papers from the 50-day proceedings fill 300 boxes, he said.

And, Mr. Davison added, "The DPP has been given all the evidence it needs to try a case." ■

BI Insurance Index



Insurance industry stocks declined for the first time in 11 weeks as the *Business Insurance* stock index dropped 5.6 points during the four-day trading period ending Dec. 24 to 411.6 points from 417.2 points on Dec. 18. Fifteen stocks posted gains during the period, 33 issues declined and 10 remained unchanged. The largest percentage gains were reported by United Fire & Casualty Co., up 6.7%; Emett & Chandler Cos. Inc., up 4.3%; Statesman Group Inc., up 4.1%; American Heritage Life Investment Corp., up 3.2%; and Frank B. Hall & Co. Inc., up 3.0%. The largest percentage losses were suffered by Torchmark Corp., down 8.4%; Kansas City Life Insurance Co., down 7.5%; Provident Life & Accident Insurance Co., down 7.1%; Northwestern National Life Insurance Co., down 6.9%; Chubb Corp., down 6.3%. The *Business Insurance* index lost 1.4% during the trading period, which was less than the 1.5% drop in the Dow Jones 30 industrials average. However, the New York Stock Exchange composite, with a 1.2% decrease, and the Standard & Poor's 500 index, with a 1.3% decline, fared better than the *BI* index.

British Issues

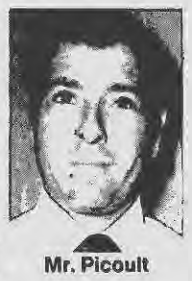
23 Dec Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	227	N/M	16.9	7.6	228—	225
Genl Accident	718	31.6	31.4	4.4	718—	702
Gdn Royal Exch	717	62.3	38.6	5.4	717—	707
Royal	787	49.2	35.0	4.4	787—	773
Sun Alliance	520	86.7	23.6	4.5	520—	512
Brokers						
CE Heath	660	8.6	37.5	5.6	663—	658
Hogg Robinson	274	11.4	13.4	4.9	274—	272
JH Minet	243	11.0	11.4	4.7	243—	230
Sedg Grp	355	14.2	17.8	5.0	355—	350
Stew Wrightson	690	13.3	32.8	4.8	690—	688
Willis Faber	793	20.4	23.6	3.0	793—	788

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

Hard market is no holiday for make-believe insurer

By MYRON M. PICOULT
Special to Business Insurance

IN PAST YEARS, in tune with the season, we have conveyed our year-end thoughts on the property/casualty industry through rhyme and verse.


Mr. Picoult

For example, in 1982 we hypothesized how Clement Clarke Moore would have viewed the industry during the competitive property/casualty cycle (*BI*, Dec. 20 1982).

Now, after the market has turned and insurers are embarking on an underwriting and earnings recovery, we are once again drawn to Mr. Moore's classic poem, "A Visit from St. Nicholas."

'Twas the night before Christmas
And the market had closed.
At FlyByNyte Insurance
All the staff was reposed.

Policies were hung
From the ceiling, with holly;
The company party
Was finally jolly.

In past years the party
Was really for naught—
No one came, they were busy
With some maudlin thought.

But this year the losses
Began to look better,
So thus did the eggnog,
And the party's poinsettia.

In fact, the whole staff
Was spending this time
With sugarplum visions
Of prices on the climb.

The claims chief was quaffing
With a guy from Underwriting:

"Look at all that snow!
And this cold's really biting!

"But it's perfect in here,"
He was philosophizing
"Current losses are down!
And the prices are rising!"

"Hey—it's not that good yet,"
I cried, "in various facets.
You guys haven't questioned
The quality of assets!"

But they'd settled their brains
And were clearly quite miffed.
"What's a janitor know?"
They glared at me and sniffed.

When out on the street
There arose such a clatter
I ran to the window
To see what was the matter.

"Whoa-ho," yelled a voice
Booming rather astute.
Then in blustered a man
In a red pin-striped suit.

"I would have come sooner,"
He said right away.
"But the parking garage
Wouldn't put up my sleigh."

I thought to myself,
"Gad, his suit's slick.
I've seen him in Sales—
I think his name's Nick."

