

Business Insurance

Reporting weekly for corporate risk, employee benefit and financial executives / \$1.75 a copy; \$70 a year

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Labor Department to study employer day-care liability issues

WASHINGTON—The U.S. Department of Labor will launch a study to determine whether market barriers are preventing employers from obtaining liability insurance for worksite child care services, the Bush administration announced last week.

"There is concern that lack of access to liability insurance may be deterring some employers from offering this form of care," the administration said in its proposed federal budget for fiscal 1990.

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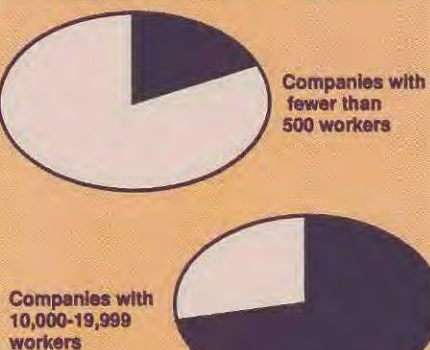
Few employers determine cost of retiree care

By JAMES M. BURCKE

Only a quarter of employers that provide retiree health care benefits have determined their future retiree health care liabilities, a new survey shows.

In addition, almost half of the employers offering retiree health care benefits do not even track retiree health care plan costs separately from active employees' health care costs.

Employers slow to assess retiree health care liabilities



■ Have determined liabilities
■ Plan to determine liabilities before 1990
□ Have not determined liabilities and have no plans to do so

But, while only 25% of the employers responding to a survey conducted last year by A. Foster Higgins & Co. Inc. had determined future retiree health care liabilities, that number represented a 20% increase over the number of employers making such a determination in the previous year.

Only 20% of the employers responding to a similar 1987 survey by Foster Higgins had tracked future retiree

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Chart: Holly Seguire

Guaranty fund owes Raymark broad cover

By DOUGLAS McLEOD

HARTFORD, Conn.—The Connecticut Insurance Guaranty Assn. is asking a state judge to reconsider his order that the state's \$300,000 cap on guaranty fund payments should be applied separately to thousands of claims against a former asbestos producer.

The order by Connecticut Superior Court Judge Arnold W. Aronson grants \$32 million in guaranty fund coverage to Raymark Corp. for asbestos-related claims that should have been paid by Transit Casualty Co., which was ordered liquidated in 1985.

Judge Aronson concluded that the \$300,000 cap on guaranty fund payments applies separately to each of thousands of claims filed against Raymark, clearing the way for Raymark to recoup the full \$32 million limits of six Transit excess liability policies.

CIGA had argued that its liability should be capped at a maximum of \$300,000 per policy, or \$1.8 million in total.

If Judge Aronson does not reconsider the ruling, CIGA will appeal it to either the Connecticut Court of Appeals or the Connecticut Supreme Court, according to Joseph C. Tanski, a lawyer with Hutchins & Wheeler, a Boston law firm representing CIGA.

"I think it's erroneous," Mr. Tanski said of the judge's decision. "I think he will be overruled on appeal."

Besides asking for a review of Judge Aronson's order, CIGA is fighting a similar attempt by Union Carbide Corp. to collect \$32.5 million on claims arising from the 1984 Bhopal, India, poison gas disaster.

Litigation between CIGA and Union Carbide—which is seeking coverage of claims payable by Transit and two other insolvent insurers—has raised several of

the same issues just decided in the Raymark case, including how the state's \$300,000 cap on guaranty fund payments should be applied.

CIGA contends that Raymark and Union Carbide will collect a majority of the guaranty fund's assets if the Raymark ruling stands and if a similar decision is reached in the Union Carbide case.

Observers agree that the ruling is the first to interpret a state guaranty fund act based on the National Assn. of Insurance Commissioners model guaranty fund law in a case involving mass tort claims against a large commercial policyholder.

Several lawyers and guaranty fund officials predict that the Connecticut ruling, if upheld, could prompt many state legislatures to adopt NAIC-recommended amendments to their guaranty fund laws, including provisions that would limit coverage of large corporations.

"These jumbo assureds were not really contemplated as objects of protection. They are not hardship cases," noted John G. Smith, a lawyer with the Chicago law firm of Lord, Bissell & Brook, representing the Illinois Insurance Guaranty Fund.

The NAIC amended its model act in 1986, adding—among other things—a provision that would require any corporation with a net worth of more than \$50 million to reimburse a state guaranty fund for liability claim payments made on its behalf.

Few states so far have adopted the NAIC amendments, however.

CIGA has warned in court papers that the combined burden of the Raymark and Union Carbide claims could devour the lion's share of CIGA's assets, triggering multimillion-dollar assessments to property/ca-

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ABA vote to aid McCarran opponents

By STACY ADLER

states.

The ABA proposal will "carry a lot of weight with Congress, especially because so many members of Congress are members of the ABA," said John Harkavy, director of governmental affairs for the Risk & Insurance Management Society Inc. in New York, which opposes the repeal of McCarran-Ferguson.

Lorraine Driscoll, legislative liaison for Citizen Action, a Washington, D.C.-based federation of consumer organizations, said the ABA recommendations "will absolutely be helpful" in her organization's drive to repeal McCarran-Ferguson.

"There's some magic in the air this year," she added, referring to the chance that Congress will amend or repeal the law.

The ABA endorsement "will be very influential" to members of Congress reviewing repeal of McCarran-Ferguson, said J. Robert Hunter, president of the National Insurance Consumer Organization in Alexandria, Va.

Currently bankers, small businesses and physicians are among the organizations backing NICO in its push for repeal of

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Photo: ABA/Bryan Dahlberg

The ABA's House of Delegates approved the proposal to repeal McCarran-Ferguson.

Large settlements won't hurt Manville trust, officials say
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Airlines' insurance rates fall despite recent disasters
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Canadian employers increase supplemental health benefits
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Update

U.S. to study day-care issue

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The study, to be directed by Labor Secretary Elizabeth Dole, would be due no later than the end of the year.

President Bush also proposes expanding federal child care tax credits for low-income working families.

The president also strongly supports flexible benefit programs, noting that employers should be encouraged to offer programs that allow employees to choose the benefits they need.

The budget package also includes several proposals made earlier by the Reagan administration, including a one-year freeze in the annual cost-of-living adjustments of pension benefits received by retired civil servants and military personnel and a less generous method for calculating COLAs after the freeze ends (*BI*, Jan. 16).

Rules due on retiree liabilities

STAMFORD, Conn.—The Financial Accounting Standards Board this week will issue its long-awaited proposed standard on how employers must recognize retiree health care liabilities and the cost of those liabilities on their financial statements.

The proposed accounting standard would require companies to switch to accrual from cash accounting for post-retirement welfare benefits like retiree health care, life insurance, tuition and dependent care assistance in fiscal years beginning after Dec. 15, 1991 (*BI*, Oct. 17, 1988).

The standard also would require balance sheet recognition of a minimum liability beginning in calendar year 1997. Employers would have to record on their balance sheets at least the present value of health care liabilities for current workers eligible to retire—called eligibles—as well as the liabilities for current retirees.

Some benefits experts have predicted the proposed accounting standard will force employers to consider ways to limit their retiree health care liabilities. But, Diana Scott, FASB project manager, said that "it's not the accounting that would cause (employers) to cancel the plan." Instead, it would be employers' awareness of their post-retirement welfare plan liabilities, she explained.

The proposed standard "does not change the nature or extent of" the benefits that companies have promised to retirees, explained James J. Leisenring, the board's vice chairman. It only requires employers "to publicly acknowledge those liabilities."

Texas eyes comp overhaul

AUSTIN, Texas—A bill introduced in the Texas Legislature last week would overhaul the state's workers compensation system in an effort to cut employers' costs and restructure benefits.

The 190-page bill, H.B. 1, introduced by Rep. Richard A. Smith, R-Bryan, closely resembles recommendations for reforming the state's workers comp system made by a joint select committee of insurers, agents and trial attorneys last year (*BI*, June 20, 1988).

The bill would eliminate the right of an injured worker to appeal a workers comp award to a state court jury, which is not allowed to consider board findings. Under the bill, a state court judge hearing an appeal would be able to rule only on whether the Texas Worker's Compensation Board—the new name the bill gives to the Industrial Accident Board—applied state workers comp law correctly. The case would be returned to the board if it had not.

Currently, most workers comp decisions by the board are appealed to trial courts.

The bill also would allow private employers to self-insure their workers comp risks for the first time. The bill calls for the establishment of a guaranty fund for self-insured employers that would be pre-funded at \$1 million. The fund would respond when the workers comp board certifies an employer has stopped paying workers comp claims, not when an employer officially declares bankruptcy or seeks reorganization.

Among benefit changes, the bill would establish a maximum weekly benefit equal to the average statewide weekly wage over the previous 13 weeks. The benefit currently is based on the assumption a worker works 300 days annually.

Maximum weekly benefits for a temporary disability would be increased to \$416 from \$238. Maximum weekly benefits for a permanent partial disability would be hiked to \$312 from \$238.

The Texas Assn. of Business fully endorses the bill, saying it addresses all of its top priorities.

METs' coverage canceled

NEW YORK—New York Life Insurance Co. is canceling group health insurance coverage for 13,500 small employers nationwide in four multiple employer trusts and one association program. The insurance covered about 125,000 employees and dependents.

New York Life, which is canceling the coverage effective April 1, cited large losses on MET business last year. "We lost over \$60 million on our MET portfolio in 1988," a spokesman said. Soaring health care costs greatly contributed to the losses, he added.

The spokesman could not provide details on the premium generated by the policies.

The METs are The Dun & Bradstreet Trust Program, based in Tampa, Fla.; The Beneficial Employees Security Trusts of Newport Beach, Calif.; Empire Trust, based in Dallas; and the Employers Dual Choice Trust Program, based in Diamond Bar, Calif. Most of the employers are based in California, Florida and New York.

The association is the American Consumers Assn. Program, which is administered by Great American Insurance Administrators of Irvine, Calif.

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Errors & omissions

• H.S. Weavers (Underwriting) Agencies Ltd. was incorrectly identified as a Lloyd's of London underwriting agency in an article in the Feb. 6 issue.

Payouts do not imperil Manville trust: Director

By STACY ADLER

DENVER—The Manville Personal Injury Trust is settling asbestos bodily injury claims more quickly and for higher amounts than originally projected, but the trust will not run out of money, trust officials say.

"Based on current projections over the life of the trust, there will be enough money to pay all the claimants, although there will be temporary cash shortfalls," explained Marianna Smith, executive director of the trust.

Technically, the trust—the centerpiece of Denver-based Manville Corp.'s massive reorganization plan—could run out of cash late this year. However, the trust is designed so that it would be replenished with proceeds from the sale of Manville stock and by tapping Manville's profits.

Ms. Smith criticized several recent news reports that have speculated the fund's temporary cash-flow problems would jeopardize payments to claimants.

"Manville has to support this

trust until the last claimant is paid," she said.

Leon Silverman, an attorney with Fried, Frank, Harris, Shriver & Jacobson in New York who represented future asbestos claimants in the Manville reorganization proceedings, agreed.

"This recent flurry of publicity should not lead to disquiet," he said. "All of these problems were anticipated in the original (trust) plan and should not result in diminution of payments to claimants."

Mr. Silverman said he expects that all claimants will be paid.

Manville filed for reorganization under Chapter 11 of the Federal Bankruptcy Act on Aug. 26, 1982. At that time, the company faced more than 17,000 asbestos bodily injury claims. And, new claims were being filed at a rate of more than 400 a month (*BI*, Sept. 6, 1982).

The trust currently faces about 30,000 claims, but it is unknown how many future claims will be filed.

Manville and various court-appointed committees representing

claimants, creditors and shareholders developed a plan that created the Manville Personal Injury Trust to pay asbestos bodily injury claims and the Manville Property Damage Trust to pay asbestos property damage claims.

The bankruptcy court confirmed the reorganization plan in December 1986 (*BI*, Dec. 29, 1986). The final appeals to the plan were exhausted in October 1988, and Manville emerged from reorganization in November 1988 (*BI*, Oct. 10, 1988).

The personal injury trust's current cash-flow problems have resulted because the trust is settling claims at a much faster clip than had been anticipated.

The trust has settled more than 14,000 claims since it began operating in late November, even though the trust was expected to settle only 7,000 to 10,000 claims per year, Ms. Smith explained.

"I don't think I or anybody else dreamed we would be able to settle so many claims so fast," she said.

Furthermore, the architects of

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Deadlines approaching for 2 directories

Deadlines are approaching for companies to return questionnaires to be listed in two *Business Insurance* directories: the directory of risk management consultants and the directory of captive management companies.

The directory of risk management consultants will appear in the March 13 issue, which will include a spotlight report on risk management services.

The captive management company directory will appear in the April 10 issue and will contain a spotlight report on domestic and international captive domiciles and on captive insurance company trends. Also included will be a chart on policyholder-owned alternative risk financing facilities.

If your company offers risk management consulting services, captive management services or manages alternative risk financing facilities and you have not yet received a questionnaire for these special issues, please request a questionnaire by calling Marilou Jones, Directory Editor, 312-649-5279.

The deadline for risk management consultants to return questionnaires is Feb. 20; captive management companies and managers of alternative risk financing facilities have until Feb. 27 to submit completed questionnaires.

ALTA acquires TPA competitor

SALT LAKE CITY—The nation's two largest third-party administrators of employee benefits claims are merging.

ALTA Health Strategies Inc. of Salt Lake City, the nation's largest TPA, has acquired Los Angeles-based U.S. Administrators Inc., the second-largest benefits TPA.

The sale of U.S. Administrators by Crown Life Insurance Co. of Toronto was finalized Feb. 8, said W. Terry Nofsinger, president and chief executive officer of ALTA Health Strategies Inc. He would not disclose details.

U.S. Administrators and a unit called simply ALTA Health Strategies for now will be operated as independent units.

"We will run companies as two separate entities under the parent company, ALTA Health Strategies Inc.," Mr. Nofsinger said. However, future plans include combining operations, he added.

Geoffrey T. Wood will continue as president of U.S. Administrators, he said.

Revenues of the combined companies will exceed \$100 million this year, bolstering ALTA's position as the largest independent benefit TPA serving self-insured employers.

U.S. Administrators, which paid \$800 million in claims for self-insurers last year, was the fourth-largest overall TPA and the second-largest benefits TPA in the *Business Insurance* rankings of third-party claims administrators (*BI*, Jan. 30).

Top-ranked ALTA paid \$1.1 billion in claims for self-insurers in 1988.

—By Kari Berman

Inside

✓ Business groups now calling for the delay or repeal of Section 89 should have spoken up when the proposal was first considered by Congress several years ago, says this week's editorial. **PAGE 8**

✓ Most European nations have laws addressing pollution incidents, but none has a "comprehensive legal regime specifically for hazardous substances liability," a West German lawyer says. **PAGE 13**

✓ In Speaking Out, Franklin W. Nutter, president of the Alliance of American Insurers, observes that regulation of traditional property/casualty insurers is in stark contrast to that of alternative markets. **PAGE 21**

✓ In Ask a Risk Manager, Susan Werner of Hardee's Food Systems Inc. says that tort reform efforts have heightened awareness of insurance problems. **PAGE 22**

✓ A surplus lines broker is suing two surplus lines insurers, their managing general agent and Marsh & McLennan over the placement of general liability insurance for scores of public housing authorities. **PAGE 29**

✓ Stock analyst Leonard M. Wilson, senior vp with Lazard

Asset Management Inc., questions whether insurance brokers can prosper in the long run if the underwriting side continues to struggle. **PAGE 35**

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Vol. 23, No. 7—*Business Insurance* (ISSN 0007-6864) is published weekly at 740 N. Rush St., Chicago, Ill. 60611-2590. Second-class postage is paid at Chicago, Ill., and at additional mailing offices. Postmaster: Send address changes to *Business Insurance*, Circulation department, 965 E. Jefferson Ave., Detroit, Mich. 48207; 800-992-9970 or 313-446-1611. Copyright 1989 by Crain Communications Inc.

Aviation rates plummet despite disasters

By STACY SHAPIRO

LONDON—Airline hull and liability insurance rates continue to plunge at a record pace despite three aviation disasters in the past two months, including last week's crash of a U.S.-owned charter jetliner in the Azores that killed 144 people.

Major airlines now negotiating April 1 coverage renewals are finding their rates being cut in half and buyers are locking in those terms for 18 months rather than 12 months, aviation insurance observers in London say.

In particular, Chicago-based United Air Lines Inc. will see its hull rates cut by about 60%, while its liability rates will be slashed by 55%.

British Airways P.L.C. likewise is expected to have its hull insurance rates reduced by 58%, while its liability insurance rates will plummet 42%.

Both airlines' hull and liability insurance programs also are expected to be renewed for an 18-month period.

"We are in a stupid market," commented a Lloyd's aviation broker who did not wish to be named. "The rates have never ever gone as low as this, as quick as this."

"If it's going to change (to a harder market), it will be October. But I wouldn't guarantee it," the broker said.

And renewing aviation insurance policies for 18-month periods are even more radical than the rate reductions, observers agree.

"Brokers feel that we are at the bottom of the cycle, so they are telling their clients to take as long as they can get," the

'It would seem there is no halt to the downward trends in the market on hulls, liabilities' and aviation product liability risks, says Peter Butler of Nicholson Chamberlain Colls (Aviation) Ltd.

broker said, referring to the length of policy periods.

"It would seem there is no halt to the downward trends in the market on hulls, liabilities" and aviation product liability risks, added Peter Butler, managing director of Lloyd's broker Nicholson Chamberlain Colls (Aviation) Ltd.

The three recent aviation losses "haven't had any effect" on the market, he said.

"All these losses will burn too many people to have any effect on the market," added another London aviation broker, explaining that no one company or syndicate will take a large enough loss on any of the disasters to force it to increase rates.

"It will take two jumbos crashing over New York before something happens" to turn the aviation insurance market, the broker said.

Late last week, brokers and underwriters awaited more information about the identity of the passengers aboard the Boeing 707 leased by Smyrna, Tenn.-based Independent

Air Inc. that crashed into mountains four miles from the airport in the Azores where it was to have refueled.

The 137 passengers on board were believed to be all Italians, while the seven crew members were Americans.

The passengers, flying from Bergamo, Italy, were bound for resorts in the Dominican Republic.

The 21-year-old hull, one of only three in Independent Air's small fleet, was insured for \$6 million, confirmed Michael Austin, managing director of Needler Heath Ltd. in London, Independent Air's broker.

The hull insurance was led at Lloyd's of London by underwriter Barry Coleman, Mr. Austin confirmed.

Independent Air purchases \$250 million of liability insurance, led in London by The Orion Insurance Co. P.L.C. Eighty percent of the hull and liability coverage is placed in the London market and 20% is placed with U.S. insurers, he said.

The coverage was last renewed on Aug. 17 and written for a 12-month policy period.

Mr. Austin said that no liability reserve had yet been established. Lloyd's aviation department has been called in to examine the remains of the jetliner to determine the cause of the crash, he added.

The size of the reserve will be determined by the New York law firm of Condon & Forsyth, which is handling the defense and administration of personal injury claims.

The law firm also will examine tickets the passengers purchased to determine what liability limitations could apply in

Continued on next page

Arbitrators rule runoff policy to pay for recoverables

By CAROLYN ALDRED

LONDON—A runoff reinsurance policy that First State Insurance Co. wrote for a Lloyd's of London syndicate must reimburse the syndicate for amounts owed by reinsurers that either cannot or will not pay the syndicate's claims, arbitrators have ruled.

In addition, the runoff reinsurance policy must reimburse the syndicate for its share of payments to asbestos producer members of the now-defunct Asbestos Claims Facility for claims owed by non-member insurers, pending recovery from those insurers.

And, the policy must cover amounts paid by the syndicate to help defray the facility's start-up and operating costs, the arbitration panel ruled. These amounts were billed to the syndicate by the facility along with settlement costs.

The private arbitration panel ruling settles a dispute between Lloyd's of London syndicate 56, managed by Gilliat, Scotford & Hayworth Ltd., and First State concerning an unlimited runoff reinsurance policy written for syndicate 56 in 1974. The policy covered all of the syndicate's liabilities for 1971 and prior underwriting years that exceed \$11.75 million.

Although the arbitration decision is not legally binding, it likely will be a boost for underwriters who are having difficulties collecting from their runoff reinsurers amounts owed to the underwriters by some reinsurers.

Robin Warrender, chairman of London Wall Holdings, the parent company of syndicate 56's manager, confirmed that the arbitration panel found unanimously in favor of the syndicate on virtually

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Experts see market soften for banks' D&O coverage

By KARI BERMAN

SCOTTSDALE, Ariz.—The market for directors and officers liability insurance for financial institutions will continue to soften, with many institutions finding they have room to negotiate. D&O coverage experts predict.

However, rates are not likely to fall as low as they did during the buyer-friendly days early in the 1980s, and some financial institutions will have to prove they are good risks to persuade insurers to ease coverage restrictions, the experts add.

"It's not like the 1982 soft market, but if you can convince us why exclusions should be lifted, there will be negotiating room," said James F. Donahue, a managing director at the Dallas office of insurance agency Bowles, Troy, Donahue & Johnson.

"In the next 12 months, most of the exclusions will be removed and policies will be more negotiable. If you have more pluses than minuses, within reason, you can negotiate based on your institution's situation," Mr. Donahue told those attending the 1989 American Bankers Assn. National Security & Risk Management Conference last month in Scottsdale, Ariz.

Other sessions during the conference focused on protecting directors and officers following mergers and acquisitions, pre-employment screening and developing a disaster recovery plan (see stories, pages 24-26).

While D&O liability coverage is becoming more readily available, not every financial institution can ex-

pect insurers to cater to them just to obtain their business, an insurance company underwriter warned those attending the conference.

"We need as much information as possible about your company so we can give you the best policy at the best price," said John Pfannenstiel, professional liability underwriting manager at Chubb & Son Inc. in Warren, N.J., a unit of Chubb Corp.

"When making a submission, we're trying to sell you a product, and you have to convince us that we should sell it to you," he added.

While D&O coverage for financial institutions is becoming widely available from domestic insurers, capacity also can be found in London and from such offshore markets as Bermuda-based A.C.E. Insurance Co. Ltd. and X.L. Insurance Co. Ltd.

Among the major domestic markets offering D&O coverage to financial institutions are:

- Commercial Insurance Resources Inc. of New York, an underwriting management unit of Primerica Corp., which recently merged with Commercial Credit Co. Commercial Insurance Resources writes on behalf of Gulf Insurance Co., a Commercial Credit unit.

Commercial Insurance Resources has recently begun to offer hard-to-place D&O coverage to smaller banks, according to Chris Watson, an executive vp at the company. Limits range from \$3 million to \$5 million with limits and exclusions set on a case-by-case basis.

- National Union Fire Insurance Co. of Pittsburgh, Pa., a New York-based unit of American International Group.

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Canadian employers broaden benefits

By JACQUELINE LaSOTA

Canadian employers are increasing the number of supplemental health care benefits they offer to employees and retirees, a recent survey shows.

"The underlying theme (of employers offering supplemental benefits) is to attract and retain their good people," said Bill McDonnell, a group benefits consultant in the Toronto office of The Wyatt Co., which conducted the survey.

Employers "are looking to provide their employees with as many benefits as possibly available," because there are so few employee benefits available on a pretax basis in Canada, largely because the government provides basic health care coverage, he said.

Governmental health plans sponsored by all Canadian provinces and territories cover, among other things, medical diagnostic services, surgical procedures, inpatient drug treatment and inpatient ward care.

Each of Canada's 10 provinces and two territories individually determines how to fund health care expenses. Currently, three different funding methods are in use: direct premiums from citizens; payroll taxes paid by employers; or general tax revenues.

With the government paying employees' basic health care costs, Canadian employers aim to provide a rich benefits package through supplemental health benefit plans.

For example, under the government's basic care, an employee requiring hospitalization would be placed in a ward with other patients. So, an employer offering a supplemental health care plan may offer its employee coverage for a semi-private room.

Nearly all respondents to the Wyatt survey—97%—offered a supplemental health care plan in 1988, a level unchanged from a 1985 survey.

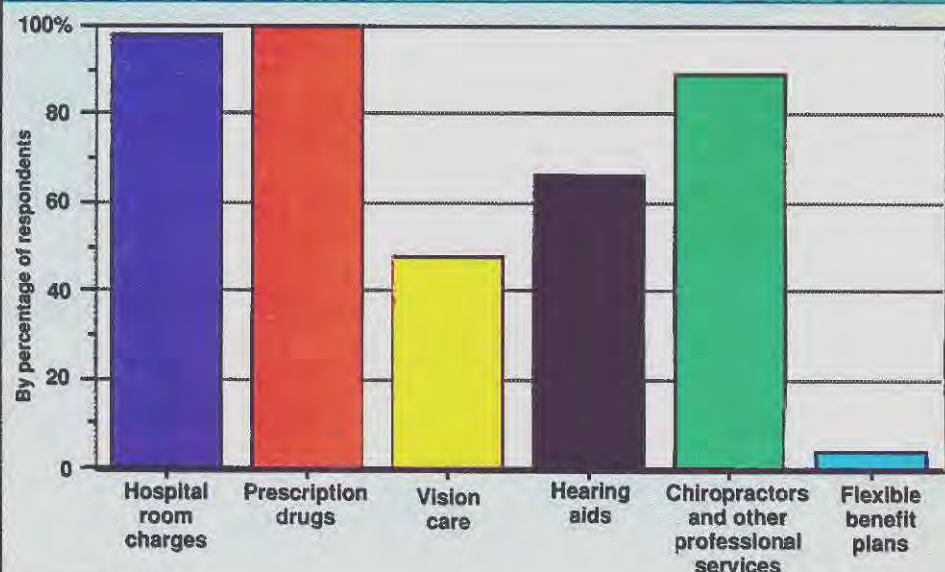
Among the variety of coverages Canadian employers included in their supplemental health plans in 1988, vision care and hearing aid coverage showed the greatest increase in number of employers offering the coverages.

