

business insurance

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North American Re warns of unauthorized policies

NEW YORK—North American Reinsurance Corp. has notified three state insurance departments that direct insurance policies are being issued in its name without authorization.

About six "totally unauthorized" direct insurance policies have surfaced, according to Associate Counsel Camille Cooper, who said she did not know who was issuing

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Banks sue insurers over missing coffee

By CAROLYN ALDRED

LONDON—Three U.S. banks are suing underwriters at Lloyd's of London, other London insurers and Affiliated FM Insurance Co. for nearly \$70 million because the insurers refuse to pay a claim involving at least 200,000 sacks of "missing" Colombian coffee.

The banks, which paid out on letters of credit on behalf of a U.S. coffee importer, contend their losses are covered under marine cargo policies the insurers wrote for the importer.

But the underwriters are refusing to pay the claim because they do not believe the coffee—which a Colombian supplier was supposed to ship to the importer between December 1985 and August 1986—ever existed, said a spokesman for the London underwriters.

In separate actions filed Jan. 8 in U.S. District Court for the Southern District of New York, Chemical Bank of New York, American Express Bank of New York and Melville, N.Y.-based National Westminster Bank U.S.A. are demanding a total payment of \$52 million from underwriters in the London and world market, and \$17 million from Affiliated FM, a Johnston, R.I.-based unit of Allendale Mutual Insurance Co.

According to the lawsuits filed by the banks and two suits filed by New York-based coffee importer Andina Coffee Inc. in New York Supreme Court in October, the dispute centers around \$96 million worth of coffee that Andina's Colombian supplier, Bogota-based Goncheol Ltda., was to deliver to Andina. The coffee has not been delivered and Goncheol is now in liquidation, court papers say.

Andina financed the purchase of 250,000 sacks of coffee with \$103 million worth of letters of credit from several U.S. banks, including those that have filed suit, court papers say.

Andina charges in its suits, seeking to stop payment on the LOCs, that Goncheol and its sister company, Goncheverri Ltd., submitted fraudulent documents to Colombian banks representing the supplier that then submitted the documents to the U.S. banks to draw on \$96 million worth of Andina LOCs for the delivery of at least

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ABA commission report could spur tort reforms

By STEPHEN TARNOFF

CHICAGO—A series of tort reform recommendations by an American Bar Assn. commission could speed the drive for tort reform in individual states, insurance industry and business leaders say.

The commission's report, the result of a year of discussions, makes 20 recommendations for improving the nation's tort system, including proposals reforming joint and several liability, punitive damages and pain and suffering awards.

However, many of those hoping the report will encourage more tort reform complain the recommended reforms are too limited. Those opposing the report say the recommendations restrict the rights of plaintiffs.

The ABA report could serve as an impetus in states that have not yet adopted tort reform, said Jon Harkavy, general counsel and director of governmental affairs for the Risk & Insurance Management Society Inc.

The recommendations are a "tacit recognition of what has taken place" in 35 states, he said, referring to the states that have enacted tort reform measures in the past year. "It's really putting the ABA stamp of approval on it."

Franklin W. Nutter, president of the Alliance of American Insurers, said the report could influence the outcome of tort reform debates in various states.

"We think it will have an impact on those legislative bodies," Mr. Nutter said.

However, some critics, particularly plaintiffs' attorneys, have blasted the report, primarily because it does not address the role of the insurance industry in the

tort system.

Commission Chairman Robert B. McKay, a law professor at New York University, hoped the report would be unanimously adopted by the panel's 14 members, but four members dissented.

"The well-orchestrated chorus of those who... have sought to place blame for the so-called 'tort crisis' or 'insurance crisis' on lawyers, juries and courts seem to have succeeded with this commission as well," said one commission member, U.S. District Court Judge Jim R. Carrigan, in his written dissent.

He noted the report issues many recommendations "directed to reform of the tort side of the equation, but not one action recommendation directed to reforming the insurance side."

While recognizing the important role the insurance industry plays in relation to the tort system, the report says that commission members did not have the expertise to thoroughly address any changes needed in the insurance industry.

It recommends, however, that the ABA establish a commission to study and recommend ways to improve the nation's liability insurance system as it affects the tort system.

The report by the Action Commission to Improve the Tort Liability System was proposed and funded by the ABA's Tort and Insurance Practice Section (TIPS), which was scheduled to discuss the report this past weekend at a meeting in Florida. The commission included representatives of the plaintiffs' and defense bar, consumer groups, the insurance industry, corporations, academia and the judiciary.

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ABA

City hands off Super Bowl liability to NFL

By ROBERT A. FINLAYSON

PASADENA, Calif.—The National Football League has more than \$5 million in liability insurance for Sunday's Super Bowl XXI at the Rose Bowl in Pasadena, following a pregame risk management handoff.

The city of Pasadena, which owns the stadium, handed the NFL the responsibility of obtaining general liability insurance with a minimum \$5 million combined single limit for the game, which matches the strong arm of Denver Broncos' quarterback John Elway against the New York Giants' devastating pass rush.

Transamerica Insurance Group of Los Angeles wrote the more-than-required liability insurance limits for the NFL, said a Transamerica spokesman.

The coverage was written through wholesaler K&K Insurance Agency Inc. in Fort Wayne, Ind. Corroon & Black Co. of New York Inc. was the league's broker.

Spokesmen for Transamerica, K&K and Corroon & Black would not comment on the limit purchased by the NFL, except to say it exceeded the \$5 million requirement.

The coverage was placed before a local newspaper reported the Rose Bowl may be a fire trap, a charge

that city officials vehemently dispute.

Like many cities in California, Pasadena lost its commercial liability insurance coverage in 1985. Even though Pasadena since has established an \$8 million self-insurance reserve to cover its liability exposures and has \$50 million in commercial property insurance covering the Rose Bowl, the city granted the NFL permission to use the Rose Bowl only after the league agreed to obtain liability insurance to cover bodily injury and property damage claims, said Robert Hays, the city's risk manager and claims coordinator.

Under a contract between the city and the NFL, the league must name the city as an additional insured on its policy, and the coverage must indemnify the city for any personal injuries or property damage that occur during the game—except if injuries or property damage are attributable to the city's negligence.

"The city basically agrees that the fact that we are self-insured doesn't relieve us of any responsibility towards the National Football League in the event of an accident that we're responsible for," noted Gary L. Gillig, deputy city attorney.

The league must provide a certificate of insurance as proof of coverage. Although Pasadena officials

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Photo: AP/Wide World

The Rose Bowl in Pasadena, which last hosted Super Bowl XVII when the Redskins beat the Dolphins, will host Super Bowl XXI on Sunday.

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update

North American Re denial

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the policies or how much premium they generated. She declined to name the purported policyholders.

North American Re—an affiliate of Swiss Reinsurance Group that does not write direct insurance—has notified the California, Illinois and Texas insurance departments of the apparently bogus policies, Ms. Cooper said.

The Texas Board of Insurance is investigating unauthorized use of Swiss Re's name by American Transportation Underwriters, a surplus lines agency in Athens, Texas, according to Bill Gibson, an investigator with the legal services division.

In filings with the Texas Railroad Commission, the agency indicated that Swiss Re insured the liability risks of about a dozen trucking firms, according to Mr. Gibson, who added that the filings also showed the name "Savoy" beside policy numbers.

Brian Davis, an Austin, Texas, lawyer for the agency's owner, Paul E. England, said that Mr. England had been falsely informed by a representative of Savoy Reinsurance Co. Ltd. of the Turks & Caicos Islands that Swiss Re had agreed to front for Savoy.

North American Re informed the Texas board that no Swiss Re affiliate had any relationship with Savoy, which is not authorized as a surplus lines insurer in Texas, Mr. Gibson said. Investigators referred the matter to the board's legal department for possible action against Mr. England and the agency, he said.

Ms. Cooper refused to say whether the trucking risks were among the unauthorized direct policies.

Meanwhile, insurance department officials in Texas and Illinois also are investigating possible false claims by two other offshore companies that they are reinsured by North American Re or Swiss Re: North American Fire & Casualty Co., domiciled in St. Kitts, British West Indies; and Macal International Ltd., believed to be domiciled in Anguilla, British West Indies. Both companies recently sought surplus lines licenses in Texas.

Boeing seeks venue change

SEATTLE—Boeing Co. and Japan Air Lines say they will admit and share liability for the August 1985 crash of a JAL 747 jet if crash litigation is transferred from a U.S. Court to Japan.

Boeing and JAL will litigate only the amount of damages if the litigation is transferred, as Boeing requests in a motion filed in King County Superior Court in Seattle, said Keith Gerrard, an attorney with the Seattle law firm of Perkins Coie, which represents Boeing. Most of the lawsuits filed by the families of crash victims have been consolidated in the court, according to Boeing.

Some 520 people died in the crash; four survived. At the time of the crash, Boeing had \$1 billion in aviation product liability coverage and JAL had \$600 million in liability coverage, London sources said (BI, Aug. 19, 1985).

Mr. Gerrard says most of the victims of ill-fated JAL Flight 123 were Japanese and therefore "Japanese standards should apply."

But Vernon Judkins, a Seattle attorney representing many of the families of the victims, says transferring the cases to Japan will delay the litigation for years under Japan's legal system. In addition, all of the information relating to the design, construction and maintenance of the JAL 747 jetliner, which is kept at Boeing's Seattle headquarters, would have to be translated into Japanese and shipped to Japan, Mr. Judkins noted.

Mr. Judkins says he plans to oppose the Boeing motion.

Five sue in Amtrak crash

WASHINGTON—At least five Amtrak passengers injured in the Jan. 4 train wreck near Chase, Md., have filed suit against Amtrak and Conrail in New York or Maryland, seeking a combined \$14.3 million in compensatory damages and \$200 million in punitive damages.

And, the Federal Railroad Administration is focusing on human error as the possible cause of the collision of an Amtrak passenger train and a Conrail train that killed 15 and injured 175.

Amtrak self-insures its first \$50 million in liability losses; Conrail has \$40 million in commercial coverage above a \$10 million retention. Both railroads are members of Bermuda-based Railroad Assn. Insurance Ltd., which writes \$50 million excess of \$50 million in liability limits. Conrail also has \$100 million excess of \$100 million through A.C.E. Insurance Co. Ltd. (BI, Jan. 12).

A&A, Posgate settle

LONDON—Alexander & Alexander Services Inc. settled for an undisclosed sum its 4-year-old lawsuit against former Lloyd's of London underwriter Ian R. Posgate, ending all litigation involving A&A and its 1982 acquisition of Alexander Howden Group P.L.C.

A&A had charged Mr. Posgate participated in the misappropriation of \$55 million from syndicates managed by Howden.

Mr. Posgate also agreed to drop his lawsuit against A&A for unfair dismissal as a director of the A&A unit, now known as Alexander Howden Group Ltd., a legal spokesman for Mr. Posgate said.

A&A sued Mr. Posgate and four other Howden directors in September 1982 for the return of assets A&A charged they purchased with diverted funds. The assets included a Picasso painting given to Mr. Posgate by former Howden Chairman Kenneth Grob.

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errors & omissions

• Information on the credentials of staffers at Aldrich & Cox Inc. was omitted in the Dec. 22, 1986, employee benefit consultants directory. In addition to designations reported, one staff member holds a master of business administration degree, and one staff member holds a Certified Employee Benefit Specialist designation.

N.Y. medical malpractice law threatens guaranty fund: Suit

By JUDY GREENWALD

NEW YORK—New York's new medical malpractice law imperils the state's property/casualty guaranty fund and could cost insurers millions of dollars in additional fund assessments, several insurer trade associations and others contend.

Provisions of the law will increase the deficits of the two already-insolvent medical malpractice insurers, thus increasing the burden on the guaranty fund when the insurers eventually are liquidated, says a lawsuit filed by the Alliance of American Insurers, the National Assn. of Independent Insurers, the New York State Insurance Assn., several insurers and two personal lines insurance buyers.

The suit asks that portions of the law be declared invalid and unenforceable.

The suit was filed to challenge the medical malpractice law, not the guaranty fund, noted attorney Kenneth R. Feinberg of the Washington firm of Kaye, Scholer, Fierman, Hays & Handler, who represents the plaintiffs.

The law, enacted in June, prohibits the state from rehabilitating or liquidating the two insurers, the New York Medical Malpractice Insurance Assn. and Medical Liability Mutual Insurance Co., until 1990, notes the suit, which was filed in U.S. District Court in New York earlier this month.

In addition, the law prohibits the state insurance superintendent from approving rate increases for the two insurers that would eliminate the deficits, the suit says (BI, June 30, 1986).

As a result, these deficits eventually will be paid by the state's guaranty fund, known as the New York Property/Casualty Insurance Security Fund, and the

property/casualty insurance industry, the suit says.

The suit, which names Gov. Mario Cuomo and Insurance Superintendent James P. Corcoran as defendants, estimates the two insurers' deficits could reach \$4.5 billion by 1990.

Quoting "unrebutted" testimony at a hearing last year before a special deputy insurance superintendent, the suit said MMIA—a statutorily created joint underwriting association—was operating with about an \$85 million deficit when the medical malpractice law was enacted last June.

MLMIC, a physician-owned and operated mutual insurance company, was operating with about a \$1.2 billion deficit, the suit says. MLMIC, affiliated with the Medical Society of the State of New York, insures 16,000—or about 70%—of the state's physicians, said an Insurance Department spokesman.

The \$85 million and \$1.2 billion deficits cited in the suit take into account the insurers' investment income. If investment income is not considered, the combined deficits of the two insurers now approach \$2 billion, the suit claims.

"In light of their clearly inadequate loss reserves, MLMIC and MMIA are currently insolvent and should be seized by the superintendent and reorganized..." the suit says.

However, since the medical malpractice law prohibits the superintendent from asking the courts to put any malpractice insurer into liquidation or rehabilitation until Jan. 15, 1990, both insurers "will rapidly accrue bigger and bigger deficits," the suit adds.

The situation is aggravated by a provision of the law affecting medical malpractice rates, the suit claims.

Previously, insurers developed and filed their own

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BI to list U.R. vendors

The Feb. 16 issue of *Business Insurance*, which will focus on employee benefits cost control, will contain a new feature: a directory of utilization review service providers.

The directory is published as an editorial service; there is no charge to be included. However, companies must fill out a BI questionnaire and return it by Jan. 30 to be listed.

Any company providing utilization review services directly to members of employer-sponsored group health plans on behalf of the employer is eligible to be included (this excludes companies contracting only with insurers, PPOs, HMOs or claims administrators).

BI defines utilization review as reviewing inpatient and/or outpatient hospital care and services through preadmission review, concurrent review, length of stay determination, discharge planning, retrospective review and second surgical opinion. In addition, companies that review psychiatric, substance abuse and dental services will be listed.

If you have not received a questionnaire, please call Marilou Jones immediately at 312-649-5279.

Offshore reinsurer figures in indictment

By DOUGLAS McLEOD

PHILADELPHIA—A New York man is facing federal charges that he tried to defraud a Philadelphia bank on a \$2.5 million loan using phony collateral backed by an offshore reinsurer.

Vishwa Shah, a citizen of Nepal living in New York, was indicted last month on six counts of wire fraud in connection with the alleged scheme, which involved a guarantee issued by Cambridge General Insurance Co. of the Turks and Caicos Islands.

Separately, the fraud bureaus of the New York and New Jersey insurance departments are jointly investigating Mr. Shah's activities in connection with Cambridge General and other offshore reinsurers, officials confirmed. However, the New York department's investigation has yet not produced any evidence of fraud by Mr. Shah, says Deputy Commissioner James W. Randolph.

The indictment, filed in U.S. District Court for the Eastern District of Pennsylvania, charges Mr. Shah schemed to defraud Philadelphia National Bank of \$2.5 million on a loan application last February for Westtown Ltd., a company whose address is shown in the indictment as a post office box in South Eastern, Pa.

Westtown was actually a front company set up by the FBI as part of a sting operation that led to Mr. Shah's indictment, said Robert N. de Luca, a Philadelphia lawyer representing Mr. Shah.

In its loan application, Westtown agreed to use as collateral a fictitious obligation of Union Guaranty Investment Co. Ltd. of Turks and Caicos, which supposedly owed Westtown \$5 million, the indictment charges. Westtown further supported its application with a guarantee from Cambridge General—identified as Union Guaranty's parent—that the obligation would be repaid.

Cambridge General is unrelated to Cambridge Reinsurance Ltd., which currently is being liquidated in Bermuda.

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departments

- ✓ This week's editorial urges insurance regulators to heed the words of former New York Insurance Superintendent Richard E. Stewart: Flex rating is doomed. Despite its adoption in New York and Washington, flex rating is contradictory to free market competition and insurer stability. **PAGE 8**
- ✓ While employers' liability for retiree welfare benefits is still being hammered out by Congress, the courts and the Financial Accounting Standards Board, benefits managers should measure future retiree health care costs and plan now for ways to control and limit those costs, says Joseph W. Duva, director of employee benefits at Allied-Signal Inc., in Ask a Benefits Manager. **PAGE 21**
- ✓ After checking last year's performance at the hypothetical Risk Adverse Brokers, Leonard M. Wilson, a principal at L.F. Rothschild Unterberg & Towbin, analyzes several factors—including the economy, insurance rates, investment income and expenses—that will affect the broker's 1987 growth. **PAGE 35**

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Dupont Plaza fire suits seek \$158 million

By STEPHEN TARNOFF

SAN JUAN, Puerto Rico—Lawsuits filed by late last week on behalf of at least 25 victims of the Dupont Plaza hotel New Year's fire seek \$157.6 million in compensatory and punitive damages from the hotel and its presumed owner.

And, plaintiffs' attorneys are plotting their strategies to bring more defendants into the litigation and to maximize recovery for victims. Among tactics under consideration are arguing for an enterprise theory of liability and filing suit under the Racketeer Influenced & Corrupt Organizations Act.

The New Year's Eve fire at the Dupont Plaza killed 96 people and injured more than 100 others, including employees and guests.

The lawsuits filed as of late last week, which mostly were filed in U.S. District Court in Puerto Rico, name either San Juan Dupont Plaza Hotel Corp., Hotel Systems International or San Juan Hotel Associates as defendants.

A spokesman for the hotel has denied that Hotel Systems International owns the hotel (BI, Jan. 12).

As of late last week, plaintiffs' attorneys still did not have access to the hotel and were unable to identify the vast majority of other potential defendants besides the hotel. More than 100 defendants are expected to be named.

"We're trying to get into the hotel and get access to identify potential defendants," said Patrick McCabe with the Me-

tairie, La., firm of Gauthier, Murphy, Sherman, McCabe & Chehardy.

"The single most important thing is to determine other culpable defendants that may have been involved in this," said plaintiffs' attorney Stanley Chesley, with the Cincinnati firm of Waite, Schneider, Bayless & Chesley.

"The single biggest piece of evidence is the hotel," said Mr. Chesley, one of the lead plaintiffs' attorneys in litigation following the MGM Grand Hotel and Beverly Hills Supper Club fires. "It has to be gone through with a fine tooth comb."

The need to identify and sue others is especially important for plaintiffs because the hotel is believed to have only \$1 million of liability insurance, written by an American International Group Inc. unit. Plaintiffs' attorneys are seeking other sources of compensation for victims.

AIG issued a press release Jan. 8 stating that it did not write any excess insurance for the hotel. And, insurance industry sources who generally are aware of applicable coverage following a disaster say they have not been able to find any excess coverage in the marketplace.

A spokesman and attorney for the hotel could not be



reached for comment.

Even when all defendants are identified, the amounts plaintiffs will be able to recover will be significantly less than plaintiffs' attorneys' estimates of \$330 million to \$400 million, according to one insurance industry source whose estimates of aggregate liability following previous disasters have proven very accurate.

Because the hotel as primary defendant apparently had a very limited amount of insurance and because arson is the cause of the fire, the maximum victims and their families will receive will be \$50 million, said the source, who asked not to be identified.

Two workers at the hotel were charged with starting the fire. Both were members of Local 901 of the International Brotherhood of Teamsters, which was engaged in intense labor negotiations with the hotel management in the weeks leading up to the fire.

Charges of arson and 96 counts of murder were filed by federal authorities last week against Hector Escudero Aponte, 35, a member of the hotel's maintenance staff. He admitted he started the fire in the hotel's ballroom.

Also, Armando Jimenez Rivera, 29, was charged with conspiracy and aiding and abetting the arson murders. Mr. Jimenez Rivera is accused of providing Mr. Escudero Aponte with materials used to set the fire and with shielding him from public view while the crime was committed.

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Guaranty plan irks Texas HMOs

By MICHAEL BRADFORD

AUSTIN, Texas—A proposal by the Texas Board of Insurance to launch the nation's first guaranty fund for health maintenance organizations is running into strong opposition from HMOs in the state.

And, an official of a Houston health care coalition says the fund is not necessary.