He pulled out a briefcase
Jammed with reports
Which he tossed out by name—
There were plenty of sorts.

"Reinsurance, now canceled!
Reserves, still corrupt!
Letters of credit
From the Banco de Rupt!"

He picked up the papers.
"FlyByNyte could still fall!
Meaningless, meaningless,
Meaningless all!"

And then in a twinkling
I saw a big smile.
The chairman came forth,
"We've been fine for a while.

"We've cut back exposures
Fixed reserves on the double.
And prices will rise
Since we're addressing our trouble!"

Then the top actuary
Stepped forward to say,
"Mr. Chairman is right,
We've been doing OK.

"BUT—casualty reserves
Are still pretty short
Though I didn't really note it
In my last report."

The chief reinsurance man
Said, "Now that it's out,
The quality of reinsurance
Is highly in doubt."

"There's problems at my end,"
The head accountant conveyed.
"The writeoffs of assets
Have been quite delayed."

(Though few people noticed
This news had its toll—
The chairman had stuck his head
In the wassail bowl.)

Nick from Sales glanced at me,
Could I add to this scene?
"I'm the janitor," I said.
"Well, the bathrooms are clean."

Nick's eyes, how they twinkled!
His dimples, how jolly!
He smiled, quite in pity
At all of this folly.

His suit vest was buttoned
Tight over his belly
Which shook while he laughed
Like a bowl full of jelly.

A tear in his eye
And a shake of his head
Told those FlyByNyte fellows
There was something to dread.

"I came to the party,"
He said, "Contemplating
That A.M. Best would give
You folks a good rating.

"But you've said it yourselves
You've got plenty to fear.
It's snowing outside
But it's worse off in here!"

He spoke no more words
And left on this hunch
With once glance at the chairman,
His head in the punch.

And laying a finger
Aside of his nose
He left us all standing
To brood with our woes.

"Why stay with this company?"
I said to myself.
So I ran off to join him—
A tag-along elf.

As we flew off, we cried
"FlyByNyte don't forget
Improving is fine
But you're not healthy yet!"