Coverage for hearing care was offered by 66% of respondents in 1988, up from 50% of employers in 1985. A supplemental vision care benefit was offered by 48% of respondents, up from 41% in 1985.

The most popular supplemental benefits in 1988 were: prescription drugs, offered by 100% of employers with supplemental health care plans, up from 94% in 1985; supplemen-

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Supplemental health care benefits offered by Canadian employers in 1988



Source: The Wyatt Co.

Chart: Holly Seguire



Photo: AP/Wide World

The Independent Air Inc. charter flight bound for the Dominican Republic crashed in the Azores last week, killing 144 people.

Plane crash

Continued from previous page
the Independent Air incident, Mr. Austin confirmed.

Normally, the Warsaw Convention limits an airline's liability for personal injuries on international flights. In most cases, the convention limits the carrier's liability to approximately \$10,000 per passenger unless the flight originates or lands in the United States. In addition the Hague Protocol Amendment, signed by most European countries including Italy but rejected by the United States, limits an airline's liability to about \$58,000 per passenger. When a U.S. stop is involved, the Montreal Agreement increases the Warsaw Convention limit to \$75,000 per passenger.

However, an airline can agree to higher liability limits to passengers than those provided in the Warsaw Convention, if the higher limit is expressed in writing on the ticket,

according to U.S. Federal Aviation Regulation, 14 C.F.R.

Warsaw/Montreal liability limitations do not apply, however, if it can be proved that the airline showed "willful misconduct" that led to the accident or if the passengers were never ticketed.

It is uncertain which liability limit, if any, will apply in the Independent Air case, said Stephen Fearon, a partner with Condon & Forsyth.

"Tickets may have special limits or conditions" because it was a charter carrier, he said.

In addition, the Warsaw Convention/Montreal Agreement liability limitations are being tested in U.S. courts.

In particular, families of passengers killed when Soviet fighter jets shot down a Korean Air Lines jetliner in September 1983 are being allowed by a U.S. District Court judge to seek more compensation from the airline than allowed under the Warsaw Convention be-

cause there is sufficient evidence to indicate willful misconduct on the part of the KAL crew (BI, Nov. 21, 1988). The trial is scheduled for July.

Also, other families of passengers seeking compensation for the KAL disaster await a Supreme Court decision, which is expected soon, on whether the limitation is voided because the limitation was written on the tickets in eight-point type instead of 10-point type as required under the agreement (BI, April 11, 1988).

The Independent Air 707 was the third major Western airliner to crash since Dec. 21, when a Pan American World Airways Boeing 747 exploded in midair over Lockerbie, Scotland, killing all 270 people on board.

Pan Am's liability insurers, led by New York-based U.S. Aircraft Insurance Group, are only reserving \$60 million for the loss because of an international airline agreement that caps an airline's liability for overseas flights.

But London underwriters believe that liability limits under the Warsaw Convention could be overturned for the Pan Am crash and that liability losses from the disaster will top \$250 million (BI, Jan. 16).

In early January, a British Midland Airways' Boeing 737-400 crashed on an emergency landing near Kegworth in the English county of Leicestershire, killing 45 people and injuring 73 passengers.

Reports suggest that the pilot shut down the wrong engine after a cockpit signal indicated that one of the jetliner's two engines was on fire. Some observers suggest faulty wiring could have caused the cockpit signal to indicate the wrong engine was on fire. Boeing has carried out an extensive investigation into its wiring on its 737 and 757 jetliners and has postponed delivery of new jets until the investigation is completed.

Meanwhile, despite these three losses, major airlines continue to finalize April 1 aviation insurance renewals that include massive rate cuts.

United has negotiated an 18-month contract that locks underwriters into a hull insurance rate of about 0.06% of the airline's insured fleet value, or about a 60% rate reduction from last year, London aviation sources concur.

The airline purchases up to \$150 million of hull insurance per aircraft. In addition, United will receive a 55.3% reduction in liability insurance rates. United maintains maximum liability insurance limits of \$850 million per accident, the sources say.

Associated Aviation Underwriters in Short Hills, N.J., will lead United's coverage in the United States, replacing USAIG. United's U.S. broker is Rollins Burdick Hunter Co. in Chicago.

About 42% of the coverage is placed in London through Sedgwick Group P.L.C., led by Orion and Lloyd's aviation underwriter David Peachey.

British Airways, whose coverage also renews April 1, has been assured an 18-month policy with a 58% reduction in hull insurance rates or around 0.06% of the insured fleet value. The airline maintains up to \$160 million of hull coverage per aircraft.

Liability insurance rates will be cut 42%, with a maximum coverage limit of \$1.5 billion.

Seventy-five percent of the British Airways coverage is placed in London through Sedgwick and led by British Aviation Insurance Co. Ltd. and Lloyd's Ariel syndicate.

Sources say British Airways also has placed a substantial portion of its insurance program for the first time with its Bermuda captive, Speedbird Insurance Co., which is managed by Sedgwick Captive Overseas Managing Ltd. in Bermuda (BI, March 14, 1988).

J&H INFOLINE

INFORMATION AND IDEAS ON RISK MANAGEMENT FROM JOHNSON & HIGGINS

NO.30

New Asbestos Insurance Company Formed.

Vermont unit to serve preferred-risk contractors.

American Safety Risk Retention Group, Inc. (ASRRG), a new stock casualty insurance company, is now providing liability insurance to preferred-risk asbestos abatement contractors.

The company is licensed by the state of Vermont and is authorized under the 1986 Risk Retention Act.

ASRRG is totally contractor owned and operated. Only shareholders can purchase insurance and only insureds may become shareholders. Shareholder/insured contribution to capital is included in the first-year premium.

Three policy forms are offered by ASRRG: claims made, reported occurrence, and occurrence. Coverage for liability arising out of asbestos abatement operations (including products and completed operations, personal injury, and professional liability) is provided. Policy limits are either \$1 million or \$2 million per occurrence and up to \$5 million in the aggregate.

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BC/BS reports health education savings

By MICHAEL SCHACHNER

Benefit beat

Promoting a healthy lifestyle can significantly reduce health care costs, according to recent Blue Cross & Blue Shield Assn. studies.

Promoting a healthy lifestyle at work and through home self-care programs can keep employees healthier, thereby reducing health care utilization, said John Riedel, director of "New Direction—A Worksite Wellness Study."

The study, which was coordinated by the Health Services Foundation, a research affiliate of the Blue Cross & Blue Shield Assn., involved introducing health education programs at several BC/BS subscribers in Michigan, Indiana, Northern Ohio and New Hampshire. The duration of the regional studies varied, lasting from one year in Northern Ohio to seven

years in Indiana.

In addition to finding that health education helped improve employees' blood pressure, cholesterol and weight levels, the health awareness programs also led to a drop in absenteeism, the study found.

In fact, one study found that for every dollar spent on the program, \$2.45 was saved in health benefits utilization.

The Michigan, Indiana and Northern Ohio studies specifically examined the impact of health promotion on employees' health risk factors, absenteeism and utilization of health insurance benefits. The New Hampshire study examined why employers subscribe to health pro-

motion plans and whether they are perceived as successful.

The Michigan study, which lasted two years, involved a control group that was not exposed to any health promotion; a second group was provided with a health appraisal; a third group was provided with a health appraisal and subsequent counseling; and a fourth group was provided with a health appraisal, counseling and health "intervention," which involved stress, cholesterol and weight control programs, an exercise regimen and a smoking cessation course.

As a result of the health promotion efforts, the fourth study group's risk of cardiovascular disease dropped to the lowest among the four

groups from the highest risk.

And, among all participants in the Michigan study, prescription drug utilization decreased.

The Michigan study results revealed that for participants, the health promotion plan would likely lead to longer life expectancy among participants and, therefore, extended pension plan benefits, he said.

Mr. Riedel pointed out that absenteeism among participants in the Michigan study dropped 29% to an average of 41.3 hours annually per employee from 58.5 hours annually per employee.

"Reduced absenteeism can translate into significant savings for U.S. businesses," Mr. Riedel said.

The seven-year Indiana study concluded that for every dollar spent on the program, \$2.45 was saved in health benefits utilization.

"Even factoring in employees who didn't participate, the savings was \$1.45 on the dollar," Mr. Riedel pointed out.

He acknowledged that the shorter-running Ohio and Michigan programs did not produce savings equivalent to those realized in the Indiana program.

But, "it usually takes more than two years to show positive cost savings from health promotion programs," Mr. Riedel noted.

The New Hampshire program examined how companies perceive whether health promotion efforts are successful.

It revealed that the employers most likely to have promising worksite health promotion programs want to boost employee morale, have modest expectations about employee participation and believe that health promotion itself is valuable.

The health education programs used in the studies were designed and administered by external organizations.

In Ohio, the program was administered by Case Western Reserve University in Cleveland; in Indiana, by the Nursing School at Indiana University in Indianapolis; in Michigan, by Health Analysts Inc. in Ann Arbor, Mich., and the University of Michigan; and in New Hampshire, by the Dartmouth College Medical School in Hanover, N.H.

The BC/BS studies were funded in part by the W.K. Kellogg Foundation of Battle Creek, Mich. The Kellogg Foundation contributed more than \$1 million of the \$2 million total cost of the studies.

Northern Trust ESOP

Employees of Northern Trust Corp. of Chicago will have a 9% stake in the bank under a new leveraged employee stock ownership plan the bank has established to replace contributions to its thrift plan.

With a \$64.3 million loan from a consortium of insurance company lenders, Citizens & Southern Trust Co. of Atlanta, the ESOP's trustee, purchased 1.44 million of newly issued shares of Northern Trust common stock at \$44.65 per share for deposit into the ESOP, according to William N. Setterstrom, senior vp-human resources.

The shares will be allocated to employees over a 10-year period.

Northern Trust also contributed 60,000 of newly issued shares to the ESOP "to provide for an immediate allocation of shares to plan participants," the commercial bank and trust reported.

"Approximately 90,000 shares will be allocated to the plan participants as of Dec. 31, 1989. Each year, thereafter, as the loan is repaid, approximately 150,000 common shares will be allocated to plan participants every Dec. 31," the company said.

Participation in the plan is based on an employee's salary.

The Northern Trust's contributions to the ESOP take the place of "approximately equivalent contributions to its present Thrift Incentive Plan," the bank said.

"Depending upon the corporation's performance, it is expected that over the next 10 years the value of the accounts within the ESOP will exceed the value of the benefit which it replaces," the company said.

Northern Trust stock, which is traded over the counter, closed at \$48.375 per share on Feb. 8.

Benefit beat keeps insurance and employee benefit managers informed on what other companies are doing and of current developments in the employee benefit field. We'd like to know if you've made any changes. Write Michael Schachner, Associate Editor, Business Insurance, 220 E. 42nd St., New York, N.Y. 10017-5806; 212-210-0143.



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Opinions

Too late to lobby

HARDLY A WEEK GOES BY without another business group calling for the delay or even the repeal of Section 89's non-discrimination rules for welfare plans.

While we understand the anger of employers that have to comply with Section 89's overly complex set of rules, we're skeptical if a delay or repeal drive has any chance of success.

Indeed, Rep. Daniel Rostenkowski, D-Ill., who as chairman of the House Ways and Means Committee will play a major role in deciding what, if any changes should be made to Section 89, recently warned that he would oppose a delay or repeal.

We wish, though, that business groups now calling so stridently for the delay or repeal of Section 89 would have spoken up when the controversial proposal was wending its way through Congress several years ago.

Some business groups, in trying to justify their tardy Section 89 lobbying efforts, complain that Section 89 "slipped" through Congress as part of the Tax Reform Act of 1986.

The facts say otherwise. Non-discrimination rules were part of some of the earliest tax reform proposals. Benefit experts, for example, warned that a non-discrimination proposal, included in the first tax reform proposal endorsed by the Reagan administration in 1985, would have a devastating effect on thousands of welfare plans (*BI*, Aug. 19, 1985).

Despite early warnings, there was no widespread business effort in 1985 and 1986 to resist complex non-discrimination rules being developed by congressional and administration staffers as part of tax reform legislation.

Even after the Tax Reform Act of 1986 was enacted into law and the complexity of Section 89 became obvious, most business groups still were silent.

It wasn't until last summer that any kind of serious effort was mounted to amend Section 89. And, even that effort suffered from a lack of broad grass-roots business support.

Unfortunately, the failure of business groups to speak out on Section 89—while there still was time to make a difference—is not the only example of the business community's failure to lobby effectively on employee benefit issues.

Many employers, for example, became aware of the massive and totally unreasonable penalties contained in the health care continuation provisions of the Consolidated Omnibus Budget Reconciliation Act only after that measure was signed into law.

We can't help but believe that if congressional staff had received thousands of letters protesting COBRA penalties—at the time the measure moved through congressional committees—that the overkill penalties would have been stripped before COBRA's enactment.

Similarly, if employers had come up with their own non-discrimination proposals and made a major effort to fight the outlandish non-discrimination rules for welfare plans proposed by well-intentioned but misguided staffers, Section 89 could have been shaped into a far more reasonable statute.

During the current congressional session, new attacks undoubtedly will be launched on employee benefit programs by those who see benefits as an easy undefended target.

One can only hope that employers have learned their COBRA and Section 89 lessons and will muster a strong defense from the very moment an attack is launched.

To sit back and complain—after the damage is done—only will invite more and more assaults on benefit programs.

Letters

Liquidation not best for all insolvencies

To the editor: Although I agree with your editorial opinion that regulation of insurance solvency should be rethought (*BI*, Jan. 30), and that insolvent companies should not be allowed to participate in the active marketplace, considerable caution should be used in reaching simple solutions to a difficult problem.

There are two serious drawbacks to the approach advocated in your editorial. First is its assumption that insolvency is readily and satisfactorily definable. Very few insurance companies are ever insolvent in a bankruptcy sense when they are placed in liquidation. Most have sufficient assets to meet their current known liabilities. The insolvency is usually based on an opinion of one or more "experts" that an insurer's ultimate liabilities will exceed its current ability to pay. Therefore, since insolvency is based on opinion rather than confirmed fact, conscientious regulators are understandably cautious in acting on insurer insolvencies.

Second is its ready acceptance of liquidation as the best option for dealing with insolvent insurers. Liquidation is wasteful, time-consuming and generally an in-

efficient method of getting assets into the hands of proper claimants. Regulators who consider all options available to them in dealing with financially troubled companies should be encouraged, not second-guessed.

What is needed is greater support for regulators to explore all possible solutions with the management, policyholders and reinsurers of financially troubled companies, without fearing the retribution of Monday-morning quarterbacks. The management of these insurers likewise should be encouraged to seek the assistance of regulators, policyholders and reinsurers to find meaningful and efficient answers without allowing conditions to worsen.

A good starting point would be to remove the Dickensian disincentives, such as statutes that presume fraud in an insolvency and the regulatory stigma against anyone associated with an insolvent insurer. Encouraging managers to seek assistance rather than driving them to the closet would be the start of an enlightened approach aimed at addressing the real issues of insolvency rather than the usually fruitless and wasteful pursuit of finding someone to punish.

Peter Bickford
Bickford Hahn & Hayes
New York

Survey of EIL market omitted an insurer

To the editor: Part of the reason environmental liability insurance may be hard to find has to do with the fact that articles such as the one printed in the Jan. 23 issue of *Business Insurance* fail to list all of the companies currently offering this kind of coverage to petroleum marketers

who own or operate underground tanks.

The Oilmen's Insurance Plan has been offering underground tank insurance to its policyholders since the inception of the program in 1983. Today this kind of coverage is available as a separate policy option to those oil companies purchasing one or more of our other lines.

Fireman's Fund Insurance Cos. and Oil Marketers Insurance Co. of Hamilton, Bermuda, bear the exposure in this program, which is offered in 25 states. Presently limits are \$500,000 per claim and \$1 million in the aggregate. On-site cleanup costs are included and the average deductible is \$15,000. Average cost runs about \$2,500 per site.

We are working to modify the policy so that it will comply with the U.S. Environmental Protection Agency's financial responsibility requirements when they become effective for the petroleum marketing businesses we serve.

Jane Jachimczyk
Senior Vp
The Oilmen's Insurance Plan
New York, N.Y.

Solvent insurers unfairly tarnished

To the editor: In the Jan. 23 issue of *Business Insurance*, a headline reads: "Two American Mutual Units Placed Into Receivership." The first paragraph does little to clear up the identity of which American Mutual companies are the subject of the article.

According to A.M. Best Co., the current title of the subject company is the American Mutual Liability Group, with two of its subsidiaries being known as American Mutual Liability Insurance Co. and

Continued on page 12

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Published by Crain Communications Inc., Chicago

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Published weekly at 740 Rush St., Chicago, Ill. 60611, Telex 6871241, Fax 312/280-3174, Cable CRAINCOM. Offices: 220 E. 42nd St., New York, N.Y. 10017, Telex 640207, Fax 212/210-0704, CRAIN COM NYK; 1 Northpark, East Suite 114, 8950 N. Central Expressway, Dallas, Texas, 75231, Fax 214/696-1936; Suite 814, National Press Building, Washington, D.C. 20045, Fax 202/638-3155; 6404 Wilshire Blvd., Los Angeles, Calif. 90048, Fax 213/655-6157; 20-22 Bedford Row, London WC1R 4EB, England, Fax 01/430-2176. \$1.75 a copy. \$70 a year in U.S. Canada and all other foreign add \$32 for surface mail. Europe and Middle East only add \$72 for air delivery. First-class mail to U.S., add \$77; to Canada add \$87. Bermuda only, \$152 per year expedited delivery. WILLIAM STRONG, vp-circulation. SHEILA GORMLEY, circulation manager. JOHN HUFFMAN, fulfillment director. Four weeks' notice required for change of address. Send subscription correspondence to Circulation Department, Business Insurance, 965 E. Jefferson Ave., Detroit, Mich., 48207, or phone 800-992-9970 or 313-446-1611, Fax 313/446-1650. Microfilm copies are available from University Microfilms, 300 Zeeb Road, Ann Arbor, Mich. 48103. Microfiche copies available: Bell & Howell, Micro Photo Division, Old Mansfield Road, Wooster, Ohio 44691. Portions of the editorial content of this issue are available for reprint or reproduction in other media. For information and rates to reproduce in general circulation media, contact: ART MERTZ, The Crain Syndicate, 740 Rush St., Chicago, Ill. 60611, 312-649-5303. For reprints or reprint permission contact: Reprint Department, Business Insurance, 220 E. 42nd St., New York, N.Y. 10017, 212-210-0229, Fax 212/210-0704.

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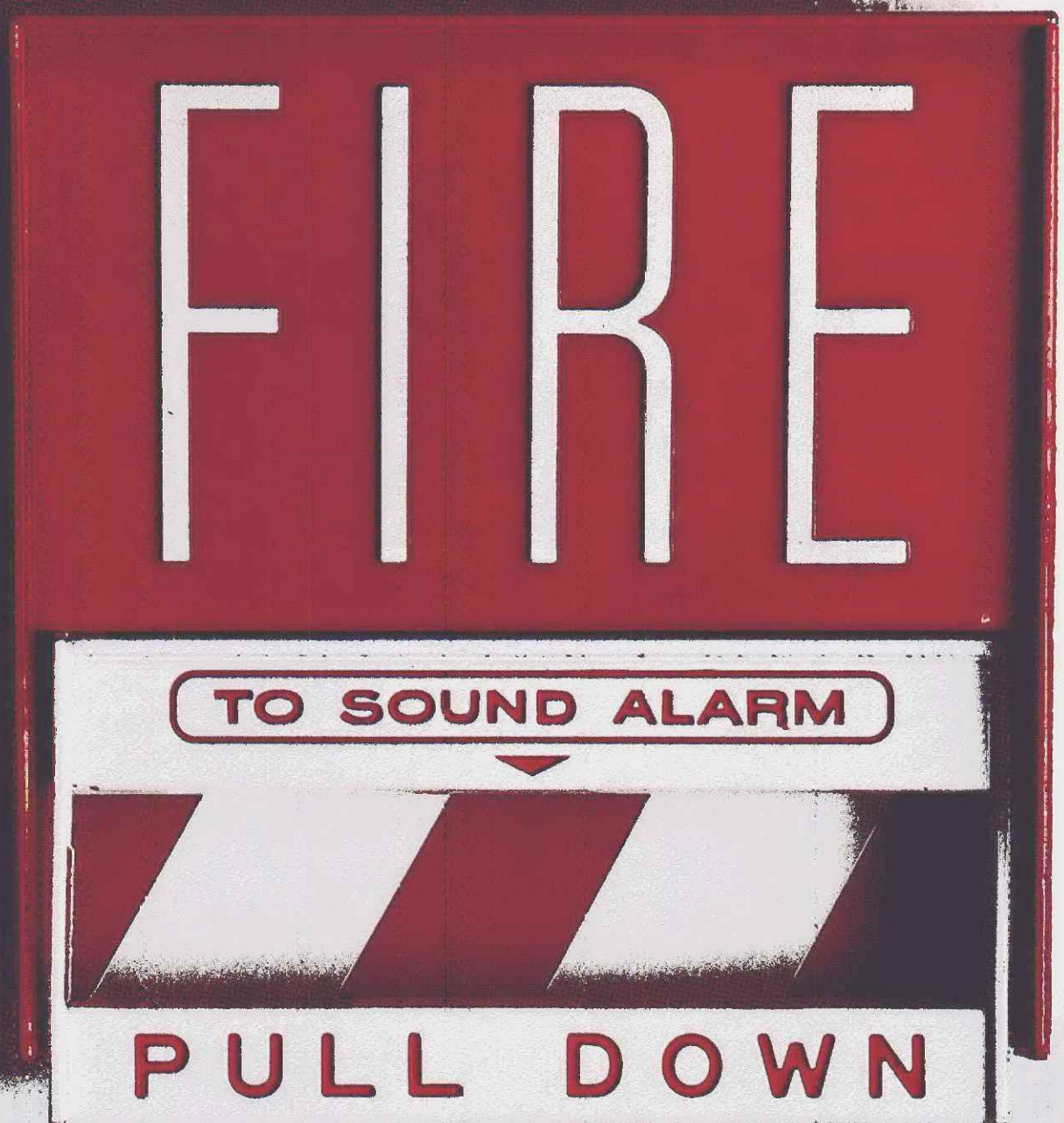
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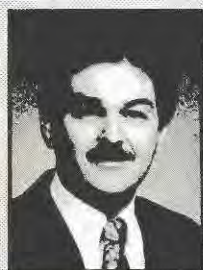
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At issue

Do employees take advantage of flexible benefit plans?



Jeff D. Rhoads
director-
benefits
planning/ad-
ministration
TRINOVA
Corp.,
Maumee, Ohio

I think flex programs have redefined the relationship between employer and employee in the area of benefits. Flex plans are based upon a shared responsibility or partnership approach to managing and delivering benefit programs. Employees are taking more advantage of flex plans as they become more accustomed to this new relationship.



James S. Wahlman
corporate
manager-
employee
benefits
The Budd
Co.,
Troy, Mich.

I believe employees generally prefer some choice in their benefit plans, all things remaining equal. However, they may be turned off if the plan is viewed as an attempt to camouflage a cost shift to employees.



Suzanne Page
corporate
pensions
manager
Dallas Corp.,
Dallas

The higher-paid employees appear to take the most advantage of "flexibility" in cafeteria plans. In manufacturing, it has been our experience that the rank and file employees will generally choose the core benefits. The one exception is child care and it is equally popular with all levels of employees.



Dan Fraser
insurance/
benefits
manager
Rocco Inc.,
Harrisonburg,
Va.

No. I feel with the restrictions imposed at the time of selection, the employees can't change their decisions once they're enrolled and, therefore, they're locked into those decisions at the beginning of the year.

Compiled by Christine Woolsey

Letters

Continued from page 8

American Mutual Insurance Co. of Boston. Also, according to Best our company is known as American Mutual Fire Insurance Co., which is part of American Mutual Fire Group.

American Mutual Fire Insurance Co. has received many calls and expressions of concern regarding the financial soundness of the company. This problem has been heightened by articles in other publications that also have not clearly identified the subject company.

William D. Hilton
Senior Vp-Sales
American Mutual Fire
Insurance Co.
Charleston, S.C.

To the editor: As reported in the Jan. 30 issue, Anglo-American Insurance Co., a Louisiana insurer, is in rehabilitation and has had its license revoked in Georgia.

I would like to make clear that this Louisiana company has no affiliation, association or relationship whatsoever with our clients, Anglo American Insurance Co. Ltd. and H.S. Weavers (Underwriting Agencies Ltd., which underwrites on its behalf.

Anglo American Insurance Co. Ltd. is an authorized U.K. insurance company and an insurer of U.S. surplus lines business. The company is wholly owned by CalFed Inc., a California-based financial services company.

As part of the H.S. Weavers stamp, Anglo American Insurance Co. Ltd. plays an important role in the London market's insuring of U.S. risks. I would also note that the company appears on the National Assn. of Insurance Commissioners' Quarterly Listing of Alien Non-Admitted Insurers.