Under the insurance board's proposal for the guaranty fund, tentatively called the Texas Health Maintenance Guaranty Assn., all HMOs in the state would be assessed in case of an HMO insolvency. The assessments would be used to pay any liabilities owed to health care providers by enrollees of the insolvent HMO, according to Woody Pogue, a deputy commissioner with the state insurance board.

Depending on how the final proposal is drafted, assessments payable by HMOs to the guaranty fund may partially offset the fees already paid under the state's licensing requirements, according to Mr. Pogue. Currently, an HMO seeking to be licensed in Texas must make a one-time deposit of \$100,000—unless the insurance commissioner approves a waiver of the charge—plus 4% of its annual premiums each year into a fund held by the state's Treasury Department to pay any liabilities the HMO cannot meet.

Meanwhile, the insurance board has agreed to consider an alternative proposal being developed by the Texas Health Maintenance Organization Assn. that the group says will address the state's concerns about insolvent HMOs without establishing a guaranty fund.

The HMO industry has been "extremely resistant" to the idea of implementing a guaranty program, explained Evelyn Ireland, executive director of the Austin-based HMO association, which represents approximately 25 licensed HMOs in Texas that cover about 850,000 enrollees. "It is a mechanism that was developed for insurance companies and is counter to the structure we have in the HMO industry," she said.

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D&O premiums up 506%: Poll

By ALISON KITTRELL

Directors and officers liability insurance premiums increased an average of 506% in 1986, according to a survey of 256 chairmen of Fortune 1,000 companies by Heidrick & Struggles, a Chicago-based executive search firm.

The tight market for directors and officers liability insurance also is helping to change the makeup and mission of boards of directors at some of the largest U.S. companies, the new survey suggests.

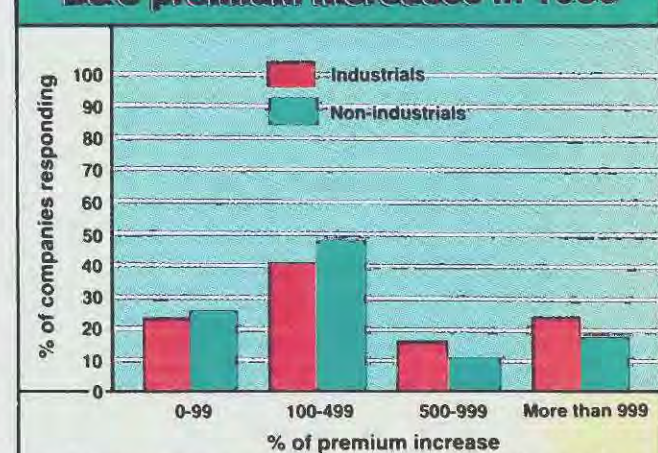
Some 78.5% of the total respondents—81.4% of the industrial companies and 74.5% of the non-industrials surveyed—reported some increase in D&O premium during 1986.

Some 22.9% of the respondents whose D&O premiums increased in 1986 reported hikes of 0.1% to 99%. For 43.5% of the respondents, premium increases ranged between 100% and 499%, and for 13.6% of the companies the increase was 500% to 999%. Twenty percent of the respondents reported D&O premium increases of more than 999% over 1985.

And, according to Heidrick & Struggles, the D&O coverage crisis and the increased liability of board members are af-

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D&O premium increases in 1986



Source: Heidrick & Struggles

Chart: Amy Palmer

Heath rebuilds after upheavals

By CAROLYN ALDRED and STACY SHAPIRO

LONDON—The new chairman and chief executive of Lloyd's of London broker C.E. Heath P.L.C. is trying to rebuild the brokerage—including its North American division—after a year of upheaval that included massive staff defections.

Heath Chairman Richard Fielding is now hiring several brokers to replace three members of Heath's North American division who resigned in August, taking with them a large chunk of Heath's North American business.

"We have a U.S. team which is going to join us," he said. For example, earlier this month, Heath hired two executives from the North American division of Gallagher Plumer Ltd.

But despite his rebuilding efforts in the North American division and elsewhere at Heath, profits will plummet for the year ending March 31, Mr. Fielding predicts.

Group profits for the world's 13th-largest broker will slide 31% to 25 million pounds (\$37 million at current exchange rates) in 1987 from 36.3 million pounds (\$53.6 million) in fiscal 1986, he said.

And, Heath's profit performance would be even worse without the 6 million-pound (\$8.9 million) profit contribution from Fielding Insurance Ltd., the broker Heath purchased in November, noted Mr. Fielding, who formerly headed Fielding Insurance (BI, Dec. 1, 1986).

Without Fielding's contribution, Heath's profits would plunge at least 41% in the year ending March 31 to no more than 19 million pounds (\$28 million at current exchange rates) from 32 million pounds (\$47.3 million) from the year before, he predicts.

Heath's performance has been affected by a series of setbacks in the last five months, including:

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Don't apologize for insurer profits: Bailey

By JUDY GREENWALD

NEW YORK—The insurance industry should take a positive, not defensive, posture in response to criticism that its profits are too high, says William O. Bailey, vice chairman of Aetna Life & Casualty Co. of Hartford, Conn.

For the next two years the industry will continue to report improved results, predicts Herbert E. Goodfriend, senior vp and analyst at New York-based Prudential-Bache Securities.

And, once intense competition returns to the market, the industry should be careful not to also return to a heavy emphasis on commodity pricing, warned Frank J. Tasco, chairman and chief executive officer of Marsh & McLennan Cos. Inc. in New York.

Mr. Bailey, Mr. Goodfriend and Mr. Tasco participated in a panel discussion on "untangling the issues" at the Insurance Services Offices' and Insurance Information In-

stitute's annual meeting and industry conference last week.

Also speaking was Paul A. Donald, president, general manager and assistant chief executive officer of Nationwide Insurance Cos. of Columbus, Ohio.

Mr. Bailey said the industry should present its position "factually and positively," and not let itself be put on the defensive by groups trying to "distract" the industry from the basic issues involved.

The industry must explain to the public that as a cyclical industry, its return on equity will be above normal for some years and below normal for others, Mr. Bailey said. The issue of profitability must be viewed both over the span of a cycle and a period of several years, he added.

The industry's earnings actually amount to less than 3 cents on the dollar, Mr. Bailey pointed out.

And, while 3 cents may be a "helluva return" in some industries, Mr. Tasco noted, it

does not adequately compensate insurers for the risks they are taking.

This is another example of how figures used by the industry can be confusing, he said. The industry does a "lousy job" in communicating, he added, which in turn makes the broker's job a "very difficult one."

But, despite all of the industry's efforts to communicate, Mr. Goodfriend said, the public still regards insurance as a "quasi-rip-off business, with all that entails." Instead of trying to explain its business, the industry should just concentrate on doing the best job it can, he suggested.

"You've been trying (to communicate the facts of the industry to the public) for a long time, and I really think it's to no avail," Mr. Goodfriend asserted.

But, "silence is no longer an option," countered Mr. Bailey. "The public, the legislators, the press just won't accept silence" for an industry as visible in solving society's

problems.

In response, Mr. Goodfriend explained that he was not suggesting silence, but merely stating that he was not optimistic about the possibility of changing society's views "in the near future."

Mr. Donald also said it is the industry's responsibility, "both collectively and individually," to make a case for itself, rather than wait for an organization to take the lead. This way the industry can "stem the tide" of negative impact caused by people who do not understand the industry, he said.

Mr. Goodfriend said while he believes there will be continuing improvement in insurers' results over the next two years, reinsurance recoverables remain an area of concern and "major pockets of disaster" also remain in insurer reserves. The reinsurance industry, he predicted, will see "even more dynamic improvement" than the primary insurance industry.

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BI's DiBlase promoted

CHICAGO—Donna DiBlase has been promoted to associate editor in the Chicago office of *Business Insurance*, Editor Kathryn J. McIntyre has announced.

Ms. DiBlase, 24, has been a staff reporter since December 1985, concentrating on reporting on employee benefits news and developing trends.

In her new position, Ms. DiBlase will continue to specialize in employee benefit news stories and spotlight reports. She also will continue to compile two regular columns in *Business Insurance*: the Benefit Beat column, which reports employee benefit plan changes, and the Markets column, which reports on new companies, mergers and acquisitions and new offices throughout the insurance business.

A 1984 graduate of Loyola University of Chicago with a bachelor's degree in journalism, Ms. DiBlase joined the *Business Insurance* staff as a proofreader in January 1984.

Ms. DiBlase is studying to earn the Certified Employee Benefits Specialist designation and has completed the CEBS course covering pension plans.

Ms. DiBlase can be reached at 312-649-5393.



Ms. DiBlase

Super Bowl

Continued from page 1
had not seen the NFL's certificate of insurance as of late last week, the certificate is already in the hands of the NFL officials in California, according to Robert E. Kalbfell, assistant vp at Corroon & Black.

Although Mr. Kalbfell declined to provide details of the NFL's coverage, he said, "We're pretty well in line here from a coverage and limits standpoint."

Mr. Kalbfell, who has been involved in the placement of the NFL's special events insurance coverage since 1980, said league officials decided to buy more than the required \$5 million in coverage because:

- A large crowd will attend the game—more than 100,000.
- California courts have a history of awarding liberal personal injury judgments.
- An earthquake risk exists in

California.

Mr. Kalbfell said NFL officials were pleased with the terms of the coverage. "We're a good risk," he said.

But, he noted that the cost of liability coverage for sports events continues to be high and that capacity is somewhat limited.

"On the whole, there hasn't been any great relief" in either price or available capacity, "and that's somewhat reflected in the program that they have," he said.

Mr. Kalbfell said losses at recent Super Bowls have been minimal, but he would not elaborate.

The NFL purchased \$5 million in liability insurance to cover its exposures at last year's Super Bowl, held at the Louisiana Superdome in New Orleans.

In addition, the state agency that owns the Superdome purchased \$25 million in liability coverage (*BI*, Jan. 20, 1986).

Under its agreement between Pasadena and the NFL, the city

will be responsible for personal injuries or property damage stemming from the city's negligence.

"That's the way it's happened in the past with other promoters and licensees and with the National Football League," Mr. Gillig said. Pasadena also hosted the 1977, 1980 and 1983 Super Bowls.

In addition to its self-insured liability reserve, the city has \$50 million in property coverage for the 65-year-old Rose Bowl, noted Mr. Hays, the city's risk manager.

The coverage, part of the city's blanket property insurance program, is written in three layers above a \$50,000 deductible.

The first two layers of \$10 million and \$15 million, respectively, are written by Lloyd's of London syndicates. Mr. Hays declined to name the syndicates involved.

Fireman's Fund Insurance Cos. writes a \$25 million layer excess of \$25 million.

The city has never filed a claim against the property coverage, which has been in place since 1983, said Fred Cumming, a vp with Booth & Simpson in North Hollywood, Calif., which brokered the coverage.

The city paid \$600,000 for the blanket coverage, which has aggregate limits of \$350 million.

The city spends a considerable amount of time on loss control techniques at the Rose Bowl to protect fans from injury and prevent damage to the aging—but stately—stadium, Mr. Cumming said.

Mr. Hays acts as the city's defensive coordinator, making sure the city's police, fire, building and stadium management departments work as a team. "My job is to make sure nobody drops the ball," he noted.

However, city officials were caught off guard last week when a local newspaper published a story alleging the Rose Bowl is not up to current building codes and charging that the facility could be a fire trap.

Pasadena Fire Chief Kaya Pekerol told *Business Insurance* that the story, which was picked up by newspapers and television newscasts across the country, was misleading, emphatically stating that the Rose Bowl is safe.

"Let me state as the fire chief of the city of Pasadena that the Rose Bowl is a very safe structure. The events that are held there are very well thought-out, planned, supervised and organized. And, I am quite confident in the safety of patrons at the bowl," Chief Pekerol said.

He noted the story attempted to compare building standards in use in 1922, when the Rose Bowl was built, with current standards. The story reported that the stadium's narrow aisles and entrance/exit tunnels are in violation of the city's building code.

However, changes made in the building code over the past six decades are not retroactive, the fire chief said, unless the change eliminates a life-threatening situation, which is not the case with the Rose Bowl.

Chief Pekerol said he feels the city has done an outstanding job of ensuring the safety of fans attending events at the Rose Bowl.

"It really kind of bothered me, because I thought if anything somebody should come in here and say how well we have our game plan together," Chief Pekerol said. "We leave nothing to chance."

The city "has never compromised on a life-safety issue," he added. "If I say I want this, they do it right away," he added.

City officials did admit they were concerned that the negative publicity stemming from the story could jeopardize the NFL's ability to obtain liability coverage for the Super Bowl. But Mr. Kalbfell said the coverage was placed before the story was published. ■

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Malpractice law

Continued from page 2

rates, which the superintendent either approved or disapproved. But under the 1986 law, the superintendent is empowered to directly establish medical malpractice rates for the period between July 1, 1985, and June 30, 1988.

The suit claims the rates set by Mr. Corcoran under the law are "grossly inadequate."

Following enactment of the new law, Mr. Corcoran approved a 14% medical malpractice rate increase for the period July 1, 1985, to June 30, 1986, and a 9% hike for the period between July 1, 1986, and June 30, 1987. Although not noted

in the suit, Mr. Corcoran has said he would permit a 9% hike for the next 12-month period as well.

The suit cites additional "unrebutted testimony" at last year's hearing before the special deputy superintendent which established that MMIA should increase its rates 128% for the 1985-86 policy

The suit charges that sections of the malpractice act 'constitute an impermissible regulatory system that greatly exacerbates the already large deficits of MMIA and MLMIC, and perpetuates the insolvency of MMIA and MLMIC.'

period and an additional 20% for the 1986-87 period.

The suit also quotes MLMIC's actuaries as stating at the hearing the insurer's rates should be increased at least 63% over the 1984-85 policy period rates.

The suit charges the special deputy superintendent recommended premium increases "of a much greater magnitude than those adopted by the superintendent," a fact Mr. Corcoran has "concealed."

The Insurance Department spokesman had no comment on any of the lawsuit's allegations.

MMIA is challenging the rate-setting provision of the medical malpractice law in a suit it filed last year in New York State Supreme Court, noted the department spokesman. A spokesman for MMIA would not comment on the litigation, and an MLMIC spokesman could not be reached.

The most recent suit also notes that property/casualty insurers in New York are required by statute to loan money to MMIA to cover its deficits, and such loans may be later recovered from MMIA's Stabilization Reserve Fund. Money in the fund is generated by a 20% surcharge on MMIA premiums. The surcharge can be levied until the fund reaches \$50 million.

However, "the loans will never be repaid, since the Stabilization Reserve Fund is inadequate to respond to a shortfall of this magnitude," the suit says.

The suit notes the law permits the superintendent to impose a surcharge on medical malpractice premiums to make up for any deficiency resulting from the premium levels he establishes during the three years he sets rates.

"However, regardless of the size of these deficiencies, the surcharge cannot exceed 8% of the approved premium rate for the July 1, 1989, to June 30, 1990, policy period," which cannot rectify the insurers' "past and present rate inadequacies," the suit says.

With the surcharge limited to 8%, the deficit will "continue to grow, and grow and grow," commented Mr. Feinberg.

The suit adds that insurers also will be required to contribute to the guaranty fund to reimburse claims owed by MLMIC and MMIA "once they are declared to be insolvent."

As a result, the plaintiff insurers, which the suit says have contributed millions of dollars to New York's guaranty fund, "will be required to contribute millions more," the suit predicts.

The suit charges that sections of the law are not only unconstitutional and unenforceable, but also "constitute an impermissible regulatory system that greatly exacerbates the already large deficits of MMIA and MLMIC, and perpetuates the insolvency of MMIA and MLMIC." It asks that these sections be declared "invalid and unenforceable."

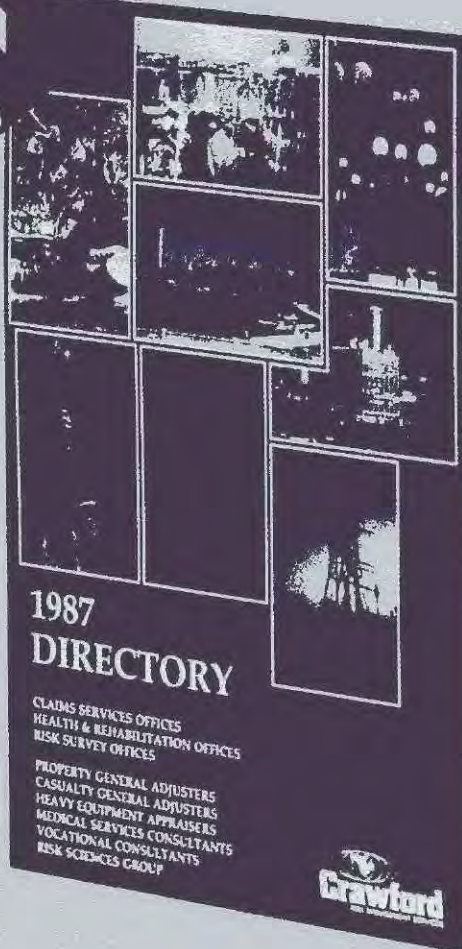
In addition to the trade associations, other plaintiffs include Allstate Insurance Co.; Government Employees Insurance Co.; Liberty Mutual Insurance Co.; Lumbermens Mutual Casualty Co.; Metropolitan Property & Liability Insurance Co., a subsidiary of Metropolitan Life Insurance Co.; and Utica Mutual Insurance Co.

Richard V. Essendelft and Gerald J. Pierce, who are described as private passenger automobile and homeowners insurance policyholders, respectively, also are plaintiffs in the suit. ■

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and the support of business in making LifeScopeSM available to employees.

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opinions

Why flex rating won't work

INSURANCE REGULATORS should heed the warnings of Richard E. Stewart: Flex rating is doomed to failure.

Mr. Stewart is well-qualified to issue such a warning. He is both a former insurance superintendent in New York and an economist.

Flex rating, which has been adopted in New York and Washington, permits insurers to increase or decrease rates within certain limits without prior regulatory approval. However, if insurers want to increase or decrease rates outside the permitted band, they need regulatory approval.

The concept: to stabilize insurance pricing.

But, as Mr. Stewart said last week, "it cannot work" (see story, page 33).

First, "the modern commercial insurance industry has too many pricing points to ever control. Rates, both as sent around within an insurance company and as filed with any public or private agency, are far from the same as real market prices." Premiums are dependent upon such complexities as deductibles, experience adjustments, dividends, debits, credits, underwriting standards, terms, endorsements and financing arrangements, Mr. Stewart explains.

letters

Differing views of industry 'professionalism'

Comrade Editor: Thank you for your editorial on professionalism (BI, Jan. 5).

We had some difficulties understanding the individuality endorsed in much of the article. However, we totalitarianly agree with your comments about the unprofessional behavior of some risk managers who placed business at rates they expected would produce big underwriting losses.

Here in our country we never have that problem: Our underwriters tell the risk manager what to pay and that it is a fair price. There is never any lasting dissent or disagreement. At one time we heard of dissent from risk managers in Afghanistan, Angola and Nicaragua, and our "free the market" envoys now are working to raise the intellectual level in those areas.

We hear that in your country the capitalist markets, such as American Industrial Group, U.S. Frequency & Catastrophe, Proletarian Mutual, Imperial Indemnity and Comrades National Allianz, often quote outrageous prices and force the risk managers to accept them. These markets are thriving only in a capitalist country—they would be made responsive to the needs of the state here in our land. The buyers know better than the sellers what a product is worth and they should be empowered to determine how much to pay, even if it is more than the market wants.

There were some markets that would not accept the higher prices that risk managers wanted to pay; they have not been in the international news lately and we cannot find out what they are doing—can you enlighten us about Idull Mutull, Friendly Ambassador, Mission Impossible Group (notice the initials are so like that of great fighter aircraft!) and Imperial Integrity.

We're not sure what to do if the buyer wants to pay less than the market wants—perhaps your knowledge of the financial results of medical malpractice JUAs, Maine workers compensation and New Jersey personal auto could be shared.

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.

There is one small problem we need your advice on. We value your magazine so highly that we insisted on paying an additional 300 rubles for our subscription. When our comrade bosses found out about this, they transferred us to our current address in Iceberia and increased our educational allotment to include Snow Shovelling 101, Controlled Dieting 544 and Advanced Shivering -22. Could you possibly write to our comrade bosses and convince them that the capitalist notion of free-market bargaining is against the best interests of the people?

We look forward to hearing from you. Please include cigarettes and gum with your reply. And do not be offended if you hear we burn your magazine—it warms our bodies as well as our minds.

Mikael Brzynski
Former Risk Manager
Gulag No. 87
Iceberia, Northern District

■ The author of this letter is Michael A. Waskom, a consultant with the Tillinghast Division of Towers, Perrin, Forster & Crosby and a former risk manager.

To the editor: I beg to differ with your disillusionment about the purpose of healthy competition in the insurance in-

Furthermore, he points out, "If management cannot control its own prices, then we ought to be able to learn by logic rather than only by experience that no outside agency possibly can."

