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update

A&A protesting contract awarded for transit project

LOS ANGELES—Alexander & Alexander Inc. is protesting a transportation board's decision to award Fred S. James & Co. Inc. the contract to serve as insurance administrator for the city's proposed $3.4 billion Metro Rail project.

James, which won the contract through a sealed-bid competition in which Marsh & McLennan Inc. also participated, will place an estimated

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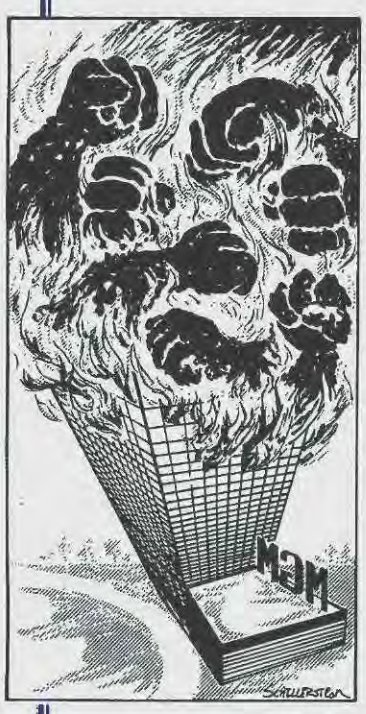
MGM retroactive insurers are now squabbling, too

By RHONDA L. RUNDLE

LAS VEGAS—A squabble among the excess insurers on different layers of the retroactive liability insurance held by MGM Grand Hotels Inc. is the latest twist in the hotel company's coverage battle.

MGM purchased $170 million in retroactive liability coverage following a fire in November 1980 at its Las Vegas hotel, but filed suit against the insurers and broker last March after the insurers stopped paying claims because of a dispute over MGM's $75 million settlement with fire victims.

Now, a divergence of interests among the retroactive insurers is surfacing publicly as they file their answers and cross-claims to the MGM suit in the 8th Judicial District for the State of Nevada in Las Vegas (*BI*, Feb. 6).



The third-layer excess insurers, which wrote a $25 million layer of retroactive coverage above the $30 million in coverage that MGM held at the time of the fire and $70 million of the $170 million it purchased later, say that underlying retroactive insurers could have settled the fire claims for $50 million.

If they had done so, the fire-related claims and related settlement costs and legal expenses would have been capped in the second layer and, therefore, the upper layers would not be exposed to losses, seven of the nine third-layer insurers argue.

"The underlying insurers failed to settle within their respective policy limits when they had the opportunity to do so in November 1982," explains Robert N. Schiff, an attorney with the San Francisco firm of Fisher & Hurst representing Insurance Corp. of Ireland Ltd., a third-layer excess insurer.

Subsequently, MGM negotiated a global settlement with remaining fire victims and other fire defendants, including a $75 million contribution by the hotel company. In addition, MGM Grand has paid an estimated $5 million in unreimbursed legal and other costs associated with the fire litigation.

The third-layer excess insurers are seeking indemnification from the lower-layer excess insurers for any eventual loss that exceeds their $70 million exposure, adds Mr. Schiff. So far, this includes $5 million from the settlement plus legal costs, but the meter is still running.

Legal costs in MGM's suit against the insurers will pick up this month as the case moves into the discovery phase.

Besides the Insurance Corp. of Ireland, other third-layer excess insurers that have filed cross-claims against underlying insurers include St. Paul Surplus Lines Insurance Co., Northumberland General Insurance Co., Guardian Insurance Co. of Canada, United States Fire Insurance Co., Northbrook Excess and Surplus Insurance Co. and The Home Insurance Co.

The two third-layer insurers that have not filed cross-claims are The Travelers Indemnity Co. and National Union Fire Insurance Co. of Pittsburgh, Pa., an affiliate of the American International Group Inc.

National Union did not join in the action because another AIG affiliate—American Home Assurance Co.—is a major participant on the second layer in the retroactive package, said an attorney for National Union.

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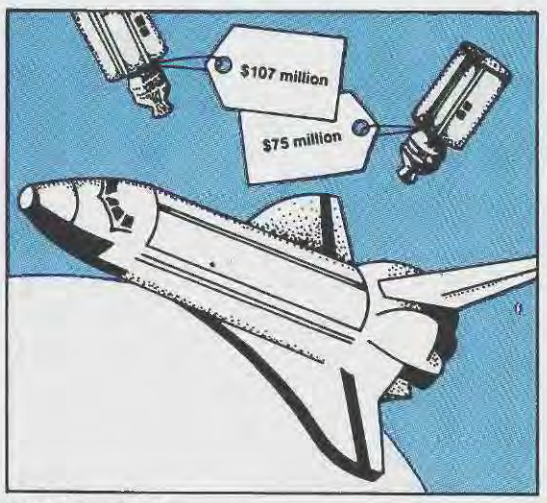
Latest satellite losses to propel rates upward

By STACY SHAPIRO

LONDON—Satellite insurance rates will lift off following two satellite losses totaling $182 million on the recent space shuttle mission, London and U.S. insurers and brokers agree.



Graphic: Amy Palmer

They say it's still too early to estimate when and by how much rates will rise. And they speculate that some underwriters will not boost prices as much as others.

But, they all agree, the debacles earlier this month will certainly cause satellite insurance capacity to tighten as the market's loss ratio approaches 200%.

"It is highly probable that premium rates will increase," said Stephen Merrett, chairman of Merrett Holdings P.L.C. and a Lloyd's of London underwriter on both of the recent shuttle satellite losses.

"There is no doubt that by and large underwriters interested in space insurance will say that (present) rates are no longer acceptable," he said.

"The answer is obvious," added Richard Nausch, president of Nausch, Hogan & Murray Inc. in New York, a brokerage specializing in satellite coverages. "When loss ratios are no longer permissible, underwriters strive to get higher rates. . .so everyone is going to want more."

"There is bound to be an impact—and a dramatic one, I think," said Tom Wallace, managing director of Sedgwick (Aviation) Ltd., which brokered the coverage for Western Union Corp., which owned one of the lost satellites.

These dire predictions were made after Westar VI, owned by Western Union, and Palapa B2, owned by the Indonesian government, failed to reach geostationary orbits 22,300 miles above the earth following their launch from the space shuttle Challenger.

Although both probes are still operating, they are currently rotating in relation to the earth—rather than remaining in a fixed position—rendering them useless as communications satellites.

The National Aeronautics and Space Administration, which operates the shuttle, believes that a motor—formally known as a Payload Assist Module—that was supposed to thrust the satellites into higher orbit failed to function properly.

Together, the two satellites will cost insurers more than $182 million in claims, making the combination the largest loss in the brief history of satellite insurance.

Mr. Merrett said last week the Westar VI was insured

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Wisconsin court says victims can sue any DES defendant

By JERRY GEISEL

MADISON, Wis.—A victim of the cancer-causing drug DES can sue and recover full damages from any DES manufacturer she chooses even if the company did not produce the medication that injured her, the Wisconsin Supreme Court says.

In a decision that dramatically increases the liability of pharmaceutical companies, the Wisconsin Supreme Court said plaintiffs can sue any one of the hundreds of companies that made the anti-miscarriage drug and do not have to prove that the manufacturer made the DES ingested in that particular case.

"The plaintiff need only establish by a preponderance of the evidence that a defendant produced or marketed the type (e.g., color, shape, markings or other identifiable characteristics) of DES taken by the plaintiff's mother," the court said.

"If the plaintiff is able to prove these elements, the plaintiff may recover all damages from the one defendant," the court added.

The Wisconsin court ruling goes far beyond and specifically rejects the 1980 California Supreme Court ruling in the now famous Sindell case (*BI*, March 31, 1980).

In Sindell, the California court ruled that when a product causing injury is made by many different manufacturers and the specific manufacturer cannot be identified, liability must be divided among them based on their share of the market for the product.

While the Sindell decision prompted criticism from the pharmaceutical and insurance industries, at least under that decision a manufacturer knew there was a limit—based on its market share—to its potential liability in a lawsuit. The Wisconsin court ruling in Collins vs. Eli Lilly & Co. et al. has removed that limit.

Limiting a manufacturer's liability in a lawsuit to the percentage of the DES market it garnered simply is not practical, the Wisconsin court said.

Many drug companies lack records that would allow a plaintiff to prove how much DES a particular manufacturer produced.

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NEWSPAPER

Public liability insurance market tightening?

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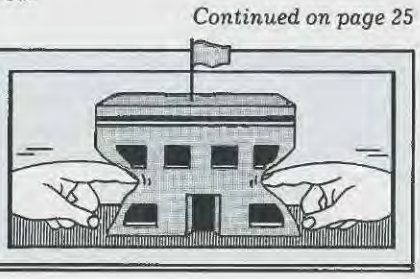

update

A&A protests James contract

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$85 million worth of coverage over a 10-year period of construction.

In a protest filed last week with the Southern California Rapid Transit District, A&A asks that RTD reverse its Jan. 26 decision to award the contract to James and award it instead to Metro Rail Insurance Administrators, a joint venture in which A&A is the major party.

A&A claims in its protest that it was the only one of the three brokers that met or exceeded all the standards required by the RTD's bidding process. It says James came in third on a rating scale established by the RTD to assess the brokers' proposals.

The RTD said the protest is without merit. It has not yet released results of the rating scale, but says that these standards were "designed to eliminate truly unqualified firms. . .and could not be applied in an absolute or arbitrary fashion."

Officials at James could not be reached for comment.

Appellate bond reduced

LOS ANGELES—National Union Fire Insurance Co. of Pittsburgh, Pa., expects to save about $50,000 annually while appealing a $13.7 million bad-faith judgment after successfully requesting that the amount of an appellate bond be reduced.

According to California law, a defendant appealing a judgment must file a bond guaranteeing payment that is 1.5 times the amount of the judgment. In this case, the $20 million bond that would be needed to cover the $13.7 judgment costs about $150,000 annually, said one of National Union's attorneys, Paul E. Glad, of the San Francisco law firm of Barger & Wolen. However, the court reduced the amount of the bond to the amount of the judgment.

National Union, an American International Group Inc. unit, is fighting a June 1983 verdict against it for failing to indemnify a California swimming pool builder who was sued over an injury (*BI*, July 11, 1983).

Manville punitive award upheld

TRENTON, N.J.—A state appellate court here is the second to uphold a punitive damage award against Manville Corp. arising out of asbestos litigation.

The decision in Fisher vs. Johns-Manville Corp. and Bell Asbestos Mines Ltd. is also the first time a New Jersey court has authorized punitive damages in tort lawsuits brought under the theory of strict liability.

The U.S. District Court for the District of New Jersey had previously interpreted New Jersey law to say that punitive damages in strict liability actions would not be allowed.

The decision by the appellate division of the Superior Court of New Jersey affirmed a $300,000 punitive damage award that assessed $240,000 against Manville and $60,000 against Bell. Manville will seek a review of the decision by the state supreme court, a Manville attorney said.

Also last week, the Massachusetts attorney general filed a $7.5 million claim against Manville to recover costs incurred to eliminate hazards in water pipes manufactured by Manville.

The suit was filed in U.S. Bankruptcy Court in New York on behalf of the state and 42 towns and water districts that installed vinyl-lined asbestos-cement pipes between 1968 and 1980.

Lilly appeals Oraflex award

COLUMBUS, Ga.—Eli Lilly & Co. of Indianapolis will appeal a $6 million jury award in a case involving the company's anti-arthritic drug Oraflex.

U.S. District Judge Robert Elliot refused Feb. 6 to reduce the amount of the award. A Lilly spokesman said the pharmaceutical company anticipated the judge's action and is prepared to appeal his ruling with the 11th U.S. Circuit Court of Appeals in Atlanta.

Lilly was ordered to pay $6 million to the son of an 81-year-old woman who allegedly suffered fatal side effects after taking the medication (*BI*, Nov. 28, 1983).

The company has excess insurance above its self-insurance to pay the verdict if it loses the appeal, a spokesman said.

Lilly faces about 200 lawsuits involving the drug. Oraflex was removed from store shelves in the United States in 1982.

Maisonpierre to head RAA

WASHINGTON—It appears to be a tit-for-tat situation between the Reinsurance Assn. of America and the Alliance of American Insurers.

Andre Maisonpierre, an Alliance senior vp in Washington, will be the new president of the RAA, replacing Frank Nutter, who will become the president of the Alliance (*BI*, Dec. 19, 1983).

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Food firms not covered for EDB-related recalls

By CAROL CAIN

The product recall coverages that gained popularity after the 1982 Tylenol tamperings aren't going to be much help to food processors recalling their products because of unacceptable levels of the pesticide EDB.

Either the companies have not bought the coverage or the number of products expected to be recalled is too small to pierce the policies' deductibles, spokesmen for the companies say.

On Feb. 3, the federal Environmental Protection Agency set tolerance levels for the cancer-causing chemical ethylene dibromide after Florida ordered certain food products, especially prepared mixes, removed from stores in December.

Since the EPA issued its guidelines, however, some states, notably Massachusetts and California, have set more stringent rules (see story, page 24).

Manufacturers have complied with the standards by removing and destroying isolated case lots of products that tests have shown to have EDB levels higher than the acceptable limits. But, these manufacturers say relatively few items are involved and the losses will be insignificant.

But consumer groups are pushing for even tougher restrictions that would prohibit the sale of food products with any trace of EDB. If they are successful, more products probably will have to be removed from shelves, though the manufacturers don't foresee a problem.

Underwriters, prompted by product manufacturers, began to devlop expanded recall insurance policies after the 1982 tragedy in which seven people in the Chicago area died after taking cyanide-laced Extra-Strength Tylenol capsules (*BI*, April 11, 1983).

Although several underwriters say the insurance has sold well in the past year and that food processors and manufacturers have been among the buyers, only two of the six food manufacturers contacted by *Business Insurance* said they have some type of product recall insurance.

The Pillsbury Co. in Minneapolis has limited recall coverage for catastrophic losses, according to Carol R. Polkinghorn, the company's assistant risk manager. However, she said the coverage would not be triggered by the EDP recall since the number of products involved is small.

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Vermont seeks open rating

By CAROL CAIN

MONTPELIER, Vt.—Employers in Vermont are giving lukewarm support to a measure that would require workers compensation insurers to compete by allowing them to establish their own rates.

The added competition probably would result in lower rates, some say, although no one is touting that reason in supporting the bill.

Open rating laws in effect in eight other states—Georgia, Minnesota, Arkansas, Oregon, Kentucky, Rhode Island, Michigan and Illinois—have shown that competitive rating lowers rates.

The Vermont measure, H.B. 639, establishes competitive rating for workers compensation insurance, as well as auto, homeowners and fire coverages.

The bill, drafted and supported by the Vermont Insurance Department, creates a "use-and-file" system under which workers compensation insurers may establish their own rating formula or use advisory rates filed by the National Council on Compensation Insurance.

"Even though the market is competitive today, the bill would guarantee competition and guarantee longer periods of competition," said Donald A. Kifer, deputy commissioner of insurance.

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Hyatt engineers failed to test design: Complaint

By STEPHEN TARNOFF

JEFFERSON CITY, Mo.—The Missouri state attorney general is charging two engineers and their firm with failing to make necessary design calculations on the skywalks that collapsed in 1981 at the Kansas City Hyatt Regency Hotel.

In a three-count complaint, the attorney general says that had the calculations involving bridge rods and connections used in the skywalks' support system been made, the rods and connections would have been found to be "grossly inadequate."

The complaint, filed on behalf of the Missouri Board for Architects, Professional Engineers & Land Surveyors, names Jack D. Gillum, Daniel M. Duncan and G.C.E. International Inc., a St. Louis engineering firm.

Mr. Gillum was responsible for the entire engineering and design of the structural aspects of the hotel project and Mr. Duncan was in charge of the actual structural engineering work, the complaint says.

According to the complaint, drawings for the hotel originally called for the skywalks to be suspended from single continuous rods but Mr. Duncan oversaw changes in the design that called for a non-continuous, split-rod configuration offset at the connection.

No calculations were done to determine the load capacity of the bridge rods and connections, however, which would have shown that they were "grossly inadequate," the attorney general's complaint says.

"At no time did respondents Duncan or Gillum, nor anyone under the direct and personal supervision of respondent Gillum, prepare a detail depicting the non-continuous, split-rod configuration offset at the connection, nor did respondents Duncan or Gillum, nor anyone under the supervision of respondent Gillum, perform calculations to determine the load capacity of the bridge rods and connections," the complaint says.

"Had respondents Duncan and Gillum prepared such a detail and performed such calculations or directed the preparation of such a detail and calculations, as they had an obligation to do, they would

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Beacon Insurance, president deny involvement in fraud

By LEN STRAZEWSKI

STATESVILLE, N.C.—Beacon Insurance Co. of Raleigh, N.C., and its president, Neill Portermain, are denying allegations that they conspired with another insurer, a reinsurance intermediary and a managing general agency to defraud a Bermuda reinsurer of $10 million in reinsurance premium, according their answer to a lawsuit here.

Instead, they are alleging any financial problems faced by the plaintiff, Universal Marine Insurance Co., are the result of "systematic looting of its assets by its parent, Ingram Corp."

Beacon also alleges that a co-defendant in the Universal Marine action, Cherokee Insurance Co. of Nashville, Tenn., owes Beacon $3.9 million in claims owed under a quota-share agreement and a previously undisclosed excess-of-loss agreement. Cherokee was reinsured on both agreements by Universal Marine, according to Beacon's court filed documents.

In an answer to a lawsuit filed late last year in U.S. District Court by Universal Marine, a subsidiary of Nashville-based Ingram Corp., Beacon and Mr. Portermain categorically deny allegations that they conspired with Cherokee, reinsurance intermediary New Orleans Reinsurers Inc. and managing general agency B.F.G Toomey Associates Ltd. to wrongly use a 50% quota-share reinsurance agreement to defraud Universal Marine, a Bermuda-based insurer.

Under the quota-share agreement, Cherokee agreed to assume 50% of Beacon's net retained liability of up to $100,000 per policy.

In its original complaint, Universal Marine alleged that the defendants engaged in conspiracy, fraud and racketeering by using Cherokee to front reinsurance for Universal Marine and then accepting risks that were larger than allowed, failing to properly allocate premium, failing to disclose previous loss experience and overcharging Universal Marine for commissions and fees (*BI*, Jan. 9).

Universal Marine also invoked a special clause of the federal Crime and Criminal Procedures statute that allowed it to treble $16.5 million in total actual damages and thus seek $49.5 million from the defendants.

Both Beacon and Cherokee publicly denied all alle-

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Some see public liability market tightening

By STEVE TARAVELLA

Liability rates for California public entities will increase 10% to 25% at July policy renewals, some leading underwriters and brokers say.

And, not only will other regions of the nation follow this lead, but the tightening of the public liability market is the forerunner of higher liability insurance rates in general, they add.

Liability rates for public entities typically increase first in California and before the liability insurance market tightens for private business, they explain.

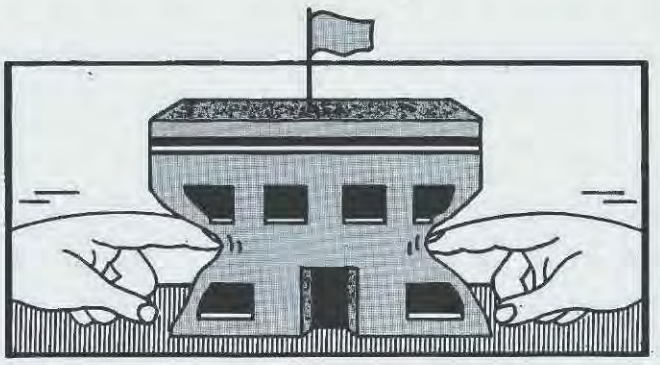
However, other industry sources and buyers do not see any tightening of the market now and don't expect major changes soon.

Those who say rate increases are imminent note that premiums for public entity liability coverage are at an all-time low nationwide. In some instances in California, they are only 10% to 20% of what they were six years ago, according to one broker.

Some insurers, frustrated at the bottom-dollar premiums, say they will relinquish their place in the California public liability insurance marketplace if they can't retain their business with higher premiums.

In fact, Canadian Indemnity Co., until recently one of the largest underwriters of liability insurance for California municipalities, stopped writing the coverage in May 1983.

Despite this, others maintain that public entities will see only modest liability insurance rate increases, if any. Some buyers who renewed policies last month report their rates were unchanged and, in some cases, reduced. They expect only the small, insignificant markets to stop writing the coverage.



Graphic: Jim Bakasetas

Others, particularly outside of California, not only don't expect the market to tighten but add that some insurers are increasingly willing to create policies that respond to public entity exposures.

D. Michael Enfield, managing director for Marsh & McLennan Inc. in San Francisco, is one who sees the market tightening.

"Whether or not the (commercial insurance) marketplace is dramatically changing... the marketplace for public agencies has already begun to constrict considerably," Mr. Enfield recently told members of the Public Agency Risk Managers Assn. in Sacramento, Calif.

"The public sector is a business that, in a soft market, everyone goes after because they have none of it—and, in a difficult market, most companies leave because they don't want any of it," he said.

"In the next six months, I'm convinced that at least three more players in the public sector will disappear. We're going to see a gradual withdrawal from the market."

However, Mr. Enfield would not name the three insurers he expects to pull out of the market.

Besides directly pulling out of the market, insurers also will show their reluctance to underwrite public liability risks by submitting higher bids for the coverage, taking too long to submit bids and offering no extension on coverage, Mr. Enfield predicts.

William G. Malone, director of Transcontinental Insurance Co.'s Western region in Los Angeles, agrees that public entities soon may find fewer insurers willing to underwrite their liability coverage.

Transcontinental, a division of CNA Insurance Cos., is one of the largest underwriters of public entity liability business in California.

"Something's going to happen. Last year at this time, I was a little skeptical. Now I'm not," Mr. Malone says. "What we see now is remarkably more visible than what we saw a year ago. Insurance carriers may well decide to put their capital and surplus dollars to better use in other areas."

He says that Transcontinental will review its existing policies on an individual basis at renewal, but that rates probably will increase an average of 10% to 25%. Most of the approximately 400 entities insured by the company have a July 1 renewal.

"Prices must move—they just have to," he says, adding that the company will not actively seek new business "until we see a significant price movement upward by our peer companies."

If Transcontinental sticks to its plan to raise rates, it well could lose some of its business at renewals. Public entities are

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Controlling costs

Monitoring hospital care reaps big savings

By STEVE TARAVELLA

Some major California employers are successfully combating escalating hospital costs with the help of a new health care cost-containment service that monitors hospital treatments.

Western Air Lines Inc. in Los Angeles estimates it saved almost $250,000 in hospital expenses in an eight-month period after adopting the service from Cost Care Inc.

In moves to contain health care costs, employers are trying new ways to cut hospital bills and communicate to employees.

The savings represent reductions in the number of hospital admissions and lengths of hospital stay for the airline's 950 non-union employees nationwide.

The Bekins Co. in Glendale, Calif., and its subsidiaries have saved about $80,000, or 4% of total employee health care costs, since initiating the new monitoring service in January 1983, estimates Tracee A. Edelen, manager of corporate and employee benefit programs.

And the nine-campus University of California system, which began working with Cost Care Jan. 1, projects savings in the first year of about $2.4 million. About one-fourth of the system's 90,000 employees throughout California will be affected.

Cost Care Inc., a 2-year-old independent health care cost management firm in Huntington Beach, Calif., targets its efforts toward what is generally the largest component of employers' soaring medical costs—hospital expenses.

Through pre-hospitalization review, Cost Care monitors both the number of days patients remain hospitalized and the number of hospital admissions. The review is designed to eliminate any unnecessary hospital expenses and to red-flag abusers of employer-sponsored medical coverage.

The company works to cut hospital costs either directly with the employer or through the employer's health insurer. About two-thirds of Cost Care's current 260 clients are insurance companies and the rest are employers that self-fund their health benefits.

Cost Care currently supervises the hospital care of about 510,000 employees and dependents.

Insurance companies contract with Cost Care to reduce the hospital expenses of group policyholders

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'Generic' communications might do job for you

By SALLIE J. DRURY

What do canned tuna and employee benefits communications materials have in common?