Nick Pearsor
Carter, Ledyard & Milburn
New York

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European pollution laws 'scattered': Attorney

By STACY SHAPIRO

LONDON—Although most European nations have enacted laws addressing pollution incidents, not one European country has a "comprehensive legal regime specifically for hazardous substances liability," a West German lawyer says.

"Rather, the applicable legal rules tend to be scattered (in Europe), like those of the U.S.," said Werner Pfennigstorf, an attorney in Stade, West Germany.

In addition, European countries are not adamant about mandating compulsory insurance for hazardous waste cleanup costs, he noted.

"Compulsory insurance is an idea whose time has not yet come," he said during a discussion at the Hazardous Substance Insurance Conference in London late last month.

But, he said, "Everyone agrees (in Europe and the United States) that the polluter pays."

Several European countries have enacted legislation that imposes strict liability on owners of facilities that pollute waterways, said Mr. Pfennigstorf.

Other countries use laws dating back hundreds of years that give public authorities the power to decree a "public nuisance," which could be used to order the owner of a hazardous waste site to clean up the site, he said.

But "environmental claims by individuals are still rare in Europe as compared to the U.S.; litigation is even rarer. Consequently, there are very few court decisions to provide guidance on the basic issues of (pollution) liability," Mr. Pfennigstorf noted.

Nevertheless, Europeans have become more concerned about the environment since the 1986 toxic waste spill in the Rhine River (BI, Nov. 24, 1986), and the 1986 disaster at the Chernobyl nuclear power plant in the Soviet Union, Mr. Pfennigstorf said.

The Chernobyl disaster cost the West German government \$250 million in compensation to individuals and businesses that suffered from radiation fallout, he noted.

Mr. Pfennigstorf and Christian Bouckaert, a trial lawyer from Paris, reviewed some of the European laws that govern pollution and environmental impairment liability during the conference and in papers submitted at the conference.

The European Commission, which adopted the "polluter pays" principle in 1975, has promised to "preserve, protect and improve the quality of the environment" in its Single European Act, which took effect June 1, 1987, Mr. Pfennigstorf said.

He noted that the act reads: "Action by the (European) Community relating to the environment shall be based on the principles that preventive action should be taken, that environmental damage should as a priority be rectified at the source and that the polluter should pay."

But the EC's Fourth Action Program on the Environment, which was established by the EC Council to finance environmental projects between now and 1992, "does not have liability or compensation among its priorities," said Mr. Pfennigstorf.

"Undoubtedly, however, the continued emphasis on reduction of pollution and the introduction of stricter standards will have an indirect effect on" pollution liability laws in various EC nations, he said.

The EC's product liability directive could be used in environmental cases, according to Mr.

Bouckaert.

However, although all member countries were supposed to implement the directive by July 1988, only three of the 12 member countries have passed legislation incorporating the directive (BI, July 11, 1988).

The product liability directive, which imposes strict liability on manufacturers, could be used in environmental cases where "hazardous substances are actually put on the commercial market and subsequently cause environmental damage," according to Mr. Bouckaert.

The EC also has on its books a directive controlling the movement of hazardous waste within the EC that was passed in December 1984 and amended in 1987, Mr. Bouckaert noted.



The directive, known as the "post-Seveso" directive, was supposed to be further amended by the EC Council last year to determine the civil liability of a producer or any other entity held responsible for pollution damage, said Mr. Bouckaert.

The council was also supposed to "determine a system of insurance" for environmental impairment, he said.

However, the council has not made any recommendations on this matter, he added.

In addition to EC pollution mea-

sures, several European countries have their own pollution liability laws, most of which apply only to water pollution, the lawyers note.

For example, West Germany in 1957 passed its "Wasserhaushaltsgesetz," a water resources law that imposes strict liability on:

- Anyone who releases any substance into the water or takes any other action through which the physical, chemical or biological quality of the water is changed.

- The owner of a facility designed to produce, process, store, dump, transport or convey any substances that contaminate surface water.

Also in West Germany, the government can demand that polluted sites be cleaned up, or state governments can do the work and bill the companies involved, said Mr.

Pfennigstorf.

Under that country's laws, polluters—even if they are homeowners—must pay for unlimited damage caused to anyone by a change of water quality, according to Mr. Pfennigstorf.

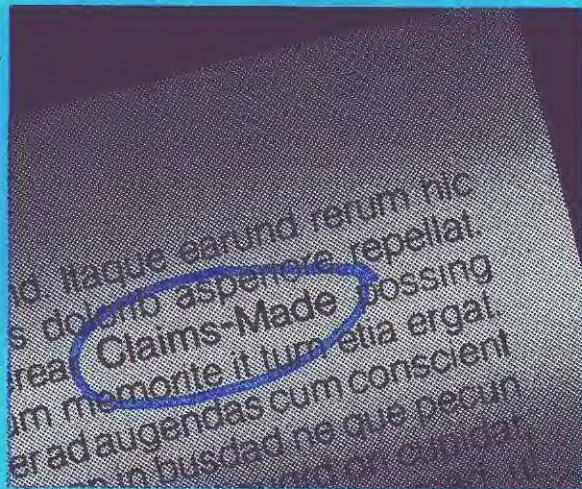
West Germany currently is considering extending strict liability to air and land pollution as well, Mr. Pfennigstorf said.

West Germany also imposes strict liability for the release of hazardous substances in the course of operating a motor vehicle, railroad or aircraft, or in certain facilities like gas plants or pipelines, power plants or nuclear installations, he said.

Switzerland adopted a water protection law in 1971 that "imposes strict liability for water pol-

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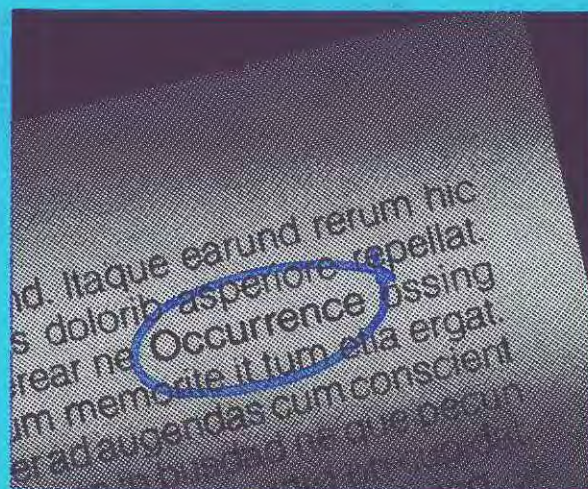
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Pollution laws protect property buyers

LONDON—"Let the seller beware" is the message in laws enacted in some states to ensure that contaminated property is not sold to unwitting buyers.

New Jersey's Environmental Cleanup and Responsibility Act requires a company selling certain types of industrial property to declare there is no on-site contamination (BI, May 23, 1988).

And if cleanup of a site is necessary, the seller must prove that it has the financial resources to perform the cleanup, said Howard B. Epstein, partner with Lord Day & Lord, Barrett Smith in New York. Companies must also provide financial assurances that a cleanup will be completed, Mr. Epstein said during the Hazardous Substance Insurance Conference in London last month.

"The government wants to be a party to the action to protect the environment," Mr. Epstein said. "You may not complete the transaction in New Jersey without approval by the government."

Illinois passed a similar law in 1988 aimed at greater disclosure of hazardous waste in property transactions, although the law is not effective until Nov. 1.

'The government wants to be a party to the action to protect the environment,' says Howard B. Epstein. 'You may not complete the (land) transaction in New Jersey without approval.'

Yet *caveat emptor* still applies to transactions involving polluted land.

Mr. Epstein suggested that the way companies and their insurers can avoid paying cleanup costs is to avoid buying contaminated property in the first place.

Companies do not want to be affiliated with hazardous waste, he told members during a speech. "McDonald's does not want to be called McWaste."

Mr. Epstein said there are several commandments that companies should follow when buying property, including:

- Thou shalt not wait until three days before the completion of the transaction to consider environmental liability. The environmental factors should be considered early in the transaction so "ambiguous" warranties and possible criminal liabilities are avoided.

- Thou shalt not rely solely on complex indemnities and warranties to void the potential hazardous waste site liabilities. "Even if they are well drawn up, how do you enforce them?"

- Thou shalt not buy without due diligence. Steps must be taken to document who knew what when about the contaminated properties before the purchase.

- Thou shalt not let business interests govern legal interests. "Don't force your counsel to make quick decisions without looking into the matter in detail," said Mr. Epstein.

- Thou shalt not enter into a deal with open-ended liabilities.

- To lawyers and environmental engineers, thou shalt expect to be abused.

—By Stacy Shapiro

Pollution laws

Continued from previous page
lution on anyone who caused it," said Mr. Pfennigstorf.

However the language of the law is "extremely broad" and, as a result, it has been applied sparingly by the government and no court decisions have interpreted the statute, he said.

So, in most instances, general rules of tort law and special statutes that impose strict liability on means of transportation and certain hazardous operations are used to impose liability for water and other forms of pollution in Switzerland, Mr. Pfennigstorf explained.

Sweden enacted an Environmental Damage Act in 1986 that imposes strict liability for water pollution and many other types of environmental impairment.

But the Swedish law only applies to land and only to impairment that is considered "unreasonable under the circumstances," said Mr. Pfennigstorf.

And Mr. Pfennigstorf said the United Kingdom passed the Control of Pollution Act in 1974, which addresses land contamination.

The law states that: "Any damage is caused by poisonous, noxious, or polluting waste which has been deposited on land, any person who deposited or caused or permitted it to be deposited in either case so as to commit an offense... is liable for the damage except where the damage was due wholly to the fault of the person who suffered; or was suffered by a person who voluntarily accepted the risk."

Conference delegates from the United States noted that the U.S. federal government's approach to pollution liability is broadening and may include requiring corporations to make the government aware of all their insurance policies that could pay for the cleanup of their hazardous waste sites.

The U.S. government also "has considered direct action against insurance (companies) for the payment of cleanup of the sites" where a waste generator cannot pay for the cleanup itself, according to Michael J. Murphy, chairman of consultant Environmental Strategies Corp. in Vienna, Va.

Mr. Murphy added that three or four times a week his consulting company advises corporations considering the environmental impact of their plans to acquire another company.

Mr. Murphy's company currently is acting as a consultant in the proposed \$600 million acquisition of a U.S. steel company, which has a total of \$200 million in environmental liabilities—"one third of the deal," said Mr. Murphy. "If the deal goes through, there will be \$200 million set aside in a fund to pay for cleanup."

NO SURPRISES

New markets for EIL risks emerging

By STACY SHAPIRO

LONDON—While still scarce, pollution coverage is becoming available in the worldwide market for environmental risks, experts say.

"The second coming of pollution liability insurance is occurring in the U.S. today. . . . We will see the development of brand new companies," predicts John J. Metelski, chairman of McLean, Va.-based Front Royal Insurance Co., which specializes in environmental impairment liability risks (*BI*, Jan. 23).

Although the Pollution Liability Insurance Assn., a U.S.-based EIL reinsurance pool, no longer is writing new business, a successor pool is being formed (*BI*, Jan. 30) and at least two other underwriting pools

'The second coming of pollution liability insurance is occurring in the U.S. today. . . . We will see the development of brand new companies,' predicts John J. Metelski, chairman of Front Royal Insurance Co., which specializes in EIL risks.

are operational in France and the Netherlands.

In addition, several risk retention groups and specialty insurers are underwriting EIL coverage, attendees of last month's Hazardous Substances Insurance conference in London were told.

Companies domiciled in France and the Netherlands can purchase pollution liability coverage from underwriting pools in their respec-

tive countries.

The Amsterdam-based MAS reinsurance pool was formed in 1984 after two years of discussions to prevent the Dutch government from starting state-funded compulsory insurance programs, explained General Manager Peter Cornelius Andre de la Porte.

Among MAS' underwriting members are most of the Netherlands' major insurers, including

Nationale Nederlanden N.V., Aegon N.V., N.V. Amev and Delta Lloyd N.V., he said.

The pool is unique in the way its coverage is structured, according to Mr. de la Porte, because all Dutch-based insurance companies must reinsure their general liability insurance policies with MAS if the policies include the claims-made endorsement that covers gradual environmental impairment.

MAS also provides reinsurance for sudden and accidental pollution risks in a general liability policy, but this coverage is not mandatory in the Netherlands.

While the pool can write up to 10 million Dutch guilder (\$4.73 million) per policy, most policyholders are only interested in buying limits of 5 million Dutch guilder (\$2.37

million), according to Mr. de la Porte.

This year, MAS will market its coverage to retail stores and hopes to reinsure 35,000 new policies, he said.

In the future "we hope to sell every existing policyholder this endorsement," he added.

In France, the pollution liability insurance pool known as Garpol has changed its name to Assurpol and increased its limits substantially.

"Garpol is dead. Long live Assurpol," said Jacques Deprimoz, delegate general of Assurpol.

Until Jan. 1 of this year, Garpol offered French companies pollution liability insurance for sudden and gradual pollution, personal injury and property damage.

But the main drawback of the pool "was their inability to offer cover in excess of 25 million French francs (\$3.93 million) per loss and per year/per policy," said Mr. Deprimoz.

"This particular drawback explains why, to date, Garpol has not been able to attract more than, say, 200 customers and why gross premiums were no more than 3 million French francs (\$471,000) in 1987



and 4.4 million French francs (\$690,800) in 1988," he added.

Of the policyholders, 60% were operators of waste dumps and waste treatment plants, and 20% were medium-sized chemical firms, he said.

To attract large operators, Garpol was dissolved and Assurpol was launched last month with 49 insurance company members and 14 major reinsurance companies, offering up to 125 million French francs (\$19.63 million) of coverage per loss and aggregate.

The Assurpol policy covers both accidental and non-accidental environmental impairment caused by third parties.

Non-accidental impairment is defined as "corrosion or any other form of slow alteration, whether gradual or repeated, of goods or installations of which the insured is owner or keeper."

"Within these limits it is possible to cover on-site cleanup and neutralization costs," said Mr. Deprimoz.

Since pollution coverage was excluded from most claims-made commercial general liability policies written in the United States since 1986, a few alternative markets have sprouted to provide the coverage to U.S. companies.

PLIA was formed in Downers Grove, Ill., in 1982 to write reinsurance for its insurer members, according to PLIA Chairman James C. Morrow. In 1983 and 1984, PLIA had a high of 49 members writing \$10 million in capacity.

However, PLIA officially dissolved as of Jan. 1 and no longer is underwriting new policies (*BI*, Jan. 16).

Meanwhile, a successor to the pool, which is still servicing its in-force policies, is expected to begin writing EIL coverage sometime this month.

Among the other U.S. sources of EIL coverage:

- National Union Fire Insurance Co. of Pittsburgh, Pa., a unit of American International Group Inc., offers up to \$15 million in pollution liability coverage on a claims-made basis; and \$1 million per loss/\$5 million aggregate for

Continued on next page

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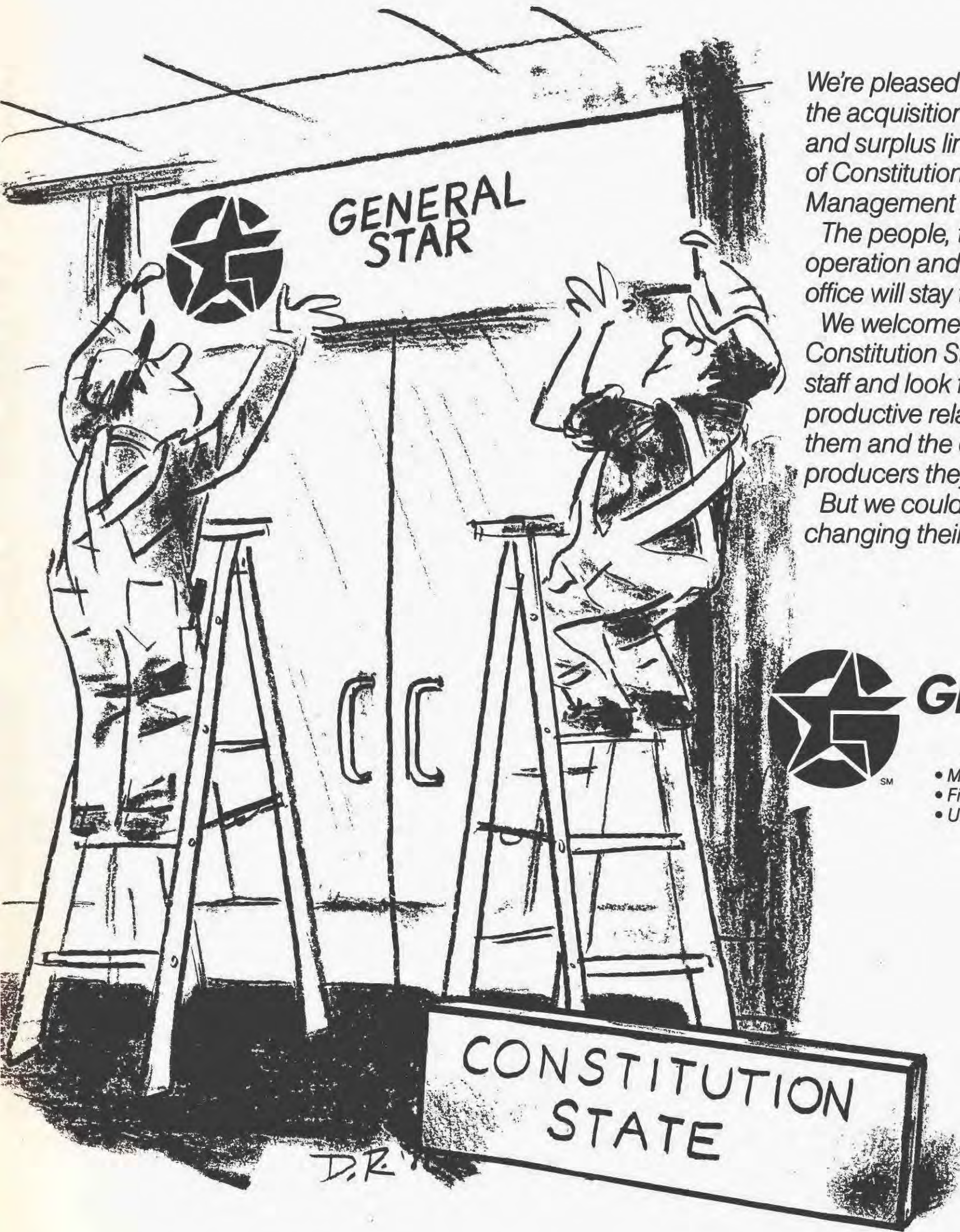
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Regulatory rebound

As insurance alternatives expand, scrutiny will increase

By Franklin W. Nutter

THE LEGISLATIVE and regulatory environment for property/casualty insurance is a high-profile public issue. The debate, which first illuminated the commercial insurance market but now focuses on today's automobile insurance problems, has had a dramatic impact on changes in insurance regulation. An overview of these legislative and regulatory changes over the last two years reflects a patchwork quilt of increasing regulatory burden.

In 1987, 45 states adopted restrictions on an insurer's ability to cancel or non-renew coverage. In 1988, 25 states took additional action—in most cases, refinements—on those laws. In 1987, 22 states adopted various forms of joint underwriting associations requiring companies to provide insurance coverage that was otherwise unavailable for various classes of insurance. In 1988, five more states adopted JUAs.

In both years, 33 states adopted some form of ratemaking restrictions on companies. These took the form of prior approval rating or flex rating schemes. In some cases, restrictions were imposed directly upon the industry's rating organizations.

Statistical reporting was also a major area of change for insurance regulation in the last two years. In most cases additional reporting was designed to secure additional information over and above the traditional reporting for solvency purposes.

In addition to these legislative and regulatory changes, other dramatic events are affecting property/casualty insurers. Notable among these is the

increasing financial burden placed upon companies by residual markets that legislators create to insure the availability of insurance. With respect to automobile insurance, these residual markets generally operate successfully and without a heavy financial drag on companies.

In some states, such as New Jersey and Massachusetts, however, these residual markets have developed astronomical deficits as a result of inadequate rates for the loss experience of the policyholders in these markets.

The workers compensation residual market is growing dramatically. In medical malpractice, seven of 10 active JUAs are technically insolvent. And solvent insurers last year bore the burden of assessments totaling \$947.1 million for guaranty funds to cover the claims of their insolvent competitors.

In a related development, judicial and legal attacks on the integrity of the insurance contract have gone on almost unabated for nearly 20 years. While there are some signs of a more conservative judiciary in some states and in federal courts, insurers have found it increasingly difficult to rely on their contracts in pricing coverage to pay claims in tomorrow's legal environment.

Finally, the industry is subjected to what some have called a "consumer revolt" reflected by California's Proposition 103, which mandated unrealistic rollbacks and imposed a system of price controls. The industry's professional critics heralded this as a "voter revolt" that will spread to all states where automobile insurance problems exist,

particularly those states allowing ballot initiatives.

These revolutionary changes in the regulatory environment for the traditional property/casualty insurer are in direct contrast with recent changes in public policy toward alternatives to traditional, admitted insurance. In these alternative, basically unregulated markets, business is booming. Observers estimate, for instance, that more than 3,000 captive insurers were created by the end of 1987 and that as much as 25% to 30% of commercial premiums have shifted to alternative markets, such as captives, risk retention groups and self-insurance.

Clearly these alternatives have many advantages. Excess and surplus lines companies and true alternatives enjoy limited regulation, as defined by the regulation of traditional insurers.

They enjoy an exemption from rate, form and coverage laws; except in one state, have no guaranty fund assessments; no residual market drag; and the freedom from regulation that allows them to tailor insurance contracts to meet individual buyer needs. These advantages, many of which have been adopted or ratified in recent years, reflect a real cross-current in the public policy of alternative markets, the excess and surplus lines market and the traditional property/casualty industry.

The question public policymakers will face in the not-too-distant future is whether these cross-currents can and should be reconciled. Traditionally commercial insurance has been a stabilizing factor for

insurance buyers. Yet, in recent years some of those buyers have characterized it as a source of instability. Ironically, one commentator has noted that alternative markets are destabilizing the traditional property/casualty insurance industry.

Certainly buyers' disenchantment with the industry's cycle and wild pricing swings has driven them to solve the mystery of commercial insurance. A Tillinghast study conducted for the Risk & Insurance Management Society Inc. concluded that the period 1985 to 1987 was one in which the property/casualty industry significantly reduced the long-term market for its own products.

In looking at the years ahead, some are predicting that to avoid heavy-handed regulation in the admitted market and to give it flexibility to offer coverage buyers want and need, commercial insurance will be increasingly provided in the alternative and non-admitted markets. Lyndon Olson, former president of the National Assn. of Insurance Commissioners, has predicted that in five years, 43% of commercial general liability coverage will be provided by non-admitted insurers.

If these predictions are true, it can be safely said that where the policyholders go, regulation will follow. Companies—whether admitted or non-admitted insurers or alternatives to traditional insurance—cannot provide pollution, product liability, public entity or medical malpractice coverage and avoid the public policy questions associated with these difficult lines of

Continued on next page

Speaking out

ASK A RISK MANAGER

Tort reforms aided awareness campaign

Q

Tort reform has been a hot topic during the last two years. Have reform activities really made a difference?

A

Tort reform became a battle cry for the beleaguered ranks of insurance buyers as the liability insurance crisis dealt a crippling blow in the mid-1980s.

Virtually no business segment was isolated from extreme price increases and the headaches of

locating markets for certain coverages. The furor also caused finger pointing and name calling, the likes of which had not been seen before.

Insurance companies blamed the legal profession, saying lawyers were responsible for creating a litigation-oriented society where "mega" awards became commonplace.

The medical profession waged its own battle. Doctors screamed foul at both insurers and lawyers because their medical malpractice insurance markets dried up.

And insurance buyers, in general, found themselves on the outside looking in, since coverage was either unobtainable or unaffordable.

Suddenly—and it did appear to occur overnight—every type of business, from large corporate America to the small-town entrepreneur, learned insurance had become an extravagant commodity. Fueling the fire was the opinion shared by the general public that the individual was not responsible for his or her actions. The common belief was that a person should try to place the blame on the other guy and go after the big bucks!

Everyone received quick education on the liability insurance crisis as the subject caught the attention of national news programs and virtually all major publications. During the media blitz several managers in my company forwarded copies of articles on the subject that appeared in their professional journals. I must admit that all of the publicity made it easier for me to advise our executives of the impact the crisis was having on our operations.

The entire concept of tort reform was aimed at placing liability issues into focus and finally understanding that insurance is not the panacea for curing the litigation disease spreading throughout our society. There is far too much garbage flooding our civil justice system. The liability crisis emphasized that clearly.

In response to your question, tort reform has made a positive impact, to varying degrees. Reform activities have differed from state to state but attempts to cap huge awards and control the joint and several liability issue received initial priority. The latter relates to the deep pocket theory whereby liability is judged to rest ultimately with the party most capable of paying a settlement.

Tort reform lobbyists sent a message to state and federal officials that government assistance was needed to ease the capacity crunch. Among the market segments particularly hardest hit were the medical profession because of its malpractice exposure, the manufacturing industry because of its product liability exposure and members of the food and beverage industry who had a liquor liability exposure. Each of these groups was rocked by claim settlements in the multimillion-dollar range.

Risk managers were thrown into the turmoil and found themselves wearing another hat! With the realization that their company's financial situation had become more vulnerable, they quickly assumed the role of underwriter, tackling the challenge of risk evaluation. Then, having a need to transfer some portion of risk to a coverage mechanism, risk managers became involved with the concepts of self-insurance, risk retention groups and captives.

