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Update

Texas insurance reform bills propose sweeping changes

AUSTIN, Texas—Sweeping insurance reform legislation introduced in Texas and supported by Gov. Ann Richards would, among other things, repeal insurers' limited exemption from state antitrust law.

Another key element of the legislation, H.B. 2 in the House and S.B. 2 in the Senate, would assign a state agency to collect data for setting "flex-rated" property, general liability and automobile insurance rates rather than relying

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AFL-CIO health policy lauded

By JOANNE WOJCIK

BAL HARBOUR, Fla.—The AFL-CIO's invitation for all parties connected with the health care delivery system to jointly work toward meaningful reform is receiving a warm reception.

Employers, benefit consultants and even health care providers say the health care reform resolution approved last week by the AFL-CIO Executive Committee indicates that labor realizes that a nationalized health care program is unlikely in the near future and that short-term solutions have a better chance of adoption.

Some even suggest that the AFL-CIO's position will make it easier for employers to push for health care cost containment when negotiating labor contracts.

"They see the employer's point of view with respect to costs," said Ellen Goldstein, director of health policy for the Assn. of Private Pension & Welfare Plans in Washington, D.C.

The AFL-CIO resolution "is a manifestation that everybody agrees there's a problem," observed Dr. James Todd, executive vp of the American Medical Assn. in Chicago.

While the resolution does not radically depart from organized labor's former position that a Canadian-style national health care system be established, "it is a tacit acknowledgement that such a system is not feasible in the short term," observed Frank McArdle, manager of Hewitt Associates' Washington, D.C., office.

The resolution, which was unanimously approved by the 35-member AFL-CIO Executive Committee at its annual winter meeting last week in Bal Harbour, Fla., is a compromise that settles a debate within the organization over whether it should push for a government-run national health insurance plan similar to Canada's or build on the current private-payer system.

The resolution represents "the first time that the AFL-CIO has initiated steps toward resolving the issues that plague the U.S. health care system with the cooperation of labor, consumers, business, providers and government," said Claudia Bradbury, policy associate in the AFL-CIO's employee benefits department in Washington, D.C.

"The issue of health care reform is not a new one to labor," she pointed out. The resolution simply "gives us the tool to enact legislation in the present day."

While maintaining the labor movement's long-held goal of a national health care program, the AFL-CIO recognizes that reform may have to come about in stages, said President Lane Kirkland in announcing the Executive Committee's resolution.

"The ever-growing urgency of America's health care crisis requires new alliances and new initiatives toward cooperation," he said. "Now is the time to make our health care system in the United States more efficient, effective and responsive to the needs of

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Insurers study S&L crisis

London panel views claims from thrifts

By STACY SHAPIRO

LONDON—An informal committee of leading financial institution underwriters at Lloyd's of London is examining underwriters' potential liabilities from the U.S. savings and loan crisis.

The S&L failures, which could cost the federal government as much as $500 billion over the next 40 years, could create a "potentially serious situation" for liability underwriters that have insured failed S&Ls and professionals like accountants and lawyers who worked for S&Ls, the Lloyd's Underwriting Agents Assn. said in a recent report.

No estimates are yet available for the claims London underwriters will face. But the report said that it's unlikely the losses will be as great as the asbestos and pollution losses that have created chaos in the London market for the past decade (see story, page 23).

The situation also could be much more serious for U.S. insurers than London companies, London underwriters suggest.

A new informal "financial institution committee," headed by Stephen Burnhope, a leading Lloyd's financial institution underwriter, will gather and disseminate information about S&L failures to London underwriters, says the report distributed earlier this month by the LUAA.

GRAPHIC BY CYNTHIA WATSON/HOLLY SEGUINE

The committee has commissioned Sedgwick Detert Moran & Arnold, a London law firm specializing in financial institutions, to monitor evolving U.S. case law and explore defense strategies, the report says.

Information from the committee and Sedgwick Detert will give underwriters "a better feel for the appropriate reserving of specific cases or books of business" and allow them to change liability policy wordings, the report says.

"We are not admitting liability" for claims arising from the series of S&L disasters, said Colin Spreckley, another leading financial institutions underwriter involved in the new committee. However, "we (at Lloyd's) have written banks for many, many years and at Lloyd's

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California judge allows coverage for punitive award

By STACY ADLER

SAN FRANCISCO—A California policyholder ordered to pay punitive damages in another state may be able to tap its liability insurance even though California law bars coverage for punitive awards, a federal court judge says.

Attorneys say the Feb. 13 decision could be influential because it marks the first time a California court has squarely addressed whether California policyholders can tap insurance for punitive awards in states that allow the coverage of such damages.

And, because the decision conflicts with the general trend in California courts to deny any coverage for punitive damages, the decision has tremendous significance for California policyholders, according to some attorneys.

"For California companies that sell products outside California and are hit with punitive damage awards in states that allow insurability, this decision could help them recover insurance," said policyholder attorney John Kazanjian of Anderson, Kill, Olick & Oshinsky in New York.

But, insurer attorneys say the court's reasoning is flawed and the ruling will have little impact.

As a result of the ruling by U.S. District Judge Thelton E. Henderson, Chicago-based Continental Casualty Co. must indemnify former asbestos producer Fibreboard Corp. of Concord, Calif., for millions of dollars in punitive damage awards stemming from asbestos bodily injury litigation.

Continental, a unit of CNA Financial Corp., wrote primary liability insurance for Fibreboard from May 1957 to March 1959.

State court juries in Texas and West Virginia have ruled that Fibreboard must pay punitive damages, in addition to compensatory damages, to some 2,600 plaintiffs who allege they suffer bodily injury from exposure to asbestos manufactured by Fibreboard.

In the Texas case, some 2,300 asbestos bodily injury claims were consolidated into a class-action lawsuit, while some 300 claims were consolidated in West Virginia.

The exact amount of punitive damages Fibreboard must pay as a result of these jury verdicts has not been determined, an attorney for Fibreboard explained.

In any case, Fibreboard believes it has adequate coverage for all bodily injury claims alleging injury prior to 1959 because the Continental Casualty policies issued between 1956 and 1959 have no aggregate limits.

Furthermore, California Superior Court Judge Ira A. Brown Jr. held in 1988 that each asbestos

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NEWSPAPER

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Update

Reform bill introduced in Texas

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on insurer advisory organizations. The law also would establish a toll-free number to give consumers rate information.

Other provisions would raise capital requirements, subject county mutuals and Texas Lloyd's companies to state regulation, and toughen penalties for fraud. The legislation also would impose an 18% penalty against insurers that fail to pay claims promptly.

In addition, the legislation would require simpler policy wording and a 45-day notice of cancellation or premium increases.

The state regulatory system also would be reformed under the legislation. The legislation would create a Texas Department of Insurance headed by an executive director responsible for the day-to-day operations. The three-member State Borad of Insurance would determine department policy, set rates and approve forms.

In addition, high-level regulators would be barred from joining the insurance industry immediately after leaving office, under the law.

"We are going to pass a bill, and we will do it during the regular session," said Deece Eckstein, the governor's director of regulatory policy.

McCarran-Ferguson overhaul

WASHINGTON—Sen. Howard Metzenbaum, D-Ohio, last week introduced a bill to overhaul the McCarran-Ferguson Act, eliminating insurers' key exemptions from federal antitrust law.

The measure, S. 430, is similar to a bill introduced in the House by Rep. Jack Brooks, D-Texas, chairman of the Judiciary Committee (*BI*, Jan. 7). It would eliminate insurers' exemptions from price-fixing rules, as well as prohibit tying the sale of insurance to any unrelated insurance product and monopolizing any part of the business of insurance.

But the bill would permit certain limited joint activity like collection and dissemination of historical loss data.

"This industry is too big, too important to every American, to remain exempt from antitrust scrutiny," said Sen. Metzenbaum, who is chairman of the Antitrust, Monopolies and Business Rights Subcommittee.

The measure, co-sponsored by Sens. Joseph Biden, D-Del., Edward Kennedy, D-Mass., and Paul Simon, D-Ill., would go into effect one year after enactment.

High court let stand Pymm case

WASHINGTON—Owners of Pymm Thermometer Co. Inc. may be sentenced as early as next month after the Supreme Court last week let stand their criminal convictions for endangering workers' safety. The court refused to hear defense arguments that federal law pre-empts local authority to prosecute workplace safety cases.

New York's highest court ruled in October that the Occupational Safety and Health Act does not pre-empt local prosecutors' right to bring criminal charges against employers that subject workers to unsafe working conditions (*BI*, Oct. 22, 1990; Oct. 30, 1989).

In that decision, the New York Court of Appeals reinstated 1987 criminal convictions. A state court had convicted William and Edward Pymm, the company's owners, of assault and reckless endangerment for exposing workers to mercury in a Brooklyn factory.

A New York Supreme Court justice had set aside the verdict, ruling that the case should be decided by a federal court because it involved alleged OSHA violations (*BI*, Nov. 30, 1987).

Sentencing could be as early as March 18 for the Pymms, who face maximum prison terms of 15 years.

A spokesman for Albert Brackley, the Brooklyn lawyer who represents the defendants, said the convictions will be appealed in state court after sentencing.

Prudential buys Hopkins HMO

BALTIMORE—Prudential Insurance Co. of America is purchasing for an undisclosed amount the Johns Hopkins Health System's health maintenance organization, which has 113,000 members in the Baltimore-Washington, D.C. area.

About 90,000 of the members are enrolled in group plans.

Newark, N.J.-based Prudential expects that the transaction will be completed in late spring, pending regulatory approval.

Under the agreement, the HMO, called the Johns Hopkins Health Plan, will become part of Prudential Health Care Plan Inc. That unit operates 28 HMOs with more than 1.6 million members nationwide.

Prudential will negotiate long-term contracts with Hopkins Health Plan providers to ensure uninterrupted service at the HMO's 11 offices.

Crash liability may be capped

LONDON—The owner of a Chilean airliner that skidded off a runway last week and crashed, killing 21 people and seriously injuring 17 others, has $500 million of liability insurance.

At least 17 of those killed were Americans.

However, liability payments could be limited to either $75,000 per passenger under the Warsaw Convention for international flights or $20,000 per passenger under Chilean law, London lawyers say.

Underwriters expect the $22 million BAe 146-200 owned by Linea Aerea Nacional de Chile S.A. to be a total loss.

The airline's hull and liability coverage is placed in Chile with Compania De Seguros Generales Aetna Chile S.A., which is partially owned by Aetna Life & Casualty Co., and is reinsured in London, led by Lloyd's of London's Ariel syndicate.

The plane had been chartered by Seattle-based Society Expeditions for a flight from Punta Arenas to Puerto Williams to join an Antarctic cruise on the passenger vessel Society Explorer.

If the passengers' tickets for the ill-fated flight were included in their tickets for the journey from the United States to Chile, the liability limits of $75,000 per passenger under the Warsaw Convention/Montreal Agreement for international flights could apply, a London lawyer said.

But if they had separate tickets for the Chilean part of the journey, Chilean law would cap liability payments to only $20,000 per passenger, since the flight would be considered a domestic flight, he said.

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Losing federal cover may not cripple BICs

By JUDY GREENWALD

WASHINGTON—A Treasury Department proposal that suggests eliminating "pass-through" Federal Deposit Insurance Corp. coverage for bank investment contracts is raising many questions in the BIC market.

However, a broad reading of a separate provision in the proposal could restore the pass-through coverage for BIC beneficiaries.

Even if the pass-through coverage is eliminated, the BIC market may not be significantly disrupted.

Pass-through FDIC coverage gives each BIC beneficiary up to $100,000 of deposit insurance. BICs, which often are offered as an investment option in 401(k) plans, can cover many beneficiaries.

Insurers that write guaranteed investment contracts have long charged that backing BICs with FDIC coverage gives the banks an unfair competitive advantage (*BI*, May 22, 1989).

While precise data is difficult to attain, banks may have written up to 30% of the $30 billion of new GICs and BICs written last year, or as much as $9 billion, estimates Bruce Vane, senior vp for Prudential Asset Management Co. in Newark, N.J.

The Treasury proposal was intended to eliminate the supposed advantage that pass-through FDIC coverage gives banks offering BICs (*BI*, Feb. 11).

In suggesting that pass-through coverage for BICs be eliminated, the Treasury proposal states that FDIC coverage "provides banks with a new opportunity to attract large deposits by expanding the use of the government's guarantee.

"Meanwhile, insurance companies offering GICs totally outside of the safety net do not have this competitive advantage. Banking organizations should be permitted to offer BICs to pension fund managers, but not with federal deposit insurance."

In a separate section of the proposal, the Treasury also suggests eliminating pass-through FDIC coverage for all bank deposits by defined benefit and defined contribution plans.

Eliminating FDIC coverage for defined benefit plans is not expected to have a significant impact because benefits offered by those plans already are insured by the Pension Benefit Guaranty Corp.

In addition, few employers buy BICs to cover defined benefit plan obligations.

In proposing that pass-through FDIC coverage be eliminated for defined contribution plans, the proposal states that while participants in these plans do not receive the same "safety net" as defined benefit plan participants do through the PBGC, nevertheless "the plans do have similar investment rules and many are professionally managed."

The proposal notes that 126,297

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Court defers to state liquidation process

SBA loses surety bond suit

By MICHAEL BRADFORD

CHICAGO—A federal agency that guaranteed a large portion of surety bonds written by a now-insolvent insurer cannot bypass the liquidation process to collect damages paid to the insurer's estate, a federal judge ruled in reversing an earlier ruling she made.

As a result, the Small Business Administration will have to wait to stake its claim for $1.2 million in damages that a contractor that failed to meet its obligations was ordered to pay to the estate of American Fidelity Fire Insurance Co., a Woodbury, N.Y.-based insurer in liquidation in New York. Pre-judgment interest and legal fees have raised the amount from an original order of $683,500 in 1987.

U.S. District Court Judge Ilana D. Rovner last October ruled in favor of the SBA's claim (*BI*, Nov. 5, 1990). However, in a Jan. 25 ruling she said that the 7th U.S. Circuit Court of Appeals compelled her to reverse her decision when it sent back for reconsideration her October ruling that the SBA was entitled to the net proceeds of the award the contractor was ordered to pay AFFI.

The federal appellate court sent the case back to Judge Rovner for reconsideration of the argument by AFFI's liquidator that the federal court should abstain from the case in deference to liquidation proceedings in New York.

The appellate court emphasized that the federal litigation threatened to frustrate the liquidator's attempts to collect AFFI's assets.

The case stems from a 1987 judgment against General Railway Signal Co. of Chicago in a suit filed in 1984 by AFFI.

The SBA guaranteed a large portion of surety bonds AFFI wrote in 1979 for Transit Systems Technology Inc. of Kankakee, Ill., for work the company was contracted to perform for transit companies in California and New York.

General Railway later acquired the contracts when Transit Systems Technology was unable to complete the work because of financial problems, court papers state.

In 1984, AFFI sued General Railway, charging that the company failed to meet its obligation under the contracts and caused the insurer to honor the surety agreements.

The SBA paid AFFI $732,872 in guarantees on the surety bonds after AFFI had paid out $803,500.

AFFI was declared insolvent in 1985 and liquidation proceedings

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Listings of captive managers due

Business Insurance will publish its annual directory of captive management companies in the April 29 issue, which will also contain a spotlight report on domestic and offshore captive insurance company domiciles.

A chart on policyholder-owned alternative risk financing facilities also will be included.

There is no charge for captive management companies or facilities to be listed; however, to be included companies must complete a questionnaire provided by *Business Insurance*.

The deadline for returning completed questionnaires is March 18.

If your company provides captive management services or manages an alternative risk financing facility and you have not yet received a questionnaire, please request one from Karen Armaganian at *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611-2590; phone: 312-280-3195; fax: 312-280-3174.

Inside

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Insurers win pollution exclusion ruling

Decision creates split in Illinois courts

By STACY ADLER

CHICAGO—The pollution exclusion in comprehensive general liability policies bars coverage for pollution that does not occur abruptly, an Illinois appellate court says.

The decision, which is a victory for insurers, is important because Illinois case law on the pollution exclusion is sharply divided, attorneys say.

The further split among the state appellate courts created by this decision could cause the Illinois Supreme Court to review the issue if it is appealed, they add. Neither side has yet decided whether to appeal.

Policyholders also won a victory when the appellate court in the same decision ruled that hazardous waste cleanup costs are covered "damages" as that term is used in comprehensive general liability policies.

Affirming a trial court decision, a three-judge panel ruled on Jan. 31 that a group of primary and excess insurers do not owe Outboard Marine Corp. of Waukegan, Ill., coverage for an estimated $20 million needed to clean up PCBs dumped into Lake Michigan. The 2nd District Appellate Court found that the pollution was gradual and, therefore, barred by the pollution exclusion in CGL policies.

That exclusion bars coverage for pollution that is not "sudden and accidental."

Interpretations of "sudden and accidental" have varied. Three Illinois appellate courts have interpreted the exclusion to mean that coverage is barred only if the policyholder expects or intends to pollute, a ruling that favors policyholders, attorneys say.

However, at least one other Illinois appellate court prior to the Outboard Marine decision gave the exclusion a more temporal meaning by excluding coverage for pollution that does not occur quickly.

The appellate court said in the Outboard Marine ruling that "the word 'sudden' is not ambiguous; it has a temporal meaning and is synonymous with 'abrupt.' "

Interpreting "sudden" to mean "unexpected or unintended" would render the phrase "nothing more than redundant surplusage," the court explained. Other provisions of the CGL policy already require that the incident giving rise to the claim be unexpected or unintended by the policyholder.

After concluding that the pollution exclusion clause bars coverage for gradual pollution, the court looked at the complaints filed against Outboard Marine by the U.S. Environmental Protection Agency and the state of Illinois. The court found that since both complaints allege pollution that occurred over 11 years, the pollution was not sudden.

"There is nothing sudden or abrupt about discharges occurring over an 11-year period," the court said. "This is precisely the type of conduct to which the pollution exclusion was intended to apply."

Therefore, the court found that Outboard Marine's liability insurers—Liberty Mutual Insurance Co., Commercial Union Insurance Co., Insurance Co. of North America and Northbrook Excess & Surplus Insurance Co.—have no duty to indemnify Outboard Marine for cleanup costs.

Boston-based Liberty Mutual wrote primary general coverage for the company from the early 1950s to 1974.

Boston-based Commercial Union wrote its primary coverage from

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Health care groups see 'friendly' D&O market

By MARK A. HOFMANN

CHICAGO—The directors and officers liability insurance market for health care organizations is "buyer friendly" and likely will remain so for the foreseeable future, according to a new D&O study.

"Most health care providers are well-positioned to improve D&O coverage and perhaps reduce costs during 1991," said Kenneth S. Wollner, a consultant with The Wyatt Co. in Chicago and author of the study.

"Historically, health care directors and officers liability insurance has been impacted by overall D&O market cycles. For example, hospitals experienced along with general business corporations a D&O insurance availability and affordability crisis during the mid-1980s. This survey documents distinctive claim, insurance purchasing and insurance market patterns for hospitals. The trend toward separation from general insurance market conditions is a very positive development" for health care institutions, Mr. Wollner said.

An earlier study of the corporate D&O marketplace indicated that a significant, though probably not severe, hardening of that market began last year (*BI*, Jan. 14).

The "1990 Wyatt Health Care Organization Directors and Officers Liability Survey," which is scheduled to be released later this week, was sponsored by the Chicago-based American Hospital Assn., which sent questionnaires to 2,800 of its approximately 5,400 members. Wyatt contacted an additional 200 or so health care providers.

A total of 856 health care providers responded. These included hospitals, large clinics and health maintenance organizations.

However, among those respondents, 218 reported that the decision of whether to buy D&O insurance rested with their corporate parent. The survey excluded those respondents, and survey results are based on the responses of the remaining 638 respondents.

Mr. Wollner said the fact that the 1990 survey contained the responses from AHA members as well as Wyatt clients precludes meaningful direct comparison of this survey's results with the results from the narrow sample of health care providers that responded to previous Wyatt surveys on the corporatewide D&O market.

The survey found that respondents purchased as much as $50 million of D&O limits but that 91% of respondents reported having limits of $10 million or less.

Indeed, health care providers on average purchased slightly more than $5 million of primary limits and about $5.5 million of primary and excess limits, according to the survey.

In its overall corporate D&O survey, Wyatt reported that the average respondent purchased $26.6 million in primary and excess D&O limits.

Health care providers generally do not have a "need to acquire huge limits," explained Dixie Arthur, president of Health Providers Service Co., a Chicago-based AHA subsidiary that develops and manages the insurance products endorsed by the AHA.

Among participants that had

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Texas judges question ERISA pre-emptions

By ADRIENNE C. LOCKE

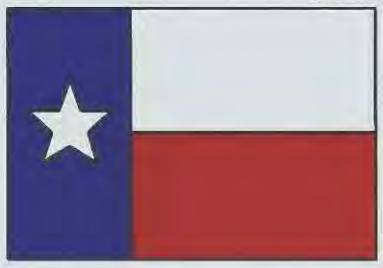
AUSTIN, Texas—Two Texas Supreme Court decisions interpreting federal law limit actions that can be taken by members of group welfare plans who are denied benefits.

However, several justices who concurred with the decision noted that federal laws unfairly penalize plan members who are denied benefits.

In one decision, the court upheld two lower court rulings that a Dow Chemical Co. worker cannot sue the company and its plan administrator under the state's Deceptive Trade Practices Act for denying 24-hour nursing care for his ill wife.

The Supreme Court concurred that the suit is barred by the Employee Retirement Security Act of 1974, which pre-empts state laws relating to employee benefit plans.

In the other case, the court upheld an appellate court decision throwing out punitive damage awards against Tenneco Inc. and its insurer for denying accidental death benefits to the widow of a Tenneco worker. ERISA precludes



punitive damage awards.

However, the high court upheld a lower court ruling that ordered the plan to pay the death benefit.

The nine-judge court ruled 6-3 in both cases on Jan. 30, but three judges in the Dow decision questioned the necessity of ERISA's broad pre-emptive powers.

In the Dow case, the company and its health care plan administrator, Metropolitan Life Insurance Co. of New York, refused to pay for round-the-clock custodial care for the wife of employee James A. Cathey. Mrs. Cathey has multiple sclerosis.

The Catheys maintained the care was medically required and is covered by Dow's self-insured health plan.

The couple sued Dow, Met Life and Michael H. Maddolin, a group health claims consultant with Met Life in state court, charging violations of the state's Deceptive Trade Practices Act. The Catheys sought the benefit and unspecified damages for mental anguish and suffering. In addition, the Texas law allows punitive damages that are treble the damages awarded.

The Catheys argued that the Texas law does not specifically relate to employee benefit plans and therefore the ERISA pre-emption does not apply in this case.

A lower court granted summary judgment for Dow in October 1987, and an appellate court agreed in December 1988.

The Texas Supreme Court upheld the appellate court.

Indeed, courts nationwide have found that ERISA broadly pre-empts state laws that in any way affect or relate to benefit plans, wrote Judge Raul A. Gonzalez in the majority opinion for the Supreme Court.

"Courts have not hesitated to find that state laws having an ef-

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Photo by Ron Vesely

Chicago Bears center Jay Hilgenberg, No. 63, is a plaintiff in a lawsuit against the NFL pension plan and its administrator.

Players' suit says NFL pension plan fumbled obligations

By ADRIENNE C. LOCKE

WASHINGTON—In the latest skirmish between National Football League players and team owners, a group of current NFL players is attempting to score a court victory against owners by suing the league's new pension plan and its administrator.

In the complaint filed Feb. 12 in U.S. District Court in Washington, D.C., the players allege that Dennis Curran, administrator of the Pete Rozelle NFL Player Retirement Plan, has failed to furnish them with required information like summary plan descriptions, annual reports and financial statements.

However, Mr. Curran and a spokesman for the National Football League Management Council in New York said last week that the plan has responded to the players' request for information.

The players' attorney was notified before the lawsuit was filed that the plan information would be provided within 30 days of receiving a request by the players on Feb. 4, Mr. Curran said. He added that the plan is fulfilling its legal obligation by responding within that 30-day period.

However, under the Employee Retirement Income Security Act of 1974, much of the information requested by the players should have been given to plan participants before the end of 1989, said Joseph

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Punitive damages

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bodily injury claim filed against Fibreboard constitutes an occurrence, making the Continental Casualty policies responsible for an infinite number of claims where the first exposure to asbestos was prior to 1959 (*BI*, Sept. 5, 1988).

The Continental Casualty policies do not exclude coverage for punitive damages.

The dispute between Fibreboard and Continental Casualty was filed in federal court in California, in part because the insurance contracts were entered into in California and premiums were paid in California. As a result, Continental Casualty argued that the law of California should apply when deciding whether Fibreboard has coverage for punitive damages.

California has long held that to allow policyholders to insure against punitive damage awards would nullify the punitive and deterrent effects of these awards.

Fibreboard, on the other hand, argued that the laws of Texas and West Virginia should apply since these are the states in which the punitive damage awards were assessed.

Both Texas and West Virginia allow policyholders to insure against punitive damage awards.

Thus, the decision by Judge Henderson of the U.S. District Court for the Northern District of California revolves around a comparison of the relative interests of California, Texas and West Virginia.

First, the court compared the standard for awarding punitive damages in West Virginia and California.

In California, punitive damages can only be assessed for intentional, willful, oppressive or malicious conduct. On the other hand, West Virginia courts can award them for "reckless" behavior.

Because the standard for awarding punitive damages in West Virginia is much more lenient than the standard in California, Judge Henderson concluded that it would not be appropriate to apply California law to bar Fibreboard from using its insurance to cover the punitive damages assessed in West Virginia.

Next the court compared the laws of Texas and California.

The standard for awarding punitive damages in Texas is virtually identical to the standard in California, the court explained. Therefore, the court had to decide whether Texas or California had a greater governmental interest in this litigation to determine which state law should apply.

The court found that because the injured victims are Texas citizens and because injury occurred in that state Texas law should govern, which would allow Fibreboard to insure the punitive damage award.