To make flex rating work, Mr. Stewart observes, would require killing competition—wiping out debits and credits, eliminating discretion in the field and establishing standard prices, commissions and deductibles.

Flex rating is not a middle ground between open competition among insurers and prior approval of rates, Mr. Stewart advises, because "there can be no middle ground."

"The structure of the insurance market, the needs of customers and the limits of government power have put us in a competitive industry," Mr. Stewart adds.

We agree, and want to see insurance remain a competitive business. Already, rates are beginning to level off and for some lines come down, due to competitive forces in the insurance industry.

To Mr. Stewart's comments, we would only add: flex rating can't work because insurance regulators won't turn down an insurer's request to drop rates below the established minimum.

dustry (BI, Jan. 5). Insurance underwriting represents one of the few global markets where pure competition can and does exist. Hooray!

Most exciting about the last 20 years is that highly sophisticated risk managers have helped make the markets work for them (and their employers). Brokers, too, have spurred the competitive energies of insurers. Of course, some players will get in trouble and go out of business. For any student of economics, this is a natural—and healthy—outgrowth of a competitive world.

Business Insurance is, unfortunately, beginning to sound like a defender and protector of the insurance industry, instead of an advocate for the insurance buyer. I thought BI's job was to be a catalyst for constructive change, not a protectionist periodical striving to preserve the status quo.

Professionalism means doing the best job for your company, balancing short-term goals and results with long-term needs. It means not being bamboozled by the self-serving outcries of vendors seeking price protection.

Susan J. Alt
Executive Vp
Donald E.L. Johnson & Associates
Chicago

What do NICO and Hunter really stand for?

To the editor: My reaction to the "NICO to Promote Insurance 'Reform'" headline (BI, Jan. 5) is that it should read "NICO to Promote NICO" (again!).

Who are these National Insurance Consumer Organization members? Are they really insurance consumers? How many are there? How many, like me, just subscribe to J. Robert Hunter's occasionally produced, low-quality, rambling "News-letter" just to keep track of him?

Does NICO, directly or through consumer advocate Ralph Nader, receive funding from the Assn. of Trial Lawyers of America or their subsidiaries? Was Mr. Hunter really the Federal Insurance Administrator or, as I recall, the acting administrator?

I'll admit, he seems like a nice guy, but it appears he is doing for insurance consumerism what Dr. Timothy Leary did for psychiatry in the early '60s.

I look forward to the details on the legal reforms NICO says will make the legal system more efficient. Presumably, they will start by analyzing the percentage of awards that are pocketed by trial

lawyers.

L.E. O'Brien
Executive vp
Associated Risk Managers
of New York State
Albany, N.Y.

■ As we reported last year in a profile of Mr. Hunter (BI, Feb. 17, 1986), Alexandria, Va.-based NICO has approximately 2,000 members. The organization was founded in 1980. Mr. Nader raised about \$150,000 in funds to start NICO and continues to personally contribute about \$10,000 a year. Mr. Hunter has denied that the Assn. of Trial Lawyers of America or state trial groups give financial support to NICO. He admits, however, that trial groups have on occasion paid his travel expenses. After a two-year stint as acting Federal Insurance Administration administrator, Mr. Hunter was nominated in 1976 to be permanent FIA administrator. However, he was eventually named deputy FIA administrator after the General Accounting Office concluded that he had been improperly appointed to the top FIA post.

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Missing coffee

Continued from page 1

200,000 sacks of coffee that have never arrived in the United States.

In that litigation, the New York Supreme Court has issued an order preventing Gonchecol's banking representatives from drawing the remaining \$7 million worth of LOCs issued by NatWest and the New York branch of Dutch bank Rabobank (Nederland).

The other U.S. banks through which Andina financed the coffee purchase include European American Bank of Uniondale, N.Y., and French bank Banque Paribas, which has a New York branch, court papers say. These banks and Rabobank have not filed any suits connected with the incident, lawyers for the banks say.

According to papers filed by Chemical Bank, Affiliated FM issued a marine open cargo policy to Andina Coffee Inc. on July 23, 1980. New York broker Trinder &

Norwood placed the policy, said Andina's attorney, Paul Giacomo of Gersten, Savage, Kaplowitz & Zuckerman in New York.

Under an endorsement, Affiliated FM agreed Chemical Bank would be recognized as a policyholder in connection with any loss or damage to the coffee.

Mr. Giacomo, Affiliated FM and Trinder & Norwood would not comment on the policy limits.

The coverage was transferred on Feb. 15, 1986, to the London market, and an open ocean cargo policy was issued by Lloyd's underwriters to Andina, court papers say. Lloyd's also issued a banker's endorsement with the policy that recognized Chemical Bank as a policyholder for any loss or damage for which it had an insurable interest, the papers note.

According to the court papers, nearly 60% of the London coverage was underwritten by 36 syndicates at Lloyd's, led by the K.J. Coles syndicate. The remaining 40% of

the coverage was written by other London markets, led by Commercial Union Assurance Co. P.L.C., which took 6% of the risk. Other companies on the risk include New Zealand Insurance P.L.C., Insurance Co. of North America (U.K.) Ltd. and Assicurazioni Generali S.p.A., the papers say.

According to the Chemical Bank suit, filed this month, the bank allowed Gonchecol to draw \$9.7 million on the LOCs between Dec. 17, 1985, and Feb. 18, 1986, during the Affiliated FM policy period. Between Feb. 18, 1986, and May 30, 1986, Chemical paid out \$33.6 million more to the supplier, the papers note.

The Chemical Bank suit does not specify which banks represented Gonchecol.

According to the papers, payments were made to Gonchecol on "the presentation of railroad and/or truck bills of lading evidencing shipment from interior Colombia to Colombian seaport."

According to the papers, drafts were drawn by Gonchecol on Chemical Bank, accompanied by the "purported documents required by Chemical's letters of credit, and Chemical paid out a total sum of \$43.3 million."

However, no on-board bills of lading ever were issued for the Colombian coffee and no coffee has ever arrived in the United States, the papers state.

The Chemical Bank suit charges:

- The coffee was lost or diverted while in truck transit from inland Colombia to a Colombian seaport.

- Or, the supplier's trucker or messenger receipts, or bills of lading or shipping receipts, were false and fraudulent.

- Or, the coffee was obtained by fraud and deceit by unknown person or persons.

All of these events are covered by both the Affiliated FM policy and endorsement and the Lloyd's policy and banker's endorsement, Chemical Bank claims in its suit.

American Express Bank is suing Affiliated FM for \$3.5 million and underwriters in the London market for \$7.6 million, also claiming it is covered under the same Andina policies and endorsements. These amounts, however, may be reduced by \$2.5 million in payments Andina made to American Express since August, before Andina began its probe into the whereabouts of the coffee, the suit says.

American Express Bank also states in court papers that it has not received any on-board ocean bills of lading for the coffee.

NatWest says in court papers it also has never received any such bills of lading. NatWest is suing Affiliated FM for \$4 million and London underwriters for \$10.8 million. NatWest also is seeking a judgment against the London underwriters for \$4.1 million worth of LOCs that two Colombian banks representing Gonchecol have not yet drawn on, in the event NatWest is required to pay on LOCs.

There is still \$7 million worth of Andina LOCs that NatWest and Rabobank have issued but that Gonchecol or its banking representative have not drawn on, said Mr. Giacomo, Andina's attorney.

In November, the New York Supreme Court issued an order that indefinitely prevents the U.S. banks from allowing the Colombian banks, Banco Credito y Comercio and Banco Occidente, to draw on those LOCs, he said.

Prior to Aug. 12, 1986, NatWest had released \$14.8 million in funds out of a total of \$18.9 million of Andina LOCs it issued to Gonchecol's banking representatives, said an affidavit filed by NatWest in the Andina litigation. The affidavit says Banco Credito drew \$12.6 million of the \$18.9 million, but it does not specify which bank drew the remaining \$6.3 million.

In addition NatWest has demanded in a cross-claim that Banco Credito pay NatWest \$11.1 million, noting that it has been able to recover approximately \$1.5 million of the funds Banco Credito drew on the LOCs.

Gonchecol or its banking representative have drawn on all Andina LOCs issued by Chemical Bank, American Express, American European and Banque Paribas, court papers say.

But according to the spokesman for the London underwriters, all of the lawsuits assume that the Colombian coffee actually existed. For example, Chemical Bank claims in its lawsuit that "the coffee was lost...or receipts in respect to such coffee were fraudulent...or the property to which the said policy was applicable was obtained by fraud."

However, the spokesman for the London underwriters said, "according to all evidence accumulated by us, there was never any coffee in the first place, so there is no basis to any claim."

"The proceedings will be defended by the (insurers) and underwriters at Lloyd's," the spokesman noted.

In its lawsuits, Andina says it negotiated letters of credit with the U.S. banks to finance "the importation of designated lots of washed Colombian coffee in an exportable state to the United States." According to the NatWest affidavit and other related court papers, Gonchecol was able to draw on these letters of credit in Colombia at the Banco Credito and Banco Occidente.

For the Colombian banks to draw on the LOCs, the supplier had to prove it "has done everything necessary to accomplish export of the coffee, including, but not limited to, payment of all taxes, duties, charges and fees assessed on the transactions," court papers say. Gonchecol had to show Banco Credito and Banco Occidente original railroad/truck bills

Continued on page 12



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Missing coffee

Continued from page 10
of lading "evidencing shipment from the interior of Colombia to the Colombian seaport," Andina says in the suit.

However, Andina says in the lawsuit that it learned from its attorney and chief executive officer in Colombia that:

- Gonchecol presented "false and fraudulent original interior bills of lading, representing bags of coffee which are not in existence."
- Banco Credito knew the physical existence of 200,000 bags of coffee Gonchecol purportedly supplied and represented by the bills of lading "could not be ascertained."
- The 200,000 bags of coffee "are missing."
- Banco Credito honored what it knew were fraudulent bills of lading and demanded payment from NatWest on the letters of credit.
- "In an attempt to shield itself

from potential losses growing out of Gonchecol's insolvency, Banco Credito is knowingly participating in an attempt to obtain payment for coffee which it has reason to believe does not exist and which it knows is not in an exportable state as required under the letters of credit," Andina alleges.

Andina has demanded a list of the present location of all coffee it had purchased from Gonchecol in this particular transaction.

NatWest paid Banco Credito on the LOCs because the Colombian bank showed it bills of lading "purporting to show that specified bags of coffee had been loaded upon trucks to be transported to a port in Colombia and exported," says NatWest Vp Russell F. Hall in an affidavit to the Andina suit.

Mr. Hall also notes that NatWest was not the only bank that paid on Andina LOCs based on the bills of lading. "As of Aug. 12, 1986, the United States banks had paid over \$90 million on such letters of credit," he said.

When the coffee failed to arrive in the United States, the banks launched an investigation to determine what happened to the coffee, Mr. Hall said.

In August, the bankers discovered "a substantial amount of the coffee financed" had not been shipped," he said.

In fact, upon arriving in Colombia, investigators discovered that "of the 250,000 bags of coffee which had been financed by the United States banks, approximately 200,000 could not be located," Mr. Hall said.

At earlier meetings with Gonchecol in July, Mr. Hall said he learned the supplier was in financial trouble. According to Mr. Hall, Gonchecol executives said the firm had sustained substantial losses from the devaluation of the Colombia peso against the U.S. dollar.

"To cover those losses, Gonchecol had caused fraudulent truck bills of lading to be issued. . . the bags of coffee, which were allegedly on trucks and in transit for export, were either in warehouses under the control of various Colombian banks to which Gonchecol was indebted, including Banco Credito, or simply non-existent," Mr. Hall said in the affidavit.

From documents Gonchecol provided the banks, Mr. Hall said he learned Gonchecol owed "millions of dollars and millions of Colombian pesos to Banco Credito."

The loans were backed by liens on the coffee owned by Gonchecol, according to Mr. Hall.

In fact, Mr. Hall claims in the affidavit that Banco Credito has control of 4,000 bags of coffee that belong to Andina. He also claims Banco Credito has deliberately concealed the existence of the coffee and its knowledge that the bills of lading were fraudulent.

"A letter of credit issued by National Westminster Bank U.S.A. is its promise to pay a specified sum to another bank which has paid out money in reliance on documents that conform to the terms of the letter and which has acted in good faith," Mr. Hall says in the affidavit. "But, BCC is not in that position. It did not act in good faith. . . . Quite the contrary, it presented documents which it knew to be false."

Banco Credito has denied the allegations made by Andina and Nat West. An amended answer from Banco Credito says that the bank acted "in good faith and without notice of any fraud or other claim or defense against them. . . ."

Banco Credito further claims Andina and Gonchecol are, in fact, related to each other and "there is no present, actual or justifiable controversy between parties."

Andina denies any business ties with Gonchecol. A Gonchecol representative was an Andina director until October but has since left the board, court papers say. ■

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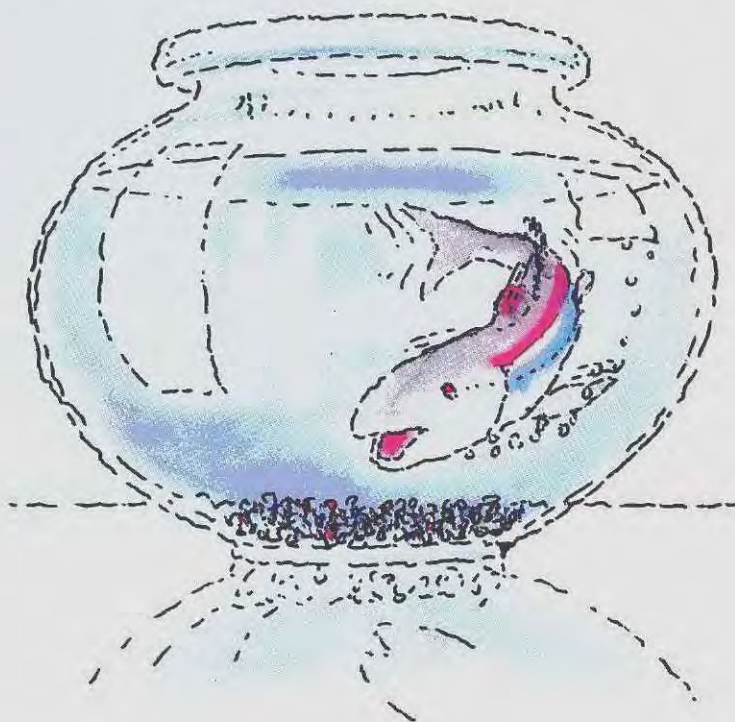
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Eight Sedgwick brokers defect to rivals

By CAROLYN ALDRED
and STACY SHAPIRO

london

LONDON—Lloyd's of London broker Sedgwick Group P.L.C. is losing eight senior brokers to rival Lloyd's brokers Willis Faber P.L.C. and Alexander Howden Ltd.

The defections, in the offshore energy and North American reinsurance units, coincide with a reorganization of senior management in the group, following the resignation of Michael Butt as chairman of Sedgwick Ltd. (BI, Jan. 5).

Mr. Butt is leaving the brokerage business to join the board of B.A.T. Industries P.L.C. as chief executive of insurance holding company Eagle Star Holdings P.L.C. He is being replaced by Sedgwick Ltd. Vice Chairman Niven Duncan.

Sax Riley, chairman of the London Trading Committee of Sedgwick Ltd. and chairman of Price Forbes Ltd., the North American division of Sedgwick, has been appointed a deputy chairman of Sedgwick Ltd.

Meanwhile, Sedgwick Offshore Resources is losing four senior directors to the oil, gas and energy division of Alexander Howden Ltd., a subsidiary of Alexander & Alexander Services Inc. The four directors are Richard Allardice, Geoffrey Clement, Liam Mulhall and Peter Stow, said a Howden spokesman.

The newly structured Howden energy division, headed by Ian Waite, has expanded rapidly since it was formed 2½ years ago, a spokesman said.

The other four senior Sedgwick brokers were from Sedgwick's worldwide reinsurance brokerage arm, E.W. Payne Cos. Ltd. The brokers, who include E.W. Payne Director John Carter, are leaving to join Carter Wilkes & Fane (Holdings) Ltd., a subsidiary of Lloyd's broker Willis Faber P.L.C.

The others Payne staffers who resigned are Gordon Clarke, Alan Wright and Michael Casenove.

Sedgwick Chairman Carel Mosselmans wished Mr. Butt "well in his new career" but refused to comment on the other resignations.

Meanwhile, Sedgwick Group P.L.C. and its North American retail operating subsidiary Fred S. James & Co. Inc. are on the acquisition trail again.

Sedgwick, the world's third-largest broker, announced that James is buying Arthur L. Owen & Co. Inc., the 69th-largest U.S. broker based on *Business Insurance* estimates, for \$16.5 million in cash.

The privately owned Dallas-based broker, which reported gross revenues of \$6.5 million for 1986, "enhances the services which we are able to offer our clients in Texas and gives Fred S. James added expertise in energy-related business," said Sedgwick Chairman Carel Mosselmans.

Although James orchestrated the purchase of Owen to complement its own business, the deal was subject to the approval of Sedgwick, said George Hilton, secretary of Sedgwick. This is the first major U.S. acquisition since Sedgwick bought Memphis, Tenn.-based The Crump Cos. Inc., the eighth-largest U.S. broker, in September (BI, Sept. 1, 1986).

Sedgwick and James are more likely in the future to continue to buy smaller regional U.S. brokers like Owen than major nationwide companies, said Mr. Hilton.

Neill report

The long-awaited Neill report on investor protection at Lloyd's of London is expected to be published and available to the public this week, a spokesman from the British Department of Trade and In-

dustry confirmed.

The self-regulatory system at Lloyd's has been under scrutiny from a British government committee, headed by Sir Patrick Neill, for the past year. The committee's report, which originally was scheduled to be published last summer, was delivered to the Secretary for Trade and Industry Paul Channon just before Christmas (BI, March 3, 1986; Dec. 22, 1986).

The Neill committee was set up to examine whether Lloyd's self-regulation under the Lloyd's Act of 1982 provides the same protection to Lloyd's members as the Financial Services Act, which became law last November, gives

other British investors.

PCW agreements

Members of Lloyd's of London syndicates formerly managed by PCW Underwriting Agencies Ltd. will be able to take legal action in U.S. courts, despite the expiration of statutes of limitation, under "standstill" agreements signed just before Christmas, according to a London lawyer.

Under the agreements concerning litigation by PCW members, parties in the PCW dispute have agreed to waive a Jan. 1 deadline for filing suits, said Christopher Crosthwaite of the firm Ashurst

Morris Crisp, which represents 400 PCW members.

The main defendants in any likely legal action have signed the agreements, which are similar to those that have been in force in the United Kingdom for the past year.

"The agreements can be terminated by any defendant on 21 days' notice, but other than that, they are 'evergreen.' That is, they have no time restriction," said Mr. Crosthwaite. "This should take the heat off temporarily."

PCW members have refused to pay underwriting losses suffered by the syndicates estimated by Lloyd's at 235 million pounds (about \$347 million at current exchange rates) net of reinsurance and are threatening to file suit against Lloyd's, Minet Holdings

P.L.C., the former manager of PCW and 36 other defendants if a settlement is not reached (BI, Nov. 17, 1986).

Among the potential defendants that have signed the U.S. standstill agreements are Lloyd's, Alexander & Alexander Services Inc., Sedgwick Group P.L.C. and accountant Arthur Young & Co., Mr. Crosthwaite said.

Lloyd's has earmarked the 235 million pounds—estimated to be the maximum amount of losses PCW syndicates face—in Lloyd's Central Fund until Lloyd's and PCW members can arrange a settlement of the losses (BI, Sept. 1, 1986).

Lloyd's Chairman Peter Miller still believes that Lloyd's and PCW members can reach a settlement on

Continued on next page



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Continued from previous page
payment of losses without going to court. But he has indicated that there must be a "significant contribution" from PCW members and from those whose actions contributed in any way to the "seriousness" of the situation (*BI*, Nov. 17, 1986).

Meanwhile, Sir Ian Morrow, chairman of Additional Underwriting Agency No. 3, the agency now managing the syndicates, said last month in a letter to PCW members that he hoped a settlement could be reached in the first few months of 1987.

Lloyd's and AUA3 had reached agreement on a settlement in principle, but there were still many complex issues to resolve, he said.

Janson, Green sale

Shareholders of Lloyd's of London broker Hogg Robinson Group P.L.C. have agreed to sell Lloyd's underwriting management agency

Janson, Green Ltd. for more than 14 million pounds (\$20.6 million) over a six-year period.

Janson, Green is the last major agency to be sold by a Lloyd's broker to comply with the Lloyd's Act of 1982, which stipulates that all Lloyd's underwriting agencies must be divested by Lloyd's brokers by July 1987.

Hogg Robinson last month sent shareholders details of its plans to sell Janson, Green. The plans already have been approved by Lloyd's.