Both are available in generic versions.

Employee benefit managers are finding that "generic" films, pamphlets and other materials meet their communications needs nearly as well as customized materials— and at a much lower cost.

One such generic product that has been available for only about a month is a cost-containment videotape called "Dollars and Sense: The Health Care Emergency."

The film was originally customized for IC Industries Inc. in Chicago. Now, the company has embarked on a joint venture with the film's producer, The Media Works Inc. of Chicago, to make the film available for other companies that want to communicate the rising costs of health care to their employees.

The 23-minute generic version is pared from the 27-minute original tape, whose release coincided with benefit plan changes at IC Industries.

When IC Industries began planning for its own videotape in early 1982, the problems it was seeking to tackle are now familiar to all benefit managers.

"The costs and quality of health care resources everyone talks about were not really developing a healthy population," says Raymond B. Werntz, benefits director at IC Industries.

"We recognized that plan design and administration would have a lot to do with decreasing utilization and lowering costs, and we wanted that. But we also wanted something a little more complicated. We wanted to actually improve health."

The company did introduce plan design and administrative changes. It merged its three different health care plans—all self-insured, but administered by three different insurers—into one, which is called the prototype plan.

Some of the earlier plans had had first-dollar basic coverage with a small deductible and copayment for major medical expenses. The prototype plan was comprehensive, with a $200 front-end deductible and a 15% copayment feature. Financial incentives for lower-cost health care—such as outpatient surgery and second surgical opinions—were built in.

Administration was improved by contracting with only one insurer. More claims information was computerized in-house, Mr. Werntz said, so benefits administrators would be freed from their "paper-shuffling jobs of the past to move into a counseling role.

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GAO urges discounting of P/C loss reserves

By JERRY GEISEL

WASHINGTON—At a time when the property/casualty insurance industry is showing signs of under-reserving to pay future losses, the General Accounting Office is recommending that insurers be required to discount loss reserves to reflect investment income that will be earned in the future.

A GAO draft report, which is now circulating among trade associations for comment, contends that property/casualty insurers get an unwarranted tax break under current tax law that allows them to reserve today the full cost of a claim to be paid years from now.

More insurance companies could face insolvency if Congress adopts the GAO recommendation to require insurers to discount their reserves, insurers say.

Requiring insurers to discount loss reserves would be a fundamental change in tax accounting for the insurance industry.

Under current law, insurers can set up reserves based on an estimate of the future amount they will need to pay claims. For example, if an insurance company believes it will have to pay a $10 million medical malpractice claim 10 years from now, it can set up a $10 million reserve and take a tax deduction for $10 million in the year the reserve is established.

The GAO says the tax deduction for the reserves eventually needed to pay claims is too high because insurers will reap years of investment income on the reserves before they have to pay claims.

'The current practice overstates the amounts needed to satisfy future claims,' the GAO says.

While tax deductions for reserves are appropriate, "The current practice overstates the amounts needed to satisfy future claims," the GAO says.

"Permitting companies to deduct an amount of reserves that reflects the expected payment rather than an amount which, coupled with investment income, will be capable of fully satisfying the claim, overstates expenses and understates taxable income," the GAO says.

To increase insurers' taxable income, the GAO recommends that anticipated investment income be included when companies calculate how much they need to pay for future claims.

Each year, insurers should use their average rate of return on investments over the previous four years and the current year to determine by how much their reserves should be discounted, the GAO recommends.

Such reserve discounting would sharply lower tax deductions taken by insurance companies. For example, if insurers in 1982 had discounted their reserves by just 5%, their tax deductions would have been reduced by about $1.1 billion and $485 million in new tax revenues generated, the GAO says.

"The higher the discount rate used, the greater the reduction in the loss reserve deduction and the greater will be the increase in tax revenues," the GAO says.

The GAO's recommendation to discount reserves is contained in its 54-page report "Congress Should Consider Federal Income Taxation of the Property/Casualty Insurance Industry."

The report, which was requested by the Senate Finance Committee, already is drawing fire even though it has not been officially released.

Insurers say that the problem wracking the industry is under-reserving to pay claims and not over-reserving.

The Insurance Services Office recently reported that the industry's total loss and loss expense reserves, as of Dec. 31, 1982, were more than 10% inadequate, with at least one line—medical malpractice—under-reserved by at least 50% (*BI*, Jan. 16).

Individual insurers, such as Fireman's Fund Insurance Cos., also have added large sums to their reserves, admitting they have under-reserved in

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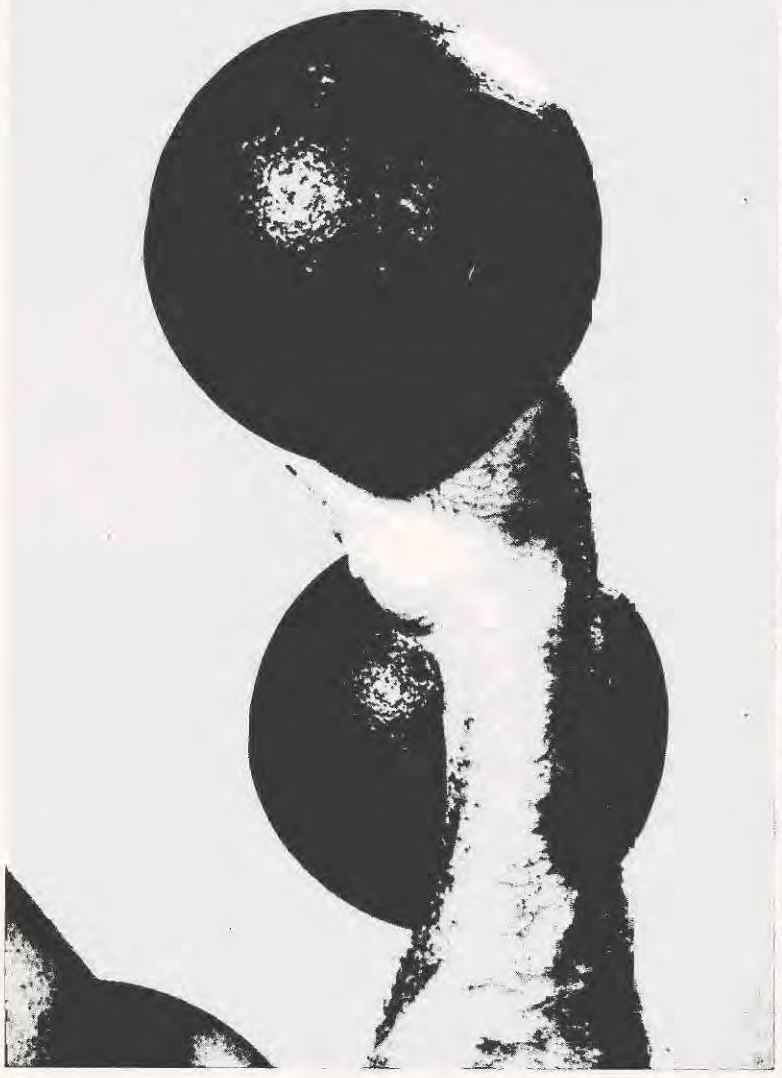

Satellite mishaps to cost underwriters $182 million

Continued from page 1

for about $107 million. Western Union officials said last week that about $75 million of the insurance covers "the commercial service, construction, launch and associated costs of the probe." The rest covers "the loss of new business" that would have been generated by the satellite, they say.

Westar VI was insured in three layers as part of a three-satellite insurance package that was originally placed Oct. 1, 1981. The coverage period lasts for 36 months.

About half of the insurance was placed in London by Sedgwick (Aviation) Ltd. and the bulk of the rest is believed to be placed in the United States by Alexander & Alexander Inc.

Sources in the United States and London markets that participated in the Westar VI insurance program say that:

- The first $80 million layer was led by Richard Maylem, Lloyd's underwriter for aviation syndicates managed by Alexander Howden Underwriters Ltd. The premium rate for Westar VI on this layer was 5.75% of the policy limit—or $4.6 million—though 20% of the premium would have been returned if there had been no loss.
- The second layer of about $20 million was led by Mr. Merrett, with Lloyd's syndicates once managed by P.C.W. Underwriting Agencies Ltd.—now called Richard Beckett Underwriting Agencies Ltd.—also on the layer. The premium for this layer is not known.
- The third layer of about $7 million was led by Orion Insurance Co, at a rate of 8.7% of the layer's limit, or $609,000 with no bonus for a good claims record.

Thus, Western Union paid at least $5.2 million, not counting the premium for the second layer.

Usually, satellite insurance is not layered, says Westar's U.S. broker Robert Tyrone, vp of Alexander & Alexander of New York Inc.

But, the coverage was placed in 1981 shortly after insurers were hit with a $77 million claim from the loss of RCA Corp.'s SATCOM III satellite, and layering was the only way to obtain the capacity needed to insure the three Westar probes, he says.

"After all, it was placed six months after the RCA loss," said Mr. Tyrone, "so we were trying to create capacity and we were quite successful."

The first two satellites in the three-satellite insurance package, Westar IV and Westar V, were successfully launched by NASA's Thor Delta rockets in 1982. Westar VI was scheduled to be launched on the European Space Agency's Ariane rocket, but setbacks in the Ariane program convinced Western Union to use the space shuttle instead, sources speculate.

Since the space shuttle had a better loss record than the Ariane program, rates were reduced when Western Union switched to the shuttle, Mr. Merrett confirmed, though he would not specify the reduction.

The second satellite to fail on the shuttle mission, Palapa B2, is insured as part of a two-satellite, 36-month insurance program originally placed Nov. 1, 1982, by broker Corroon & Black/Inspace Inc. of Washington, D.C., and Lloyd's broker Crawley, Warren Ltd. in London.

The first probe in the series, Palapa B1, was successfully launched by the space shuttle last June (*BI*, June 27, 1983).

Originally, the second Indonesian probe was to be insured for $85 million, but the Indonesians reduced the value of the probe to $75.394 million shortly before launch.

The satellite was insured by a consortium of Indonesian insurers led by Jasa Insurance Co., the state insurance company, and reinsured by 150 underwriters around the world.

The reinsurance is led in London by Mr. Merrett at Lloyd's. Fifty percent of the coverage is placed with Lloyd's, with 15% placed with other insurers in London, 27.5% placed in the U.S. market and 7.5% with European and other overseas underwriters.

Palapa B2's premium was adjustable according to the two satellites' loss record. For every 70 cents in claims, the Indonesians pay $1 in premium, up to a maximum premium of $12.004 million. If there had been no loss, the minimum premium would have been $7.5 million.

The impact of the two losses on the satellite insurance market, coupled with more than $200 million in other losses since 1977, is expected to be severe, sources agree.

"As far as the future is concerned, the market will harden, but it is too early to tell what the rates will do," said Tony Bolton, chairman of Bowring Space Projects, a subsidiary of Lloyd's broker C.T. Bowring & Co. Ltd.

Mr. Bolton notes that total satellite losses now stand at just less than $400 million, against premium income for just more than $200 million, though the premium figure does not include premiums for satellites that have not yet been launched.

Tom Wallace, managing director of Sedgwick (Aviation) Ltd., Western Union's London broker, says that some of the insurers hit with the recent losses will leave the market, "which will make (satellite) insurance a scarce commodity."

Up until now premiums for a $100 million satellite ranged from between $5.5 million to $7 million if it was launched aboard the space shuttle, he says, adding that premiums rise slightly if a probe is launched aboard an Ariane rocket.

Eddie Simms, Lloyd's underwriter for the Ariel Syndicate, which once led most satellite insurance programs, agrees that satellite premiums will rise, but he says the

Continued on page 8

Insurance claims near the $400 million mark

LONDON—Total satellite insurance claims will soar to just less than $400 million as a result of the two losses earlier this month, estimated at $182 million.

Other major insured satellite losses include:

- The $77 million loss of RCA Corp.'s SATCOM III, which failed in 1981 after it achieved orbit aboard a Thor Delta rocket (*BI*, Nov. 16, 1981). It had been the largest satellite loss until the recent mishaps.
- Another $20 million claim by RCA for an older SATCOM F2 that was discovered malfunctioning last year (*BI*, July 25, 1983).
- The $65 million loss of the Indian government's INSAT telecommunications satellite in 1982 (*BI*, July 19, 1982).
- The $20 million loss of the Marecs B telecommunications satellite owned by INMARSAT, an international maritime satellite consortium, aboard an Ariane rocket in 1982 (*BI*, Sept. 20, 1982).

Rescue mission could cut costs

Satellite losses, like the two during the recent space shuttle mission, may someday be avoided if a shuttle experiment proves successful.

On board the Challenger last week was a payload owned by the West German government that was to test if satellites can be retrieved in space.

The German space platform was equipped with a special cradle that allows astronauts aboard the shuttle to easily retrieve it. Such a cradle can be affixed to other satellites to ease recovery should they malfunction.

Astronauts are scheduled to actually repair a crippled probe later this year.

A NASA spokesman, however, said that the satellites that were lost during the shuttle mission could not be retrieved since they were not equipped with the cradle.

If, however, there had been a cradle similar to one on the German platform, "then there would be something to hold onto and something to put the satellite back into the shuttle with—if we could reach it," the NASA spokesman explained.

A Lloyd's of London underwriter who insured both of the lost probes, Stephen Merrett, chairman of Merrett Holdings P.L.C., said he did not think attempting to salvage the probes would benefit insurers because of the cost of such a mission.

However, the NASA spokesman said that "underwriters have expressed interest in retrieving the satellites." He explained that this could be done on future shuttle missions by attaching new motors to the probes and then attempting to lift them into higher orbit.

In fact, the spokesman said, if insurers decide to mount a salvage expedition, NASA will not charge them for a shuttle launch if the attempt is made within nine months, according to the launch agreement.

Mr. Merrett said last week that Westar VI, one of the lost probes, will probably fall from orbit and burn up into the earth's atmosphere. The other lost probe, an Indonesian communications satellite, is in a higher orbit and probably will remain there.

Although no one is predicting that the two satellites could cause damage to other probes, the payloads have between $500 million and $750 million in liability coverage as part of NASA's special liability insurance package arranged last year (*BI*, June 27, 1983). ■

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opinions

What happened to causation?

THE RECENT WISCONSIN Supreme Court decision that allows a DES daughter with injuries to recover damages from a single manufacturer of the drug even if there is no proof that the manufacturer made the drug her mother took is at odds with fundamental fairness and due process (see story, page 1).

Plaintiffs' attorneys hail this as a victory in the evolution of product liability law. We think it is a travesty to abandon the fundamental principle of causation.

Yes, the underlying complaints in these suits—the injuries, pain and suffering these daughters have endured as a result of their mothers taking DES when they were pregnant—are filled with tragedy. The extent of those tragedies obviously motivated the search for a legal remedy for these injured women by the Wisconsin Supreme Court and, earlier, the California Supreme Court in the Sindell decision that established industry-wide liability.

But, we can't endorse the fundamental changes in law that these courts made to provide that remedy.

Interestingly, the Wisconsin court rejected as unworkable the California Sindell decision that apportions liability according to market share among all manufacturers of a product that caused injury when the specific manufacturer can't be identified. We agree that it is unworkable.

Unfortunately, manufacturers have few allies in protecting themselves against these fundamental changes in product liability law. Sen. Robert Kasten, R-Wis., sponsor of federal product liability legislation, abandoned manufacturers on this point in the summer of 1982 when he deleted from his bill a provision that would have required a plaintiff in a product liability suit to prove "by a preponderance of evidence" that a product was produced by a specific manufacturer in order to estalish liability. Instead, Sen. Kasten's bill, now numbered S.44, specifies only that the plaintiff must make a reasonable effort to identify the specific product manufacturer before suing a group of companies that made the same product.

The only hope manufacturers have is that the U.S. Supreme Court will not let this ruling stand. We think that may be a slim hope, considering the Supreme Court allowed the California Sindell decision to stand.

letters

It would be wise to call on industrial hygienist

To the editor: I read with interest Lawrence Postol's Perspective article, "Occupational Diseases: Successful Defense Depends on Counsel's Expertise" (*BI*, Jan. 23). The emphasis of Mr. Postol's article is that counsel's expertise will determine the outcome of an occupational disease claim, and that appropriate expert witnesses from the medical profession should be obtained. He suggests basing the defense entirely on determining whether the disease is from an occupational cause or non-occupational cause, based solely on medical evidence.

It appears that investigation of the presence of the alleged causative agent in the workplace and the degree of exposure, if any, to the claimant has been entirely overlooked. A certified industrial hygienist called upon to evaluate current and past conditions in the claimant's workplace can be an extremely valuable expert witness.

Within our Occupational Disease Claims Investigation Group at INA Loss Control Services Inc., we have proven in several cases, through the investigation and testimony of our industrial hygienists, that the etiology of the claimant's alleged occupational disease was not consistent with the nature of his or her work. Our industrial hygienists have also provided valuable guidance to attorneys in the development of a proper defense and gathering of depositions.

I support Mr. Postol's view that adequate preparation is required to successfully defend an occupational disease claim, but contend that the supporting expertise of a certified industrial hygienist experienced in claims investigation can be as valuable as that of an occupational physician.

Alice C. Farrar
Certified Industrial Hygienist
Assistant Vp
INA Loss Control Services Inc.
Macon, Ga.

Do the rules change when game is international?

To the editor: I read with interest the article concerning the legal wrangling surrounding the Australian brush fires, "Insurers Want Broker to Pay Claims for Australian Fires" (*BI*, Jan. 30).

It seems the hassle boils down to who told what to whom in placing liability insurance for brush fires for Southern Electricity Commission of Victoria. Not being a player in the international insurance brokerage field, perhaps my observations are naive, but I seem to recall a precept that relationships among agents, brokers and underwriters were that of utmost good faith. Each other's fortunes are tied to this idea and, to me, past claims history, whether specifically called for by the underwriters or not, is essential to maintaining that trust.

I feel the attitude of Sedgwick's attorney on 1977 brush fires as quoted, "(The broker) was not required to include details of claims on those fires in a written presentation," is contrary to the utmost good faith doctrine.

I was under the impression that full disclosure of material facts benefited the underwriter and the producer in the long run. Perhaps this perception is clouded by being a small-town, independent agent and not an international broker with Sedgwick's clout.

Are the rules different in the international arena? I sincerely hope not.

Evan H. Mandigo
Bismarck, N.D.

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Losses mount for satellite underwriters

Continued from page 4
two losses will have other effects.

Spacecraft underwriters, he explains, will also have to rethink how they evaluate space risks. Up until now, the launch vehicle was the major criterion on which satellite coverage was rated, Mr. Simms notes.

Satellite launched aboard the Ariane had the highest rates since that rocket has the worst loss record of any of the available launch vechicles.

Probes launched aboard NASA Thor Delta rockets were charged the next-highest rates, followed by those sent aloft on the space shuttle, since there had been no insured shuttle losses so far.

Now, Mr. Simms says that "underwriters will have to look at the type of satellite that is being used rather than the launcher." Underwriters probably will base rates on the manufacturer of the satellite, what type of equipment will be used to put the probe into a geostationary orbit and other criteria, he said.

A&A's Mr. Tyrone agrees, adding that underwriters probably also will take into account the number of satellites to be launched at one time, to protect against the multiple losses they encountered last week.

However, satellite owners may not see rate rise beyond reach, says Mr. Nausch, the New York broker. A few satellite underwriters, like Mr. Simms, are believed to be untouched by the recent losses and, thus, may be able to moderate their rate hikes.

"Not all underwriters have the same underwriting results and they may not all react the same way," Mr. Nausch said.

"I am not sure there ever was a bargain in satellite insurance, but I do not think that underwriters will act in unison."

Mr. Tyrone says brokers may still be able to find reasonable rates and sufficient capacity.

And, others point out that NASA soon may be able to recover and repair malfunctioning satellites, which could cut claims costs (see story, page 4).

Mr. Tyrone notes that he must soon place coverage for Westar VII, which is scheduled for launch in November 1985.

"I cannot wait until 1985 to find the coverage," Mr. Tyrone said. "We will be back in the market in the next few months. I don't want to be the first in, but I don't think anyone does."

Whatever the impact of the losses, satellite owners may not feel the sting for some time. At least 25 satellites yet to be launched are already insured, and underwriters are not expected to renegotiate these premiums.

As insurers and buyers wondered last week what effect the losses would have on the market, NASA and satellite manufacturers wondered what went wrong.

Although NASA is continuing its investigation, the space agency and satellite underwriters so far agree the shuttle probably was not responsible for the losses.

Both satellites were manufactured by Hughes Aircraft Co. of Culver City, Calif., though the PAMs, the motors that are thought to have failed, were manufactured by McDonnell-Douglas Corp. of St. Louis.

Last week, Hughes and McDonnell-Douglas began an investigation into the malfunctions. They noted that the PAMs had been successfully operated before.

"Two similar failures after 18 consecutive space firings obviously suggests a common technical problem may have existed with these two motors," said Richard Brandes, Hughes' group vp and manager of its commercial systems division.

Officials at Western Union would not comment on whether it is thinking of suing either Hughes or McDonnell-Douglas for the losses. Mr. Merrett said it was "highly unlikely" that the underwriters would press such a suit, though he would not rule it out.

Under a hold-harmless clause in the launch agreement, NASA and satellite owners cannot sue each other for damages to the shuttle or the satellites during a shuttle launch and the deployment of payloads.

And, sources close to the satellite industry say such an agreement may also exist between McDonnell-Douglas and the satellite owners, though no one connected with either side would comment. ■

Beacon response

Continued from page 2
gations of wrongdoing at the time of the complaint and Beacon's response reaffirmed its position.

Beacon's response also elaborated on its earlier public statement that alleged Universal Marine was suing only as a "last-ditch" effort to avoid financial difficulty.

The court answer specifically charged that Universal Marine's assets had been "systematically looted over the past five years" by its parent company, dramatically reducing its policyholder surplus.

However, Mr. Portermain admitted that he and his insurer did, at one time or another, hold an ownership interest in both B.F.G. Toomey Associates and New Orleans Reinsurers, as alleged by Universal Marine. Universal Marine contended in its suit that Toomey produced the business for Beacon in London and that New Orleans Reinsurers misused binding authority on behalf of Beacon to place risks with Universal Marine through Cherokee.

The response, however, notes that the defendants did not gain interest in New Orleans Reinsurers until after the expiration of the quota-share agreements and that no attempt was made to hide ownership interest in the London managing general agency.

In a cross-claim filed with the reponse to the Universal Marine suit, Beacon also alleged that its co-defendant, Cherokee, and its parent, Dana Corp., owe it about $3.9 million in reinsurance payments that should be drawn against letters of credit secured by Cherokee's bank, First American Bank National Bank of Nashville.

The cross-claim says that the original reinsurance agreement—by which Cherokee agreed to reinsure 50% of all "special risks" to $100,000 accepted by Beacon and then reinsure the risks with Universal Marine—was binding upon Cherokee and that the Nashville insurer owes Beacon about $2.2 million in claims already paid.

Beacon also claims that Cherokee owes it $1.7 million payable under an excess-of-loss agreement with Cherokee which, according to court documents, was also reinsured by Universal Marine.

The excess-of-loss agreement, which is not mentioned at all in Universal Marine complaint, called for Cherokee to reinsure Beacon for 92% of losses in excess of $100,000 to a maximum loss level of $500,000. Universal Marine reinsured Cherokee for all of its 92% of this excess-of-loss reinsurance. According to the documents, American Centennial Insurance Co. reinsured Beacon for the remaining 8% of the $400,000 excess of $100,000 reinsurance layer.

American Centennial is not involved in this litigation.

As part of its response to Universal Marine's suit, Beacon also sought and received an order preventing Cherokee from seeking legal action in any other jurisdiction to prevent Beacon from drawing upon the letters of credit.

The court also ordered Cherokee to deposit $3.2 million in the First National Bank of Charlotte, N.C., in the name of the court, pending the outcome of the cross-claim.

In an affidavit, Beacon Treasurer Thomas L. Harrison said that without access to Cherokee's letters of credit, Beacon would suffer "severe and irreparable injury with regard to its business viability and its reputation."