The Risk Retention Act of 1986 proved to be a major step toward establishing alternatives to commercial liability programs. Recently proposed revisions to the original legislation should clarify much of the uncertainty over the regulation of risk purchasing groups.

Companies that were forced to take a larger share of risk internally placed a greater emphasis on loss prevention programs.

Claims management efforts concentrated more aggressively on avoiding the hassles of litigation or closely controlling the cases that found their way into the courthouse. At the height of the liability crisis, nuisance-type claims had escalated to an almost unmanageable level. It was difficult for a claims administrator to negotiate what was once a routine settlement since the claimant's first call following an alleged accident was more than likely to an attorney.

Our company's recent experience with litigated

cases has shown jurors to be more responsible in determining the existence and extent of liability. They also appear to be more conservative when awarding damages.

The public has finally realized that the crisis, if uncontrolled, will eventually affect the standard of living as the cost of some services increases or, in an extreme case, a particular type of service is no longer available because a business has been forced to close when insurance becomes too expensive or not available. We continue to hear stories of physicians who are leaving their profession because of the malpractice insurance dilemma.

California's Proposition 103, approved by the electorate in November 1988, has created an entirely new set of problems for the insurance industry. The legislation calls for reductions in insurance "charges" for many property/casualty coverages. Regulators are faced with the complexities of implementing the proposition. To be sure, other states are keeping an anxious eye on the activities!

The liability crisis was a natural progression of the attitude of our times. Tort reform lends cautious optimism that we are becoming wiser and better prepared to deal with the aftermath.

Would you like advice from an experienced colleague on a risk management, benefits management or actuarial problem? Four features in the Perspective section of Business Insurance can give you some answers.

Ask A Risk Manager, Ask A Benefit Manager, Ask A Benefit Actuary and Ask A Casualty Actuary answer written questions from readers on risk and benefits management issues and actuarial problems.



Ms. Werner

This month's column on risk management issues is written by Susan M. Werner, director of risk management at Hardee's Food Systems Inc. in Rocky Mount, N.C. Joseph W. Duva, director of employee benefits at Allied-Signal Inc. in Morristown, N.J., answers benefits management questions. William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions on benefits issues. And, Richard E. Sherman, a principal with Coopers & Lybrand in San Francisco, answers actuarial questions in the casualty field.

Mr. Duva's and Ms. Werner's columns appear alternately on the second Monday of each month. Mr. Miner's and Mr. Sherman's columns appear alternately on the first Monday of each month.

Ms. Werner's next column will appear in April. Address your questions to ASK, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. Please give us your name, title and employer; however, Business Insurance will consider unsigned letters.

Regulatory scrutiny

Continued from previous page
insurance. If these coverages do not return to the admitted market, it is inevitable that regulators will track them.

Others have predicted that vertical integration of risk financing or joint risk financing between the policyholder, the non-admitted market and alternative markets will continue. Buyers are now creating their own risk facilities and will move next to integrate their various options.

It seems safe to predict that the more insured risk goes outside traditional regulation, the greater the risk of federal regulation of some portions of the business.

Congress itself served as a midwife to the creation of many alternative markets. Indeed, congressional desire to facilitate business coverage led to the adoption of the Risk Retention Act and its amendments. Depending upon the outcome of litigation to exempt or

control these alternatives within traditional state regulation, the buyers themselves or advocates for federal regulation may move to a system of federal control.

Traditionally the non-admitted surplus lines insurance market has filled gaps in admitted markets and provided coverages where the admitted market was unable to meet a need. We can safely predict that where the non-admitted market fills gaps in traditional lines of insurance, it invites residual market mechanisms and guaranty funds. The excess and surplus lines market has always been a pioneer because it solves problems. If the traditional property/casualty industry recedes from some lines of insurance and the excess and surplus lines market moves to fill this vacuum, the risk of assessments for guaranty funds and assigned risk plans is greatly increased.

Another safe prediction is that the

current trend toward increasing financial responsibility requirements for the excess and surplus market will continue. Bonds and minimum capital requirements are a trend that cannot be denied.

In conclusion, the cross current between the public policy environment of the traditional property/casualty insurance industry and the non-admitted insurers and alternatives will continue. We are greatly concerned that dramatically increased regulation of the traditional insurers is slowly choking them. By contrast, the vitality of the non-admitted and alternative markets is due in large part to the relief they enjoy from the heavy hand of regulation with respect to contracts and assessments.

As traditional insurers assess their commitment to markets in light of the impact of regulation on them, the dynamics between the admitted and

alternative markets will accelerate. If the distinction between the servicing of the same risks by regulated and unregulated markets becomes blurred, both markets will be targeted to respond to the social issues associated with these lines of insurance.

Public policymakers and regulators would be well-advised to maintain a regulatory environment for traditional insurers that is conducive to them if they desire to preserve the benefits of alternative markets. A blending of regulation for traditional insurers and alternatives is not inevitable.

Franklin W. Nutter is president of the Alliance of American Insurers in Schaumburg, Ill.



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D&O markets

Continued from page 3

National Union writes up to \$25 million in D&O limits on both a primary and excess basis, according to Lena Mkhitarian, an assistant vp at National Union.

AIG requires that banks seeking D&O coverage have a minimum of \$50 million in assets.

- Executive Risk Management Associates of Simsbury, Conn., a subsidiary of Hartford, Conn.-based Aetna Casualty & Surety Co.

After issuing D&O policies for two years, ERMA has written an estimated \$100 million in D&O premium, according to Stephen Sills, vp of underwriting at ERMA.

ERMA will write up to \$30 million of D&O limits on both a primary and excess basis with varying policy exclusions.

"We write from the smallest to the largest financial institutions in the country," Mr. Sills said.

- Chubb & Son Inc.

Chubb & Son offers D&O limits of \$25 million on both a primary and excess basis to banks with a minimum of \$50 million in assets, according to Mr. Pfannenstiel.

Other insurance companies not represented at the ABA conference but cited by the panel of experts as leaders in the D&O coverage market include:

- CNA Financial Corp. of Chicago.

CNA offers D&O coverage limits of up to \$15 million and prefers banks with assets of at least \$25 million, the insurer

confirmed.

- Great American Insurance Co. of Cincinnati, a unit of American Financial Corp.

Great American will write up to \$25 million of D&O coverage for financial institutions on either a primary or excess basis. It prefers banks with assets of at least \$100 million and excludes coverage for savings and loan institutions, a spokesman for the insurer said.

- Reliance Insurance Co. of Philadelphia.

Reliance offers D&O limits of up to \$10 million and, although all types of banks are eligible, the larger the bank's assets, the better the chances of obtaining the D&O coverage, a spokesman said.

Minimum deductibles for D&O liability policies written by most insurers begin at \$5,000 for individual coverage for directors and officers and at \$20,000 for corporate coverage, the market representatives speaking at the conference said.

For example, at National Union the individual director's or officer's retention level for D&O coverage is zero, while corporate retention levels vary beginning at \$25,000, said AIG's Ms. Mkhitarian.

While coverage is also available in the London market, underwriting guidelines are not as clearly defined as in the U.S. market, according to Mr. Donahue of Bowles, Troy, Donahue & Johnson.

"D&O coverage is available and underwriters will entertain financial institution risks, but it is on a strictly negotiated basis with little or no pre-publication of what they

are interested in underwriting," Mr. Donahue said.

Meanwhile, offshore facilities represent a quickly emerging D&O market that will be "geometrically expanding and not decaying," in the future, he added.

Mr. Donahue cited Hamilton, Bermuda-based A.C.E., Corporate Officers & Directors Assurance Ltd. and X.L. as being the key players in the Bermuda offshore D&O marketplace.

"These are significant markets not because of the number of financial institutions they now write but because of the number of institutions that they can write and may write in the future," said Mr. Donahue.

Mr. Donahue estimated that CODA and A.C.E. write D&O coverage for 25 financial institutions apiece, while X.L. insures about 10 financial institutions.

"A.C.E. and X.L. are significant players on the excess side with undeniable capacity," he said.

A.C.E. will write up to \$50 million in excess D&O limits, and X.L. will write up to \$25 million in excess D&O limits.

However, because financial institutions seeking coverage from A.C.E. and X.L. must be larger institutions—they must have \$250 million in their equity accounts—"Bermuda is not a viable option for many financial institutions," he said.

Besides A.C.E., X.L. and CODA, other policyholder-owned sources of D&O liability coverage not mentioned at the conference include: Bankers Insurance Co. Ltd.; Directors and Officers Liability Insurance; Drayton Co. Ltd.; and Financial Institutions Reserve Ltd. (BI, April 18, 1988). All four facilities are based in Bermuda.

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Business Insurance
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D&O cover reshaped by courts: Expert

By KARI BERMAN

SCOTTSDALE, Ariz.—Recent court decisions are changing the way directors and officers liability coverage is interpreted, according to a D&O liability expert.

Even when all the necessary precautions are taken, anything can happen to directors and officers in the courts, particularly in the case of a merger or acquisition, said Dan A. Bailey, an attorney with the Columbus, Ohio, law firm of Arter & Hadden, and co-author of the fourth edition of "Liability of Corporate Officers and Directors."

Mr. Bailey was speaking at the 1989 American Bankers Assn. National Security & Risk Management Conference late last month in Scottsdale, Ariz.

"If it goes to the jury, anything can happen," Mr. Bailey said.

Mr. Bailey, reiterating a topic he has spoken on in the past, cited three recent court decisions as evidence of the unpredictability of court decisions in D&O cases (BI, Oct. 10, 1988; May 16, 1988).

"We have lost the predictability in the D&O market because courts can rewrite the policy and you never know what you have until you're three layers into an appeal," Mr. Bailey explained.

Among the landmark cases broadening D&O exposures is the March 1988 U.S. Supreme Court decision in *Basic Industries vs. Levinson*, Mr. Bailey said.

In this case, some shareholders of the Cleveland-based chemical manufacturer argued that company officials deliberately misled them during merger talks with Stamford, Conn.-based Combustion Engineering Inc. in 1977-78.

The plaintiffs claimed they would not have sold their Basic stock for far less than Combustion later paid for it if Basic officials had not denied merger talks were occurring.

Although the court did not clarify what merger information must be disclosed to shareholders, it ruled that directors and officers cannot mislead shareholders about merger discussions.

The court also ruled that investors who receive misleading information from company officials during merger talks can successfully file class-action suits against the company's directors and officers.

In his presentation, Mr. Bailey also referred to the 1985 Delaware Supreme Court decision in *Smith vs. Van Gorkum* as another landmark D&O ruling resulting from a

Continued on next page

Mergers pose D&O threat: Experts

By KARI BERMAN

SCOTTSDALE, Ariz.—Risk managers of financial institutions involved in mergers and acquisitions must make sure that the directors and officers of the acquired company are protected after the transaction is finalized, according to experts.

"At the day of closing, you have to assume the worst, which is that everyone will hate the directors and officers of the old company and they have to be protected from legal actions," said Dan A. Bailey, an attorney with law firm Arter & Hadden in Columbus, Ohio, and co-author of the fourth edition of "Liability of Corporate Officers and Directors."

Mr. Bailey made his comments during a panel discussion at the 1989 American Bankers Assn. National Security & Risk Management Conference in Scottsdale, Ariz., last month.

Mergers and acquisitions among financial institutions will continue to create the most serious liability exposures for directors and officers, concurred consultants, underwriters, brokers and financial institution risk managers serving on the panel.

"The fastest growing area of D&O claims are among those involving mergers and acquisitions where you think everyone is friends and they're not," said James F. Donahue, managing director of Bowles, Troy, Donahue & Johnson in Dallas.

"A director or officer's job is such that no matter what they do during a merger or acquisition, someone is going to be unhappy and disagree with their decision," which can result in a lawsuit, according to Mr. Bailey.

The Wyatt Co.'s 1988 "Survey on Directors & Officers Liability" found financial institutions to have the greatest number and most susceptibility to D&O liability claims.

The study, which surveyed 1,708 U.S. companies, also reported that companies involved in a recent merger or acquisition experienced twice as many D&O claims as those companies not involved in merger activity (BI, Dec. 19, 1988).

According to Wyatt's statistics, there was an average of more than one D&O claim for every two companies involved in a merger, acquisition or divestiture.

The survey also reported that companies not experiencing mergers or acquisitions had fewer than half the number of D&O claims, averaging only one D&O claim for every four companies.

Bank risk managers and insurance brokers play an important role in making sure that D&O coverage for the newly merged entity is not a Swiss cheese package, experts say.

It is usually either the risk manager's or the insurance broker's responsibility to make certain that the previous directors and officers are protected from any D&O claims brought after they have left their posts. Otherwise, the results can be financially damaging for all involved, according to the panel.

"There ought to be mandatory broad indemnification for the old D&Os by whatever surviving entity exists," said Mr. Bailey. "It has to be as broad as possible and preferably one that is a stand-alone run-off policy that is prepaid and untouchable for 5 to 7 years."

Dean P. Felton, senior vp at Alexander & Alexander Inc. in New York, advises the acquiring company's risk manager to "look back into the acquiree's insurance history at least six years," particularly where D&O coverage is concerned.

"A copy of the acquisition agreement, a complete insurance policy portfolio of the acquiree, a financial history and a record of all prior or pending litigation will aid in a smoother merging of companies," said Mr. Felton.

And, with the merger and acquisition trend among financial institutions expected to continue into the 1990s, underwriters are responding to the increased threat of D&O claims by writing hostile takeover exclusions into policies.

Underwriters began incorporating hostile takeover exclusions into D&O policies around 1987 when the effects of D&O claims resulting from hostile bank takeovers became apparent, according to Lena Mkhitarian, assistant vp of National Union Fire Insurance Co. of

Pittsburgh, Pa., a unit of American International Group Inc.

Underwriting philosophies regarding hostile takeover exclusions vary among insurance companies as some write them directly into the policy while others add the exclusion as amendments to the exclusion, she added.

At National Union, the takeover exclusion does not apply if the policyholder's director or officer seeks favorable legal and investment advice before making decisions, according to Ms. Mkhitarian.

"With the broadening of interstate banking in the 1990s, this issue will continue to be with us for a while," Ms. Mkhitarian said.

"We need the directors and officers to be prudent in their decision-making process" and, at National Union, coverage for hostile takeovers will exist as long as the directors and officers seek opinions from the proper advisers, Ms. Mkhitarian said.

She further advised financial institution risk managers to make sure that they understand the hostile takeover exclusions in their policies and be aware of how the coverage will respond to their needs if a merger occurs.

Other members of the panel include John Pfannenstiel, professional liability underwriting manager for Chubb & Son Inc. in Warren, N.J.; Stephen Sills, vp of underwriting at Executive Risk Management Assn., a unit of Aetna Life & Casualty Co. in Hartford, Conn.; and Chris Watson, executive vp of Commercial Insurance Resources Inc. in New York.

The session was moderated by Leila Cowan, a vp with A&A in Dallas.

Crisis planning critical to survival, bank experts say

By KARI BERMAN

SCOTTSDALE, Ariz.—Contingency planning for the worst-case scenario is critical for a financial institution to recover quickly from a catastrophe, according to risk management experts.

"Solid contingency plans should be designed to insure your own survival in a time of crisis," said Richard H. Klovstad, vp at Norwest Corp. of Minneapolis.

Mr. Klovstad spoke from experience at the 1989 American Bankers Assn. National Security & Risk Management Conference last month in Scottsdale, Ariz.: A 1982 five-alarm fire destroyed the 17-story building that headquartered Norwest Corp. (BI, Sept. 26, 1983).

Also destroyed in the fire were the offices of subsidiary Northwestern National Bank of Minneapolis, now called Norwest Bank Minneapolis N.A.

Although Norwest risk management officials had updated the bank's contingency plan six months before the fire, the plan was not as complete as it could have been because Norwest officials had not contemplated the total destruction that occurred, Mr. Klovstad said.

"We never thought that a fire would destroy as much as it did, and we learned that you have to think of the worst-case scenario and plan for it," he said.

When designing a contingency plan, company officials should ask themselves "not only if they can perform a function after a disaster, but also the consequential damages if they can't," said Yvonne A. Carlton, a Norwest contingency planning specialist.

"You have to think about what would financially happen if money or wire transfers could not be completed. Look at the critical components of keeping the bank going and worry about the complexities later," Ms. Carlton advised.

Mr. Klovstad agreed: "You still have to be able to maintain daily business and keep customers happy. Their concern is in having their banking needs met, and if a disaster stops this ability, then you lose customers."

Ms. Carlton recommended that a typical contingency plan for a

Continued on next page

D&O decisions

Continued from previous page

merger. This ruling expanded the liability exposures directors and officers face by limiting their decision-making ability.

In the case, shareholders brought a class-action suit against the directors of Chicago-based Trans Union Corp. for approving the 1981 sale of the company to Chicago-based Marmon Group Inc. for substantially less than its value.

The court ruled that the directors of Trans Union were personally liable for failing to properly investigate the takeover offer.

The case ultimately was settled for \$23.5 million, most of which was paid by Trans Union's new owner and Trans Union's D&O insurer, Los Angeles-based Harbor Insurance Co., a unit of New York-based Continental Corp. (BI, Aug. 26, 1985; Aug. 19, 1985).

"The courts believed that the directors and officers breached their fiduciary duty by deciding to sell the company," Mr. Bailey said. The decision frightened directors and officers across the country because it limits their ability to make boardroom decisions and weakens the business judgment rule that holds that all business officials make honest judgment errors and should not be held liable.

Where the directors and officers were found liable for agreeing to a merger in *Smith vs. Van Gorkum*, in another landmark decision that came six months later in *Revlon Inc. vs. MacAndrews & Forbes Holdings* directors were found liable for the opposite position, according to Mr. Bailey.

The Delaware Supreme Court ruled that New York-based Revlon's directors breached their fiduciary duties because they opposed a takeover and issued a "lock-up" option during a hostile takeover bid for controlling interest in Revlon.

Revlon's directors were held personally liable and were ordered to pay \$20 million.

"In the first case, they were liable because they agreed and, in the second, because they opposed. These two cases dramatically illustrate how directors and officers are damned if they do and damned if they don't in many situations in the D&O takeover arena," Mr. Bailey said.

Other members of the panel of which Mr. Bailey was a member agreed that because increased mergers and acquisitions are clearly on the horizon and, in turn, D&O activity has increased, the key to controlling exposures is to hire competent, cautious and experienced individuals when restructuring the new corporation (see related story).

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Banks advised to screen employees

By KARI BERMAN

SCOTTSDALE, Ariz.—Pre-employment screening programs can help protect financial institutions from employee dishonesty or negligence, experts say.

Financial institutions need to be particularly cautious when hiring because they face the constant risk of employees embezzling funds.

Since the use of lie detectors by private employers—including banks—to screen most potential employees was banned last year, employers are turning to alternative screening methods to weed out dishonest applicants (BI, Sept. 19, 1988).

Among the devices used by financial institutions to screen prospective employees are drug testing, fingerprinting and computer-aided handwriting analysis.

But while these newer prescreening tools may prove beneficial, they also have some drawbacks, according to experts who spoke at the 1989 American Bankers Assn. National Security & Risk Management Conference held late last month in Scottsdale, Ariz.

"Banks and all companies want to take precautions on hires because of the various risks involved, and the high turnover rate among bank employees makes protection even more difficult," said Peter J. Kiefer, first vp of human resources management at Security Pacific National Bank in Los Angeles.

"The sheer cash volume involved makes banks particularly susceptible to internal crime," Mr. Kiefer said.

Mr. Kiefer outlined a hypothetical pre-employment screening plan, while stressing that he was not recommending the plan and that Security Pacific's pre-employment screening does not include all of the elements mentioned.

The pre-employment screening model that Mr. Kiefer demonstrated utilizes three tiers of screening, each corresponding to the level

within the corporate hierarchy for which the applicant is being hired.

For example, while an entry-level candidate would be subject to minimum screening composed of drug and honesty testing, as well as fingerprinting, more sophisticated background searches, interviews with past employers and consumer credit reports might be added to the list for potential middle-management hires.

And, for individuals applying for top executive positions, a full background check should be conducted in addition to all tests performed for lower positions. Such a check often includes personal interviews with references and colleagues from different periods of the candidate's life, according to Mr. Kiefer.

'Banks and all companies want to take precautions on hires because of the various risks involved, and the high turnover rate among bank employees makes protection even more difficult,' says Peter J. Kiefer, first vp of human resources management at Security Pacific National Bank in Los Angeles.

Within the banking industry, "most of what we are suffering from in terms of employee problems is the result of drug use," he said.

While employers may reduce their drug-related problems by making drug testing a mandatory part of the hiring process, it is nearly impossible to have a completely drug-free workforce and some drug users always slip through the cracks, according to Mr. Kiefer.

"When you are going to use drug testing for prescreening employees, the application should state that you have the right to test," Mr. Kiefer noted.

He also told attendees to make sure that the application is signed by the applicant to fend off any future legal action.

And, drug use among the current work-

force can be controlled by either employer testing based on probable cause or random testing, Mr. Kiefer said.

However, he cautioned of the problems inherent in these types of drug testing programs.

"You have to be careful of who is asking for a test on probable cause and make sure it is not a personal problem between a supervisor and employee," Mr. Kiefer said.

He also explained that random testing can decrease employee morale "because they don't like the idea of having their name pulled out of a hat and being tested one morning for no reason."

Although Security Pacific does administer pre-employment drug tests for positions in certain areas of the bank and reserves the

right to test based on probable cause, random drug testing is not practiced, Mr. Kiefer said.

The Employee Polygraph Protection Act, which prohibits the use of lie detector tests of current and prospective employees among most employers, has sent many companies in search of other prescreening techniques.

One available alternative to polygraph tests is fingerprinting potential employees and then sending the prints to the FBI for a background check.

The ABA administers a fingerprinting program for its participating members, acting as a bridge between the financial institution and the FBI, Mr. Kiefer said.

The FBI searches its nationwide criminal records and reports if the person has a criminal record.

An ABA spokesman said that the fingerprint check is the soundest way to protect against losses resulting from internal fraud, reporting that 10% of submitted prints result in a "hit"—meaning that the individual has a criminal background.

However, because there is often a four- to six-week waiting period for the results, often the individual is hired before the FBI check is complete, according to Mr. Kiefer.

But, a newly hired employee with a criminal record who does not disclose that information before being hired can be legally released without penalties to the company, he said.

"Most will discharge an individual for a conviction on acts of dishonesty," Mr. Kiefer said.

Another way that financial institutions can screen potential employees before hiring them for sensitive positions, such as those with access to a bank's assets, is through computer graphology, Mr. Kiefer said.

Computer graphology, or high-tech handwriting analysis, is emerging as a popular means of evaluating potential employees, according to Mark Hopper, president of Phoenix, Ariz.-based Handwriting Resource Corp., who also addressed the ABA conference.

Handwriting analysis can provide companies with personality profiles and risk assessments of applicants, allowing the company to determine if the job fits the individual.

Handwriting Resource Corp. feeds a 10-line writing sample into a computerized image scanner that matches up the sample with personality traits that have been pre-programmed.

About 500,000 personality calculations are made from the sample within minutes, Mr. Hopper explained.

Handwriting analysis "can tell you what makes the person tick and can evaluate their levels of whatever the employer is most interested in knowing, including honesty, integrity and even predisposition to substance abuse," Mr. Hopper said.

Crisis planning

Continued from previous page
financial institution include:

- Lists of recovery teams and clear definitions of their responsibilities, which should be distributed to employees in advance.
- Disaster recovery strategies that explain emergency bank procedures to employees in the event of different types of disaster situations.
- Initial recovery response instructions, which tell employees what steps should be taken immediately, such as notifying other employees of a secondary meeting place and recovery centers.
- Lists of off-site materials and where recovery teams and employees can obtain them.
- Quick decisions need to be made in stressful surroundings

during a crisis, and employees need to understand the contingency plan and know exactly what to do," Mr. Klovstad said.

While it is essential to have a broad contingency plan for all employees to follow, specialized plans also should be implemented for a bank's most vital departments, such as its computer centers and its telecommunications system.

"The bank's loss of computer centers and data processing assets usually has one of the most crippling effects on a financial institution and should be high on the list of priorities in contingency planning," Ms. Carlton said.

"Having data centers established at various sites is crucial in disastrous situations," Ms. Carlton said. "You have to be able to get the data information needed for business from data centers not involved in the fire," she added.

Norwest officials agreed that having dual operation sites and two additional data processors outside of the bank's main building helped the bank recover quickly because much of the data destroyed in the fire was available on the back-up systems.

According to Ms. Carlton, important elements of a bank's computer system recovery plan are:

- Selecting a computer recovery coordinator and team that will be ready to assume responsibility for computer and data processing during a time of crisis.
 - Determining how impaired the organization would be without some or all of its data processing capabilities.
 - Assessing the data processing needs of the various divisions of the financial institution and developing guidelines on each division's critical computer needs.
- Another key consideration for a contingency plan is the structure

of the financial institution's telecommunications system and how long it will take to restore it if damaged.

Ms. Carlton said the breakup of American Telephone & Telegraph Co. complicates contingency planning because of the numerous vendors now involved in telecommunications.

"There is no longer one number to dial to have all of your services restored, and the new Baby Bells are ill-prepared for a crisis," she said.

Ms. Carlton strongly advised banks to establish off-site, back-up telecommunications systems because of the length of time it could take to restore a bank's system if the central office is destroyed.