"The court recognizes that in many states punitive damages have been wrenched from their fundamental purpose—to punish—and have entered into a compensatory function," explained product liability expert attorney Victor Schwartz.

When the standard for awarding punitive damages is less than willful, conscious wrongdoing, public policy is not offended if policyholders are allowed to use insurance proceeds to pay punitive awards, said Mr. Schwartz, who is with Crowell & Moring in Washington, D.C.

Policyholder attorney Mr. Kazanjian agreed: "There is at least a tacit recognition by the court that punitive damages are awarded in product liability cases for conduct that is less than willful and wanton," said Mr. Kazanjian. "Often gross negligence suffices."

"In view of the lesser standard for which punitive damages can be awarded, there is no public policy that is violated in allowing policyholders to insure against punitive damages," he said.

"For California companies forced to pay punitive damage awards in states that allow insurability, this decision will have considerable significance," said Fibreboard attorney Kelly Wooster of Brobeck, Phleger & Harrison in San Francisco.

However, insurer attorney Raoul Kennedy of Crosby, Heafey, Roach & May in Oakland, Calif., disagreed: "This is a very narrow opinion of limited applicability. The judge's conflict of law analysis is flawed and superficial.

"There is no suggestion that collectibility of the judgment depends on insurance. I don't see where Texas or West Virginia have an interest in seeing where the money comes from," said Mr. Kennedy. "California, on the other hand, has a strong interest in seeing that companies that do business within its borders behave responsibility and don't act reckless, snug and secure that some insurance company will pick up the pieces."

"This is a result-oriented decision written by a judge with a long history of a pro-policyholder orientation," criticized insurer attorney Paul E.B. Glad of Sonnenschein, Nath & Rosenthal in San Francisco.

"The judge skirts the fundamental question of whether California law governs the relationship between a California policyholder and its insurer," he said.

"This decision is a clear departure from prior California law," said insurer attorney Larry Trent of Buchalter, Nemer, Fields & Younger in Los Angeles.

"A California state court would not have reached the same result in light of California's long-standing public policy against insurance for punitive damages," he said.

"If the decision is appealed, it likely will be reversed," said Mr. Trent.

Attorneys for Continental Casualty could not be reached for comment on whether they plan to appeal Judge Henderson's decision.

However, one insurer attorney, Victor Levit of Barger & Wolen in San Francisco, said he would not be surprised if Judge Henderson's decision became the law in California. More and more courts are "backing off" from the notion that punitive damage awards can never be insured, he said. ●

Continental Casualty Co. vs. Fibreboard Corp., U.S. District Court for the Northern District of California; No. C 90 1452.

Gavin Souter joins *BI* staff in London

Gavin Souter has joined *Business Insurance* as an associate editor in the London office, Editor and Associate Publisher Kathryn J. McIntyre announced.

Mr. Souter, 27, will report on the London and continental European insurance markets. He replaces Carolyn Aldred, who resigned to raise a family. Ms. Aldred will continue as a *Business Insurance* correspondent.


Mr. Souter

Mr. Souter previously was editor of Reinsurance magazine in London. He also was a reporter at Post magazine in London.

Mr. Souter received a bachelor of arts degree in theology from the University of Nottingham, England, in 1985.

Mr. Souter can be reached at 011-44-71-404-4228. ■

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At Wausau's Fire Protection Laboratory, we've started and put out thousands of fires. That's how we teach our loss control specialists, policyholders, even fire departments about the causes of fire and the best ways to extinguish them.

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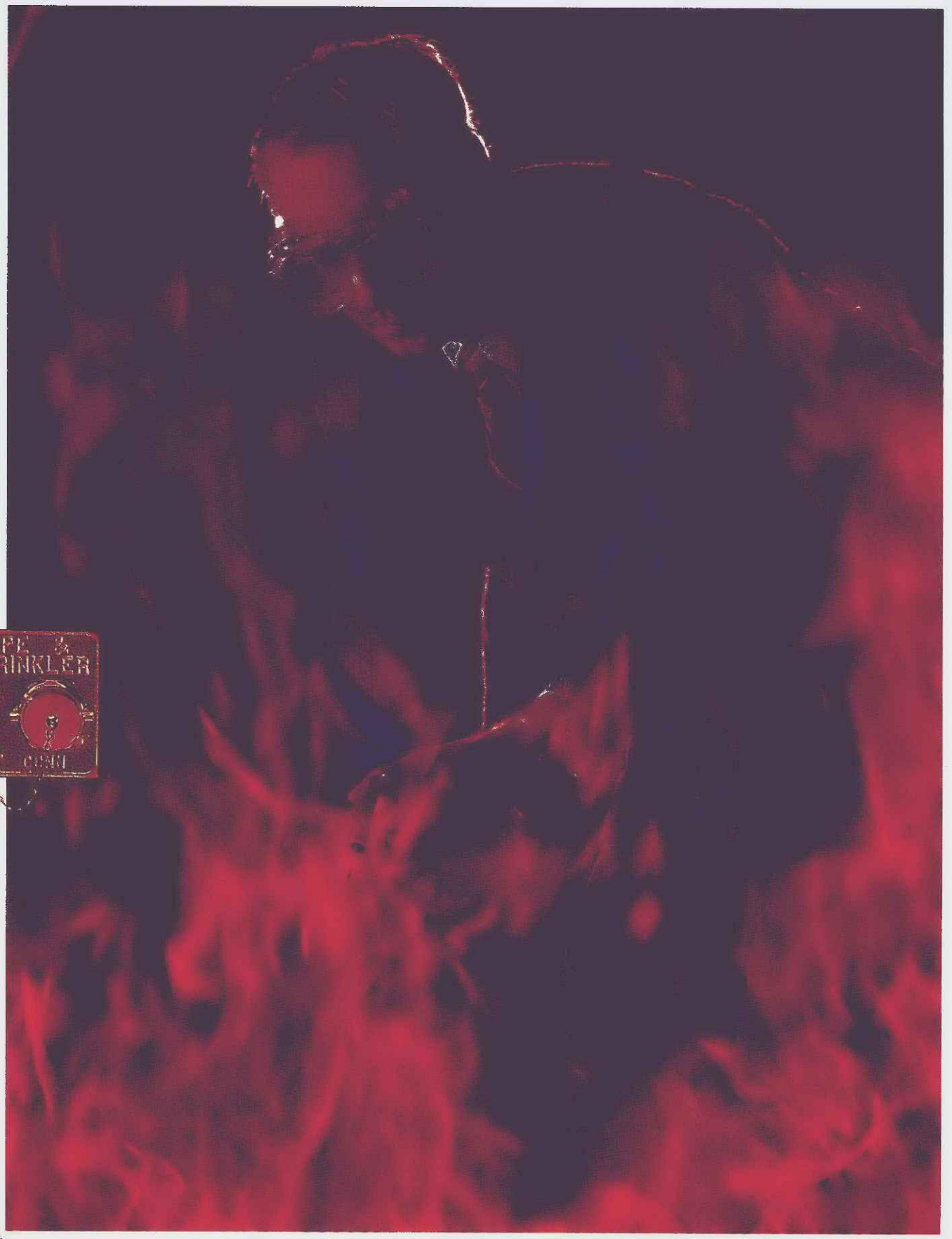
It is vital to understand that you can protect your property with insurance,



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Automakers put daycare in fast lane

By MICHAEL SCHACHNER

Benefit beat

Two automobile manufacturers are revving up plans to provide more than 6,300 employees with child care facilities, just months after another automaker opened the first on-site daycare center for auto workers.

Highland Park, Mich.-based Chrysler Corp. and the United Auto Workers union are planning to establish a 24,000-square-foot combination child daycare and employee training facility about one-half mile from the company's Acustar Inc. plant in Huntsville, Ala.

The center will begin serving 2,800 Chrysler employees by the end of this year, accommodating up to 300 children between the ages of 6 weeks and 5 years.

A Chrysler spokesman said the automaker and the UAW have not determined how much the center will cost to build, how much employees will pay for day care or who will manage the facility.

The plan to build the facility stems from the national training center agreement first hammered out in the company's 1985 basic bargaining agreement with the UAW, which also calls for the company and the union to provide workers remedial math and reading courses and high-tech training, according to the Chrysler spokesman.

Torrance, Calif.-based Toyota U.S.A. announced that it will break ground next month on a family center and child care facility at its Georgetown, Ky., manufacturing site.

The facility will replace a daycare center the automaker opened in 1989 that is five miles from the Georgetown plant. Toyota purchased a convent for $1 million and converted it to a daycare center.

Some 165 children of the plant's 3,500 employees are enrolled at the off-site facility, as well as 10 children from the community. It has the capacity to care for 240 children.

Costs to parents are $48 per week for children younger than 2, and $45 per week for older children.

Toyota contributes about $200,000 annually to operate the center, which is managed by Scott County, Ky., employees.

Toyota says it will donate the off-site facility to Scott County after the automaker opens its on-site facility.

Toyota is not providing details on the expected costs of building the on-site center, which is scheduled to be operational some time in 1993.

And, Saturn Corp. is partially subsidizing the cost of a 7,300-square-foot on-site child care center it opened late last year adjacent to its assembly plant in Spring Hill, Tenn., which has more than 4,000 workers.

The center—the first on-site facility opened by a U.S. automaker—can accommodate 90 children between the ages of six weeks and five years.

Saturn employees are required to pay between $52 and $86 per week for the care of each child. Weekly rates depend on age, explained Dick Sanderson, Saturn's human resources adviser. He said the portion of costs parents pay covers all operational expenses of the facility.

Saturn is covering the cost of building the structure and the land lease. Mr. Sanderson declined to provide details on Saturn's costs. Nashville-based Corporate Child Care Inc. staffs and manages the facility.

Plans at Toyota and Saturn for providing daycare facilities were reached outside of basic bargaining agreements, spokesmen said.

Mental health UR

In an effort to better manage rising mental health and substance abuse costs, Detroit-based General Motors Corp. has contracted with Preferred Health Care Ltd. to perform all of GM's mental health utilization review, precertification and case management.

PHC on July 1 will begin managing mental health and substance abuse benefits for 1.5 million GM employees, retirees and dependents covered by GM's self-insured health care plan. Blue Cross & Blue Shield of Michigan will provide UR services until July.

GM's remaining 500,000 covered lives are enrolled in various health maintenance organizations.

GM, which spent more than $3 billion on total health care in 1990, would not say what percentage of overall health care was attributable to mental health and substance abuse. But, a spokesman said GM in 1990 reduced its substance abuse treatment costs by 7% to about $65 million from more than $70 million in 1989.

But, "the reduction in costs does not stem from a reduction in usage of benefits," the spokesman said.

"We have had some successful gatekeeping under our old UR contract, but we can do better. That's why we are hiring Preferred Health," he said.

National health care

A national health care system is a viable solution to rising health care costs, say more than half of the personnel managers responding to a survey conducted by Employee Benefits Services Inc.

Of the 270 members of the International Personnel Managers Assn. polled by New York-based employee benefits communications consulting firm EBS late last year, 53% support a national health care system to contain skyrocketing health care costs. And, 78% believe that a national health insurance program will become a reality within 10 years.

The second annual survey of IPMA members, 73% of whom represent firms with fewer that 1,000 employees, also found that medical costs at the respondents' companies increased between 10% and 20% from late 1989 to late 1990 and that respondents anticipate medical costs will increase by a similar amount this year.

Survey respondents reported they have implemented or may implement several cost-containment measures to combat rising health care costs. For example:

- Eighty-five percent said they require employees to contribute toward the cost of health care coverage, and the other 15% are considering such a requirement.
- Ninety percent have increased required contributions in the past several years, while the other 10% are considering doing so.
- About 78% said they have increased employee deductibles during the past few years, and the remainder said they are considering raising deductibles.
- Ninety-two percent said that utilization review and case management have become integral parts of their benefit plans over the past few years, and the remainder are considering implementing those measures.

Free copies of the "The EBS/IPMA Second Annual Survey" are available from Dennis Stone, Managing Director, Employee Benefits Services Inc., 555 Madison Ave., New York, N.Y. 10017; 212-980-5353. ■

SUBSTANCE ABUSE IN THE WORKPLACE— THE BLUE COLLAR VIEW.

One in an ongoing series of conversations between Argonaut Insurance Company, our clients and their brokers, dealing with issues important to their business. The intent is to keep the lines of communication open. We invite your participation.

THE PARTICIPANTS: **CURTIS WESSELN,** *Vice President of Wesseln Construction;* **DENNIS DELUCCIO,** *Superintendent Wesseln Construction;* **JESS GORMAN,** *Superintendent, Wesseln Construction;* **DICK MURY,** *with Frank E. Hall Corporation Wesseln's broker;* **STEVE LA SHIER,** *Senior VP Safety Management, Argonaut Insurance Company;* **LARRY EVANS,** *Manager of Safety Management, Argonaut Insurance Company.*

MODERATOR We've been talking about some of the problems a construction company like Wesseln faces in dealing with substance abuse in the workplace. The lack of testing guidelines the lack of union programs, the difficulty of staying competitive. Does Argonaut have clients in similar businesses that have found a way to deal with the problems?

SL: This is how one contractor deals with the testing problem. I quote from his employee manual: "The company recognizes that alcohol and drug abuse are illnesses. It is with this philosophy that the following guidelines have been established: An employee terminated for violating a policy shall not be eligible for rehire for a period of 30 calendar days. During that period, it will be the individual's responsibility to seek rehabilitation. They will then be required to take a second test at their own expense at the company-approved laboratory which must result in a negative diagnosis." This policy is signed by the president of the company and given to every employee. As a result, they have a reputation as a drug and alcohol-free workplace. And their comp premiums have gone down more than 40% in one year.

CW: What kind of contractor is it?

SL: A general contractor. High rise and low rise.

CW: That's a different story than ours. They might be on a high rise project for two years. Residential is very sporadic. Our guys are in and out, you never know who you're going to have back. That's a big difference.

SL: You said you have a core group of about 200 guys you work with all the time. Are they loyal enough to your company to say to you, "Hey, this guy's drinking." Or "This guy's snorting."? Will they finger him, or is that snitching or a blue collar macho thing?

CW: Snitching. But it's up to the individual. They don't want to work a roof with somebody who's been drinking or taking drugs, and just by their own subtle process, they'll make sure that guy's not going to be employed.

DD: Personally, I think it would be much better if everyone was tested before they were hired, instead of after an accident. That's a nice thought, but I think the directive has to come from somebody above us. We can help initiate it, but we need help from the builder we work for.

CW: We are a framing business. We don't know all the rules and options concerning abuse programs. We need some information and support. That's one of the reasons we went with Argonaut and Frank B. Hall. At least now we're getting feedback from both companies. With our former broker and insurance company, there was very little contact.

> A substance abuse program with a testing policy statement helped lower one contractor's premium 40% in one year.

DD: In a meeting I attended, they were talking about putting a printed safety policy with all the rules in everybody's paycheck. I don't know how effective it would be. I'd be nervous about the reaction. But it would be great if we could do it.

MODERATOR If the unions knew you had a drug-free operation, wouldn't they send you the best people?

CW: We pretty much demand the best people anyway. And then they're screened by their production and what they do on the job site.

JG: What if a guy only goes out drinking every few months? How could pre-employment screening catch him? And even if we do find him and suspend him for 30 days, he'd just go to work somewhere else.

DD: Another problem with a 30 day suspension is that 90% of these guys live paycheck to paycheck. Tell them "You're suspended for 30 days, seek help." and what they're going to seek is another job. They can't afford to be off work for a month. If somebody paid them to attend the program, that's fine. But if they don't get that regular paycheck, they'll lose their house, their wife and everything else.

SL: Curtis, say you put out a flyer that says you're instituting a complete substance abuse program. All future employees will be tested. All current employees will be tested. You are providing access to assistance for anyone who feels they have a problem. They have 120 days to square their act away. As an employer, you're not going to know who uses the program. If they have not squared themselves away in those 120 days, do you really want them around? Because sooner or later, they'll become a statistic.

CW: That's where businesses like ours need help. We don't have the time to investigate programs or ways to set them up. I have to rely on other people for this kind of information.

SL: I agree with you, Curtis. And you don't have to reinvent the wheel. It's just that the industry as a whole is slow to respond. In 1971, the construction industry injured 14.8 workers per hundred every year. We've only reduced that to 14.6 today. Not much of an improvement in 20 years.

JG: Does Argonaut have a substance abuse policy?

SL: Yes. And I'll be honest with you, there was a lot of fear, apprehension and misunderstanding about it, just like in a lot of companies across America. We've instituted the policy and provide access to assistance programs. We also have a Corporate Wellness Program. So you see, we understand a lot of the problems companies face because we're facing them ourselves.

JG: You should tell people "We have instituted the policy..." "This is what we do here at Argonaut." "This is what some of our clients do." That's what we need. Examples. Success stories.

SL: How about this. That contractor I told you about, in the three and a half years he's had that program, there hasn't been one single legal contest.

> You don't have to pay for an assistance program, just provide access.

CW: What does it cost to test someone?

SL: The initial test will cost you about $30 per employee. But if anyone tests positive, you have to confirm it with a $60 GC mass spectrometry test. If you don't, you'll end up in court. A good example: has anyone here taken Advil? I have a bad shoulder. I took two Advil on Sunday before I went out to play golf. Three days later I guarantee you I'll test positive for marijuana. Advil shows up as marijuana on the first screening. GC mass spectrometry would show I took 400 milligrams of Advil within the last 48 hours. So you *must* confirm any positive test.

MODERATOR What would happen if you took the lead and talked to builders about instituting a drug progam? Would they think you'd give them added value, or do they just look at cost?

DD: Cost, cost, cost. And production. If you have a testing program and your bid is the same as someone that doesn't, that's fine.

MODERATOR Wouldn't having a program enhance your reputation?

CW: We already have a reputation for delivering top quality work. Having a testing program might enhance it. But the bottom line is still production and cost. The builders would come back to us and say, "It's nice that you have a program, but so and so is 7% lower and we're going with them."

JG: Last week I bid a job and the guy said we were way too high. When I asked him if the guy with the low bid paid his comp premium, he said "Frankly I don't care as long as I have the certificate." It all comes down to money. That's always the bottom line.

LE: So whether you have a high or low accident rate really isn't considered?

JG: Only if it shows up in our price.

LE: Which is right where it will show up eventually.

Continued next week

We'd like to hear what you have to say about substance abuse in the workplace, and about our discussions on topics that concern your business. Send your comments to Mike Crall, President, Argonaut Insurance Company, 250 Middlefield Road, Menlo Park, CA 94025.

Argonaut

Opinions

Risk act changes benefit all

BALANCING THE CONCERNS of businesses that need access to affordable insurance and regulators that want to protect policyholders and enforce solvency standards is not easy when it comes to the Risk Retention Act. But the Risk Retention Act overhaul legislation proposed by the Bush administration this month is a good first step in achieving a better balance (*BI*, Feb. 18).

Regulators are rightly concerned that the current law makes it too easy for thinly capitalized insurers to write big blocks of business for risk purchasing groups.

The proposed amendments—addressing a major oversight in the current law—set tough new solvency standards for purchasing group insurers. In order to write purchasing group business, an insurer generally would have to meet the same capital and surplus requirements as admitted insurers in every state it provides coverage.

If this requirement were enacted into law, a purchasing group insurer could not, as some have tried to do under the current law, simply meet the capital and surplus requirements of one state—often a state with a minimal requirement—and then try to write business nationwide.

Just as the new solvency standard addresses the concerns of regulators, it also would protect the interests of buyers.

While a purchasing group insurer generally would have to meet capital and surplus requirements imposed on admitted insurers in every state it operates, the purchasing group insurer would not actually have to be admitted in that state.

If a purchasing group insurer had to be admitted in every state, it would limit the available market of purchasing group insurers to those already licensed in all states. It would be too expensive for a regional insurance company, for example, to seek licensing in other states to serve only a few purchasing members located in those other states.

Also increasing businesses' access to purchasing group insurers is the new provision that a purchasing group insurer only needs to meet the rate and form requirements imposed by the state which is the purchasing group's principal place of business. This reduces potentially burdensome rate-and-form requirements.

The legislation does significantly increase the amount of information that purchasing groups and their insurers must provide to state regulators, but it is not too burdensome. For example, a purchasing group insurer generally would only have to comply with filing requirements of the purchasing group's principal state of business, providing all other states only with copies of those filings.

"IT LOOKS LIKE WE'RE ON THE RIGHT PATH!"

No doubt the administration's legislation can use fine-tuning.

On the face of it, there should be no disagreement between regulators and businesses over the proposed requirement that risk retention and purchasing groups be controlled by the policyholders, not by insurers, brokers, agents or other advisers. Policyholder control is essential to ensure that a group is run in the best interests of its members. But, the Bush proposal could be better worded. The legislation is not clear if this control provision would be satisfied—as it should be—by members when its trade association helps to organize a purchasing group or risk retention group for its members.

In addition, the requirement that a purchasing group insurer must maintain a premium-to-surplus ratio of no greater than 3-to-1 is too arbitrary. It does not address the degree of risk being assumed by the purchasing group insurer, which may warrant a higher or lower premium-to-surplus ratio.

No doubt other changes will be necessary. But we're encouraged that Bush administration officials have said they are open to suggestions for improving the legislation.

Above all, we hope that the administration proposal prods Congress into action so that a new and much improved Risk Retention Act can be approved before the next hard market.

Letters

Surplus lines rates not falling for chemical firm

To the editor: Our company is a distributor of industrial chemicals in Western Michigan. We place the highest emphasis on both safety and service to our employees, customers and the environment. As with many companies, insurance costs are one of the largest expenses we incur annually.

I found your Jan. 7 article, "Rates Tumble in Surplus Lines Market" extremely informative. But, after unsuccessfully attempting to purchase additional excess general liability/product liability coverage at a reasonable cost, I found a great disparity between the published article and the actual premium quotes presented by our broker. Your article states there is a softening in the rates for excess lines coverage, but we are experiencing the reversal of this position.

I welcome any suggestions your readers might wish to share with me.

Richard A. Topp
Webb Chemical Service Corp.
Muskegon Heights, Mich.

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

Economic family theory makes sense

To the editor: You editorialize that premiums paid to captives and self-funded loss reserves should be deductible for income tax purposes (*BI*, Feb. 11).

A case can be made that self-funded loss reserves are analogous to loss reserves (including incurred-but-not-reported losses) established by insurance companies and should therefore be deductible.

But, if a captive is allowed an IRS deduction for its loss reserves, which are derived from premiums paid by its parent, would not some expense dollars be deducted twice; i.e., first as a premium expense by the parent, then as loss reserves by the captive?

Granted, the procedure is similar to obtaining insurance from an unrelated insurance company. But, in fact, the parent company merely transfers funds from one pocket to another to the detriment of the taxpayers.

The Internal Revenue Service's "economic family" theory seems logical to this former underwriter.

Edward J. King
Denville, N.J.

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Health reforms would hike employer tax bills

By ADRIENNE C. LOCKE

WASHINGTON—Raising revenue through limiting tax deductions for health insurance expenses or by increasing employer payroll taxes is at the heart of two proposals to reform the nation's health care system that may be introduced in the House this month.

One bill—a wide-ranging health care reform proposal from the Republican Task Force on Health Care—will probably cap the amount that employers can deduct from federal income taxes for health care expenses, said Rep. Rod Chandler, R-Wash., a task force member. He did not disclose at what point deductions would be capped.

Limiting deductions for health care expenditures would help offset the cost of tax incentives that might be included in the proposal to encourage employers to offer health insurance, he said.

However, the GOP proposal to extend health care coverage to the uninsured differs sharply from one by Rep. Martin A. Russo, D-Ill. Under that proposal, employers' taxes would be increased to raise $165 billion a year to fund a single-payer universal health care system much like the Canadian universal health care plan.

"I favor a single-payer system because it is a more efficient way to administer and finance health care," Rep. Russo said.

Both congressmen made their case to executives at a Washington Business Group on Health/National Assn. of Manufacturers conference last month in Washington, D.C.

Their proposals would bring to three the number of major proposals before the House to increase access to health care. Rep. Fortney (Pete) Stark, D-Calif., introduced a universal health care measure last month (*BI,* Feb. 4).

Reforming the U.S. health care system will be painful for all involved, says Rep. Chandler, adding that sharing the burden among all parties will keep the discomfort to a minimum.

Rep. Chandler outlined a wide range of provisions that the Republican health care reform bill could contain.

For instance, the bill could include medical malpractice reforms to make health care more affordable. The proposal could call for measures like required pre-litigation screening, a cap on punitive damage awards in medical malpractice cases and incentives to set up alternative dispute resolution mechanisms.

In an attempt to extend access to health care coverage, the bill may exempt small firms from state benefit requirements, allowing them to offer "no-frills" coverage. Risk pools could also be established through the legislation to provide health care coverage for small employers and individuals, Rep. Chandler said.

Practice guidelines for doctors may also be included in the reform bill, along with a reimbursement system designed to discourage treatment and testing that is considered unnecessary, he said without elaboration.

Rep. Chandler says he is trying to avoid—but would not rule out—requiring businesses to offer a minimum health care benefits package. "Assuming that we pass this package and we don't get the response we wanted, then you might have to consider that."

By contrast, Rep. Russo favors making the nation's multiple-payer health care system into a single-payer system that would be administered jointly by the federal government and by the states.

To finance the system, Rep. Russo would levy a 6% payroll tax on employers and would raise corporate income tax rates to 38% from 34% for businesses with more than $75,000 in profits.

Rep. Russo also favors raising personal income tax rates in the upper brackets—to 30% and 34% from the current 28% and 31%. In addition, a new top rate of 38% would be instituted for families with income exceeding $200,000.

States also would be required to help fund the national health care system, Rep. Russo said, though annual state health care spending would decrease about 15% to $71 billion from $83 billion in 1989 under his system.

He projects the first-year costs at $549 billion—or about 6.8% less than the estimated $589 billion the nation spent on health care in 1989.