Janson, Green, its fellow subsidiary Janson Services Ltd. and its associate company Crescent Underwriting Agencies Ltd. will become subsidiaries of a newly formed company known as Janson, Green Holdings Ltd., controlled by the management of Janson, Green.

Sir Peter Green, chairman of Janson, Green and a former Lloyd's chairman, will be chairman of the holding company.

Under the Lloyd's act, Hogg Ro-

binson had several options for structuring the sale, including asking for a share of Janson, Green's profit commissions over a specified time period.

According to Hogg Robinson Chairman Albert Wheway, Hogg Robinson will share more than 14 million pounds (\$20.6 million) of Janson, Green's profit commissions for the underwriting years 1984 to 1989, which the agency will begin to collect this year under Lloyd's three-year accounting system.

For 1984, for example, Hogg will receive 90% of the first 1.75 million pounds (\$2.57 million) of profit commission, 50% of the next 500,000 pounds (\$735,000) and 5% of profit commissions above that.

"Your board considered it important that some level of contribution to profits should continue to be made over the next few years," said Mr. Wheway.

This formula will ease the adverse effect the sale of Janson, Green could have on Hogg's prof-

its. Janson, Green has produced up to 25% of Hogg Robinson Group's profits in recent years.

Howden restructured

Alexander Howden Ltd., the wholesale brokerage arm of Lloyd's of London broker Alexander Howden Group, is restructuring its group of wholesale companies into five separate units.

Included in the restructuring are the aviation division, headed by Michael Hughes; the marine worldwide division, headed by Bernard Steinart; the North American non-marine divisions, headed by Richard Drain; and the oil, gas and energy worldwide divisions, headed by Ian Waite. A fifth unit combines the International non-marine division, Holmes Johnson Lessiter Ltd., Halford, Shead & Co. Ltd. and the captive division under the chairmanship of Paul Chilton.

Also, Brian Ainsworth has been

appointed chairman of an operations committee formed to deal with the day-to-day operations of the wholesale group.

"AHL will soon have more than 800 people. The new structure and operating committee will allow us to introduce a greater delegation of authority throughout the wholesale group," said Chairman Dennis Mahoney.

Tanker coverage

A 2,600-ton deadweight tanker that sank after hitting a rock off the coast of Iceland on Christmas Eve is insured for hull and machinery plus third-party liability with the London-based mutual insurer, British Marine Mutual Insurance Assn. Ltd., a spokesman for the insurer confirmed.

The policy was placed for the ship's Gibraltar-based owner by London broker Berisford Mocatta & Co. Ltd.

All 12 members of the tanker's crew died, said Gordon Haggerstone, the ship's British managing agent. The ship, which was built in Sweden in 1969, was bought by Gibraltar-registered Syndicated Tankships in 1985. It was carrying no cargo when it foundered, said Mr. Haggerstone.

Prudential shares

Shares in Prudential Corp. P.L.C., the British insurance group, are being traded for the first time in the United States.

The shares are being traded in the form of American Depositary Receipts—certificates issued by Morgan Guaranty Trust Co. of New York, giving the investor ownership of shares held by the bank. The shares, which will be sold in U.S. dollars, will be traded on the over-the-counter market, said a spokesman.

Prudential's move into ADRs follows its acquisition of Michigan-based Jackson National Life Insurance Co. for 405 million pounds (\$602.6 million) in September 1986. Prudential Chief Executive Brian Corby said the move was in response to growing interest in the company from U.S. investors.

British companies already trading in ADRs include Unilever P.L.C. and Jaguar P.L.C. Only last month, Lloyd's of London broker Sedgwick Group P.L.C. set up an ADR facility (*BI*, Dec. 15, 1986).

Opera star sued

Concert promoters in the Netherlands and Britain are suing the opera singer Placido Domingo for a total of \$170,000 due to the singer's cancellation of a string of concerts during the past year.

A spokesman for The Kruger Organization (Concert Promotion) Ltd. said no insurance covered the cancellation of the concert due to the non-appearance of Mr. Domingo. "We rarely take out cancellation insurance because of the high cost of premiums," he said.

Kruger, based in Brighton, England, has filed the lawsuit against Mr. Domingo and his British agent, Stafford Law Associates, claiming 100,000 pounds (\$147,000) in damages after Mr. Domingo refused to play at Wembley Arena in London on Dec. 17, said a spokesman from Kruger.

Mr. Domingo announced less than a day before the Wembley concert that he would not appear because he thought the prices charged for seats were too high. The concert had been arranged after Mr. Domingo had canceled two previous engagements in Britain, said a spokesman for Kruger.

Also, in Holland, IAN Concert Promotions has filed legal action against Mr. Domingo claiming damages of 50,000 Dutch guilders (\$23,000), arising from the singer's cancellation of three successive

Continued on next page

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Rittenhouse new risk manager at GenCorp

Thomas J. Rittenhouse has been named director of risk management at GenCorp Inc., an Akron, Ohio-based company that owns General Tire Co., a tire maker; RKO General Inc., the film and broadcasting concern; DiversiTech General, a diversified manufacturer; and Aerojet General, a defense contractor. Mr. Rittenhouse, 40, supervises a risk management staff of five and reports to Michael Steuert, vp/treasurer. He replaces **Denis A. Julien**, who left GenCorp. to join Florida Progress Corp. in St. Petersburg as director of risk management. Previously, Mr. Rittenhouse was risk manager at H.H. Robertson Co., a manufacturer of building products in Pittsburgh. He received a bachelor of arts degree in economics from Point Park College in Pittsburgh, and holds the Associate in Risk Management designation.

* * *

Thomas Catledge Jr., 40, has been named corporate risk manager for Days Inn of

comings & goings: buyers

America Inc. in Atlanta. In this position he will be responsible for property/casualty insurance, loss prevention and safety programs, handling claims and training in risk management for the motel and restaurant concern. Mr. Catledge reports to Robert S. McKinney, senior vp-human resources, and replaces **Jeffrey Smith**, who left Days Inn in August. Prior to joining the motel and restaurant chain, Mr. Catledge served as risk manager for Cobb County, Ga., an Atlanta-area governmental agency. Prior to that, he was a senior risk management consultant with Marsh & McLennan Inc. in Atlanta. Mr. Catledge received a bachelor of business administration degree from the University of Georgia in Athens, and a doctor of law degree from the Atlanta Law School. Mr. Catledge is a member of the American Judicial

Society, the State Bar Assn. of Georgia's Fee Arbitration Program, the Public Risk & Insurance Management Assn. and the Government Offices Financial Assn. In addition, Mr. Catledge is a deputy member of the Risk & Insurance Management Society.

* * *

Terry Bone, 37, has been named risk manager for the Puget Sound Schools Risk Management Pool in Seattle. In this newly created position she will oversee coordination of excess insurance and loss prevention for the property and liability pool, which became operational Sept. 1, 1986. The Puget Sound Schools Pool consists of 65 school districts. Ms. Bone reports to Florice Swanson, assistant superintendent of Educational Services District No. 121, which contracted to administrate the pool. Prior to joining the

Puget Sound Schools Pool, Ms. Bone served as pool administrator for Colorado Counties Inc., which is an association of county commissioners, where she oversaw administration of three pools that provide coverage to 47 counties: health benefits; property/casualty; and workers compensation. Ms. Bone received a bachelor of science degree in journalism from the University of Colorado in Boulder and a master of public administration degree from the University of Colorado at Denver. In addition, she holds the Associate in Risk Management designation and is a vp of the Public Risk & Insurance Management Assn.

We'd like to report on staff changes in your company's risk management, safety or employee benefits department. Just drop a note to Paul Winston, assistant copy editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611, or call 312-649-5442. Please send a photograph, too.

london

Continued from previous page
Dutch dates between May and December, said the company's director Ian Knoop in Amsterdam.

IAN Concert Promotions had cancellation insurance of 500,000 guilders (\$230,000 million) placed in the London market for one of the three concerts, said Mr. Knoop, who would not comment on the identity of the insurers.

However, "as the artist himself chose to withdraw, we have no valid claim under the insurance policy," Mr. Knoop said.

Sources at Lloyd's also say that any cancellation insurance policy would not pay a claim if a concert was canceled because a performer voluntarily chose to cancel a show. Cancellation insurance generally pays for the loss of revenue if a concert is canceled because a performer is sick, injured or dies.

Mr. Domingo's agent, David Law, refused to comment on the cancellations and lawsuits, saying the matter was in the hands of Mr. Domingo's lawyer. Mr. Domingo could not be reached for comment.

Elton John surgery

John Reid Enterprises, the London-based manager of rock singer Elton John, is insured for the cancellation of the remainder of Mr. John's Australian tour, following the removal of a non-malignant lesion from his throat earlier this month.

However, John Reid did not buy cancellation insurance to cover the U.S. leg of Mr. John's world tour, which was scheduled from late January to March, sources say.

Mr. John, who has nearly finished his 200-performance world tour, is not expected to perform again this year following the surgery.

John Reid's cancellation insurance policy, which is led in London by Sun Alliance Insurance Group P.L.C., was purchased under the policy name "William A. Bong," said Bob Taylor, managing director of John Reid's London broker, Robertson, Taylor Insurance Brokers Ltd. Mr. Taylor would not comment on the policy's limits.

The policy name refers to the Australian word "billabong," a backwater forming a stagnant pool.

Mr. John's hospitalization is not covered under his accidental injury insurance policy, which is led by Lloyd's of London underwriter Burt Stratton of Haynes & Clack Underwriting Agency Ltd. However, that policy, which currently is being renewed, probably will "be renewed as before, pending further information on Elton John's recovery," Mr. Stratton said.

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CertiFacts automatically keeps an online diary that tracks the case from its onset. It flags and confirms significant dates for the reviewer, including admis-



Chrysler encourages managed care plans

The Detroit-based Chrysler Corp. hopes to hold the line on its annual health care cost increases by encouraging employees to elect health care coverage through managed care plans, like health maintenance organizations and preferred provider organizations.

"It's difficult to say how much we will save because health care costs are a moving target," explained Donald L. Longnecker, manager, finance and planning-health care and group insurance for Chrysler. "But, we hope to reduce year over year cost increases" by offering managed health care plans.

The automobile manufacturer estimates that it spent about \$460 million on health care-related expenses during 1986.

To better manage health care

costs, Chrysler introduced preferred provider organization options to 72,500 salaried and hourly employees in Michigan, Indiana, Ohio and St. Louis, Mo., in July.

Various health maintenance organization options also are available to employees.

Through a comprehensive benefit communications campaign conducted jointly by Chrysler, the United Auto Workers Union and Lincolnshire, Ill.-based Hewitt Associates, "40% of our employees chose the managed care options in those areas where there was a PPO and an HMO choice," Mr. Longnecker said.

Almost 20,000 of employees

chose the PPO option and about 10,000 chose the HMO option, he said.

The communications program included an information kit detailing and comparing health plan options. Twenty-four different versions of the kit were produced that were tailored to various employee groups.

A video also was shown at employee meetings to introduce the benefit options.

"We used all of the media for the promotion of the managed care options only," said Mr. Longnecker.

"We virtually said not a word about our traditional indemnity plan," he added.

"If I were to pinpoint a specific reason for our success, it was Chrysler's inviting the UAW to cooperate in the development of the communication and education for the very first time," Mr. Longnecker continued.

"The reason the PPO enrollment was so high was that the PPO combined the best features of the HMO and the indemnity plan," he said.

"I think the poor response associated with HMOs is directly related to the fact that employees joining the HMO have to go to the HMO doctor or hospital to get coverage.

"One of the significant advantages of the PPO was that while we created incentives for employees to receive care from network providers, they still get some cov-

erage if they choose to receive care outside the network," he explained.

Chrysler employees in southeastern Michigan were offered two PPO options in addition to the indemnity plan and HMOs.

Under SelectCare, which was offered only to employees in Michigan, if employees use preferred providers, they do not pay deductibles.

Copayments are required only on certain services, such as \$3 on prescriptions and \$5 for physician's office visits.

However, if employees use physicians outside the network, they still receive partial health care coverage.

Employees still do not pay a deductible, but they do pay a 20% copayment, up to a maximum out-of-pocket expense of \$500 for individual coverage and \$1,000 for family coverage.

In addition to coverage of hospital and physician services, SelectCare covers "wellness" services such as well-baby care, allergy tests and injections, and preschool immunizations.

Chrysler employees opting for SelectCare have a choice of more than 2,000 physicians and 13 hospitals.

The Blue Preferred Plan, sponsored by the Blue Cross/Blue Shield, was offered to Chrysler employees in southeastern Michigan, as well as in Indiana, Ohio and St. Louis, Mo.

Under this plan, if employees use non-preferred providers, they pay a 20% copayment, up to a maximum out-of-pocket expense of \$500 for individual coverage and \$1,000 for family coverage.

The PPO covers all expenses when employees use preferred providers.

Blue Preferred also covers "wellness" services such as up to \$100 in routine office visits for infants up to 1 year old and immunizations for children under 6.

This PPO includes more than 6,000 physicians and 100 hospitals.

Chrysler also amended its self-insured indemnity plan in July to include a mandatory pre-admission certification program.

The plan, which is administered by Blue Cross/Blue Shield of Michigan, does not require employees to pay deductibles, but employee copayments are required on some services.

If employees do not have their hospital admissions certified, or if they decide to enter the hospital if admission is denied, they must share in the costs of the hospitalization.

Employees then pay a \$100 per person deductible and a 20% copayment, up to an out-of-pocket maximum expense of \$750 for individual coverage and \$1,500 for family coverage.

The plan also includes a mandatory second surgical opinion program. Coverage levels are reduced if employees do not obtain a second opinion for certain elective surgeries.

The amount of reduction varies among locations.

Employees now pay a \$5 copayment on prescriptions, up from \$3. If employees do not use preferred pharmacies, they pay the \$5 copayment plus 25% of the total cost of the prescription.

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ASK A BENEFIT MANAGER

Retiree welfare benefits subject of scrutiny in '87

Q

I have read in many publications that in 1987 the retiree health care issue will be a major topic in Washington. I would be interested in your reviewing the major factors that will affect this issue. What actions

should companies take with regard to retiree health care?

A

Until the last few years, the cost of continuing medical benefits after retirement had received relatively little attention. However, several developments are bringing this issue into sharper focus.

Companies began by offering

post-retirement medical coverage as a supplement to Medicare, then started to provide coverage to employees who retired prior to age 65 to make early retirement options, etc., more attractive. Companies expected that Medicare would continue to cover a substantial portion of the medical costs incurred by retirees over age 65.

The fact is that the government has been reducing the Medicare benefits it provides while increasing the contributions for those over age 65. In addition, the early retiree rolls have grown substantially due to corporate restructuring and early retiree incentive programs.

Based on these factors, the retiree supplements provided by companies have been more costly than were expected. Since most companies didn't foresee retiree coverage as a significant cost when they established the plans, few companies set up the proper systems to track and analyze the costs and projected liabilities.

To get a better perspective of the problem, let's review who in the United States are covered by private retiree health plans and the types of plans they are covered by.

One of every six elderly Americans is receiving a portion of their health coverage from an employer. In 1983, an estimated 6.9 million retirees and their dependants were covered by private health insurance programs. It is primarily large companies that provide this continuation coverage to retirees. In most companies, employees become eligible to receive health benefits when they retire from the company. Employees who do not meet the requirements for benefits at retirement or who leave the company before retirement usually do not qualify for health benefits.

Many plans provide additional coverage for the retiree's spouse and other qualified dependants. These benefits are sometimes provided only if the retiree pays the additional premium costs, and their availability often terminates on the death of the retiree.

Continued coverage through group plans provides important protection for many retirees from the higher cost of purchasing supplemental coverage individually or paying costs not covered by Medicare out of pocket. If retirees are not continued in group plans, they have the option at retirement of converting the employer policy to an individual policy. Conversion policies are more expensive than policies sold in the individual market because they are issued without regard to pre-existing conditions and there is no waiting period.

Employer-sponsored health insurance provides significant benefits for those who have it. The Department of Labor indicates that for retirees covered in employer-sponsored group plans, private insurance or self-insurance paid for 23% of their

total health care expenditures in 1977. This is in sharp contrast to the benefits provided under most individual policies. For those with non-group insurance plans in 1977, private insurance paid for slightly less than 12% of total health care expenses.

Cost-sharing varies significantly among firms. As a result of the dramatic increase in health costs in recent years, some companies have increased employee premium contributions or changed from first-dollar plans to comprehensive plans with up-front deductibles for active and retiree coverage in an effort to limit their cost.

As we know, Medicare is the basic health benefit for retirees, age 65 or over, and covers more than 26 million people. However, Medicare has not met the complete needs of the over-65 age group and the gaps continue to grow. Medicare coverage is not available to retirees under age 65. In addition, Medicare focuses on the acute-care needs and provides little or no preventive care, long-term care or catastrophic protection.

Although Medicare pays almost half of the health care expenses for those over 65 (primarily the costs of hospitalization and a substantial share of the costs for physician services), two-thirds of the people over 65 purchase additional coverage to supplement their Medicare coverage.

Most companies that provide coverage for retired employees and their families generally provide full coverage in the company's plan until age 65. Many plans then either adjust coverage in the employee health plan or provide a separate plan to take Medicare benefits into consideration.

One of two approaches is generally used: a "carve-out" or a "Medicare supplement." The "carve-out" continues the retiree in the employer's group plan, but carves out benefits provided by Medicare to avoid duplication. The "Medicare supplement" specifies exactly the benefits offered. In addition, the supplement can tailor benefits to the needs of the retiree.

What is the security of retiree health benefits today? As a result of the rising cost of providing retirees with health insurance, many companies have attempted to reduce or discontinue retiree health benefits. Retirees have brought suit under the Employee Retirement Income Security Act of 1974 and for breach of contract against their former employers. The courts have acknowledged the power of an employer to reserve the right to modify or terminate these benefits. Yet, the courts have imposed stringent standards on companies desiring to alter their retiree health plans. Both written descriptions and oral representations of the benefits must clearly and unambiguously establish the employer's unqualified right to alter the plan.

When the court has been called upon to interpret ambiguous contractual language, retiree benefits are generally presumed to be provided for life.

Retiree health benefits are not afforded the same protections that ERISA mandates for pension benefits. ERISA draws a distinct line between employee pension benefit plans and employee welfare benefit plans. Employee welfare benefit plans must comply with ERISA reporting and disclosure requirements and fiduciary standards to ensure that any plan funds are handled properly. However, unlike pension plans, employee welfare benefit plans are not subject to ERISA standards concerning who must participate in the plan, how long a person has to be covered to be entitled to benefits (vesting) or how much should be set aside each year to pay for future obligations (funding). Moreover, the employee welfare benefits are not insured by the Pension Benefit Guaranty Corp.

There are no federal regulations governing the security of welfare benefits, but ERISA contains a sweeping presumption clause that supercedes state laws relating to both employee pension and welfare benefit plans sponsored or maintained by employers. Only commercially insured plans regulated under state insurance and banking laws

are exempt from ERISA. The absence of statutory regulation concerning non-insured welfare benefits has resulted in considerable litigation to determine whether or not an employer can modify or terminate health benefits in a variety of circumstances.

Because of the absence of a definite Supreme Court decision in this area, the law is still in a developing state. Several cases before the 6th U.S. Circuit Court of Appeals have become the focal point for analyzing the emerging legal problems.

The court held in its April 1986 decision, *Hansen vs. White Farm Equipment Co.* (6th Cir. 1986), that an employer was not absolutely prohibited from terminating retiree health benefits. However, the court outlined stringent standards the employer must meet to establish the right to amend the plans in question.

Most, but not all, of the applicable case law involves collectively bargained welfare benefit plans. The issue involved is whether or not employers must continue to provide health benefits to retirees after the collective bargaining agreement expires. In cases where the terms of the contract clearly limit the duration of benefits, the court allowed termination. See *UAW vs. Cleveland Gear Corp.* (6th Cir., 1984); *UAW vs. Roblin Industries Inc.* (W.D. Mich., 1983); *Turner vs. Teamsters Local 302* (9th Cir., 1979); *United Rubber Workers vs. Lee National Corp.* (S.D.N.Y., 1971).

If the provisions of the contract dealing specifically with retiree health benefits are ambiguous concerning their duration, then the courts have looked to other clauses in their collective bargaining agreement that contained durational limitations. In *UAW vs. Yard-Man Inc.* (6th Cir., 1983), the court concluded that because specific durational limitations relating to other benefits were not applied to retiree benefits, these benefits were intended to survive the expiration of successive agreements. In addition, a general contract expiration clause did not indicate an intent of the employer and employees that all benefits provided by the collective bargaining agreement terminate at the expiration of the agreement.

The impact of Yard-Man is that retiree health benefits are presumed to be provided for life in the absence of a clear contractual limitation on their duration.