Once the basic structure of the contingency plans is developed, perhaps the most crucial element for a successful execution is timing, according to Ms. Carlton.

She stressed that financial institutions should be fully operating under the emergency procedures within 48 hours at most after a catastrophe, partly because of other companies' reliance on banks' financial services.

In fact, 24 hours is preferable, she said.

"We have a 30-hour recovery time frame with an hour by hour schedule of what needs to be done to maintain business transactions," Ms. Carlton said.

"You have to ask all bank units involved not how much time do we have for recovery, but rather how fast they need us to do the job," she added.

By contrast, Other industries that are not as dependent on data processing can usually take a week to resume operations and survive, she said.

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Canadian employee benefits

Continued from page 3

tal hospital room coverage, offered by 98%, up from 92%; coverage for medical supplies and appliances, offered by 96%, up from 92%; coverage for private duty nursing, offered by 93%, up from 90%; coverage for hospital rooms and services outside Canada, offered by 91%, up from 87%; and chiropractors and other professional services coverage, offered by 89%, up from 85%.

Of supplemental health care plans surveyed in 1988, 27% required some employee contribution toward the cost of coverage, 69% required no contribution and 4% offered no response.

Fifty-four percent of supplemental plans in 1988 required a deductible for individual coverage, while 39% required no deductible and 7% did not respond.

Of that 54% requiring a deductible, 36% required \$25; 14% required less than \$25; and 4% required more than \$25.

And, for family coverage in 1988, 60% of supplemental plans required a deductible, 36% no deductible and 4% did not respond.

Of that 60%, 24% required \$25; 19% required \$50; 13% required less than \$25; 2% required more than \$50; and 2% required \$26-\$49.99.

Meanwhile, some employers found that they were not increasing their deductibles to match inflation and, as a result, "a \$25 deductible may be worth only \$21.95 the next year," Mr. McDonnell said.

So, rather than increase the size of the deductible, some employers decided that picking up the deductible tab was worth the employee satisfaction it provided, he said.

"Employers are looking for a more tangible, dollar-in-the-pocket improvement (in benefits) that employees can see,"

Mr. McDonnell said.

All survey respondents provide some type of group life insurance. Sixty-one percent of the respondents also allowed employees to purchase some type of supplemental life insurance.

The Wyatt survey also found that a significant number of companies extend supplemental benefits to part-time workers and retirees.

Thirty-four percent of employers surveyed offered part-time employees supplemental health care benefits in 1988, and 35% offered part-timers a basic group life insurance plan.

For retirees, 42% of employees offered a supplemental health plan in 1988, and 48% offered a basic group life insurance plan.

Due to changes in the format of the 1988 survey, comparisons cannot be made to 1985 survey results for part-time employee and retiree benefits.

Other survey findings include:

- Canadian employers are increasingly adopting flexible benefit programs.

While only 4% of employers surveyed had a flexible benefit program in 1988—up from 3% in 1985—an additional 9% of respondents said they are planning to introduce a flex plan within the next two years.

"The growing interest in flexible benefits is based on a desire to increase employee satisfaction," Mr. McDonnell commented. "Employers are increasing the mix and flexibility of their benefits" to retain employees, he said.

- Seventy-three percent of employers offer a benefits package to salaried employees that includes life insurance, supplemental health, long- and short-term disability and dental coverage. Only 35% of employers offer this package to their hourly employees, while 20% offer this to part-

time employees.

- Ninety-nine percent of responding employers provide some type of disability benefit, which may include paid sick leave, short-term disability and long-term disability. Seventy-three percent of employers provide paid sick leave—covering a minor illness for a short period of time; 82% of respondents offer short-term disability; and 97% offer long-term disability coverage.

- Employers offering dental plans increased to 92% in 1988 from 84% in 1985. Additionally, 64% of those employers offered first-dollar coverage in 1988, up from 41% in 1985. Of those plans that do require a deductible, the most common deductible amounts are \$25 for an individual and \$50 for family coverage, the same amounts as in 1985.

Wyatt's "1988 Canadian Group Benefits Survey" is based on the responses of 638 Canadian employers, covering 625,000 salaried employees. The study, which is conducted triennially, surveys employers that represent a broad spectrum of Canada's leading manufacturing, financial, service-oriented and non-profit organizations from each of the nation's 10 provinces and two territories.

Large employers, those with more than 1,000 employees, accounted for 20% of respondents; medium-sized firms employing 250-1,000 accounted for just more than 30% of the sample; and employers with 250 or fewer employees make up the remaining 48% of the survey sample.

Copies of "1988 Canadian Group Benefits Survey" are available free of charge to employers participating in the survey. Others may obtain the survey for \$1,000 Canadian (\$1,180 at current exchange rate) from any Wyatt office in Canada or by writing to The Canadian Research & Information Centre, c/o The Wyatt Co., 150 York St., 17th Floor, Toronto, Ontario M5H 3S5.

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FEB. 21. Postemployment Benefits and the Proposed New Accounting Standard seminar in Washington, D.C., sponsored by the Financial Executive Institute; \$295 for FEI members; \$335 for non-members. Also Feb. 23 in Chicago. FEI, 10 Madison Ave., P.O. Box 1938, Morristown, N.J. 07960; 201-898-4629.

FEB. 21. The Greenhouse Effect-Implications for Insurers conference in London, sponsored by the Insurance & Reinsurance Research Group Ltd.; 210 pounds (\$371.70). Insurance & Reinsurance Research Group Ltd., Bridge House, 181 Queen Victoria St., London, England EC4V 4DD; phone: 01-236-2175.

FEB. 21-24. Reinsurance Contract Wording seminar in Tarrytown, N.Y., sponsored by Robert W. Strain Seminars Inc.; \$1,445. Also Sept. 5-8. Robert W. Strain Seminars Inc., P.O. Box 1000, Wingdale, N.Y. 12594; 914-832-9384.

FEB. 22. Human Factors in Loss Control course in New York City, sponsored by The College of Insurance; \$195 for College sponsors; \$245 for non-sponsors. Professional Programs, The College of Insurance, 101 Murray St., New York, N.Y. 10007-2132; 212-962-4111.

FEB. 23. Managing Underground Storage Tanks in Illinois seminar in Rolling Meadows, Ill., sponsored by Gallagher Bassett Services Inc.'s Center for Risk Management Training; \$85 for center clients; \$110 for non-clients. Gallagher Bassett Services, 60 Gould Center, Rolling Meadows, Ill. 60008; 312-640-8555.

FEB. 23-24. Occupational Health Nursing Principles and Certification Review course in Denver, sponsored by Fireman's Fund Risk Management Services Inc.'s Occupational Health Consulting & Ergonomics division; \$295. Also March 9-10 in Cambridge, Mass.; and March 30-31 in Arlington, Va. Annette B. Haag, Occupational Health Consulting, Fireman's Fund Risk Management Services Inc., P.O. Box 777, Novato, Calif. 94998-9002; 415-899-2423.

FEB. 23-24. Transportation of Hazardous Materials/Waste course in Los Angeles, sponsored by the University of Southern California's Institute of Safety and Systems Management; \$100. Also March 20-21 in Sacramento, Calif., June 12-13 in Sacramento, Calif., and July 10 in Los Angeles. University of Southern California, Institute of Safety and Systems Management, Office of Extension and In-Service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 213-743-6383.

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FEB. 23-25. Qualified Plans, PCs and Welfare Benefits course in Phoenix, Ariz., sponsored by the American Law Institute-American Bar Assn. Committee on Continuing Professional Education; \$525 plus \$25 non-refundable processing fee. Registrar, ALI-ABA, 4025 Chestnut St., Philadelphia, Pa. 19104; 800-253-6397; 215-243-1661 within Pennsylvania.

FEB. 24. Surviving Chaos, Issues and Answers for Uncertain Times seminar in Phoenix, Ariz., sponsored by the Arizona Central Chapter of the Risk & Insurance Management Society; \$55 for RIMS members; \$65 for non-

members. James A. Brackney, Pinnacle Capital Corp., 502 S. Second Ave., Station 2352, Phoenix, Ariz. 85072-3999; 602-262-1053.

FEB. 24. Hot Topics: Section 89 in '89 Conference for Consultants and Plan Administrators in Dallas, sponsored by the Employers Council on Flexible Compensation; \$285 for ECFC members; \$335 for non-members. Employers Council on Flexible Compensation, 927 15th St. N.W., Suite 1000, Washington, D.C. 20005; 202-659-4300.

FEB. 26-28. 1989 HMO Policy Conference in Washington, D.C., sponsored by the Group Health Assn. of America; before Jan. 30: \$495 for GHAA members; \$595 for non-members, \$390 for government employees; after Jan. 30: \$580 for GHAA members, \$680 for non-members, \$390 for government employees. Group Health Assn. of America, 202-778-3228.

FEB. 27-28. Back Injury Prevention course in Los Angeles, sponsored by the University of Southern California's Institute of Safety and Systems Management; \$280. University of Southern California, Institute of Safety and Systems Management, Office of Extension and In-Service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 213-743-6383.

FEB. 27-MARCH 3. Government Risk Management Seminars: Basic Fundamentals, Quantitative Methods, Advanced Techniques and School Risk Management seminars in Tucson, Ariz., sponsored by the Public Risk Management Assn.; \$450 for PRIMA members; \$500 for non-members; \$50 discount for additional registrants from same organization. PRIMA GRM Seminars, 1120 G St. N.W., Suite 400, Washington, D.C. 20005; 202-626-4650.

FEB. 28-MARCH 1. Reinsurers' Perspective on Environmental Claims seminar in New York City, sponsored by Preston, Thorgrimson, Ellis & Holman; \$995; \$795 for second registrant from same company; \$595 for third registrant from same company; \$595 for training manual only. James Stirn, Preston, Thorgrimson, Ellis & Holman, 1735 New York Ave. N.W., Suite 500, Washington, D.C. 20006.

MARCH 7. Maximizing Coverage, Minimizing Costs workshop in Milwaukee, sponsored by the Society of Chartered Property & Casualty Underwriters; \$150 for Society of CPCU members; \$180 for non-members; early registration discount available. Also March 28 in Akron, Ohio. Mari Jennings, Society of CPCU, 720 Providence Road, CB#9, Malvern, Pa. 19355; 215-251-2735.

MARCH 7-9. The Oregon Governor's Occupational Safety and Health Conference—Accident Prevention: A Key to Oregon's Future in Portland, Ore., co-sponsored by the Accident Prevention Division of the Department of Insurance and Finance and the Columbia-Willamette Chapter of the American Society of Safety Engineers; \$50. Dianne Mekkers, Oregon Department of Insurance and Finance, 503-378-3272.

MARCH 8-10. Insurance Insolvency and Liquidation course in Honolulu, sponsored by The College of Insurance; \$895 for College sponsors; \$995 for non-sponsors. Also July 10-12 in Chicago. Professional Programs, The College of Insurance, 101 Murray St., New York, N.Y. 10007-2132; 212-962-4111.

MARCH 9. Strategies for Managing the Foreign Exchange Risk in Insurance conference in London, sponsored by the Insurance & Reinsurance Research Group Ltd.; 210 pounds (\$371.70) plus VAT. Insurance & Reinsurance Research Group Ltd., Bridge House, 181 Queen Victoria St., London, England EC4V 4DD; phone: 01-236-2175; fax: 01-489-1487.

MARCH 13-15. International Health Care Management Conference: Diagnosing and

Treating the Issues in Chicago, sponsored by the Corporate Benefits Institute of the International Foundation of Employee Benefit Plans; \$615 for IFEBP members; \$690 for non-members. International Foundation of Employee Benefit Plans, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

MARCH 14-15. Advanced Reinsurance Seminar in Dallas, sponsored by the University of Dallas' Reinsurance Management Institute; \$750 (includes meals). Bruce Evans, University of Dallas Graduate School of Management, 1845 E. Northgate Drive, Irving, Texas 75062-4799; 214-721-5360.

MARCH 15. AIDS in the Workplace seminar in Columbus, Ohio, sponsored by the Ohio Manufacturers' Assn.; \$105 for OMA members; \$140 for non-members. Ohio Manufacturers Assn., 33 N. High St., Columbus, Ohio. 43215.

MARCH 15-16. Dynamic Company Exposed: A Practical Forum on Insuring and Managing Exposure in Chicago, co-sponsored by the Risk Management, Underwriting, Claims, Agency Administration, Reinsurance, International Insurance and E/S/SL Sections of the Society of Chartered Property & Casualty Underwriters; \$175 for section members; \$185 for Society of CPCU members; \$225 for non-members. Mari Jennings, Society of CPCU, 720 Providence Road, Malvern, Pa. 19355; 215-251-2734.

MARCH 15-17. The Florida Symposium on Workers Compensation in Daytona Beach, Fla., sponsored by the National Symposium on Workers Compensation; before Feb 15: \$295; after Feb. 15: \$350. The Collyer Co., 716 S. Beach St., Ormond Beach, Fla. 32074; 904-672-4584.

APRIL 9-14. 27th Annual Risk Management

and Employee Benefits Conference in Atlanta, sponsored by the Risk & Insurance Management Society Inc.; full week: \$695 for members, \$795 for non-members; partial week: \$575 for members, \$675 for non-members; one-day registration: \$195 for members and non-members. Risk & Insurance Management Society Conference Department/Registration, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

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Retiree health care

Continued from page 1
health care liabilities.

The sudden increase in the number of employers estimating their future retiree health care liabilities is directly related to the Financial Accounting Standards Board's proposal to require companies to recognize their retiree health care liabilities and the cost of those liabilities on their financial statements, said Edward Winterbauer, a consulting actuary and Northeast retiree health care practice leader for Foster Higgins in Princeton, N.J.

"There are a lot of employers that are acting now as opposed to waiting" until the FASB rule takes effect, "just in case they need some plan changes," he said.

FASB is expected to release an exposure draft of the proposal this week. Based on previous FASB proposals, the exposure draft is expected to:

- Require companies to identify their retiree health care liabilities as a footnote to their balance sheets by the 1992 fiscal year. Companies then must gradually amortize this liability to the balance sheet, which could take as long as 15 years. However, companies by fiscal 1997 must show a minimum health care liability on

their balance sheets for all existing retirees and active employees eligible for retirement.

- Require companies to expense retiree health care liabilities on their financial statements using accrual accounting methods—rather than the "pay-as-you-go" method now used by nearly all companies—by fiscal 1992. This change could cut U.S. corporations' reported annual profits by billions of dollars, some suggest (BI, Oct. 17, 1988).

In addition to the 25% of surveyed employers that have already estimated future retiree health care liabilities, 23% more say they plan to estimate these liabilities before 1990, while 53% say they neither have determined their future liabilities nor plan to do so.

Interestingly, the Foster Higgins survey says more companies have forecast retiree health care plan liabilities than was reported in a survey by The Wyatt Co. released last month. The Wyatt survey reported that only 14% of employers with retiree medical plans had prepared actuarial valuations or forecasts to determine plan liabilities (BI, Jan. 9).

Foster Higgins' survey also reports that large companies are more likely to have assessed their future retiree health care liabilities than smaller firms (see chart,

page 1).

Only 11% of the companies with fewer than 500 workers have determined their liabilities, while only 7% plan to do so before 1990. The other 82% have no plans to determine their liabilities.

Meanwhile, 53% of the companies with 10,000 to 19,999 employees have determined future retiree health care liabilities, while 19% plan to do so before 1990. Only 28% have no plans to determine their liabilities.

The large number of employers that offer retiree health care benefits that do not plan to determine future liabilities is not surprising: 44% of the surveyed employers currently do not separate retiree health care costs from their active employees' health care costs, the Foster Higgins survey shows.

In addition, 84% of employers said they financed retiree health care benefits on a pay-as-you-go basis, while 9% said they pre-funded the costs and another 9% gave some other answer. The total equals more than 100% due to multiple responses.

Mr. Winterbauer said he was not surprised by the high percentage of companies that do not yet have a handle on their retiree health care costs and liabilities.

Many companies have not yet started to estimate their liabilities

because "FASB was unable to release an exposure draft in 1988," he said. "I would anticipate that with the release of the exposure draft within a few days, we will see more interest and activity in measuring liability in 1989 and 1990."

"There's clearly time to do the job, but there are a considerable number of employers out there that have a lot to do before the 1992 fiscal year," Mr. Winterbauer added. "With the 1992 effective date of the FASB proposal approaching, you will see a groundswell of interest in doing this."

To compile the survey, Foster Higgins polled 1,633 employers last August on a variety of health care benefit-related topics (BI, Feb. 6).

Those employers that do track retiree health care costs reported that health plan costs for retirees under age 65—excluding coverages like dental and vision care—averaged \$2,397 per retiree in 1988, or about 11% more than the average cost of medical care coverage—excluding coverages like dental and vision care—for all plan participants including retirees.

However, the average cost varied significantly by industry. For instance, insurance industry employers reported average plan costs for retirees under age 65 of \$2,795 per participant, while financial services employers reported plan costs of only \$1,774 per retiree under 65.

Health care plans costs for retirees over age 65, who are eligible for federal Medicare benefits, averaged \$1,372 per retiree, or 42.7% less than the cost for retirees under age 65.

The cost of retiree coverage accounts for an average of 13.7% of an employer's overall health care benefit costs, according to the survey. However, 15% of the employers surveyed reported that retiree health care costs accounted for 20% to 29.9% of all health care plan costs, while 12% said retiree costs accounted for 30% or more of total plan costs.

Of course, an employer with a large proportion of retirees compared with active employees will face higher health care plan costs.

For instance, employers that reported that only 1% to 9% of their health care plan participants were retirees reported average plan costs of \$2,211 per participant, while employers that reported that 10% to 19.9% of plan participants were retired reported average health plan costs of \$2,484 per participant.

Moreover, employers reporting that 20% to 29.9% of plan participants are retired reported average plan costs of \$2,676 per participant.

And, those employers whose health care plans are 30% or more composed of retirees reported average plan costs of \$3,209 per participant.

Overall, 62% of the employers surveyed by Foster Higgins offered health care coverage to retirees under age 65, while 55% offered coverage to retirees over age 65.

As noted above, the survey shows that larger employers are much more likely to provide retiree coverage than smaller organizations. Only 33% of employers with 500 or fewer workers provided health care coverage to retirees under age 65, compared with 97% of those with more than 40,000 workers. Likewise, only 29% of the employers with fewer than 500 workers provided benefits to Medicare-eligible retirees, compared with 91% of the employers with more than 40,000 employees.

Employers in certain industries also are more likely to provide retiree health care coverage. For instance, 98% of the utility industry employers and 94% of the energy/petroleum companies surveyed offered coverage to retirees under age 65, while only 28% of the com-

panies in the technical/professional services industry and 37% of health services employers offered benefits to retirees under age 65.

Sixty-eight percent of the employers in the South Atlantic region, which includes Florida, offered coverage to retirees under age 65, while 52% of New England-based employers offered coverage.

Of the employers that offer coverage to retirees under age 65, 84% offered the same coverage to retirees as offered to active employees. Four percent required higher deductibles and/or copayments from retirees compared with active employees, while 6% only offered retirees "core" medical benefits and not other coverages, like prescription drug and vision care benefits. Six percent offered retirees some other type of plan.

Thirty-eight percent of the employers offering coverage to retirees under age 65 pay the entire premium for retiree-only coverage. Twenty-five percent require the retirees to pay the entire premium, while 37% share the cost with retirees. Retirees pay an average of 57% of the premium in those plans that require contributions.

However, only 26% of the employers that provide coverage to retirees under age 65 pay the entire premium for dependent coverage, while 31% force retirees to pay the entire premium and 44% share the cost with retirees. Retirees pay an average of 58% of the premium in plans that require contributions.

Of the employers that offer coverage to retirees over 65 and, thus, eligible for Medicare, 47% pay the entire premium, 21% force retirees to pay the entire premium and 32% share premium costs with retirees. Retirees over 65 pay an average of 57% of the premium in those plans that require contributions.

But, only 34% of the employers offering coverage to retirees over 65 pay the entire cost of dependent coverage, while 29% ask the retirees to pay the entire cost while 37% share costs with retirees. Retirees pay an average of 61% of the premium in those plans that require retiree contributions.

Moreover, only 11% of employers pay all of retirees' Medicare Part B premiums, which cover physician services, while 6% pay part. The other 83% contribute nothing toward Part B premiums.

Of those providing coverage to Medicare-eligible retirees, 43% offer a "Medicare carve-out" plan, in which normal plan benefits are determined and then directly reduced by Medicare payments. Thirty-three percent coordinate retiree health care benefits with Medicare so that claimants can receive up to 100% coverage of expenses from Medicare and the employer-sponsored plan. Only 24% offer a Medicare supplement plan, which offers specific add-on benefits to Medicare.

Thirty-nine percent of the employers that offer retiree health care coverage have made some type of plan change in the last two years. Of those:

- 55% have increased retiree contributions toward the cost of the plan.
- 32% have decreased benefits.
- 18% have increased benefits.
- 10% have incorporated retiree health care benefits into a flexible benefit plan.
- 9% have redesigned their plan so that it offers only fixed-dollar benefits.
- 3% have terminated their retiree health care plan.

Copies of the "Health Care Benefits Survey: 1988" findings are available for \$25 from Pamela Blake, A. Foster Higgins & Co. Inc., 212 Carnegie Center, CN 5323, Princeton, N.J. 08543-5323. The complete survey report, including tables of responses and monthly reports, costs \$500.

Administrative costs lower among self-insurers: Study

Employers that self-insure their health care plans face smaller administrative expenses than employers that purchase insured plans, a survey shows.

Health care plan administrative expenses for self-insured employers total 5.2% of paid claims, while insured employers' administrative expenses total 6.6% of paid claims, according to the survey by A. Foster Higgins & Co. Inc.

Overall, surveyed employers reported that administrative expenses amounted to 5.7% of paid claims.

One reason for the difference in administrative expenses between self-insured and insured employers "may be that self-insured employers have more latitude in negotiating administration fees, while in fully insured plans the fee generally is built into the premium," the survey authors explain.

In addition, "the self-insured group is predominantly large employers, which receive discounted rates and benefit from economies of scale," the survey adds.

As reported earlier, the survey reveals that 48% of employers self-fund their health care plans, while 23% buy experience-rated insured plans; 15% purchase minimum premium plans, which combine aspects of self-insurance and conventional insurance; and 14% purchase non-experience-rated insured plans (BI, Jan. 30).

While almost half of the surveyed employers self-fund their health care benefits, few—only 7%—self-administer their programs. The total does not equal

100% because of multiple administrators for some plans.

Fifty-one percent of the employers said a commercial insurance company administered their plans, while 29% said a Blue Cross/Blue Shield plan handled plan administration, and 20% contracted with a third-party administrator.

The surveyed employers reported an average turnaround time of 15 workdays for routine claims, though 6% reported that routine claims took an average of more than 30 workdays to process. Claims requiring investigation took an average of 25 days to process, with 36% of employers responding that it took an average of more than 30 workdays to process these claims.

Employers reported that an average of 4% of claims were subject to processing errors, though 2% of employers reported an administrative error rate of more than 20%.

Coordination of benefits provisions save an average of 5.1% of paid claims, the survey reports.

The survey also reported on various issues concerning the health care coverage continuation provisions of the Consolidated Omnibus Budget Reconciliation Act.

For instance, an average of 16% of employees eligible for continued coverage under COBRA actually enrolled in coverage. However, 59% of employers said less than 10% of those eligible for COBRA coverage actually enrolled.

—By James M. Burcke

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Housing agency cover triggers litigation

By MICHAEL SCHACHNER

BOSTON—A surplus lines broker is suing two surplus lines insurers, their managing general agent and Marsh & McLennan Cos. Inc. over the placement of general liability insurance for scores of public housing authorities in New England.

The surplus lines broker, Boston-based Surplus Marketing Service Inc., is seeking \$3 million in damages under the Racketeer Influenced and Corrupt Organizations act, charging that the insurers illegally replaced it with M&M in March 1988 as the broker for the authorities.

Robert J. Power, president of Surplus Marketing, also alleges in a suit in U.S. District Court in Boston that defendants committed common law fraud and violations of Massachusetts' unfair competition and unfair or deceptive insurance acts.

The defendants are National Casualty Co. and Scottsdale Insurance Co., both affiliates of Columbus, Ohio-based Nationwide Mutual Insurance Co.; New York-based Danmar Associates Ltd., National's MGA; and Marsh & McLennan.

Damages against the defendants could be trebled to \$9 million under RICO if the court finds for Surplus Marketing.

But, in counterclaims, the insurers and Danmar claim that Surplus Marketing:

- Held onto premiums two months beyond the date it was required to forward them to Danmar.

- Attempted to place some housing authority coverage with an insurer unauthorized to write the business.

- Attempted to bill the housing authorities for coverage placed by Surplus Marketing after it had been removed from the account.

Meanwhile, an August 1987 suit filed against Surplus Marketing in Massachusetts State Superior Court by Danmar, National and Scottsdale charging Surplus Marketing with withholding excessive commissions has been stayed until the federal court case is resolved, lawyers involved in the litigation say.

In the state court suit, the insurers and Danmar charge that between June and August 1987 Mr. Power withheld \$145,000 of excess commissions. The suit says Mr. Power and Surplus Marketing withheld a 12% commission instead of the agreed-upon 7.5%.

The morass of litigation centers around the placement of general liability insurance for the New England Housing Authority, an umbrella organization of 135 federal housing authorities in Massachusetts, Maine, New Hampshire, Rhode Island, Vermont and Connecticut.