Meanwhile, Universal Marine is suing in London to collect from reinsurers on reinsurance for risks underwritten by Beacon, reinsured by Cherokee and retroceded through New Orleans Reinsurers to Universal Marine.

In a lawsuit filed last October in the British High Court of Justice, Universal Marine is seeking $759,223 from four alleged reinsurers, Administratia Asiguralior de Stat of Romania (ADAS), Ajax Insurance Co. of Bermuda, Grand Union Insurance Co. Ltd. of Hong Kong and Elkhorn Insurance Co. of Louisville, Ky.

The writ also names London broker Charman Mauduit (Insurance Brokers) Ltd. as a defendant.

According to the writ and supporting documents, including coverage line slips and claims forms dating from 1979 through 1981, the four defendants reinsured 92% of $400,000 excess of $100,000 of losses resulting from a portfolio of railway liability and other surplus lines risks underwritten by Beacon, reinsured by Cherokee and retroceded into Universal Marine.

The reinsurance, according to the documents, was brokered in London by Charman Mauduit. Fifty percent of the risk was split equally between Grand Union and Elkhorn (through underwriting managers Stetzel Thomson & Co. Ltd.). The other 42% was provided by B.F.G. Toomey Associates Ltd., which bound 17% of the reinsurance to Adas and 25% to Ajax.

Approval of reinsurance agreement was signed by R.M. Schirmer, president of New Orleans Reinsurers, on behalf of Cherokee.

Correspondence filed with the writ indicates that the remaining 8% of the risks Beacon underwrote were reinsured for Cherokee by American Centennial Insurance Co. through Charman Mauduit.

The writ alleges that two of the defendants, Elkhorn and Grand Union, refused to pay their portion without explanation and that Ajax was in "financial difficulty" and preparing a statement of its affairs for regulators. Ajax is now being liquidated in Bermuda.

ADAS, the writ says, refused to pay its portion of the reinsurance recoverage on the grounds that the reinsurance had been underwritten by Toomey through Promotora de Occidente de Panama S.A., a now-defunct Panamanian reinsurance intermediary that claimed to underwrite reinsurance for several worldwide pools of reinsurers. ADAS was one of several fronting insurers that believed they were reinsured by POSA pools, but eventually found themsleves unable to collect after POSA shut down in 1980 (*BI* Aug. 30, 1982).

Universal Marine attorney Sol Kroll of the New York law firm Kroll, Pomerantz & Cameron had been unaware of the British lawsuit until contacted by *BI*, but later confirmed its existence after discussion with company officials.

The reinsurance agreement in the British suit, Mr. Kroll said, is a separate book of business and therefore is unrelated to the quota-share agreement cited in Universal Marine's North Carolina lawsuit.

The conditions and exclusions in the line slips and claims information contained in the London action and the format of the retroceded reinsurance all correspond to the provisions of the excess-of-loss agreement Beacon mentioned in the North Carolina action.

No responses to the lawsuit have been filed with the British court and sources in London say that the writ may not yet have been served to defendants. ■

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RIMS opposes taxing retiree life insurance

By JERRY GEISEL

WASHINGTON—Employer-provided term life insurance coverage for retirees shouldn't be taxed, the Risk & Insurance Management Society says.

Legislation, S. 1992, introduced by Sen. Lloyd Bentsen, D-Texas, proposes that life insurance premiums paid by a former employer for retiree coverage above $50,000 be counted as taxable income. Retirees currently are not taxed on such coverage.

However, taxing group term life insurance would cause economic hardship to retirees and could put more financial pressure on the Social Security program, RIMS said in testimony submitted to the Senate Finance Committee.

"By making it less attractive for employers to offer—and for retirees to receive—group term life insurance coverage, an important foundation of financial security for a retiree's survivor payments may be lost," RIMS noted.

"This in turn would create pressure for higher survivor payments under Social Security. Thus, any dubious revenue enhancement benefit to the Treasury may be offset by increased government financial aid to the survivors of retirees."

But the Treasury Department says there is no justification for excluding from taxes the cost of an unlimited amount of term life insurance for retirees.

In the first place, retirees have less need for large amounts of term life insurance than wage earners, who currently are taxed on term life insurance premiums for coverage exceeding $50,000.

"After retirement, an employee's salary is replaced by pension benefits and Social Security. To some extent, these benefits continue to be provided to the surviving spouse of a retired employee," noted John Chapoton, assistant treasury secretary for tax policy.

The cost of retiree group term life insurance can be substantial. The annual premium for a $1 million policy for a retired 65-year-old executive is about $25,000, while the same policy for a 70-year-old retiree would cost $40,000 and increase to $100,000 for a retiree who is 80 years old, according to the Treasury Department.

Taxing term life insurance premiums for coverage exceeding $50,000 for retirees also is contained in a tax bill, H.R. 4170, now pending on the House floor.

Plan assets sought

Celanese Corp. is asking a federal agency for permission to split its defined benefit pension plan into two plans to recover about $300 million in excess assets.

In a letter to the Pension Benefit Guaranty Corp., New York-based Celanese said that it wants to split its plan into one plan for employees and one for retirees.

Under the terms of the proposal, plan assets with an estimated market value of about $285 million will be retained in the employees' plan to assure that all accrued benefits in the plan are fully funded.

The balance of the assets, with a value of about $415 million, will be transferred to the retirees' plan. To guarantee benefits for 7,343 retirees and survivors, Celanese will purchase annuities from an insurer, costing about $115 million.

After the annuities are purchased and distributed, Celanese will terminate the retirees' pension plan. That will leave Celanese, a diversified producer of chemicals, fibers and plastics, with additional assets of at least $300 million.

The PBGC must issue a letter to Celanese certifying that the plan has sufficient assets to pay participants' benefits before the plan can be terminated.

Single-piece tire rims

Employers will have to provide more protection for workers who service single-piece tire rims for trucks and buses, the Occupational Safety and Health Administration says.

OSHA is extending the same safety rules that protect workers who service multipiece rims to cover single-piece rims, too. Under the standard, which goes into effect March 5, workers at 102,000 workplaces—primarily retail gasoline stations and garages—must be protected by barriers and restraining devices. Employers also must teach workers how to handle the potentially explosive rims.

Since the restraining devices are the same as those currently required for servicing multipiece rims, the major cost of the OSHA standard will be for training employees.

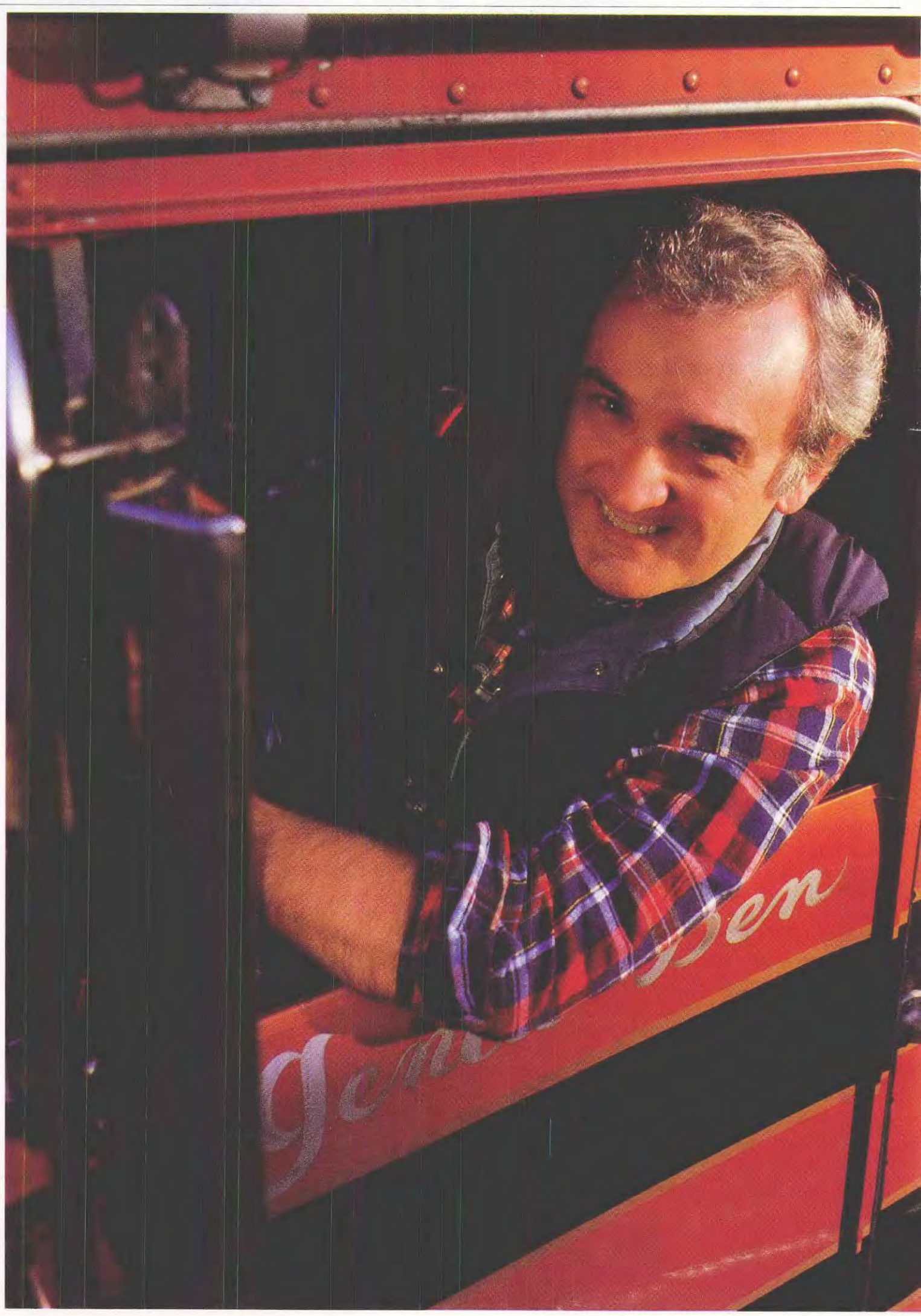
OSHA estimates the national cost of the standard at $2.5 million during the first year and $900,000 in succeeding years. First-year costs for a typical small garage operator with one supervisor and two employees would be about $32.50, OSHA estimates.

About 15% to 20% of large vehicles now use single-piece rather than multipiece rims, but that percentage is expected to increase to 50% by 1990.

"Thus, over a 10-year period, as more of these rims replace multipiece rim wheels, there could be 210 to 262 fewer accidents and 37 (to) 50 fewer deaths. . . ." OSHA chief Thorne Auchter said.

The rule was published in the Feb. 3 Federal Register. ■

washington



New syndicate joins New York exchange

The New York Insurance Exchange has added a new underwriting member, a new broker and a new associate broker.

J&H, WF Syndicate B Inc. will specialize in property/casualty reinsurance and has been capitalized at $3.75 million. It is the second New York Insurance Exchange syndicate to be organized and managed by Johnson & Higgins Willis Faber (USA) Inc.

E&S Intermediaries Inc., formerly an associate broker on the exchange, has changed its status to that of a full broker member.

In addition, NSEW International Inc. has joined the exchange as an associate broker member, acting as an intermediary for both foreign and domestic facultative and treaty reinsurance.

The latest addition brings the number of underwriting syndicates on the New York exchange to 42. The number of brokerage members on the exchange now stands at 94.

markets

Brokerage formed

Reager-Harris, an insurance brokerage based in a Louisville, Ky., suburb has been formed by former officers of three area brokerages.

Richard L. Martin, former president of The Reager Co., was named the new brokerage's chief executive officer. Other officers once worked for Harris & Co. and Nahm, Turner, Vaughan & Landrum, which was acquired by Alexander & Alexander Inc.

Reager-Harris specializes in commercial property/casualty coverages, contract surety insurance and benefit programs. Offices are located in the Atrium Center, 10400 Linn Station Road, Plainview, Ky.

Casualty consulting

Tillinghast, Nelson & Warren Inc., an actuarial consulting firm, has added a casualty insurance consulting division in its New York office.

The new operation, headed by Vp Michael A. Walters, offers consulting services on casualty loss reserving, pricing, reinsurance, new product development, projection of financial results and valuation of insurance companies for acquisition.

National accounts

American Re-Insurance Co. has formed a new national account division for facultative casualty reinsurance that will coordinate the resources of the company's home and branch offices.

The division, which will be headed by Stephen M. Satler, was formed to service the increasingly complex needs of large-premium, high-risk casualty accounts, the company said.

Surplus increased

The Toa-Re Insurance Co. of America has increased its surplus to $15 million with the addition of a $5 million contribution from its parent, Toa Fire and Marine Insurance Co. Ltd. of Tokyo.

The increase is in line with Toa-Re's plans, announced when the company entered the U.S. reinsurance market in 1982. Toa-Re said it plans to further increase surplus to $20 million by the end of 1984.

Acquisitions

Reed Stenhouse Cos. Ltd. announced that its Australian subsidiary has acquired **Edward Lumley (Brokers) Ltd.**, an insurance brokerage with offices in Sydney, Melbourne, Adelaide and Brisbane, Australia. The purchase was made with a combination of cash and Reed Stenhouse stock.

Hallmark Insurance Group has acquired **American Risk Assurance Co.** for an undisclosed sum. American Risk Assurance is a specialty lines underwriter authorized to operate in Florida, Louisiana, Texas and Oklahoma.

Western World Insurance Co. of Keene, N.H., has acquired **Tudor Insurance Co.**, an excess/surplus lines insurer also based in Keene, from **Swiss Reinsurance Co.**

Wilcox, Veteto & Thill, an insurance brokerage based in Oceanside, Calif., has merged with **Barney & Barney**, a San Diego-based brokerage.

Frank B. Hall & Co. Inc. announced the acquisition of two insurance brokerages: **Chas. Lunsford Sons & Associates Inc.** of Roanoke, Va., and **Riggs-Edwards Insurance Agency** of Salinas, Calif. Lunsford, bought for $3.5 million in Hall stock, will become **Frank B. Hall & Co. of Virginia Inc.**, while Riggs-Edwards, acquired for $681,000 in Hall stock, will be merged into the company's Salinas branch office.

Jaffe & Associates Ltd., a Chicago-based actuarial consulting firm, has merged with **Tillinghast, Nelson & Warren Inc.**

Corroon & Black Corp. has acquired **RKC & Co.**, a San Diego-based brokerage firm.

New offices

Burns & Wilcox Ltd., a managing general agency, has opened a new branch office in St. Louis. The mailing address is Box 27385, St. Louis, Mo. 63141; 314-993-6440.

The Houston branch of **U.S. Insurance Group**, a **Crum & Forster Corp.** unit, has moved to new offices at 9800 Centre Parkway, P.O. Box 721375, Houston, Texas 77272; 713-270-6100. ■

Florida begins Gulf American liquidation

CLEARWATER, Fla.—The Florida Insurance Department has begun liquidating Gulf American Insurance Co., a multiline insurer that specialized in group health and workers compensation coverage.

Gulf American, founded in 1979, was placed into receivership in November after an Insurance Department examination revealed inadequate assets to pay outstanding claims from an estimated 3,500 policyholders.

The insurer wrote more than $19.8 million in direct premiums in 1983, but has only about $750,000 in available assets to pay as much as $4.5 million in outstanding claims, according to a department spokesman.

Once remaining assets are exhausted, claims from Florida policyholders will be paid either by the Florida Life & Health Insurance Guaranty Assn. or the Florida Insurance Guaranty Assn., Florida's two state-administered guaranty funds, the spokesman noted.

Guaranty funds in other states where Gulf American did business—including Alabama, Georgia, Louisiana, Mississippi, South Carolina and Tennessee—are expected to pay policyholders in their respective states.

One of the biggest problems leading to Gulf American's financial difficulties, according to Insurance Department sources, was its group health insurance business marketed through Gulf American Health Trust, an insured multiple employer trust.

Although Gulf American had reinsurance for losses exceeding $25,000 per covered individual, reserves for retained losses were inadequate, said Insurance Department sources.

Gulf American's workers compensation business, however, appears to be properly funded, the sources say.

The liquidation order, handed down Jan. 25 by Leon County Circuit Court, provides for cancellation of all policies in force as of March 3, 1984, and sets Sept. 7, 1984, as the deadline for filing claims.

around the states

Safety recognition

ANN ARBOR, Mich.—Seven Michigan municipalities are among a group of public entities to receive recognition for outstanding safety achievement from the Municipal Workers' Compensation Fund of Michigan—the largest workers compensation pool in the state.

The municipalities—Adrian, Center Line, Gaylord, Harrisville, Lathrup Village, Romeo and Sault Ste. Marie—were joined by three municipal hospitals, two housing authorities and three public utility groups in receiving the kudos.

The fund, initiated by the Michigan Municipal League, began in 1977 with a 10% advance premium discount off standard commercial workers comp rates. This discount continued to increase and in 1983 stood at 40%.

Work comp board

SACRAMENTO, Calif.—Three attorneys with backgrounds in workers compensation and labor law are the newest members of the California Workers Compensation Appeals Board.

C. Gordon Taylor, Marilyn C. Lazar and Charles L. Swezey recently were sworn in as members of the board for four-year terms.

Mr. Taylor, 51, was named chairman of the WCAB. He's an affiliate with the San Francisco law firm of Sedgwick, Detert Moran & Arnold and past president of the California Compensation Defense Attorneys Assn.

Ms. Lazar, 58, previously was a workers compensation judge at the WCAB's Van Nuys office. She had served as a trial attorney and then chief counsel to the state Division of Labor Standards Enforcement, a agency of the state Industrial Relations Department.

Mr. Swezey, 60, was reappointed to the board. He was first named to the post in 1974. His 30-year state government career includes work as senior counsel of the state Compensation Insurance Fund; serving as a referee with the WCAB; and serving as the board's secretary and deputy commissioner.

One more seat on the seven-member board still must be filled.

Automatic awards

SPRINGFIELD, Ill.—The Illinois Industrial Commission will stop automatically awarding statutory minimum permanent partial benefits in certain workplace bone fracture cases where a serious and permanent disability is not proven.

The action is based on a recent Illinois Supreme Court ruling that clarifies the section of the Workers' Compensation Act that has to do with permanent partial disability benefits for certain bone fractures including the skull, vertebra and facial bones.

In that section of the 1975 statute, which has since been amended, minimum benefit amounts were stated for specific fractures. The commission had been acting for years on the assumption that the minimum awards—anywhere from 20 to 100 weeks of benefits under the old statute—were automatically given if there was one of the specified fractures.

But the high court pointed to another sentence in that section of the statute that said the employee had to sustain "serious and permanent injuries."

Because there was no proof of serious and permanent injuries in this case heard by the court, which involved an employee of Archer-Daniels-Midland Co. in Decatur, it upheld a lower court's ruling and sent the case back to the Industrial Commission.

"I think it makes it clearer in this decision that when permanent partial payments are made, they have to be predicated on some permanent disability. That's a message that I think is a natural part of the workers comp act," said Chicago attorney Thomas Nyhan, who is executive secretary of the Illinois Self-Insurers Assn.

This message, employer representatives hope, will be applied to other permanent partial awards not covered specifically in this section of the act.

"We hope that this decision will carry over into more common types of fractures," said Leonard Day, manager of labor relations for the Illinois Chamber of Commerce.

"Our members have been complaining for years that it's like a reward for having an accident. Where there's no permanent disability, the injured worker goes back to the job, but gets an award."

Some 60% of all workers compensation dollars in Illinois go to permanent partial awards, according to Mr. Day. This decision is expected to reduce that rate slightly.

"I think it will save employers some money... but I really don't know how extensive it will be."

Injury records

OLYMPIA, Wash.—About 45,000 private Washington state employers are no longer required to keep records of on-the-job injuries and illnesses.

Recent changes in the record-keeping requirements of the Washington Industrial Safety & Health Act affect businesses and industries where workers have been judged to have low exposures to hazards, said Sam Kinville, director of the Department of Labor and Industries.

Among employers that do not have to keep these records are auto dealers and service stations, most retail stores, financial institutions, restaurants, private educational institutions, laundries and beauty shops.

Public institutions of learning and government agencies are not included in the new exemptions.

The new rules, which reflect federal requirements, free these companies from requirements to complete supplementary records and post annual injury summaries, Mr. Kinville said. But the changes do not affect industrial insurance reporting requirements, he added.

Acting regulator

DENVER—Daniel J. Colaiannia, Colorado's deputy insurance commissioner, has assumed responsibility for the state Insurance Department following the retirement of J. Richard Barnes.

Mr. Colaiannia, 53, has been named acting interim commissioner and will serve until a permanent commissioner is named. He has been with the department for almost 20 years, and was a financial examiner with the department before becoming deputy insurance commissioner.

Mr. Barnes, the state's insurance commissioner for nearly 20 years, had announced that he would retire during the first quarter of this year (*BI*, Nov. 21, 1983).

Colorado is the only state in which the insurance commissioner's post is filled through the civil service system, not through political appointment. However, legislation that would make the position an appointed or elected post is now under consideration.

For now, the next commissioner will be selected by the executive director of the Department of Regulatory Agencies.

Liability limits

SACRAMENTO, Calif.—The California Senate has passed a bill by a 28-3 vote to modify a controversial legal rule that apportions liability for negligent conduct.

Under current California law, a defendant in a multidefendant situation can be held liable for the entire damages suffered by a plaintiff, even though the defendant is only partly to blame.

S.B. 575, sponsored by Sen. John Foran, D-San Francisco, would limit a defendant's responsibility for non-economic losses—including pain and suffering—to the percentage of total damages established by a jury as the defendant's comparative fault.

The bill would continue the current law with respect to providing for "joint and several liability" for economic losses, but would change the law regarding non-economic damages in instances where a defendant's comparative fault is less than 40%.

"By abolishing the rule of joint liability in personal injury and product liability actions, S.B. 575 establishes a more equitable doctrine: that the degree of fault of each defendant should determine each defendant's liability for damages, at least as that applies to non-economic damages," according to a statement issued by the Assn. of California Insurance Companies.

The bill also is supported by the Assn. for California Tort Reform, a broad-based coalition of cities, employers and insurance companies.

"The 'deep-pocket,' or joint and several liability, rule allows people who file lawsuits to raid the pocketbooks of state and local government, businesses and people who are reponsible enough to carry insurance," notes ACTR Chairman Gene Livingston.

The passage of S.B. 575 marks the third time in five years that the California Senate has voted overwhelmingly to limit the joint and several liability rule. In 1979 and 1982, similar bills were killed in the state Assembly Judiciary Committee with intense opposition from the California Trial Lawyers' Assn.

MET crackdown

OLYMPIA, Wash.—Insurance Commissioner Dick Marquardt will take strong action against agents and brokers who market benefit packages through illegal or mismanaged multiple employer trusts.

"Agents and brokers marketing coverage on behalf of unauthorized insurers place their insurance licenses in jeopardy and no doubt expose their own assets to risk," Mr. Marquardt warned in a bulletin.

"I will not tolerate abuse or evasion of the insurance code with resulting financial loss to innocent people," he stressed.

The warning is consistent with Commissioner Marquardt's intention to closely monitor the activities of METs operating in the state, said an Insurance Department spokesman.

Most METs offer employee benefit packages to small employers. Some are self-funded or partially self-funded, others are fully insured and still others are insured some of the time, the bulletin notes.

With disturbing frequency, such arrangements have led to unpaid claims. For example, 400 Washington employers and several thousand employees were left without coverage when Pacific Insurance Administrators in Boise, Idaho, collapsed last summer (*BI*, Aug. 29, 1983).

"One day they had coverage, the next day it was gone, to the great embarrassment of some over-trusting agents," the bulletin points out.

In the wake of this calamity, the state enacted legislation last year that makes all health care plans subject to the authority of the state insurance commissioner unless the plan's administrator can show that the plan is regulated by another state or federal agency.

METs established and maintained by third-party administrators and marketed to employers that have no common interests other than the coverage itself are not qualified employee benefit plans under the Employee Retirement Income Security Act of 1974 and are subject to all state laws and regulations, says the bulletin. ■

datebook

MARCH 13. Data Workshop and National Statistical Data Base briefing in Atlanta, sponsored by the Health Research Institute; free. Also **April 10** in Boston; **May 22** in Chicago; **June 12** in New York; **July 17** in San Francisco; **Aug. 7** in San Diego. Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596.