There also have been cases in which retirees have contested the right of employers to amend or terminate employer-provided health benefits that have not been collectively bargained. In *Eardman vs. Bethlehem Steel Co.* (W.D.N.Y., 1984), the court determined from summary plan descriptions,

Continued on next page

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

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

This month's column, on employee benefits issues is written by Joseph W. Duva, director of employee benefits at Allied-Signal Inc. in Morristown, N.J. Ralph F. Perry Jr., vp and director of risk management at Amfac Inc. in San Francisco answers risk management questions. And, William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions on benefits issues. Richard E. Sherman, a principal with Coopers & Lybrand in San Francisco, answers casualty actuarial questions. Mr. Duva's and Mr. Perry's columns appear alternately, usually on the second Monday of each month. Mr. Miner's and Mr. Sherman's columns appear alternately on the first Monday of each month. Mr. Duva's next column will appear in March.

Address your questions to ASK, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. Please give us your name, title and employer; however, Business Insurance will consider unsigned letters.



Mr. Duva

Retiree health benefits will be hot topic in '87

Continued from previous page

employee handbooks and statements made to employees in exit interviews and in plant-shutdown presentations that the company intended to provide lifetime benefits. The court rejected the company's contention that the absence of language guaranteeing the benefits for life demonstrated the intent to retain the right to terminate or amend the plan. In fact, the court cited with approval the language in *Yard-Man* that "retiree benefits are, in a sense, 'status' benefits which, as such, carry with them an inference that they continue as long as the prerequisite status is maintained."

Thus, both *Yard-Man* and *Bethlehem Steel* suggest that an employer may alter retiree health benefits only if he has unambiguously reserved the right to do so in the applicable contracts and clearly communicated this fact to employees.

The concept that retiree benefits are "vested" by reason of retiree status was expanded by the district court decision in *Musto vs. American General Corp.* (M.D. Tenn. 1985). The court treated retirees' welfare benefits as "deferred compensation" that has been earned in exchange for the services provided by the former employee. However, the court qualified its sweeping rationale in allowing unilateral modification when disaster threatened. Since American General was financially secure, the court held that such a necessity did not exist.

The implications of the *Musto* decision have been dulled by the 6th Circuit opinion in *White Farm*. Because welfare benefits are explicitly excluded from the vesting and funding standards mandated by ERISA, the court held that retiree health benefits did not vest automatically at retirement but could be vested only by the contractual terms. Nevertheless, the court believed that mandatory vesting of retiree welfare benefits might be appropriate but was an issue for the legislature, not the courts, to decide.

In the absence of statutory regulations that insure the security of retiree health benefits, the court had to determine whether these benefits were promised for life in the applicable contracts. The court examined all written and oral representations made to employees to determine whether *White Farm*, in fact, intended to provide health benefits to retirees for life. In defining the inferences and presumption that should be used in interpreting plan documents or collective bargaining agreements, the court cited *Yard-Man* and other cases which held that in the absence of a specific limitation on the duration of retiree health benefits, these benefits were intended to be provided for life. (See *UAW vs. Cadillac Malleable Iron Co. Inc.* (6th Cir., 1984), *UAW vs. Yard-Man Inc.* (6th Cir., 1983).)

In summary, the court ruled in *White Farm* that an employer may terminate the benefits in question if he has unambiguously reserved the right to do so. However, the court established a strict standards in determining "unambiguous" language. Although *White Farm* had stated in its 1978 summary booklet

issued to employees and retirees that "the Company does reserve the right to change the plans and, if necessary, discontinue them," the court concluded that the termination provisions and their applicability to the benefits in controversy were not, in fact, clear and unambiguous.

Now let's review how the cost of retirees' health benefits are presently treated. Almost all firms finance retiree health benefits on a pay-as-you-go basis. Pre-funding is rare. The present value of the accrued liability for retiree health benefits was estimated to have been \$98.1 billion in 1983, though I have seen estimates as high as \$2 trillion. If employers had been prefunding retiree health insurance, the 1985 annual accrual for new benefit liabilities would have been an estimated \$750 million.

In the short run, prefunding retiree health benefits would increase employer costs. If the accrued liability of \$98.1 billion were amortized over 20 years, private employers' total costs for retiree health benefits would have been roughly \$10.8 billion in 1985. This would have been \$6.2 billion more than the \$4.6 billion employers were estimated to have paid in 1985 for the benefits they provided to current retirees on a pay-as-you-go basis.

Despite the greater cost burden of prefunding in the short run, employers' costs for retiree health insurance would be lower over the long haul if these benefits were prefunded using a tax-exempt trust.

The prefunding issue is a classic example of how fast things are changing. In the 1970s and early 1980s, employers did not perceive much of a funding problem and, thus, only a few took advantage of the options available under Section 501(c)(9) or 401(h). Congress then eliminated the 501(c) option under the Deficit Reduction Act of 1984 just as the issue was generating attention. Now, Congress seems to want employers to prefund, more employers want to do so, yet the incentives for funding have neither been restored nor replaced with a better option. Clearly there is a public interest in business-government cooperation to facilitate prefunding.

So much for the background, what is the future of retiree health benefits? The Financial Accounting Standards Board will be a major influence and has addressed the issue of retiree welfare benefits several times in the past few years. In its 1982 Preliminary Views on pension accounting, it expressed a preference for expensing retiree welfare benefits during the active working careers of employees expected to receive such benefits. It considered requiring employers to determine retiree welfare costs in much the same way pension costs are calculated and treat these actuarially measured costs as a current compensation expense.

In a subsequent 1983 Discussion Memorandum, FASB considered having employers disclose their unfunded retiree welfare benefit liabilities—or even move them onto corporate balance sheets. Then, in

November 1984, with Statement No. 81, it softened its previous position, requiring only footnote disclosure of the types of post-retirement benefits employers provide to specific employee groups, their current accounting and funding policies and the cost of their benefits recognized for each accounting period.

For most employers, this requirement is not much of a hardship. In fact, employers do not even have to calculate separately the cost of retiree benefits. If such information is not readily available, they may disclose only the total cost of welfare benefits for all employees (that is, active employees and retirees).

Nevertheless, FASB's decision to move slowly in this area does not mean that it has abandoned its desire to act decisively—only that it is wisely taking its time to be able to draw upon more resources. On the basis of its findings, FASB may well conclude that retiree welfare costs should be charged to the same accounting periods for which revenue is recognized. The question is not whether the FASB will act—only when.

Second only to new accounting requirements in its potential cost impact—and perhaps even more dangerous—is the Treasury Department's study of minimum participation, vesting, accrual and funding standards for retiree welfare benefits. Such legislation could make it difficult, if not impossible, for firms to terminate existing plans or curtail benefits, to say nothing of its effect on a company's profits, taxes, credit rating and stock values.

Will "ERISA II" become a reality? To a Congress searching for creative ways to reduce Medicare costs, shifting more of the burden to the private sector through mandatory private coverage looks mighty appealing. And in view of recent attempts by LTV Corp. and other employers to terminate retiree benefits, concern about benefit security is mounting in Congress. It was that very concern—touched off by the failure of Studebaker Corp.—that ultimately led to the passage of ERISA.

As the courts, the FASB and Congress decide on the ultimate direction of retiree welfare plans, you must establish your own plans and objectives. Given the magnitude of retiree benefit costs and liabilities and the almost certain prospect of accounting changes, cost-containment strategies are essential. Also, innovative and better plan design can provide control on the cost of the plan.

Right now, the area of retiree welfare benefits is riddled with more "ifs" than certainties: Will the courts uphold the common law principle established in *White Farm*? What actions will FASB take and when? Will Congress enact ERISA-type legislation? Although the answers remain guesses at best, you cannot await the developments. You must deal with these issues—uncomfortable as they are—because they simply will not go away. You must review written and oral communication policies. Also, you must measure future retiree medical costs and identify strategies to absorb and limit these costs now.

Insurer's duty to defend job bias suit: Court

An insurer was held to have breached its duty to defend its policyholder in a suit that claimed employment race discrimination, according to the Court of Appeals of Washington.

In 1976, Castle & Cooke Inc. was sued in federal court in an employment discrimination class action.

The company was covered under an insurance policy issued by Great American Insurance Co. that obligated the insurer to pay all sums the company became legally obligated to pay as damages because of personal injury. Personal injury was defined to

include racial discrimination not committed by or at the direction of the policyholder. The policy excluded coverage for mental anguish or bodily injury to any employee arising out of and in the course of employment.

The federal racial discrimination suit sought lost wages and damages for physical suffering, arbitrary treatment and mental anguish. Castle & Cooke notified Great American of the suit. However, Great American denied coverage and refused to defend the company. Castle & Cooke then

brought this suit seeking a declaration that Great American had a duty to defend and damages for breach. The trial court ruled for the policyholder.

The appellate court concluded that the employee exclusion in the policy was clear and unambiguous. "Although there is no insurance coverage and no duty to defend employee claims for bodily injury or mental anguish, there is a duty to defend non-intentional employment race discrimination claims which allege damages for lost wages and

arbitrary termination," the court maintained.

The court concluded that Great American had a duty to defend Castle & Cooke, although the court also held that Great American had not acted in bad faith. *Castle & Cooke Inc. vs. Great American Insurance Co.*, Court of Appeals of Washington, Jan. 6, 1986 (BI/01/N.—\$10)

These abstracts were prepared by Cases Unlimited Inc. Copies of these decisions are available by sending a \$10 check payable to Cases Unlimited to Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. List the number for each opinion.

legal briefs

Thinking small

'Little guys' can profit from having their own RMIS, too

By David A. Tweedy

MANY RISK MANAGEMENT professionals erroneously believe that only the "big guys" need a risk management information system. While it is true that the major corporations derive great benefits from well-designed systems, it also is true that smaller to medium-sized business can profit from having their own RMIS.

One of the more frequent questions I am asked at conferences is how the smaller to midsized firm can effectively use a risk management information system. Since we usually focus on larger-client RMIS applications, this month I plan on dealing with this important topic. After all, there is a considerable untapped market existing beyond the Fortune 500-sized firms that can use an RMIS.

To gain a better perspective on this market segment, I spoke at length with Tom Seligman, president of Seligman Information Systems in Roslyn Heights, N.Y. His firm specializes in providing stand-alone risk management information systems for smaller to midsized firms.

The following is a summary of that interview:

- Defining "small."

Small is a relative term. For the purposes of an RMIS, small is not a function of the standard measures of a business' size, such as sales volume or number of employees or even resulting payroll. Indeed, many Fortune 500 companies could be classified as small in regard to risk management information systems. Conversely, many "mom and pop" operations may require a sophisticated RMIS.

- When an RMIS is applicable.

One key factor is the number of claims generated each year and the resulting cost of those claims. Although each situation and company is unique, a rough minimum requirement to observe when considering a vendor-provided RMIS is 100 claims per year.

Another barometer, though even less accurate, is gross annual premium expenditure. Workers compensation premiums (especially under retrospectively rated plans) and other casualty lines exceeding \$100,000 in premium per line may indicate a need for an RMIS.

Finally, there are unique needs. Perhaps some companies have a large number of properties they own, rent or manage that require periodic replacement cost valuations. Other companies may have several locations upon which to allocate costs.

- Independent collection of data.

An RMIS provides the opportunity for independent collection of data to verify the information provided by the insurance company. Verification of such basic claims data as claimant name, date of accident and cost center can improve the accuracy of charge-back and cost-allocation

systems. Having correct information helps avoid those angry calls from the location managers complaining they have no John Jones working in their department.

Verification of claims assigned to retrospective adjustment can mean direct dollar savings. If you have ever checked the details of yearly retro adjustment, you may have found claims that were not yours. This type of error is very common. One single keystroke error by the data-entry clerk at the insurance company can take someone else's claims and charge them to your policy.

A few hundred-dollar claims that the insurance company assigns to your retrospectively rated program by mistake can cost your company thousands of dollars. An RMIS provides an easy and cost-effective means of checking the claim data used in the retro adjustment.

the system. You can generate a report whenever you want it—without a three-week or longer wait for the insurance company loss run.

- Better renewals.

A prime advantage of an RMIS to any sized organization is the better position a risk manager finds himself/herself in during renewals. Maintaining accurate exposure information (losses, payroll, employee number, property values, vehicle costs, etc.) is increasingly important to underwriters. They are apt to treat a renewal more favorably if the information is nicely packaged through an RMIS.

Moreover, much of the standard material continually requested by brokers and underwriters can be kept within the RMIS data base with updated adjustments as necessary. This will relieve the risk manager of burdensome, repetitive completions of

- Better reports.

Your insurance company may give you monthly or quarterly loss runs—and little more. The losses run may be an alphabetical list or in some other order, but you have no control over how the information is presented. An RMIS will give you more useful reports and give you more control over how and when the reports are produced.

The RMIS will have reports such as:

- ✓ Total claims by payment type.
- ✓ Total payments and reserve changes last month.
- ✓ A list of claims with payments or reserve transactions last month.
- ✓ Frequency and severity reports by cause of accident, cost center, time of day and many other factors.
- ✓ Employees with more than one compensation claim.
- ✓ Cost of risk allocation.

Of course, the RMIS will have the ability to produce lists of claims using many different selection criteria. Claims lists can be very useful. However, the analytical and summary reports produced by an RMIS will soon become the preferred way of looking at claim information.

With a claim list or loss run, you have to do the work of summarizing the data to turn it into useful information. This can be a very time-consuming task. The RMIS can take over this clerical task of summarizing the data and leave you with the time to interpret the information and use it. The data and report are unimportant. The use that you make of the information is most important.

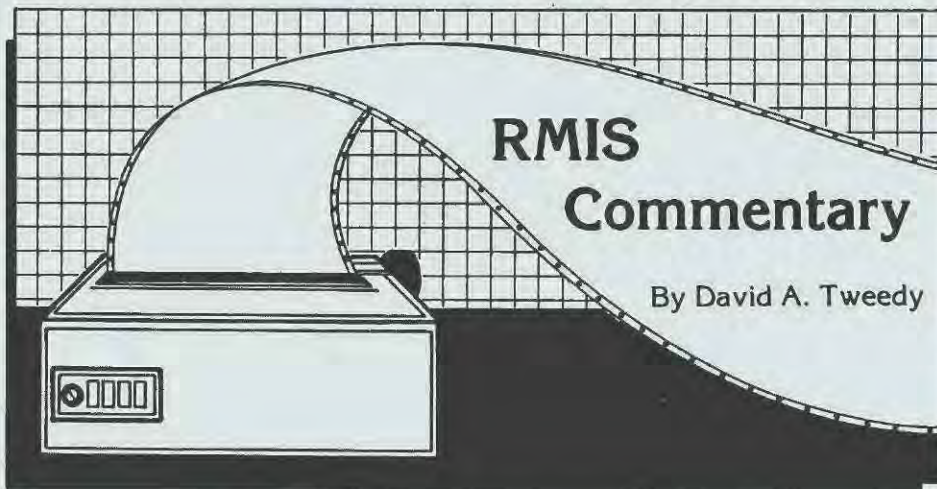
In summary, both large and small businesses can benefit from an RMIS. The benefits to the smaller business can mean better management of the claim and risk of the business.

There also can be direct dollar cost savings when an RMIS is used to check and verify insurance company information such as a retrospective policy adjustment.

All businesses with high claims volumes, no matter what their sales, are candidates for an RMIS. Construction firms, municipalities, amusement parks, retail operations, heavy manufacturing, restaurants and other industries tend to have large numbers of claims. They all should consider a risk management information system.

David A. Tweedy is a risk management consultant for D.A. Betterley Risk Consultants Inc. in Worcester, Mass. He is the assistant editor of Betterley Risk Management Commentary and the author of RMIS Update, a yearly

publication analyzing major risk management information systems and vendors. His column on risk management information systems appears the third Monday of the month.



- Better information.

Insurance companies collect only the data they need for their own use in adjusting the claim. This is usually very limited and always in their own coding system. Important information about the claim can be lost. By having an RMIS, safety data and other information can be saved for use in studies to aid in the prevention of accidents.

Preventing just one accident could pay for the entire cost of a small stand-alone RMIS. Additional data that you may want to collect that the insurance companies do not provide includes:

- ✓ A complete description of the accident, instead of a code that does not apply to your industry very well.
- ✓ Your own claim number to track the claim.
- ✓ The physical place where the accident happened.
- ✓ OSHA severity information.
- ✓ The name of the supervisor on duty.

- Timely collection of data.

Insurance companies can be very slow in collecting and providing claim data. It is not unusual for months to elapse before a claim shows up on the loss run from the company. This delay can prevent you from taking actions to hold down the cost of the claim.

An RMIS gives you control over how fast data is collected and entered into

applications.

- Data control.

With your own RMIS, you own the data. This becomes very important when you want to market your program to different insurers. You can produce the "hard copy" loss information that all underwriters require before evaluating you as a risk.

Besides providing the underwriter with just a loss run, you can give them reports that analyze and summarize your claims. These reports can emphasize your company's positive steps in controlling its risks.

For example, suppose you had a high frequency of claims resulting from a specific operation associated with the manufacture of a now-discontinued product. A frequency report showing claims resulting from that product and after it was discontinued could convince the underwriter that you are an improved risk. A simple loss run from the insurance company would not show this improvement in your operations.

After changing insurance companies or if there is more than one company providing coverage at a time, the RMIS provides a common data base combining the data from all the companies into one system. Reports can be run combining all this data and using one set of meaningful codes and descriptions.



New consultant specializes in HMOs, PPOs

Health Systems Management Inc. is a new consulting firm specializing in health care delivery systems, such as health maintenance organizations and preferred provider organizations.

"We'll work with insurers, employers, HMOs, PPOs, providers, hospitals and trade associations," among others, said Laird Miller, chief executive officer of the Minneapolis-based firm.

Services provided by Health Systems Management include negotiating preferred provider contracts, benefit plan design and health care purchasing strategies, he said.

Mr. Miller is the former director of health systems for Minneapolis-based Honeywell Inc.

He also is a member of a joint task force of the Washington Business Group on Health, an employer health care coalition, and the Group Health Assn. of America, a Washington-based trade association representing prepaid health plans.

The task force was organized to work on solving problems between employers and alternative health care delivery systems. The group recently developed a standard data form to be used by health maintenance organizations in reporting health care data to employers (BI, Dec. 15, 1986).

markets

Health Systems Management is located at 2840 W. River Parkway, Minneapolis, Minn. 55406; 612-729-1733.

Broker McAlear sold

Grand Rapids, Mich.-based wholesale broker, McAlear Associates Inc., has been sold for \$18.5 million to Willis Faber Europe B.V., a subsidiary of London-based broker, Willis Faber P.L.C.

McAlear, which was owned by Harleysville Group Inc. of Harleysville, Pa., specializes in placing excess coverages for manufacturers, public entities and recreational facilities. The wholesale broker had 1985 premium volume of more than \$90 million and gross revenues of about \$8.4 million.

McAlear will retain its name, locations and operations, said Chairman Charles A. McAlear.

Municipal program

Broker Alexander & Alexander Inc.'s Financial Products Group and AMBAC Indemnity Corp. are establishing a joint program to help municipal self-insurance programs pay liability claims by guar-

anteeing renewable lines of credit with banks.

A municipality can use the Municipal Liability Claims Funding program to help it establish a line of credit with a bank, preferably a local bank, for a set period of time, usually one year.

The municipality pays a fee for the bank's promise that if the municipality needs money to pay a liability claim, the bank will issue a loan up to a predetermined amount. Interest rates may be set according to an agreed-upon formula, although the terms and conditions of the line of credit are determined by the local bank and AMBAC, AMBAC officials said.

A municipality can establish a line of credit ranging from \$2 million to \$50 million to pay claims related to public officials, police professional and miscellaneous general liability exposures. The funds also could be used to fill in gaps at various levels of a municipal program.

The municipality can repay a loan through general revenues or a general obligation bond, said Merry K. Anderson, first vp-marketing for AMBAC Indemnity Corp.

Should the public entity default on the loan, the bank is protected through an AMBAC guarantee, Ms. Anderson said.

"We expect that banks will be able to offer municipal entities lower commitment fees and interest rates as a result of the loan guarantee. In addition, banks should be more likely to lengthen the maturity of the loan facility while relying on AMBAC's underwriting expertise," said H. Russell Fraser, AMBAC's president and chief executive officer.

"The program provides municipalities or their self-insurance facilities with a flexible alternative that can complement or replace traditional insurance and financing programs," said Michael K.

White, A&A's president and chief executive officer.

For more information on the new facility, contact Karen Bellus, Vp, Alexander & Alexander Inc., 220 E. 42nd St., New York, N.Y. 10017; 212-973-4200.

ISP Services Division

Insurance Software Packages Inc. of Tampa, Fla., has formed a new insurance services division.

ISP Services Division offers comprehensive medical claims cost control services, such as claims reviews, medical case file evaluations and staff training.

Insurance Software Packages provides software systems for the administration of workers compensation, health benefits, commercial auto, general liability and property claims management.