Under a single policy issued to the New England Housing Authority, Scottsdale writes \$1 million of occurrence-based general liability insurance for each of three federally funded housing authorities operated by the state of Maine in Old Town, Portland and Westbrook. National writes the same coverage for each of the remaining 132 federally funded housing authorities.

The insurance adviser in the Boston office of the U.S. Department of Housing and Urban Development arranged with Mr. Power in 1985 to develop the group program in an effort to help the housing authorities keep their general liability insurance costs down during the liability insurance crisis, according to Mr. Power.

Total premium for the coverage amounted to \$2.9 million for the 1987-88 policy year.

Many states did not prohibit group purchases of casualty coverage before the 1986 amendments to the Risk Retention Act, which allowed such purchases in most liability lines.

Surplus Marketing was named as the original broker when it won the account in a public bid in May 1985.

'When things were tough back in 1985, the account was ours,' says Robert J. Power. 'But, with \$500,000 in annual commissions available, this is quite obviously a case of the big guy becoming a bully in the school yard.'

It brokered the general liability coverage that National and Scottsdale wrote for the housing authorities for three one-year policy periods from June 1, 1985, through May 31, 1988.

In Surplus Marketing's May 1988 RICO lawsuit filed in U.S. District Court, the surplus lines broker claims that National and Scottsdale—both based in Scottsdale, Ariz.—illegally replaced Mr. Power and Surplus with M&M as the official broker for the account in March 1988 after fraudulently deceiving housing representatives into believing that Mr. Power and Surplus stole premiums, failed to conduct contractual duties and refused to place disputed premiums in an agreed-upon escrow account.

According to court papers, National and Scottsdale informed Danmar in a letter dated Feb. 9, 1988, that they no longer would use Surplus Marketing to broker the housing authorities' coverage because of the pending litigation in Massachusetts state court over the commissions that Surplus Marketing withheld for the 1987-88 policy renewals.

Surplus Marketing charges that on Feb. 26, 1988, Danmar informed a representative of the New England Housing Authority that Mr. Power and Surplus no longer would be recognized as the broker of record.

The letter also was sent to a representative of the Connecticut Housing Authority. The state-funded authority, which previously had acquired coverage as part of the federally funded housing authority group, decided to seek general liability coverage for the 1988-89 policy year separately, according to court papers. However, it sought the same limits and terms of coverage.

Danmar informed the housing authority officials that they had 15 days to respond with their choice of a new broker or that National and Scottsdale would appoint a broker for the account, according to copies of the letters included in court documents.

The insurers later appointed M&M as broker.

But, in an interview, Mr. Power said that Surplus had a written "open-ended contract" with the housing authorities until National and Scottsdale canceled the policy. Moreover, if National and Scottsdale did cancel, Surplus Marketing would have the opportunity to place the authorities' general liability coverage with another insurer, he said.

Mr. Power conceded that the open-ended contract is uncommon in the industry. "That's where my expertise came in," he said. "I convinced the insurers to take it, and I convinced the insureds to accept it, too. There's no doubt in my mind that the policy would have gone on for 10 or 20 years."

Robert W. Mahoney, an attorney with the Boston firm of Hale & Dorr, which represents National, Scottsdale and M&M, said he knew of "no law" supporting Mr. Power's claim of an open-ended contract.

Mr. Power will face a "heavy burden" establishing the terms of the open-ended contract, Mr. Mahoney said. "It is certainly something that we'll challenge in court."

Mr. Power insists that neither the New England Housing Authority nor the Connecticut authority requested a new broker.

Surplus Marketing claims that Danmar, National and Scottsdale did not have the right to force the housing authorities to change brokers and that the defendants' "intentional and

fraudulent misrepresentations by mail and the inducement of fear of economic harm in the insured entities caused Surplus lost income of at least \$3 million" and as much as \$10 million in future income due to the nature of the open-ended contract.

The lawsuit claims that the defendants' actions damaged the surplus lines broker's reputation and caused Surplus Marketing and Mr. Power to lose a substantial amount of current and future income and valuable clients.

"When things were tough back in 1985, the account was ours," said Mr. Power in an interview, referring to the hard property/casualty insurance market. "But, with \$500,000 in annual commissions available, this is quite obviously a case of the big guy becoming a bully in the school yard."

In counterclaims filed in September and October last year, National, Scottsdale and Danmar charge Mr. Power and Surplus Marketing with conversion and misappropriations of premium between May 1987 and August 1987 and demand that Surplus Marketing and Mr. Power account for the premiums.

Among other things, the counterclaims allege that Mr. Power and Surplus Marketing intentionally withheld until late August 1987 about \$2.9 million of premiums that were to be paid to National and Scottsdale through Danmar by July 1, 1987.

The suit charges that Surplus Marketing instead tried to place general liability coverage for the Connecticut and New England authorities with Manchester, N.H.-based New Hampshire Insurance Co., a subsidiary of the American International Group Inc. of New York.

The suit claims that Surplus Marketing was not authorized to place the coverage with New Hampshire because National and Scottsdale won the right to write the coverage in a public bid and because the U.S. Department of Housing and Urban Development had not authorized the surplus lines broker to place the coverage with any other insurer.

The Connecticut Housing Authority paid a \$689,730 premium due on the 1987-88 National policy to Surplus Marketing, according to the counterclaims.

Both counterclaims state that Surplus Marketing then forwarded the premium, minus a 10% commission,

to New Hampshire although the broker knew that the Connecticut Housing Authority had not authorized Surplus Marketing to use other insurers.

The Connecticut Housing Authority subsequently confirmed in a letter to New Hampshire on Oct. 26, 1987, that it had not given Mr. Power the authority to place the coverage with New Hampshire. On March 10, 1988, the attorney general of Connecticut also confirmed in a letter to New Hampshire that the coverage was to be placed with National and that Surplus Marketing was not authorized to place the coverage with New Hampshire.

In December 1987, having been informed that National intended to initiate litigation to obtain the \$620,757 in premiums, New Hampshire forwarded it to National.

Lawyers for New Hampshire said it was company policy to refrain from commenting on cases in litigation.

The countersuits also claim that Mr. Power attempted to place the New England Housing Authority's coverage with New Hampshire after National and Scottsdale won a public bid for the coverage for the 1987-88 policy year.

Mr. Power claims he approached New Hampshire after National refused to bind the coverage. Mr. Power said he tried to place the coverage with National through Boston MGA, Swartz & Corcoran Insurance Agency Inc.

National would not talk with Mr. Power and refused to meet with him, according to Mr. Power.

The Boston HUD office, which oversees the New England Housing Authority but is not a named insured, confirmed on July 24, 1987, that Surplus Marketing tried to place coverage for various New England public housing agencies with New Hampshire but directed Mr. Power to forward all premiums for the 1987-88 policy year to Danmar.

"I think it is important that both Mr. Power and New Hampshire realized what they did and forwarded the premium" to Danmar, said Mr. Mahoney, the attorney for National, Scottsdale and M&M.

The counterclaims also allege that for the 1987-88 policy year, Surplus Marketing and Mr. Power failed to forward to Danmar by July 1, 1987, any of the \$2.9 million of premiums from the housing authorities.

"This was the third year of the account," Mr. Power said in the interview. "As a practical matter, it is impossible to collect from (135) sources in 30 days."

Mr. Power also said that the previous year's payment was made in December. "They only brought the 30 days into account after I filed the lawsuit," he said.

On Aug. 27, 1987, Surplus Marketing sent National and Scottsdale a check in the amount of \$2.5 million, which Surplus Marketing claimed to be the total amount of premiums collected on behalf of the two insurers, minus commissions.

The counterclaims also allege that Surplus Marketing sent invoices to housing authorities in an effort to misappropriate and wrongfully convert the premiums due for 1988-89 after the broker was removed from the account. The counterclaims say Surplus Marketing and Mr. Power have wrongfully received and retained in excess of \$100,000 in premiums for the 1988-89 coverage written by National and Scottsdale.

Mr. Power explained that Surplus Marketing was unaware that M&M had been named the new broker.

"Had I known Marsh was issuing bills, I never would have sent the bills," Mr. Power said in the interview.

Other charges against Surplus Marketing in the counterclaims allege that Surplus Marketing and Mr. Power:

- Failed to conduct their duties of completely listing the housing authorities insured under 1987 policies. National and Scottsdale claim this left them unable to confirm whether all entities seeking coverage were eligible, whether all premiums were paid and whether additional premiums were due from housing authorities with increased or modified units.

Mr. Power called these allegations "blatant lies."

- Altered the declaration page on the 1988-89 National policies by substituting Surplus's name and address for that of Danmar's in the area designated "Agent Name and Address."

Mr. Power explained in the interview that he received the policies from National for distribution to the housing authorities and Danmar instructed him to put Surplus' name in the box designating the agent.

Mr. Power said he collected \$230,000 in premiums from six insureds before he became aware that M&M was billing the same policyholders. He said he has since forwarded the premiums to the insurers.

Robert F. Muse, a lawyer with the Boston firm of Muse & Muse, representing Surplus and Mr. Power, declined to comment on the case.

Danmar's attorney, Thomas Santory of the Boston firm Goulston & Storrs, said his client's pleadings speak for themselves and he declined to comment further.

Attorneys for Mr. Power and Surplus have brought the case to the attention of the Massachusetts Insurance Department. The department has issued a letter saying it will wait until the litigation is complete before it looks into the matter.

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Vice-presidents, directors, managers, and other related department personnel of insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations 10,994
Sub-total 24,719
Associations 477
Government, Unions and Educational Institutions 979
Commercial Consumers
Sub-total 26,175
Insurance Agents and Brokers 10,557
Insurance Companies 7,380
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First State arbitration

Continued from page 3

all of the issues in dispute. However, Mr. Warrender did not comment further on the ruling.

First State, a Boston-based unit of Hartford Fire Insurance Co., did not attempt to void the policy. However, it refused to reimburse the syndicate for, among other things, reinsurance recoveries that could not be collected by the syndicate from other reinsurers.

The dispute was a "technical issue over whether First State should pay the syndicate's losses net or gross," said a spokesman for First State.

First State also argued that the runoff reinsurance policy should not respond to settlements that syndicate 56 made as a member of the now-shuttered Asbestos Claims Facility that reflect amounts actually owed by insurers that were not members of the facility.

The facility was created in 1985 with the signing of the Wellington Agreement by 34 asbestos producers and 16 of their insurers—including Lloyd's underwriters—to resolve asbestos claims more efficiently.

According to the syndicate's annual report published last year, the arbitration proceedings with First State concerned the "admissibility of claims in respect of Asbestos Claims Facility surcharges and gaps, and the credit that should be allowed to (First State) for specific reinsurance recoveries not yet received by the syndicate."

The syndicate accounts state that in 1974 "the syndicate effected an unlimited reinsurance policy on all business attaching to the 1971 and prior underwriting accounts" with First State.

According to the annual report, the syndicate paid a premium of \$1.88 million in December 1974 for the unlimited runoff policy, which covered its liabilities stemming from the 1971 underwriting year that exceeded \$11.75 million.

Cash recoveries received so far under the policy by the

The First State settlement is of 'substantial benefit to the syndicate and a great relief to syndicate members,' says one Lloyd's members' agent, who did not wish to be named.

syndicate total more than \$11 million. Anticipated recoveries under the policy total 21.33 million pounds (\$37.1 million), according to the report for the year ended Dec. 31, 1987.

However, "no provision has been included... for net claims incurred but not reported in respect of the 1971 and previous years of account as these are wholly reinsured with The First State Insurance Co.," the syndicate's report states.

According to a First State spokesman, the arbitration decision involved a small proportion of the total amount of claims payable under the policy.

"The actual award in terms of a direction to pay was very small—no more than \$1.5 million," he said.

However, the decision relates only to claims filed by the syndicate against First State prior to Dec. 31, 1985. Subsequent claims could total tens of millions of dollars, some sources say.

"To the extent that the arbitrators considered matters (at) issue, it will result in First State being required to pay very substantial runoff costs to the syndicate over the next 20 years," said a syndicate spokesman.

The settlement is of "substantial benefit to the syndicate and a great relief to syndicate members," said one members' agent, who did not wish to be named.

However, "damages into the future based on losses going back to the 1950s are speculative at the moment, and we believe we are adequately reserved," the First State spokes-

man said.

The decision also will be of interest to many other insurers and reinsurers, though it is a private arbitration and, as such, sets no legal precedent.

For example, several other Lloyd's syndicates also have similar runoff reinsurance policies with First State and were awaiting the outcome of the arbitration, sources say.

The First State spokesman confirmed that the company wrote other similar runoff policies for Lloyd's syndicates but added that no other policies were in arbitration.

Many other insurer members of the Asbestos Claims Facility and their reinsurers also are disputing the extent to which reinsurers should be held liable for claims settled through the facility (BI, Nov. 16, 1987).

Additional rulings of this kind could further aggravate severe cash-flow problems already faced by several runoff reinsurers.

Some reinsurers have been hesitant to pay asbestos-related claims, arguing that ceding companies did not adequately document the underlying policies and the resulting claims.

If a ceding insurer or reinsurer, like syndicate 56, can successfully argue that its runoff reinsurer must pay claims that other reinsurers either cannot or will not pay, the liability of runoff reinsurers will undoubtedly increase.

However, the success of any argument depends on the wording of each particular runoff reinsurance contract, lawyers say.

For example, some of the runoff reinsurance policies written by Lloyd's of London underwriter Richard Outhwaite during the early 1980s do allow policyholders to claim interim payments in case of slow payments from reinsurers, while others do not (BI, Jan. 25, 1988).

However, R.H.M. Outhwaite (Underwriting Agencies) Ltd. is denying liability under the runoff policies in cases where the ceding companies' reinsurers refuse to pay claims, even though it has admitted that some policyholders may interpret their policies to provide for uncollectible reinsurance.

Lloyd's seeks review of bonds' tax status

By CAROLYN ALDRED and STACY SHAPIRO

London

LONDON—More than 30 Lloyd's of London underwriting agents are seeking a judicial review of a ruling by Britain's Inland Revenue that could cost them tens of millions of pounds in additional taxes, Lloyd's Chief Executive Alan Lord confirmed.

Between 30 and 40 agents have applied to the London High Court for a judicial review of an Inland Revenue decision that would tax the redemption profit of U.S. Student Loan Marketing Assn. investment bonds as revenues rather than as a capital gain, said Mr. Lord.

The Inland Revenue move would cost syndicates at Lloyd's, which placed much of their investments in Sallie Maes, at least 15 million pounds (\$28.2 million at applicable rate) for the 1985 underwriting year, which closed in 1987 under Lloyd's three-year accounting system.

The agents also will have to make additional reserves for increased tax demands in 1986 and more recent years.

If the underwriting agents lose their battle with the tax authority, members of Lloyd's during 1985 will be asked to contribute to the additional tax bill because most Lloyd's syndicates already have closed their 1985 accounts without allowing for the additional tax payment.

Concern over the possible change in the Inland Revenue's tax treatment of the bonds was raised last year (BI, March 14, 1988).

Enchova rig disaster

Lloyd's of London's declaration that the loss of a Brazilian oil drilling platform should be accounted for in the 1986 underwriting year has at least one marine syndicate up in arms.

The \$330 million loss of the Enchova drilling platform in April 1988, off the coast of Brazil, is being accounted for in the 1986 underwriting year, which closed Dec. 31, 1988, under Lloyd's three-year accounting system.

Many underwriters had expected the loss—1988's second-largest oil rig loss—to be accounted for in 1987 results, because the rig's 24-month policy was placed on Sept. 1, 1987. However, Lloyd's Claims Office and underwriters leading the risk decided that the loss will go into the 1986 underwriting year because that is when Lloyd's Policy Signing Office received the premium.

The decision to place the Enchova loss in the 1986 underwriting year came as a blow to some Lloyd's syndicates, which are expected to show banner profits for the 1986 underwriting year.

In fact, Chatset Ltd., which compiles Lloyd's League Tables of syndicates' financial results, suggests that Lloyd's will show a gross profit of 1 billion pounds (\$1.81

billion) in 1986, compared with 557 million pounds (\$1.05 billion) in profits in 1985, before syndicate runoff and open year accounts are included.

Retired Lloyd's underwriter Norman T. Evennett, chairman of Lloyd's underwriting agency N.T. Evennett & Partners Ltd., opposes assigning the Enchova loss in the 1986 underwriting year.

According to a Jan. 16 interim letter sent to members of syndicate 658/9 by Mr. Evennett and the syndicate's underwriter, P.C. Tebbutt, meetings were held with the leading underwriters of the Enchova platform, other Lloyd's underwriters and the technical adviser of Lloyd's Underwriters Assn. to move the loss into the 1987 account.

"I believe (1987 is where) it correctly belongs," Mr. Tebbutt said.

However, the Lloyd's Policy Signing Office Committee recently affirmed that the loss is correctly placed in the 1986 account.

"We remain firmly of the opinion that this is not so," said Mr. Tebbutt. "This situation was, unfortunately confirmed—in my view wrongly—by underwriting agreement at the leader's box and further initially condoned by all underwriters, including ours. The matter was only questioned on enquiry by me, such enquiries taking much time and effort but, alas, without achieving a positive result," said Mr. Evennett.

As a result of the decision, the syndicate's underwriting profit will be lowered by 940,000 pounds (\$1.7 million) for 1986, although "a modest underwriting profit should ensue," said Mr. Tebbutt.

The syndicate still expects to show an underwriting loss in 1987, the year in which the \$1.4 billion Piper Alpha drilling rig loss is assigned, he noted.

Accounts moving

Lloyd's of London brokerage group Sedgwick Group P.L.C. has lost four U.K.-based accounts to C.T. Bowring & Co. Ltd. since Christmas.

Hamish Ritchie, chairman of Bowring's U.K. division, confirmed that Bowring is now broker for the entire property/casualty insurance programs of Britain's largest pharmacy chain, Boots the Chemist Ltd.; newspaper distributor Menzies; British Railways; and Amalgamated Metal Corp.

The accounts produce total brokerage revenues "in excess of 500,000 pounds," said Mr. Ritchie.

Although he said he was "delighted" with the new accounts, Mr. Ritchie pointed out that this was not necessarily a bad reflection on Sedgwick because accounts change brokers all the time.

All of the accounts moved for different reasons, he noted.

Sedgwick also clarified the loss of the accounts. A spokeswoman explained that Bowring already had a major portion of the Boots account; Sedgwick still has an "ongoing relationship" with British Rail; Menzies followed its U.S. subsidiary in moving to Bowring; and Sedgwick only brokered a small proportion of the AMC account.

"Business is moving faster between brokers than ever before," she said. "We have had a consolidated move on a large number of our accounts and a substantial gain overall on our multinational accounts in 1988."

Reports say that Sedgwick recently became the sole broker for Unilever P.L.C. after four brokers bid for the account, but Sedgwick would not comment.

Meanwhile, Michael Rosen, the Bowring executive in charge of brokering accounts, has been appointed finance director of C.T. Bowring Reinsurance Ltd. following the resignation of Keith Salway, who left to join the London law firm of Clifford Chance.

Minet divests broker

London broker Minet Holdings P.L.C. is selling its 50.1% shareholding in a South African subsidiary company, Minet Insurance Brokers South Africa Propriety Ltd.

The decision to cut shareholding ties with the South African broker was made by Minet's U.S. parent company, The St. Paul Cos. Inc., and follows substantial divestment of South African interests by many U.S. companies, said Christopher Keays, deputy chairman of Minet in London.

As a result of the sale, South African banking company Nedbank Group Ltd. will increase its stake in the company from about 40% to about 75% through Syfrets Trust Ltd., a Nedbank subsidiary.

And employees of the South African brokerage will increase their shareholding to 25% from 10%, said Mr. Keays.

Rates continue to dive

Marine and aviation underwriters are continuing to slash rates despite last year's "appalling" insurance losses, according to the chairman of the Institute of London Underwriters.

A worldwide surplus of insurance is causing direct rates to continue falling to a point where marine and aviation underwriters likely will make an underwriting loss this year, said ILU Chairman John Parton.

The ILU consists of marine and aviation underwriters from the London market.

The London marine market bore the brunt

of 1988's catalog of huge losses, including the destruction of the Piper Alpha North Sea oil rig, with total insurance claims estimated to reach \$1.4 billion, and the explosion of the Brazilian Enchova oil rig, which cost insurers \$325 million "at a time of unbelievable reductions in ratings," said Mr. Parton.

London marine underwriters are reluctant to raise rates for fear of losing business to competitive overseas markets such as Japan, Scandinavia and the United States, he said.

Comings & goings

A.A.M. Pinset has been appointed chairman and managing director of Leslie & Godwin Ltd. to replace Robert Topple, who has retired. Mr. Topple, however, will remain chairman of Frank B. Hall Holdings Ltd.

Adrian Underwood has been promoted to underwriter for non-marine syndicate 529, managed by Sterling Underwriting Agencies, a subsidiary of Donner Underwriting Agencies Ltd. Mr. Underwood, who previously was deputy underwriter, replaces Edward Cowen, who was dismissed by the underwriting agency, which cited a breakdown in "trust and confidence between the company and Edward Cowen."

Colin Bryan has been appointed a director of Lloyd's of London broker Nicholson Chamberlain & Colls Ltd. Mr. Bryan is chairman of Nicholson Chamberlain & Colls (Reinsurance Brokers) Ltd., a new subsidiary specializing in non-marine reinsurance.

William M. Man has been appointed chairman and chief executive of London Insurance Brokers Ltd., which is jointly owned by C.T. Bowring & Co. Ltd. and Minet International Professional Indemnity Ltd.

Jonathan Ignarski, Paul Neagle, Nicholas Sansom and John Nicholls have been appointed directors of Through Transport Mutual Services Ltd.

Paul Dingli has been appointed deputy chairman and Martin Greensted has been appointed a director of Sedgwick U.K. (London) Ltd.

John Gordon has been appointed chairman of Sedgwick Lloyd's Underwriting Agents Ltd., succeeding Carel Mosselmans who is retiring in April.

Chris Trickett has been appointed a director of Sedgwick Associated Risks Ltd., and John Garwood has been appointed a director of Sedgwick Offshore Resources Ltd.

Chris Brown, William Calder, Ian Denham, Jeremy Hutchinson, Guy Northam and John Russell have been appointed directors of Price Forbes Ltd.

David Johnstone has been appointed general manager of Transglobe Underwriting Management (Guernsey) Ltd. Mr. Johnstone joined Transglobe in 1982 as an accountant in the captive management division.

ABA proposal

Continued from page 1

McCarran-Ferguson, according to Mr. Hunter. However, the ABA endorsement is one of the more important yet, he said.

"The ABA is a very influential lobbyist," said Mr. Hunter. "They are smart, big and everywhere."

However, representatives of some of the nation's major insurance industry trade associations criticized the ABA's proposals, saying the recommendations will serve only to weaken state regulation of the insurance industry without alleviating insurance problems.

The 447-member ABA House of Delegates, meeting last week in Denver, passionately debated the proposals for nearly two hours, as if they were making law rather than only recommending changes to Congress.

Members of ABA sections on Antitrust Law and on Tort and Insurance Practice urged the House of Delegates to reject the proposal to repeal McCarran-Ferguson, while representatives of the Commission to Improve the Liability Insurance System, which drafted the proposal, urged acceptance.

Meanwhile, others urged the House of Delegates to simply defer action on the issue until it can be studied further.

The commission's original proposal suggested that the ABA recommend that Congress repeal McCarran-Ferguson and also adopt new legislation providing safe harbors for cooperative activity by insurers.

Among the cooperative acts in which insurers would be allowed to engage are the collection and dissemination of past loss experience data and joint underwriting agreements "so long as those activities actually enhance competition."

However, the proposal said insurers should be banned from cooperating in the development of advisory rates and the projection of future loss trends.

The House of Delegates amended the proposal to change the words "actually enhance competition" to "do not unreasonably restrain competition in the industry."

James T. Halverson, a delegate from the ABA Antitrust Law Section, said the amended language is the language used in the Sherman Antitrust Act.

Furthermore, under the amended language passed by the delegates, insurers would simply have to show that cooperative activities do not impede competition rather than having to show that these activities promote competition, said Mr. Halverson, who is with Shearman & Sterling in New York.

However, the amendments did not tone down the at-times heated debate.

Harvey S. Perlman, dean of the University of Nebraska College of Law, maintained that insurers' limited exemption from antitrust laws is "no longer necessary or desirable."

"The insurance industry should be subject to the same antitrust laws as every other company," agreed John C. Coughenour, a U.S. district judge for the Western Dis-

trict of Washington in Seattle and a member of the commission.

However, Lowell Beck, president of the National Assn. of Independent Insurers in Des Plaines, Ill., countered by arguing that "few industries are as competitive as the U.S. insurance industry."

Simply because there is a perception that McCarran-Ferguson encourages collusion among insurers is not a justification for repealing the law, said Mr. Beck, who also was a member of the commission and dissented from its recommendation to repeal McCarran-Ferguson.

Furthermore, small insurance companies would be the companies most severely hurt by repeal of the law, he said.

"The commission suffered from the delusion that McCarran is about antitrust; it is about state vs. federal regulation of the insurance industry," said Spencer Kimball, executive vp of the Chicago-based American Bar Foundation, which is the legal research arm of the ABA.

The proposal "will be used as an unqualified endorsement of a shift in power from the states to the federal government," said Mr. Kimball, who is a professor at the University of Chicago College of Law.

Bob Sayler, an attorney with Covington & Burling in Washington, D.C., criticized the commission's proposal saying the panel "lacks a factual basis" upon which to make its recommendations.