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

BI Industry Stock Report

December 25, 1985 **12/19/85 thru 12/25/85**

		Price	% Chg.	P/E	$ Div.	% Yld.	High	Low	Vol.(000)
Brokers									
Alexander & Alexander Svcs	NYSE	32.25	-4.4	0.0	1.00	3.1	33.38	32.25	208.0
Baldwin & Lyons Inc	OTC	67.00	0.0	14.8	0.80	1.2	70.50	67.00	0.6
Corroon & Black Corp	NYSE	55.00	-3.5	74.3	1.00	1.8	57.13	55.00	92.7
Crump E H Cos Inc	OTC	21.50	2.4	23.1	0.25	1.2	21.50*	21.13	102.3
Emett & Chandler Cos Inc	OTC	18.25	4.3	31.5	0.00	0.0	18.25	18.00	34.6
Gallagher Arthur J & Co	OTC	48.50	1.0	23.8	0.28	0.6	48.75	48.25	7.2
Hall Frank B & Co Inc	NYSE	25.75	3.0	0.0	0.00	0.0	25.75	24.75	148.1
Marsh & Mclennan Cos Inc	NYSE	81.38	-0.5	19.4	2.70	3.3	81.88	81.25	226.4
Poe & Assoc Inc	OTC	13.50	0.0	0.0	0.80	5.9	13.50	13.50	3.1
AGENTS/BROKERS	AVERAGE			147.6		1.9			
Conglomerates & Holding Cos.									
American Express(Fireman's Fd)	NYSE	51.63	-3.3	16.5	1.36	2.6	52.75	51.63	3,704.3
Anderson Clayton(Ranger/PanAm)	NYSE	55.75	5.2	38.7	1.32	2.4	55.75*	53.63	155.0
Amco Inc	NYSE	9.25	1.4	0.0	0.00	0.0	9.25	9.00	735.0
Berkley W R Corp	OTC	31.75	0.8	99.2	0.32	1.0	32.13*	31.75	283.7
CIGNA Corp	NYSE	62.00	0.4	30.1	2.60	4.2	62.50	62.00	585.0
CNA Finl Corp :CNA)	NYSE	63.63	0.6	19.9	0.00	0.0	64.25	63.00	84.9
General Re Corp	NYSE	99.88	-3.0	108.6	1.56	1.6	102.00	99.88	306.5
ITT (Hartford Group)	NYSE	37.25	2.8	11.7	1.00	2.7	37.25*	36.38	3,115.9
Sears Roebuck & Co. (Allstate)	NYSE	37.63	-4.4	10.5	1.76	4.7	39.88	37.63	3,712.9
Teledyne Inc (Argonaut)	NYSE	307.75	2.2	6.7	0.00	0.0	307.75*	298.50	186.7
Transamerica Corp (Occidental & Fred S. James)	NYSE	33.63	-2.5	16.3	1.68	5.0	34.00	33.63	366.7
CONGLOMERATES/HOLDING COS.	AVERAGE			12.2		1.5			
Insurers									
Aetna Life & Cas Co	NYSE	51.63	-1.2	19.4	2.64	5.1	52.75	51.63	896.9
American General Corp	NYSE	33.25	-2.9	10.1	1.00	3.0	33.75	33.13	940.3
Amern Heritage Life Invt Co	NYSE	40.25	3.2	11.6	1.20	3.0	40.25*	39.25	10.9
American Indty Finl Corp	OTC	20.25	-2.4	0.0	1.12	5.5	20.75	20.25	23.5
American Intl Group Inc	NYSE	105.00	-2.1	26.2	0.44	0.4	107.50	105.00	555.8
Amerco Reins Ltd	OTC	0.75	0.0	0.0	0.00	0.0	0.75	0.75	4.7
Avemco Corp	NYSE	35.63	-2.1	14.1	0.60	1.7	36.25	35.63	32.0
Business Mens Assurn Co Amer	OTC	11.50	-0.8	8.8	1.04	3.3	31.75	31.00	28.9
Chubb Corp	NYSE	51.75	-6.3	18.7	1.56	3.0	54.38	51.38	282.7
Combined Intl Corp	NYSE	51.00	-1.0	9.3	2.16	4.2	51.38	51.00	92.2
Continental Corp	NYSE	44.25	-4.1	21.9	2.60	5.9	45.75	44.25	1,143.4
Crown Life Ins Co	OTC	252.75	-0.9	15.2	0.00	0.0	252.75	252.75	0.0
Durham Corp	OTC	39.75	-0.6	7.3	1.28	3.2	40.25	39.75	50.4
Farmers Group Inc	OTC	66.25	-4.5	11.2	1.76	2.7	68.63	66.25	450.4
Fireman Fd Corp	NYSE	31.38	-4.6	0.0	0.30	1.0	32.63	31.38	553.8
Fremont Gen Corp	OTC	23.88	0.5	2.3	0.48	2.0	24.00	23.75	136.2
Great West Life Assurn Co	OTC	490.00	0.0	12.6	1.60	0.3	490.00	490.00	0.0
Home Group Inc	AMEX	24.13	-4.5	0.0	0.00	0.0	25.50	24.13	858.3
Hanover Ins Co	OTC	51.50	0.0	53.6	0.56	1.1	51.75*	51.50	45.9
Hartford Steam Boiler Inspctn	OTC	62.00	0.0	14.6	2.00	3.2	62.00	62.00	31.1
Kans City Life Ins	OTC	27.75	-7.5	10.9	0.87	3.1	29.75	27.75	7.5
Kemper Corp	OTC	72.13	0.0	20.8	1.80	2.5	72.38*	72.13	251.0
Liberty Corp S C	NYSE	34.00	-1.8	14.7	0.72	2.1	34.88	34.00	18.8
Lincoln Natl Corp Ind	NYSE	49.88	-2.2	11.8	2.00	4.0	50.50	49.88	205.6
Mission Ins Group Inc	NYSE	2.75	0.0	0.0	0.00	0.0	0.00	0.00	0.0
Monumental Corp	OTC	34.88	-0.7	11.8	1.40	4.0	35.25	34.88	8.2
Nobel Ins Ltd	OTC	12.00	0.0	15.8	0.25	2.1	12.00	11.50	75.1
Northwestern Natl Life Ins	OTC	23.63	-6.9	6.2	0.80	3.4	24.88	23.63	251.2
Ohio Cas Corp	OTC	66.63	-4.0	22.4	2.80	4.2	68.00	66.63	59.0
Old Rep Intl Corp	OTC	35.50	1.1	9.6	0.74	2.1	35.50	35.25	64.6
Orion Cap Corp	NYSE	31.38	0.0	0.0	0.76	2.4	31.38	30.88	41.6
Protective Corp	OTC	21.50	-2.3	8.0	0.66	3.1	22.00	21.50	96.1
Provident Life & Acc Ins Co	OTC	26.25	-7.1	7.1	0.76	2.9	28.00	26.25	136.5
St Paul Cos Inc	OTC	79.25	-3.2	0.0	3.00	3.8	81.75	79.25	189.4
SAFECO Corp	OTC	45.13	-1.6	16.0	1.60	3.5	46.25	45.13	217.9
Sri Corp	OTC	16.50	-4.3	550.0	0.80	4.8	17.25	16.50	107.1
Seibels Bruce Group Inc	OTC	20.00	0.0	4.1	0.80	4.0	20.00	20.00	58.9
Statesman Group Inc	OTC	4.75	4.1	0.0	0.05	1.1	4.88	4.75	189.5
Tokio Marine & Fire Ins Co	OTC	220.25	0.3	41.5	1.05	0.5	221.00	218.25	2.7
Torchmark Corp	NYSE	21.88	-8.4	8.6	0.60	2.7	24.25	21.88	1,098.6
Travelers Corp	NYSE	46.63	-1.6	11.3	2.04	4.4	47.75	46.63	1,136.3
United Fire & Cas Co	OTC	32.00	6.7	15.0	1.20	3.8	32.00*	30.00	4.9
United States Fid & Gty Co	NYSE	38.00	-4.7	0.0	2.20	5.8	40.25	38.00	849.0
Uslife Corp	NYSE	37.50	0.3	8.4	1.12	3.0	38.25	37.50	110.8
Washington Natl Corp	NYSE	26.13	-2.3	9.0	1.08	4.1	26.38	26.00	113.3
Zenith Natl Ins Corp	OTC	24.25	1.0	0.0	0.68	2.8	24.50*	24.13	149.3
INSURANCE COMPANIES	AVERAGE			17.3		2.0			