Reduced administrative burdens on providers would account for most of the $40 billion in savings Rep. Russo foresees. Providers wouldn't have to keep up with eligibility requirements and other data from hundreds of insurance plans, he said.

"Currently, 18% of hospital spending is for administration and billing, and close to 45% of gross physician income goes toward billing," he said.

Employers would not have to buy workers compensation medical coverage or group health insurance for employees. But the new taxes would raise business expenditures on health care $23 billion to $199 billion from $176 billion in 1989, he said.

Much of that increase, Rep. Russo contends, would come from employers that offer no health insurance now. Employers that provide coverage would save money with the plan, he said.

"A multi-payer system places an inordinate burden on business. My plan would spread costs over all segments of society, because everyone should pay their fair share for health care," he said.

Under the Russo proposal, individuals would pay neither deductibles nor copayments and could choose their own doctors and hospitals. Providers would be prohibited from billing individuals for amounts not paid by the health care program.

Benefits would include:

- All medically necessary hospital services, with a 45-day limit for mental health services.
- Nursing home services and hospice care.
- Dental services.
- Prescription drugs.
- Preventive care.
- Home-based and community services for those with difficulty performing at least two activities of daily life.
- Any other medical or health-related items or services deemed appropriate by the secretary of health and human services.

To critics who believe a single-payer system would lead to health care rationing, Rep. Russo replies: Rationing already takes place. The uninsured are less likely to be given routine diagnostic tests or to have important surgery and more likely to die during a hospital stay, he said.

"This illustrates that the U.S. rations health care in the cruelest way imaginable—based on the ability to pay," he said, adding that his proposal would grant every citizen equal access to all aspects of health care without gaps in coverage or barriers to care.

Rep. Chandler concedes that serious changes in the health care system are needed. "Clearly, with over 30 million uninsured and national health care expenditures exceeding 11% of GNP, something more than tinkering needs to be done," he said.

However, he argues against scrapping the existing system, especially for a Canadian-style alternative.

"Instead, we ought to build on the system that we have, expand on those things we do well and correct the problems we all know exist," he said.

Both Reps. Chandler and Russo doubt Congress will pass significant health care reform legislation, though both legislators say they want to encourage debate on the topic.

"My proposal does not attempt to answer every detail. It is intended as a framework for how a national health insurance program should be structured," Rep. Russo said. "I hope my proposal will spur debate on the issue of national health insurance and move us closer to solving our health care crisis."

"I urge the same spirit of compromise and cooperation from everyone I talk to about this issue. I am convinced that the only way to overcome this health care crisis, short of scrapping our current system and going to a system of national or 'socialized' health care, is to work together," Rep. Chandler said. ■

Doctors view ethics of cost control

By ADRIENNE C. LOCKE

WASHINGTON—Employers trying to control medical costs should examine the ethical implications of their cost-cutting programs, two physicians warn.

While employers may feel that controlling access to health care is necessary to keep rising medical costs in check, such polices can interfere with a patient's need for care, said Ralph Muller, president of the University of Chicago Hospitals.

"Increasingly we are making judgments on who is worthy and who is not worthy of medical care," he said.

Instead of trying to limit access to care, employers, government and providers should fulfill their obligations to provide care, Dr. Muller said.

Dr. Muller spoke at a Washington Business Group on Health/National Assn. of Manufacturers conference last month in Washington, D.C.

Health care payers, like employers, are able to dictate access to health care because the focus of medical care itself has changed, said Mark Siegler, professor of medicine and director of the Center for Clinical Medical Ethics at University of Chicago Hospitals.

For many years, the will of the doctor ultimately prevailed: Whatever the doctor thought was best was done, he said.

This philosophy lasted until the 1960s, when patients' rights began to be emphasized, Dr. Siegler said. "Cost was not seen as a relevant factor when weighed against a patient's goals and needs."

However, by the mid-1980s, as health care costs began to rise significantly, health care payers began to hold providers and patients more accountable for the services requested and provided, Dr. Siegler said.

Conceding that health care costs are out of control, Dr. Siegler attributes this largely to problems with the public health care system for the elderly and poor and the lack of medical insurance for the working uninsured. He referred to the practice of "dumping the poor." The lack of coverage for these groups causes hospitals to shift costs onto other payers, like insurers and self-insured employers, he said.

"Costs keep going up not because the services are more expensive, but because you are paying for those who are walking away from their responsibility," Dr. Muller said, referring to the government and to companies that provide no health insurance.

Dr. Muller said some government programs pay hospitals only 60% of the cost—not the price—for the services they provide. Hospitals also provide a great deal of uncompensated care.

As an example, he cites a patient transferred to the University of Chicago Hospitals for a liver transplant.

The original hospital, which could not perform the operation, is affiliated with a health maintenance organization.

The surgery was performed, Dr. Muller explained, but, when the bill came due, the HMO said it didn't cover transplants.

Dr. Muller said the HMO also told hospital officials that hospitals have a moral duty to care for anyone that comes through the door, but an HMO has no such obligation.

The hospital still awaits the $50,000 reimbursement for the transplant, he said.

Dr. Siegler calls another common cost containment policy "blame the victim."

"Employers identify a wide variety of illness and conditions, determine that they are self-inflicted and exempt them from coverage," he said, citing as examples obesity and uncontrolled high blood pressure.

Dr. Muller said these "self-inflicted" illnesses also can include another group of "above the neck limitations"—like mental health, dental and vision care—for which employers won't provide health coverage.

Excluding these medical conditions from health insurance changes the doctors' role from caring for the sick to modifying behavior, Dr. Siegler said.

Employees are told to exercise but not to participate in sports, or to eat wisely but not to diet too much, he noted.

There is also the "pass the hot potato" strategy, whereby employers refuse to provide coverage for a "pre-existing condition," that often may be as routine as a pregnancy or a sports injury, according to Dr. Muller.

Such policies, said Dr. Siegler, fail to recognize that many of these conditions are not uncommon but may result from prevailing social or cultural influences.

Yet another emerging cost containment strategy is "kill the dying," indicating that care should not be wasted on the chronically or terminally ill patients who would not benefit from it, Dr. Siegler said.

He said the high cost of dying can be seen in the Medicare program, where 28% of all expenditures stem from patients' last year of life. Most expensive are the last 60 days, he said.

Medical care should not be wasted on those who will not benefit from it, but it is very difficult to determine where to draw the line, he said.

Definite changes are needed to help eliminate restrictions on care, Dr. Muller said. For example, he believes Congress should approve a basic level of health care benefits for all citizens, though he did not elaborate on the idea.

Dr. Muller favored expanding Medicaid to the poor and nonworking uninsured. And he called for increased national regulation of provider fees. "There has to be limits on what hospitals and doctors make."

Doctors and hospitals, he said, should be more responsible for utilization. At rates of up to $1,000 a day for a hospital stay, "you shouldn't be in the hospital if you don't need to be there," Dr. Muller said. ■

Executives debate health care problems

By ADRIENNE C. LOCKE

WASHINGTON—Employer-provided health insurance should be extended to uninsured workers, while tax incentives should be used to make such coverage more affordable to small businesses, a corporate executive says.

Congress should require employers to offer at least limited coverage for necessary and routine preventive services, said Michael R. Peevey, president of Southern California Edison Co. in Rosemead, Calif.

"These (services) have small upfront costs, but large long-term paybacks" in improved overall health, he said.

The government also should provide health insurance for those not in employer plans and make sure public health programs are adequately funded to avoid unfair cost shifting to employers, Mr. Peevey said.

However, John J. Sweeney, president of the Service Employees International Union in Washington, D.C., said he believes that some form of a national "all-payer system," or nationalized health care system, is the only way to solve the United States' health care problems.

"We won't have control of health care costs in this country unless and until we have all payers—public and private—acting as a single payer," Mr. Sweeney said.

"I believe that the evidence is now conclusive that plan-by-plan, employer-by-employer, we can't tame the forces that are driving health care costs, no matter how adroit we become as purchasers," he said.

Under the system envisioned by Mr. Sweeney, reimbursement for hospitals, doctors and other providers would be set on a national basis. Fees would be adjusted to bring health care spending within federal targets, he said.

Mr. Sweeney said business and labor must begin acting now to ensure reform of the nation's health care system because neither business or labor can rely on Congress or the Bush administration to come up with a solution.

Both Mr. Sweeney and Mr. Peevey spoke at a Washington Business Group on Health/National Assn. of Manufacturers conference held last month in Washington, D.C.

Apart from their different proposals for achieving health care reform, Mr. Peevey and Mr. Sweeney agree that the issues of cost, quality and access to health care must be resolved.

Universal access is a vital step to controlling health care costs, because the medical costs of the estimated 32 million uninsured Americans are shifted to those Americans with coverage, according to Mr. Peevey.

"If this unfair reimbursement policy continues, private health plans will become too expensive for employers to purchase or maintain," Mr. Peevey said.

Mr. Sweeney agreed: "We'll never control costs if we don't have everybody in the system."

In the short term, universal health care coverage will create new costs for employers not currently providing coverage and for the federal government, which would subsidize health insurance offered by small business and would finance the cost of coverage for the non-working poor, Mr. Peevey said.

However, universal access to health care will mean early treatment of illnesses at a reasonable cost, so people won't delay treatment until their illnesses become acute and much more expensive to treat, Mr. Peevey said.

Mr. Peevey also said that employers and government must use proven cost control measures in the health care programs.

For example, "fair and equal" fees for providers services should be established, Mr. Peevey said. These fees would be charged to all health care payers, including the government, to eliminate cost shifting from Mecicare and other programs.

In addition, plan participants should pay part of their health insurance costs, Mr. Peevey said.

"Historically, people with medical benefits have been indifferent to the cost of their treatment. In fact, they often request or accept unneeded services which increase medical costs," he said.

Mr. Peevey says any health care system should provide financial disincentives for unnecessary care, and adds that about one-quarter to one-third of all medical procedures are inappropriate or unnecessary.

However, "we must manage health care services efficiently and cost-effectively without jeopardizing the welfare of the recipient," he said.

At Southern California Edison, for example, utilization review programs have been effective in reducing the volume of such procedures. But UR programs only work when plan participants face reduced coverage if they do not use the program, he said.

Over the long run, such cost containment measures will make health insurance more affordable for those employers that cannot afford it now, Mr. Peevey said.

The union's Mr. Sweeney said physicians should be held more accountable for deciding what care to provide, adding that doctors sometimes call for inappropriate care.

"Physicians, not patients, control utilization where it counts," he said.

Purchasers of health care don't what to second-guess providers or "micro-manage" care, but they do expect that medical practices be socially and medically justifiable, he said.

No matter what type of universal health care plan is approved—a plan largely administered by employers or a single-payer nationalized system—health care reform must be implemented as soon as possible, with business and labor leading the way, Mr. Sweeney said.

Labor and management in the past were not as active in the national health care debate because they were locked into their own disagreements over health care policy, he said.

However, both sides have learned the hard way that neither business nor labor can win under the current health care system, Mr. Sweeney said. "The only way to win is to change the rules."

Although Congress and the Bush administration would "prefer to ignore" the health care crisis, they must be forced to take up health care reform and make serious changes now, Mr. Sweeney said.

"I don't think waiting another 10 years for incremental reforms to solve the problem in realistic. I think it's suicidal," Mr. Sweeney said. ■

Employers told to lead health care reform

By ADRIENNE C. LOCKE

WASHINGTON—Employers must take the lead in the debate over national health care reform, two business leaders say.

"Medicine is big business," pointed out Mary Jane England, president of the Washington Business Group on Health, a business-backed policy and research organization in Washington, D.C. Because employers pay such a large portion of the nation's health care bill, their ideas and opinion must be heard, she said.

Ms. England spoke at a conference sponsored by the Washington Business Group on Health/National Assn. of Manufacturers conference Jan. 28-30 in Washington, D.C.

Jerry Jasinowski, president of Washington, D.C.-based NAM, said that while employers have made significant progress in controlling health care costs, they have not been totally successful.

Costs are still rising 10% to 20% a year for large companies, compared with are increases of up to 50% to 100% for smaller companies, he noted.

U.S. manufacturers have made "much less progress in health care" than in other areas, like improving their competitiveness with foreign firms, according to Mr. Jasinowski.

Bringing health care costs under control is a top goal of industry, but Mr. Jasinowski says employers should not sacrifice quality and access to health care to control costs.

Both access to health care and ensuring quality care are issues of great importance to NAM and the WBGH, he said.

Ms. England says a large part of her job as president of the Washington group will be to build a consensus on national health care reform.

"We have the skills and knowledge to have the highest-quality and most sophisticated health care system in the world. It won't be modeled after any other system—it will be uniquely ours," Ms. England said.

Business always has tried to respond to the health care needs of its workforce, she noted.

With the onset of war in the Persian Gulf and the subsequent activation of thousands of reservists, many employers—without any obligation—have voluntarily extended health insurance to these employees and their dependents, she said (*BI*, Jan. 28; Sept. 10, 1990).

"Just another example of how corporate America really comes through when situations affect the lives of its employees," Ms. England said. ■

WBGH/NAM meeting draws 280

WASHINGTON—More than 280 people attended the Washington Business Group on Health/National Assn. of Manufacturers' Seventh Annual Health Agenda Conference, held Jan. 28-30 in Washington, D.C.

NAM is the largest industrial trade organization in the nation, with more than 12,500 members.

The Washington group is a non-profit policy and research organization that provides information on corporate health care issues. More than 180 large corporations are members.

Next year's conference also will be held in Washington, D.C. during the last week of January. For more information contact the NAM at 1331 Pennsylvania Ave. N.W., Suite 1500 N., Washington, D.C. 20004; 202-637-3124.

New York restricts junk bond holdings

NEW YORK—A new amendment to a 1987 New York Insurance Department regulation will further restrict the junk bond holdings of life insurers and the life insurance units of multiline insurers.

The amendment to Regulation No. 130 also adopts the bond rating system developed by the National Assn. of Insurance Commissioners, a department spokesman said (*BI*, June 18, 1990; May 14, 1990).

The amendment retains the 20% overall limit on investments in medium- and lower-grade bonds set by Regulation No. 130. However, effective Jan. 1, 1992, it establishes new "inside" limits on the lower-rated bonds.

For example, it will not allow an insurer to invest more than 10% of its admitted assets in bonds rated "four," "five" or "six," which is the equivalent of rating agencies' "B" rating or below, according to the department spokesman.

The new NAIC bond rating system became effective last week. Bonds are to be rated from "one," the equivalent of triple-, double- and single-A ratings, to "six," which is considered "near default."

Under the previous system, bonds were rated in descending order of quality, "Yes," "No*," "No**," and "No."

Also effective last week under the New York amendment, all private placements would be subject to the regulation. Previously, private placements valued at more than $50 million were exempt, the spokesman said.

—By Judy Greenwald

NFL pensions

Continued from page 3

A Yablonski, an attorney for the players with Yablonski, Both & Edelman in Washington, D.C.

The suit is the latest battle in the ongoing war between players and owners. The players have been without a contract since their 1987 strike. They returned to work without a contract only after games were staged with replacements.

The players then focused their attention on an antitrust suit against the league. They lost.

Mr. Yablonski filed the benefits suit in U.S. District Court in Washington, D.C., on behalf of players Earnest A. Byner, Gary C. Clark, Darrell Green and Jim Lachey, all of the Washington Redskins; Lomas Brown Jr. of the Detroit Lions; and Jay Hilgenberg of the Chicago Bears.

The Rozelle pension plan, which took effect in April 1989 and covers about 1,500 players, provides retirement, disability and death benefits. Players who participated during the 1989 and the 1990 seasons have earned benefits under the plan named for former Commissioner Pete Rozelle.

The Rozelle plan succeeded the Burt Bell pension plan following negotiations between team owners and players in 1988 and 1989. The Bell plan, which was established in 1969, also is named after a former NFL commissioner.

The Rozelle pension plan is a defined benefit plan that is solely funded and administered by the owners, while the Bell plan—which is jointly administered by the players and the owners—is a defined benefit plan that was funded by some player contributions.

Both of the plans offer identical benefits, the only difference between them being that players under the Rozelle plan no longer have to make the employee contributions that were required under the Bell plan.

Players receive retirement benefits of $150 per month for each season they play. They are vested by the third game of their fourth year in the league and normally receive their pension benefits beginning at age 65.

In addition, players can receive benefits of at least $4,000 a month for football-related and other specified total disabilities and $750 a month for other total disabilities.

And survivors of players can receive death benefits of up to $1,500 a month for 48 months depending upon the years the player was active. A reduced benefit is paid after 48 months.

In their suit, the players are seeking to force the plan to disclose all required data, plus additional information like the plan's assets and liabilities and its annual tax statement, Mr. Yablonski said.

The players also want to confirm that the plan's administrators are complying with their fiduciary responsibility and are meeting with ERISA and Internal Revenue Code standards. In addition, the players want to know who has been appointed to the owners' committee to administer the plan, he said.

And, Mr. Yablonski said the suit attempts to force the plan's administrator to tell the players what benefits they have accrued so far under the new plan. "We don't know at this point whether benefits have started," he said.

"I think that it is an outrage that there is this other plan out there to provide comparable benefits that the players have not been informed of," Mr. Yablonski said, referring to the Rozelle plan.

The complaint asks the court to fine Mr. Curran $100 a day for each day the plan has failed to provide the plan information, as well as for reimbursement of reasonable attorneys' fees. ■

At issue

Should driver training programs should be mandatory for employees who drive on the job?

Patrick T. McGovern
Risk Manager
Connecticut Mutual Life Insurance Co.
Hartford, Conn.

Yes. Employees who routinely drive on company business should receive a full program of defensive driver training. Other employees, whose driving on company business is on a non-regular basis, should receive information and training tailored to the extent of driving they do.

Christopher E. Mandel
Director-Risk Management Division
American National Red Cross
Alexandria, Va.

Absolutely! Having spent five years at Bell Atlantic, where the "Bell System" philosophy of giving safety a high priority was strictly adhered to, I've seen it work. Both at Bell and at Red Cross, I've seen defensive driving techniques used to produce improved loss results in both frequency and severity. There's no better investment to affect the auto cost of risk.

Chris Anderson
Insurance & Risk Manager
Worldwide Church of God
Pasadena, Calif.

Regulation is for those who fail to regulate themselves. Corporations that appreciate the responsibility inherent in fleet operations already have effective driver training programs. For those who fail to comprehend the gravity of the responsibility, mandating effective programs is necessary.

Scott E. Tarbet
Vp-Risk & Insurance Management
Columbia Savings & Loan
Irvine, Calif.

Driver training is effective, is relatively inexpensive, can be customized and therefore has great potential for a desirable cost/benefit ratio. Firms should weigh their overall automobile-related cost of risk vs. the cost of administering a training program, to determine whether such a program is a "buy." Firms electing to adopt a driver training program should make it mandatory.

ERISA rulings

Continued from page 3

fect on employee benefit plans relate to such plans and are therefore pre-empted by ERISA," he wrote.

Judge Gonzalez also said that the U.S. Supreme Court has found that ERISA's civil enforcement remedies were intended to be exclusive.

Indeed, the U.S. Supreme Court ruled in a 1987 case involving an insurer's handling of a disability claim: "The deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive. This conclusion is fully confirmed by the legislative history of the civil enforcement provision."

In addition, the U.S. Supreme Court last December invoked ERISA's pre-emption powers in overturning a Texas Supreme Court ruling that allowed workers to proceed with litigation in state court against a former employer that they charged fired them to avoid paying pension benefits (*BI*, Dec. 10, 1990).

"The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA," Judge Gonzalez wrote.

However, Judge Lloyd Doggett wrote in a separate concurring opinion joined by two other concurring judges that ERISA's pre-emption provision is too broad. "Through peculiar federal judicial interpretation, a statutory addition to workers' rights has been converted into a statutory removal of those rights. The law has been reshaped into a form that achieves the converse of its original purpose," he wrote.

"I join with a growing number of courts and commentators who express the concern that through continued misconstruction, ERISA has become 'quicksand' that 'will continue to expand and pre-empt everything in its meandering path,' " Judge Doggett wrote, citing a 1985 Alaska state court ruling.

"For the more than 56 million Americans who are enrolled in group health insurance plans like the one in which James Cathey was a member, ERISA has become more than mere quicksand; it has become a black hole," he said.

Insurers have little or no incentive to deal properly or fairly with plan participants if ERISA can pre-empt every state law that may be loosely defined as relating to an employee benefit plan, he observed.

However, William J. Toppeta, vp and associate general counsel at Met Life, said ERISA provides adequate relief for employees who have been subjected to improper practices by benefit plans. He noted that under ERISA, benefit plans can, among other things, be ordered to:

- Provide participants the benefits that were denied as well as future benefits.
- Pay the plan participant's attorneys' fees.
- Replace the plan's fiduciaries if there was a violation of fiduciary responsibility.

Mr. Toppeta also observed that Congress was trying to protect employers as well as employees in drafting ERISA. "Congress was doing a balancing act, saying we want to encourage employers and unions to set up these kinds of employee benefit plans, but on the other hand we want to protect employees," he said.

Without ERISA pre-emption insurance and other laws in each state would apply to multistate employers, which would be very costly for the employers and their plans, he said.

Janet Van Alsten, senior attorney for Dow in Midland, Mich., agreed.

"We have a limited amount of resources to provide benefits. If we are to continue to provide these benefits, we can't afford double and treble damages" allowed under some state laws, she said.

During the state court litigation, the Catheys also filed a lawsuit in federal court seeking the benefits they were denied. But, a U.S. District Court in June 1989 and a federal appeals court in August 1990 ruled in favor of Dow.

The Catheys now are seeking review by the U.S. Supreme Court, said plaintiffs' attorney Mark Kincaid of Longley & Maxwell in Austin.

In the Tenneco case, Pamela Chambers Gorman alleges that Tenneco and Philadelphia-based Life Insurance Co. of North America, a CIGNA Corp. unit, wrongly denied her a $250,000 accidental death benefit after her husband died in an automobile accident in 1982.

The lawsuit charged Tenneco with breach of fiduciary duties and LINA with lack of good faith in violation of various state insurance codes.

The defendants argued that the benefit was denied because Mr. Gorman was not acting within the scope of his job when the accident occurred.

A state court jury ordered LINA to pay $550,000 and Tenneco to pay $500,000 in punitive damages in addition to the death benefit and Mrs. Gorman's attorneys' fees.

Tenneco and LINA appealed and for the first time argued that the accidental death benefit plan is an ERISA-governed plan. Tenneco contended that the lower court did not have jurisdiction to hear Mrs. Gorman's claim of breach of fiduciary duty.

The appellate court allowed Tenneco and LINA to raise the ERISA defense and overturned the punitive damage awards. However, the court ruled the insurer must pay the death benefit.

The Texas Supreme Court upheld the appellate decision.

"Since the petitioner's claim for breach of fiduciary duty relates to an employee benefit plan governed by ERISA. . .it falls within the exclusive jurisdiction of the federal courts. Thus, the trial court did not have jurisdiction to hear this claim," the high court ruled.

However, ERISA allows plan beneficiaries to seek payment of denied benefits in either state or federal courts, the high court said.

Judge Doggett again criticized ERISA in the Tenneco case, though he again concurred with the majority. "I reluctantly concur based on the analysis provided in my concurrence in the" Cathey case.

"The harsh effect of this conclusion is that an insurer may now defeat a claim by asserting an ERISA defense for the first time on appeal after a Texas judge and jury have found it guilty of engaging in false, misleading or deceptive acts or breaching its duty of good faith and fair dealing," Judge Doggett said.

Mrs. Gorman has asked the Texas Supreme Court for a rehearing.

Plaintiffs' attorney Clinard J. Hanby of Essmyer & Hanby in Houston said he will argue that Tenneco should not have been allowed to first raise its ERISA pre-emption defense at the appellate level.

Tenneco would not comment on the case while it is pending.

However, Patrick A. Nitsch, Tenneco's senior corporate attorney, said: "We are pleased with the Texas Supreme Court ruling and we believe the court stands on firm ground in making this ruling."

Judge Doggett's comments in his concurring opinions are just one more criticism in an ongoing debate over ERISA's broad pre-emptive powers and the lack of stronger enforcement remedies, said Henry Saveth, a principal at A. Foster Higgins & Co. Inc. of New York.

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James C. Cathey and Bette Cathey vs. Metropolitan Life Insurance Co., Dow Chemical Co. and Michael H. Maddolin; Texas Supreme Court, No. C-8323; Pamela Chambers Gorman et al. vs. Life Insurance Co. of North America, and Tenneco Inc.; Texas Supreme Court, No. C-7806.

Dismissal appealed in Ideal Mutual suit

By JUDY GREENWALD

NEW YORK—Plaintiffs are appealing the second dismissal of a shareholder suit originally filed six years ago in the aftermath of Ideal Mutual Insurance Co.'s liquidation.

U.S. District Court Judge Charles S. Haight in December dismissed for the second time a complaint filed by shareholders against Ideal Mutual; Optimum Holding Corp., its downstream holding company; Optimum directors; both companies' officers; and accountant Arthur Andersen & Co. He had dismissed a similar complaint in 1988 (*BI*, Feb. 28, 1988; Feb. 11, 1985).

In both cases, Judge Haight said the plaintiffs failed to adequately prove fraud had been committed by the defendants.

The plaintiffs filed a notice of appeal with the 2nd U.S. Circuit Court of Appeals last month.

The case was originally filed by Meyer Kimmel, an Optimum shareholder. Optimum was 51% owned by Ideal and 49% publicly held. The suit sought compensatory and punitive damages related to the decline in value of Optimum stock.

A second suit was filed by Richard Samuel, as trustee for Las Cruces, N.M.-based Patlex Corp., and was consolidated with the Kimmel suit in May 1988, according to plaintiffs' attorney Jeffrey Squires, with Kaufman, Malchman & Kirby of New York.

Plaintiffs in the case are attempting to tap a $25 million directors and officers liability policy underwritten by National Union Fire Insurance Co. of Pittsburgh, Pa., an American International Group Inc. unit.