And, the so-called safe harbors recommended by the ABA are "totally illusory," said Mr. Sayler, who represents Allstate Insurance Co. of Northbrook, Ill.

Before voting to approve the commission's modified proposal, members of the House of Delegates voted down attempts to defer the issue.

The most notable attempt to defer was a proposal by the ABA's Tort and Insurance Practice Section to establish a national commission "to determine whether there is a need for the enactment of legislation to modify the McCarran-Ferguson Act."

"If we are going to change a law that affects an entire industry, indeed affects the entire country, we must go slowly," said T. Richard Kennedy of Werner, Kennedy & French in New York.

However, Mr. Halverson said this alternative proposal was, "simply put, another attempt to defer this at a time when Congress is considering repealing McCarran-Ferguson."

Establishing another commission to study McCarran-Ferguson will render the ABA "irrelevant to the process," he said.

Although the ABA House of Delegates left virtually intact the commission's recommendation to repeal McCarran-Ferguson, it did water down the commission's recommendation that an agency with subpoena powers should investigate whether "insurers participated in illegal collusive activity and, if so, the extent to which such activity may have contributed to problems of insurance availability and cost."

Many critics of the commission's proposal said the commission seemed to prejudice the guilt of the

Limit federal suits: Rehnquist

DENVER—Congress must limit access to the federal courts because the system is overloaded, asserts Supreme Court Chief Justice William Rehnquist.

"We must think not about creating new federal causes of action, but of remitting to state courts some of the business now handled by federal courts," Chief Justice Rehnquist told members of the American Bar Assn. at their midyear convention in Denver last week.

"We can't reasonably expect more work out of the judges themselves. We are doing our best with computerization; we are taking advantage of additional judicial personnel such as magistrates and bankruptcy judges which Congress has authorized; and we are pretty much at the limit of the number of law clerks we may have without converting the job from a judicial task into an administrative task," the chief justice explained.

The solution is to limit the types of lawsuits that can be brought in federal courts, he said.

Specifically, Chief Justice Rehnquist suggested that Congress limit the number of cases that may be filed in federal court because the parties reside in different states rather than because their dispute involves federal law. These cases, known as diversity cases, are among the most common federal court cases.

The chief justice also urged Congress to limit the number of lawsuits alleging violations of the Racketeer Influenced and Corrupt Organizations act heard in federal courts. RICO charges often are included in business fraud suits because they can yield treble damages to successful plaintiffs.

In addition, Chief Justice Rehnquist said personal injury lawsuits filed by railroad and maritime workers in federal courts under two federal laws could be handled by state courts.

And, he suggested that lawsuits alleging wrongful denial of Social Security benefits bypass U.S. district courts and go directly to federal courts of appeals, since the losing side in these cases has the automatic right to appeal.

"There is virtually no unused capacity in the system as it presently exists," Chief Justice Rehnquist said.

"In short, the federal court system is like a city in the arid Southwest part of this country, which is using every bit of its water system to supply current needs. We must think not of building new subdivisions, but of conserving water. More accurately, we must think of conserving water and cutting down on some present uses of water because we know that some new subdivision will inevitably be built."

—By Stacy Adler

insurance industry by using such perjorative language.

As a result, the House of Delegates voted to accept an amendment to the original proposal that softens the language to read: "Because of the high level of public concern, an inquiry (rather than an investigation) should be conducted by a special commission or agency or tribunal having full discovery and subpoena powers to determine whether insurers participate or have participated in undesirable activity and, if so, the extent to which such activity may contribute or has contributed to problems of insurance availability and cost."

In addition, the amended proposal says this question might be answered by the antitrust litigation against insurance industry defendants brought by 19 states' attorneys general, if the litigation is brought to judgment (BI, Sept. 26, 1988; Sept. 12, 1988; March 28, 1988).

"It is our view that if that case is tried and judgment is rendered, it would satisfy this recommendation," said Mr. Kennedy of the Tort and Insurance Practice Section.

After the amendment was adopted, other members of the House of Delegates attempted to defer action on this issue, saying an ABA recommendation might prejudice the pending antitrust litigation. However, these attempts to sidestep the issue were thwarted.

The remaining portions of the commission's December report were passed by the House of Delegates without much hoopla.

The ABA House of Delegates voted to recommend that:

- Additional data be gathered from insurers and through the court system to document the costs and the benefits of the tort system, including the effect of the system on the cost and availability of insurance, on loss reduction and on compensation of injured victims.

Originally the commission wanted laws pertaining to data collection to be drafted by the

Conference of Commissioners on Uniform State Laws; however, the House of Delegates amended this proposal to include consultation with the state insurance commissioners.

- States require plain-language explanations of claims-made policy forms and prohibit insurers from including defense costs within policy limits except when the policyholder agrees to assume both some costs of the defense and a role in control of the defense.

- States permit midterm cancellations of liability insurance policies only under specific conditions and require reasonable notice and a statement of reasons for cancellation or non-renewal.

- Congress overhaul the 1986 amendments to the Risk Retention Act to clarify uncertainties that are impeding growth of risk retention and risk purchasing groups.

- State regulators closely monitor current experiments with "flex rating" plans to determine whether they can fulfill their promise to provide a measure of price stability without unduly restraining competition.

Insurance industry observers last week blasted the House of Delegates' decision to rubber-stamp the commission's proposals, especially the recommendation to repeal McCarran-Ferguson.

"The American Bar Assn.'s decision to support repeal of the insurance industry's limited federal antitrust immunity is illogical and unsubstantiated by fact, and serves only to breed more litigation," said Franklin W. Nutter, president of the Alliance of American Insurers in Schaumburg, Ill.

"The vote demonstrates that the ABA does not understand either the regulation of insurance or the issues involved when it illogically calls for both increased competition and increased price controls," he said.

Craig Berrington, general counsel for the American Insurance Assn. in Washington, D.C., said:

"While professing to support state regulation, the commission's recommendation would place a straitjacket on state insurance regulators. The states no longer would be authorized to determine the regulatory framework that best meet their needs."

"Moreover, it is clear that the commission's McCarran-Ferguson recommendations would do nothing to alleviate the availability and affordability problems in the marketplace," said Mr. Berrington.

"The commission determined that legislative changes were appropriate because of 'public perception' that change was necessary," he said. "Public policy changes, however, should not be based on unfounded perceptions or symbolic notions."

Mr. Beck of the NAII said the ABA "made the mistake of thinking that there is a political fix to what is really a national social problem."

However, he said the insurance industry has lost only a battle, "not the war."

"The real fight goes to Congress now where we will have to convince members that repealing McCarran will reduce competition and availability and raise prices for the consumer," said Mr. Beck.

"McCarran-Ferguson is being scapegoated as the cause of the insurance availability and affordability crisis," said RIMS' Mr. Harkavy.

Legislators will be "sorely disappointed" when these changes do not end the problems in the insurance industry, he said.

"The ABA ignores the changes in the civil justice system that may have contributed to the liability crisis," said Mr. Harkavy.

He added that RIMS' biggest fear is that if McCarran-Ferguson is repealed and the Insurance Services Office is no longer allowed to promulgate advisory rates, states will establish mandatory rates.

"This would just be substituting one monster for another," said Mr. Harkavy. ■

RIMS, others file brief in punitive damages case

WASHINGTON—A group of business associations, including the Risk & Insurance Management Society Inc., have filed an amicus curiae brief with the U.S. Supreme Court that maintains that certain punitive damage awards are unconstitutional.

The brief was filed in the case of *Browning-Ferris Industries of Vermont Inc. and Browning-Ferris Industries Inc. vs. Kelco Disposal Inc. and Joseph Kelley*.

At issue in the case is whether a \$6 million punitive damage award against Browning-Ferris for allegedly attempting to monopolize the waste disposal market in Burlington, Vt., violated a constitutional prohibition against excessive fines (BI, Dec. 12, 1988).

The \$6 million in punitive damages is more than 100 times the \$51,146 in compensatory damages awarded by a federal court jury in 1987.

In addition to RIMS, groups that filed the amicus curiae brief include the U.S. Chamber of Commerce, the National Assn. of Manufacturers, the Business Roundtable and the Product Liability Alliance.

"The punitive damages judgment in this case vastly exceeds every legislatively established penalty, civil or criminal, for any form of non-violent wrongful conduct in the State of Vermont, and for every legislatively established punitive damages award for the identical conduct—predatory pricing—in every state in the nation with a specified punitive

damages award for that type of conduct," the brief from RIMS states.

"Empirical data show that the standardless punitive damages systems . . . selectively (aimed) at corporations and other 'deep pockets' have had drastically deleterious effects on the range of products made available to further the health, comfort and productivity available to the American public, and on the ability of manufacturers equitably to settle other claims," according to the brief.

Therefore, the U.S. 2nd Circuit Court of Appeals ruling affirming a district court's punitive damages judgment should be reversed, advised the brief.

—By Deborah Shalowitz

Guaranty fund

Continued from page 1

casualty insurers admitted in Connecticut and delaying payments to other Connecticut claimants.

The Connecticut Legislature in 1987 adopted the NAIC amendments in its guaranty fund, including the \$50 million net worth limitation. However, the amendments came too late to affect the Raymark and Union Carbide claims.

CIGA filed suit against Trumbull-based Raymark in Hartford Superior Court in 1986, seeking a declaratory judgment of its obligations to cover asbestos-related claims against the company.

As of January 1988, Raymark—a successor company to asbestos producer Raybestos-Manhattan Inc.—had been hit with 59,817 claims, of which 27,741 had been settled and 32,976 were still pending, according to court filings.

Claims continue to be filed against the company at a rate of about 1,000 per month, and the cost of settling an average claim is \$5,000, court papers say.

While Raymark had a total of \$393 million in liability insurance limits available to pay asbestos claims, the only coverage remaining consists of three excess policies with \$30 million in aggregate limits and whatever the company is able to collect from CIGA on its Transit policies, court papers say.

The six Transit policies, in force between 1979 and 1982, provided total limits of \$32 million.

In court papers filed last September supporting a motion for summary judgment, CIGA argued that its potential liabilities to Raymark and Union Carbide would severely strain its resources and that CIGA's liabilities should therefore be strictly limited.

While CIGA assessed insurers in the state a total of \$13.2 million between 1971 and 1985, assessments for 1986 alone amounted to \$22.8 million as the number of insurer insolvencies rose, court papers note.

Manville trust

Continued from page 2

the trust estimated that claimants would receive settlements averaging \$25,000 each. However, to date, the trust's settlements have averaged \$36,500.

Ms. Smith explained that a couple of factors account for the higher-than-anticipated settlement amounts.

For instance, the trust has begun paying the most expensive types of claims first, such as those that seek damages from Manville only, and those involving shipyard workers, whose claims are much more serious than other claimants'.

In the future, the trust will pay many more claims by claimants who are not as severely injured as the shipyard workers, Ms. Smith said. As a result, the average settlement amount almost certainly will decrease, she said.

"Everybody in the business expects the value of the claims to drop," Ms. Smith said. "I am confident that in the end the average settlement will be less than it is now."

But, she could not predict whether settlements ultimately will average \$25,000, which is about the average claims settlement paid by other asbestos producers.

Ms. Smith said she is angered by press reports—which were based on information filed in October with a U.S. Bankruptcy Court in New York before Manville emerged from reorganization in November—indicating that the trust fund was paying too much too soon.

"My charge from the court was to settle all of these claims and not cherry-pick them," she said. Ms. Smith thus has directed her 90-member staff to first handle the earliest claims filed with the bankruptcy court, regardless of their size.

However, this system could lead to temporary cash-flow problems since the earlier claims are often the most serious claims, she explained.

One solution to the expected temporary cash-flow problem would be to offer claimants structured settlements or installment payments, Ms. Smith suggested.

"Most claimants contacted have been pretty receptive" to such offers, she said.

Payments to claimants would be delayed only if the claimants refused structured or installments settlements and the pace and size of settlements did not diminish, according to Ms. Smith.

In that event, claimants would receive IOUs from the trust. This could be troublesome for asbestos victims who currently are facing expensive medical bills, ex-

CIGA now has about \$58 million in its account covering claims besides workers compensation and automobile claims, including \$30 million from a 1987 assessment, according to Paul M. Gulko, president of Guaranty Fund Management Services, CIGA's Boston-based manager.

Additional assessments at the allowable maximum of about \$33 million annually are likely for 1988 and 1989, CIGA court papers add. The 1988 assessment has not yet been collected, Mr. Gulko said.

If the \$64.5 million in Raymark and Union Carbide claims—added to claims from other companies—surpass CIGA's available assets, subsequent claims payments would have to be prorated, with the balance of prorated claims payable from assessments in future years.

The result would be a lion's share of CIGA's current assets going to Raymark and Union Carbide, while other Connecticut claimants "would receive relative pittance on their smaller but otherwise valid claims," CIGA argued.

"The underlying claims against Raymark and Union Carbide are, for the most part, asserted by persons having no connection with Connecticut," CIGA argued. "Both Raymark and Union Carbide demand, however, that the Connecticut insurance-buying public bear the burden of paying such claims. The magnitude of this burden and the potential liability of CIGA for other existing and future insurer insolvencies thus compel a precise delineation and a careful application of the various limitations on CIGA's obligations which the Legislature included in the CIGA act."

One such limitation, CIGA contended, would be a ruling that Raymark has only one "covered claim" against the guaranty fund for each Transit policy, meaning that the CIGA cap of \$300,000 per claim would allow Raymark a total recovery of \$1.8 million under the six Transit policies.

CIGA also argued that:

- Raymark must exhaust all coverage from other excess liability policies before collecting claims from CIGA.

- CIGA has no duty to defend Raymark against asbestos claims. Raymark argued that it was entitled defense costs in addition to the Transit policy limits, costs that could amount to several million dollars, court papers say.

- CIGA's \$100 deductible on covered claims should be interpreted so as to reduce the available limits under each Transit policy by \$100 for each claim covered by that policy. Thus, if Raymark were found to have 500 covered claims under one policy, the policy's limit—and CIGA's liability—should be reduced by \$50,000, CIGA argued.

However, in his Jan. 18 order, Judge Aronson sided with Raymark on most of these issues.

Rejecting CIGA's attempt to limit its liability to \$300,000 per Transit policy, Judge Aronson noted that the guaranty fund act "specifically provides that it is a claim, not a policy, that is being considered for payment whether it be on behalf of a policyholder or claimant."

"CIGA argues that Raymark should be treated as a claimant under the six policies of Transit. Under this theory, Raymark would be limited, as a claimant, to the \$300,000 cap per claim. Of course, that is not the situation here. Raymark is not the claimant. The claimants are the thousands of persons who are making claims against Raymark for injuries arising from their contact with asbestos manufactured by Raymark. Raymark, in these circumstances, is an insured, not a claimant."

Judge Aronson also rejected CIGA's assertion that Raymark must exhaust the limits of all other excess policies before tapping the guaranty fund.

CIGA had based this argument on a section of the guaranty fund act stating: "Any person having a claim against an insurer under any

Continued on next page

Update

METs' coverage canceled

Continued from page 2

New York Life notified the METs and the association of the cancellation on Jan. 1, the New York Life spokesman said. "Contractually, we only have to give 31 days' notice of cancellation. However, we've given the employers three months' notice," he explained.

UAL pilots win pension credits

CHICAGO—A group of senior pilots for United Airlines Inc. stands to collect more than \$5 million in added pension benefits, a federal judge has ruled.

U.S. District Judge Prentice H. Marshall ruled Jan. 27 that United must grant pension credit to pilots working past the normal retirement age of 60 and still employed after the effective date of the Omnibus Budget Reconciliation Act of 1986.

Upholding Internal Revenue Service regulations that interpret OBRA, the judge ruled that United may not disregard years of service past normal retirement age, including years of service before OBRA's effective date (BI, Jan. 2).

Chicago-based United, which had discontinued further pension credit for employees working past age 60, argued that this interpretation would improperly make OBRA retroactive and that credit should only be granted as of OBRA's effective date.

While ruling in the pilots' favor on pension credits, the judge ruled in United's favor on the question of when OBRA is effective for United retirement plans.

The general OBRA effective date was Jan. 1, 1988, but United argued—and Judge Marshall agreed—that the collectively bargained United plans triggered a special rule rendering the law effective Jan. 1, 1989, and Dec. 31, 1988, for two separate retirement programs.

United has not yet decided whether to appeal.

Sailor awarded \$31 million

NEW YORK—A Brazilian shipowner is insured for a \$31 million New York State Supreme Court jury award to a merchant seaman who was denied indemnification for rehabilitation costs after his leg was amputated.

The award to the New York man, which includes \$24 million in punitive damages, is one of the largest personal injury awards ever in the state, according to Justice Edward J. Greenfield, who presided over the case.

The shipowner, Brazilian company Frota Oceanica, is insured by Bermuda-based protection and indemnity club Steamship Mutual Underwriting Assn. Ltd. The shipowner's insurance covers punitive damages, said a London-based spokesman for Steamship Mutual.

The jury applied international maritime law rather than New York law, under which punitive damages are not insurable.

Steamship Mutual has reinsurance above a \$200,000 retention through a worldwide reinsurance arrangement with the international group of P&I clubs, the spokesman said.

If Justice Greenfield confirms the jury award, the shipowner likely will appeal the award, the spokesman pointed out.

In the case, Starkaiser Pires, who now lives in New York, was struck by a railroad locomotive in Galveston, Texas, while on an errand from the bulk cargo vessel Frotaleste.

Steamship Mutual paid the sailor's medical expenses for a leg amputation but refused to pay additional expenses for rehabilitation care in New York.

Lloyd's members may join suits

LONDON—Hundreds of Lloyd's of London members of defunct syndicate 895, managed by Spicer & White (Underwriting Agencies) Ltd., and syndicate 553, managed by CJW (Underwriting Agents) Ltd., will meet March 15 to discuss filing joint litigation against their underwriting agencies to recover millions of pounds in losses for which members are liable.

Other Lloyd's members from troubled syndicates managed by Oakley Vaughan (Underwriting Agencies) Ltd. also may attend the meeting to decide whether to combine their legal actions with those of syndicate 895 and 553 members, sources say.

The members have suffered more than 100 million pounds (\$174 million) in underwriting losses, which they claim is partially due to the negligence of their managing and members agencies (BI, Jan. 9; Nov. 2, 1987).

Among other things, the members will discuss a proposal to finance the joint litigation through an unnamed financier, who has agreed to fund the cost of the litigation in exchange for a percentage of any recoveries.

Lloyd's member Tom Benyon, who will chair the meeting, last week spoke to 400 to 500 U.S. members of the three syndicates to try to enlist their support for the joint legal action.

Briefly noted

Bermuda Premier John Swan's United Bermuda Party maintained control of Parliament in Thursday's election, even though it finished with only 23 seats in the 40-seat chamber, down from 31 previously. Finance Minister Clarence James was among the UBP candidates who lost their seats. . . **International Surplus Lines Insurance Co.** last week appealed a California appellate court decision that rewrites the claims-made general liability policy form in the name of public policy (BI, Jan. 16). Several insurance industry associations are expected to join ISLIC in its appeal. . . **Troy, Mich.-based Volkswagen of America Inc.** will appeal a New Jersey appeals court's reinstatement of a \$100,000 punitive damage award against it. The case involved a 1983 incident in which an Audi 5000 sedan crashed through a brick wall into a house, allegedly due to sudden acceleration. A lower court judge dismissed the punitive award, saying Audi had not consciously disregarded public safety in the vehicle design. But the appellate court said Audi knew of problems with the placement of brake and gas pedals but instead "decided to blame driver error" in the case.

Connecticut guaranty fund

Continued from previous page

provision in an insurance policy, other than a policy of an insolvent insurer, which is also a covered claim under this chapter, shall exhaust first his rights under such policy."

The judge noted that the purpose of this provision, as stated in a previous Massachusetts auto liability case, was to bar a claimant from collecting from both the guaranty fund and another policy written by a solvent insurer.

Given this purpose, "the obligation to exhaust falls upon the claimant, not the insured, to avoid double recovery," the judge wrote. "In this situation, Raymark is not a claimant and therefore has no duty to exhaust."

On the defense cost issue, Judge Aronson noted that if the language of the Transit policies obligated the insurer to defend Raymark, CIGA would be bound by those contractual obligations even if defense costs were in addition to policy limits.

However, because the interpretation of the Transit policies was not presented as a separate issue, the judge declined to rule on whether CIGA is obligated to cover Raymark's defense costs.

The judge also concluded that the guaranty fund's \$100 deductible should be applied separately to each of the thousands of claims against Raymark rather than singly to each Transit policy.

However, the opinion did not directly address CIGA's argument that the Transit policy limits should be reduced by \$100 for each covered claim.

In a Feb. 6 motion asking Judge Aronson to reconsider his rulings in the case, CIGA also requests a ruling on its deductible argument.

CIGA's motion for reconsideration and a separate motion for clarification of the ruling are pending.

Meanwhile, CIGA is battling Union Carbide over coverage of \$32.5 million in Bhopal-related claims that should have been covered by Transit, Midland Insurance Co. of New York and Integrity Insurance Co. of Paramus, N.J. Midland entered liquidation in 1986, while Integrity was ordered liquidated in 1987.

The claims stemmed from the Dec. 3, 1984, release of poison gas at Union Carbide's plant in Bhopal, which killed more than 2,000 people and injured more than 100,000 others (BI, Dec. 24-31, 1984).

Massive litigation against the chemical company over the worst industrial accident in history is still pending in an Indian court.

Union Carbide, which had \$200 million in excess liability coverage at the time of the accident, offered to settle the claims for \$300 million and had approval from its board of directors to increase the settlement amount to \$350 million under certain circumstances, according to court papers, which noted that this offer was rejected.

CIGA originally filed a declaratory judgment action against Union Carbide over its Transit-related claims in Hartford Superior Court in 1986, making essentially the same arguments it did in the Raymark action.

On Jan. 6, Union Carbide filed a summary judgment motion rebutting CIGA's arguments and seeking coverage for the full \$32.5 million limits of six policies:

- Transit policies in two different excess layers with limits of \$10 million and \$5 million, respectively.

- Integrity policies in two excess layers with limits of \$5 million and \$1 million, respectively.

- Midland policies in two excess layers with limits of \$6.5 million and \$5 million, respectively.

In its summary judgment motion, Union Carbide follows most of the arguments made by Raymark, asserting that the \$300,000 cap applies to each Bhopal claim and not to each policy.

Union Carbide also argues that it should not be required to exhaust its other excess policies before tapping the guaranty fund, noting that the question is irrelevant in any case since its full \$200 million in limits certainly will be exhausted by Bhopal claims.

In addition, the chemical company rejects CIGA's position that the policies' limits should be reduced by the \$100 deductible for each covered claim. With roughly 500,000 separate Bhopal injury claims, this interpretation of the deductible provision would wipe out any guaranty fund liability for the six policies, Union Carbide notes.

Colorado fund pays Manville \$15 million

DENVER—The Colorado Insurance Guaranty Assn. last month paid \$15 million to Denver-based Manville Corp. to settle asbestos-related claims otherwise payable by Transit Casualty Co. and Midland Insurance Co. Both insurers are in liquidation.

While a Colorado guaranty fund lawsuit against Manville raised several of the same issues decided in the Connecticut dispute involving Raymark Corp., the Colorado litigation was dismissed because Manville, which had filed for reorganization under Chapter 11 of the Federal Bankruptcy Act, was found to be under the sole jurisdiction of a New York bankruptcy court, said John Rodman, a Denver lawyer representing the Colorado fund (also see story, page 2).

Meanwhile, the chemical company also asserts that the three insolvent insurers were obligated to cover Union Carbide's defense costs and that CIGA is therefore liable for these expenses.

Union Carbide has so far submitted \$6.4 million in Bhopal defense cost claims to its liability insurers, court papers say.

However, the company's lead \$5 million excess policy, underwritten by Royal Indemnity Co., included an endorsement stating that as of March 1, 1984, all expenses under the lead excess and underlying policies would be self-insured by Union Carbide.

This endorsement—and any effect it may have on defense cost coverage in Union Carbide's excess liability program—is not mentioned in court papers filed so far in the Connecticut case.

Union Carbide officials could not be reached for comment.

Insurers earnings to improve: Report

By DEBORAH SHALOWITZ

Washington

WASHINGTON—The property/casualty insurance industry's financial condition will improve this year, with the industry projected to earn aftertax income of \$15.7 billion, according to a government forecast.

That estimate represents a 25.6% increase over the \$12.5 billion in aftertax income earned by property/casualty insurers in 1988 as estimated by A.M. Best Co.

Net written premiums are expected to reach \$204 billion, up 3% from 1988's estimated total of \$198 billion, according to the Commerce Department. Also, "insurance capacity will increase, putting some downward pressure on rates during the year," the report noted.

The "1989 U.S. Industrial Outlook" also predicted that tort re-

form—both at the federal and state levels, possible repeal of the McCarran-Ferguson Act, and the progress of the attorneys general's antitrust lawsuits will be the key industry issues in 1989 (BI, Dec. 26, 1988).

Long term, the property/casualty insurance industry probably will face increased competition in the coming decade, the report said. "Despite its lack of success in 1988, the banking industry will continue efforts to obtain expanded insurance powers and the controversy over commingling banking and insurance activities will retain its high profile well into the 1990s."

The reinsurance industry also is expected to do well in 1989, according to the Department.

However, "revenue growth will slow because of increased competition among reinsurers," the report cautioned.