The firm is located at 5118 N. 56th St., Tampa, Fla. 33610; 813-621-6069 or 800-237-8133.

New EIL captive

Alexander & Alexander Inc. will hold meetings this month to provide information on the new risk retention group the broker is organizing to provide primary environmental impairment liability coverage to small and medium-size companies.

The risk retention group—whose official name will be Environmental Protection Insurance Co.—will be chartered in Illinois, said A&A vp Harry Shuford in New York.

EPIC, which could issue its first policies in July, will offer coverage of \$5 million per claim and \$10 million annual aggregate on a claims-made form.

In providing more details on EPIC, Mr. Shuford said EPIC's premium volume could hit the \$50 million mark during the group's first full year. The average premium is expected to be about \$100,000. Premiums will be based on risk assessments and a rating plan. The range of expected premiums was not available.

Capital for EPIC, a stock com-

pany, will be raised by contributions by member-owners. Mr. Shuford said capital contributions could range from \$20,000 for a policyholder with a single low risk site to \$1 million or more for those with a high number of high-risk sites. The average capital contribution is expected to be about \$100,000.

Shand Morahan & Co. Inc., will act as EPIC's underwriting manager and provide claims administration and defense coordination.

Technical services will be provided by Environmental Strategies Corp. of Washington, D.C. The law firm of Lord, Bissell & Brook in Chicago will act as EPIC's corporate counsel.

A&A anticipates that EPIC could attract as many as 500 participants.

Meeting dates include: Jan. 22 in Chicago; Jan. 23 in New York; Jan. 26 in Boston; Jan. 27 in Atlanta; Jan. 28 in Los Angeles; Jan. 29 in Houston; and Jan. 30 in Dallas.

For more information, contact W. Lee Carter III, director of research and development, Alexander & Alexander Inc., 717 N. Harwood, Dallas, Texas 75201; 214-880-0321.

Mergers/acquisitions

Affiliated Insurance Consultants Inc., a Western Springs, Ill.-based brokerage firm, has acquired **Hamilton Grant Corp.** Hamilton Grant Corp. is an insurance agency based in Oswego, Ill.

Beech Street Inc., which specializes in health care cost and quality management, has acquired **General Health Inc.** of Washington, D.C. General Health specializes in health claims analysis and health risk appraisals of employee groups. General Health will remain at its current location, operating as a subsidiary of Atlanta-based Beech Street.

The two Baltimore-based actuarial and benefit consulting firms of **Offutt Group and Bolton Associates Inc.** have merged to form **Bolton Offutt Co.** The new firm offers total benefit consulting services, including the areas of health, pension and retirement savings plans.

The Hartford Steam Boiler Inspection & Insurance Co. has acquired **Professional Loss Control Inc.**, an engineering services company in Oak Ridge, Tenn., specializing in fire protection and environmental services. Hartford Steam Boiler insures machinery, equipment and property and provides related inspection and engineering services.

Partners National Health Plans has acquired San Bernardino, Calif.-based health maintenance organization company, **Inland Health Care Inc.** The company's HMO, Inland Health Plans, provides health care for 56,000 members through a network of 53 hospitals and about 2,000 physicians. The acquisition is part of Partners' market strategy to develop and acquire local HMOs to form a nationwide health plan network. Partners is a joint venture between Aetna Life Insurance Co. and VHA Enterprises Inc., the equity arm of Voluntary Hospitals of America.

Chicago-based broker **Rollins Burdick Hunter Co.** has acquired five regional insurance agencies for a total purchase price of about \$40 million. The acquired agencies are: **Allen, Hart, Franz & Zehnder** of Los Angeles; **Pilot Insurance Agency** of Winston-Salem, N.C.; **Schroeter, White & Johnson** of Oakland, Calif.; **Springhouse Financial Corp.** of Philadelphia; and **Todorovich Insurance Agency** of St. Louis. ■

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Serious inquiries with regard to syndicate formation, investment or management may be addressed to the attention of Larry J. Spilkin, General Counsel.

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C.E. Heath rebuilds

Continued from page 3

• The August resignations of the three North American division directors, including division Chairman Nigel Chamberlain. All three men joined Stewart Wrightson Holdings P.L.C.

Heath may have lost as much as 8 million pounds (\$11.8 million) in North American brokerage and 7 million pounds (\$10.3 million) in profits because of the resignations, sources have said.

"The defection of Heath's U.S. team saw a significant and serious loss of business, presenting us with a serious problem but an exciting challenge," Mr. Fielding admitted to *Business Insurance*, although he would not say how much business has been lost. "We have lost a lot of business. There is no use denying that."

"But U.S. broker Rollins Burdick Hunter (which provides most of Heath's North American business) remains very supportive of Heath. We have lost part of their business, but much of that went self-insured."

• An unfriendly takeover attempt launched by PWS Holdings P.L.C. in October.

The 6-month-old holding company for Lloyd's broker Pearson Webb Springbett Ltd. proposed a stock swap for Heath worth 180 million pounds (\$266 million), which Heath's board described as "unsolicited, opportunistic and inadequate" (*BI*, Oct. 27, 1986).

In a 22-page report to shareholders, Heath pointed out that there would be mass defections if PWS took over the company.

Instead, Heath shareholders supported a 71 million-pound (\$105 million) merger with Fielding Insurance, which was consummated on Nov. 21. Fielding was 81% owned by investment bank Hambros P.L.C.

Mr. Fielding, the chief executive of Fielding Insurance, became chief executive of Heath, replacing Peter Methley, who resigned after only one year with Heath.

• The mass resignation, despite the Fielding merger, of 28 Heath employees in December to join Lloyd's broker Citicorp Insurance Brokers Ltd. The resignations are effective this week (*BI*, Jan. 5).

The Heath employees joining CIB this month include John Bassett, chairman of the aviation division; John Percy-Davies, chairman of the international division; Tony Frost, chairman of the marine division; Tony Hamilton, chairman of the Latin American division; and Hugh Tilney, director of C.E. Heath Development.

The Heath employees approached Citicorp when PWS made its unfriendly takeover bid because the employees were concerned that PWS might acquire Heath, said Mr. Tilney.

"It was nothing negative towards Fielding," he said. "Then we realized just what a big opportunity Citicorp was."

"We saw Citicorp as a marvellous opportunity," added Mr. Tilney. "Everyone in the market recognized Citicorp as a potential major broker wanting to build itself."

On the day the mass defection from Heath occurred, Heath's share price dropped 6% to 4.35 pounds (\$6.40) per share.

Mr. Fielding admits that there will be repercussions affecting Heath's business following the mass defection, believed to be the biggest ever in London's insurance brokering sector. However, he will not elaborate.

• The resignation of Heath Chairman Derek Newton.

Mr. Newton announced on Christmas Eve that he was resigning after only two years in office, to be replaced by Mr. Fielding.

"After nearly 30 years with Heath, I am sad to be leaving the company,"

Continued on page 26



Mr. Fielding

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update

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Heath rebuilds

Continued from previous page
said Mr. Newton. "But, I believe that shareholders' interests are best served by my making room for new management."

• The retirement of Brian Juggins, co-founder of Fielding Insurance Holdings, announced earlier this month. Mr. Juggins had been working part time for Fielding for the last two years.

Despite Heath's troubles, Mr. Fielding said in an interview late last year and in subsequent conversations that he is confident he can turn the brokerage around.

For example, earlier this month, Mr. Fielding hired Dick Owles as managing director of Heath's North American division. Mr. Owles, who resigned as chairman of Gallagher Plumer Ltd.'s North American division, will be joined by Robert Alldis, another former Gallagher Plumer staff member.

Mr. Owles helped set up Gal-

lagher & Co. (U.K.) Ltd.'s North American division 10 years ago and became chairman and managing director of the division following last year's merger of Gallagher (U.K.) and Plumer & Co. Ltd. Before that, he worked for 10 years at Stewart Wrightson P.L.C. under U.S. casualty broker Pat Osborne.

In addition, Fielding Director Paul Hughes has become administrative director of Heath's North American division.

Mr. Fielding also has replaced four defecting Heath divisional executives with Fielding directors. Callum Stewart will become chairman of Heath's aviation and aviation reinsurance divisions; Michael Kier will become chairman and managing director of Heath's Latin American division and chairman of the international division; John Mackenzie-Green will become managing director of Heath's international division; and Anthony Money will become chairman of C.E. Heath (Insurance Broking) Ltd.

John Sheldon, a partner of Gough & Sheldon Ltd., which was 51% owned by Fielding, has become chairman of C.E. Heath & Co. (Marine) Ltd. and C.E. Heath & Co. (Marine Reinsurance) Ltd. in the restructuring of Heath's marine insurance and reinsurance divisions.

In addition, Hambros—the investment bank that now owns 16.8% of Heath following the merger with Fielding—will strengthen Heath's position in the market, Mr. Fielding predicts.

Mr. Fielding also believes the Fielding merger can contribute a great deal to Heath's recovery.

For example, Heath will focus on brokerage—which comprised 100% of Fielding's revenues—instead of underwriting, which comprised 45% of Heath's revenues, he said.

Also, Mr. Fielding said he is determined to change the style of management at Heath. Mr. Fielding, a broker for 30 years, believes that Heath must be run by people with solid brokering experience.

"Brokers need a carrot and stick type of management. They need motivation. They also need to know that if necessary, you can pick up the slip yourself and go and broke it."

Mr. Fielding, now 53, is no stranger to Heath. He first joined Heath in 1968 when he was invited by the company chairman to run the reinsurance division, after spending 14 years with broker Bland Welch Ltd., which since has merged into Sedgwick Group P.L.C.

Mr. Fielding rose through the ranks of Heath—first in the international division and then with the U.K. division—until he became joint managing director of the group.

"Then, in 1975, they kicked me out following disagreements over how the company should be run," Mr. Fielding said, explaining that he disagreed with Heath's management structure at the time.

"No format of management was given to executives. There was no discipline and no method of reporting. The whole thing had got out of control," he said.

Mr. Fielding subsequently established his own brokerage, with majority backing from Hambros, an investment bank. Fielding Insurance, known as a non-North American insurance and reinsurance broker, was doing so well after a decade in business that it planned to be listed on the London Stock Exchange prior to the merger with Heath, he said.

Now, with the merger behind him, Mr. Fielding said he is confident about Heath's future.

"We already have a big international account which we would like to see grow. Further acquisitions are not a priority. We have got to get this company in a better shape before we can start approaching others."

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ABA report

Continued from page 1

The report also will be considered by the ABA House of Delegates, the ABA's policy-making body, in what promises to be a hotly contested debate at the ABA's midwinter meeting next month in New Orleans.

Commission members would not predict whether the report would be approved by the House of Delegates, but several attorneys said they thought the report and its recommendations would be adopted.

While the report does not recommend drastic alteration of the tort system, it does recommend some controversial changes.

"The system on the whole is about right," Professor McKay said last week, noting that the tort system needs "fine tuning" rather than major changes. "Many of the recommendations have to do with process."

Among the recommendations in the report are that:

- Limits should not be placed on the size of awards for pain and suffering, but trial and appellate courts should more aggressively use their power to reduce excessive verdicts or to increase awards if they are too low. In addition, the commission recommended that judges should give more guidance to juries on the range of damages appropriate for pain and suffering in a particular case.

- Punitive damages should be awarded only where the defendant's conduct indicates substantially greater indifference to the safety of others than ordinary negligence. Examples include intentional conduct or conduct in conscious disregard of others' rights.

- Punitive damages should be awarded in cases in which the plaintiff proves the defendant's misconduct by the strict standard of "clear and convincing" evidence, rather than a preponderance of evidence.

- A certain portion of punitive damage awards should go toward "public purposes" rather than solely to the plaintiff and his attorney.

- The doctrine of joint and several liability should be modified so that defendants whose responsibility is "substantially disproportionate" to the liability for the entire loss are liable only for their share of the plaintiff's non-economic damages. Joint and several liability for economic loss should not be reformed, the report says.

- Contingent fees should be based not on the gross amount of recovery, but on the net amount recovered after litigation expenses such as filing fees, deposition costs and fees for expert witnesses. Whenever a judgment is entered in a court case, fee amounts for each party should be submitted to the court, which would have the authority to disallow any portion of a fee found to be "plainly excessive."

- Alternative dispute resolution mechanisms should be encouraged in both federal and state courts.

Other recommendations by the commission include streamlining the litigation process through various methods of discouraging frivolous claims and unnecessary delays and limiting secret and coercive agreements between defendants' and plaintiffs' attorneys.

The report also recommends that the ABA establish a commission as soon as feasible to study the problem of mass torts, like asbestos injury litigation.

Last week, insurance industry officials and defense attorneys were cautious in their comments about the report, though they generally approved the ABA's attempt to develop a consensus from widely divergent groups.

"I think it is a very, very substantial contribution to the subject matter under discussion," said

Bert M. Thompson, senior vp and general counsel for Evanston, Ill.-based underwriting manager Shand, Morahan & Co. Inc.

It is a "very favorable development" that the ABA recognizes the tort liability system is a dynamic one and that some adjustments should be to make it fairer for all parties, said Mr. Nutter.

Mr. Harkavy endorsed the report's position on punitive damages, particularly that they should be donated for a "public purpose."

Mr. Thompson also applauded the tougher standards for punitive damages recommended by the report because the potential for punitive damages distorts and increases the settlement value of tort cases.

But while Mr. Harkavy said he welcomed the report's recommendation on joint and several liability, he said any restriction on joint and several liability should apply to both economic and non-economic

Continued on next page

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ABA report

Continued from previous page
economic damages. However, "I'll take what I can get," Mr. Harkavy said.

Applying any reform of joint and several liability only to non-economic damages is a compromise that mirrors legislation enacted in several states, Mr. Nutter said. The commission "would have been better advised to evaluate the merits of the joint and several issue."

Mr. Nutter also noted that the report recommends that judges closely and aggressively review non-economic damage awards and examine attorneys' fees so they are commensurate with time and services rendered.

"Greater judicial activism on awards and fees is very appropriate and commendable," he said.

Despite the dissents by some members of the commission, Mr. Harkavy also applauded the fact that the ABA addressed the tort

issue separately from a study of the liability insurance crisis.

"We want the tort system evaluated on its own merits," he said.

While industry officials were generally pleased with the recommendations, some were critical of the report.

John B. Crosby, senior vp and general counsel for the National Assn. of Independent Insurers, criticized the ABA for being behind the times and failing to adequately address major tort reform issues.

"It shows how irrelevant and out-of-touch the ABA is with the legal community and the clients they purport to represent," he said.

Mr. Crosby also criticized comments in the report that said there has not been a litigation explosion. The report "does not adequately address the impact that lawsuits have on the insurance claims process," he said.

In addition to the belief that the commission also should have examined the role of the insurance industry, the dissenting commission members and some plaintiffs' attorneys also objected to the report on other grounds.

Judge Carrigan said in his dissent that the report's recommendations would sacrifice victim's rights for defendants' interests.

"Many of the commission's action recommendations would reduce or eliminate rights presently held by innocent tort victims—the 'consumers' of tort law," he said.

"No action recommendations would diminish the rights of defendants or their insurers. Thus, the clear implication of the overall report is that plaintiffs and their lawyers, along with juries and judges, have somehow created a 'tort crisis' that can be cured or alleviated by these recommended actions," he added.

Plaintiff's attorney and commission member Leonard Decof said he did not agree with the recommendation that judges take a greater role in approving attorneys' fees.

"There are implications of lawyer-bashing in the report," said Mr. Decof with the Providence, R.I., firm of Decof & Grimm.

Mr. Decof also objected to the recommendations for stricter standards on the awarding of punitive damages, though he did not oppose the proposal that some punitive damages be used for a public purpose.

Plaintiffs' attorney Leonard Ring, who was not a member of the commission, also objected to the recommendation that judges become more actively involved in the awarding of damages for pain and suffering—to the point of recommending a range of awards given in previous cases.

"That to me is an encroachment on the jury system," said Mr. Ring with the Chicago firm of Leonard M. Ring & Associates.

He explained that no two cases are the same, and added that it is meaningless and misleading to compare pain and suffering awards in different cases.

However, Mr. Ring speculated that the full ABA House of Delegates would approve the report, in part because it does not support caps or make major inroads into the tort system. "They are mostly procedural changes," he said.

The report is an outgrowth of an ABA committee chaired by former U.S. Attorney General Griffin Bell that resulted in "Toward a Jurisprudence of Injury: The Continuing Creation of A System of Substantive Justice in American Tort Law," a systematic review and evaluation of the tort system completed in late 1984.

While the Bell committee did not recommend specific tort reform proposals, the Action Commission to Improve the Tort Liability System was formed in 1985 to address specific tort reforms.

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Indictment

Continued from page 2

On Feb. 24, 1986, Mr. Shah told "an individual purporting to represent" Philadelphia National Bank that Westtown had invested \$5 million with Union Guaranty in September 1985, even though he knew no such investment was ever made, the indictment charges.

Mr. Shah then produced a fake, back-dated receipt on Union Guaranty letterhead purporting to show its receipt of \$5 million from Westtown, the indictment alleges. Mr. Shah also produced a back-dated letter from Cambridge General purporting to induce Westtown to deliver \$5 million to Union Guaranty by unconditionally guaranteeing repayment of the obligation, the indictment charges.

Mr. Shah agreed to deliver the phony receipt and the Cambridge General guarantee to the bank before disbursement of the loan proceeds, the indictment says.

Meanwhile, Mr. Shah had created a document to cancel Union Guaranty's and Cambridge General's potential liability to Westtown for the fictitious obligation, the indictment says.

Mr. Shah—who the indictment says was to receive \$2 million of the loan proceeds—said he wanted the money certified in the financial statement of a domestic insurer, then moved to a reinsurer, then moved again to an investment company to make the \$2 million look like a \$6 million asset, the indictment says. It does not name any of the companies that were to be involved in these transactions.

Ronald K. Noble, assistant U.S. attorney in Philadelphia, would not elaborate on the indictment or comment on the charges.

Mr. Shah pleaded not guilty at his arraignment last month and was freed on \$50,000 bond, Mr. Noble said, adding a plea bargain agreement is being discussed.

Mr. de Luca said "a variety of negotiations" are in progress and that a trial date is set for sometime in March. He added Mr. Shah was not an owner of either Union Guaranty or Cambridge General.

In the meantime, the New York and New Jersey insurance departments are investigating Mr. Shah's connections with Cambridge General—formerly known as Union Guaranty Insurance Co.—and other offshore property/casualty reinsurers, including:

- Marble Arch Insurance Co. of Tortolla, British Virgin Islands.

- Great Intercontinental Insurance Co., also domiciled in Tortolla and formerly known as Matterhorn Insurance Co.

- Universal Casualty & Surety Co. Ltd., domiciled in the Cayman Islands and now in liquidation.

During a July 1985 attempt to serve subpoenas, New York department investigators found that Great Intercontinental was being operated from a studio apartment maintained by Mr. Shah in Manhattan, Mr. Randolph said.

Mr. Shah, who returned to the apartment while investigators were there, fled when he saw them, Mr. Randolph said.

Mr. Shah later was served with a subpoena to testify before department investigators, but successfully contested the subpoena on the grounds of ill health, Mr. Randolph said.

Universal Casualty—which Cayman regulators petitioned to wind up in 1984—is insolvent by about \$16 million, said Allan Gee, senior manager of Ernst & Whinney in Cayman and court-appointed liquidator for Universal Casualty.

Liquidators have been unable to locate any of Universal Casualty's assets—thought to have exceeded \$10 million—other than about \$440,000 in reinsurance recoverables, Mr. Gee said. He is also uncertain of Universal Casualty's ownership, explaining that as

many as eight individuals or entities—including Mr. Shah—may have had ownership interests.

A federal bankruptcy court judge in New York has ordered Mr. Shah to turn over all assets of Universal Casualty within his control, but no such assets have yet been turned over, Mr. Gee said.

Ceding insurer clients with claims against Universal Casualty include the defunct Kenilworth Insurance Co., which claims it is owed \$3.3 million, according to a report to Universal Casualty creditors. In addition, Fremont Indemnity Co. is owed \$3.5 million on paid claims, said Alan Faigin, vp and assistant general counsel.

The New Jersey department's investigation of Mr. Shah is focusing on Cambridge General, according to Stanford Tice, director of the department's fraud bureau. Premiums due Cambridge General were paid into a bank account at First Fidelity Bank in Hoboken, N.J., Mr. Randolph said. ■

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Administrative:

CEO's Presidents and Owners 2,803
Vice-presidents, General Managers and Other Administrative Personnel 2,601

Financial:

Chief Financial Officers and Vice-presidents of Finance 1,890
Secretaries, Treasurers, controllers and other Financial Personnel 6,127

Risk/Employee Benefits:

Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations 7,471
Sub-total 20,892
Associations 477
Government, Unions and Educational Institutions 1,357

Commercial Consumers

Sub-total 22,726
Insurance Agents and Brokers 10,795
Insurance Companies 7,168
Financial Institutions 897
Actuaries, Attorneys, Adjusters, Appraisers and Consultants 4,536
Others Allied to the Field 1,505
TOTAL 47,627

* Source Business/Occupational breakdown of qualified circulation, May 26, 1986 issue, as submitted to BPA for June 1986 BPA Publisher's Statement.