New York regulators placed Ideal into rehabilitation in December 1984 after a triennial examination found the company was insolvent by $155.3 million as of Dec. 31, 1983. State Supreme Court Justice Stanley Parness approved the insurer's liquidation by the department in February 1985.

In his 10-page decision, which dismissed the case without leave to replead, Judge Haight said both complaints have failed to identify the necessary circumstances "indicating 'conscious behavior' by the defendant from which an intent to defraud may fairly be inferred."

Both complaints, noted Judge Haight, focus on the 1984 insurance department report on Ideal Mutual. The plaintiffs, he said, had purchased Optimum shares in 1983 and early 1984, before the report's completion and release.

Ideal consistently disagreed with preliminary department findings and conclusions, Judge Haight noted. And while it consented to a court order placing the company in rehabilitation, the company also reserved the right to contest the examination's conclusions.

"The officers, directors and accountant of a company may disagree with a state agency's tentative findings and conclusions without retroactively convicting themselves of fraud if the state agency ultimately rejects their contentions and issues an adverse report," said Judge Haight. "That is so even if the agency, implementing its own report, liquidates the company."

Under these circumstances, he said, "it is legally insufficient for plaintiffs to itemize perceived discrepancies between Optimum and Ideal reports and forms issued between 1980 and 1983, and the conclusions and criticisms of the (New York insurance superintendent) issued in December 1984."

Judge Haight said "other deficiencies abound in the amended complaint" as well. Among them, he said, is that "all defendants are indiscriminately lumped together throughout the pleading." In addition, the defendants' motive to engage in the alleged fraud is "problematical," he said.

"I think the judge looked at the reading of the situation and found there is no merit to making claims based on a disagreement with the company," commented John M. Nonna, an attorney with New York-based Werner & Kennedy, who represents National Union in the litigation.

"I think the notice of appeal speaks for itself," said Mr. Squires, when asked to comment on Judge Haight's decision. ■

Travelers names Booth president, COO

Richard H. Booth has been elected president and chief operating officer at Travelers Corp.

Mr. Booth, who had been vice chairman and chief insurance officer, replaces **Edward H. Budd** as president of the Hartford, Conn.-based insurer. Mr. Budd remains chairman and chief executive officer.

Mr. Booth, 43, has been with Travelers Corp. since 1976.

Other insurer changes:

Douglas A. Jensen promoted to senior vp and Eastern field group director from vp-marketing for Zurich-American Insurance Group in Schaumburg, Ill. At two other Zurich Insurance Co. units—the Swiss company's U.S. branch and American Guarantee & Liability Insurance Co.—four vps were named: **Don Adams**, **Patrick Gray**, **Dick Hennig** and **Fred Kees**.

Richard J. Roth, a senior vp-marketing, has been named senior staff officer-underwriting for Arkwright Mutual Insurance Co. of Waltham, Mass.

Warren, N.J.-based Chubb Corp. announced that **Teresa M. Stone**, formerly a principal with Morgan Stanley & Co. Inc., joined Chubb as a senior vp. Chubb also recently announced these changes at its Chubb & Son Inc. unit: **Donna M. Griffin**, a senior underwriter and manager of the Cleveland office, named vp; **Richard P. Munson**, an assistant national manager for the department of financial institutions, named vp; **Doris M. Johnson**, claims manager for the New York zone, named vp; and **Thomas F. Taylor**, assistant national manager for the department of financial institutions and manager of professional liability underwriting for worldwide operations, named vp.

James E. Malling joined MBIA Corp., a municipal bond insurer in Armonk, N.Y., as senior vp for corporate marketing and new products. He had been president of CIGNA Corp.'s CIGNA International Finance Inc. unit.

Gerald Clark, who has been with Metropolitan Life Insurance Co. since 1968, was named executive vp and a member of the corporate management office. He was named senior vp in 1986.

Daniel N. Milazzo appointed regional vp in charge of a new RLI Corp. directors and officers liability underwriting office in San Diego. Before joining the Peoria, Ill.-based company, Mr. Milazzo had been with Harbor Insurance Co. of Los Angeles.

Henry Krizl named senior vp with Fremont Insurance Group Inc. of Los Angeles and its workers compensation subsidiaries: Pacific Compensation Insurance Co.; Beaver Insurance Co.; and Fremont Compensation Insurance Co. He had been senior vp-claims with Pacific Compensation. **Daniel G. Platt** also named vp at Pacific Compensation, which is based in San Bruno, Calif.

Mike Riney named vp-claim operations in the agency and brokerage group at Continental Corp. in New York. He had been vp and claims officer in Columbus, Ohio.

Ed Wilson promoted to executive vp from senior vp for the Northern region with Superior National Insurance Group Inc. of Calabasas, Calif.

Anne Marie Faria elected vp-group life and health and **Eileen T. McCarthy** elected vp-client services with New England Mutual Life Insurance Co. of Boston.

Thomas E. Hartman appointed regional vp with Provident Mutual Life Insurance Co. of Philadelphia. He had been with New England Mutual Life Insurance Co.

Lawrence H. Schenk named vp in the commercial underwriting department with Guaranty National Insurance Co. of Englewood, Colo. He had been vp/underwriting manager of specialty programs with Reliance Insurance Co. in Philadelphia.

Gene L. Householter appointed vp-large account underwriting at Blue Cross of California in Woodland Hills.

William J. Ackerman appointed senior vp of Southwest Fire & Casualty Insurance Co., a specialty company in Scottsdale, Ariz.

Ronald B. Colby named president of United Health & Life Insurance Co., a United HealthCare Corp. subsidiary in Minneapolis. He had been vp for group pricing and compliance with Lincoln National Life Insurance Co.

Peter R. Kongstvedt named senior vp-health care delivery for Blue Cross/Blue Shield of the National Capital Area in Washington, D.C. Mr Kongstvedt will maintain his current position as president of Capitalcare Inc., a health maintenance organization in Vienna, Va.

Reinsurance

Dorothy Combes, vp of F&G Re Inc., the reinsurance underwriting subsidiary of United States Fidelity & Guaranty Co., is retiring as of March 1. Ms. Combes was the Assn. of Professional Insurance Women's Insurance Woman of the Year in 1979.

Robert T. McLaughlin named vp in the claims division of American Re-Insurance Co. in Columbus, Ohio. He had been an assistant vp for the Princeton, N.J.-based company.

Hansa Reinsurance Co. of America and StellaRe Management Corp., which manages the Tarrytown, N.Y., reinsurer, announced these changes: **Scott Gottesman**, **Aspasia Gruber**, and **Robert Lipperman** have been named vps of both companies. ■

Comings & goings: industry

Pollution ruling

Continued from page 3

January 1974 to March 1976.

Philadelphia-based INA, now a CIGNA Corp. unit, wrote primary coverage for the company from March 1976 to March 1977.

Northbrook, Ill.-based Northbrook Excess & Surplus Insurance Co., a now-defunct unit of Allstate Insurance Co., wrote first-layer excess insurance from Jan. 1, 1975, to Jan. 1, 1978.

None of the attorneys contacted would disclose Outboard Marine's policy limits. However, an attorney for the company said it would have had sufficient insurance to cover the estimated $20 million cleanup if it had won the dispute.

The EPA and the State of Illinois both sued Outboard Marine in 1978. The cleanup therefore became a known loss in 1978 that would not be covered by a policy in force at that time or thereafter, insurer attorneys explain.

The EPA amended its complaint in 1982 in response to the Comprehensive Environmental Response, Compensation & Liability Act, better known as Superfund.

In addition to ruling on the pollution exclusion, the court looked at language in the company's liability policies that state the insurers "will pay on behalf of the policyholder all sums the policyholder shall become legally obligated to pay as damages."

Adopting the pro-policyholder interpretation of the term "damages," the court found that Superfund cleanup costs are insurable.

"The terms 'damages' in the policy provision at issue is ambiguous and must, therefore, be construed in a manner favorable to the insured," said the court.

In reaching its conclusion, the court looked at an earlier Illinois appellate court holding that "damages" includes cleanup costs and a recent ruling from the California Supreme Court that the term "damages" includes cleanup costs (*BI*, Nov. 26, 1990; March 20, 1989).

To date, supreme courts in five states—California, Massachusetts, Minnesota, North Carolina and Washington—have held that the costs of cleaning up polluted property are "damages" under the CGL policy (*BI*, June 25, 1990; June 11, 1990; Feb. 19, 1990; Jan. 15, 1990). Only the Maine and New Hampshire high courts have ruled that they are not "damages" (*BI*, April 16, 1990).

Attorneys say the Illinois ruling on the pollution exclusion is far more important than the ruling on the issue of "damages" because Illinois appellate courts are so sharply divided on interpreting the pollution exclusion.

"This creates a clear conflict in Illinois on the pollution exclusion," said insurer attorney Thomas Brunner of Wiley, Rein & Fielding in Washington, D.C.

This decision is "squarely contrary" to an earlier Illinois appellate court ruling involving Specialty Coatings Inc., said policyholder attorney Eugene Anderson of Anderson, Kill, Olick & Oshinsky in New York.

In the Specialty Coatings case, the 1st District Illinois Appellate Court held that the pollution exclusion only bars coverage for pollution that is expected or intended by the policyholder (*BI*, March 20, 1989). The 1st District also held that the exclusion does not apply to policyholders that hire third parties to dispose of chemical wastes.

The state high court refused to review the Specialty Coatings decision, but may be more motivated to review the Outboard Marine decision, according to attorneys.

The conflict among Illinois appellate courts created by the Outboard Marine decision "makes it more likely the Illinois Supreme Court will rule on this issue," said Mr. Brunner, who filed an amicus curiae brief on behalf of the Insurance Environmental Litigation Assn. in the case.

If the decision is reviewed by the Illinois Supreme Court, "it could become the leading case in Illinois on the pollution exclusion," said Outboard Marine attorney Louis Brydges Sr. of Brydges & Riseborough in Waukegan, Ill.

"The Illinois Supreme Court is going to have to review this issue," said Mr. Brydges, adding that it is simply a question of which case the court will review.

Currently, there is an asbestos coverage dispute before the Illinois Supreme Court in which insurers are raising the pollution exclusion as a defense, he noted.

Should the court decide to review the Outboard Marine ruling, it could be consolidated with the asbestos case, Mr. Brydges explained.

Attorneys say a consolidated opinion would have tremendous precedential weight inside Illinois and would influence courts nationwide.

Until the Illinois Supreme Court rules on the pollution exclusion, it is difficult for Illinois policyholders and their insurers to determine if there is coverage for various environmental claims in Illinois, explained attorney Katrina Veerhusen, who represented Specialty Coatings in the earlier case.

"The OMC decision makes the water muddier than before," quipped Ms. Veerhusen, who is with Kevin M. Forde Ltd. in Chicago.

The ambiguity among courts is not a problem in Illinois alone: Courts nationwide are split over interpreting the pollution exclusion.

INA attorney Paul Koepff of Mudge, Rose, Guthrie, Alexander & Ferdon in New York, however, said the trend in rulings concerning the pollution exclusion "is definitely in favor of insurers."

Commercial Union Attorney Jay Krafsur added: "A clear trend in the last several years is to interpret 'sudden' to mean 'abrupt.' "

Those decisions that find the word "sudden" to mean "unexpected or unintended" are "result-oriented decisions by courts trying to do something for the policyholder," charged Mr. Krafsur, who is with Rivkin, Radler, Bayh, Hart & Kremer in Chicago.

But policyholder attorney Mr. Anderson says 43 decisions on the pollution exclusion now favor policyholders, while only 25 favor insurers.

•

Outboard Marine Corp. vs. Liberty Mutual Insurance Co. et al., Appellate Court of Illinois Second District; No. 2-90-0349 & No. 2-90-0399.

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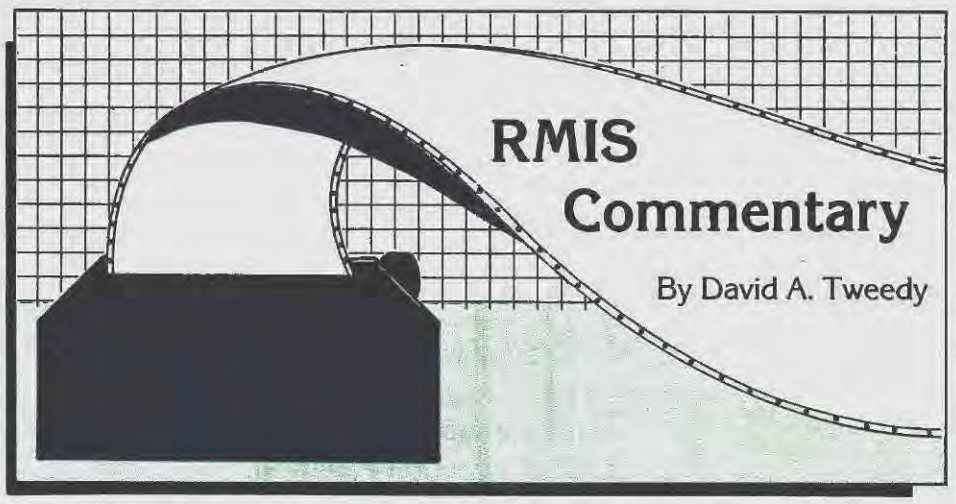
Measuring RMIS efficiency

Determine claims management needs



MEASURING THE effectiveness of a risk management information system is a key task facing risk management professionals.

The user can ask a host of questions:

- "Does it work?"
- "Does it provide the information I'm looking for when I need it?"
- Does it provide information at a reasonable cost?"
- "Is the information reliable?"
- "Am I able to anticipate and, therefore, mitigate chance exposures against the company/public entity that I've been hired to protect?"
- "Is what I have paid—or am paying—for this service reasonable in exchange for what I am receiving?"
- "When something goes wrong, how quickly and efficiently is the problem resolved?"

Many other common sense questions like these could be added to this list.

However, the point is obvious. One should not invest in a risk management information system without expecting to get something in return.

And, considering the time, expense and frustration risk managers go through in obtaining the "ideal" RMIS, they have every right to expect what has been promised to them by zealous and mostly well-meaning system vendors who advocate a particular system.

Therefore, I feel it is a worthwhile pursuit over the next few months to discuss the effectiveness of a risk management information system.

How does one measure this intangible quality of "effectiveness"? To start with, I'd like to center on the most popular and predominant function of an RMIS: claims management.

Before I get into this, I need to step back and provide a larger perspective and describe the basic components of an ideal, comprehensive risk management information system.

Envision this system as a pyramid. One side of the pyramid is totally devoted to claims exposures, while the other sides have different exposures.

The foundational layer of the pyramid is data itself: pure claims information (workers compensation, liability, etc.) and other exposure data (vehicles, property values, locations, product sales, square footage, employee classifications, etc.).

The next level is the claims administration system, used by the third party administrator or, if self-administered, by the company's internal claims department. At this level, the focus is on actually receiving, reserving and processing the claims.

The third level is the claims monitoring system, which most vendors provide to the buying public.

Most risk management information systems begin with this third level. Firms will buy/lease a variety of systems from timeshare to a PC-based system to *monitor* their base exposures (although property values and locations may be kept on a PC-based spreadsheet program).

Various kinds of loss runs, loss analysis reports and others are generated for analysts by the risk manager. Most insurers and TPAs will regularly provide some type of generic (with some customization) reports for their clients.

The more advanced RMIS allow on-line, ad hoc query features to provide a variety of reports. This is the key level on which I'd like to focus, since most RMIS purchased or leased have this function, which can allow meaningful analysis of how claims management is performed.

The fourth level in the pyramid is interactive, combining data elements from a variety of different source data bases (i.e., finance, accounting, personnel and risk management) to provide management information reports. This is the decision-support level of the comprehensive RMIS and requires a certain type of hardware and software configuration to allow the proper importing of data with a minimum of difficulty.

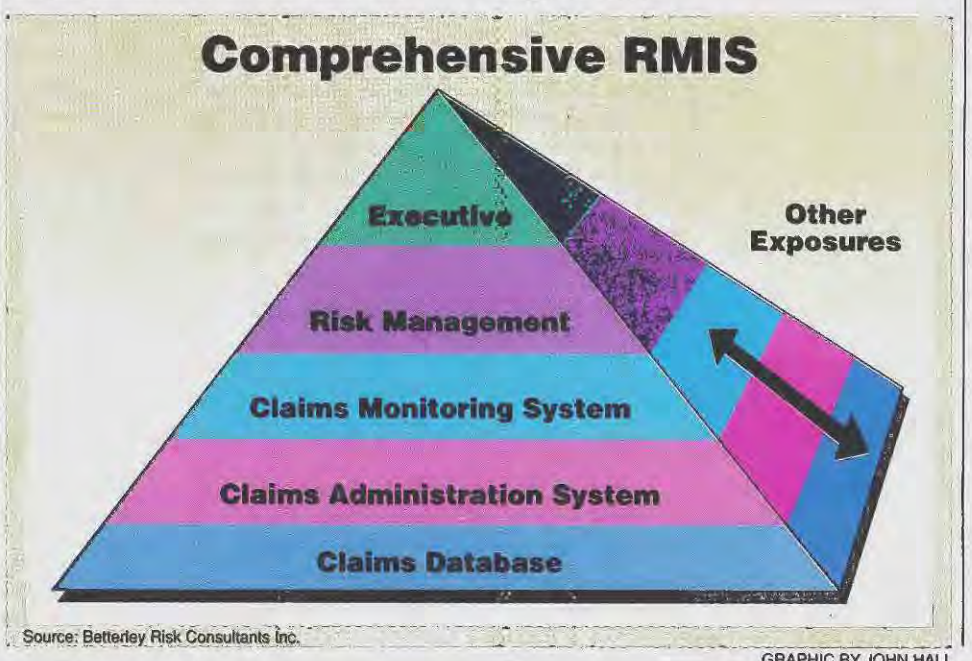
The emergence of the structured query language (SQL), UNIX/XENIX operating systems and other innovations in the software industry allow a better degree of communication between different platforms of hardware and different software programs, thus providing a powerful management tool to the risk manager.

The last level is the executive information system, which may really be an extension of the previous level but has moved the risk manager and superiors into a position where they can, with little programming skill at all, extract useful information at any time using simple commands.

The executive information system is interactive with many of the systems throughout the company itself and even to external vendors and sources of information.

Describing the comprehensive RMIS could go on for several columns, but this is adequate to set the stage for proper examination of the basic levels at which claims management and claims administration are performed.

Claims management efficiency can be evaluated from a variety of perspectives. For most risk management professionals, evaluating the quality of claims administration as provided by an external vendor (insurer or TPA) is the most valuable. Self-administered organizations wish to evaluate, in more specific detail, certain elements of efficiency, productivity and accuracy. In both cases, a claims management information system (the bottom two levels of the comprehensive RMIS) is of great value.



Source: Betterley Risk Consultants Inc.

GRAPHIC BY JOHN HALL

Again, another caveat: The best RMIS/claims management system cannot solve poor claims handling and incomplete/inaccurate data entered into the system. Too many times I have seen quality RMIS vendors maligned because the claims organization was either not using the system properly or the claims administrators were just plain not doing their job.

Many times, a system can help identify these problems, and I suspect that many risk managers are not really using the claims management information system features of their RMIS to do so.

What are the critical areas, then, of identifying claims management effectiveness? There are several:

- Efficiency in reporting a claim to the TPA.
- Proper contact time of an injured claimant.
- Sufficient investigation.
- Adequacy of reserves.
- Management of expense items (litigation, medical, etc.).
- Proper claims resolution strategies.
- Proper claims closures so as not to affect retrospectively rated programs.
- Examiner/adjuster's case load and productivity.
- Subrogation effectiveness.

There are probably more, but these are some of the highlights on which I can comment. Perhaps the most popular and most requested feature of an RMIS claims function is reserve evaluation, but in my opinion that is not the most critical. Before accurate case reserves can be studied at all, the risk manager must know whether or not the claims person has received the claim in time to do an adequate job of investigation. Most claims management information systems offered today either include or can be modified to include the tracking/monitoring functions that can provide this kind of very useful data.

In future columns I will discuss some of the ways to use one's claims management function, and the kinds of reports one should be looking for. Today, especially in workers compensation and other casualty lines, it is a critical area. ■

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

Building insurance programs

Firms decide among different coverage options

By The Insurance Institute of America

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

This month's question and answer, taken from the Course Guide for ARM 56—Essentials of Risk Financing—highlights some key decisions an organization must make in "marketing" its insurance needs and on some of the potential advantages and disadvantages of some of the options it may choose.

Q: Describe (1) two significant advantages and (2) two significant disadvantages of each of the following decisions that an organization may make with respect to selecting among insurers, their representatives and the coverages they offer.

- An organization decides to use just one insurance broker, rather than several, through which to purchase its insurance.
- An organization decides to obtain as much of its property/liability insurance as possible through manuscript policies, rather than standard policies.
- An organization decides to obtain as much of its property/liability insurance as possible from admitted insurers rather than from non-admitted insurers.

ARM excercises

A: • Relying upon only one broker (or agent), rather than several, can have a variety of potential advantages, such as greater bargaining leverage with that broker and with the insurers it serves in securing more favorable policy provisions and/or more favorable settlements of specific claims.

Another advantage to using a single broker is greater broker familiarity with, and commitment to, fulfilling the policyholder's coverage and other risk management needs.

The potential disadvantages of relying on only one broker (or agent) are reduced access to the great variety of insurance companies, coverages and insurance-related products and services that a larger number of brokers could provide.

In addition, there is a greater tendency of the broker to take the policyholder's business for granted because it does not face any ongoing competition from other marketing representatives.

A disadvantage to a company using only one insurance broker is that there is a greater tendency of the broker to take the policyholder's business for granted because it does not face any ongoing competition from other marketing representatives.

• Using manuscript coverages, rather than standardized policies, may have such potential advantages as broader coverages, including more kinds of property, liability, net income and life/health coverages against a broader range of perils.

Using manuscript coverages also provides the insurer with the ability to more closely tailor coverages to the policyholder's particular needs.

The potential disadvantages of using manuscript coverages are the increased likelihood of errors or oversights in drafting the manuscript policies.

Another disadvantage to manuscript coverages is more limited access to insurance companies, because relatively few insurers are willing to consider manuscript coverages, especially against certain exposures.

• Seeking to use only admitted insurers, rather than non-admitted insurers, may have the advantage of greater ease in securing payment for claims. This is because the insurer and the insured are more likely to be within the same legal jurisdiction and, the insurance company is also more likely to be effectively regulated than if the insurance company were non-admitted (not licensed in the policyholder's state).

Another advantage is the enhanced ability to determine the insurer's financial soundness, again because of more effective state regulation than that typically applied to non-admitted insurers.

The potential disadvantages of using only admitted insurers include the increased cost of coverage because of the policyholder's reluctance to use often lower-cost coverage from non-admitted insurers, and the inability to purchase types of coverage available only from non-admitted insurers. ■

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

Buyer's guide is a small firm's godsend

"The Insurance Buyer's Guide to the New Insurance Market"
By The John Liner Organization
John Liner Press, 210 Lincoln St., Suite 700, Boston, Mass. 02111-2491.
128 pages, $34.50

By Kevin M. Quinley

Book review

Good things come in small, if pricey, packages. Skeptics may wonder how anyone can cover the current insurance market in 128 pages, but the authors of "The Insurance Buyer's Guide to the New Insurance Market" almost pull it off. This is a very useful, readable book that should be on the shelf of every risk manager and insurance buyer. It is chock full of practical ideas on structuring an insurance program.

Most firms do not have and cannot afford a risk manager. Thus, many small business professionals need guidance, extending beyond the counsel they receive from their insurance agents and brokers. For these buyers, particularly, the guide is a godsend. Experienced risk managers, though, may find little that is new in this book. It does not pretend to be a risk management guide in the sense of addressing such topics as non-insurance methods of transferring risk or loss control.

Since individual contributors are anonymous, the authors' identities for this book are unknown; presumably the book was a committee effort. It is hard to fit a thorough analysis of the insurance market into so few pages, but the book's authors do a fine job.

Insurance buyers thinking about choosing, firing or changing insurance agents and brokers will find the book worth the price by the first chapter, "How to Choose an Insurance Agent or Broker." This may make your current brokers nervous, but shouldn't if the brokers are doing the job they should be doing.

The chapter on "Auditing Your Insurance Program" is a useful self-diagnostic designed to avoid developing "gaposis" in your coverage.

The chapter on electronic data processing coverage is very much state-of-the-art. Businesses increasingly are computer-dependent, and a loss of data through power outage, computer virus or hacker sabotage can cripple a business. As a result, the guide's authors discuss specific types of policies and non-insurance techniques useful in addressing the computer exposure.

Another section on "How to Handle Competitive Bids" is particularly interesting and packed with practical tips for risk managers:

- How to establish ground rules.
- How to draft specifications in your request for a proposal.
- How to evaluate proposals.

A chapter on workers compensation explains ways that insurance buyers can double check the classification systems underlying their premium computation.

In one instance, the guide recounts, a medical center's insurer reported reserves for some claims twice. A spot audit of workers compensation reserving practices of the insurer dropped the company's experience modification factor by 37%. Premium savings in one year's policy amounted to $74,000. That should send plenty of risk managers scurrying back to their loss runs!

On some specific lines of coverage, the authors even recommend specific insurers. This is extremely helpful. However, it also invites a situation in which the book can become quickly outdated when the insurance market changes, as it doubtlessly will.

A few weaknesses mar the guide. It does fixate on insurance as *the* means of addressing risk, but does not set out to do more. While the writing style is pithy and to the point, some readers may be unsatisfied and view John Liner's effort as a Chinese food approach to insurance management—after 30 minutes you're hungry again. Those looking for a more scholarly slant will be disappointed.

The newness of the slant is both a strength and a weakness. Timeliness is a virtue, and the book succeeds in being up-to-date. On the other hand, the risk is that the suggestions can become outdated by events, especially if and when the insurance market hardens. ■

Kevin M. Quinley is vp of risk services for MEDMARC Insurance Co. Risk Retention Group Inc. and subsidiary Hamilton Resources Corp., both of Fairfax, Va. Mr. Quinley holds the Chartered Property & Casualty Underwriter and Associate in Risk Management designations.