Long term, "reinsurance markets for the next four or five years will suffer from a lack of capacity relative to demand for certain uninsurable risks," the report said. "For the next few years, reinsurance will continue to be a high-risk industry in which the potential for profits and losses could vary widely from year to year."

needed to provide those plans. Additionally, small employers will incur this expense without regulatory assurance that they have followed the dictates of the law.

"At a time when federal policy is properly focusing on expanding and encouraging voluntary health care coverage, federal action which would discourage employer provision of health coverage must be avoided," Mr. Abdnor wrote.

Family leave bills

Businesses would be required to grant working parents unpaid leave to care for a newborn, a newly adopted child or a seriously ill child or parent and for their own serious illnesses under legislation introduced in both houses of Congress earlier this month.

The Senate bill, S. 345, which was introduced Feb. 2 by Sen. Christopher Dodd, D-Conn., would allow parents to take up to 10 weeks of unpaid leave over two years to care for new or ill family members and up to 13 weeks of unpaid leave over one year for a serious illness. The legislation closely follows bills Sen. Dodd introduced in the 99th and 100th Congresses. The legislation is co-sponsored by 19 other senators.

According to the U.S. General Accounting Office, the legislation would cost employers about \$236 million annually, primarily due to the requirement that employers continue to contribute to an employee's group health insurance coverage for workers on leave.

To be eligible for the unpaid leave benefit, a worker would have to have completed at least one year of service working at least an average of half-time or more. Firms with fewer than 20 employees would be exempt.

A similar bill, H.R. 770, was introduced the same day by Rep. William Clay, D-Mo., and 138 co-sponsors.

There are three key differences between the House and Senate bills.

Under the House bill, employees would be entitled to 15 weeks of medical leave over a one-year period, compared with the 13 weeks allowed by the Senate bill.

And, under the House bill, employers with fewer than 50 workers are exempt from the legislation's mandates for three years after enactment. Then employers with fewer than 35 workers would be exempt from the legislation.

Lastly, under the House bill employers would not be required to grant unpaid leave to certain key employees—either the five top earners in the firm or the top 10% of earners, whichever is greater. The Senate bill does not contain a similar provision.

Benefits lobbying

The Employers Council on Flexible Compensation is establishing a telephone lobbying mechanism to allow members to send an overnight message to key members of Congress and the administration.

The number, 800-444-5446, is similar to a line established by ECFC in 1987 during the lobbying on a proposed \$500 tax cap on flexible plan benefits.

At that time, more than 60,000 messages were delivered to members of Congress.

The telephone line is being established in response to recent concerns over possible taxes on employee benefits, according to Ken Feltman, executive director of the Washington-based ECFC.

For \$19.95, which can be charged to an American Express, VISA or MasterCard charge card, a personal message can be sent to any congressman, senator or member of the Bush administration.

Fire safety

Hotels would be encouraged to install fire safety equipment, such as sprinklers and smoke detectors, under legislation introduced in Congress last month.

The bill, H.R. 94, would prevent federal employees from receiving reimbursement for stays at hotels that lack fire sprinklers and smoke detectors. Hotels with fewer than three stories without interior corridors would need only smoke detectors.

The legislation was introduced last month by Rep. Sherwood Boehlert, R-N.Y.

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Section 89 rules

The U.S. Small Business Administration is urging the Treasury Department to delay implementation of Section 89 non-discrimination rules for welfare plans.

In a letter to Treasury Secretary Nicholas Brady, SBA Administrator James Abdnor noted that the law is "complex, the standards are new and the details are largely undefined by regulation."

"You would advance good fringe benefits policies by announcing a delay in enforcement of this section," Mr. Abdnor said. Also, "the burdensome Section 89 requirements will further deter small employers from initiating or maintaining health benefit plans by adding considerably to the expense

Brokers' fortunes are tied to gloomy insurer outlook

By LEONARD M. WILSON
Special to Business Insurance

IN THE ANALYTICAL FRAMEWORK, we have grown accustomed to treating insurance brokerage and underwriting as distinct businesses with their own set of characteristics. But the two segments are interdependent, and therefore it is relevant to ask whether brokers can prosper in the long run if the underwriting side is struggling.

We began to mull over this connection after listening to two insurance company executives expound their views on the current state of underwriting. Glum might be the best word to describe the mood.

They made it patently clear that pricing in commercial lines was at a dismal stage. Underwriting results would suffer grievously as a consequence. Combined ratios might get into the mid-teens before the price cutting abated. The liability system is still bad for everyone but lawyers, it was affirmed. And California's Proposition 103 was populism run amok.

The underwriter opined that the 1985-86 recovery in commercial rates ended sooner and has dived more deeply than anyone expected. Too much capital in the hands of property and casualty underwriters has precipitated the price competition. The inverse correlation between pricing and industry capital was cogently set forth in a chart. The presentation ended inconclusively, but the role of surplus capital in price cutting seemed persuasive.

Explanations for soft pricing took a different tack in prior cycles. In the soft market of

Explanations for soft pricing take a different tack in each cycle. In the bloodbath of 1979-1984, multiple explanations were adduced. Ultimately, though, pricing chaos could be attributed to the central problem of too much capital in an ease of entry business chasing a finite volume of underwriting opportunities.

1972-73, cash-flow underwriting was said to be the culprit. Companies could not resist the temptation to bid for underwriting dollars to bolster investment income.

In the bloodbath of 1979-1984, multiple explanations were adduced. Reinsurance was too cheap, interest rates were high, companies were after market share, there was a crisis in the tort system. Ultimately, though, pricing chaos could be attributed to the central problem of too much capital in an ease of entry business chasing a finite volume of underwriting opportunities.

We have observed in past columns that the period from 1979 through 1989 will have witnessed only two years of rising prices in commercial lines. It would appear from this record that excess capital is a chronic phenomenon.

If so, property and casualty underwriters may have to face a reality marred by substandard returns and continuing volatile pricing cycles.

Certainly, it has become more difficult to find followers of property/casualty stocks who are not skeptical of the industry's ability to achieve competitive returns. But perhaps there are corrective forces at work.

Capital has already begun to flow out of the industry. Share buybacks have become more common. Share buybacks recognize the merits of providing value to the shareholder when funds cannot be employed in the enterprise at an attractive rate of return.

Some insurance company managements have begun to shift to an investment strategy emphasizing capital appreciation. This approach tacitly allocates capital to the higher return activity, investing at the expense of

the lower and purportedly less attractive activity of underwriting.

Capital depletion is also foreshadowed by continuing deterioration in underwriting results and rising tax liabilities under present regulations.

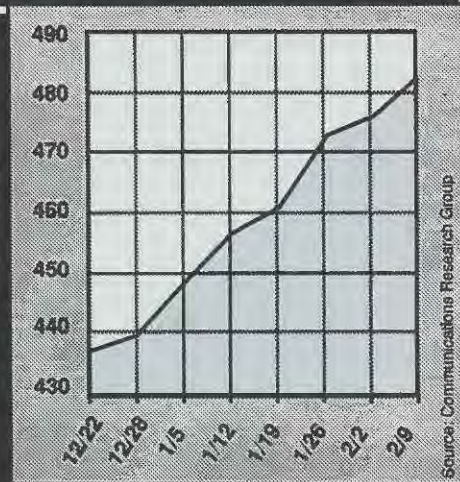
This erosion of the industry's capital base could bring about an equilibrium of adequate returns in the 1990s. The collision between diminished capital and rising premium volume might well translate into less volatile pricing cycles in the 1990s. The history of the property/casualty industry warrants a degree of caution on this point, but other industries in recent years have undergone a process of decapitalization and emerged stronger and more profitable.

We noted at the outset that prosperity for insurance brokerage may not be attainable without a constructive environment for underwriting. If the 1990s turn out to be a decade of greater stability in pricing for commercial lines, and correspondingly improved profitability for underwriters, the public insurance brokers are likely to register strong gains as well.

We have little doubt about the brokers' ability to grow at an average rate of close to 15% annually over a full insurance cycle, provided the amplitude of cycles and their duration are moderated.

It is not necessarily the wisdom of insurance company managements that will bring about orderly pricing and enhanced returns to underwriting capital. If commercial insurance is to become more consistently profitable, the instrumentality is likely to be the ineluctable quest of capital for a competitive return.

BI Insurance Index



Insurance industry stocks continued their ascent last week, as the *Business Insurance Index* rose 6.2 points to 483.2 on Feb. 9, from 477.0 on Feb. 2. Advancing issues were led by Sierra Health Services, up 19.7%; U.S. Healthcare Inc., up 15.1%; and United Health Services, up 12.1%. Decliners followed: Western Health Plans Inc. and Maxicare Health Plans, both down 8%; and Northwestern National Life Insurance Co., down 6%. The most active issue was U.S. Healthcare, 6.8 million shares traded. The *BI Index* gained 1.3% for the period; the Dow Jones 30 Industrials lost 0.5%; the Standard & Poor's 500 fell 0.3%; and the New York Stock Exchange composite lost 0.1%.

British Issues

		1 Week			
Feb. 9	Price	P/E	Div.	Yield	High-Low
Companies	price		price	%	price price
Comml Union	400	12.9	25.3	6.3	400-390
Genl Accident	1000	9.9	58.0	5.8	1005-979
Gdn Royal Exch	216	11.6	13.1	6.0	214-208
Royal	436	14.2	30.0	6.9	445-434
Sun Alliance	1137	8.7	54.7	4.8	1137-1121

		1 Week			
Brokers					
Bradstock	233	12.2	9.0	3.9	233-227
CE Heath	480	15.2	34.5	7.2	481-473
Hogg Robinson	159	14.7	8.0	5.0	165-156
Lloyd Thompson	209	16.5	8.0	3.8	209-209
PWS Holdings	129	18.4	5.2	4.0	130-128
Sedgwick Grp	279	23.2	16.0	5.7	279-264
Steel Brl Jones	225	20.1	13.3	5.9	225-223
Willis Faber	259	17.6	15.3	5.9	259-253

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

BI Industry Stock Report

FEBRUARY 9, 1989

2/3/89 THRU 2/9/89

BROKERS

		Weekly	Year to Date	Annual								
		Price	% change	% change	High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
Alexander & Alexander Svcs	NYSE	23.38	1.1	-0.5	28.13	17.75	206	1.00	4.3	16.0	3.71	6.30
Corroon & Black Corp.	NYSE	32.75	2.3	5.2	34.75	28.00	223	1.08	3.3	4.9	12.40	2.64
Gallagher Arthur J. & Co.	NYSE	18.00	4.3	7.5	19.13	13.88	52	0.48	2.7	12.8	5.46	3.30
Hall Frank B. & Co.	NYSE	2.88	-4.0	0.0	5.50	2.50	61	0.00	0.0	-1.6	0.00	N/A
Hilb, Rogal & Hamilton	OTC	15.00	-4.8	-1.6	15.75	9.75	57	0.00	0.0	11.8	4.60	3.26
Marsh & McLennan Cos. Inc.	NYSE	57.75	0.9	2.7	59.63	45.25	338	2.50	4.3	14.1	6.74	8.57
Poe & Assoc. Inc.	OTC	8.25	0.0	0.0	9.25	6.75	1	0.40	4.8	9.3	0.27	30.56
BROKERS	AVERAGE		-0.0	1.9					2.8	9.6		

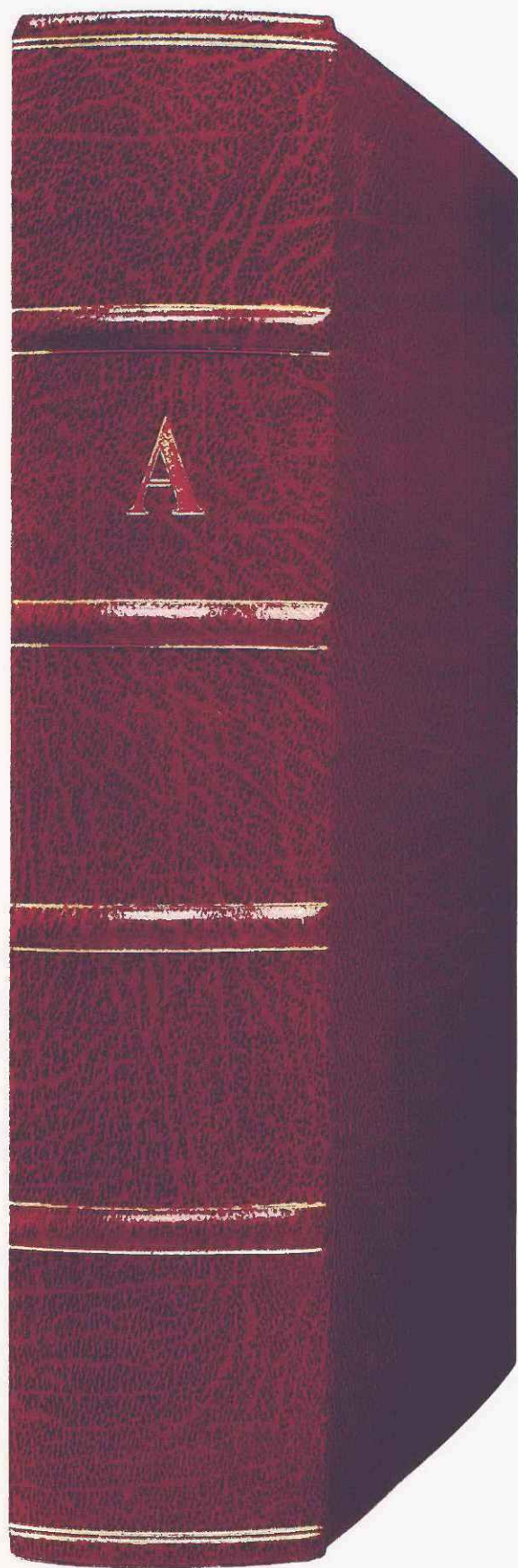
CONGLOMERATES & HOLDING COMPANIES

Berkley W.R. Corp.	OTC	32.50	1.5	10.2	33.25	23.50	336	0.36	1.1	7.0	17.63	1.84
Berkshire Hathaway Inc. DEL	NYSE	4950.00	-1.0	41.8	5050.00	2755.00	47	0.00	0.0	19.9	2492.68	1.99
ITT (Hartford Group)	NYSE	54.13	-0.2	6.0	55.75	43.25	1660	1.48	2.7	7.1	52.23	1.04
Sears Roebuck & Co. (Allstate)	NYSE	42.25	-1.5	3.4	46.13	32.25	2833	2.00	4.7	11.0	34.74	1.22
CONGLOMERATES	AVERAGE		-0.3	15.9					2.1	11.2		

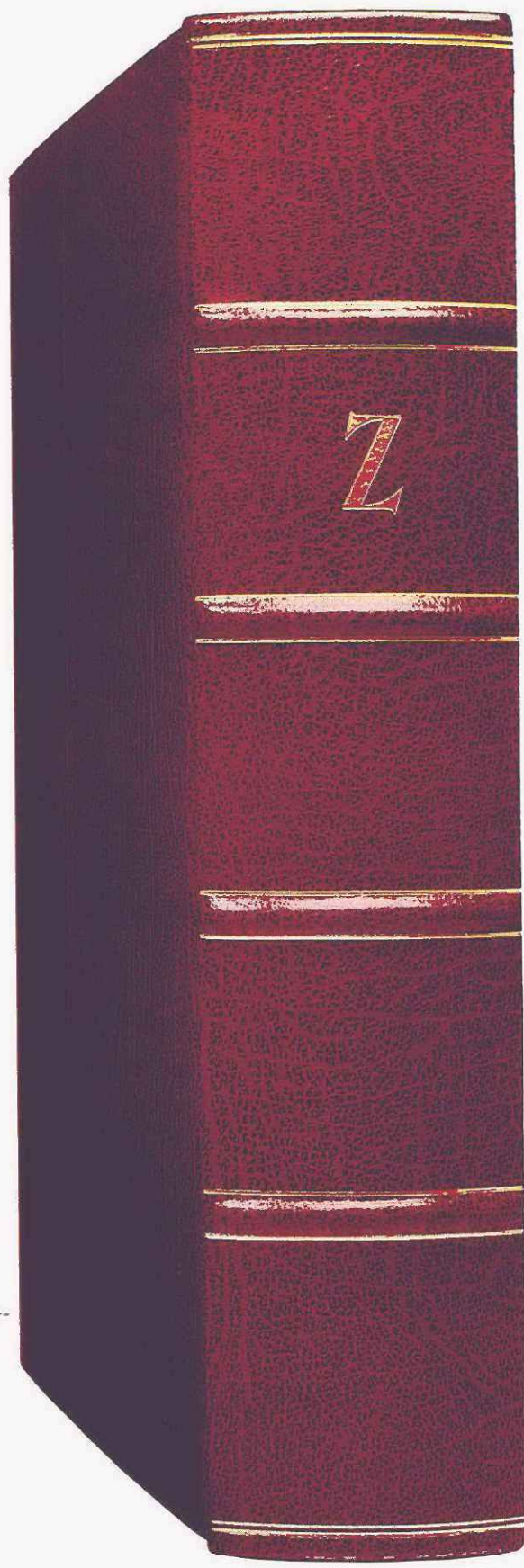
INSURERS/REINSURERS

Aetna Life & Cas Co.	NYSE	50.25	1.0	6.3	52.50	39.50	938	2.76	5.5	8.3	53.56	0.94
American General Corp.	NYSE	32.88	-1.9	10.0	36.38	27.50	625	1.50	4.6	9.6	28.04	1.17
Amer Heritage Life Inv't	NYSE	26.00	2.0	1.0	27.00	24.00	2	1.08	4.2	11.0	20.98	1.24
Amer Indty Fin'l Corp.	OTC	10.75	-1.2	2.4	12.00	8.25	5	0.56	5.2	7.0	17.06	0.63
American Intl Group	NYSE	73.25	-0.5	8.1	74.63	49.00	1419	0.40	0.5	10.8	33.55	2.18
Aon Corp.	NYSE	28.88	2.2	3.1	29.00	21.88	188	1.28	4.4	9.5	15.13	1.91
Argonaut Group	OTC	50.50	2.0	15.4	50.75	29.50	105	0.00	0.0	7.5	34.94	1.45
AVEMCO Corp.	NYSE	25.25	3.6	-2.4	28.75	17.88	110	0.40	1.6	12.4	7.74	3.26
Baldwin & Lyons Inc.	OTC	15.63	5.0	5.0	16.38	12.13	126	0.20	1.3	6.5	17.57	0.89
Belvedere Corp.	AMEX	4.75	-5.0	5.6	5.00	4.00	4	0.04	0.8	7.0	7.87	0.60
Chandler Insurance	OTC	10.50	-4.5	13.5	11.25	4.25	36	0.00	0.0	5.1	4.81	2.18
Chubb Corp.	NYSE	64.00	3.2	10.3	65.25	51.25	622	2.16	3.4	7.2	46.13	1.39
CIGNA Corp.	NYSE	53.88	3.4	14.3	55.38	42.75	667	2.96	5.5	10.0	49.19	1.10
CNA Fin'l Corp.	NYSE	58.50	-0.6	-3.3	66.13	51.00	198	0.00	0.0	9.2	46.40	1.26
Continental Corp.	NYSE	34.38	-0.7	6.2	41.63	31.50	1093	2.60	7.6	11.0	42.10	0.82
Durham Corp.	OTC	31.38	-2.7	-4.9	36.75	21.50	17	0.92	2.9	36.5	26.00	1.21
Fireman's Fund Corp.	NYSE	32.50	-0.8	11.1	33.50	25.75	412	0.50	1.5	6.9	30.91	1.05
Forum Re (Bermuda)	OTC	1.63	0.0	0.0	4.00	1.13	2	0.00	0.0	4.5	2.58	0.63
Fremont Gen Corp.	OTC	14.50	3.6	8.4	14.13	8.75	260	0.60	4.1	9.8	16.24	0.89
Frontier Insurance Group	OTC	13.00	-3.7	4.0	13.75	6.50	88	0.00	0.0	6.5	5.97	2.18
General Re Corp.	NYSE	60.50	2.8	9.0	61.50	45.50	853	1.36	2.2	12.0	26.21	2.31
Home Group Inc.	NYSE	11.75	-6.0	6.8	14.38	10.50	228	0.20	1.7	4.9	17.75	0.66
Hanover Ins. Co.	OTC	30.00	6.2	12.1	30.25	20.50	109	0.36	1.2	5.7	25.10	1.20
Harleysville Group Inc.	OTC	18.75	-3.3	4.2	19.63	13.38	35	0.48	2.6	7.4	16.65	1.13
Hartford Steam Boiler	OTC	39.13	1.6	6.5	38.75	22.50	228	1.40	3.6	11.3	10.65	3.67
Kans City Life Ins	OTC	34.00	3.8	-1.4	39.50	25.25	10	0.00	0.0	10.8	39.22	0.87

		Weekly	Year to Date	Annual								Mkt/Bk.
		Price	% change	% change	High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	value
Kemper Corp.	OTC	30.25	1.7	26.0	31.50	20.75	1441	0.84	2.8	8.6	26.50	1.14
Lawrence Ins. Group	AMEX	7.88	1.7	0.0	11.63	4.50	3	0.24	3.0	17.5	2.90	2.72
Liberty Corp. S. C.	NYSE	37.25	0.7	3.5	47.25	33.88	12	0.80	2.1	12.9	17.40	2.14
Lincoln Nat'l Corp.	NYSE	48.75	1.8	10.8	53.50	40.25	325	2.48	5.1	12.6	36.62	1.33
NAC Re Corp.	OTC	34.00	5.4	7.1	33.75	18.50	261	0.00	0.0	15.2	19.92	1.71
Navigators Group	OTC	21.50	2.4	7.5	22.00	14.50	8	0.00	0.0	10.4	12.88	1.67
Nobel Ins Ltd	OTC	4.75	0.0	0.0	9.50	3.75	125	0.42	8.8	-18.3	7.76	0.61
Northwestern Nat'l Life	OTC	27.25	-6.0	-12.5	34.50	22.63	673	1.12	4.1	6.5	35.05	0.78
Ohio Cas Corp.	OTC	40.75	-5.2	14.0	45.25	32.25	314	1.88	4.6	6.2	27.86	1.46
Old Rep Int'l Corp.	OTC	26.38	-2.8	9.9	28.88	19.13	342	0.74	2.8	6.2	27.82	0.95
Orion Cap Corp.	NYSE	20.75	5.1	34.9	20.75	13.13	87	0.76	3.7	7.1	9.34	2.22
Phoenix Re Corp.	OTC	10.63	3.7	11.9	11.00	6.75	100	0.00	0.0	5.8	11.08	0.96
Protective Life Corp.	OTC	14.00	0.0	5.7	15.13	12.25	25	0.70	5.0	17.1	17.25	0.81
Re Capital Corp.	AMEX	10.00	0.0	9.5	11.75	7.88	3	0.00	0.0	22.2	11.49	0.87
Provident Life & Acc Ins Co.	OTC	22.50	2.3	16.9	25.00	15.63	332	0.68	3.0	18.9	21.96	1.02
St. Paul Cos. Inc.	OTC	48.25	0.5	10.9	51.00	38.25	1010	2.20	4.6	6.6	35.83	1.35
SAFECO Corp.	OTC	26.75	-1.8	13.2	30.00	22.75	1410	1.08	4.0	7.5	23.94	1.12
SCOR U.S. Corp.	NYSE	7.88	-3.1	-13.7	9.50	5.63	112	0.20	2.5	5.7	9.38	0.84
Seibels Bruce Group Inc.	OTC	12.50	0.0	9.8	14.25	11.00	24	0.80	6.4	8.4	12.51	1.00
Selective Ins Group Inc.	OTC	22.75	0.5	-1.1	26.50	19.25	220	1.24	5.5	5.1	19.52	1.17
Statesmen Group Inc.	OTC	3.50	1.7	11.8	5.56	2.75	214	0.05	1.4	-350.0	3.48	1.01
Tokio Marine & Fire Ins	OTC	89.38	4.8	-2.2	98.00	63.25	13	0.22	0.2	54.2	0.00	N/A
Torchmark Corp.	NYSE	32.38	0.8	6.2	33.50	24.50	142	1.20	3.7	10.5	12.24	2.65
Transamerica Corp.	NYSE	34.50	2.6	1.8	36.75	29.75	438	1.88	5.4	7.9	24.94	1.38
Travelers Corp.	NYSE	38.13	3.1	9.7	40.00	33.00	1551	2.40	6.3	9.2	45.28	0.84
Trenwick Group Inc.	OTC	14.50	0.0	0.0	15.25	9.75	174	0.24	1.7	14.2	15.41	0.94
United Fire & Cas Co.	OTC	30.75	0.8	0.8	30.75	24.00	4	1.08	3.5	5.1	22.56	1.36
United States Fid & Gty	NYSE	31.38	5.0	10.1	34.38	28.50	2870	2.64	8.4	8.8	19.52	1.61
UNUM Corp.	NYSE	28.88	2.2	7.0	28.63	17.88	471	0.48	1.7	12.1	28.53	1.01
USLIFE Corp.	NYSE	38.63	-2.8	10.8	40.13	28.00	127	1.36	3.5	10.2	46.77	0.83
Washington Nat'l Corp.	NYSE	26.88	3.4	-0.4	28.75	24.00	25	1.08	4.0	-7.8	32.33	0.83
Zenith Nat'l Ins Corp.	NYSE	18.75	5.6	7.1	23.88	15.00	138	0.80	4.3	8.8	12.53	1.50
INSURERS/REINSURERS		AVERAGE	0.8	6.5					3.0	3.6		



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