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Texas HMO fund

Continued from page 3

noting the most of an insolvent HMO's liabilities would be owed to providers rather than enrollees.

If a proposal for a guaranty association is drafted by state officials, it would spark a "bloody battle" between the state's HMOs and the proponents of such a proposal, she said.

Any proposal to establish an HMO guaranty fund must be approved by the Texas Legislature.

Ms. Ireland would not release details of the compromise proposal her group is submitting to the insurance board.

Sandra Person, executive director of the Houston Area Health Care Coalition, noted that the state board is "about five years too late."

The proposal "was born out of a problem in 1982," when several Texas prepaid health care plans became insolvent and the state

first started talking about an HMO guaranty fund, Ms. Person said. "And now that HMOs are growing, there is still that lingering doubt."

"But the truth is, HMOs are well-funded and a guaranty fund is not needed," she said.

Under the state board's proposal, participation in the guaranty association would be mandatory and it would assess all state HMOs only when the insurance commissioner determines an HMO is impaired and "well on its way to becoming insolvent," Mr. Pogue explained.

That assessment would be used to pay the impaired HMO's uncovered liabilities, but annual assessments would not exceed 0.5% of an HMO's total premium volume.

Ms. Ireland said a premium assessment could total as much as \$3.25 million, based on 1986 premium volume of \$650 million.

The proposed guaranty fund would cover such liabilities as the medical claims of plan participants not covered by hold-harmless agreements between an HMO and health-care providers. Providers that sign such hold-harmless agreements cannot take action against an HMO enrollee to recover amounts owed by an HMO.

But, the HMO association also is concerned that if a guaranty association is created, providers in the state may be reluctant to sign hold-harmless agreements, believing it would be easier to receive payment from the fund than try to collect from insolvent HMOs.

Mr. Pogue said the earliest the Legislature would approve any proposal would be Sept. 1, explaining, "We're a long way from finalizing anything."

D&O survey

Continued from page 3

fecting more than corporate insurance expenditures.

"There was a time when the allure, the status of being on someone's board, was not an insignificant part of being asked to serve," said Charles C. Ratigan, partner and manager in the Chicago office.

But, Mr. Ratigan notes, that was before the number of lawsuits—and awards—against corporate directors began to skyrocket. Today, he says, "An individual asked to join a board finds himself or herself financially at risk."

Fewer executives are willing to take that risk, the survey notes, especially at corporations that have been unable to find D&O coverage. More than three-quarters—76.8%—of the board chairmen surveyed said they would not serve on a board that did not offer D&O coverage, the study shows.

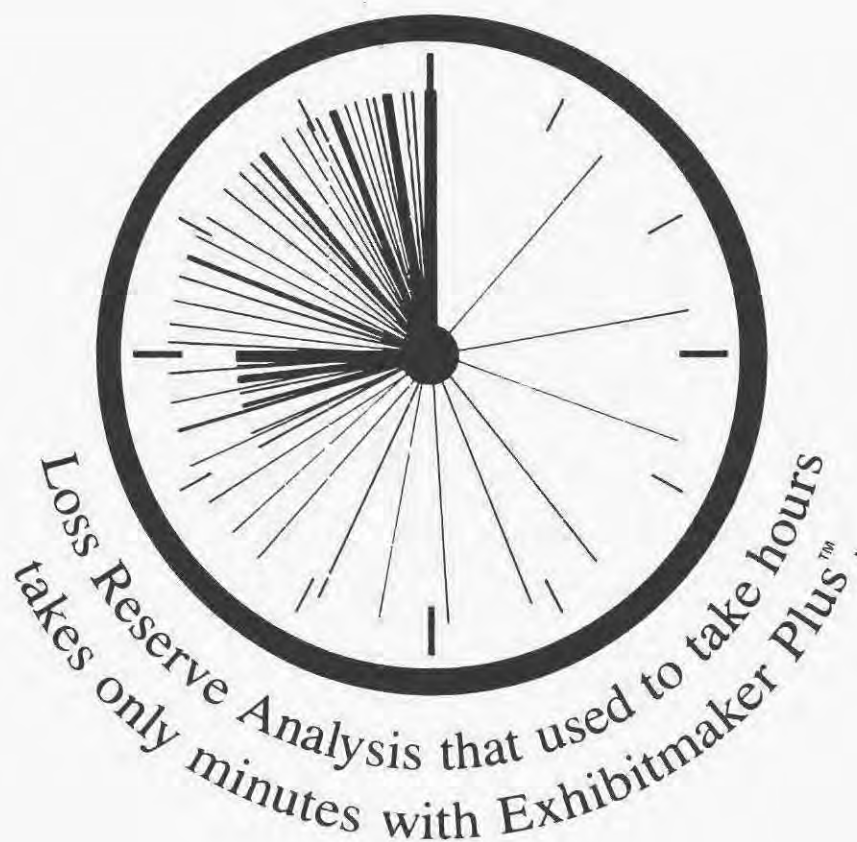
And, the percentage of outside directors decreased for the first time since 1979. In the 1986 survey, the board chairmen of the country's largest companies reported that 57.5% of their members are outside directors, compared with 63.2% in similar survey in 1985.

Corporate officers now account for 33.8% of the membership of these boards, while the remaining 8.7% is made up of company-affiliated non-management members.

But, Mr. Ratigan says there is a positive aspect of the D&O crisis: "The individuals, if they choose to join a board, knowing what is at risk, will do a better job," he said. "They will be more inclined to render independent thought, do better research... and be more inclined to speak their mind, because they personally have more at risk."

The study notes that 90% of the chairmen surveyed rank their board's performance in protecting corporate assets for the long-term interests of shareholders as outstanding or above average.

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BI 1/19

Positive stance

Continued from page 3

Mr. Bailey, who said he agreed with Mr. Goodfriend that insurers' results will improve, added that "by and large" the industry will have used up its tax loss carryforwards by 1988, putting it in a taxable position in 1988. And, because taxes will contribute to the cost of doing business, insurers are not about to slash prices, he said.

Mr. Goodfriend also said that insurers having difficulty recovering from the soft market will be forced to consider whether they should remain independent, or merge.

"If they don't, I think others will," he added, referring to the possibility of takeovers.

But new capital will not create another "amateur night," such as that which occurred in the last cycle, when companies from the industrial sector that were unfamiliar

with insurance got into the business, said Mr. Goodfriend.

Instead, he said, much of the new capital will come from Europe and Japan, where companies prefer to work with the U.S. insurance industry on a joint-venture basis.

However, "if that doesn't work," he said, then over the course of time a "force majeure" may result, prompting unfriendly takeovers.

Mr. Goodfriend also stressed the importance of cutting the insurance industry's expense ratio by at least five to seven points. If insurers fail to reduce expenses, he warned, "somebody's going to do it for them."

Obviously, however, the industry's "main thrust" should be on trimming its loss ratio, he added.

In response to a question on the Risk Retention Act amendments, Mr. Tasco said: "We think it's going to have a tremendous impact, and we're getting ourselves ready to

deal with it." The amendments allow special multiowner captive insurers, called risk retention groups, to operate nationwide to provide member-owners with all types of commercial liability coverages except workers compensation.

He later added, however, "We are almost totally dependent on the traditional market" and remain committed to it.

Because buyers felt they were dealing with a commodity during the soft market, "they lost the sense of the value of insurance," Mr. Tasco noted. There was "tremendous surprise" when capacity was cut in 1984, he said, adding that buyers are "now possibly beginning to realize" the importance of insurance.

To avoid having insurance regarded as a commodity, he said, other factors, including insurers' financial stability and continuity, must be stressed. "We're going to work with you as much as we can to see that pricing is kept in a proper perspective," he said.

"One of the things that's always confused me is the inability of this industry to get any credit for continuity," said Mr. Bailey.

The industry also should take a positive approach when dealing with opponents of civil justice reform, Mr. Bailey said.

A "real industry communication challenge exists" because even significant tort reform changes are not immediately reflected in significant price changes, said Mr. Donald, though he added, "We have now, at least, made a case that the public has become interested in."

Mr. Bailey, said he feels "enormous surprise and satisfaction" over the fact that from a "standing start" 18 months ago, there have been at least modest tort reform measures approved in 39 states.

The push for tort reform must continue, he said.

Mr. Bailey will advocate civil justice reform in advertisements beginning this Friday in The Wall Street Journal.



Mr. Bailey



Mr. Goodfriend



Mr. Tasco



Mr. Donald

Flex rating won't work, former regulator asserts

By JUDY GREENWALD

NEW YORK—Flex rating systems are the wrong approach to solving the insurance industry's pricing problems, says a former New York insurance superintendent.

Rather, letting the competitive market function and largely balance itself is "certainly the best system for today and for the foreseeable future," said Richard E. Stewart, who is now chairman of Stewart Economics in New York.

Mr. Stewart made his remarks at the Insurance Services Office's and Insurance Information Institute's annual meeting and industry conference in New York last week.

Recalling monopolies, rating boards and bureaus and prior approval of rates in the past, he noted that "today's way of suppressing competition is a modified prior approval called band or flex rating," which permits price variation within certain limits without government approval. Approval only is needed to adjust prices beyond those limits.

The New York and Washington insurance departments both promulgated flex rating regulations last year (BI, Jan. 5; Sept. 22, 1986).

While flex rating is a "well-meant" idea, it cannot work, Mr. Stewart said. "The cost in suppressing competition would be much higher than widely supposed and, even so, the benefits would not arrive."

Flex rating cannot bring price stability, because the modern commercial insurance industry "has too many pricing points...to control," he explained.

Factors such as "coverages, deductibles, experience adjustments and dividends..." are complex, he said. "They vary from risk to risk and day to day," and are largely decided jointly in the field by the broker and underwriter.

"Insurance is always in tension between charging everyone the same and charging each according to his likelihood to have a loss," he said.

The "last chance" for flex rating, or for meaningful prior approval of any kind, was 40 years ago, when manual rates were closer to market prices, coverage variations were limited and the insurance business was dominated by local independent agents, he contends.

But this is not the case today, Mr. Stewart said, noting that "band or flex rating lives in nostalgia even more than in hope."

"The only chance for regulation to work is to kill price competition first, just in order to have something to regulate," Mr. Stewart said. "Usually, we think of lack of competition as a result of regulation but, at least in insurance, it's really a precondition."

In addition to the problems associated with stifling competition, flex rating perhaps would be most disastrous in special lines, where statistics are least credible because of the size of the market. "In just those areas, a price problem translates most quickly into an availability problem," he said.

"The list of market prohibitions would constantly expand, for we are talking about re-establishing a cartel," Mr. Stewart asserted. Businesses and people "exercise creativity around the edges of cartels," and the "accepted way to pull them back into line is to extend the cartel's reach and power" by making regulation broader.

It might seem, nonetheless, that flex rating could work in small commercial lines, as it did in earlier years when small businesses mainly bought fire insurance, Mr. Stewart said.

But, the price of flex rating would be to deprive small business of most of the advances in competition and sophistication that occurred over the last 40 years, he said.

"The inevitably unsuccessful experiment with band or flex rating would have one last, rather sad, cost," Mr. Stewart said. "It would come when prices are leveling off and starting to decline, because prices do rather quickly reflect costs in a competitive insurance market. That would mean the effort to kill competition was unnecessary," he noted.

However, it also could be taken as evidence that flex rating was working, and therefore "beguile us to the thought of going back to an imaginary insurance world, where everybody won the benefits of competition and nobody paid for the prize," he said.

"The structure of the insurance market, the needs of customers and the limits of government power have put us in a competitive industry," he said. "We will end up there, however much we pay for detours of hope that we...ever can go home again" to a time when stable pricing was possible.



Mr. Stewart

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update

A&A, Posgate settle

Continued from page 2

Mr. Posgate sued A&A in October 1982 to get his job back (BI, Oct. 18, 1982; Sept. 27, 1982).

A&A settled in 1984 with the other ex-Howden directors—including Ronald Comery, who died in a car crash recently—for about \$21.6 million in recovered assets (BI, April 23, 1984).

A&A also recently collected \$24 million in a settlement with former Howden auditors (BI, Nov. 10, 1986).

HMO contribution rule targeted

WASHINGTON—The Reagan administration last week proposed dropping a rule requiring employers to make equal per-employee premium contributions to the federally qualified health maintenance organizations and indemnity plans they provide.

The so-called equal contribution rule—an integral part of the 1973 HMO Act—subsidizes an industry that no longer needs such protection, administration officials say.

The equal contribution rule is an unnecessary federal intrusion in the group health care market that can increase an employer's overall health care costs, said William L. Roper, administrator of the Health Care Financing Administration.

Employers have opposed the equal contribution rule, arguing they should pay HMOs less than indemnity plans because younger, healthier employees with fewer medical expenses are more likely to opt for HMOs than for indemnity plan coverage.

But James Doherty, president of the Group Health Assn. of America, an HMO trade group, blasted the administration proposal, charging that it would punish HMOs and enrollees.

Shand, Morahan may be sold

NEW YORK—Alexander & Alexander Inc. says it is considering selling Shand, Morahan & Co., its underwriting management subsidiary, which has a 52% interest in Evanston Insurance Group, the nation's sixth-largest surplus lines insurer.

Shand, Morahan ranked as the second-largest U.S. underwriting manager in 1985 with \$281.6 million in premium volume.

A&A, the nation's second-largest insurance brokerage, is considering "various options" regarding Shand, an A&A spokesman said. "One of the options may be a partial or total divestiture."

Such a transaction would reflect A&A's strategy to end its underwriting operations, the spokesman said. He said that A&A already has received inquiries from potential purchasers and has retained the investment firm Smith Barney Harris Upham & Co. Inc. in New York "to evaluate the options."

Employer Medicare plan offered

WASHINGTON—The Reagan administration will ask Congress for legislation permitting employers to provide Medicare benefits to retired employees through their group health care plans.

Under the proposal, Medicare would make monthly lump-sum payments—equal to about 95% of its per participant benefit costs—to an employer that assumes full responsibility for providing health care benefits to Medicare beneficiaries. Beneficiaries would have to select coverage through the employer.

If an employer could provide benefits at a cost lower than its reimbursement from Medicare, it could pocket the profits.

"We regard the private health plan option as a means to give Medicare beneficiaries greater choice in health care," said William L. Roper, administrator of the Health Care Financing Administration. "We think this greater choice will benefit all concerned with health care—consumers, providers and government."

Several firms have been involved in demonstration programs (BI, Sept. 29, 1986).

Briefly noted

The **Illinois Insurance Exchange's** estimated 1986 gross premium volume jumped more than 272% to \$253.6 million from \$68.1 million in 1985. The **Insurance Exchange of the Americas** in Miami estimates 1986 gross premium volume increased about 55% to \$204 million from \$132 million in 1985, and the **New York Insurance Exchange** estimates that gross premium volume was slightly less than \$300 million in 1986, about a 3% decline from the 1985 gross premium volume of \$309.5 million. . . . A federal judge has given **A.H. Robins**, the former manufacturer of the Dalkon Shield, until Feb. 5 to file a reorganization plan with the court. . . . Last week's termination of three hugely underfunded **LTV Corp.** pension plans will almost double the Pension Benefit Guaranty Corp.'s deficit to more than \$4 billion. . . . A federal appeals court last week said Union Carbide Corp. and the Indian government must have **equal access to evidence** in the Bhopal disaster case, but turned down Union Carbide's request for U.S. court oversight of Indian court proceedings. The court also rejected U.S. plaintiffs' attorneys request to determine the fairness of a \$350 million settlement offer made by Union Carbide last year, ending the role of U.S. plaintiffs' attorneys in the litigation. . . . States can require employers to provide **unpaid leave to pregnant employees**, the U.S. Supreme Court ruled last week in upholding a California law. . . . The establishment of a reinsurer to be owned by European policyholder-members may be delayed due to the **death of Hank W. Arntz**, founder of the reinsurer and risk manager of the captive insurance broker division of Dutch chemical company AKZO. . . . The Supreme Court will decide in what cases **military contractors** can avoid liability for accidents involving their products by claiming the products were manufactured to government specifications. . . . **Pinnacle Reinsurance Co. Ltd.** is asking a federal judge to reconsider his ruling denying Pinnacle's motion to dismiss it from a suit filed by liquidators of Mentor Insurance Ltd., arguing that the judge made a factual error in denying the motion.

Fire suits

Continued from page 3

In other legal developments last week involving the fire:

- Four plaintiffs' attorneys filed a petition with the U.S. Panel on Multidistrict Litigation in Washington to rule on which federal court should hear the cases for pretrial proceedings.
- The panel, which is composed of several federal judges, meets next in March.
- Plaintiffs' attorneys and hotel representatives—although denied access to the hotel pending completion of a criminal investigation—have worked out procedures for inspecting the hotel once they are permitted to enter. Attorneys expected approval from local judicial authorities would come early this week.
- The Puerto Rican Bar Assn. is investigating the conduct of plaintiffs' attorneys who allegedly approached victims of the fire. The Federal Bar Assn., which represents attorneys practicing before the federal court in Puerto Rico, also has been asked to join the investigation.
- Among the lawsuits filed so far include one on behalf of 21 fire victims and their families by attorney Jorge Ortiz Brunet in U.S. District Court in Puerto Rico.
- In all, the suit includes 32 plaintiffs.
- The suit names the San Juan Dupont Plaza Corp. and San Juan Hotel Associates, based in Dallas, and seeks \$21.6 million in compensatory damages, said Mr. Ortiz Brunet with the Hato Rey, Puerto Rico, firm of Ortiz Toro & Ortiz Brunet.
- The lawsuit does not seek punitive damages because they are prohibited in Puerto Rico.
- However, Mr. Ortiz Brunet pointed out that the prohibition may ultimately be challenged as unconstitutional.
- The plaintiffs include families of those who died in the blaze and persons who suffered burns or smoke inhalation. They include Puerto Rican and U.S. residents.
- Another suit was filed in federal court in Los Angeles on behalf of family members of Hector Miranda, a 52-year-old supervisor of croupiers who was working in the casino at the time of the fire.
- Mr. Miranda was supposed to be off the day of the fire but had agreed to come into work, said Michael Baum, an attorney for the family with the Los Angeles office of the firm Coal, Kananack & Murgatroid.
- The suit seeks \$5 million in compensatory and \$10 million in punitive damages.
- In addition, a New York attorney has filed a suit in state court in New York on behalf of two New York residents who were trapped on the seventh floor of the hotel and suffered significant amounts of smoke inhalation.
- The suit seeks \$1 million for each plaintiff in compensatory damages and \$100 million in punitive damages.
- Two other lawsuits seeking \$19 million were filed within days of the fire.
- All the suits filed to date allege various counts of negligence and several allege gross negligence at the hotel.
- Among the allegations in the suit filed by Mr. Ortiz Brunet are that the hotel and its owners were negligent because:
- They knew there was a labor dispute; they had received threats from known sources there would be a fire on Dec. 31; two other fires had occurred in previous days; and Puerto Rican police were not allowed to enter the premises after a bomb warning was received on the day of the fire.
- They permitted the Teamsters local to meet in the ballroom where the fire started, when the owners

All the suits filed to date allege various counts of negligence and several allege gross negligence.

knew there was a "high level of animosity" by the union toward management.

- They closed the doors of the casino as the fire began and locked people in the casino without providing another way to exit.
- "Defendants were also negligent in keeping the doors locked at the different floor levels in an apparent attempt to maintain security at the hotel, but without realizing that they were negligently creating a death trap for the hotel's guests," the suit adds.
- They permitted new and highly flammable furniture wrapped in a volatile plastic material to be stored in the ballroom and operated the hotel when they knew the building had a large amount of inflammable material within its walls and had not previously established safeguards such as adequate sprinkler systems, fire walls, shut-off valves, fire alarm system and other safety measures.
- Plaintiffs' attorneys have formed a plaintiffs' litigating committee composed of attorneys that have filed lawsuits, said Wendell Gauthier, with the same firm as Mr. McCabe and a lead counsel in the MGM fire litigation.
- Eventually, an executive committee of the group will be formed that will lead the litigation, another attorney said.
- Mr. Chesley said that plaintiffs' attorneys would use very creative and innovative theories in the litigation.

Among potential defendants are Sheraton Corp., which originally owned the hotel; the board of directors of the Dupont Plaza's parent company; and even American Airlines, which arranged package tours that flew persons to Puerto Rico and offered accommodations at hotels including the Dupont Plaza.

Mr. Chesley speculated that because American selected the Dupont Plaza and that purchasers had little choice of where to stay, the airline might bear some responsibility for ensuring the hotel's safety.

"We're investigating the law now," Mr. Chesley said. "What I see in the law is very favorable."