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New insurance regulators in three states

Newly elected Republican governors in Ohio and Minnesota recently appointed insurance regulators, while Illinois' new GOP governor has named an acting insurance director.

Ohio Gov. George Voinovich named Harold T. Duryee as director of the state Department of Insurance.

Mr. Duryee, 60, most recently was a consultant in government relations and federal property insurance programs.

From 1986-1990, he oversaw the National Flood Insurance Program as federal insurance administrator for the Federal Emergency Management Agency. Before that, Mr. Duryee served two years as the federal agency's executive deputy administrator.

Mr. Duryee also was deputy administrator of the Ohio Bureau of Workers' Compensation from 1977 to 1984. In addition, he served as executive director of the Ohio Republican Party from 1970 to 1977.

He has served on the Ohio Elections Commission and the North Canton City Planning and City Charter commissions.

Mr. Duryee graduated from Kenyon College in Gambier, Ohio.

Minnesota Gov. Arne Carlson named Bert J. McKasy as commissioner of the Minnesota Department of Commerce.

Mr. McKasy, 49, served the previous two years as chief of staff for Minnesota Sen. David Durenberger.

In addition, he was a member of the Minnesota House of Representatives from 1982 to 1988.

Mr. McKasy also has held management posts with First Trust Co. in St. Paul and Fritz Co., a diversified candy and tobacco wholesaler.

Mr. McKasy also founded and owns a corporate travel agency.

He received a law degree from the University of Minnesota in Minneapolis and has practiced corporate law.

Mr. McKasy also has served as a director of several organizations including the St. Paul Area Chamber of Commerce, the Ramsey County Bar Assn. and the Minnesota World Trade Center.

Illinois Gov. Jim Edgar named James W. Schacht, the chief deputy director of the Illinois Insurance Department, as the department's acting director.

The action followed the resignation of Insurance Director Zack Stamp, who is opening an office in the state capital of Springfield for the Chicago-based law firm of Peterson & Ross.

—By Meg Fletcher

Around the states

State UST program

OLYMPIA, Washington—Owners and operators of underground petroleum storage tanks in Washington now can buy pollution liability insurance that is reinsured by the state.

The state, which is reinsuring amounts excess of $75,000, is charging insurers writing the pollution liability policies 1% of premium.

Several experts estimate that reinsurance for this kind of risk usually would cost between 40% and 60% of premium.

The insurers' savings are passed on to tank owners and operators through lower premiums, said James Sims, director of the Pollution Liability Insurance Agency. Washington's PLIA bears no relation to the pollution reinsurance pool with the same acronym that went out of business in 1989 (*BI*, Jan 16, 1989).

Front Royal Group Inc. of McLean, Va., and underwriters at Lloyd's of London, represented by Sedgwick James of Washington Inc. in Spokane, have agreed to sell the policies. The insurers were selected after the state sent out a request for proposals last spring.

Both companies expected to begin writing policies last month.

Under the program, Washington acts as the reinsurer, covering cleanup costs that exceed $75,000 per occurrence. Policy limits can be as high as $1 million per occurrence/$2 million aggregate.

Policies cover on-site and offsite cleanup costs.

In addition, policyholders are provided $100,000 of legal defense coverage outside of policy limits.

The state funds its costs through three mechanisms: a 0.5% tax on the wholesale value of petroleum products as they enter the state; interest on the funds it has collected and not spent; and the reinsurance premiums.

Officials will activate the petroleum tax as needed to maintain a PLIA fund balance of $7.5 million to $15 million.

PLIA also partially reimburses tank owners and operators if necessary for costs of tests needed to determine insurance eligibility.

Prices vary depending on the number, location, age and quality of the tanks, both insurers said.

For example, premiums for a pollution liability policy from Front Royal Group for a petroleum marketer with five or fewer tanks per site would range from $2,200 to $5,600 per site, according to Front Royal Vp Bill Gulledge.

The standard deductible for petroleum marketers is $15,000, he said.

The coverage is written on a first-dollar basis, so the insurer pays that amount and then collects the deductible from the policyholder.

The minimum premium for petroleum marketers buying a Lloyd's policy is $2,500 per policy, according to Roy Arnold, senior vp of Sedgwick James.

The minimum premium for nonmarketers is $1,500. Deductibles can range from $5,000 to $60,000, but the standard deductible is $10,000, he said.

Coverage also is written on a first-dollar basis.

—By Deborah Shalowitz

AIDS privacy ruling

SAN FRANCISCO—A physician hired by a workers compensation insurer may be sued for violating a worker's privacy rights by disclosing in workers comp litigation that the worker had the virus that causes AIDS, a state appeals court has ruled.

But in California's first ruling on liability for HIV-status disclosures, the 1st District Court of Appeal in San Francisco ruled that the insurance company cannot be sued by the estate of the now-deceased worker.

Improper disclosure, the appellate court also ruled, did not violate a 1985 state AIDS confidentiality statute.

The worker, Gary Urbaniak, had tested positive for the human immunodeficiency virus, which causes acquired immune deficiency syndrome. He suffered a disabling head injury in 1985 while working as a printing press operator for Lesher Communications Inc. of Walnut Creek, Calif.

He filed a workers comp claim, later agreeing to be examined by Dr. Frederick H. Newton, who was hired by Allianz Insurance Co. of Los Angeles.

After equipment used in the exam inadvertently drew blood from Mr. Urbaniak, he warned a nurse in confidence that the equipment should be sterilized because he was HIV-positive, according to Elizabeth Summers, a lawyer for the estate of Mr. Urbaniak, who died in 1989.

Mr. Urbaniak said he did not tell Dr. Newton that he was HIV-positive but that the doctor learned of it from the nurse.

Dr. Newton, however, reported to Allianz and to the Workers Compensation Appeals Board that Mr. Urbaniak informed him of his status, said Ms. Summers, who is with Bien, Summers & Dale in Oakland, Calif.

In his report to the Workers Compensation Appeals Board, Dr. Newton said the virus could be contributing to Mr. Urbaniak's headaches and shoulder and back pain.

Allianz terminated his workers comp medical benefits and offered him a $5,000 settlement, which he accepted.

Mr. Urbaniak then sued Dr. Newton, Allianz and its attorneys, claiming invasion of privacy under the California Constitution and the AIDS confidentiality statute, Ms. Summers said.

A San Francisco Superior Court judge granted summary judgment to the defendants and dismissed the case in 1988.

After Mr. Urbaniak died, his estate continued the suit.

In reversing the dismissal on Jan. 14, the appeals court ruled that Dr. Newton's disclosure constituted an "improper use" of confidential information under California's right-to-privacy law and provides the basis for a suit.

But a suit under the AIDS confidentiality law was not allowed. The court said that law is limited to improper disclosures of blood tests.

In addition, the court upheld the dismissal of the suit against Allianz and its attorneys. No evidence indicated either one knew the information had been obtained through an invasion of privacy, the court said.

Mr. Urbaniak's estate can seek to recover special damages and punitive damages.

However, because Mr. Urbaniak has died, his estate cannot recover damages for his emotional distress, the court ruled.

—By Louise Kertesz

High-risk health cover

SPRINGFIELD, Ill.—Illinois' medical insurance program for high-risk individuals who otherwise are uninsurable expects to incur a $20 million deficit for fiscal 1991, but the deficit is within its budget.

The Comprehensive Health Insurance Plan reported a $10.1 million deficit for fiscal 1990.

Limiting admissions helped keep the plan within budgets approved by the General Assembly and governor, which allocated general revenue to cover anticipated deficits, said Richard W. Carlson, executive director of CHIP.

As of Dec. 28, 1990, CHIP insured 4,361 residents and had offered coverage to 169 more. Another 941 people were on a 10- to 12-month waiting list.

Coverage is written primarily for individuals, but employers with 10 or fewer employees may participate if at least one individual qualifies for the coverage (*BI*, Jan. 23, 1989; Feb. 1, 1988).

New employees of larger companies may also be eligible if the employer's health plan will not cover them.

—By Meg Fletcher

Insurers face claims by patient of dentist who contracted AIDS

By CHRISTINE WOOLSEY

INDIANTOWN, Fla.—A man who was infected with the AIDS virus by a Florida dentist is seeking at least $1 million in damages from his dental preferred provider organization and the dentist's malpractice insurer.

Richard Lee Driskill is one of three people that federal authorities believe contracted the virus that causes acquired immune deficiency syndrome during tooth extractions performed by a Stuart, Fla., dentist. The dentist, Dr. David J. Acer, died of complications from AIDS in September 1990.

Mr. Driskill's complaint, filed Feb. 14 in the 19th Judicial Circuit Court of Martin County, seeks unspecified damages from CIGNA Dental Health of Florida Inc., a PPO unit of CIGNA Corp. to which Dr. Acer belonged.

Mr. Driskill also seeks $1 million from Continental Casualty Co., a unit of CNA Financial Corp. in Chicago that wrote medical malpractice insurance for the dentist.

Another patient, Kimberly Bergalis, sued the dentist's estate and the same insurers in October (*BI*, Nov. 5, 1990). Continental Casualty last month settled Ms. Bergalis' action for $1 million.

A third patient, Barbara Webb, a retired teacher for the Martin County School District, had not yet filed suit as of last week, her attorneys said.

Mr. Driskill is a citrus worker who was covered by a contract his wife's employer—the Martin County School District—had with CIGNA Dental Health of Florida, according to his attorney, Robert Montgomery of Montgomery & Larmoyeux in West Palm Beach, Fla. Montgomery & Larmoyeux represents all three patients.

Mr. Driskill's lawsuit alleges that CIGNA was negligent in allowing Dr. Acer to continue to treat patients after he was diagnosed with AIDS.

"CIGNA Dental Health of Florida Inc. referred the Driskill family to Dr. Acer and represented that he was competent in all respects to practice invasive dentistry even though he knowingly continued to practice with HIV and AIDS," Mr. Montgomery said.

The suit further alleges that Dr. Acer "failed to implement and maintain infection control procedures in his office to protect his patients."

A CIGNA spokeswoman would say only that the Philadelphia-based insurer had been served with the suit. Continental Casualty would not comment.

The Department of Health and Rehabilitative Services and the Centers for Disease Control in Atlanta issued a report in January that identified Mr. Driskill as one of three people the dentist infected with AIDS during tooth extractions. The report also identified Ms. Bergalis and Ms. Webb.

"The CDC reported that there was a 99.94% probability based on DNA sequencing tests that he contracted HIV from Dr. Acer," according to Mr. Montgomery. The Centers for Disease Control dismissed the possibility of any other risk factors, Mr. Montgomery said.

Mr. Driskill's wife and daughter, who also were patients of Dr. Acer, have tested negatively for the HIV virus. ■

INTERNATIONAL

Lloyd's members' losses grow

More syndicates to seek cash calls

By STACY SHAPIRO

LONDON—Cash calls on Lloyd's of London members will be in vogue this year as Lloyd's syndicates close their 1988 underwriting accounts under the market's three-year accounting system.

Although 1988 is expected to be a profitable year overall for Lloyd's, cash calls already are being calculated for syndicates that have left past accounting years open, including Lloyd's largest syndicate.

That syndicate, managed by Merrett Underwriting Agency Management Ltd., may close its open 1985 account this year but not before asking syndicate members for about 70 million pounds ($136.5 million) in a cash call.

Also, two syndicates managed by John Poland (Managing Agency) Ltd. recently told members to expect a $120 million cash call by June 30 this year to boost reserves for known and unknown asbestos and pollution losses stemming from open 1985 accounts.

Other syndicates—especially syndicates writing marine coverage and London market excess-of-loss retrocessions—will seek cash from their members to close their 1988 accounts because the syndicates were hit by a string of marine losses that year, including the

Continued on next page

Feltrim's names study reinsurance

By CAROLYN ALDRED

LONDON—Lloyd's of London members are investigating the reinsurance arrangements of several excess-of-loss reinsurance syndicates that were forced to close last year following massive losses.

A group of members of syndicates 540, 542 and 847, formerly managed by Feltrim Underwriting Agencies Ltd., have formed an ad hoc steering committee to investigate the causes of the syndicate failures.

The closures were announced late last year when the Corporation of Lloyd's agreed to set up a runoff company—Additional Underwriting Agencies (No. 7) Ltd.—to manage the syndicates' runoff (*BI*, Nov. 19, 1990).

Syndicate losses are estimated to far exceed $250 million for the 1987 through 1990 underwriting years.

Up to 2,000 members belonged to the Feltrim syndicates. Some members' agents fear the syndicates' saga will turn into a crisis to rival the Outhwaite debacle, in which

Continued on next page

E.C. proposal contains tough cleanup rules

By WILLIAM PITT

PARIS—Assurpol, the French reinsurance pool for pollution risks, paints a bleak picture for European insurers and businesses if the European Community approves proposed pollution cleanup requirements.

In a paper distributed at the Assure Expo conference in Paris earlier this month, Olivier Bezier, a divisional director of Assurpol, said that the European Commission—which has issued the proposal—risks making pollution claims uninsurable.

The E.C. proposal that so alarms Mr. Bezier and his colleagues would expose insurers to unlimited liability for pollution caused by policyholders, he said.

The proposal is contained in amendment No. 27 to the European Commission draft directive on public liability for damage caused by waste products. The proposed directive would impose both strict liability and joint and several liability for all companies in the European Community that produce waste (*BI*, Nov. 27, 1989). The measure would set a statute of limitation of three years from the time of damage or injury and 30 years from the time of an incident that leads to damage or injury.

Since Amendment No. 27 was tabled last summer, European insurers have been lobbying for its elimination.

Mr. Bezier argued that the amendment would create an entirely new risk for insurers. It would "compromise the insurability of the liability system with a mass of potential claims that in-

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Photo by William Pitt

Assure Expo drew more than 27,000 attendees to the CNIT Conference Centre near Paris.

LONDON

Coleridge foresees more acquisitions of Lloyd's agencies

LONDON—The past three years have been financially difficult for Lloyd's of London syndicates, but the current hardening of rates in many sectors of the market will ensure better results over the next few years, said the chairman of Sturge Holdings P.L.C.

Financial problems among Lloyd's managing agents could help Sturge make acquisitions this year, said David Coleridge, who is chairman of Lloyd's as well as chairman of Sturge.

"Many Lloyd's agencies will find the next two or three years extremely difficult as profits are squeezed by increasing expenses and severely reduced profit commissions. For some of these agencies, with their own expertise and other intrinsic advantages, there may be attractions in combining with a group like ours," Mr. Coleridge said at Sturge's annual general meeting.

Since 1988, many syndicates, including those managed by Sturge, have suffered from excess capacity, low rates and high natural and other catastrophe losses, Mr. Coleridge said.

Total underwriting capacity for Sturge syndicates for 1991 increased to 1.24 billion pounds ($2.43 billion at current exchange rates), compared with 1.19 billion pounds in 1990 ($2.3 billion at year-end exchange rates), said Mr. Coleridge.

"Looking forward, however, we are confident that, in many sectors of the market, rates will continue to harden and allow the syndicates once again to produce a reasonable

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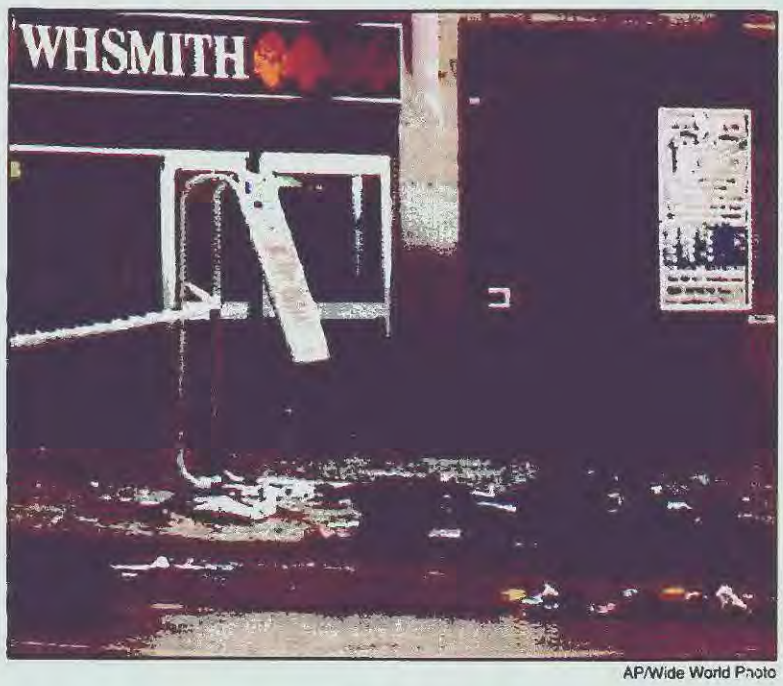
IRA bombs spur rail security measures



AP/Wide World Photo

Debris litters London's Victoria Station where a terrorist bomb explosion killed one person and injured about 40 others last week.

By CAROLYN ALDRED

LONDON—British Rail is increasing security and safety measures at all of its mainline London rail stations following terrorist bomb attacks at two London stations last week.

At least one passenger died and about 40 were injured—many seriously—when a bomb exploded at Victoria Station at the height of the Monday morning rush hour. Four hours earlier, an explosion had damaged the roof at Paddington Station. No one was injured in that explosion.

The Irish Republican Army has claimed responsibility for both attacks.

At Victoria Station, the bomb was planted in a trash can on the station concourse.

As a result, trash cans are being removed from all mainline London railway stations, a British Rail spokesman said last week.

The British Rail spokesman would not comment on other security measures, saying only that railroad officials are consulting with police.

Threats related to the Persian Gulf War had already prompted public transportation officials to tighten security.

The incidents caused chaos for commuters and have increased concern about how to protect the public from indiscriminate terrorist attacks.

While police and bomb squad officers were handling the Paddington bomb, the London Transport Travel Centre received a suspicious phone call at 7 a.m.

The caller, a man with an Irish accent who claimed to be from the IRA, warned that bombs would explode at all mainline stations in 40 minutes.

The bomb at Victoria Station exploded at 7:46 p.m. as police searched the station.

All 14 London mainline stations were then closed to the public, causing massive disruption to about 500,000 commuters.

Some mainline stations outside of London, like the Southampton station, also were closed for searches. And Heathrow Airport was closed for several hours Monday afternoon as a result of a bomb scare.

Meanwhile, the British Railways Board, which governs the state-owned railway, must wait to see whether its third-party liability insurance and property insurance programs will cover claims from last week's attacks.

However, market sources say that claims probably will not exceed the railroad's liability and property insurance deductibles.

British Rail has more than 100 million pounds ($196 million) of third-party liability coverage with a 10 million pound ($19.6 million) deductible for any one loss or series of claims arising from one occurrence, sources say.

The first 25 million pound ($49 million) layer above the deductible is led in the London company market by Guardian Royal Exchange P.L.C. and at Lloyd's of London by underwriter Michael Payne of syndicate 683. The remaining coverage is placed with ACE Ltd. and X.L. Insurance Co.,

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INTERNATIONAL

Cash calls

Continued from previous page
$1.4 billion Piper Alpha North Sea oil platform disaster.

Some syndicates in the marine market "will take a bath," commented one Lloyd's underwriting agent.

In addition, as many as 40 syndicates are expected to make cash calls this year for the 1989 underwriting year, which does not close until the end of 1991, primarily because of the $4 billion in losses from Hurricane Hugo. And other underwriters are expected to make cash calls by July for the 1990 accounting year, which does not close until the end of 1992, primarily due to the $8 billion in losses from 1990 storms in Europe.

Therefore, underwriters may take advantage of 1988 profits to ask for cash now for the 1989 and 1990 accounts so that members can offset their future losses by this year's profit, underwriting agents say.

For example, syndicate 216, managed by Devonshire Underwriting Agencies Ltd., has notified members that a 20.6 million pound ($40.4 million) cash call will be made March 1 for the 1989 accounting year.

"It is primarily a question of Hurricane Hugo which will stem from the Caribbean and North America," said Brian Peters, joint managing director of Devonshire. 1989 "is going to be a disastrous year for the market There may be 20, 30 or 40 syndicates that have to make cash calls."

Syndicate 384, managed by Aragorn Agencies Ltd., has also notified members they will be asked to pay 30% of their premium income in 1989 in a cash call due July 1.

"Certain syndicates are making 50% cash calls and others are making calls on 1990," said Alistair Wallace, chairman of Aragorn.

"Lloyd's anticipates a number of cash calls this year," confirmed the Lloyd's spokesman. "There is not a lot of money sloshing about."

All syndicates must file 1988 results by the end of May, so that Lloyd's can calculate results of the entire market by mid-June.

However, some underwriting agencies already have warned members about their syndicates' results.

For example, Merrett Syndicates Ltd. this month sent a note to all members explaining the latest position of the 1985 open year of marine syndicate 418/417, managed by sister managing agency Merrett Underwriting Agency Management Ltd.

Syndicate 418/417, the largest syndicate at Lloyd's, has kept its 1985 accounting year open until it settles its disputes over runoff reinsurance policies. Last year, the 4,000 members of the syndicate were asked to pay a total of 35 million pounds ($59.1 million at applicable exchange rates) to cover losses (*BI,* June 11, 1990).

MUAM has said that it would close the 1985 syndicate account if all the runoff reinsurance policy disputes are settled, explained Dennis Purkiss, an underwriter on sub-syndicates of 418/417. Only one runoff policy dispute remains to be settled and "we are hopeful of doing that this year," said Mr. Purkiss, which means MUAM could close the 1985 year by the end of May.

Syndicate 418/417, however, may ask for a substantial cash call if the 1985 account is closed, warned the members' agency.

"The managing agent is in no position, at this stage, to confirm the amount of reinsurance premium which would be required to secure the equitable final closing of this open year," stated the members' agency. However, the members' agency "feels sure that the final closing of the 1985 account must require a further cash call on names."

According to a schedule enclosed with the letter to members, Merrett Syndicates Ltd. calculates that the cash call could equal 40% of the premium income each member wrote in 1985. As syndicate 418/417 had a premium income capacity of 174.8 million pounds ($328.6 million at applicable exchange rates) in 1985, the members could pay as much as 69.9 million pounds ($131.1 million at current exchange rates).

The members' agency stresses, however, that "these estimates represent our worst-case guess in the complete absence of any formal figures from the managing agent and reflect our desire to enable you to have the option of some flexibility in your future financial planning. For this reason we have determined, we hope, to err on the side of caution."

Meanwhile, managing agent John Poland Managing Agency Ltd. earlier this month announced to members and their members' agents that syndicate 105/106/109 and syndicate 108/768 may ask for cash calls on July 1 totaling $120 million to boost reserves for asbestos and pollution claims.

The estimates of $80 million for syndicate 105/106/109 and $40 million for syndicate 108/768 were derived from an actuarial report by accountant Ernst & Young that gives a range of low, medium and high estimates of the "amount required to meet all known and unknown liabilities based on the most recently available data concerning asbestos and pollution claims for the United States," John Poland stated.

The Ernst & Young report shows that marine syndicate 108—one of the longest-established syndicates at Lloyd's—and its incidental non-marine syndicate 768, established in the 1950s, have reserves of about $56 million at year-end 1989 and need to boost reserves to about $96 million. The losses stem primarily from syndicate 768.

Ernst & Young's reserve estimates for pollution claims are substantially higher than for asbestos bodily injury and property damage claims, however, mainly because liability policies on which asbestos losses have occurred are being exhausted. Asbestos loss reserves should total $13.4 million, while pollution loss reserves should reach $55 million, says the Ernst & Young report. Reserves for other types of losses total $27.6 million.

Ernst & Young estimates that syndicate 108/768's cash call should be $23.5 million at July 1, but John Poland is asking for the entire reserve deficiency of $40 million.

The report also shows that non-marine syndicate 105/106/109 has reserves of $83 million but should have reserves of nearly $162.3 million. Pollution claims comprise about half of the syndicate's losses.

Ernst & Young recommends a cash call for syndicate 105/106/109 of $50.4 million, but John Poland is making a cash call of the entire reserve deficiency of nearly $80 million.

In both cases, Ernst & Young also has recommended the purchase of time-and-distance reinsurance policies that would pay some of the outstanding losses when they come due.

The members of the two John Poland syndicates so far have faced cash calls totaling about 20.5 million pounds ($40.2 million at current exchange rates). About 100 members are suing John Poland and 20 members' agents that placed them on the syndicate in High Court in London for negligence and breach of duty (*BI,* Dec. 3, 1990).

"Our names have been aware for some time of problems associated with the open years on these syndicates and we have been very conscious of the need to keep them as fully informed as possible to minimize the fear of the unknown," stated John Poland Managing Director Trevor Bradley. "I believe that this (Ernst & Young) report represents a realistic assessment of the scale of the liabilities."

John Poland does not expect to close these two syndicates' 1985 accounts until at least Dec. 31, 1994, "when more information should be available about the development of asbestos and pollution claims," the agency states.

"While I am confident that we shall not have to make any further cash calls before Dec. 31, 1994, I cannot give any assurance that further calls will not eventually be required," Mr. Bradley added. ■

Feltrim losses

Continued from previous page
hundreds of members are suing members' agents for placing them on loss-riddled syndicate 317/661 managed by R.H.M. Outhwaite (Underwriting Agencies) Ltd.

Members of the Feltrim committee, however, say that they are trying to explore other "avenues" of dealing with the problem before considering litigation.

Feltrim syndicate members charge that the losses are so large that reinsurance arrangements must have been negligently inadequate.

Members also claim that they were given no indication of the extent of the losses until 1990, even though the syndicates had taken heavy losses as early as 1987.

Most members knew "the syndicates were high-risk XL syndicates, but one would equally expect that they would be run by people of more than average competence," said Peter Uttley, a member of the Feltrim Names' Committee.