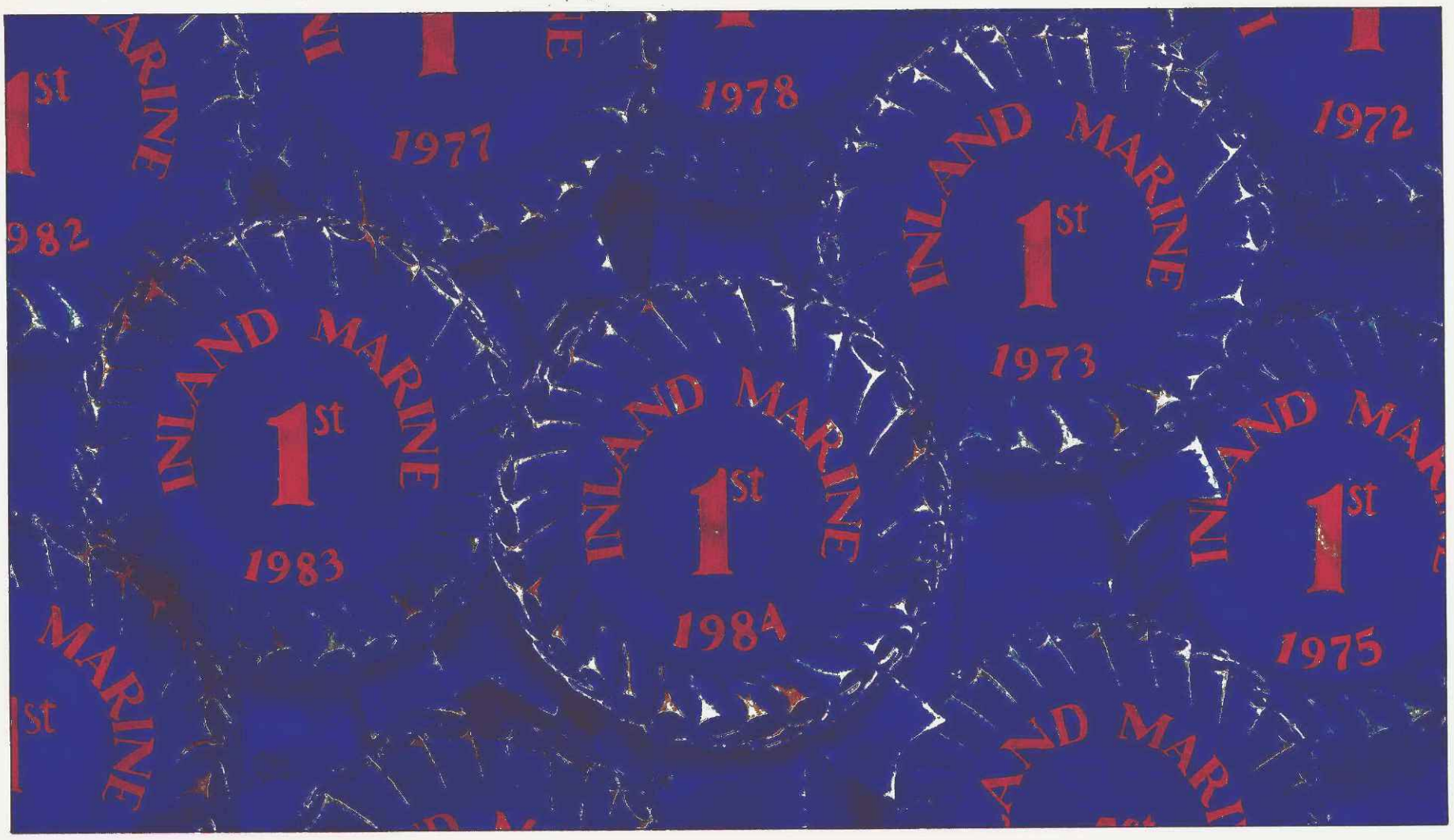
System design: Altman Information Systems