MARCH 13. Risk Financing & Captives briefing in Bermuda, sponsored by Risk Planning Group; $250. Risk Planning Group Inc., 722 Post Road, Darien, Conn. 06820; 203-655-9791.

MARCH 13. Risk Management Information Systems conference in St. Louis, sponsored by Corporate Systems; $50. Matt Davis, Corporate Systems, Box 31780, Amarillo, Texas 79120; 806-376-4223.

MARCH 13-14. Auditing Techniques and Conduct seminar in Hartford, Conn., sponsored by the Premium Audit Advisory Service of the American Insurance Services Group; $90. Also **April 10-11** in Atlanta; **June 19-20** in St. Louis. Faye E. Stiles, Premium Audit Advisory Service, American Insurance Services Group; 85 John St., New York, N.Y. 10038; 212-669-0511.

MARCH 13-14. Health Care Cost Containment workshop in Atlanta, sponsored by the Health Research Institute; $395. Also **April 9-10** in Boston; **May 21-22** in Chicago; **June 11-12** in New York; **July 16-17** in San Francisco; **Aug. 6-7** in San Diego. Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596.

MARCH 13-15. Reasoning Reinsurance seminar in Irving, Texas, sponsored by the University of Dallas; $475. Professor Bruce Evans, Reinsurance Management Institute, University of Dallas, Irving, Texas 75061; 214-721-5360 or 214-721-5299.

MARCH 14. Advanced "Post-Graduate" Cost Containment workshop in Atlanta, sponsored by the Health Research Institute; $195. Also **April 11** in Boston; **May 23** in Chicago; **June 13** in New York; **July 18** in San Francisco; **Aug. 8** in San Diego. Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

MARCH 14. Health Improvement/Prevention workshop in Atlanta, sponsored by the Health Research Institute; $195. Also **April 11** in Boston; **May 23** in Chicago; **June 13** in New York; **July 18** in San Francisco; **Aug. 8** in San Diego. Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

MARCH 14. Hospital Trustee workshop in Atlanta, sponsored by Health Research Institute; $195. Also **April 11** in Boston; **May 23** in Chicago; **June 13** in New York; **July 18** in San Francisco; **Aug. 8** in San Diego. Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

MARCH 14. Risk Management Information Systems conference in Kansas City, Mo., sponsored by Corporate Systems; $50. Matt Davis, Corporate Systems, Box 31780, Amarillo, Texas 79120; 806-376-4223.

MARCH 14. Third-Party Administrator workshop in Atlanta, sponsored by the Health Research Institute; $395; $195 for subsequent registrants. Also **April 11** in Boston; **May 23** in Chicago; **June 13** in New York; **July 18** in San Francisco; **Aug. 8** in San Diego. Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

MARCH 14-16. Eighth International Captive Insurance and Reinsurance forum in Bermuda, sponsored by Risk Planning Group; $675; $600 for subsequent registrants from same company. Risk Planning Group Inc., 722 Post Road, Darien, Conn. 06820; 203-655-9791.

MARCH 14-16. Financial Information Systems Eighth Annual conference in Chicago, sponsored by the National Institute for Management Research; $595; group discounts available. Also **May 9-11** in New York; **July 9-11** in Washington. National Institute for Management Research, Department K-FISCHICAGO123456, P.O. Box 3727, Santa Monica, Calif. 90403; 213-450-0500.

MARCH 14-16. Petroleum Insurance conference in New Orleans, sponsored by the Professional Development Institute; $395. Mellira Mahan or Genevieve Mehan, Professional Development Institute, North Texas State University, P.O. Box 13288, Denton, Texas 76203-3288; 817-565-3344 or 800-433-5676.

MARCH 15-16. Longshoremen's and Harbor Workers' Compensation Act advanced seminar in Seattle, sponsored by Shepard & Associates, in coordination with the U.S. Department of Labor; $95. Shepard & Associates, P.O. Box 60066, Seattle, Wash. 98160; 206-542-1535.

MARCH 15-16. Quantitative Techniques for Risk Management course in San Francisco, sponsored by The College of Insurance; $485. Also **April 5-6** in Toronto. Property-Liability Insurance Division, The College of Insurance, 123 William St., New York, N.Y. 10038; 212-962-4111.

MARCH 18-21. 1984 Corporate Benefits Management conference in Palm Springs, Fla., sponsored by the International Foundation of Employee Benefit Plans; $500 for members; $575 for non-members. Also **July 15-18** in McAfee, N.J.; **Dec. 2-5** in Miami. IFEBP, P.O. Box 69, Brookfield, Wis. 53005; 414-786-6700.

MARCH 19-20. Computer Litigation 1984 program in San Francisco, sponsored by the Practising Law Institute; $375. Practising Law Institute, Department KSC, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700.

MARCH 19-20. Reinsurance in the 1980s: Buying, Pricing and Negotiating seminar in New York, sponsored by Executive Enterprises; $650; $575 for subsequent registrants. Christine Wanakas, Executive Enterprises; 33 W. 60th St., New York, N.Y. 10023.

MARCH 19-21. Advanced Safety Management seminar in Atlanta, sponsored by the International Loss Control Institute; $350. Richard Jump, International Loss Control Institute, P.O. Box 345, Loganville, Ga. 30249; 800-544-6001 or 404-466-2208.

MARCH 19-21. Basic Safety Management seminar in Houston, sponsored by the International Safety Academy; $425. Also **April 30-May 2** in Philadelphia. International Safety Academy, 1600 Arch St., P.O. Box 8527, Philadelphia, Pa. 19101; 800-231-3147 or 215-241-5800.

MARCH 19-21. Human Resources conference in Boston, sponsored by the American Management Assns.; $525 for members; $595 for non-members; group discounts available. American Management Assns., 135 W. 50th St., New York, N.Y. 10020; 518-891-1500.

MARCH 19-21. Society of Fire Protection Engineers annual symposium in Leesburg, Va.; $375. Marianne Casey, Society of Fire Protection Engineers, 60 Batterymarch St., Boston, Mass. 02110; 617-482-0686.

MARCH 19-21. Techniques of Risk Management seminar in Chicago, sponsored by the Risk & Insurance Management Society; $445 for members; $545 for non-members. Also **June 6-8** in New York; **Sept. 10-12** in Toronto; **Dec. 10-12** in Denver. RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

MARCH 19-23. Highly Protected Risk Property Conservation course in Long Grove, Ill., sponsored by Kemper Group; $400. Also **May 7-11** and **Oct. 1-5** in Long Grove, Ill. W.P. Thomas Jr., Manager of Engineering Reasearch and Staff Development, HPR Development, Kemper Group, A-1, Long Grove, Ill. 60049.

MARCH 19-23. Industrial Ventilation course in Los Angeles, sponsored by the University of Southern California; $650. University of Southern California, Institute of Safety and Systems Management, Office of Extension and In-Service Programs, Los Angeles, Calif. 90089; 213-743-6523/6524.

MARCH 19-23. Fundamentals of Hygiene Monitoring course in Long Grove, Ill., sponsored by National Loss Control Service Corp.; $490; group discounts available. Also **May 14-18, Sept. 10-14, Nov. 12-16** in Long Grove, Ill. John Garis, Industrial Hygiene, National Loss Control Service Corp., Long Grove, Ill. 60049; 312-540-2026.

MARCH 20. Product Liability and the Engineering Executive workshop in Madison, Wis., sponsored by the University of Wisconsin; $295. Richard A. Moll, Engineering Department, University of Wisconsin—Extention, 432 N. Lake St., Madison, Wis. 53706; 608-263-4712.

MARCH 22-23. Self-Funding Your Employee Benefits course in New York, sponsored by American Management Assns.; $620 for members; $715 for non-members. Also **April 5-6** in Chicago; **May 7-8** in Los Angeles. American Management Assns., 135 W. 50th St., New York, N.Y. 10020; 518-891-1500.

MARCH 25-28. National Assn. of Independent Insurers 30th Annual workshop in Salt Lake City; $125 for members; $275 for non-members. Charles J. Lorenz, NAII, 2600 River Road, Des Plaines, Ill. 60018; 312-297-7800.

MARCH 26-27. Flexible Compensation for Hospitals, Universities and Public Sector Employers seminar in Washinton, sponsored by the Employers Council on Flexible Compensation; $350. Margaret Shemo, Employers Council on Flexible Compensation, 1700 Pennsylvania Ave. N.W., Suite 600, Washington, D.C. 20006; 202-393-1728.

MARCH 26-27. New Profit Opportunities for Banks in Insurance Business conference in New York, sponsored by Executive Enterprises; $650; $575 for additional registrants. Christine Wanakas, Executive Enterprises, 33 W. 60th St., New York, N.Y. 10023.

MARCH 26-28. Evaluating Security Software: Choosing the Right Package seminar in New York, sponsored by the Computer Security Institute; $750 for members; $795 for non-members; group discounts available. Computer Security Institute Education Resource Center, Department ERC, 43 Boston Post Road, Northborough, Mass. 01532; 617-845-5050.

MARCH 26-28. Principles and Practices of Insurance Buying seminar in Chicago, sponsored by American Management Assns.; $695 for members; $800 for non-members. Also **June 11-13** in New York and Dallas. American Management Assns., 135 W. 50th St., New York, N.Y. 10020; 518-891-1500.

MARCH 26-30. Respiratory Protection course in Los Angeles, sponsored by the University of Southern California; $750. University of Southern California, Institute of Safety and Systems Management, Office of Extension and In-Service Programs, Los Angeles, Calif. 90089; 213-743-6523/6524.

MARCH 27-30. 1984 Risk Management and Insurance conference in Cambridge, England, sponsored by the Assn. of Insurance & Risk Managers in Industry & Commerce; $492 plus value-added tax; discounts for AIRMIC, AEAI and RIMS members and for teams. AIRMIC, Plantation House, 31/35 Fenchurch St., London EC3M 7DX.

MARCH 28. One-Day Health Care Cost Containment seminar in Portland, Ore., sponsored by the International Foundation of Employee Benefit Plans; $140 for members; $165 for non-members. Also **March 29** in Los Angeles; **June 6** in St. Paul, Minn.; **June 7** in Rosemont, Ill.; **Sept. 6** in Boston; **Sept. 7** in Tarrytown, N.Y.; **Sept. 17** in Dearborn, Mich.; **Sept. 18** in Cleveland; and **Sept. 19** in St. Louis. IFEBP, 18700 W. Bluemound Road, P.O. Box 69, Brookfield, Wis. 53005; 414-786-6700.

MARCH 29-30. Introduction to Communications Safety seminar in New York, sponsored by the Computer Security Institute; $545 for members; $575 for non-members; group discounts available. Also **June 21-22** in Atlanta. Computer Security Institute Educational Resource Center, Department ERC, 43 Boston Post Road, Northborough, Mass. 01532; 617-845-5050.

MARCH 30. Right to Know: Illinois Toxic Substances Disclosure Act of 1983 conference in Chicago, sponsored by the Illinois State Chamber of Commerce; $80 for members; $120 for non-members. Also, **April 10** in Chicago, **April 11** in Springfield, Ill. Illinois State Chamber of Commerce, Center for Business Management, 20 N. Wacker Drive, Chicago, Ill. 60606; 312-372-7373.

APRIL 1-6. 22nd Annual Risk & Insurance Management Society conference in New York; $520 for members; $620 for non-members. RIMS Conference Department, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

APRIL 2-3. Industrial Hygiene and Safety Applications of Microcomputers course in Los Angeles, sponsored by the University of Southern California; $375. University of Southern California, Institute of Safety and Systems Management, Office of Extension and In-Service Programs, Los Angeles, Calif. 90089; 213-743-6523/6524.

APRIL 3. Surety Claims '84, Contract Bond Claims—"The Options" conference in Chicago, sponsored by CMA Consulting Group; $295. Arlene D. Brower, CMA Consulting Group, 170 E. Hanover Ave., Box 2287R, Morristown, N.J. 07960; 201-267-7171.

APRIL 5-6. 14th Annual Employee Benefits institute in New York, sponsored by the Practising Law Institute; $350. Nancy B. Hinman, Practising Law Institute, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700.

APRIL 5-7. Insurance Consultants Society Spring Educational conference in New York; $75. Barron S. Wall, P.O. Box 2326, South Hackensack, N.J. 07606; 201-343-8833.

APRIL 9-11. Planning an EDP Disaster Recovery Program seminar in Chicago, sponsored by the Computer Security Institute; $750 for members; $795 for non-members; group discounts available. Also **June 18-20** in Atlanta. Computer Security Institute Educational Resource Center, Department ERC, 43 Boston Post Road, Northborough, Mass. 01532; 617-845-5050.

APRIL 9-12. Inspector Training seminar in Houston, sponsored by the International Safety Academy; $490. International Safety Academy, 1600 Arch St., P.L. Box 8527, Philadelphia, Pa. 19101; 1-800-231-3147 or 215-241-5800.

APRIL 9-12. Seventh Annual Conference on Prevention, Behavior, Cleanup of Spills and Waste Sites sponsored by the Bureau of Explosives, the Chemical Manufacturers Assn., the U.S. Coast Guard and the U.S. Environmental Protection Agency; $200; $150 for early registration. 1984 Hazardous Material Spills Conference, 1629 K St. N.W., Suite 700, Washington, D.C. 20006; 202-887-1209.

APRIL 9-13. Advanced Instruction in Retirement Plans for Bank Trust Personnel seminar in Winston-Salem, N.C., sponsored by Booke & Co.; $775. Also **Sept. 24-28** in Winston-Salem. Booke & Co., P.O. Box 66, Winston-Salem, N.C. 27102; 919-748-1120.

APRIL 9-13. Loss Control Management seminar in Atlanta, sponsored by the International Loss Control Institute; $625. Richard Jump, International Loss Control Institute, P.O. Box 345, Loganville, Ga. 30249; 800-544-6001; 404-466-6001.

APRIL 12-13. 1984 National Workers Compensation seminar in Atlantic City, N.J., sponsored by Workers' Compensation Monthly; $195. Workers' Compensation Monthly, Box 829, East Falmouth, Mass. 02536.

APRIL 18-20. End Crisis Management: Designing and Managing an In-House Retirement Planning Program workshop in St. Louis, sponsored by Retirement Advisors; $425; discounts for early registration. Also **May 16-18** in New York; **June 20-22** in Chicago; **Oct. 17-19** in Ft. Lauderdale; **Nov. 28-30** in Dallas. Miriam Naemanie, Retirement Advisors, 919 Third Ave., New York, N.Y. 10022; 212-421-2400. ■

The Datebook is compiled from notices sent to Business Insurance. Notices should be sent at least eight weeks in advance to Datebook, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. Business Insurance reserves the right to select meetings of most interest to its readers and cannot guarantee that notices will be printed.

Missouri retailers set up self-insured comp pool

JEFFERSON CITY, Mo.—More than 80 retail businesses in Missouri are joining to self-insure their workers compensation risks, hoping to cut at least 15%—and perhaps as much as 35%—from their annual work comp costs.

The Missouri Retailers Assn. Self Insurers Fund is the eighth self-insurance pool in Missouri under a law that has allowed such arrangements since July 1, 1982. The fund was established Jan. 1.

"Retailers historically have had low loss ratios, so they can really benefit from a plan such as this," said Tom Pearl, branch manager of the Jefferson City office of Summit Consulting Inc., an administrator of self-insurance pools based in Lakeland, Fla. The firm administers the Missouri program, as well as similar programs in Florida, Georgia and Louisiana.

Pool members pay an annual premium based on payroll, just as they would for commercial insurance. But, under Missouri law, pool members may be allowed to deviate up to 15% from rates filed by the National Council on Compensation Insurance.

The retailers' self-insurance fund filed for the maximum 15% deviation, which was granted by the workers compensation division of the state Department of Labor and Industrial Relations. The fund reports annual premiums of more than $375,000.

"But (the fund) is also a dividend plan," Mr. Pearl explained. The amount of the return of premium is based on the overall profitability of the fund and the safety record of each individual member, he said.

"Members with no losses will receive a higher dividend," he said.

To receive a dividend, a retailer must still be a member of the fund at the time the dividend is declared. This provision differs from a model law adopted by the National Assn. of Insurance Commissioners in December, which would not require an employer to remain a member of a work comp pool in order to receive a refund (*BI*, Dec. 12, 1983).

Based on self-insurance work comp funds administered by Summit in other states, annual dividends can be as much as 20% to 30%, Mr. Pearl said. ■

Most hospitals offer alternative services

Crain News Service

Most hospital administrators responding to a recent survey say they are offering some form of alternative health care service, including home health care, wellness or occupational health services.

And, most of the administrators also anticipate a greater role for alternative delivery systems, like health maintenance organizations and preferred provider organizations.

The survey of 449 administrators —conducted for Modern Healthcare magazine by National Research Corp., a Lincoln, Neb., market research firm—indicates that many administrators are attuned to consumers' cost-control demands.

For instance, three-quarters of the surveyed hospitals now offer some some type of alternative care service and another 15% are planning to offer such services by July.

Large hospitals are more likely to offer alternative health care services than smaller institutions. All hospitals with 500 or more beds that were surveyed either currently offer or plan to offer some form of alternative health care service in the near future.

More hospitals offer home health care—or have affiliations with other providers to offer home care —than any other type of alternative service. One-quarter of the surveyed hospitals provide home care and another 33% plan to offer the service by the end of July.

Hospitals with more than 100 beds are more likely to offer these services. For instance, 69% of surveyed hospitals with 300 to 499 beds either offer or plan to offer home health care this year.

About 20% of the surveyed hospitals are operating wellness centers. Again, a hospitals with more than 200 beds are more likely to operate the centers, with 44% of the hospitals with more than 500 beds offering the services.

The proportion of respondents now offering occupational health services parallels hospitals' involvement in wellness activities, with 43% now offering or planning to offer occupational services.

Occupational and wellness services often go hand-in-hand, being offered as a package by hospitals to employers. However, the Modern Healthcare survey shows that more hospitals are interested in developing occupational health programs than wellness programs.

Typically, hospitals with more than 200 beds are offering or planning to offer occupational health programs, with 68% of the hospitals with more than 500 beds currently offering or developing services in this area.

More than a third of the surveyed respondents offer birthing services, again with larger hospitals more likely to offer the option. Among hospitals with more than 500 beds, 44% have birthing centers and 20% plan to develop them.

Freestanding primary care centers are being operated by 21% of the hospitals surveyed. The percentage of surveyed hospitals operating primary care centers is double the percentage of those offering urgent care centers.

Among other types of alternative health services:

- 21% of the surveyed hospitals are offering rehabilitation services.
- 20% offer alcohol treatment centers.
- 19% of all hospitals, and 36% of those with more than 500 beds, offer nursing home services.
- 14% offer freestanding surgical centers.

Besides showing their support for alternative health services, most of the hospital administrators surveyed believe that alternative delivery systems—like health maintenance organizations and preferred provider organizations—will someday be a significant force in the health care market.

However, most respondents predict that only 1% to 10% of the employed residents in their areas will belong to an alternative system by 1987.

The larger the hospital, the greater the percentage of administrators who believe that people in their areas will belong to HMOs or PPOs. Also, administrators at larger hospitals predict a larger proportion of people will join such organizations.

For instance, among administrators at hospitals with more than 500 beds, 40% believe that at least 20% of the employed people in their areas will belong to an HMO or PPO by 1987; 15% believe between 21% and 40% will belong; and 12% predict membership of at least 40%.

Among all survey respondents, 45% believe a new PPO or HMO will be established in their service area within the next year. Hospital administrators in the West and Midwest predict the greatest influx of PPOs and HMOs.

Among administrators at hospitals with more than 500 beds, 75% are expecting new PPO or HMO developments within the next year.

●

Copies of the Modern Healthcare survey are available for $50 from William C. Jackson, Vp, National Research Corp., 300 S. 17th St., Lincoln, Neb. 68508; 402-475-2525.

RIMS renames placement service

NEW YORK—The Risk & Insurance Management Society has changed the name of its Executive Referral Committee to the Executive Counseling and Placement Service.

The service provides career counseling, helps employers recruit risk managers and helps risk managers looking for new positions. For information call Hillary Levine at 212-286-9292. ■

Lloyd's probing six underwriting agencies

By STACY SHAPIRO

london line

LONDON—Six Lloyd's of London underwriting agencies owned by Lloyd's broker Bellew Parry & Raven (Holdings) Ltd. are the targets of Lloyd's latest investigation.

Last week, Lloyd's appointed Sir Edward Singleton, former president of the British Law Society, to study the reinsurance activities of the six agencies:

- Bellew & Raven (Underwriting Agencies) Ltd.
- K.F. Alder (Underwriting Agency) Ltd.
- A.R.E. Chamber Underwriting Agency Ltd.
- Coucher Underwriting Agency Ltd.
- Haynes & Clack Underwriting Agencies Ltd.
- R.P. Milligan (Underwriting Agencies) Ltd.

Lloyd's wants to know if any of the 18 syndicates managed by the agencies placed reinsurance directly or indirectly with companies controlled by Bellew Parry & Raven directors, their associates or their families. Lloyd's is also investigating if employees of these agencies have had interests in any of the reinsurers the syndicates use.

Sir Edward will look specifically at premiums and claims that flowed directly or indirectly via reinsurance to companies controlled by the group's directors, A.H.B. Gratton-Bellew, J.R. Parry and F.C. Raven, or by their associates or families, Lloyd's said.

A Lloyd's spokesman said the new inquiry arises from an earlier investigation into Lloyd's underwriting agent Brooks & Dooley (Underwriting) Ltd. and two of its executives, who had links with Bermuda-based Fidentia Marine Insurance Co.

The executives, underwriters Raymond Brooks and Terence Dooley, are facing charges at Lloyd's (*BI*, Jan. 9) for improperly channeling large sums of syndicated funds through reinsurance contracts to Fidentia.

Among the people involved in the latest investigation is Edward Nelson, a former Lloyd's Committee member and chairman of K.F. Alder, who says he is astonished by the new inquiry.

"I do not know what is happening," says Mr. Nelson. "We were only told about this the day the notice went up the board in the Lloyd's underwriting room."

Warranty coverage

More than 130,000 policyholders who bought extended warranty insurance policies for their electrical appliances may have to pay claims themselves because the insurers are now defunct.

The insurers were not authorized by the Department of Trade and Industry to cover extended warranty risks. Therefore, policyholders will not be covered under the 1975 Policyholders Protection Act, which requires that all London insurers pay policyholders for their losses in the event of an insurer's collapse—but only if the insurer is authorized.

Two weeks ago, the British High Court granted the department's request to liquidate Cavelier Insurance Co. Ltd. and Universal Guarantee Insurance Agency Ltd.

The department shut them down because Cavelier, an authorized property insurer, was not authorized to underwrite extended warranties. Universal Guarantee was not authorized to insure any line, nor was its parent company, Universal Guarantee Assurance Assurance Co. Ltd. in New Zealand.

Both companies last year accepted extended warranty insurance business from Multi-Guarantee Ltd. after Lloyd's of London disputed the validity of the policies, said a Department of Trade spokeswoman. Cavelier alone wrote more than 130,000 policies, she said.

Lloyd's disputed the extended warranties insurance policies, marketed by Multi-Guarantee, because it believed they were altered. A Lloyd's investigation into the matter continues, and the market has since set up a fund to pay any valid claims (*BI*, March 21, 1983).

Multi-Guarantee, which denied altering the policies, closed last year.

Defunct insurers

Business is thriving for companies that specialize in running off insurance business.