"People who are members of Lloyd's are in the business of accepting losses as well as profits. We have no quarrel with that. But in this instance it would appear that there have been weaknesses in the reinsurance arrangements. . .We are not looking at normal losses, we are looking at negligence," he charged.

"The reinsurance was not planned as it should have been by a reasonable and prudent underwriter," he contends.

Members face losses averaging 100% to 300% of the underwriting capacity they put up—far too high even for a high-risk catastrophe reinsurance syndicate, said Colin Hook, acting chairman of the steering committee.

"Our quarrel is not that we have sustained a loss but that had the reinsurance been in place in a proper way the loss would have been contained in a reasonable manner," Mr. Uttley said.

Members, however, should know that high-risk excess-of-loss catastrophe syndicates are quite capable of making large losses as well as large profits, said Tony Berry, managing director of Lloyd's underwriting agency Cotesworth Berry Ltd., which is advising AUA No. 7 on the Feltrim syndicates' runoff.

"There are many high-risk XL syndicates at Lloyd's which expose members to 100% of their underwriting capacity, and if you have three years of heavy catastrophe losses, members can lose up to 300% of their capacity," Mr. Berry said.

"If you look at 1989—which saw Hurricane Hugo, the Philips Petroleum loss and the Exxon Valdez spill—you have more than $10 billion in losses. Someone has to pay," he said.

Meanwhile, Feltrim members also are concerned that they did not know of losses sooner, said Mr. Hook. "It seems rather strange that 2½ years after underwriting losses began, the losses come to light.

"We were aware that the 1987 windstorm and the Piper Alpha (oil platform) loss were going to hit Lloyd's badly, but what was not appreciated was the extent to which the syndicates had failed to get reinsurance properly in place," he said.

The steering committee plans to meet with Lloyd's executives, directors of AUA No. 7 and members' agents.

"One of our tasks is to meet as many people as possible and find out Lloyd's attitude and what help they are prepared to give us," said Mr. Hook.

In addition, the steering committee will be contacting as many Feltrim members as possible, seeking support for a general meeting of names.

No suits are planned, they say.

Several groups of Lloyd's members already are taking legal action over huge losses sustained by the Outhwaite syndicates and others, and litigation by members is becoming far more frequent.

"We are not a committee set up to lead a 'Charge of the Light Brigade' into the courtroom. We are looking at other forms of solution first," said Mr. Uttley.

"We do not want to create problems for Lloyd's, but we want to see that names are given a fair deal if there has been negligence," Mr. Hook pointed out. "If you look at past situations, chances are that it will come to litigation. But we hope that there are other avenues that can be explored." ■

E.C. proposal

Continued from page 23

surance would be unable to master."

Patrick Peugeot, chairman of Paris-based Societe Commerciale de Reassurance S.A., France's largest reinsurer, said that as Europe develops pollution liability standards, "the American experience is full of implications for us."

Mr. Peugeot said he hopes European insurers and major commercial policyholders might cooperate to produce a "formula for a technical audit" of all of a policyholder's pollution risks. Such rigorous forward planning might help avoid the "laxity" that led to disasters like the massive pollution of the Rocky Mountain Arsenal in the United States, he said.

Cleaning up the arsenal will cost the U.S. Army and Shell Oil Co. an estimated $750 million to $4 billion (*BI*, March 27, 1989). And a jury ruled in 1988 that Shell has no coverage for its share of the costs (*BI*, Dec. 26, 1988).

"The role of insurance is to analyze the situation as far upstream as possible," Mr. Peugeot stressed.

But, insurers and risk managers at Assure Expo said the incentive to do a "technical audit" like that proposed by Mr. Peugeot and to insure identified risks depended on the penalties for "laxity."

Alain Perroy, the director responsible for environmental issues at Rhone Poulenc S.A., a chemical firm based in Courbevoie, France, said "the government should lay down the rules of the game."

But national governments are eager to avoid penalizing their own industry with costly anti-pollution measures if rival economies are not doing the same.

Phillipe Rocard, head of the industrial environment division of the French Ministry of the Environment, admitted that "one of our problems is knowing how fast to impose things. The investment required from a company is sometimes very high. Should it be made over one or three years?"

Another problem identified by Mr. Rocard was learning the views of the French public on environmental responsibility. "It is easier for us to understand the views of industrialists, harder for us to understand the views of the general public. So we are carrying out polls and meeting representatives of environmental bodies," he said.

The French government's cautious approach has so far put no strain on the country's liability insurance system.

Assurpol, which is composed of 50 insurers and 15 reinsurers, was founded in 1989 and last year wrote a modest 11 million francs ($2.1 million at year-end exchange rate) in premiums.

Mr. Bezier told *Business Insurance* that Assurpol's premium volume is expected to rise to between 17 million and 18 million francs ($3.3 million to $3.5 million at current exchange rates) this year. "We're still small but we're growing fast," he said.

The members of Assurpol offer pollution liability insurance limits of 130 million francs ($25.7 million). Coverage is site specific and is written for industrial risks in France, French territories and Morocco. Assurpol covers sudden and accidental, as well as gradual, pollution; reimbursement of cleanup costs; defense costs; and third-party damages resulting from fire or explosion (*BI*, Jan. 21).

A 1976 French law subjects some 50,000 industrial and agricultural installations, ranging from abattoirs—or slaughterhouses—to zirconium processing plants, to pollution regulations. But, Assurpol's relatively low premium volume suggests that the bulk of these businesses do not perceive a need for special pollution coverage.

That could change dramatically if France enacts the E.C. directive containing amendment No. 27, Mr. Bezier suggests. Under the amendment, each installation would be required to have 70 million European Currency Units ($95.9 million) worth of liability insurance limits per occurrence, plus 50 million ECU ($68.8 million) in limits for cleanup costs, he said.

Mr. Bezier argued that the cost of insurance in these circumstances would "doubtless prove prohibitive for businesses."

Insurers continue to lobby against the amendment, he said. ■

Lloyd's negotiating to join bourse

By WILLIAM PITT

PARIS—The Council of Lloyd's of London has taken a major initiative to help Lloyd's syndicates attract new business from France.

Lloyd's traditionally has preferred to allow individual syndicates to build their own bridges into new or unexploited markets. But Quentin Paillard, Lloyd's representative in Paris, is now negotiating for Lloyd's to join the Paris fire insurance bourse.

The Bourse des Risques Industriale is an exchange writing French commercial property insurance business. Members of the bourse operate a line slip similar to a Lloyd's slip, although the Bourse's underwriters are not all located in one room or building as at Lloyd's.

ASSURE EXPO

Premiums and claims payments are processed by the Bureau Central de Reassurance, which annually processes nearly $2 billion of gross premiums.

Sturge Lloyd's Agencies Ltd., a subsidiary of Lloyd's underwriting agency Sturge Holdings P.L.C., joined the bourse last March (*BI*, March 12, 1990), targeting small and medium-sized commercial lines business.

However, Mr. Paillard now is advising other Lloyd's syndicates and underwriting agencies to wait

Continued on next page

French bourse

Continued from previous page

for Lloyd's itself to gain admission to the bourse rather than individually apply for admission to the French market.

Mr. Paillard spoke at Assure Expo, the insurance conference and exposition held earlier this month.

French brokers have long argued that if Lloyd's wanted to improve its current, modest share of the French market, it must join the bourse.

Christian Rocheteau, chairman of Societe Generale de Courtage d'Assurances S.A., France's third-largest insurance brokerage, said that it was "absolutely indispensable" for a Lloyd's syndicate to join the bourse in order to insure small and medium-sized French businesses.

Lloyd's has been legally established in France since 1947, but its market share is less than 1%. According to Mr. Rocheteau, certain Lloyd's syndicates made a strong effort to win small-scale commercial lines business in France in the early 1970s through "cover holdings," or binding authority, extended to local brokers.

However, they withdrew from the market later in the decade because the business was unprofitable, said Mr. Paillard.

He said it was important for Lloyd's image in France to be seen as proceeding in an orderly, coordinated way, rather than in a haphazard fashion.

"Since we want to be integrated in the French market, we need to be on the bourse," he said.

Mr. Paillard also argued that French insurers that are already members of the bourse would take more kindly to one single application from Lloyd's rather than a trickle of applications from several Lloyd's syndicates.

Nevertheless, he stressed that membership in the fire insurance bourse should not be miraculously expected to improve Lloyd's standing in the French insurance market. The bourse does not transact "an enormous amount of business," he said. As French insurers increase in size, the more they increase their retentions and the less they need to spread their risk through a line slip, he observed.

Mr. Paillard said Lloyd's hopes its application to join the bourse will be granted this year. ■

UNISON vacancy doesn't faze Lucas

By WILLIAM PITT

PARIS—If Gras Savoye S.A. is growing impatient with Johnson & Higgins' protracted efforts to find a new London member for the UNISON retail brokerage network, the chairman of the French broker is hiding it well.

Gras Savoye, the second-largest broker in France and 18th largest in the world, became the French member of UNISON in 1975.

It replaced Societe Generale de Courtage d'Assurances S.A., which now is 49.9% owned by Alexander & Alexander Services Inc. and forms part of A&A's European network.

Patrick Lucas, chairman of Gras Savoye, told *Business Insurance* that replacing Willis Faber P.L.C., which last year merged with Corroon & Black Corp., is "essentially their (J&H's) responsibility. It is not our preoccupation to get a London member."

His nonchalance may be explained by the limited volume of business Gras Savoye gains from referrals from other network members.

Business generated by those network affiliates is "negligible," comprising less than 5% of Gras Savoye's total business, according to Mr. Lucas.

The value of belonging to UNISON, he said, is that it helps Gras Savoye "keep existing clients and win new ones."

Mr. Lucas denied that Willis Faber's departure has had any major impact on Gras Savoye. After the merger, "we went from 18th to 17th place on *Business Insurance*'s ranking" of the world's largest brokers, he quipped.

Gras Savoye still maintains a close relationship with Willis Corroon P.L.C., and both continue to participate in Gras Savoye Willis Faber, a reinsurance brokerage venture in Paris.

Mr. Lucas said relations between members of a "horizontal network" such as UNISON tend to be better than between members of a vertical network, like one formed in Europe by Marsh & McLennan Cos. Inc. UNISON members are, for the most part, wholly independent companies, he added.

Mr. Lucas cited the "difficulties" M&M had last year with its French network member, Faugere & Jutheau S.A., which is the country's largest insurance broker and 15th largest worldwide.

After M&M gained a majority stake in Gradmann & Holler, a brokerage in Stuttgart, Germany, in late 1989, there was much talk of it wanting to do the same in France, Mr. Lucas said (*BI*, June 18, 1990).

A number of shares in the French brokerage became available at about that time. But, Mr. Lucas noted, Faugere & Jutheau Chairman Robert M.G. Husson moved to ensure that the Jutheau family, of which he is a member, retained control.

Among the world's three largest insurance brokerages, only Sedgwick Group P.L.C. currently has majority control of its French operation. ■

For Eastern Europe, hopes and risks rise

By WILLIAM PITT

PARIS—American insurers see great opportunities in Eastern Europe, but are proceeding with caution, two insurer executives say.

There is no advantage in rushing into Eastern European markets, said Bengt Westergren, senior representative for American International Group Inc. in Paris and executive vp of the Central and Eastern European division of American International Underwriters, an AIG unit.

"It's important not to rush in. I've turned down many opportunities, more than I've accepted," Mr. Westergren said at the Assure Expo conference held in Paris earlier this month.

AIG late last year set up joint ventures in Hungary and Poland (*BI*, Nov. 19, 1990).

CIGNA Corp. also is considering various options for expanding into Eastern Europe, said Finley Middleton, vp of Central and Eastern Europe for CIGNA Corp., who was contacted at his Vienna, Austria, office.

Four markets appear particularly promising—Hungary, Czechoslovakia, Poland and, albeit with some reservations, the Soviet Union—he said.

Mr. Middleton—who has spent the last six months traveling widely in Eastern Europe, weighing the attractions and detractions of each market—was scheduled to submit several proposals for investment in Eastern Europe to the CIGNA directors in Philadelphia last week.

The insurer, he claims, is willing to make "the same commitment to Eastern Europe as we have made to the rest of Europe."

Although CIGNA coordinates its extensive Western European operations from a central office in Brussels, Belgium, Mr. Middleton said he sees "no absolute need to have a (different) focal point for Eastern Europe."

He described Hungary as "an incredibly attractive market," but lamented the high minimum capital requirement for foreign insurance companies. Minimum capital for a multiline insurer currently is $17 million, but new legislation is expected to make it possible to set up either a life or property/casualty insurance company with $8 million, Mr. Middleton said.

The current threshold is "way out of line" with other European countries, he said. "It does an injustice to the insurance consumer," he said.

Messrs. Middleton and Westergren agree that Czechoslovakia is an attractive but "difficult" market.

The Czech government has yet to set terms for foreign insurers wanting to trade in the country. The effective date for this law originally was Jan. 1, but has been pushed back to April 1.

The new date also is beginning to look unlikely, AIG's Mr. Westergren said.

Nevertheless, CIGNA's Mr. Middleton gives the Czechs credit for being "very honest. They don't feel they're ready yet to combat the threat (from foreign insurers). They don't pretend they've got another motive."

In the Soviet Union, there is a risk of "bucking the system" by forming relationships with the newly independence-minded Soviet republics, he said.

If central power is reasserted, these contacts might be unable to deliver what they promise, Mr. Middleton said. ■

INTERNATIONAL

Assure Expo exhibits French market

PARIS—Billed as "Europe's insurance exhibition," Assure Expo is really an exhibition of the French market.

The annual conference and exhibition earlier this month drew more than 27,000 underwriters, brokers and risk managers to the CNIT Conference Centre at La Defense, the modern business district outside Paris. Fewer than than 800 attendees were from outside France.

Assure Expo's growing importance as a place for foreign insurance companies to display their products and services was evidenced this year by major delegations from two very different insurance organizations: the Soviet insurer Ingosstrakh and Lloyd's of London.

Major U.S. insurers like CIGNA Corp., Chubb Corp. and American International Group Inc. also were prominently represented.

Less conspicuous were the major brokerages, whether French or not. Conference organizers listed only six brokerages as among the 220 exhibitors and one of these, Linkline, is not a broker but the marketing arm of Lloyd's non-marine syndicate 190, managed by F.R. White & Others.

However, brokers and agents have historically represented the biggest single group of visitors at Assure Expo.

Next year's meeting will be held Feb. 4-7 at the CNIT Conference Centre, La Defense, Paris. For more information, contact Vidal S.A., 29 Rue Druout, 75009 Paris; 1-482-47601.

—By William Pitt

Terrorist bombs

Continued from page 23

both of Bermuda (*BI*, Jan. 14).

British Rail also has 100 million pounds ($196 million) in property insurance placed in the London market excess of a 7.5 million pound ($14.7 million) deductible, sources say.

If liability and property claims exceed the deductibles retention, British Rail's ability to collect on its insurance will depend on which group is determined to be responsible for the two bombings under police investigation, according to observers.

All standard U.K. property and liability policies exclude claims arising "directly or indirectly, by reason of or in connection with war, invasion, acts of foreign enemies, or civil war."

As a result, if insurers are able to prove that the bombs were planted by Iraqi sympathizers or were in any way related to the Persian Gulf War, they could void the policy.

However, the Assn. of British Insurers, as well as sources at Lloyd's, confirmed that IRA attacks in mainland Britain usually have been covered by standard property/liability policies issued for risks in Scotland, Wales and England.

Risks in Northern Ireland are not insured against terrorist acts and compensation to victims in those cases is provided by the British government, according to an ABI spokesman. ■

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return," according to Mr. Coleridge.

Mr. Coleridge said that it was too early to establish the Sturge syndicates' overall liability to directors and officers liability claims and professional indemnity claims emanating from the U.S. savings and loan crisis (see story, page 1). However, "the overall effect on the results for our shareholders should be minor," he said.

Asked by a shareholder how his election as Lloyd's chairman would affect Sturge, Mr. Coleridge replied: "I have been chairman of Sturge since 1978, and I think that there comes a time in the life of a chairman or executive chairman when it is useful to slightly withdraw from the front line. Whether I had become chairman of Lloyd's or not, I would have relinquished the reins from quite a number of companies in the Sturge group."

Mr. Coleridge said that he had resigned his directorships in most Sturge subsidiaries in September 1990.

—By Gavin Souter

Train settlement

The British Railways Board is paying 339,000 pounds ($664,400) to a widow whose husband died in a London train accident in December 1988.

Under the settlement approved by the London High Court, Karen Hadfield will receive the compensation for shock, grief and loss of financial support following the death of her husband, Paul.

As part of the settlement, 25,000 pounds ($49,000) will be paid to the couple's daughter, Simone, who was born eight months after her father died, a British Rail spokesman confirmed.

So far British Rail has paid out some 4 million pounds ($7.8 million) to the victims of the 1988 Clapham Junction rail disaster, in which 35 people were killed and another 401 passengers were injured.

By the end of last month, British Rail had settled 273 of 401 personal injury claims and 15 of 35 claims from relatives of people who died in the train collision, the spokesman said.

British Rail's property and liability insurance at the time of the accident was led by Royal Insurance P.L.C. in London and brokered by Sedgwick Group P.L.C. British Rail had 50 million pounds ($98 million) of liability coverage placed in the London market excess of a 7.5 million pound ($14.7 million) deductible (*BI*, March 13, 1989).

British Rail changed its broker and increased its coverage before the April 1989 renewals. (*BI*, Jan. 14).

—By Carolyn Aldred

Solvency rules

The United States should institute uniform insurer solvency laws to help detect problem companies before they hurt the whole industry, said Dean O'Hare, chairman and chief executive officer of Chubb Corp.

Speaking at an Insurance Institute of London meeting, Mr. O'Hare said that the entire U.S. property/casualty industry is facing criticism from consumers and legislators, despite the financial security of most insurance companies.

"Are these expressions of concern warranted? In a few isolated cases, perhaps. Are we an industry in dire fiscal straits? No, we are not. Overall, the industry ended 1990 with operating results slightly better than those of 1989," he said.

Conceding that some insurers have problems, Mr. O'Hare said the gap between secure and unstable companies is widening.

"In my view, the objective is effective solvency regulation, regardless of who does it: state or federal governments. Politically, I welcome attention directed to solvency rather than to rate rollbacks, which serve only to undermine solvency," he said.

—By Gavin Souter

Ship loss insured

A Singapore-registered bulk carrier that sank off Newfoundland last month could result in hull and liability claims exceeding $6 million, London sources say.

The Protektor, an 80,184-metric ton dead weight vessel, went down with its cargo of 75,000 metric tons of iron ore in heavy weather on Jan. 12. All 33 of the ship's crew members died.

A spokesman for broker Lowndes Lambert Group Ltd. in London confirmed that it placed coverage for the Protektor through its Hong Kong office on behalf of the ship's manager, Wallam Ship Management Co.

The hull risk was led by the Swedish Club, which retained 75% of the risk, according to a spokesman for the Goteborg, Sweden-based protection and indemnity club.

Neither Lowndes Lambert nor the Swedish Club would give the insured value of the vessel, but London sources say the vessel was quoted in November in the London market for a value of $5 million.

The cargo and liability risk was placed with the London Steamship Owners' Mutual Insurance Assn. Ltd. A spokesman for the London P&I club would not estimate the liability loss, but said that the sum of the cargo loss and compensation payments to the crew's dependents would probably not exceed the $1.6 million retention.

The London P&I club confirmed, though, that the cargo's value was in excess of $1 million.

—By Gavin Souter

Grand Union liquidators

London and Hong Kong courts earlier this year ordered separate liquidations for Grand Union Insurance Co. Ltd. of Hong Kong and its London subsidiary.

The move followed petitions by two creditors to wind up the two companies. Grand Union, facing severe cash flow problems, had pleaded with brokers to commute insurance and reinsurance policies it had written (*BI*, Dec. 31, 1990; Dec. 17, 1990; Dec. 3, 1990).

On Jan. 31, after London's High Court wound up the company, creditors appointed Michael Jordan and Ian Barker Bond of the London firm Cork Gully, a unit of Coopers & Lybrand, as liquidators of Grand Union in London. Mr. Jordan and Mr. Bond had been operating as provisional liquidators.

Five days later, Hong Kong creditors named Jan Blaauw and Philip Hilliard from Coopers & Lybrand in Hong Kong as joint liquidators. Sources estimate that creditors in Hong Kong are owed at least 10 million pounds ($20 million).

—By Stacy Shapiro

Hardship at Lloyd's

In only its first year, the "hardship committee" at Lloyd's of London has received 164 applications from members seeking help in covering their losses.

But only 13 members have actually taken aid, costing Lloyd's Central Fund less than 1 million pounds ($2 million), according to Lloyd's Chief Executive Alan Lord. So far, only 22 members have been offered assistance.

Members who accept those offers of assistance must sign a standard "hardship agreement." And a new deposit trust deed requires members who accept assistance to execute a lien in favor of Lloyd's over their home or other property until the debts are paid.

Some members have also agreed to share future syndicate underwriting profits with Lloyd's in exchange for help in paying current losses.

The hardship committee will report quarterly to the Council of Lloyd's. Reports will focus on the amounts that are outstanding from members who have applied for aid; whether offers have been made; and whether members have agreed to them.

—By Stacy Shapiro

Unauthorized insurer

The British Department of Trade and Industry is warning insurance buyers that a company called Ocean Pacific Insurance Co. is not authorized to write any insurance business in the United Kingdom.

The DTI believes that Ocean Pacific has confined its underwriting to taxi and car hire drivers in the British county of Kent. The Ramsgate, Kent, police are currently investigating the case.

"The Department of Trade and Industry wishes to make it clear that Ocean Pacific is not authorized in any way to carry on any class of insurance business in the United Kingdom," the government department announced earlier this month. "Any person holding a cover note (or policy) should consult their insurance adviser urgently with a view to obtaining alternative cover."

Ramsgate Police Officer D.C. Johnstone says that Ocean Pacific "would appear to be totally false and totally fraudulent and totally fictitious" and apparently is not licensed in any country.

Ian Mattinson, who allegedly collected about 22,000 pounds ($43,760) in premiums in exchange for Ocean Pacific cover notes, was arrested in mid-January "for obtaining property by deception," said Officer Johnstone. Mr. Mattinson is also wanted for alleged theft of automobiles in other parts of the country, Officer Johnstone said.

Comings and goings

Mark Boucher, Michael Reid, David Scott and **John Turner** have been appointed to the board of Alexander Howden Ltd.

Nicholson Chamberlain & Colls Ltd. has formed Nicholson Chamberlain Colls Marine Ltd. with a team of brokers who formerly were with rival Lloyd's broker Citicorp Insurance Brokers Ltd. The new division is led by **Christian Young**, chairman and managing director, and Directors **Graham Gardner, Andrew Gardner**, and **Tim Kyd**.

Lloyd's broker Thompson Heath & Bond has formed a professional indemnity division. The divisional director is **Chris Henney**, who was formerly with J.H. Minet & Co. Ltd.

Malcolm Cullum has been promoted to executive director of the North American casualty and benefits division at Minet, from division director. **Simon Emmerson**, formerly senior broker, has been promoted to divisional director.

Conor Finn, formerly with Steel Burrill Jones P.L.C., has been appointed divisional director of Minet's North American property and energy division.

Thomas Tannion has been appointed manager-U.K. business development of Engineering Insurance Co. Ltd. He joins the company from Gerling Global Insurance Co. Ltd.

Bain Clarkson Ltd. has established a new Risk Management Services division and appointed **Brian Lee**, who was formerly with Alexander Stenhouse U.K. Ltd., its managing director.

John Oughton has been promoted to Bain Clarkson's international division's board. ■

Surety bond suit

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began in New York.

In 1987, the Cook County Circuit Court ordered General Railway to pay $683,500 to AFFI's liquidator, then-New York Insurance Superintendent James Corcoran. General Railway lost an appeal of the case.

Following that award, the SBA filed a motion for summary judgment to directly collect the $683,500, arguing that language in the surety bond agreements entitled the SBA to "the salvage recovered by AFFI on each bond" up to the amount the federal agency paid in guarantees.

Judge Rovner last October agreed with the SBA and granted the agency's motion for summary judgment.

AFFI's current liquidator, New York Insurance Superintendent Salvatore R. Curiale, appealed to the 7th Circuit, and the appellate court on Jan. 3 called for Judge Rovner to reconsider her decision.

Upon review, Judge Rovner granted the motion by AFFI's liquidator asking that the case be dismissed on the grounds that the federal court must abstain in deference to the liquidation proceedings in New York.

The $683,500 award has grown to $1.2 million because of prejudgment interest and legal fees, and "it's been paid in full" to AFFI's liquidator, according to attorney William Goldberg of Holleb & Coff in Chicago, who represents Mr. Curiale in his role as AFFI liquidator.

Judge Rovner said in reconsidering the case that "this court is somewhat perplexed by the Court of Appeals' discussion of the abstention issue. The Court of Appeals emphasized that abstention involves factual determinations that it was not in a position to make based on the appellate record, and that it therefore would not rule on abstention."

For example, the 7th Circuit admitted that it did not have "the benefit of facts or briefs which might allow it to come to a reasoned decision on the abstention issue," even though the abstention issue "necessitates a fact-specific inquiry," Judge Rovner pointed out, using the 7th Circuit's own language.

Still, "the Court of Appeals then proceeded to clearly indicate that this court should abstain," Judge Rovner wrote.

As a result, the lower court had no choice but to vacate the portion of its opinion that addressed abstention and dismiss the case, Judge Rovner ruled.

Although the 7th Circuit recognized that federal issues might be involved in the case, it noted that "a federal court may abstain even from a case posing mixed federal and state law issues."

In addition, the 7th Circuit emphasized that the litigation "arguably threatens to frustrate the superintendent's efforts to collect the assets of the now-bankrupt insurance company."

There is a "comprehensive New York state scheme for insurance regulation and liquidation," the appellate court pointed out.