Amwest Insurance Group

Amwest Insurance Group Inc. has commenced its initial public offering of common stock.

The offering consists of 800,000 shares at $9 a share, of which 600,000 shares are being sold by the company and 200,000 shares are being sold by Amwest shareholders. The offering was increased in size from the 650,000 shares originally filed with the Securities and Exchange Commission.

Amwest, which is headquartered in Woodland Hills, Calif., underwrites surety bonds in California and 12 other states, primarily in the West and Southwest. Its common stock will be traded on the over-the-counter market under the NASDAQ symbol "AMWE." ■



BROKERS' ATTITUDES ABOUT OUR UNDERWRITING HAVE KEPT US IN OUR PLACE.

For the 13th year in a row, Best's has named AIG Number One in Inland Marine insurance in America.

Why is it that so many brokers continue to bring us their inland marine business and keep us in first place year after year?

Basically, it's because they feel our underwriting philosophy strengthens *their* place in the market, too.

For example, brokers appreciate the way our underwriters look carefully at each account and then design a policy specifically suited to that client's needs.

In fact, we don't believe there's any such thing as a "standard" risk. Instead, we believe every risk can be better served by a creative underwriting approach.

Brokers also like the fact that our underwriters still emphasize long-term financial stability and strength over the short-term "benefit" of price.

In contrast, many of our competitors have lowered their underwriting standards in the interest of immediate cash flow—and now they're being forced to re-evaluate their positions in the market. Which is raising a lot of questions among their brokers and insureds.

Finally, brokers approve of the way we work with them to provide clients with quality service. Together with most brokers, we think it's important to give clients the attention they need, no matter how long it takes, instead of rushing through things in the pursuit of high sales volume.

With these kinds of unwavering underwriting standards, it's no wonder more and more brokers prefer to bring their inland marine business to us every year.

That's why, whatever the competition decides, we'll continue to remain true to our tried and proven underwriting standards.

And we'll hope the majority of brokers will, too.

For more information about Inland Marine Insurance from The AIG Companies, write Dept. A, American International Group, 70 Pine Street, New York, N.Y. 10270

NAME/TITLE

COMPANY

ADDRESS

PHONE

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ONCE AGAIN THE ANSWER IS AIG.