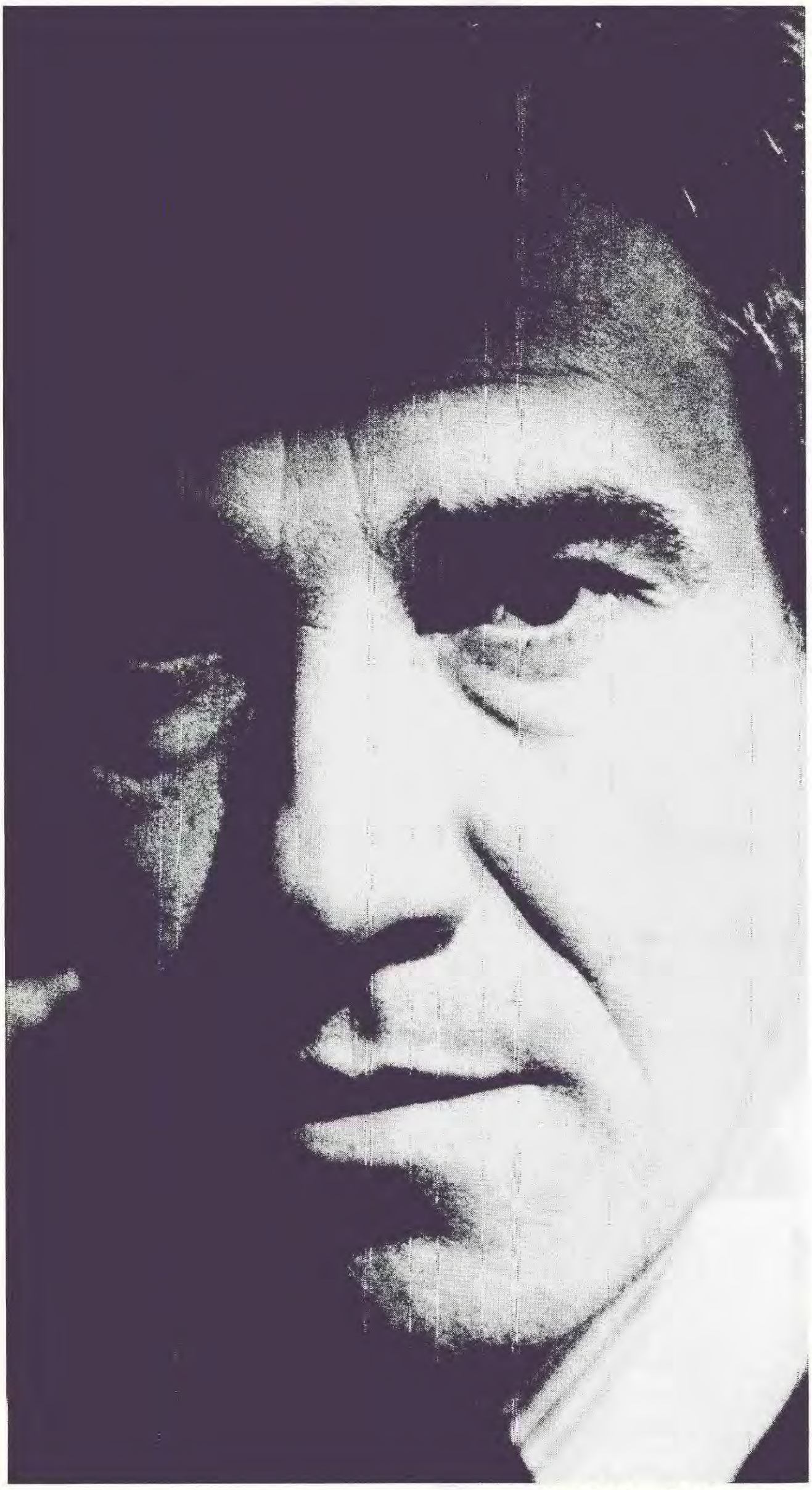
As the London market tightens, more companies are closing their insurance operations. And, they need someone to look after the administration of claims and recovery of any premiums, one insurer says.

"It is a growth area, which is a sad thing to say," said Chris Keeling, executive director of corporate management for English & American Insurance Co.

Usually, insurers that go out of business suffer from poor underwriting results, with losses alone topping 130%, said Mr. Keeling. Sometimes, too, poor management and improperly maintained records contribute to disaster.

English & American is offering runoff services to insurers that are closing their London offices.

"We will offer whatever service the claim wants," Mr.Keeling said, "and we will go in and pick up the files, look for receipts of cash and payment of claims." English & American, however, will handle claims only for companies that have sufficient reserves to meet debts. ■



"When you're talking about putting sophisticated computer systems in the hands of non-computer users, you're talking about a heavy training commitment. And I don't mean a bunch of ten-pound user manuals and a see-you-later. A lot of computer companies forget that."

Wang doesn't.

Because while other computer companies are just getting their foot in the office automation door, Wang has been there.

From day one.

And from the beginning, Wang people have made support and service their number one priority.

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The Office Automation Computer People.

HEALTH CLAIMS AUDITS

Reviews can turn up errors and, sometimes, savings

By Robert H. Booz

"I HAVE NEVER deducted anything in such situations. And remember, health insurance generally pays for the entire OB care, even if the garbage man delivers the baby."

Medical Economics magazine published this response of a physician consultant to another physician's question about how to adjust his fee when the patient had her baby in a police car en route to the hospital. The questioning physician wrote, "By the time I was notified and got to the hospital, it was all over."

What chance does your health insurer or claim administrator have of detecting and reducing payment in a similar situation?

According to studies of claims paid by more than 15 group health insurers or claim administrators for more than 20 group health insurance programs, detection is virtually impossible.

Audits of health claims processing programs show that error rates, in terms of dollars paid, average 3.7% and run as high as 14%. These startling dollar errors are often combined with a large number of procedural errors, which could lead to other dollar errors.

These health claims audits were performed on major insurers or third-party administrators; some even had dedicated service units for the account being reviewed.

When thinking about a health claims audit, employers ask why they should audit their group health insurance programs. How is the audit performed? What kind of errors are found? How can errors be prevented? What are the benefits of audits to employers?

The reasons an employer should have a health claims audit include:

- Concern about the company's controls and those in effect at the insurer or third-party administrator.
- Concern about the appropriateness of health coverage offered to employees.
- Recognition that health care costs, although alarmingly high, are no longer viewed as uncontrollable.
- Recognition that errors are made and a desire to quantify those errors.

Some audits involve special segments of the group health insurance package, such as independent review and verification of hospital bills. Other audits encompass the entire health insurance payment mechanism, including individual claims review, regardless of source or payee.

While these reasons are valid, their importance increases even more when combined with the concern of many employers that the claims audit should be conducted to improve overall internal controls.

Robert H. Booz is an audit manager at Arthur Young & Co. in Chicago.

The use of a third-party administrator allows the administrator to issue checks from the employer's account. Many companies view a regular group health claim audit as a necessary part of overall management responsibility. Symptomatic of the need for claims auditing are typical problems such as:

- Rapidly rising and unexplained health insurance costs.
- Detection of errors through day-to-day operations.
- Unusual and unexplained fluctuations in reported payments/reserves.
- Sudden increases in new claims.
- Increased or markedly decreased employee complaints concerning claims with inadequate or ambiguous answers from the third-party administrator.

Translating concerns about health care costs into action to review claims can be a long process. Often, there is the unnecessary fear that a special relationship between the insured and the insurer or third-party administrator may be broken.

Once an employer decides to proceed with a health claims audit, the auditor works with it and the insurer or administrator to establish a statistically accurate sample of claims.

An auditor's proprietary software tests the dollars paid instead of individual claims documents per se. Non-essential procedural errors and small-dollar errors can be separately evaluated. Using statistically proven and tested methodologies, individual error rates on claims are extrapolated to the universe of all dollars paid.

This evaluation aids client understanding of the kinds of errors made and their financial effect.

Our experience indicates that the most common errors are:

- Lack of support for payments made in excess of "reasonable and customary" charges.
- Services are not applicable to the illness.
- Incorrect deductible calculations or applications are made.
- Math and clerical errors appear.
- Duplicate payments are made.
- There is a failure to recognize coordination-of-benefits payments.
- Medicare complimentary calculations are made incorrectly.
- There is a failure to recognize and pursue subrogation of benefits.
- Payment is made under the wrong benefit plan or program.
- Eligibility and effective date errors appear.
- There is inadequate support for payments made.

In more than 20 claim audits performed by our firm during the last two years, 46.5% of claims dollars paid in error were due to payment of non-covered or duplicate services. Incorrect payment of covered services comprised 24% of the errors. Coordination-of-benefit or subrogation errors or failure to pursue these savings comprised 10.5% of payments made in error. Simple math or clerical errors resulted in a mispayment of 7.7% of claim dollars.

Details of a composite of two recently completed audits, show where errors were detected. Based on those audits, the estimate of total payment errors for those 318 claims is approximately $446,100 or 4.84% of total claims dollars paid (see chart). With a 95% confidence rating, the amount of overpayments ranges from $176,400 to $999,300.

There are other errors frequently made in handling health claims. Another common error involves the misuse of employee eligibility information.

Many times, the employer, not the insurer, is at fault for not reporting terminations, additions, coordination of benefits or subrogation information. When this information is reported, it should be used.

Employers do not react well to reporting monthly dependent data only to find that their claims are paid solely by contract type and not according to the eligibility of the dependent in question.

Another frequent error, payment for

Continued on next page

Health claims audit findings

Company name: ..... Sample Corp.
Insurer: ..... Minimum Premium Inc.
Period tested: ..... Year ending Dec. 31, 1982
Number of claims paid during period: ... 34,700
Total dollars paid during period: $9,202,000
Number of claims sampled: 318

Payment errors	Number of claims	Overpayments
Hospital charges exceeded negotiated room rate.	9	$ 4,509.00
Services relating to workers compensation case.	1	3,594.19
Accident-related services not pursued for potential subrogation of benefits.	7	47,001.50
Medical procedures billed in error.	4	598.60
Payment for personal items while hospitalized.	15	74.84
Payment for apparent cosmetic surgery.	2	4,192.10
Errors, including duplicate payments and non-covered service payments.	12	3,278.54
Subtotal of known payment errors.	50	$63,248.77
Coordination of benefits not investigated or pursued despite previous or subsequent COB recoveries for that individual.	778	$190,588.07
Total of known payment errors.	828	$253,836.84

Procedural errors	Number of claims	Overpayments
Files not available for review.	6	$35,891.25
Payment reasons not documented or otherwise established; eligibility file and other miscellaneous procedural errors.	165	—*
	171	$35,891.25

Source: Arthur Young & Co.

*No known dollar value for procedural errors.

CALLING A HALT TO FIRES

Insurance incentives would encourage fire-resistant furniture

By Stephen S. Showers

IN 1981, 930 fatalities were attributed to bedding fires in the United States.

Nearly 1,400 lives were lost to fires in upholstered furniture, prompting the Consumer Product Safety Commission to call these materials "the biggest killer of all the products under the jurisdiction of the agency."

Mattresses, bedding and upholstered furniture were involved in 45% of the fatal fires before 1981 that were reviewed by the National Bureau of Standards.

The means of reducing these tragic losses—by new foams and fabrics used in upholstered furniture and bedding—are readily available. But, heightened awareness among businesses and institutions, as well as insurance rate incentives, are needed to promote widespread investment in these life- and property-saving products.

Estimated property losses from building fires were about $6 billion in the United States in 1981, an increase of almost 7% from 1980.

Institutional facilities, including hospitals and schools, lost more than $38 million in 1981, up 52% from 1980. It is apparent that the goal set 10 years ago by the National Commission on Fire Prevention to reduce fire losses by 50% has not been met.

Some of the same problems of a decade ago still exist. Ninety-five cents of every fire-service dollar is used to extinguish fires, according to the commission. Only 5 cents is spent on fire prevention, inspection and public education.

Also, the commission found that building and product designers were content to meet minimum standards. Many assumed that fire codes provided adequate safety measures rather than minimum ones.

An article in the Dec. 19, 1983, issue of Forbes magazine, "Where There's Smoke, There Are Lawyers," reported a trend for injured parties to raise "questions of liability in complex legal squabbles over whether a building is a product or not."

The article concluded, "Those builders, manufacturers and landlords who aren't aware of these legal changes are taking big risks."

The fire safety problem is two-fold.

First, federal, state and local regulations have focused on fireproof buildings, not on building contents, with the belief that a fireproof building will protect against fire.

Second, most existing standards are minimum ones, often based upon results from small-scale laboratory tests rather than large-scale testing.

The National Fire Protection Agency reports, "Fire-resistive structure construction is an important life-safety measure. However, severe fire may occur in the contents of fire-resistive buildings, and highly combustible decorations and interior finish materials may more than offset the fire safety value of non-combustible structures."

Fire protection specialists have noted that, in general, contents fires present a greater life-safety hazard to building occupants than the ignition of the building. The cause and early stages of fires are most often traced to building contents and the interior finish materials.

No matter what the building construction, a contents fire must be controlled in order to save lives.

Boston has perhaps the nation's strongest fire code regulating upholstery in public buildings. Boston Fire Department chemist Edward V. Clougherty explains the code's rationale: "The control of the contents of a building is as important a part of the fire safety program as the construction of the building. Taken together with the prevention measures, such as sprinklers, control of contents is an integral part of an overall safety plan.

"Control of furnishings, the upholstery, is the way of keeping the fire small. It could otherwise lead to a large fire with loss of life," Mr. Clougherty says.

"The professional liability of designers and manufacturers also is involved. Not only business, but also those who supply business should be concerned," he adds. "There are now a number of products on the market that offer substantially better fire protection than in past years. This makes our code enforcement easier to sell. People are not so limited in the materials that will do the job."

Although most new buildings are constructed in accordance with a national fire code such as the NFPA 101 Life Safety Code, no national code regulates upholstered furniture. The federal mattress standard reflects a safety level for mattresses based only on their susceptibility to cigarette ignition, not to open flame—the major cause of fire in residences.

Fire safety concern has led some institutions to test upholstered furniture and mattresses and to rewrite their purchasing specifications. In the process, the need for large-scale tests became apparent.

For instance, radiant panel tests (where radiant heat causes the ignition of a substance) show that a polyurethane foam chair treated with flame retardants had a lower flame-spread rating (the rate at which flame spreads through the material) than the rating shown by large-scale tests.

Yet, when the same treated chair was

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Health claims audits can turn up savings

Continued from previous page

non-covered services, results from both poor documentation and sloppy handling.

For example, an extensive medical review is not needed to deny delivery room charges for a 65-year-old man. Nor is a hospital report needed to deny payment for a whole body CAT scan for a fractured ankle.

When errors are made, research should be done to find the reason for the mistakes. Reliance on a data-processing system is not enough.

For instance, another claims audit revealed that all dental claims paid in one year stemmed from an incorrect computer-based payment calculation. A faulty data-processing system that goes unchecked can be disastrous.

The single and most disturbing reason for errors is a lack of clear, definitive guidelines for claims processing. Individual adjuster decisions are often made in error and these decisions become precedent-setting. Some of these potential processing errors include:

- Ad hoc policies written on scraps of paper or as notes from telephone conversations.
- Inadequate definitions about which services are to be paid. In one recent claims audit, nearly every reasonable and customary allowance calculation was overpaid; the employer was not aware that its specific requests or understanding of what was to be paid were overriden by the insurer's general operating policy.
- Vague contract language or lack of application of contract language.

Most—if not all—of these errors were preventable. And, prevention is far less costly than attempting to recover money paid in error.

The process to save health claims money begins with a cooperative effort between the insurer or third-party administrator and the employer to address common problems.

Claims-handling procedures should be defined and taught to the adjusters. Internal controls should be reviewed and tested. Policy decisions must be made. Precedents must be established on individual case-by-case decisions documented in concert with the employer's wishes.

The benefits of an audit vary from client to client depending on the extent of the review and the internal controls currently in place. These benefits generally can be expected:

- Improved controls at the employer and the insurer or third-party administrator.
- More efficient and cost-effective administration of health care costs.
- Validation of adequate program administration.
- Potential financial returns.
- Improved position for the employer with the insurer or administrator.
- Identification of unusual payment patterns.
- Specialized computer tests of known error categories.
- Teaching employer staff claims audit techniques.

'The single and most disturbing reason for errors is a lack of clear, definitive guidelines for claims processing. Individual adjuster decisions are often made in error and these decisions become precedent-setting.'

One of the most gratifying results of a claim audit is the increased communication between the insurer or administrator and the employer. We have seen a number of cases where, despite some serious processing issues and errors, the insurer was retained. New contracts were written to eliminate ambiguities and responsibilities of the employer and insurer or administrator were redefined.

Regardless of audit findings—whether individual errors are found and corrective measures sought or no major errors are found and confidence is established through testing—the claims audit serves a worthwhile purpose.

The audit identifies weaknesses, helps to establish corrective measures and keeps the employer and the insurer or administrator on an "equal" footing. Each becomes more aware of the other's concerns.

Ultimately, the employee is a beneficiary of a health claims audit. Mispayments or inconsistent applications of policy restrictions are inherently inequitable. Equality of payment procedures is one of the best protections against discrimination litigation. Also, correct payment procedures may lower administrative costs and would lower health insurance costs in both the short and long run.

Control of self-insured health coverage requires careful overview. Health claims audits have become increasingly popular as health care costs rise and their effect on the bottom line becomes greater.

Prudent managers should pursue a health claims audit either with outside consultants or with their own internal audit staff. And administrators or insurers should not be surprised to find their clients pursuing claims audits.

Continued from facing page
tested against an untreated polyurethane foam chair in large-scale tests, both were totally enveloped by fire and sustained maximum damage. Both chairs gave off an enormous amount of smoke.

The National Bureau of Standards' Fire Research Center released data concerning the rate of heat release and the smoke generation of major generic materials used in mattresses. The data, expressed in subjective units where lower numbers indicate better fire performance, showed that:

- Low-smoke neoprene foam had a heat release rate of 16 to 22 with 0.04 to 0.05 smoke generation.
- Cotton batting was rated at 45 to 119 heat release and 0.02 to 0.36 smoke.
- Polyurethane foams, with and without flame retardants, were rated at 144 to 187 and 0.33 to 1.97 smoke.
- Polyvinyl chloride foam registered 104 to 239 heat release and 0.87 to 4.46 smoke.
- Styrene butadiene had a rate of 624 on heat release and 9.38 on smoke generation.

The bureau also stated that the order, with low-smoke neoprene first and syrene butadiene last, remained unchanged when different mattress cover materials were tested over the cushioning materials.

The test data showed that fire characteristics of a piece of furniture are normally governed by the cushioning materials used.

(These and other small-scale test results do not, by themselves, represent the performance of any material under actual fire conditions.)

Of these generic materials, the top three—low-smoke neoprene, cotton batting and polyurethane—were tested by E.I. du Pont de Nemours & Co. at its large-scale test facilities in Wilmington, Del.

A simulated institutional room with common commercial mattresses was used for testing. Paper placed in a trash can was ignited and allowed to contact the bedclothes. The bedclothes then ignited the mattresses.

When the polyurethane foam mattress was tested, it was engulfed by flame within four minutes. After seven minutes, the test was stopped when the temperature in the room reached 825 degrees.

The cotton batting mattress treated with boric acid became fully involved in flame within 20 minutes and produced a large amount of smoke.

Finally, the mattress with low-smoke neoprene foam was tested. In 10 minutes, only the bedclothes were burning, producing light smoke in the room. In 15 minutes, the smoke was still minimal. In 25 minutes, the fire was almost out.

In these large-scale tests, the order remained the same for fire performance characteristics. Low-smoke neoprene foam performed best, followed by cotton batting and polyurethane foam.

Each of the top three materials has advantages and disadvantages. Most types of polyurethane foam are inexpensive, but extremely flammable. Polyurethane has good physical properties, because it's comfortable and retains its shape.

Cotton with flame retardants is slower-burning, but the burning rate can vary greatly. The burning rate depends on how much boric acid is added to the cotton and how well it has been dispersed. Cotton, however, has poor physical characteristics.

Large-scale testing shows that low-smoke neoprene foam has excellent flame resistance and is ideal for use where intentional ignition is a factor, such as in prisons and mental institutions. It is currently used in many hospitals, most rail transportation, naval vessels and some universities. Low-smoke neoprene also has good physical properties.

The hazards to which furniture could be exposed will, to a large extent, determine the type of material that best meets fire safety requirements. The likelihood of cigarette ignition, open flames, the proximity of combustibles, population density and liability exposure all play a part in furniture selection.

Buildings in high-vandalism areas should be furnished with material made with low-smoke neoprene foam, which has good flame resistance. Furniture that may be subject to accidental ignition should contain cigarette-resistance materials.

A primary consideration, of course, is the cost of fire-resistant furniture. Fire-safe furnishings can require a slight increase in investment. Yet, more and more institutions and businesses are taking a good look at the fire safety of their building contents.

Encouragement from the insurance industry—in the form of reduced fire insurance rates—could have a significant, positive impact on the decision to provide fire-safe furniture.

The insurance industry has a well-earned reputation for backing and promoting efforts to save lives and property. The industry should support the installation of fire-resistant furnishings and finishing materials as a major step in reducing fire-related losses.

This step also deserves the support of commercial and industrial insurance buyers to keep lives and assets from going up in smoke. ■

'The hazards to which furniture could be exposed will, to a large extent, determine the type of material that best meets fire safety requirements. The likelihood of cigarette ignition, open flames, proximity of combustibles, population density and liability exposure all play a part in furniture selection.'

The Perspective section, which is a forum for readers' opinions, is compiled and edited by Assistant Copy Editor Claudette Dampier. She can be reached at 312-649-5282.

Stephen S. Showers is director of housing and residence life at West Virginia University in Morgantown, W.Va.

Mental patient can keep work comp benefits

legal briefs

A CLAIMANT acquitted of a crime because of total insanity and committed to a mental institution did not lose his right to previously awarded workers compensation benefits, according to the Court of Appeals of New York.

Peter Tallini injured his back May 5, 1979, in a work-related accident and was awarded benefits based on permanent partial disability. Thereafter, Mr. Tallini moved back to his native Italy.

He later was arrested for fatally shooting two people and injuring a third. An Italian court acquitted him on the grounds that he was insane at the time he committed the acts. The court ordered him committed to a hospital for the criminally insane.

Mr. Tallini's former employer and its insurer applied to the workers compensation board for permission to suspend paying compensation while he was confined. While the board suspended payments, an appellate court ordered them to be continued.

"To penalize a worker who has suffered a permanent disability solely because he or she has subsequently been afflicted by mental illness would in no way further the goals behind the workers compensation law," the appellate court said.

Thus, the court held that the commitment of a worker for treatment of mental illness should not in itself bar continued benefits as long as the work-related disability continued to affect the former employee. *Tallini vs. Martino and son*, Court of Appeals of New York, March 30, 1983 (*BI*/04/F.-$5).

Bankers bond violation

A person may exceed his authority without a dishonest purpose. And, although the terms of a banker's bond should be broadly construed, there is no justification for extending coverage to all unauthorized acts, a federal court of appeals ruled.

Rock Island Bank was insured under two bankers blanket bonds issued by Aetna Casualty & Surety Co. The bonds insured the bank against losses resulting from dishonest or fraudulent acts by employees.

During the policy period, the bank's president issued seven letters of credit on behalf of Cortland Silver in amounts that greatly exceeded his loan authority. In addition, he had extended the credit without consulting the loan committee of the bank.

By July 3, 1970, the amount of outstanding letters of commitment issued on behalf of Cortland Silver was more than $1 million. Cortland Silver declared bankruptcy and one of the outstanding letters of credit resulted in a judgment against the bank for $372,000. Aetna declined to meet the judgment.

The bank sued Aetna and recovered a summary judgment of more than $530,000, including attorneys' fees.

The appellate court reversed, concluding that it was an error for the trial court to rule for the bank because there was a question of fact in regard to the character of the bank president's conduct.

According to the court, willfulness and an intent to deceive must be present in order for an employee's actions to be dishonest or fraudulent. Since there was no unequivocal evidence here of deception, the court concluded that it was necessary for the case to be remanded for trial. *The Rock Island Bank vs. Aetna Casualty & Surety Co.*, 7th U.S. Circuit Court of Appeals, April 28, 1983 (*BI*/05/F.-$5).

Work product exclusion

A liability insurer that includes a "work product" exclusion in its policy was not liable for damages to the work product of an insured due to negligent, faulty or defective workmanship, a Louisiana appellate court ruled.

The court said that such liability policies are not performance bonds.

Old River Terminal Co-op contracted wth Davco Corp. to construct a building. Industry General Corp. contracted with Davco to do the engineering design work.