Plaintiffs' attorneys may also sue the hotel's insurers, including its workers compensation insurer, for failure to properly inspect the hotel. At least 19 of those killed and 15 injured in the fire were hotel employees.

The hotel workers compensation insurance is written by the Puerto Rico State Insurance Fund, a monopolistic state fund.

Mr. Chesley added that plaintiffs' attorneys may allege an "enterprise liability" theory so that if plaintiffs are unable to determine which company is responsible for manufacturing a particular product contributing to the fire, the burden is shifted to all manufacturers of similar products to prove they did not make the product.

Plaintiffs' attorneys also have not given up on obtaining punitive damages, even though they are prohibited under Puerto Rican law.

They also are investigating the possibility of charging the hotel with violations of RICO, which provides for treble damages, Mr. Chesley said. If the hotel hid information from the public, there could be a violation of RICO, he said.

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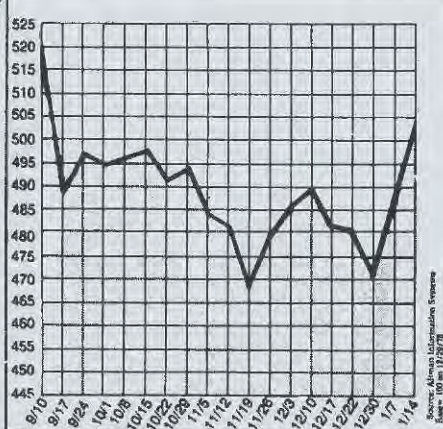
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BI Insurance Index



Brokers face challenges to maintain profit growth

By LEONARD M. WILSON
Special to Business Insurance

THE CURTAIN HAS rung down on 1986, and it is now time to grapple with 1987 through the budgeting process. Before embarking on a review of the possibilities for this year, we decided to take a look at our hypothetical budget for 1986, set forth a year ago (BI, Jan. 13, 1986).

At that time, encouraged by the strong trend in insurance rates, we felt reasonably confident in projecting a buoyant rise of 25% in total revenues. Some of the public brokers exceeded this figure, but it proved to be close to the eventual result for those brokers posting solid new business growth.

Since expenses tend to follow the direction of revenues, we also allowed for a sizable jump of 20% in expenses despite lingering tendencies toward austerity on the part of some public brokers. We probably did not incorporate fully the dramatic escalation in the brokers' own insurance premiums. Nonetheless, brokerage expenses did escalate at a pace that tended to reflect more prosperous conditions.

The postulated expansion in revenues and expenses worked out to earnings growth well above 30% for 1986, based upon our numbers. Here, our expectations were met and, perhaps, slightly surpassed. Profit margins expanded, and either reached or began to approach the levels of the 1970s.

Will our forecasting acumen or luck hold in 1987? Budget makers face changes. For starters, insurance rates are clearly losing upside steam. But then, every year brings its uncertainties. With that knowledge, we have compiled the assumptions for the profit plan of our fictitious brokerage firm, Risk Adverse Brokers.

The economy is likely to continue on a fairly desultory course, registering real



Mr. Wilson

Leonard M. Wilson, a principal at L.F. Rothschild, Unterberg, Towbin in New York, specializes in insurance brokerage stocks. He is a member of the New York Society of Security Analysts.

New business momentum is pronounced and should be the mainstay of growth in 1987. An easing in capacity may mean that the highly professional broker has to work a little harder to get the new client in the door in contrast to 1985 and 1986 when a lot of new business seemed to come in over the transom.

growth of 2% to 2.5%—not a boom but steady as she goes. Capital spending is a question mark due to the uncertain impact of the newly minted tax reform. But inventories and payrolls should expand in line with the economy.

Inflation last year was lower than our forecast of 3% to 4%, but this year there are straws in the wind that suggest a slight increase in the inflation rate. We will stick with an inflation rate of 3% to 4% again for 1987.

Insurance rates are likely to contribute no more than 0% to 5% to the growth in commissions. In effect, the impetus of rising rates is now behind the brokerage industry. By the end of 1987, rates could actually be a tad negative.

Lost business typically rose in 1986 from traditional levels as clients, stung by massive rate increases over the past two years, were receptive to shopping the market. This year, the attrition in the existing client base may be better contained.

New business momentum currently is pronounced and should be the mainstay of growth in 1987. An easing in capacity may mean that the highly professional broker has to work a little harder to get the new client in the door in contrast to 1985 and 1986 when a lot of new business seemed to come in over the transom.

Factoring in these relevant variables, Risk Adverse counts on commission gains of 16% to 18% in 1987.

Reinsurance brokerage revenues also will experience a deceleration in price increases. Reinsurance is nearing rate adequacy. Commission growth of upwards of 30% in 1986 may give way to a rise of 15% to 20% this year, which is still robust by any standards.

Employee benefits consulting should be spurred by changes in the tax law. Corporate clients will be clamoring for consulting time to evaluate the effects of the legislation. For those brokers with a strong position in the

employee benefits consulting area, revenues should move ahead 15% to 20% in 1987, above the trend line growth rates of this sector.

International insurance brokerage did not experience the capacity squeeze in liability insurance that the U.S. market underwent. Premium rates seem to be firm outside the United States and foreign gains could be in the area of 12% to 13%, excluding foreign currency effects.

Investment income may be hard pressed to grow at all. Increased premium volume may be neutralized by slippage in average yield. Short-term interest rates may stay around current levels for all of 1987.

Expenses are the last building block in the budget. Headcount should advance about 5% to help service incremental growth in volume and assure a continued brisk production effort. With inflation at 3% to 4%, the embedded rate of increase in employment cost should be around 10%, but incentives and upgrading of staff could lift the final number for cost increase to 15% to 17%. Other operating outlays should advance at a similar pace.

Since total revenues are expected to rise only slightly faster than this range, it is clear that cost control becomes more critical in 1987 to attainment of the profit plan.

Assuming that expenses meet the budget, Risk Adverse can look forward to pretax earnings growth of 20%, well below last year's performance, but gratifying nonetheless. Tax reform, though, will lower the tax rate and, therefore, aftertax earnings may expand by about 30%.

Convincing the organization that the heyday of rate increases is finished will be the challenge of 1987. It is back to pushing hard for new business and keeping a close watch on costs. The responsiveness of budgets and management information systems could be thoroughly tested in the year ahead. Clearly, the margin of error has narrowed.

British Issues

Jan. 13	Price	P/E	Div.	Yield	High-Low
Companies	pence		pence	%	pence pence
Comml Union	282	16.1	18.3	6.5	295-282
Corroon & Black	847	14.1	37.7	4.5	865-839
Gdn Royal Exch	812	13.3	46.5	5.7	832-799
Royal	854	9.0	42.2	4.9	879-854
Sun Alliance	684	15.2	29.5	4.3	762-678

Brokers	Price	P/E	Div.	Yield	High-Low
	pence		pence	%	pence pence
CE Heath	447	12.8	34.5	7.7	458-447
Hogg Robinson	368	12.5	16.2	4.4	374-368
JH Minet	239	10.6	12.0	5.0	240-236
Sedg Grp	323	15.4	16.9	5.2	325-320
Stew Wrightson	469	15.1	19.0	4.1	475-468
Willie Faber	439	15.7	15.5	3.5	444-430

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

BI Industry Stock Report

January 14, 1987

1/8/87 thru 1/14/87

Brokers									Price % Chg. P/E \$ Div. % Yld. High Low Vol.(000)										
Alexander & Alexander Svcs	NYSE	28.00	12.0	400.0	1.00	3.6	28.00	24.50*	2,184.3	Fairmont Finl Inc	AMEX	17.75	6.0	14.2	0.00	0.0	17.88	17.00	92.9
Baldwin & Lyons Inc	OTC	22.00	4.8	17.9	0.20	0.9	26.00	21.00	1.7	Firearm Fd Corp	NYSE	37.38	2.4	0.0	0.30	0.8	38.25	37.38	663.5
Corroon & Black Corp	NYSE	35.38	2.2	16.0	0.65	1.8	36.50	35.00	348.4	Freemont Gen Corp	OTC	17.25	2.2	0.0	0.48	2.8	17.88	16.75	232.2
Gallagher Arthur J & Co	OTC	31.00	10.7	22.6	0.20	0.6	31.00	28.75	94.7	Great West Life Assurn Co	OTC	700.00	0.0	14.4	18.00	2.6	700.00	700.00	0.0
Hall Frank B & Co Inc	NYSE	16.25	-1.5	0.0	0.00	0.0	16.38	16.00	91.9	Home Group Inc	AMEX	22.38	2.3	36.1	0.00	0.0	22.38	21.50	355.7
										Hanover Ins Co	OTC	69.00	5.3	14.6	0.56	0.8	69.00	67.00	30.8
Marsh & McLennan Cos Inc	NYSE	68.38	1.3	21.8	1.90	2.8	69.25	68.38	670.6	Harleysville Group Inc	OTC	16.38	12.9	10.4	0.32	2.0	17.00*	15.38	342.8
Poe & Assoc Inc	OTC	12.25	2.1	15.5	0.32	2.6	12.25	12.00	7.0	Hartford Steam Boiler Insptn	OTC	51.75	2.7	13.2	1.60	3.1	52.50*	51.75	109.8
				=====		=====				Kans City Life Ins	OTC	28.00	1.8	11.7	0.87	3.1	28.25	28.00	24.9
AGENTS/BROKERS	AVERAGE			22.4		2.2				Kemper Corp	OTC	29.13	0.4	11.7	0.60	2.1	29.50	29.00	1,096.5
										Liberty Corp S C	NYSE	39.75	-0.6	13.4	0.72	1.8	40.50	39.25	14.1
Conglomerates & Holding Cos.																			
Anderson Clayton(Ranger/PanAm)	NYSE	65.63	0.0	18.8	0.00	0.0	0.00	0.00	0.0	Lincoln Natl Corp Ind	NYSE	50.38	-0.7	11.6	2.16	4.3	51.50	50.38	481.8
Armco Inc	NYSE	6.25	4.2	0.0	0.00	0.0	6.25	6.13	826.0	Mission Ins Group Inc	PAC	1.63	0.0	0.0	0.00	0.0	4.38	1.25	2.9
Berkley W R Corp	OTC	30.25	7.1	16.7	0.24	0.8	31.25	29.50	710.2	Monumental Corp	OTC	55.63	0.0	18.8	0.00	0.0	55.63	55.63	1.1
Berkshire Hathaway Inc Del	OTC	3000.00	-0.2	174.0	0.00	0.0	3000.00	2950.00	1.2	Nac Re Corp	OTC	30.50	2.5	0.0	0.00	0.0	30.50	28.75	243.0
CIGNA Corp	NYSE	68.63	5.9	0.0	2.60	4.3	68.88	59.25	1,816.7	Nobel Ins Ltd	OTC	18.00	1.4	13.5	0.37	2.1	18.25	17.75	64.8
CNA Fint Corp (CNA)	NYSE	58.00	2.7	14.6	0.00	0.0	58.00	56.50	385.0	Northwestern Natl Life Ins	OTC	30.88	-2.0	10.3	0.86	2.8	31.50	30.88	353.6
General Re Corp	NYSE	59.38	-1.0	25.6	0.88	1.5	61.25	59.38	1,856.1	Ohio Cas Corp	OTC	83.00	4.1	15.6	3.00	3.6	83.00	81.75	117.6
ITT (Hartford Group)	NYSE	57.38	1.3	23.6	1.00	1.7	57.88	57.25	3,807.9	Old Rep Intl Corp	OTC	29.25	-2.5	11.3	0.78	2.7	30.38	29.25	106.7
Sears Roebuck & Co. (Allstate)	NYSE	44.25	1.7	12.1	1.76	4.0	44.25	43.38	4,147.2	Orion Cap Corp	NYSE	29.38	4.9	0.0	0.76	2.6	29.50	28.38	138.0
Transamerica Corp (Occidental)	NYSE	36.00	3.2	10.3	1.76	4.9	36.00	35.13	1,437.3	Protective Corp	OTC	20.25	8.0	11.1	0.70	3.5	20.25	19.00	452.8
				=====		=====				Provident Life & Acc Ins Co	OTC	25.38	-0.5	9.6	0.84	3.3	25.50	25.00	203.8
CONGLOMERATES/HOLDING COS.	AVERAGE			87.2		0.2				St Paul Cos Inc	OTC	44.25	3.5	13.6	1.50	3.4	44.25	43.75	659.0
										SAFECO Corp	OTC	59.00	4.0	12.9	1.70	2.9	59.00	57.50	332.2
Insurers																			
Aetna Life & Cas Co	NYSE	60.88	1.9	10.6	2.64	4.3	60.88	60.25	4,019.1	Scar U S Corp	OTC	11.50	0.0	23.0	0.00	0.0	11.50	11.25	280.0
American General Corp	NYSE	40.75	2.2	11.2	1.12	2.7	40.75	40.25	1,610.5	Seibels Bruce Group Inc	OTC	17.50	12.9	0.0	0.80	4.6	17.75	15.25	64.3
Amern Heritage Life Intvt Co	NYSE	39.88	0.9	14.3	1.32	3.3	39.88	39.25	1.0	Selective Ins Group Inc	OTC	23.00	2.2	45.1	0.92	4.0	23.25	22.75	72.5
American Indty Fint Corp	OTC	18.25	-1.4	0.0	1.12	6.1	19.00	18.25	10.1	Statestman Group Inc	OTC	5.25	2.4	0.0	0.05	1.0	5.38	5.25	75.2
American Intl Group Inc	NYSE	66.00	1.9	18.9	0.25	0.4	66.88	65.50	1,546.2	Tokio Marine & Fire Ins Co	OTC	61.63	3.8	69.2	0.17	0.3	61.63	58.00	88.7
Aneco Reins Ltd	OTC	2.13	0.0	0.0	0.00	0.0	2.13	2.13	31.4	Torchmark Corp	NYSE	30.00	2.1	11.5	1.20	4.0	30.50	29.25	726.5
Avenco Corp	NYSE	30.50	3.4	15.0	0.50	1.6	30.50	29.50	19.2	Travelers Corp	NYSE	47.50	0.3	11.4	2.28	4.8	49.13	47.50	2,275.1
Business Reins Assurn Co Amer	OTC	26.50	1.0	0.0	1.10	4.2	27.25	26.25	33.6	Tremick Group Inc	OTC	18.25	5.8	140.4	0.00	0.0	18.25	17.00	121.4
Chubb Corp	NYSE	65.00	1.6	26.1	1.68	2.6	66.88	65.00	917.8	United Fire & Cas Co	OTC	32.00	3.2	15.0	0.80	2.5	32.25	31.75	14.8
Combined Intl Corp	NYSE	61.88	1.2	11.6	2.24	3.6	61.88	60.38	195.4	United States Fid & Gty Co	NYSE	42.75	0.9	49.1	2.32	5.4	42.75	42.00	1,110.9
Continental Corp	NYSE	48.88	1.3	232.7	2.60	5.3	49.13	48.13	606.0	Unum Corp	NYSE	30.00	4.8	8.8	0.40	1.3	30.50*	29.63	918.3
Crown Life Ins Co	OTC	375.00	0.0	13.0	6.40	1.7	375.00	375.00	1.0	UsLife Corp	NYSE	47.50	3.8	12.3	1.20	2.5	47.50	45.63	165.7
Durham Corp	OTC	41.75	0.0	12.8	1.36	3.3	41.75	41.25	6.3	Washington Natl Corp	NYSE	32.00	0.8	14.5	1.08	3.4	33.25	31.88	133.4
Farmers Group Inc	OTC	45.75	3.4	15.3	1.00	2.2	45.75	45.00	1,175.1	Zenith Natl Ins Corp	OTC	25.00	-4.8	30.1	0.80	3.2	25.75	25.00	1,060.7
										INSURANCE COMPANIES	AVERAGE			14.7		2.5			

System design: Altman Information Systems

New Aetna unit offers D&O cover

HARTFORD, Conn.—Aetna Casualty & Surety Co. has begun issuing directors and officers liability coverage through a newly formed management company, Executive Risk Management Associates.

The facility is offering primary or excess D&O limits—or a combination of both—of up to \$15 million per risk (BI, Aug. 11, 1986). Aetna will retain \$2.5 million of each risk, reinsuring \$10 million on a quota-share basis with Executive Risk Insurance Co., a former Aetna subsidiary recently recapitalized exclusively to reinsure the D&O program. The remaining \$2.5 million per risk will be reinsured with other commercial reinsurers, a spokesman said.

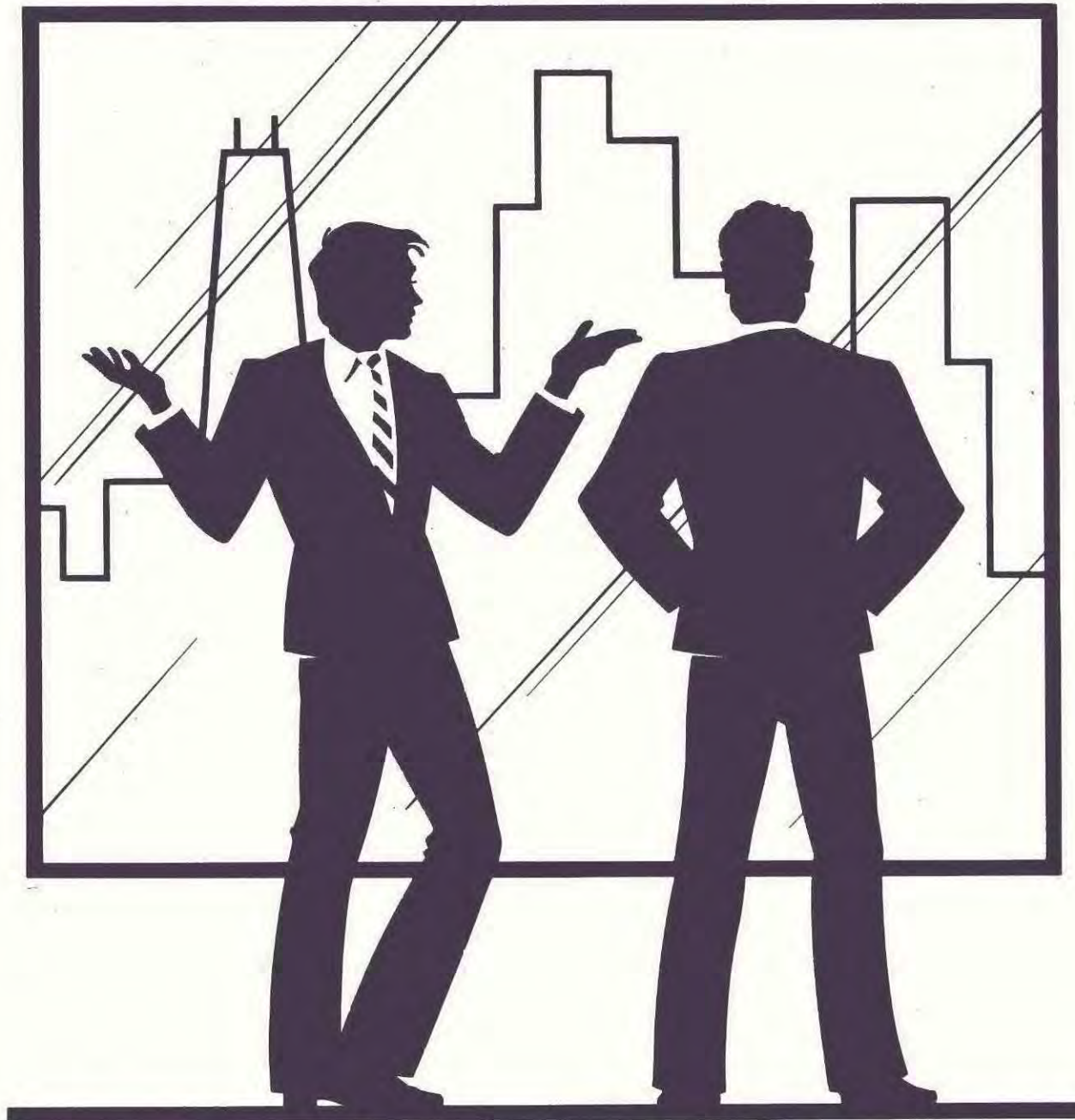
About \$27 million of ERIC's \$115 million in capital was contributed by Aetna, Chase Investment Bank, Conning & Co., Johnson & Higgins, Willis Faber & Dumas Ltd. and London United Investments P.L.C. The remaining \$88 million was raised in a private placement from other corporate investors.

Additional investors are expected to join, and organizers expect ERIC's capitalization to increase to \$150 million, one source said, adding that Aetna hopes eventually to offer D&O limits of \$25 million per risk.

The D&O policies are now available in 20 states, and Aetna is seeking regulatory approval in all states.

William A. Pollard, former chairman of Reliance Insurance Group, has been named chairman and chief executive of ERIC.

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