To deprive the superintendent "of the power to have his claims against others litigated in the New York liquidation proceeding would prevent the superintendent from executing half of his job" of collecting and distributing assets of the insurer, the appeals court ruled.

Eric S. Benderson, associate general counsel for litigation at the SBA, said no decision has been made on whether to appeal the ruling but that the agency "probably won't" appeal.

Mr. Benderson emphasized that although the SBA must stake its claim through the liquidation proceedings, it will be near the front of the line when payouts to AFFI's creditors are made, because bankruptcy laws entitle a government agency to a priority status among creditors when assets are distributed.

Mr. Goldberg, who represents Mr. Curiale, said it is unlikely there will be any further appeal.

"By reason of payment, the case is moot," Mr. Goldberg said. "I don't know what is left to appeal."

Before Judge Rovner's first decision last fall, the SBA also had written to General Railway that it was putting the company "on notice" that the debts the company pays before a government claim is settled do not relieve it of obligations to the government.

General Railway later filed an interpleader action in federal court charging it was being subjected to "multiple liability on the same funds."

The SBA does not intend to seek the amount of the guarantees from General Railway, Mr. Benderson said. ■

Health care institutions' D&O coverage

Continued from page 3
renewed policies during the period covered by the survey, 80% reported that they had maintained their previous limit, 11% increased their limit and 9% decreased their limit.

One significant difference between the health care D&O market and the corporate D&O market that was surveyed earlier is the role of excess insurance.

Only 28 of the 638 health care providers—or about 4%—reported purchasing excess coverage, while 435 of the 1,442 participants responding to the corporate D&O survey—or 30%—reported purchasing 875 excess policies.

Health care providers reported paying $28,000 on average for primary D&O coverage and $30,100 on average for all D&O coverage, according to the survey.

In the corporate D&O survey, respondents reported paying $253,649 on average for primary limits and $425,463 on average for all D&O coverage.

Not all of the health care providers responding to the survey purchased D&O insurance. But although 113—or 17.7%—of the 638 survey respondents did not buy the coverage, availability was not cited as an impediment.

In fact, only 9% of those without D&O coverage said that they were unable to obtain it.

Twenty-six percent of health care providers reported they did not obtain D&O coverage because they felt it was unnecessary, and another 26% said the coverage was too expensive, according to the survey.

Other reasons cited for not obtaining the coverage were:

- The coverage was too limited, cited by 12%.
- Counsel advised them not to obtain the coverage, cited by 8%.
- Unspecified other reasons, cited by 19%.

Twenty-three percent of the respondents to the corporate survey reported they did not obtain D&O coverage. The most common reason given was that the coverage was too expensive.

The health care D&O market survey detected a "slight but perceptible trend toward premium increases."

Among survey respondents renewing coverage sometime from the third quarter of 1989 through the third quarter of 1990, 32% reported a premium increase, 38% renewed their policies with no change in premium and 29% said their premium decreased.

Among survey respondents that purchased coverage during the third quarter of 1989, 26% said it had increased, 37% said their premium was unchanged and 33% said it had decreased, with the remaining 4% having had no previous coverage.

But, by the third quarter of 1990, the trend was definitely toward higher premiums: Thirty-eight percent reported they paid a higher premium, 32% said that their premium remained the same and 28% said their premium had decreased. The remaining 2% reported they had no previous coverage.

In contrast, by the third quarter of 1990, 47% of the participants in the earlier corporate D&O survey reported premium increases, up from only 24% during the third quarter of 1989.

A possible reason for the disparity is the magnitude of D&O claims made against health care providers compared to those against corporations.

Ninety-six of the 638 health care provider respondents reported a total of 153 claims over the 1981-89 period. Eighty-eight—or 58%—of those claims had been settled when the participants filled out their surveys, with an average payment of $456,000, according to the survey.

In stark contrast, the 1,442 participants in the corporate survey reported a total of 852 claims during the same period. Nearly 57%—or 482—of those claims were settled by the time participants filled out their surveys, with an average payment of $1.94 million, according to the corporate survey.

Mr. Wollner pointed out that the nature of D&O claims made against health care institutions differs from those made against corporations. Whereas slightly more than half—50.9%—of the claims reported in the corporate survey were made by shareholders and other investors, only 2.9% of the claims against health care providers were filed by shareholders.

Instead, nearly three-quarters—73%—of the D&O claims against health care providers were filed by employees or physicians.

Employees accounted for 42.3% of the claims. For example, 25.5% of all D&O claims against health care providers were made by employees claiming wrongful dismissal.

Physicians accounted for 30.7% of D&O claims against health care providers. The most common source of claims from physicians involved the granting of staff privileges, also known as credentialling, which accounted for 17.5% of all D&O claims against health care providers.

"Health care (D&O) claims lend themselves quite well to loss prevention," according to Mr. Wollner. "By refining your termination policies and credentialling procedures, you can avoid a lot of these types of claims," he said.

The survey showed that no one insurer dominates the health care D&O market, according to Ms. Arthur.

She also pointed out that "the growth of hospital-formed insurance companies has broadened the range of carriers that provide the coverage."

In fact, one hospital-formed insurer, PHICO Insurance Co. of Mechanicsburg, Pa., owned by the Hospital Assn. of Pennsylvania, ranked fifth-largest in terms of premium volume, accounting for 4.2% of the survey respondents' primary D&O premium volume, and sixth-largest in terms of primary policy count, writing 8.3% of the respondents' accounts.

Another hospital formed insurer, Princeton, N.J.-based Health Care Insurance Exchange, owned by Princeton-based NJHA Inc., ranked ninth in terms of primary premium volume at 1%.

HCIE also tied for 10th in terms of primary policy count at 1% with Oklahoma City, Okla.-based Hospital Casualty Co., an insurance company sponsored and owned by the Oklahoma Hospital Assn. in Oklahoma City.

Policyholder-formed insurance groups accounted for 12% of the respondents' primary D&O policies and 7% of their premium volume.

But the dominant insurer among participants in terms of both premium volume—with 26.9%—and primary policy count—21%—was Chubb Corp. of Warren, N.J.

Other major D&O markets for health care providers are:

- Executive Risk Inc., formerly known as Executive Risk Management Associates, a unit of Aetna Life & Casualty Co. of Hartford, Conn. Executive Risk ranked second in terms of primary premium volume with 22% of the respondents' premiums, and third in primary policy count with 14.3% of their policies.
- American International Group Inc. of New York, which ranked third in primary premium volume with 17.5% and fourth in policy count with 10.4%.
- Royal Group Inc. of Charlotte, N.C., which ranked fourth in primary premium volume with 12.6% and second in policy count with 17%.
- St. Paul, Minn.-based St. Paul Cos. Inc., which ranked sixth in primary premium volume with 2.9% and fifth in primary policy count with 9.8%.

In contrast to the D&O market for health care providers, two insurers—AIG and Chubb—accounted for nearly 58% of the primary corporate D&O premium volume reported by respondents to Wyatt's earlier corporate survey.

"One of the reasons (that the market for health care provider D&O insurance is likely to remain competitive) is that there are many players with significant market positions that are aggressively pursuing this business. Along with that, there seems to be an increasing recognition among the underwriting community that this is a distinctive class of D&O business that needs to be treated separately from other D&O business," said Mr. Wollner. He stressed the fact that the most common D&O exposures faced by health care providers can be managed through loss control.

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The "1990 Wyatt Healthcare Organization Directors and Officers Liability Survey" will be available for $85 on March 1. Companion peer group reports describing the claims and insurance purchasing patterns for segments of the survey participants also can be purchased for $175 by survey participants and $350 by non-participants. American Hospital Assn. members can obtain the reports at a discount. The reports can ordered by contacting Donna Juhlin or Mary Maze at The Wyatt Co., Risk Management Services, 303 W. Madison St., Suite 2400, Chicago, Ill. 60606-3308; 312-704-2719.

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Business Insurance

AFL-CIO policy

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all Americans."

Accordingly, the AFL-CIO will support measures that would move the nation toward the labor union's goals, Mr. Kirkland said.

For example, the AFL-CIO resolution supports:

- A nationwide cap on health care spending.
- A nationwide system for managing the now-uncontrolled duplication of technology and improve the allocation of resources.
- A federal authority that would negotiate uniform reimbursement rates with hospitals, doctors and other providers to be used by all payers.

These measures would save approximately $165 billion by the end of the decade, Mr. Kirkland estimated.

While the AFL-CIO resolution does not endorse a single, particular measure, it states that the group "will form coalitions with consumer groups, employers, community-based organizations and providers to call on Congress for expeditious enactment of federal legislation" that would, among other things:

- Guarantee universal access to health care by establishing a national health insurance program for the currently uninsured that would include workers, the unemployed and others not in the labor force and would incorporate Medicare and Medicaid.

However, the resolution does not specifically call for a mandate on employers to offer health care benefits to their workers.

- Create a national commission of consumers, labor, management, government and providers that would administer the program.
- Establish a core package of guaranteed health care benefits. Supplemental benefits above the core would be provided on a voluntary basis or through collective bargaining.
- Develop "progressive and equitable" financing mechanisms that would require all employers to contribute toward the cost of health care coverage.

Some observers have viewed this suggestion as an endorsement of a proposal last year by the blue-ribbon Pepper Commission that employers be required to provide health benefits or pay new payroll taxes to fund coverage for the uninsured (*BI*, March 5, 1990).

However, Ms. Bradbury said the resolution is not an endorsement of the Pepper Commission's play-or-pay mandate.

- Reduce employers' retiree health care costs by dropping Medicare eligibility to age 60, which would be more in line with the average retirement age.

Ms. Bradbury noted that a large percentage of the uninsured are early retirees who are no longer covered by their employer health care plan but are not yet eligible for Medicare.

- Improve quality of care through the widespread dissemination of information to physicians through practice guidelines, create a national system for technology assessment and build a national data base on the cost and quality of care.
- Encourage physicians to avoid unnecessary tests and medical procedures, and at the same time develop a better system for handling malpractice disputes.
- Devise a strategy to provide all Americans with access to long-term care and to make home care available to the chronically ill.

One element of the AFL-CIO's far-ranging proposals that is "quite significant" is the call for a national cost containment policy, commented Hewitt's Mr. McArdle. "Though it is vague on specifics, this resolution comes out with cost containment proposals," which is the one ingredient that has been missing from congressional health care proposals that have been introduced thus far, he said.

In fact, he predicted that several of the proposals outlined in the AFL-CIO resolution will likely appear in the health care legislation that will emerge on Capitol Hill.

Mr. McArdle also noted that the AFL-CIO proposal would cap provider fees.

"One thing that the Pepper Commission did was walk away from controls on provider payments," he said.

The AMA's Dr. Todd said he did not object to the concept of capping provider fees because providers "are already working on negotiating fees" with employers and the federal government.

However, the AMA is opposed to the concept of systemwide health care budgets because it could lead to rationing of care and long waits, as occurs in the British and Canadian health systems, Dr. Todd said.

The AFL-CIO's cost control suggestions are 'ambitious' and 'intriguing,' says Ms. Goldstein.

"It has to be rational cost containment," he said.

The Washington Business Group on Health favors the AFL-CIO's endorsement of a universal health care program jointly supported by the public and private sector, said Mary Jane England, the organization's president.

"Employers are very concerned about the lack of universal access," she said. However, the solution should lie in the existing multi-payer system "with the employers continuing to pay and the government continuing to pay."

The employer health coalition also is pleased with the AFL-CIO's proposals to improve quality of health care services.

"Quality is probably the biggest issue for large employers," she said. "Providers are going to have to develop practice guidelines and be more involved in quality."

The APPWP's Ms. Goldstein described the AFL-CIO's cost containment suggestions as "ambitious" and "intriguing."

"Cost is the driving issue for all of our health care problems," she said. "It appears that they are quite serious about getting at cost."

However, "we should be careful before we invite government in to fine-tune" the health care system, she cautioned.

Ms. Goldstein also took exception to the AFL-CIO's contention that some employers are "refusing" to provide health care coverage to their employees.

"Employers that aren't providing coverage aren't refusing. They aren't offering it either because they can't or because they can't afford it," she asserted.

Ms. Goldstein also expressed concerns about the contents of the AFL-CIO's proposed "core benefit program."

The list of mandated benefits "keeps growing," she said, pointing as evidence to the numerous benefits that many states now require insured health plans to offer.

In addition, Ms. Goldstein said that the AFL-CIO's proposal to reduce the Medicare eligibility age to 60 from 65 would indeed cut employer's retiree health care costs. But, she noted that such a change would go against national policy to gradually raise the retirement age for Social Security purposes.

"That's the wrong direction to go if they're serious about containing costs," Ms. Goldstein said.

Some observers suggested that the success of recent point-of-service managed care programs, like those implemented by Southwestern Bell Corp. and Allied-Signal Inc., may have helped convince organized labor that managed care is not a reduction in benefits, but an enhancement.

Both the CustomCare program at Southwestern Bell and the Health Care Connection plan at Allied Signal have kept the companies' health care cost increases far below the national average (*BI*, Feb. 18).

"There have been some interesting agreements" recently, all of which have been "cooperative efforts between labor and management in which everyone benefitted," said the WBGH's Dr. England.

In both the Southwestern Bell and Allied-Signal programs, employees who select network providers receive more comprehensive benefits than those who select non-network providers.

Dr. England also predicts that labor's apparent shift toward endorsement of managed care will make it easier for employers to negotiate cost containment measures in future labor contracts.

"Now, if there's agreement between labor and management" in the area of health care cost containment, "they'll move on to other issues," she said.

The resolution is not the first time that members of the AFL-CIO have supported the concept of labor and management working together to develop health care cost containment strategy.

In 1987, the Labor-Management Group, a private organization composed of AFL-CIO union leaders and the chief executive officers of corporate members of the Business Roundtable, endorsed a joint effort to reduce health care costs (*BI*, Feb. 15, 1988).

And, in the early 1980s, labor was often in the forefront of proposing cost-containment measures as an alternative to employer-mandated benefit cuts.

The AFL-CIO includes more than 90 unions representing 14.2 million workers nationwide. Among the many unions represented are the United Auto Workers, United Mine Workers, Service Employees International and Communication Workers of America. ■

BIC coverage

Continued from page 2
private pension plans nationwide maintain deposits of more than $100,000 in depository institutions. More than 94,000 of these plans, or 74%, are defined contribution plans. A total of about $53 billion of defined contribution plan assets have been deposited in banks and thrifts and receive pass-through insurance, the proposal says.

But, the proposal adds, there should be an exception for "self-directed" plans.

"Unlike plans where an institutional investor makes investment decisions on behalf of beneficiaries, self-directed plans give beneficiaries the discretion to choose such investments as bank deposits," the proposal states.

"When these beneficiaries make such a choice, they should be eligible for the same deposit insurance treatment as individual savers who do not participate in such plans," it states.

But, observers point out that almost all 401(k) plans offer employees a choice of investment options. Therefore, if the exception relating to self-directed plans that the Treasury proposes is broadly interpreted, it could apply to virtually all 401(k) plans.

"I think it's pretty muddled," said Kim McCarrel, a consultant with The Wyatt Co. in Portland, Ore.

Ted Athanassiades, executive vp of New York-based Metropolitan Life Insurance Co., agrees that the language of the proposal is confusing. However, he said the Treasury intended that the exception to eliminating pass-through FDIC coverage apply to only self-directed Individual Retirement Accounts.

"It does not apply to pass-through coverage where the employer buys BICs for millions of dollars," he said.

There are other unanswered questions, as well.

For instance, if FDIC coverage for BICs is eliminated, it is unclear whether BICs that have already been written will be grandfathered.

The Bush administration soon is expected to propose enabling legislation that is expected to clarify the confusing language in the proposal.

Meanwhile, the House Banking Committee is considering two bills that would clearly eliminate pass-through coverage for bank investments made by most pension plans.

Committee Chairman Henry B. Gonzales, D-Texas, and Rep. Chalmers Wylie, R-Ohio, a ranking minority member of the committee, have proposed reform legislation that would eliminate pass-through FDIC coverage for BICs covering most retirement plans, say spokesmen for the congressmen.

Rep. Gonzales' bill is H.R. 6, while Rep. Wylie's legislation is H.R. 15.

Eliminating the pass-through FDIC coverage probably is not expected to significantly hurt major banks that have offered BICs like Bankers Trust Co., Citibank and Morgan Guaranty Trust Co.

Pension plan sponsors generally have focused on the banks' underlying credit rather than relying on the FDIC coverage, explains Brian Ternoey, a consultant with A. Foster Higgins & Co. Inc. in Princeton, N.J. "I think most of the people would continue as they did before," he said.

However, Dan Schukarbt, assistant treasurer for Chicago-based FMC Corp., disagrees.

"Absolutely, it would change our attitude" toward BICs because insurers tend to have higher credit ratings than most banks, he said.

Only a handful of U.S. banks have double-A ratings, he noted. And only one bank, Morgan Guaranty, has a triple-A rating.

"It would be a major factor for us to deal with," Mr. Schukarbt said. "Our normal criteria for buying a guaranteed investment contract would require a long-term debt rating of the institution much higher than the banks have."

Eliminating pass-through FDIC coverage for BICs is expected to hurt smaller, less creditworthy banks that rely on FDIC coverage in their marketing efforts.

"Those banks are going to have to do something to address that whole concern in a totally different way," said William D. Templeton, director of insurance consulting in Atlanta for TPF&C, the benefit consulting division of Towers, Perrin, Forster & Crosby Inc.

Meanwhile, some major banks already are offering a type of guaranteed investment contract that is not backed by FDIC coverage, called synthetic GICs.

These instruments, which are not considered deposits and therefore are not eligible for FDIC coverage, are backed by a pool of securities, like Treasury notes.

The investments are placed in a separate account that belongs to the pension plan rather than to the institution. ■

IIE seeks to examine syndicate's records

By MEG FLETCHER

CHICAGO—The Illinois Insurance Exchange has issued a cease-and-desist order against Alliance Syndicate Inc. because syndicate officials refuse to turn over all the syndicate's books and records.

The syndicate, one of 12 in the exchange, refused to give adequate information to the IIE board's audit and regulatory oversight committee at a Feb. 19 hearing, according to IIE President James M. Skelton.

The order prevents the syndicate from accepting any new or renewal coverage that was not quoted by 5 p.m. last Friday, Mr. Skelton said. In addition, that coverage must become effective by March 24.

IIE officials want to question some transactions, including reinsurance commutations between the first and third quarters of 1990, Mr. Skelton said.

"We are asking for their help and essentially, they are stonewalling us," Mr. Skelton said.

But, Eric Rahn, the Alliance Syndicate's executive vp and chief operating officer, said: "The cease-and-desist order is unwarranted and unjustified and probably illegal."

The syndicate late last week was seeking a restraining order from a state court to prevent implementation of the order, Mr. Rahn said.

"We believe that we have been more than reasonable in providing complete access to our books and records," he said.

Mr. Rahn emphasized that the order would not affect the operation of Alliance General Insurance Co. in Chicago, which owns the Alliance syndicate.

Alliance had not determined whether it would appeal the order to the IIE's board, Mr. Rahn said.

The IIE does not know whether the Alliance syndicate is in financial difficulty or not, Mr. Skelton said.

For the first three quarters of last year, the Alliance reported a net aftertax loss of $1.14 million on $5.32 million of gross premiums, Mr. Skelton said.

The syndicate also reported $3.28 million of policyholders surplus and $18.74 million of assets, he said.

However, Mr. Rahn reported that the syndicate's net aftertax loss had shrunk to $648,000 as of Dec. 31. Its year-end surplus was $3.7 million, he said.

"The Alliance syndicate is unequivocally not in financial difficulty," Mr. Rahn said.

The Alliance syndicate mostly writes primary general liability insurance, including product liability coverage for manufacturers, distributors and others.

The syndicate will write limits of up to $2 million, and it is reinsured primarily by Lloyd's of London, Mr. Rahn said.

About 20% of the syndicate's business consists of commercial property coverage and commercial package policies.

The IIE ranked as the fourth-largest U.S. surplus lines insurer based on 1989 non-admitted direct premiums of $136 million (*BI*, Aug. 13, 1990).

The exchange monitors and controls its syndicate members but is also subject to oversight by the Illinois Insurance Department.

The exchange's syndicates have combined policyholder surplus of about $130 million and a combined asset base of more than $500 million, the IIE reports. In addition, the IIE has a guaranty fund containing more than $25 million. ■

S&L study

Continued from page 1

we've been selling continuity. What we see is something disturbing that continuity over the horizon."

The information the new committee will gather will allow the underwriters to make changes to policy wordings if necessary to allow them to continue underwriting financial institution risks rather than pulling out of the class of business altogether, said Mr. Spreckley.

"Nobody's panicking. We're merely trying to educate ourselves," he said.

If the committee discovers that losses are worsening, "it's far more likely that we'll change the pricing of the product," added Andrew Beazley, another committee member.

The 14-page report, "The Saving and Loan Crisis and Its Implications for the London Insurance Market," was written by Andrew Beazley, another leading Lloyd's financial institutions underwriter, and his claims manager, Sarah M.M. Fitzgerald. Both are with underwriting agency Beazley Furlonge & Hiscox Ltd.

"The purpose of this paper is to act as an aid memoir for underwriting agents and is, therefore, written with a view to the overall scenario as opposed to a comprehensive thesis on the subject," said the Beazley report.

This release of the report follows media attention concerning the S&L crisis, including estimates by London law firm Davies Arnold & Cooper that S&L failures could cost London underwriters $3 billion to $5 billion (*BI*, Dec. 31, 1990).

Those figures, contends Mr. Burnhope, are no more than "speculative" estimates made by guessing that the London market will incur about 1% of the total savings and loan losses.

"The point we are trying to communicate is that there is no first-party coverage," he said. "The mere fact that there is an injury doesn't constitute a claim. The financial distress has largely been due to economic causes."

Some have speculated that the exposure to the London market is similar in magnitude to asbestos and pollution claims, which have cost the market billions of dollars.

But the Beazley report points out that asbestos and pollution losses were written on occurrence—rather than claims-made—policies so that policies written more than 40 years ago had to respond to losses arising today.

With the S&L crisis, "this is the first time the liability sector of the insurance market has been faced with a potentially serious situation affecting current policies, the result of which will differ from previous losses," noted the Beazley report. The magnitude of the insured losses from the S&L crisis will be contained because:

- Most of the affected policies are written on a claims-made basis, so that only policies written recently will be triggered.
- Most claims-made policies include defense costs and legal expenses within policy limits. Thus, the policies will be exhausted more quickly.
- Most of the policies have an aggregate limit of liability, thus capping the amount underwriters are obligated to pay regardless of the number of claims. Many of the policies triggered by asbestos or pollution claims had no aggregate cap.

S&L-related liability is far more serious for U.S. than for foreign insurers, said Mr. Burnhope. "It's not primarily a London problem. It's primarily a U.S. problem."

However, representatives of the major U.S. property/casualty insurer trade groups said they knew of no similar U.S. group studying S&L losses.

The Beazley report points out that for London underwriters the S&L debacle could be the greatest U.S. financial crisis since the Great Depression. "It is being said that more than one-third of (U.S.) savings and loan institutions will fail as well as a number of commercial banks," says the report.

Officials now project the final price tag for the financial institution failures at $500 billion over the next 40 years, the Beazley report says. "This represents a cost to every man, woman and child in the U.S.A. of $2,000," says the report.

This estimate quoted in the Beazley report comes from a July 1990 report titled "FSLIC's Losses—When and How They Accumulated" by analyst Bert Ely of Ely & Co. Inc. in Alexandria, Va. Mr. Ely reported that the then-current cost incurred by the government to "clean up" already failed S&Ls had reached $147 billion (see chart, page 1).

Government action by mid-1983 could have held the total to $47 billion to date, he said.

"Claims that crooks stole a big chunk of the money that the S&L cleanup is going to cost are simply not true," said Mr. Ely. "Crime, at most, cost insolvent S&Ls $5 billion, or approximately 3% of the total cost of the (S&L) mess."

Nevertheless, the Resolution Trust Corp.—the federal agency that takes over failed thrifts—expects to discover fraud in 40% of the 450 major savings and loan failures, says the Beazley report.

"The RTC argues that it has discovered both mismanagement and fraudulent activity," said the Beazley report. The RTC last September reported that criminal investigations were pending in 437 of the 493 S&Ls that were in conservatorship or had been closed.

The RTC also said that it has so far recovered $13.5 million in professional negligence liability claims, but it is not known how much has been recovered from insurers.

Meanwhile, the Federal Deposit Insurance Corp. has 500 S&L-related lawsuits pending, of which about 400 are against directors and officers; 50 are against attorneys for malpractice; and 25 are against accountants, said the Beazley report.

"The government, therefore, is formally seeking restitution from those individuals who might bear some responsibility for the losses," warns the Beazley report. "This could include directors and officers of the failed institutions, and their advisers: lawyers, accountants, appraisers and real estate advisers.

"This, in turn, presents a potential exposure to any insurer who has indemnified these key individuals under various liability policies," the report said.

"The FDIC has a duty on behalf of the government to show that it is mitigating the cost to the taxpayer by any means which are reasonably cost-effective. This would include, for instance, pursuing litigation against directors and officers of an institution and any professional advisers who FDIC believes have contributed to the losses through their negligence."

The government's determination to seek compensation presents an "exposure" for London underwriters that have written or reinsured:

- Directors and officers liability insurance. FDIC Chairman L. William Seidman has said that federal bank regulators are considering taking legal action against directors and officers of 1,300 failed thrifts and banks. There are also shareholder actions alleging various breaches of fiduciary duty by the directors.

D&O policies do cover "wrongful acts." But regulatory exclusion clauses in most would bar coverage for actions on behalf of failed institutions filed by regulators like the FDIC, said the Beazley report.

"The coverage debate is a current issue, but these exclusions should be valid defenses to the regulatory actions and so mitigate or avoid many of the D&O liability suits."

The report does not comment on a 1990 Maryland court decision that strikes down the regulatory exclusion in D&O policies (*BI*, May 14, 1990).