Fireman's Fund Insurance Co. issued a $2-million performance bond. The co-op accepted the work as basically completed on March 15, 1977.

Later, subsidence resulted in substantial damage to the building and silos. Old River sued Davco and Industry General. The latter, in turn, sued nine insurers that had issued comprehensive liability or excess liability policies to Davco and Industry General during construction and thereafter. Yet, each of the policies contained a work product exclusion.

The insurance companies then requested that the suit against them be dismissed. The trial court agreed.

On appeal, Davco claimed that the work exclusion was intended only to exclude coverage for losses to products of the insured where the loss was directly attributable to the product's own inherent defects, not to a faulty subsurface survey, as alleged here.

But, the court said the question here was what was defective—and the defective objects were the cracked silos. A liability policy with a work product exclusion, the court said, does not insure any obligation of the policyholder to repair or replace his own defective work or defective product. The trial court decision was upheld. *Old River Terminal Co-op vs. Davco Corp.*, Court of Appeal of Louisiana, March 17, 1983, *rehearing denied*, May 25, 1983 (*BI*/01/M.-$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.

Employers say monitoring service cuts costs

Continued from page 2
and of employers that hire the insurers to administer their self-funded plans.

Under these arrangements, Cost Care is paid by the insurer, which then charges the employer a predetermined monthly fee. The employer that works with Cost Care through its insurer can benefit from reduced premium increases or some other means arranged between the employer and the insurer.

A self-funded employer works directly with Cost Care benefits through a direct reduction in health care costs. The savings probably will be greater than those of the employer that works through an insurer because any reduction in hospital expenses is realized immediately by the self-insurer.

Cost Care's monthly fees range from 85 cents to $2 per employee covered, including coverage of dependents, explains Dr. Gerard N. Mazo, Cost Care's vp and corporate medical director. An initial setup fee of $1 per employee also is charged, with a minimum payment of $500.

Major life and health insurers that participate in the program include Equitable Life Insurance Co., Northwestern National Life Insurance Co., Aetna Life Insurance Co., Pacific Mutual Life Insurance Co., Occidental Life Insurance Co., Travelers Life Insurance Co. and Prudential Life Insurance Co.

To receive the maximum benefit under an employer's health plan, a hospital-bound employee must have his or her physician notify one of Cost Care's 200 consulting physicians to approve treatment. The physicians discuss the need for hospitalization and agree on an estimated length of stay.

Benefit managers say this doctor-to-doctor relationship works well and, since both individuals are professionals, conflicts are rare. Attending physicians are less likely to extend a patient's stay unnecessarily if they know they are held in check by a fellow physician, they say.

Emergency admissions must be reviewed within 48 hours of admission for the patient to qualify for full benefits.

If employees fail to notify Cost Care before their hospital treatment, the benefits they receive may be severely reduced. Cost Care offers employers two options to encourage employee compliance:

- They can reduce the base to which they apply coinsurance payments—normally the amount of the hospital bill—for those patients who do not notify Cost Care before their hospitalization. The base is usually reduced by 20% to 50%. For example, a patient whose hospital bill is $1,000 would normally be reimbursed for 80% of that cost, $800. However, if the patient fails to consult Cost Care, the health plan then might only pay 80% of as little as $500 of the hospital bill.
- They can offer a low deductible, perhaps $100, to employees who have hospitalization approved by Cost Care. Conversely, the employee who fails to notify Cost Care will be hit with a very high deductible, perhaps as much as $1,000.

Employees may regard this as a penalty for not using Cost Care, but the cost management firm doesn't think so.

"This isn't meant to be punitive. It's really just to guarantee compliance, to see that we are notified at the start," says Dr. Mazo. "It's really risk-sharing by the noncompliant employee. He risks sharing the extra cost."

Cost Care says that 96% of the employees whose hospitalizations it monitors comply with the program. And, it apparently is paying off.

The average annual number of hospital admissions per 1,000 employees enrolled in the Cost Care program is 75, compared with the 120 to 150 admission per 1,000 workers reported by health insurers that do not use the program, Cost Care says.

And Cost Care reports the average annual number of bed days per 1,000 employees it monitors is about 324, well below the 650 to 700 reported by health insurance companies.

This performance and Cost Care's projections of cutting hospital expenses by 11% to 23% has attracted some major clients throughout the country, though most of Cost Care's current employer clients are based on the West Coast.

Besides Western Airlines, Bekins and the state university system, employers that now use Cost Care include International House of Pancakes in North Hollywood, Calif.; Fluor Corp. in Irvine, Calif.; ARA Services Inc. in Philadelphia; Rolm Corp. in Santa Clara, Calif.; Toyota Motor Manufacturing USA Inc. in Long Beach, Calif.; San Diego Trust & Savings Bank; the State of Nevada; the city of Palm Springs, Calif.; and Sunkist Growers Inc. in Sherman Oaks, Calif.

Sunkist has worked with Cost Care through its insurer, Northwestern National, for a little more than a year, to curb hospital expenses for about 700 employees nationwide, says Stan Haberkorn, Sunkist's manager of employee benefit administration.

Sunkist's most recent premium increase was reduced to 45% from 80%, a reduction Mr. Haberkorn attributes in part to working with Cost Care. He estimates that Cost Care will help Sunkist to eventually reduce its premium costs by an additional 8% to 10%.

"We're very encouraged by what we're seeing," he says.

So is International House of Pancakes.

IHOP has saved more than 10% on its hospital costs since the company began working with Cost Care, estimates Patricia J. Henslee, insurance administrator.

IHOP has worked with Cost Care since September 1982, when the restaurant chain decided to try the service on a three-month basis with its California employees. It adopted the program nationwide in January 1983.

"We had a miraculous elimination of people going into the hospital," Ms. Henslee recalls of the pilot period.

When IHOP decided in December 1982 to change health insurers, "We were so impressed with Cost Care that we wouldn't take an insurer who wouldn't work with them," she says.

Prior to that time, IHOP paid Cost Care 85 cents per month per covered employee through Prudential, its insurer. When IHOP chose Home Life Insurance Co. as its new health insurer, it had to convince Home Life of Cost Care's merits.

Home Life does not provide Cost Care with the volume of clients that Prudential does, so IHOP now must pay $1.25 per month per covered employee of Cost Care services but, "We were willing to pay the extra to have Cost Care," Ms. Henslee says.

Besides its monitoring activities, benefit managers say Cost Care also provides helpful statistical information each month about how employees use their company's health program.

The information is broken down by geographical region, number of admissions and bed days and into more than 30 admitting categories. Using these statistics, Cost Care is able to make certain cost-cutting recommendations.

For example, a high incidence of hernia operations may indicate that employees need to be trained in proper lifting procedures, explains Lawrence Goelman, Cost Care's president.

And a residual benefit of the program is a greater awareness of health costs among employees, notes Sunkist's Mr. Haberkorn.

More and more employees are shedding their "let-the-boss'-insurance-pay" attitude and are becoming cognizant of how the size of their contribution to the benefit plan is directly related to the employer's costs, he explains.

Cost Care's concept of monitoring hospital costs is the result of experimentation by a former health insurer, Health Maintenance Life Insurance Co. of Fountain Valley, Calif., says Mr. Goelman.

HML offered its policyholders strong financial incentives to obtain prior authorization for all hospital admissions, including length-of-stay authorization. A tough market forced HML to cease its group business in California in late 1981, though the company still holds its state license and continues to operate in Utah and Guam, according to the California Insurance Department.

Most of Cost Care's founders came from HML or its parent company, Family Health Plan, a California-based health maintenance organization.

Mr. Goelman, who worked for the HMO, says Cost Care will succeed where HML failed for several reasons. For instance, Cost Care uses physicians to review admissions; HML used nurses. And, he adds, Cost Care's activities have the cooperation of the medical community, something HML struggled to achieve in the 1970s.

Also, Mr. Goelman notes, Cost Care can focus its energies on service, rather than risk-bearing activity, because it is independent of an insurer. ■

Hospices cheaper than hospitals: Study

Crain News Service

WASHINGTON—Hospices are more economical than hospitals for treating terminally ill patients, especially if patients enter the hospice during the last two months of life, a government-sponsored study shows.

Also, home-based hospices are less expensive than hospital-based hospices, according to data reported in the three-year National Hospice Study.

(Hospital-based hospices are loosely defined as a hospice that is sponsored by a hospital, while home-based hospices are sponsored by independent companies or associations.)

The study indicates that home-based and hospital-based hospices would save the federal Medicare program money if the program's new hospice benefit—which covers up to 210 days of hospice care—is used for no more than two months.

However, hospital-based hospices begin to cost more than conventional inpatient hosptal care after two months of care, the report concludes.

The cost of home-based hospice care doesn't begin to rise above the cost of conventional hospital care for six months, it adds.

When Congress enacted the new Medicare hospice benefit last year, it estimated that the benefit would save the federal government $13 million through 1985 by reducing inpatient hospital care. The Department of Health and Human Services' Health Care Financing Administration, however, has contended that the benefit would increase Medicare spending.

Hospices do save money and are especially economical if patients are admitted to the hospice when they have just one month to live, says the study's principal investigator, Dr. David S. Greer, dean of medicine at Brown University in Providence, R.I.

Compared with conventional care, the hospital-based hospice would save the Medicare program $657 per patient during the last week of a patient's life, while a home-based hospice would save $910, the study says.

One reason for hospices' savings, Dr. Greer explained, is that both types of hospices reduce the time the patient spends in the hospital, where costs are usually higher.

Health care policymakers should try to encourage home-based hospices because they are less costly and more likely to keep patients at home, Dr. Greer adds.

However, hospital-based hospices may be preferable for patients needing treatment for pain, he notes. The study shows that hospital-based hospices tend to provide more pain control than home-based hospices.

Although home-based hospices are regarded by the study as more economical than hospital-based models, a comparison of costs shows that hospital stays for patients in the home-based hospice model are costlier than stays for patients in a hospital-based hospice.

The inpatient cost per day for the home-based hospice patient were $278, compared with $218 for the hospital-based hospice patient.

But, because patients in the home-based model stay in the hospital less frequently, this model's overall costs are lower. The daily costs per patient for the home-based model are $66, compared with $95 for the hospital-based model.

Dr. Greer found that hospital stay costs were higher for the home-based hospice patient because more ancillary services are used. That could be because the home-based hospice patient is sicker upon admission to a hospital and needs more treatment and ancillary services.

It's conveivable, however, that a hospital-based hospice administrator could negotiate with the hospital to lower the use and cost of ancillary services for hospice patients, says Howard Birnbaum, director of long-term care and public programs at Abt Associates, a Cambridge, Mass., research and consulting firm.

Dr. Birnbaum did the economic analysis for the hospice study.

A hospice administrator must realize the importance of integrating the hospice model into the overall health care delivery system, he noted.

For example, the report shows there is a "financially optimal time" for admitting a patient to a hospice to ensure that hospice care is less expensive than conventional care, he said.

The longer the patient stays in the hospice, the less economical hospice care becomes, he explains. Therefore, a hospice administrator should try to determine whether a patient should be admitted to a hospice or receive care from some other component in the health care delivery system. ■

Generic messages

Continued from page 3

"We didn't do a lot of soul-searching that a lot of companies go through," he said. "We knew we had to reduce costs, and we did. It was a dramatic change. We reduced our costs by 17%."

IC's chairman described these changes and the reasons behind them in the original version of the film.

The generic version does not include the IC chairman but it does use the same health care providers —physicians, nurses and hospital administrators—as well as an insurance company vp to convey the problem of high costs and overutilization.

"Employees came up to us after seeing the videotape and asked, 'Are you blaming me?'" Mr. Werntz recalled.

"We are not putting it entirely on the back of the employee, but we are the users of the system, and the way we manage health affects how we use the system."

"The overall plan of the videotape is to inform employees of things that are important in their lives so they can make better (more healthful) decisions," said Gary Bergland, vp of marketing for Media Works.

"It asserts that we are *all* part of the problem, so we must all work together for a solution."

"Companies that have similar problems with high health care costs and like the approach IC Industries has can buy the generic tape, or we can customize the generic version," Mr. Bergland pointed out.

But, the cost of a generic version is considerably less than that of a customized videotape. For example, a single copy of "Dollars and Sense" would cost $550; the cost of a completely custom-designed videotape could range from $50,000 to $100,000.

But, lower cost is not the only appealing feature of generic communications materials.

"A generic videotape solved the problem of appearing too self-serving," said Sherry Kalan, associate director of employee communication at Travenol Laboratories Inc. in Deerfield, Ill., one of the companies that already has purchased the IC tape. "It tells employees that health care costs are not a problem faced only by Travenol, but by everyone."

"That the tape is generic is good," said Dan Cohen, coordinator for benefit utilization programs at U.S. Steel Corp.'s Gary Works in Gary, Ind., another purchaser of the film.

"It's intended to be an overview, it's not a program unto itself," he added. "Every company has its idiosyncracies that they want to communicate, so maybe a company will want to add some footage in front or at the end.

"I like it because it's general enough that just about anybody can understand what it's trying to say," he continued.

"There wasn't a lot on the market in this area that I had seen. And, IC Industries did an excellent job. It has an 'NBC White Paper' approach."

However, some companies will find that generic communications materials will need to be modified before they can be effectively used with their employees.

"The tape was very well-done in terms of production and content," said Jack Forbes, director of employee benefits at Batus Inc. in Louisville, Ky., which also bought the IC Industries film. "But, my biggest criticism is the length. We may have to trim it down."

"I don't think we are going to be able to use (the videotape) in the format it's in right now," Travenol's Ms. Kalan said. "It's a little long for our purposes."

And, companies will have to carefully scrutinize the generic materials they find to see if the company could stand behind the message.

Since the availability of the generic version of the film is a joint venture between Media Works, which acts as marketer and distributor, and IC Industries, which owns the copyright, both parties benefit; IC Industries has a cooperative agreement with the consultant for future communications projects at IC.

Although the generic film has been available only about one month, 21 companies have ordered copies already, Mr. Bergland said.

And, though Media Works is a communications consultant that usually develops personalized materials, other consultants specialize in generic formats.

One is Benefit Communicators Inc. in San Diego. With programs aimed at small- to medium-sized companies, this company can develop a benefits communication package for a company, print the material and monitor employee attitude.

Unlike the IC Industries videotape, Benefit Communicators has a generic base of materials that can be "individualized" by plugging in information specific to a company, like the amount of a deductible, and can be printed with the company name. But, because the material is derived from that generic base, this type of communications also offers companies a cost savings.

"Costing was tremendously high for either developing an in-house communications program that would meet our needs or contracting with one of the major consulting or brokerage houses," said Bruce M. Klein, director of corporate affairs for Belding Heminway Co. Inc. in New York, a diversified textile firm with 1,500 employees. Instead, it bought a program from Benefit Communicators.

The average cost to communicate a generic program to 1,000 employees would be about $13 per employee, estimated Douglas D. Lonergan, president and founder of Benefit Communicators.

A typical package from Benefit Communicators, based on generic material, would include: employee attitude surveys; a loose-leaf employee handbook with company-specific information plugged in; a newsletter dealing with health subjects and distributed quarterly, which can incorporate company-provided copy; payroll inserts dealing with health issues and accompanying posters for display at the worksite; and customized benefit summaries.

Also, a generic audiovisual program is on the drawing board, Mr. Lonergan said.

Mr. Lonergan admitted that the reusable quality of the product line may be unappealing to some.

That the material is not absolutely unique is not a big concern to Belding Heminway.

"We submit our own copy for the newsletter, and they add their own articles on health care," Mr. Klein said. "We were looking for communications professionals, and I was impressed with Mr. Lonergan's credentials. They know more about communicating than I do."

Also, the generic quality of the materials is balanced by lower and more controlled costs, he said.

"Since they control everything in-house, they can tell me the exact cost of a program right off the bat," Mr. Klein said. "They have the writers and they do the printing. There are no uncertain fees paid to a third party. I like that."

While generic communications products would not be appropriate for all companies, health care cost containment is a universal concern.

"If our goal is behavior modification so we really do have healthier employees, then communications is crucial," Mr. Werntz of IC Industries said.

"There are a lot of common elements there. I would like to find some kindred spirits so, together, we can find the right way to reach employees."

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For more information on "Dollars and Sense: The Health Care Emergency," write The Media Works Inc., 300 W. Washington, Suite 711, Chicago, Ill. 60606.

Hyatt engineers cited

Continued from page 2

have discovered that the connections were so grossly inadequate that they not only lacked the capacity to bear the design loads intended or to comply with the Kansas City, Missouri building code, but also were grossly inadequate to support even the weight of the bridges themselves."

The complaint says also that despite approval of the split-rod configuration, the engineers continued to use the single continuous rods, and that no one performed calculations to determine if they were adequate or sufficient.

The complaint also states following a collapse of a portion of the hotel atrium roof in October 1979 during construction, the firm did examine and check the structural design of the entire atrium including the bridges.

They failed, however, to perform any calculations to determine the adequacy of the steel rods used to suspend the bridges spanning the atrium area of the lobby of the hotel, the complaint adds.

It also alleges that Mr. Duncan was not licensed as a professional engineer in Missouri at the time he was placed in charge of structural engineering work for the Hyatt project and that Jack D. Gillum & Associates, a predecessor company of G.C.E., was not certified to perform professional engineering services at the time it assumed responsibility for the project.

The complaint adds that as a result of their actions, their licenses and certificates of authority are subject to disciplinary action which may be brought in cases of gross negligence, incompetence, misconduct, or unprofessional and dishonorable conduct.

It asks the state Administrative Hearing Commission to hear the allegations and to issue findings of fact, conclusions of law and a decision that they are subject to disciplinary action by the Missouri Board for Architects, Professional Engineers and Land Surveyors.

If the commission upholds the allegations, the board can suspend or revoke the engineers' licenses, a spokesman for the state attorney general's office said.

The complaint comes as part of a 30-month investigation into the collapse by the board.

The National Bureau of Standards investigated the cause of the collapse and blamed design changes for the collapse but did not affix blame.

A spokesman for G.C.E. last week said that neither Mr. Gillum nor Mr. Duncan had received copies of the complaint. CNA Insurance wrote liability insurance for Jack D.Gillum. ■

Some see public liability market tightening

Continued from page 3
notorious for buying from the lowest bidder, underwriters say.

But if Transcontinental does lose market share, this will not reflect a conscious withdrawal on the company's part, Mr. Malone says. "We just don't intend to chase depressed premiums."

About 20% of Transcontinental's current business is public liability coverage, which generated $4 million in premiums in 1983. About 10% of the company's current public sector policyholders were formerly insured with Canadian Indemnity.

Canadian Indemnity, based in Winnipeg, Manitoba, stopped writing the coverage in May 1983 when it had about 130 policyholders, about half of which were municipalities and the rest fire and water districts, says Dennis A. Riley, vp-operations and U.S. manager for Canadian Indemnity in Costa Mesa, Calif.

The multiline company had written the coverage for about three years and its loss ratio on the public business was "extremely unacceptable," Mr. Riley said.

He says that current rates are simply too thin to warrant covering such great exposures. These exposures include city landfill pollution risks, potential hazards from faulty street or highway design and police officers liability.

"I think it can be written, but at the moment the circumstances are very difficult for an insurer who wishes to reach pure, adequate underwriting results on these risks alone," Mr. Riley says.

He expects coverage on all of Canadian Indemnity's municipal policies to expire by the end of April, but notes that the company will continue to underwrite a few fire and water district policies.

"We expect to continue to entertain the writing of these lines, though not aggressively," he explains. "And," he points out, "we're still in the liability business (for private business) and plan to be for the future."

Canadian Indemnity assumed all of its municipality risks through one producer that had underwriting authority—California Institutional Insurance Administrators, a subsidiary of Corroon & Black Corp. of San Diego.

Mr. Riley says the insurer was dissatisfied with CIIA's underwriting criteria and calls the relationship "an unacceptable arrangement."

When Canadian Indemnity decided to stop underwriting public liability risks, CIIA placed the risks with another insurer for whom it underwrites, Twin City Fire Insurance Co., a unit of Hartford Insurance Group.

"Fortunately, it (Canadian Indemnity's withdrawal) hasn't affected us one iota," said CIIA President Verne Watts. "Other companies we do business with were able to absorb it."

Mr. Watts says the relationship with Canadian Indemnity suffered because of management upheaval and personality conflicts on the part of Canadian Indemnity and because Canadian Indemnity had trouble adjusting to the way business is conducted in the United States.

Mr. Watts agrees that public entities will face rate increases soon, but he does not foresee other insurers pulling out of the market.

"Within the last month, we definitely feel there is tension—the start of the tightening," Mr. Watts says. "We feel 1984 is going to make a reasonable change, but nothing too drastic."

He expects public entity rates to increase nationwide by about 10%. However, he does not expect to increase rates for CIIA policyholders because the agency's underwriting strategies have generated good loss ratios, he says.

The overall loss ratio for CIIA's public entity liability underwriting in 1983 was about 53%, the company reports.

"Come July, we will not be a factor in the marketplace if the rates stay low," says Steve Petrakis, president of San Diego-based Steve Petrakis Insurance Services, a subsidiary of E.H. Crump Cos. Inc.

Petrakis Insurance Services has underwriting authority for the Planet Insurance Co., another major insurer of California public liability risks. A unit of the Reliance Insurance Cos., Planet for about two years has insured city and counties in several Western states, including California, Colorado and Arizona.

"We like the public entity field, but unfortunately, if it gets to the point where we can't support it, we'd be the first to tell the broker not to come to us with it," said Mr. Petrakis.

Bill Martin, director of the Texas Municipal League Joint Self-Insurance Fund, a year-old pool of 101 Texas cities, expects rates to increase as much as 20% in Texas this year.

"I think quite a few of the underwriters have over-extended themselves," he says. They've been buying business and they can't continue to do that without getting hurt. I think quite a few will drop out this year."

"Everyone in the marketplace is sitting around the table, looking at each other, asking, 'How can we raise the rates?'" says James S. Gault, area vp for broker Arthur J. Gallagher & Co. in Chicago, a major Midwest broker for public entities. "But nobody really wants to take the lead. Who's going to do it first?"

He expects rates to rise, but not immediately, predicting an average rate increase of 8% to 10% for public entities in the Midwest in late 1984 or January 1985.

Mike Bogen, vp of Cal-Surance Group, a broker in Torrance, Calif., agrees that any premium increases that might occur aren't likely to happen before the January 1985 renewals, if they occur at all.

"I don't see problems now for the July people," he says. Mr. Bogen, who places coverage for about 30 cities in Northern and Southern California, says he has seen "no change in the past three years, and I don't anticipate one now."

Others wholeheartedly agree with his view.

"I find that there's no tightening of the market whatsoever," says Jim Spivey, executive director of the insurance and risk management agency of Charlotte Mecklenberg in North Carolina.

"It's very soft and very competitive, and I have no trouble getting coverage of the type I want at a price I'm willing to pay," he says. He acknowledges the possibility of rate increases, but says, "That has not demonstrated itself at this particular time in this part of the country."

In fact, he has seen an increasing willingness on the part of underwriters to meet the needs of public entities.

For example, he cites a new liability policy that would provide a municipality with coverage for school district officials as well as for police professionals. The policy, which he recently purchased from National Union Fire Insurance Co. of Pittsburgh, Pa., a unit of American International Group Inc., is one that Mr. Spivey had unsuccessfully sought to purchase for several years.

Allen F. Hyman, director of safety and risk management for Corpus Christi, Texas, and vp of the Public Risk & Insurance Management Assn., also says the public liability insurance market is more creative.

"For a few years, those who know more than I do have been saying that the market will turn. Well, it has turned—into a creative market. The options being offered now are innovative and exciting and tailored to our real needs."

Because of this, Mr. Hyman reports a decrease in Corpus Christi's most recent liability insurance premium, despite higher coverage limits.

And, he does not expect any rate increases soon in his area.

"What happens on the West Coast doesn't happen to the rest of us. Unless the economy changes, I see it (pricing) staying right where it is," he says.

Craig Ellis, risk manager for the city of Lakewood, Colo., also has not noticed any reluctance on the part of underwriters to assume public liablity risks and describes his general liability premiums as "very, very stable.

"If we maintain a relationship with our present carrier, I don't see any significant increase in the next few years," he says. The city's underwriter is United States Insurance Group, a subsidiary of Crum & Forster.

Steven P. Kahn, a partner in Advanced Risk Management Techniques, a Laguna Hills, Calif.,-based consulting firm, says insurers are not turning away from the market.

"They are still pretty interested," he says. "There may be some withdrawals, but I don't see them as the major ones."

Robb Tarr, assistant vp at Robert Driver Co., a Newport Beach, Calif.,-based broker with about 50 public entity clients in California, also does not see the market changing by July renewals.

"I've seen nothing at this point in time that precipitated what happened in 1974-75," he said. When the market turned in the mid-1970s, several major insurers withdrew suddenly from the public liability insurance market or doubled or tripled their rates, leaving some public entities uninsured and without reasonable alternatives. ■

Discounting of loss reserves recommended

Continued from page 3
the past.

"If you have to discount reserves that are already inadequate, you run the risk of insolvency," said Les Cheek, vp-federal affairs for Crum & Forster. "A federal law that will require the discounting of reserves will do anything but help the industry pay its long-tail claims," Mr. Cheek added.

"It is in the interest of buyers to have a strongly reserved industry," said Myron Picoult, an analyst with Oppenheimer & Co. in New York. A change in tax law to require discounting would weaken the stability of insurers, he said.

While it is generally agreed that many insurers could be underreserved to pay claims today, analysts also have pointed out that in years insurers are earning underwriting profits they are inclined to beef up reserves.

Investment income earned on strong reserves built up during the last period of underwriting profits in the industry helped support the recent price competition among insurers, analysts have said.

An insurance industry trade association spokesman questioned the GAO's linkage of the discount rate to be used and a company's previous investment income performance.

Previous rates of return can be an indication of the future, but not an absolute indicator, the spokesman said.

If commercial insurance companies were required to discount reserves, the same requirement presumably would extend to such risk-funding vehicles as captives and doctor-owned mutual insurance companies, observed Walter Vinyard Jr., a Washington tax attorney.

The financial attractiveness of captives could be diluted if they were forced to discount reserves, pointed out Oppenheimer's Mr. Picoult.

Interestingly, the GAO report sidestepped other vital property/casualty insurance issues, such as whether coverage offered by captives to their parent companies really is insurance. Experts had thought the GAO would make recommendations on this issue.

"It is an inadequate and incomplete report," said Crum & Forster's Mr. Cheek.

Natwar Gandhi, author of the GAO report, told *Business Insurance* that the report was supposed to examine other issues, such as a definition of insurance, but lack of time and resources forced the GAO to narrow the scope of the report.

Still, experts say the report will be the catalyst for congressional overview of the taxation of property/casualty insurers.

"The GAO report is the opening kickoff. It indicates that we are beginning a period of serious scrutiny of the property/casualty industry," said Mr. Vinyard.

Although no action is expected this year, by 1985 there will be congressional hearings on property/casualty insurer taxation, Mr. Vinyard predicts.

The final report is expected to be released in April. ■

Vermont considering open rating

Continued from page 2
"No one's (asking) the question if this will create a decrease in rates. Since the market is competitive at this time, we anticipate some decrease, but not much right away," Mr. Kifer said.

Rates in Vermont are expected to rise this year, since an average 16.6% rate increase is pending before the Insurance Department. These rates, based on experience, were filed by the NCCI in late December in hopes they would be approved by Feb. 1.

Last year, workers compensation rates were increased twice: 15% in March based on loss experience and 1.9% in July due to a minor law change, said Joann Porter, the NCCI's director of government, consumer and industry affairs.

Employers are just getting a look at H.B. 639, but some say that open rating does not automatically mean a decrease in rates.

"We don't think (the bill) is going to do any damage. We have a fairly low system right now in costs," said Peter Foote, executive vp of the Associated Industries of Vermont, a 64-year-old trade association with 425 members.

"I think there has been a feeling in the state that competition never hurt anyone," Mr. Foote said.

But, the Alliance of American Insurers believes that open rating in workers compensation would "dilute" the system.

"Currently, we have no problems in the state of Vermont," said Joseph P. Hegarty Jr. a senior vp with the Alliance's Boston office.

There are no complaints from employers, insurers or injured workers, he said "so we just say, 'Why bother?'"

The Alliance initially opposed an open rating measure because it was concerned that the data base would not be preserved. However, since H.B. 639 includes provisions to maintain a data base, the Alliance has softened its opposition.

One group of insurers, the American Insurance Assn., is supporting the measure. The AIA wrote an initial draft of an open rating bill in 1981 when the Insurance Department began looking at such a system.

Because of that involvement, the bill often is called an "AIA bill."

"We're in favor of open rating," said the AIA's Vermont attorney, Tom Dowling of the Rutland firm of Ryan, Smith & Carbine. "The bill reflects a lot of what is happening now."

The bill, which would go into effect July 1, has been assigned to the House Commerce Committee, where hearings must still be scheduled. The Associated Industries of Vermont and the state Chamber of Commerce are meeting this month to study the bill before those hearings get under way. ■

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Food companies not covered for recalls

Continued from page 2

"We would assume (the losses) of small recalls," Ms. Polkinghorn said. For catastrophic losses, the coverage has a high deductible, she said, without specifying the deductible or other coverage elements.

General Mills Inc. in Minneapolis also has recall insurance, but a spokesman said it was against company policy to discuss it. The company manufactures the Betty Crocker cake mixes, some of which have been recalled in California.

Spokesmen from three other food manufacturers said their companies do not carry recall insurance and would self-insure any losses because of EDB contamination.

"At this point we would self-insure. . .but we don't expect it to be an overwhelming amount," said George Bell, senior vp of administration for Martha White Foods Inc. in Nashville, Tenn., a subsidiary of Beatrice Foods Co.

He stressed, as did other manufacturers and state health departments, that the EDB levels differ from box to box and from lot to lot, so that only a few products would be involved.

"It's isolated cases—generally a (case) lot." For instance, he said the recall of 5½-ounce boxes of Martha White Buttermilk Pancake mix in Illinois last week would affect a relatively small proportion of the product on grocers' shelves.

Cincinnati-based Procter & Gamble Co., which manufacturers Duncan Hines products that have been recalled in Massachusetts and California, is "voluntarily withdrawing from our warehouses and store shelves the (suspected) products," a spokeswoman said.

"Our best estimate is that 2% of all baking mix products are involved. But we don't expect this to have any impact on the company."

Procter & Gamble, which was involved with a massive recall of Rely tampons in 1980, does not carry recall insurance on any product, she noted.

And Quaker Oats Co. in Chicago also says it does not carry recall insurance. A spokesman said the company has not removed any of its products from store shelves and that those it tested fell within the federal EPA guidelines. But in Massachusetts, where the acceptable levels are only 6.5% of the EPA levels, some Quaker Oats products may have to be removed, according to the Massachusetts Department of Health.

A sixth manufacturer contacted by *BI*, Nabisco Brands in Parsippany, N.J., refused to discuss its insurance program. The company's Dromedary corn bread mix was one of the items pulled from California grocery shelves.

"Food processors are looking at it now," said a vp with broker Frank B. Hall & Co. Inc. in Briarcliff Manor, N.Y., who did not want to be identified. He said most have stayed away from such a product because historically it has been very expensive and there haven't been any major recalls.

An undisclosed Hall client, a major conglomerate with food processing operations, recently purchased "product protection" insurance, a coverage written by the Chubb Group of Insurance Cos. that Hall sells.

This particular manuscript policy contains a $5 million deductible and a $150 million limit, the Hall vp said. The premium for the coverage is $500,000.

"It's expensive stuff, with very few players," he noted, explaining that the company probably wouldn't have purchased the coverage except that it was necessitated by a contract with another company supplying an ingredient for a new product line.

But, he added, there does appear to be the first tinge of competition among product recall underwriters and that may prompt more companies to buy the coverage.

"The market for this was created after the Tylenol incident. Initially it was expensive, but the prices have moderated," noted Alec Biele, product manager for Chubb Group in Warren, N.J.

Chubb's product protection coverage is sold as a separate policy and covers two types of recalls: Tylenol-type incidents where there is intentional or malicious contamination, and more traditional recalls caused by a defect in the product, Mr. Biele said.

Generally, the policy has a $25 million limit and requires a deductible varying from $10,000 to $10 million, he said.

The Home Insurance Co. in New York also sells recall insurance and food processors are among its clients, noted a spokesman.

Called "Extra-Strength product liability coverage," the product is an "enhancement" to its standard product liability coverage, he said.

The insurance will pay to repair or replace products that were damaged because of a defect and also will reimburse a manufacturer for all expenses involved if a product is ordered recalled by the government, or is recalled because of an extortion threat, or for any other reason to which Home gives its consent, he said.

The Home product is competitively priced with varying deductibles, he added without elaboration.

Other brokers differed on whether food processors were buying this type of coverage.

For instance, William S. Jennings, a senior vp with Johnson & Higgins in Hartford, Conn., said that food manufacturers were among its targeted markets when it began selling products integrity impairment insurance two years ago.

"That's where we concentrated our efforts and we were reasonably successful," he said, though he could not say how many food manufacturers bought the coverage.

However, Lawrence Drake, a managing director for Marsh & McLennan Inc. in New York, says there are few food manufacturers that purchase recall insurance because the industry hasn't seen that many recalls.

Most food manufacturers don't buy recall coverage because they feel the expense is greater than the cost of the product they are covering, Mr. Drake explained.

There seem to be more serious problems for product manufacturers in other goods, especially heavy machinery, he said. "But it doesn't appear to be at all uniform." ■

Some state EDB limits stricter than EPA's

The recent recalls of food products were triggered Feb. 3 when Environmental Protection Agency Administrator William D. Ruckelshaus announced an emergency ban on the use of EDB as a grain fumigant and set recommended residue levels for grain and grain-related products.

Those permissible residue levels are:

- 900 parts per billion for raw grain intended for human consumption, like wheat, corn and oats.
- 150 parts per billion for products like flour, baked goods mixes, hot cereals and other products that require cooking before consumption.
- 30 parts per billion for ready-to-eat products, like cold cereals, snack foods, bread and all baked goods.

But, three days later, the Massachusetts Public Health Council adopted emergency measures that set the acceptable EDP level at 10 parts per billion for all food products to be sold to consumers until March 1, when the acceptable level will drop to 1 part per billion.

Of 138 products tested in Massachusetts, 18 had EDB levels higher than 10 ppb, while 60 had levels higher than 1 ppb.

In California, the State Department of Health Services is working with the State Department of Food and Agriculture to continue to test products there for EDB residue and will use the federal EPA guidelines—except for baby food, in which no trace of the chemical will be allowed.

"So far, we've tested nine different baby food products and none showed any EDB residue," a health services spokesman said.

Ruling widens DES defendants' liability

Continued from page 1

"We view defining the market and apportioning market share as a near-impossible task if it is to be done fairly and accurately in order to approximate the probability that a defendant caused the plaintiff's injuries," the court said.

The "waste of judicial resources which would be inherent in a second 'minitrial' to determine market share militates against its adoption by this court," it added.

The plaintiff in the Sindell case finally settled for $20,000 without any trial.

Victims should be allowed to sue and recover damages from any DES manufacturer because each defendant contributed to the risk of injury to the plaintiff, the Wisconsin court said.

"Thus each defendant shares, in some measure, a degree of culpability in producing or marketing what the FDA, many scientists and medical researchers ultimately concluded was a drug with possibly harmful side effects," the court said.

While an innocent manufacturer may be sued, "We must accept this as the price the defendants, and perhaps ultimately society, must pay to provide the plaintiff an adequate remedy under the law," the court concluded.

Plaintiffs' attorneys applauded the decision as a victory for DES victims who were injured through no fault of their own.

"An entire industry was negligent in producing a product. What defense can there be for an industry that was producing a useless product?" asked Thomas Bleakley, co-counsel for Therese Collins, a 26-year-old Wisconsin woman who was diagnosed as suffering from vaginal cancer 13 years after her mother allegedly ingested DES.

"Sindell has proven totally unworkable," Mr. Bleakley noted. "What is market share? Is it a manufacturer's share of the local pharmacy, a state market or national market? The Collins decision is much fairer," he added.

But defense attorneys say courts, in their desire to compensate victims, are losing sight of essential legal principles.

"As a society, we are beginning to accept things we shouldn't," observed Victor Schwartz, an attorney with Crowell & Moring in Washington and the former chairman of a federal government task force on product liability.

"There is a fundamental in our law: causation," Mr. Schwartz said. Now, under Collins, damages can be recovered even if the manufacturer didn't cause the injury.

"Plaintiffs will target big, rich companies that have lots of money," Mr. Schwartz said.

The ability to pick and choose a defendant ultimately will discourage efforts to find which manufacturer actually made the product, Mr. Schwartz said.

But Mr. Bleakley said it should not matter whether a particular manufacturer's product injured the plaintiff.

"Say 20 people poured gasoline on one person and started a fire at a rock concert and 5,000 people burned to death. Just because their action was directed at one person would not absolve the 20 from the harm they caused the 5,000 people," Mr. Bleakley said.

The Collins decision does not mean that DES victims can automatically recover damages from manufacturers. Courts still would have to consider:

- Was the DES defective when it left the possession of the drug company?
- Was DES unreasonably dangerous to the user?
- Was the defect the cause of the plaintiff's injuries?
- Was the drug company in the business of producing DES?
- Could the product be expected to reach the consumer without substantial change in the condition when it was sold?

It will be up to the defendant—not the plaintiff—to prove that it did not market DES in the relevant market in which the plantiff's mother purchased the drug.

After a plaintiff sues a manufacturer, the company can try to bring other manufacturers into the case as third-party defendants, the court said.

In assigning a percentage of liability to each defendant, juries would consider:

- Did the drug company test DES for its safety?
- Did the company take the lead or did it merely follows others in producing DES?
- Did the company issue warnings about the dangers of DES?
- Did the company have a large or small market share in the relevant area?
- Did the company produce DES after it knew or should have known of the possible hazards DES presented to the public?

Mr. Schwartz, though, questioned whether a manufacturer could bring other companies into an action. For example, many small firms that made DES now may be out of business and thus could not be joined in a legal action.

The Wisconsin Supreme Court decision now allows Ms. Collins' lawsuit to go to trial.

Ms. Collins is one of the millions of daughters of women who took DES, short for diethylstilbestrol, to avoid miscarriages. Daughters of some women who took the drug have developed cancer and other abnormalities of the vagina and cervix. Several hundred lawsuits have been filed against the manufacturers of the drug, which the FDA removed from the market in 1971. ■

DES firms suffer second setback

LANSING, Mich.—The Wisconsin Supreme Court isn't the only court that is increasing DES manufacturers' liability.

The Michigan Supreme Court last week ruled that DES victims do not have to identify the specific drug manufacturer in order to file suit.

However, unlike the Wisconsin Supreme Court ruling in the Collins case (see story, page 1), the Michigan court did not give DES victims the right to select any DES manufacturer and sue for full damages. Instead, victims must sue all manufacturers that potentially could have produced the product.

The Michigan court also did not specify how liability would be divided in cases where there are multiple defendants.

By contrast in the Collins case, the Wisconsin Supreme Court handed down a specific list of factors—including whether the manufacturer ever tested the drug for its safety—that jurors must consider in apportioning liability among defendants. ■

MGM retroactive insurers squabbling

Continued from page 1

The Travelers executive handling the litigation was unavailable for comment. However, the insurer "has a general position of not filing cross-claims against other insurers because they don't help to resolve anything," said Floyd Knowlton, vp-casualty/property claim department.

The $50 million settlement offer by MGM to its insurers is documented in a letter sent by MGM attorney Allan B. Goldman to a New York attorney representing first-layer insurer Union International Insurance Co. Ltd. (U.S. Branch), a unit of broker Frank B. Hall Inc. in Briarcliff Manor, New York, which placed the retroactive package.

In that letter dated Nov. 10, 1982, Mr. Goldman reconfirmed earlier discussions with insurers' representatives that if insurers contributed $50 million to a settlement, MGM would contribute the rest up to $25 million.

"Given the fact that MGM has paid $39 million for the insurance, this would mean that MGM, on its own proposal, could end up paying $64 million plus the investment interest, which it has lost," wrote Mr. Goldman.

The letter goes on to say that if a settlement with fire victims can be reached for $75 million and the insurers refuse to make the $50 million contribution, "they have been and hereby are put on notice that MGM will look to them for payment of all the potential damages."

The $50 million setttlement offer was first made in the New York offices of Condon & Forsyth, attorneys for Hall and Union, during a conference to which all the retroactive insurers were invited, said Mr. Goldman in an interview. There were about 30 attorneys present, including representatives from all four layers of retroactive coverage, he recalls.

"They all showed up and were going to get a written (settlement) proposal to us by Thanksgiving—about two weeks later," he continues.

Thanksgiving passed, and there was no response.

Mr. Goldman says he called key attorneys representing first-and second-layer insurers who said, 'We're still trying to move, tell the judge we're trying.'

A trial date for the remaining fire claims had already been set for January and MGM was determined to reach a settlement before then, says Mr. Goldman. Soon after Thanksgiving, when no written proposal had been received from its insurers, MGM decided to begin negotiations with the (fire) plaintiffs' legal committee.

"MGM was willing to pay $25 million to get the matter settled and the litigation behind it," says Mr. Goldman. "If the trial had gone forward, who knows how long it would have gone on.

"MGM was willing to pay $25 million for some assurance, some certainty that insurers would pay. . .that kind of certainty is worth a lot to a corporation like MGM," stresses Mr. Goldman.

However, some of the attorneys representing retroactive insurers interpret the offer differently. They say that it is tantamount to an admission by MGM that part of the proposed $75 million settlement was for punitive damages, which are excluded under their policies.

"The only expense item not covered in the retroactive policies was punitive damages," comments Mr. Schiff. "Our view is that if MGM was willing to concede $25 million, it must have been for punitive damages."

Attorneys representing first- and second-layer insurers downplay the importance of the third-layer cross-claims, saying that the chief focus of the litigation remains the coverage dispute with MGM Grand. The matter of punitive damages is at the heart of that battle.

"We're not terribly concerned about the cross-claims," says Paul Nelsen, an attorney with the San Francisco firm of Hancock Rothert & Bunshoft, representing insurers who underwrote about two-thirds of the limits in the second layer.

"The essence of the case still involves what portion of the MGM settlement was for punitive versus compensatory damages," he stresses.

The hotel company wants its retroactive insurers to indemnify it for the full amount of the $75 million settlement with fire victims, including legal fees, costs, and possibly other unspecified damages from separate litigation stemming from the fire (*BI*, March 21, 1983).

But, all or most of the retroactive insurers argue that the settlement contains a substantial payment of punitive damages.

So far, MGM Grand has received about $11.4 million from Union International, which underwrote all of the first $35 million layer of retroactive insurance, $3.5 million in the second layer and possibly up to $19.8 million in the fourth layer. Another Hall unit, Union Indemnity Insurance Co. of New York, underwrote another $3.5 million of the fourth layer.

Union and Hall contend in recently filed answers to MGM's suit that it is premature for MGM to be seeking indemnification from its insurers because the amount of MGM's "ultimate net loss" cannot be known until all of the other fire defendants have contributed to the global settlement with the victims of the fire.

Among the eight defendants that have not yet settled with fire victims is Del E. Webb Corp. in Phoenix, a general contractor responsible for the design, construction and alteration of additions under construction at the hotel at the time of the fire.

Union and Hall say that Webb must ante up its $150 million in liability limits before MGM can tap its retroactive coverage to pay fire claims. It filed suit in June against the hotel company, the contractor and its insurers to the effect that its coverage is excess of Webb's coverage (*BI*, July 18, 1983).

The Webb and MGM insurance coverage suits were consolidated in the 8th Judicial Court in Nevada state court about three months ago and trial has been set for Nov. 5.

"We don't know yet what MGM's ultimate net loss is because we don't know what Del Webb and its insurers are contributing," emphasized Hall Vp and General Counsel Thomas G. O'Brien III.

And, in their answers to MGM, Union and Hall ask the court to determine what portion of MGM's claim is for punitive damages, he continues. Furthermore, Hall responds that it was not negligent in putting the retroactive package together as charged by MGM.

Mr. O'Brien says that neither Hall nor Union has made a formal estimate of how much of the $75 million settlement with fire victims was for compensatory damages.

But, "in no way was it $50 million," he said. "MGM's $50 million settlement offer to insurers contained punitive damages," he added.

The maximum amount of compensatory damages from all injuries and deaths arising from the fire to be shouldered by all of the defendants in the fire litigation might be $40 million to $50 million —$60 million—tops, he said.

By comparison, the global settlement including $75 million contributed by MGM and about $65 million by other fire defendants comes to $140 million (*BI*, May 9, 1983). This does not include other settlements reached by MGM and others with plaintiffs prior to the global settlement, which tapped its original $30 million in coverage (*BI*, Jan. 10, 1983).

Other retroactive insurers may dispute Hall's and Union's numbers, but they agree that the mass settlement with plaintiffs was grossly excessive.

"It is the biggest overpayment to plaintiffs in history," sums up Mr. Nelsen.

It also failed to settle all pending claims, he points out. This is another reason why the first- and second-layer insurers rejected MGM's $50 million settlement offer, he says.

But, MGM vehemently defends the reasonableness of the settlement. Presiding U.S. District Court Judge Louis C. Bechtle termed the settlement 'fair' and 'reasonable,' and said it was for compensatory damages, MGM argues.

But, Judge Bechtle ruled that the MGM contribution was reasonable vis-a-vis MGM's exposure. He was not concerned with what was reasonable for indemnification, said an attorney representing second-layer insurers.

"He was not concerned about whether MGM was paying too much—only that it might be paying too little," he added.

After Hall and Union saw a copy of the proposed settlement plan, they advised MGM that the plan was "inappropriate, excessive and outside the scope of their policies," says Mr. O'Brien.

"MGM was on notice prior to the time the settlements were entered in January 1983 that we did not consider them appropriate or covered," he reports.

Last month, MGM revised its original complaint against Hall, Union and 20 other excess insurers on the first three retro layers to include the retroactive insurers on a fourth layer of $75 million above $125 million.

The fourth layer was brought into the litigation because two other separate lawsuits threaten to eventually push MGM's total losses and costs attributable to the fire through the $125 million ceiling of the third layer, said Mr. Goldman.

The hotel company is suing Hall and the first- and second-layer insurers—but not the third- and fourth-layer insurers, for punitive damages.

American Excess Insurance Co., one of the excess insurers that underwrote a portion of the $30 million in liability coverage held by MGM at the time of the fire, is disputing the amount and timing of legal fees claimed by MGM in its layer (see related story).

Also, some of the hotel's tenants whose shops were destroyed in the fire are filing third-party property damage claims against MGM.

Here is a complete summary of MGM's retroactive insurance program as it is described in MGM's second amended complaint dated Jan. 5, 1984:

First layer ($35 million excess of $30 million): Union International Insurance Co. Ltd. (U.S. Branch) for the entire layer.

Second layer ($35 million excess of $65 million): American Home Assurance Co., $10.5 million; The Central National Insurance Co. of Omaha, $8.8 million; Union International, $3.5 million; Federal Insurance Co., $2 million; underwriters at Lloyd's of London through Robin Jackson at Merrett Holdings P.L.C., $1.75 million; International Surplus Lines Insurance Co., $1.125 million; and Industrial Insurance Co. of Hawaii Ltd., $500,000.

Apparently, it is still unclear as to which insurer(s) underwrote the remaining $6.8 million portion of the layer because a policy is still missing. MGM has a binder from Hall showing that Central National agreed to pay more than $16.1 million in the layer.

However, Central National says that it actually accepted only $8.8 million and that the remainder was underwritten by a group of foreign companies through Lloyd's broker C.T. Bowring & Co. Ltd. The so-called "second-layer foreign companies" claim that they are reinsurers of Central National and not direct insurers of MGM.