The report also points out that a thrift failure cannot be regarded as prima facie evidence of a "wrongful act."

"This is especially so in the context of so many failures occurring in so short a space of time. The problems caused to the industry by government deregulation, political interference and ineffectual regulatory supervision have all played their part, as have simple economic causes, such as the real estate collapse experienced in several territories."

- Fidelity policies and bankers blanket bonds, which provide coverage against dishonest or fraudulent acts committed by employees.

Although the government has alleged fraud in many of the failures, "there are stringent proof-of-loss requirements in order for a claim to be successfully presented (and) the various policy conditions and definitions to be satisfied," the Beazley report says.

- Lawyers errors and omissions/malpractice coverages. Regulators now allege that some law firms that represented and advised S&Ls "gave incorrect advice or failed to act with due diligence in that they knew or should have known that certain transactions were either illegal or were of such magnitude and danger as to jeopardize the financial security of the institution," the report says.
- Accountants E&O insurance. While lawsuits have been filed by the U.S. government against accountants of failed S&Ls, "negligence and causation must be proven in a specific situation and the large firms have shown every indication of vigorously defending these allegations," the Beazley report says. ■

Court won't rule on parent's liability

WASHINGTON—The U.S. Supreme Court last week refused to review a federal appellate court ruling that a parent company cannot be held directly liable under the Superfund law for cleaning up pollution caused by a wholly owned subsidiary.

The 5th U.S. Circuit Court of Appeals in January 1990 held that nothing in the Comprehensive Environmental Response, Compensation and Liability Act extends the definition of site "owner or operator" to include the parent of a liable subsidiary (*BI*, Feb. 5, 1990).

The appeals court said the corporate veil separating parents and subsidiaries can be pierced only when a subsidiary is a "sham" set up to avoid liability.

The litigation stems from a lawsuit filed by Macedonia, Ohio-based Joslyn Manufacturing Co. Inc. The company was trying to force Ruston, La.-based T.L. James & Co. to pay the costs of cleaning up pollution at a Bossier City, La., plant run by Lincoln Creosoting Co. Inc., a former James subsidiary. Joslyn purchased Lincoln Creosoting in 1950.

—By Stacy Adler

Update

DES granddaughter suit

ALBANY, N.Y.—The granddaughter of a woman who ingested the anti-miscarriage drug DES 30 years ago may appeal the dismissal of her product liability suit against five pharmaceutical manufacturers to the U.S. Supreme Court.

New York's highest court dismissed the suit last week, ruling that product liability would have been expanded beyond manageable limits if the case had gone to trial.

In the case, 9-year-old Karen Enright claimed that her grandmother's ingestion of DES, or diethylstilbestrol, set in motion a chain of events that caused the girl's cerebral palsy. The girl sued the five manufacturers under the so-called market share theory of liability (*BI*, Jan. 14).

In its 5-1 decision, the New York Court of Appeals cited its 1981 decision in a suit filed by the brain-damaged daughter of a woman whose uterus was punctured during an abortion prior to the plaintiff's birth. The court ruled then that allowing the plaintiff's suit would have extended traditional tort concepts beyond manageable limits.

"It is our duty to confine liability within manageable limits. Limiting liability to those who ingested the drug or were exposed to it in utero serves this purpose," the court ruled in the Enright case.

"It's a major decision that should dissuade plaintiffs from filing similar cases in New York," said attorney A. Edward Grashof of Winthrop, Stinson, Putnam & Roberts in New York, who represents RXDC Inc.

The girl's attorney, Leonard L. Finz in New York, said he may seek review by the U.S. Supreme Court. The plaintiff also may ask the state Legislature to pass a law that would permit such lawsuits.

Settlements in Delta crash

AUSTIN, Texas—The liability insurer for Delta Air Lines Inc. is paying $1.9 million to settle three lawsuits related to the 1985 crash of Delta Flight 191 at Dallas Fort Worth International Airport.

United States Aircraft Insurance Group in New York agreed to pay $1 million to the three adult children of a woman killed in the crash, $650,000 to the parent of a woman who died in the accident and $250,000 to a woman—with several relatives aboard the jet—who witnessed the crash, according to Mike Davis, a plaintiffs' attorney with Byrd, Davis & Eisenberg in Austin, Texas.

The crash, which killed 140 passenger and crew, occurred during a thunderstorm as the plane approached the airport (*BI*, Aug. 12, 1985).

A federal appellate court earlier this year upheld a 1989 lower court ruling that the jetliner's crew was responsible for the crash (*BI*, Jan. 7).

Pettegrew resigns from pool

WALNUT CREEK, Calif.—The chief administrative officer of a large municipal risk financing pool has resigned in the wake of an audit report critical of the pool's management controls.

Jeffrey W. Pettegrew, who headed the Contra Costa Municipal Risk Management Insurance Authority, resigned Feb. 15 after taking voluntary administrative leave. Mr. Pettegrew was named *Business Insurance* Risk Manager of the Year in 1989 (*BI*, April 10, 1989).

An auditor hired by directors of the authority—whose members include 17 Contra Costa County municipalities—criticized authority financial controls and questioned various expenses that employees charged to the authority. Individual employees were not identified.

Attempts to reach Mr. Pettegrew were unsuccessful.

Joseph Tanner, Pleasant Hills city manager and authority board president, said: "Jeff Pettegrew saved the cities of Contra Costa County millions of dollars. No one can take that away from Jeff Pettegrew."

Robert Stockwell, former city manager of Sparks, Nev., was named interim replacement for Mr. Pettegrew he said.

Unocal settles safety dispute

SANTA ANA, Calif.—Unocal Corp. of Los Angeles will pay more than $900,000 to settle a dispute with the Orange County District Attorney over the safety of the oil company's underground storage tanks.

Under a settlement approved last week by an Orange County Superior Court judge, Unocal agreed to pay civil penalties of $750,000, investigation costs of $75,000 and another $78,845 to purchase a gas chromatograph so county health officials can analyze soil that contains gasoline. In addition, Unocal has 30 days to obtain safety permits for all its underground tanks.

Prosecutors sought an injunction to shut down 72 of Unocal's 143 Orange County distributorships because the company had failed to obtain the permits required for its underground storage tanks.

Non-compliance with the county permit law poses a serious threat to underground water supplies, county officials charged.

Had the injunction been filed, Unocal would have faced daily fines of $500 to $5,000 for each non-complying tank, amounting to $150 million to $1.5 billion for the 4½ years it allegedly did not comply.

Unocal distributors can purchase up to $1 million per incident/$1 million annual aggregate in environmental impairment liability insurance in a company-sponsored program. The coverage is underwritten by Great American Insurance Co. of Cincinnati and brokered by Thorson & Associates of Diamond Bar, Calif.

Briefly noted

Legislation, S. 448, introduced in the Senate last week by Sen. Steve Symms, R-Idaho, would allow tax-exempt organizations to offer **401(k) salary reduction plans** to their employees. . . .High winds caused an estimated **$10 million of insured property damage** to portions of Florida on Feb. 15, reports the Property Claim Services division of the American Insurance Services Group. . . .The Senate last week approved legislation to require employers to reinstate health insurance coverage for employees when they return from **military service**. The measure also would allow doctors and other professionals in the military to suspend premium payments for malpractice insurance without endangering their coverage. The House passed a similar bill last month (*BI*, Feb. 4). . . .**DeRoy C. Thomas**, president and chief operating officer of ITT Corp. and former chairman and chief executive of ITT's Hartford Insurance Group, will join LeBoeuf, Lamb, Leiby & MacRae as a partner March 1 upon his retirement from ITT.

Brokers hurt by static rates

By LEONARD M. WILSON

Special to Business Insurance

INSURANCE BROKERAGE RESULTS for the fourth quarter and full-year 1990 are now on the table. Retrospective analysis is of interest principally to discern emerging trends or changes that illuminate upcoming potential. For the public brokers, this means an attempt to read the tea leaves of the premium rate environment.

On the strength of fourth-quarter operating reports, an observer would understandably conclude that no material shifts in rates had taken place. However, renewals are currently under negotiation for April and May, a leap forward in time that could validate widening expectations for flattening rates.

Mr. Wilson

U.S. retail brokerage in the fourth quarter mustered only narrow commission gains for the public brokers. Allowing for some variation in individual performance, we calculate roughly a 4% average increase in commissions for the final quarter of the year. Modest commission growth was registered whether for Marsh & McLennan Cos. Inc.'s book of business dominated by jumbo accounts or Hilb, Rogal & Hamilton Co. with its smaller commercial clientele.

Comparing this fourth-quarter growth in commissions with that of the full year, we find only slight acceleration. Apparently, premium rates on commercial lines were still easing year over year. We estimate a fourth-quarter decline in premium rates of close to 5%, assessing the interaction of new and lost business and growth in the renewal book.

Reinsurance brokerage on the domestic side fared modestly better than direct brokerage, with fourth quarter rises in the area of 6% to 7%, excluding special factors. Rate stability and increased facultative business account for the better comparisons. Lower retentions on the part of primary insurers appear as yet not to be a contributor to progress in domestic reinsurance brokerage.

International brokerage commission growth, both direct and reinsurance, benefitted from a depreciating dollar. This translation effect boosted commission gains above those achieved domestically. Unfortunately, the currency effect cuts in the wrong direction for broker profitability on North American business that is serviced in the United Kingdom.

Benefit consulting typically advanced about 15% for the quarter and the full year, backing out the effect of acquisitions. Marsh & McLennan and Alexander & Alexander Services Inc. both posted advances in that range. The momentum of consulting shows no signs of decelerating, even though the recession could crimp client outlays.

Investment income was mixed with some brokers posting solid gains, while others began to feel the effect of the year-over-year decline in short-term interest rates.

New business, as we have discussed in prior columns, has in fact slowed somewhat. We believe that new business averaged 13% to 14% of the quarter's commissions. With lost business at an estimated 6%, net new business amounted to 8% of commissions, a fairly robust rise for this stage of the cycle.

Expenses were a little more difficult to analyze than usual due to year-end accruals that distorted comparisons. We discern no letup in the zeal for cost control. Nonetheless, profit margins remained under pressure as a result of the anemic performance of revenues. Insurance brokerage headcount is not rising to any degree. Most of the expansion in staff is aimed at supporting benefit consulting with its strong forward motion.

Brokerage forecasts for 1991 increasingly call for renewals to be on an as-is basis. Some contacts have hedged as to the timing of the flattening with the possibility that soft first-half rates will be balanced by a limited degree of firming in the second half. Other factors, though, partly discernible in fourth-quarter results, will impede 1991 comparisons.

The decline in short-term interest rates will hurt investment income. Although investment income is a small proportion of total revenues, any shortfall drops immediately to the bottom line, and can have a material impact on year-over-year comparisons. Growth in premium throughput will provide only a modest offset to an almost unavoidable drop in yields.

Contingent commissions also may be a burden in the first half of the year, as they were in 1990. Contingents, too, are small relative to total revenues, but concentrated in the first quarter they can have a noticeable impact as well.

Having noted the negatives, we still expect operating progress for each of the brokers in 1991. Marsh & McLennan could receive a lift from the strong rise in capital markets, which bolsters the value of assets supervised by its Putnam Management subsidiary.

Alexander & Alexander continues to work very hard at expense control. Measures to improve internal productivity could enhance comparisons in 1991.

Arthur J. Gallagher & Co. should be able to sustain its highly productive new business program. The company's self-insurance subsidiary shows no signs of slackening and may again post gains of close to 20%.

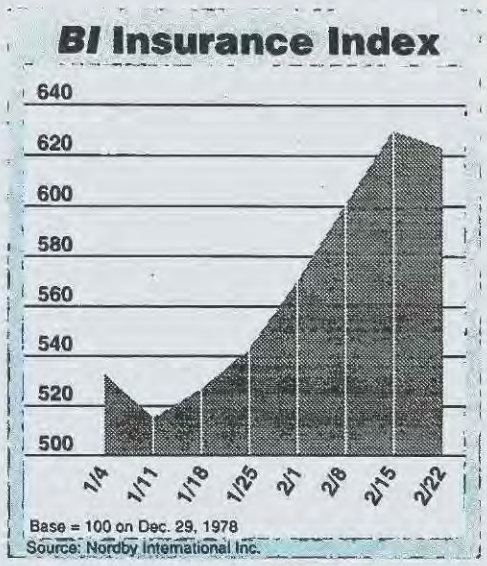
Frank B. Hall & Co. Inc. has achieved brisk revenue growth in recent quarters, in spite of the soft market. Further progress seems a reasonable expectation.

Willis Corroon P.L.C. has not yet reported fourth-quarter and full-year results. The amalgamation of Corroon & Black and Willis Faber seems to be proceeding, and conceivably 1991 synergies may emerge in both revenues and costs.

The striking rise in the stock market in the past eight weeks has lifted the prices of brokerage shares. But we sense restraint on the part of investors toward brokerage stocks owing to continued uncertainty over the course of premium rates. Investors blow hot or cold on brokerage stocks depending upon their perception of the rate environment. Currently, that perception is less optimistic than a few months ago when strong comparisons by General Reinsurance Co. raised expectations.

Brokerage earnings would accelerate nicely in a truly flat rate environment, provided that the increase in expenses is held to 8% to 9%, a range that ought to be attainable. Many brokers are persuaded that 1991 will be a year of flat rates. But investors have a distinctly "show-me" attitude, which we think will be dispelled only when revenue growth accelerates and finally relieves pressure on operating margins and year-over-year comparisons. ■

Leonard M. Wilson is a senior vp with Lazard Asset Management Inc. He is a member of the New York Society of Security Analysts.



Insurance industry stocks dropped last week as the *Business Insurance* Index fell 6.0 points to 624.7 on Feb. 22, from 630.7 on Feb. 15. Advancing issues for the week were led by Chandler Insurance, up 11.1%; Statesman Group Inc., up 6.2%; and Trenwick Group Inc., up 4.9%. Declining issues for the week followed SCOR U.S. Corp., down 9.8%; Kemper Corp., down 8.7%; and USF&G Corp., down 7.3%. The most active issue for the week was Sears, Roebuck & Co. (Allstate), with 4.5 million shares traded. The *BI* Index was down 1.0%; The Standard & Poor's 500 fell 0.9%; the Dow Jones 30 Industrials were down 1.5%; and the New York Stock Exchange Composite lost 0.8%.

British Issues

Feb. 21 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Commi Union	520	23.8	28.7	5.5	525—515	
Genl Accident	568	17.1	33.4	5.9	568—543	
Gdn Royal Exch	213	18.5	15.3	7.2	219—211	
Royal	431	22.9	34.0	7.9	431—418	
Sun Alliance	365	12.9	16.7	4.6	377—365	
Brokers						
Bradstock	291	16.5	12.0	4.1	292—289	
CE Heath	487	14.1	34.5	7.1	487—482	
Hogg Group	175	11,4	9.7	5.5	181—175	
Lloyd Thompson	319	21.3	10.0	3.1	321—319	
PWS Holdings	93	11.2	4.7	5.0	100—93	
Sedgwick Grp	240	17.8	16.0	6.7	259—240	
Steel Brrl Jones	279	16.5	14.7	5.3	279—270	
Willis Corroon	278	20.5	16.0	5.7	292—278	

Source: Philip Olsen, Insurance Industry Analyst London

BI Industry Stock Report

FEBRUARY 19, 1991 THROUGH FEBRUARY 22, 1991

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander	NYS	25.63	-3.76	10.81	28.88	16.13	250	1.00	3.90	19	9.18	2.79
Gallagher Arthur J & Co	NYS	25.25	3.06	8.60	25.00	19.75	289	0.64	2.53	18	5.33	4.74
Frank B. Hall	NYS	3.25	-3.70	-10.34	4.25	2.00	33	0.00	0.00	-7	-2.80	-1.16
Hilb, Rogal & Hamilton	OTC	13.88	1.83	-5.93	16.50	11.25	162	0.36	2.59	19	4.60	3.02
Marsh & McLennan	NYS	77.00	-2.38	-1.28	82.00	59.75	654	2.60	3.38	19	10.56	7.29
Poe & Associates	OTC	9.75	0.00	21.88	13.00	7.75	0	0.40	4.10	9	1.93	5.05
BROKERS	AVERAGE		-0.7	3.4					2.4	11		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W R Corp	OTC	44.00	1.15	17.33	45.00	28.50	90	0.44	1.00	12	25.06	1.76
Berkshire Hathaway Inc	NYS	7900.00	2.60	18.35	8900.00	5675.00	0	0.00	0.00	25	2869.00	2.75
ITT (Hartford Group)	NYS	55.25	-4.74	15.10	60.88	40.25	1312	1.72	3.11	8	56.33	0.98
Sears (Allstate)	NYS	32.38	-3.36	27.59	41.88	22.00	4482	2.00	6.18	12	37.75	0.86
CONGLOMERATES	AVERAGE		-1.1	19.6					2.6	14		
INSURERS/REINSURERS												
Aetna Life & Casualty	NYS	45.38	-6.92	16.35	54.38	29.00	767	2.76	6.08	8	58.11	0.78
Ambase Corp	NYS	0.69	0.00	119.81	9.00	0.16	310	0.00	0.00	0	29.08	0.02
American General	NYS	36.88	1.37	19.92	50.63	23.50	803	2.00	5.42	8	34.68	1.06
American Heritage	NYS	23.13	-3.54	10.12	24.50	19.63	2	1.00	4.32	11	22.60	1.02
American Indemnity/Fin'l	OTC	6.38	2.00	96.15	7.25	2.75	1	0.08	1.25	-19	17.38	0.37
American International	NYS	90.50	3.98	17.72	92.25	57.00	1022	0.44	0.49	13	41.92	2.16
Aon Corp	NYS	34.88	-5.10	0.36	41.38	26.75	408	1.52	4.36	10	19.62	1.78
Argonaut Group	OTC	73.00	-2.67	14.06	78.00	53.00	66	1.60	2.19	7	36.83	1.98
AVEMCO Corp	NYS	28.00	0.00	10.89	30.13	21.13	9	0.44	1.57	18	9.52	2.94
Baldwin & Lyons Inc	OTC	21.00	-1.18	12.00	21.88	17.00	1	0.28	1.33	8	20.80	1.01
Belvedere Corp	ASE	2.88	0.00	15.00	5.38	1.75	0	0.04	1.39	72	8.03	0.36
Chandler Insurance	OTC	3.75	11.11	-45.45	10.00	2.75	50	0.00	0.00	2	9.53	0.39
Chubb Corp	NYS	68.00	-1.45	25.35	70.25	34.63	895	1.32	1.94	11	55.49	1.23
CIGNA Corp	NYS	47.50	-1.28	16.21	55.50	33.25	507	3.04	6.40	11	66.64	0.71
CNA Financial Corp	NYS	89.00	1.14	29.69	91.00	49.50	141	0.00	0.00	15	54.87	1.62
Continental Corp	NYS	28.50	-6.56	14.57	31.38	15.75	210	2.60	9.12	11	41.36	0.69
Durham Corp	OTC	26.25	-0.94	-6.25	34.00	23.00	4	0.92	3.50	13	26.32	1.00
Fund American Corp	NYS	57.88	-0.64	11.57	58.50	29.50	344	0.68	1.17	24	32.74	1.77
Fremont General Corp	OTC	16.13	0.78	11.21	21.13	10.13	113	0.80	4.96	5	19.09	0.84
Frontier Insurance Group	NYS	20.75	-1.19	9.21	33.00	15.38	6	0.00	0.00	9	7.29	2.85
General RE Corp	NYS	97.25	-2.14	4.57	99.88	69.00	566	1.68	1.73	14	29.04	3.35
Hanover Insurance Co	OTC	29.25	0.86	10.38	30.50	21.00	36	0.44	1.50	13	32.03	0.91
Harleysville Group	OTC	25.75	-2.83	12.57	26.50	13.50	14	0.64	2.49	8	18.94	1.36
Hartford Steam Boiler	NYS	59.88	4.81	22.82	62.13	43.50	126	1.80	3.01	16	18.94	3.16
Kansas City Life Ins	OTC	33.00	3.13	6.88	36.50	30.00	4	1.20	3.64	8	39.22	0.84
Kemper Corp	NYS	30.13	-8.71	26.84	43.13	17.13	311	0.92	3.05	116	29.97	1.01
Lawrence Insurance Group	ASE	6.88	0.00	-1.79	9.13	6.38	0	0.36	5.24	11	4.40	1.56
Liberty Corp.	NYS	46.00	-3.16	11.85	50.25	39.00	8	0.92	2.00	15	31.82	1.45
Lincoln National	NYS	49.25	-2.48	14.53	56.50	30.75	247	2.72	5.52	12	49.19	1.00
NAC Re Corp.	OTC	37.50	0.67	13.64	38.25	25.50	42	0.20	0.53	16	22.81	1.64
Navigators Group	OTC	39.00	-2.50	19.08	40.00	24.75	2	0.00	0.00	15	15.22	2.56
Nobel Insurance LTD.	OTC	3.13	2.02	4.17	3.75	1.88	117	0.00	0.00	-	7.76	0.40
NWNL Companies	NYS	25.88	-5.91	53.33	34.50	11.75	404	1.32	5.10	5	37.50	0.69
Ohio Casualty Corp.	OTC	44.50	-2.20	8.54	50.75	26.75	199	2.32	5.21	10	33.30	1.34
Old Republic Int'l	NYS	27.88	-2.62	21.86	28.75	19.00	80	0.76	2.73	6	30.70	0.91
Orion Capital Corp.	NYS	21.25	-0.58	21.43	23.00	13.00	13	0.92	4.33	6	19.72	1.08
Phoenix RE Corp.	OTC	9.75	4.00	25.81	12.50	5.00	3	0.20	2.05	122	12.99	0.75
Protective Life Corp.	OTC	15.50	-6.06	4.20	17.50	10.25	92	0.76	4.90	7	14.54	1.07
Provident Life	OTC	20.75	-1.19	18.57	26.25	12.00	330	0.92	4.43	5	23.24	0.89
Re Capital Corp.	ASE	15.25	0.00	18.45	15.25	11.75	31	0.00	0.00	11	14.43	1.06
RLI Insurance Corp.	NYS	15.00	2.56	3.45	15.50	9.50	26	0.44	2.93	7	12.42	1.21
St. Paul Companies	OTC	69.00	1.47	9.96	70.25	47.00	611	2.60	3.77	8	43.47	1.59
SAFECO Corp.	OTC	38.13	-2.56	15.97	40.50	25.13	525	1.36	3.57	9	24.87	1.53
SCOR U.S. Corp.	NYS	13.75	-9.84	11.11	15.25	8.38	49	0.20	1.45	10	10.61	1.30
Seibels Bruce Group	OTC	6.75	3.85	58.82	11.75	4.25	30	0.36	5.33	21	13.75	0.49
Selective Ins. Group	OTC	15.75	0.00	18.87	19.00	12.50	35	1.04	6.60	6	15.72	1.00
Statesman Group Inc.	OTC	2.69	6.20	71.98	3.00	1.25	444	0.00	0.00	4	4.19	0.64
Tokio Marine & Fire	OTC	51.75	-5.69	9.52	58.13	34.50	18	0.26	0.50	31	70.93	0.73
Torchmark Corp.	NYS	54.50	-0.91	11.51	55.50	38.00	223	1.40	2.57	13	13.23	4.12
Transamerica	NYS	36.50	1.04	11.88	41.00	23.25	403	1.96	5.37	11	34.63	1.05
Travelers Corp.	NYS	20.13	-5.29	21.05	34.88	11.50	1224	1.60	7.95	-11	44.85	0.45
Trenwick Group Inc.	OTC	27.00	4.85	16.76	26.75	16.25	60	0.48	1.78	11	16.91	1.60
United Fire & Casualty	OTC	38.50	-2.53	9.61	40.00	28.75	1	1.32	3.43	9	22.56	1.71
USF&G Corp.	NYS	11.13	-7.29	48.33	30.13	7.00	1256	1.00	8.99	7	22.87	0.49
UNUM Corp.	NYS	56.88	-5.21	21.98	63.00	32.13	612	0.80	1.41	11	31.20	1.82
USLIFE Corp.	NYS	33.38	-6.64	19.20	41.75	23.25	80	1.48	4.43	8	54.34	0.61
Unitrin	OTC	36.25	0.69	17.89	36.75	24.50	288	0.80	2.21	15	33.99	1.07
Washington National	NYS	13.50	0.00	24.14	25.00	9.38	96	1.08	8.00	56	32.90	0.41
USLICO Corp.	NYS	20.25	-0.61	27.56	23.00	14.75	62	1.00	4.94	8	27.73	0.73
Zenith National Ins.	NYS	16.00	3.23	17.43	18.13	9.88	61	1.00	6.25	-31	13.81	1.16
INSURERS/REINSURERS	AVERAGE		-1.1	20.4					3.4	15.0		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	21.75	-5.43	42.62	23.25	9.75	1132	0.00	0.00	18	3.54	6.14
HMO America Inc.	OTC	7.69	-5.38	18.28	8.50	4.25	240	0.00	0.00	11	1.12	6.86
Pacificare Health Sys.	OTC	21.50	-5.49	32.31	26.00	12.00	278	0.00	0.00	15	6.35	3.39
Safeguard Health Enter.	OTC	4.88	2.63	2.63	7.63	4.00	325	0.00	0.00	11	2.99	1.63
Sierra Health Services	ASE	20.25	-2.41	47.27	21.38	5.50	294	0.00	0.00	60	0.62	32.66
United Healthcare Corp.	OTC	31.38	-3.46	34.95	33.88	9.00	2001	0.12	0.38	25	0.34	92.28
United Medical Corp.	ASE	8.63	-5.48	7.81	11.38	6.63	12	0.20	2.32	11	5.70	1.51
U.S. Healthcare	OTC	41.50	1.84	41.28	42.88	10.13	2491	0.48	1.16	26	3.07	13.52
HMOs	AVERAGE		-2.9	28.4					0.5	22		
ALL COMPANIES	AVERAGE		-1.2	19.1					2.9	15		

System design: Nordby International Inc.

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