Both of the Central National placements were handled through Global Surplus Insurance Services Inc., another Hall unit that acts as managing general agent for Central National, said an attorney in the litigation who believes that the confusion about this aspect of the coverage will be resolved within the next couple of weeks.

Third layer ($25 million excess of $100 million): National Union Fire Insurance Co. of Pittsburgh, Pa., $10.5 million; Insurance Corp. of Ireland Ltd., $5 million; St. Paul Surplus Lines Insurance Co., $3.2 million; Northbrook Excess & Surplus Insurance Co., $2.5 million; The Travelers Indemnity Co., $1 million; United States Fire Insurance Co., $1 million; The Home Insurance Co., $1 million; Northumberland General Insurance Co., $750,000; and Guardian Insurance Co. of Canada, $200,000.

Fourth layer ($75 million excess of $125 million): underwriters at Lloyd's of London, $27 million; British National Life Insurance Society Ltd., $3.3 million; Stronghold Insurance Co. Ltd., $100,000; Insurance Corp. of Ireland, $3 million; Southampton Insurance Co. Ltd., $750,000; Royale Belge Vie-Accidents, S.A., $1.5 million; Eagle Star Insurance Co. Ltd., $250,000; Union Indemnity Insurance Co. of New York, $3.5 million (according to a binder issued by Leslie & Godwin North American (Non-Marine) Ltd., another Hall unit); Union International through two separate policies, $6.5 million; Union International, $13.3 through a binder but no policy; Federal, $2 million; International Reinsurance Management Pty. Ltd. on behalf of Mercantile Mutual Insurance Co. Ltd., $3 million; Grand Union Insurance Co. Ltd., $1.5 million; Travelers, $2 million; The Oriental Fire and Marine Insurance Co., $225,000; City Insurance Co., $1 million; Employers Insurance of Wausau, $3 million; Birmingham Fire Insurance Co. of Pa., $1.5 million; Cia Colombiana de Seguros, S.A., $75,000; Falcon Insurance Co., $1.5 million.■

MGM, insurer battling over defense costs

LAS VEGAS, Nev.—American Excess Insurance Co. and MGM Grand Hotels Inc. are disputing how much and when the hotel company will be reimbursed for some defense costs stemming from the 1980 fire at its Las Vegas hotel.

American Excess paid out its policy limits of $10 million in excess liability coverage in the wake of the November 1980 fire that killed 85 people and injured more than 700 others.

And, MGM is demanding more than $4.5 million in legal expenses, which it claims it spent on legal defense while the American Excess policy was in effect.

But American Excess says its liability for defense costs cannot be determined until all claims from the accident have been settled and asked a court here in July 1981 to rule.

The insurer is asking that its liability for defense costs be limited to a percentage of the total legal expenses that the hotel company incurs due to the fire.

Since total costs cannot be determined until all claims have been settled, American Excess wants to waive any payments until then.

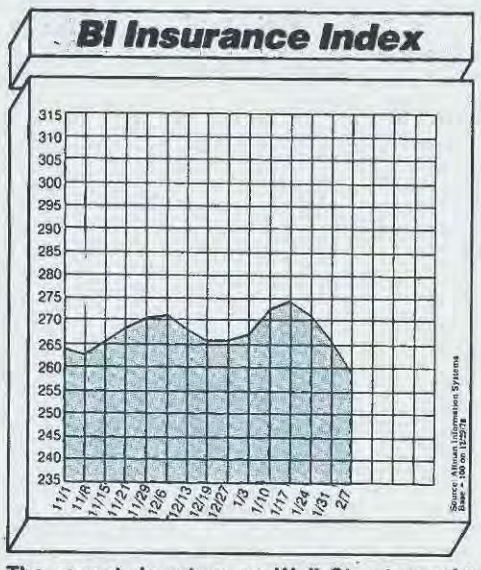
American Excess, a subsidiary of American Reinsurance Co., underwrote a $10 million excess of $10 million layer in the $30 million liability coverage that the hotel had at the time of the fire. The insurer paid out its policy limits during the first half of 1981.

The liability policy that MGM had with New York-based American Excess stipulates that American Excess "shall contribute to the costs incurred by the insured in the ratio that its proportion of the ultimate net loss, as finally adjusted, bears to the whole amount of such ultimate net loss," according to the underwriter's attorney, David J. Garthe of Boornazian, Jensen and Garthe in Oakland, Calif.

To determine its share of defense costs accordingly, American Excess wants to divide the total amount it paid—$10 million—by the total amount for which MGM finally resolves litigation, Mr. Garthe explains.

Mr. Garthe points out that this action is separate from pending litigation over the hotel firm's retroactive insurance coverage (see related story, page one).

A hearing in the American Excess case is scheduled for March 7 in the 8th Judicial District Court of the State of Nevada and a decision is expected. ■



The recent downturn on Wall Street caught up with insurance industry stocks in the trading period closing Feb. 7 as the *Business Insurance* stock index took a nosedive, losing 5.6 points to 259.3 from 264.9. Only seven issues posted an advance, 40 stocks declined and 15 were unchanged. The leading gainers included Frank B. Hall & Co. Inc., 4.2%; USF&G Corp., 4.1%; Banks Iowa Inc., 3.1%; St. Paul Cos. Inc., 2.3%; and Provident Life & Accident Insurance Co., 1.4%. The issues posting the largest declines were Statesman Group Inc., 11.4%; Washington National Corp., 9.4%; Zenith National Insurance Corp., 8.8%; United Fire & Casualty Co., 8.6%; and American Bankers Insurance Group, 7.7%. Insurance industry stocks, though, fared better than the market in general. The NYSE composite fell 2.8%, compared with only a 2.1% dip in the *BI* index.

British Issues

7 Feb Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	182	30.3	16.86	9.3	188—	182
Genl Accident	440	12.9	26.43	6.0	460—	440
Gdn Royal Exch	535	13.7	30.71	5.7	547—	535
Phoenix	438	19.0	26.00	5.9	445—	432
Royal	525	13.5	39.23	7.5	537—	525
Sun Alliance	1413	16.2	78.57	5.6	1425—	1400
Brokers						
CE Heath	355	8.9	22.86	6.4	370—	355
Hogg Robinson	162	12.5	9.43	5.8	175—	161
JH Minet	142	10.9	7.57	5.3	148—	142
Sedg Grp	225	11.3	11.43	5.1	237—	225
Stew Wrightson	317	10.6	22.57	7.1	328—	317
Willis Faber	690	14.4	30.00	4.3	700—	690

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

A peek at M&M's results boosts optimism for '84

By LEONARD M. WILSON

Special to Business Insurance

MARSH & McLENNAN Cos. Inc. is the only public broker to have reported fourth-quarter and full-year 1983 results at this writing. Excluding a capital gain on a divestiture, M&M's earnings of $3.39 per share were in line with expectations.

Mr. Wilson

For a securities analyst, the quarterly earnings report is a window for sizing up operating trends with a view toward assessing upcoming prospects. Insights emanate from close analysis of operating results in the company's business segments.

We estimate that Marsh & McLennan's domestic insurance brokerage, excluding the contribution from reinsurance intermediary Guy Carpenter & Co. Inc., posted a narrow revenue gain of perhaps 2% to 3% in the fourth quarter.

This anemic rise is consistent with earlier quarters and suggests that, despite talk of a change in premium rate competition, there was no relief in the fourth quarter. In fact, it is quite possible that across the full book of business, rates may have deflated renewal commissions by as much as 10%.

If we are correct in our estimate of rate deflation, then new business was the principal factor sustaining comparisons. For the past several years, the company has registered pronounced gains in new business production, and the momentum of this effort seems likely to carry through 1984.

In contrast to direct brokerage, reinsurance brokerage through Guy Carpenter posted a strong gain in the fourth quarter. We would like to witness another quarter of similar progress before reaching a definitive conclusion that reinsurance brokerage is benefiting from the widely advertised firming in many categories of reinsurance. Even so, the improved performance is welcome and holds promise for gains in 1984.

Leonard M. Wilson, a special limited partner at L.F. Rothschild, Unterberg, Towbin in New York, specializes in insurance brokerage stocks. He is a member of the New York Society of Security Analysts.

British-based revenues increased in the low double-digit range, before translation into dollars, which is no aberration. The fourth-quarter progress follows on the heels of comparable advances in the prior nine months. The flow of reinsurance to the London market, along with a generous influx of new business, probably accounts for the growth. With firmer reinsurance rates, revenue gains in this sector seem likely to continue in 1984.

Employee benefits and investment management both outstripped the overall growth of corporate revenues in the fourth quarter. Employee benefits have proved a counterweight to the softness in property/casualty brokerage over this cycle, while investment management, still a relatively modest element in total results, bounded ahead in 1983 due to the bull market.

Employee benefits should post moderate gains in 1984. But, the growth of investment management activities could moderate as a result of unsettled stock market conditions.

Notably, investment income achieved the first year-over-year quarterly rise in a long time. With steady short-term interest rates, investment income could be a positive factor in 1984.

Fourth-quarter expenses rose a slim 5.5% on a year-over-year basis. M&M's expense control has proven exemplary over the past few quarters. Consequently, it is reasonable to conclude that the disciplines are in place to keep costs under close rein.

This restraint offers the potential for improving profit margins in 1984—if an easing in rate competition occurs and then translates into accelerating revenue growth.

Marsh & McLennan's operating profit margins narrowed to 21.3% in 1983 from 22.7% in 1982. This was a pretty solid performance, given the intensity of premium rate competition. Pressure on profit margins, though, could abate in 1984, with an easing in the degree of rate competition.

The potential for positive operating leverage is an important facet of the publicly held insurance brokers' longer-term investment appeal. Through most of the current competitive cycle, the public brokers were late in trimming expenses in response to slowing growth in revenues. Now that expense controls are demonstrably in place, the potential exists for an expansion of profit margins.

But the leverage hings on an acceleration in the rate of revenue growth. When premium rates firm, expenses are likely to lag the increase in revenues, the corollary of the lag on the downside.

Marsh & McLennan's earnings performance has been creditable in a difficult environment. Fourth-quarter results indicate the reasons why. Almost all areas except domestic insurance brokerage had favorable results. Diversification—both geographically and in product sectors—has mitigated the ravages of rate competition.

If 1984 turns out to be another difficult year for commercial lines pricing, this diversification will cushion the impact on M&M. If pricing stabilizes, the company's upside earnings leverage may admittedly be less than that of the other public brokers.

On balance, though, the fourth-quarter window of Marsh & McLennan's results provides the basis for at least a hint of optimism. But, the hoped-for easing in rate competition is not yet evident in the operating numbers for domestic insurance brokerage. ■

BI Industry Stock Report

FEB. 7, 1984 — 2/1/84 THRU 2/7/84

Insurance Cos.		Price	% Chg.	P/E	$ Div.	% Yld.	High	Low	Vol. (000)
Aetna Life & Cas Co	NYSE	35.50	-1.4	5.6	2.64	7.4	35.88	34.63	818.1
American Bankers Ins Group	OTC	13.50	-7.7	10.9	0.50	3.7	14.38	13.50	57.1
American Gen Ins Co	NYSE	21.50	-1.7	9.4	0.80	3.7	21.75	21.50	481.4
American Indty Finl Corp	OTC	21.25	-2.3	18.5	1.12	5.3	21.75	21.25	2.3
American Intl Group Inc	OTC	55.75	-4.3	9.3	0.44	0.8	57.00	55.75	1,437.5
American Natl Ins Co	OTC	21.38	-2.3	7.7	0.96	4.5	22.25	21.38	138.5
Aneco Reins Ltd	OTC	3.25	-7.1	23.2	0.00	0.0	3.38	3.25	5.6
Avemco Corp	AMEX	20.63	-6.8	13.4	0.58	2.8	23.38	20.63	27.9
Banks Iowa Inc	OTC	50.50	3.1	16.3	1.52	3.0	50.50*	49.00	3.0
Bitco Corp	OTC	16.50	0.0	0.0	1.33	8.1	17.00	16.50	9.3
Carolina Cas Ins Co	OTC	6.50	0.0	0.0	0.20	3.1	6.50	6.50	1.1
Chubb Corp	OTC	61.13	-3.0	8.9	3.12	5.1	63.63	61.13	339.2
Combined Intl Corp	NYSE	33.00	-4.7	9.8	2.00	6.1	34.25	32.25	614.1
Continental Corp	NYSE	26.38	0.0	35.6	2.60	9.9	26.50	25.88*	779.8
Crawford & Co	OTC	15.50	-3.1	11.0	0.66	4.3	15.75	15.50	12.0
Crown Life Ins Co	OTC	120.50	-2.4	7.9	3.20	2.7	123.50	120.50	0.2
Employers Cas Co	OTC	32.00	0.0	7.2	1.20	3.8	32.00	32.00	20.7
Equifax Inc	NYSE	25.88	-1.4	10.8	1.60	6.2	26.38	25.88*	19.4
Farmers Group Inc	OTC	39.25	0.0	9.7	1.52	3.9	40.38	39.25	176.4
Foremost Corp Amer	OTC	24.75	-1.0	11.5	0.88	3.6	25.50	24.75*	171.2
Fremont Gen Corp	OTC	13.25	-1.9	0.0	0.48	3.6	13.25	13.00	253.0
Great West Life Assurn Co	OTC	270.00	0.0	9.7	12.00	4.4	270.00	270.00	0.0
Hanover Ins Co	OTC	52.50	-0.9	6.7	0.88	1.7	52.75	52.50	13.3
Hartford Steam Boiler Insptn	OTC	53.00	-3.6	7.7	3.00	5.7	54.00	53.00	5.3
Jefferson Natl Life Ins Co	OTC	44.50	-2.2	15.0	0.76	1.7	44.50	44.00	57.7
Kemper Corp	OTC	36.75	-1.3	7.9	1.80	4.9	37.13	36.63	108.4
Lincoln Natl Corp Ind	NYSE	29.50	-11.3	8.5	1.68	5.7	32.25	29.50	388.8
Mission Ins Group Inc	NYSE	20.00	-7.0	8.1	1.00	5.0	21.00	19.88*	405.2
Nationwide Corp Ohio	OTC	41.75	0.0	15.3	0.70	1.7	0.00	DID NOT TRADE	
Northwestern Natl Life Ins	OTC	37.25	0.0	9.8	1.50	4.0	38.00	37.25	14.6
Ohio Cas Corp	OTC	43.75	-1.1	9.0	2.52	5.8	45.13	43.75	269.2
Old Rep Intl Corp	OTC	32.50	0.4	7.0	0.90	2.8	32.50	32.50	48.7
Orion Cap Corp	NYSE	27.88	-5.5	13.4	0.76	2.7	29.50	27.88	28.6
Preferred Risk Life Ins Co	OTC	20.75	0.0	7.9	0.67	3.2	20.75	20.75	4.9
Provident Life & Acc Ins Co	OTC	71.00	1.4	7.4	2.60	3.7	72.00*	70.00	26.1
St Paul Cos Inc	OTC	55.75	2.3	7.5	2.80	5.0	56.38	55.75	295.8
SAFECO Corp	OTC	54.25	-4.4	8.1	2.60	4.8	56.50	54.25	208.2
Sri Corp	OTC	16.00	-5.9	8.0	0.68	4.3	17.25	16.00	189.9
Seibels Bruce Group Inc	OTC	20.75	-2.9	13.5	0.80	3.9	21.50	20.75	21.5
Statesman Group Inc	OTC	7.75	-11.4	6.7	0.15	1.9	8.50	7.25	102.0
Tokio Marine & Fire Ins Co	OTC	111.50	-0.7	22.5	0.96	0.9	112.25	111.50	15.6
Travelers Corp	NYSE	30.00	-2.4	7.6	1.92	6.4	30.00	29.13	1,631.9
United Fire & Cas Co	OTC	29.25	-8.6	10.4	0.88	3.0	32.00	29.25	2.7
United States Fid & Gty Co	NYSE	57.00	4.1	9.4	3.84	6.7	57.00	55.63	299.0
United Svcs Life Ins Co	OTC	25.38	0.0	7.4	1.00	3.9	25.50	25.38	17.8
Uslife Corp	NYSE	25.38	-2.4	7.3	0.96	3.8	26.00	25.38	130.9
Washington Natl Corp	NYSE	24.50	-9.3	11.7	1.08	4.4	26.75	24.50	66.3
Zenith Natl Ins Corp	OTC	13.00	-8.8	8.8	0.60	4.6	14.25	13.00	31.4
INSURANCE COMPANIES	AVERAGE			9.7		4.0			
Agents/Brokers									
Alexander & Alexander Svcs	NYSE	21.00	-4.5	0.0	1.00	4.8	21.63	21.00	140.9
Baldwin & Lyons Inc	OTC	37.00	0.0	15.4	0.80	2.2	37.00	37.00	0.5
Corroon & Black Corp	NYSE	24.38	-0.5	15.3	1.00	4.1	24.63	24.00	27.7
Crump E H Cos Inc	OTC	11.00	1.1	15.1	0.40	3.6	11.00	10.75	7.5
Emett & Chandler Cos Inc	OTC	10.00	-4.8	27.0	0.00	0.0	10.50	10.00	7.5
Hall Frank B & Co Inc	NYSE	24.63	4.2	22.4	1.53	6.2	24.63	23.63	369.3
Integrated Res Inc	AMEX	23.50	-1.1	7.6	0.00	0.0	23.63	22.50*	412.0
Marsh & Mclennan Cos Inc	NYSE	45.00	-1.6	12.9	2.20	4.9	45.75	45.00	148.5
Poe & Assoc Inc	OTC	5.25	0.0	0.0	0.00	0.0	5.25	5.25	4.8
Reed Stenhouse Cos Ltd	OTC	12.00	-1.0	14.6	0.60	5.0	12.25	11.88	79.1
AGENTS/BROKERS	AVERAGE			16.4		3.5			
Conglomerates/Holding Cos.									
American Express(Fireman's Fd)	NYSE	28.50	-5.0	11.3	1.28	4.5	31.25	28.50	3,516.8
Anderson Clayton(Ranger/PanAm)	NYSE	31.00	-3.9	14.4	1.32	4.3	31.75	30.75	13.0
Amco Inc	NYSE	20.50	-3.5	0.0	0.40	2.0	21.25	20.50	704.2
Baldwin Utd Corp	NYSE	2.63	-4.5	0.0	0.00	0.0	2.75	2.63	217.2
CIGNA Corp	NYSE	40.88	-0.3	7.0	2.48	6.1	40.88	40.38	886.1
City Investing Co. (Home Ins.)	NYSE	35.13	-6.3	8.7	1.80	5.1	37.25	34.63	518.1
CNA Finl Corp (CNA)	NYSE	21.50	-2.3	7.0	0.00	0.0	21.75	21.25	140.6
Control Data (Comml. Credit)	NYSE	41.13	-8.6	9.8	0.66	1.6	43.75	40.25	1,234.3
General Re Corp	NYSE	55.75	-5.5	11.8	1.28	2.3	59.13	55.63	540.8
Gulf Utd Corp	NYSE	29.88	0.0	9.2	1.32	4.4	0.00	DID NOT TRADE	
ITT (Hartford Group)	NYSE	41.00	-5.7	9.2	2.76	6.7	43.50	40.88	2,391.0
Optimum Hldg Corp	OTC	5.38	0.0	41.3	0.00	0.0	5.38	5.38	0.7
Sears Roebuck & Co. (Allstate)	NYSE	34.50	-6.4	9.1	1.52	4.4	36.88	33.75	3,108.9
Teledyne Inc (Argonaut)	NYSE	161.38	-5.1	10.9	0.00	0.0	167.88	161.25	665.8
Transamerica Corp (Occidental & Fred S. James)	NYSE	25.00	-6.5	9.0	1.56	6.2	26.63	25.00	473.4
CONGLOMERATES/HOLDING COS.	AVERAGE			13.0		2.9			

*Record high/low since Jan. 1, 1983

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Financial briefs

Gallagher goes public

Arthur J. Gallagher & Co. has made it official: The insurance brokerage based in Rolling Meadows, Ill., is going public.

In a preliminary prospectus filed with the Securities and Exchange Commission, Gallagher will sell 754,636 shares to the public, while 455,364 shares will be sold by selling stockholders. The company, the nation's 10th-largest insurance broker based on 1982 revenues, estimates that public offering price will be between $15.50 and $18.50 per share. The proceeds will be used to provide additional working capital (*BI*, Sept. 12, 1983).

According to the prospectus, Gallagher's 1983 revenues were $53.4 million, up 14% from 1982 revenues of $48.5 million.

In addition, Gallagher reported net earnings of $4.27 million in 1983, up from $3.22 million in 1982, an increase of 32.7%.

Gallagher's most highly compensated executive officers in 1983, as reported to the SEC, were: Robert E. Gallagher, president, $160,000; John P. Gallagher, executive vp and secretary, $160,000; Michael J. Cloherty, vp-finance and treasurer, $125,000; Warren Van der Voort Sr., vp, $107,500; and Donald Krutek, vp, $107,000.

Shares will be traded over the counter under the NASDAQ symbol of AJGC. Morgan Stanley & Co. is managing the offering.

St. Paul

St. Paul Fire & Marine Insurance Co. says the sale of AFIA Worldwide Insurance to CIGNA Corp. will produce $17 million in net pretax operating earnings in the first quarter.

St. Paul's 14.6% share of AFIA produced $31.39 million gross, based on the final purchase price of $215 million. However, a St. Paul spokesman said that amount was reduced by $12 million, St. Paul's share of AFIA's fourth-quarter 1983 loss, which was booked in the first quarter along with the gain from the sale. Also, other costs related to the sale reduced St. Paul's profit by about $2 million, he said.

Continental

Standard & Poor's Corp. has added Continental Insurance Co., a unit of Continental Corp., to its CreditWatch list of debt securities that could be subject to a rating change.

S&P expressed concern about continued deterioration of Continental Insurance's underwriting performance. That, the rating service said, could have negative rating implications for 39 industrial development bonds issued by Firemen's Insurance Co. of Newark, N.J., a Continental affiliate. ■

The Hartford introduces Starscan.℠

"Now you can get all the advantages of flexible benefits– without the drawbacks."

Ray Drury, Vice President, Special Markets Department, tells Benefit Plan Managers how The Hartford's Starscan serves the interests of employee and employer alike.

Q. What advantages does the Starscan approach have over traditional group benefit plans?
A. Starscan provides the flexibility needed to meet the more complex and varied insurance needs of employees today. It gives employees an important say in benefit programs by letting them select which benefits they prefer among traditional coverages such as life, medical, dental, disability, and pensions. But the Starscan approach can also incorporate emerging, non-traditional coverage choices as well. And it lets employees—within limits—select levels of coverage.

Other advantages include more effective and efficient use of employer contributions, the opportunity to contain escalating benefit costs, greater employee appreciation of benefits, reduced pressure for across-the-board increases in benefits, and a progressive employer image. Not least, Starscan helps employers recruit and retain employees.

Q. How does the Starscan flexible benefit approach work?
A. In the way best suited to meet the needs of you and your employees. For example, existing benefits might be kept as they are, or reduced to a standard core for all employees. In either case, employees would be given credits to purchase additional benefits to fit their needs. Benefits beyond those the credits would buy could be purchased through payroll deductions.

Or, set benefits might be offered with different levels of coverage. By choosing a higher level of one benefit and a lower level of another, employees could match benefits more closely to their needs.

Q. What support services does The Hartford offer?
A. Working closely with your agent, broker, consultant, or third party administrator, we'll provide whatever services you require.

Depending on your needs, we offer consulting services for feasibility studies and plan design, alternative data processing services, complete communications support, and a variety of health care cost-containment programs. And, of course, we can provide a full range of coverage and funding options, along with pension and actuarial expertise.

Q. What about cost?
A. Obviously, changing a traditional benefit program to a tailored flexible plan involves initial costs. But selecting only those items you need from the Starscan menu can make those costs much lower than you might expect. And the kind of synergy involved in this approach has a real impact on bottom-line results, and can lead to significant cost savings over traditional group benefit plans.

Q. How can I get a brochure describing Starscan?
A. Just write to Starscan, Special Markets Department B, 8 Griffin Road North, Griffin Office Center, Windsor, CT 06095. Or call David Washburn, Director of New Products, at (203) 683-8435.

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