

Business Insurance

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Employers do not have to report dependent care expenses on W-2s

WASHINGTON—Employers will not have to report reimbursements for dependent care expenses on employees' 1988 W-2 salary statements, the Internal Revenue Service said last week.

In special relief Notice 89-13, the IRS said the W-2 reporting requirement would be waived for 1988 if employers maintain adequate records concerning dependent care expenses and furnish a written statement—by Jan. 31—to each employee showing dependent care ex-

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Wal-Mart chief fined \$11.5 million for court absence

By MICHAEL SCHACHNER

FORT WORTH, Texas—Wal-Mart Stores Inc. Chairman Sam Walton's repeated failures to comply with court orders to testify in a slip-and-fall injury case against the discount store chain may end up costing the company more than \$11.5 million in court sanctions.

A state district court judge in Fort Worth, Texas, has ruled that Bentonville, Ark.-based Wal-Mart must pay a Houston man \$11.5 million in sanctions because Mr. Walton delayed giving a deposition in the personal-injury suit the man filed against the company.

A jury also awarded the plaintiff nearly \$36,000 in damages after the presiding judge found Wal-Mart liable for the plaintiff's injuries.

Several industry experts are astounded by the amount of the sanctions, and attorneys say that any directors and officers liability insurance the publicly held company may carry probably 'would not respond.'

In addition, they said Mr. Walton's actions could jeopardize any general liability insurance Wal-Mart may have to cover the liability award.

Wal-Mart attorneys and spokesmen would not comment on Wal-Mart's risk financing program.

However, Wal-Mart's claims are handled by Corporate Services Inc. of Detroit, a subsidiary of New York-based Alexander & Alexander Services Inc. CSI is responsible for safety and claims loss control for captives and fronted programs.



Mr. Walton

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Superfund damages are covered: Judge

By STACY ADLER

SANTA CLARA, Calif.—Costs incurred by policyholders responding to government-mandated hazardous waste cleanups are covered by comprehensive general liability policies, a California state judge ruled last week.

As a result, some 174 primary and excess insurers that wrote general liability coverage for Chicago-based FMC Corp. could be held responsible for tens of millions of dollars in cleanup costs associated with 46 polluted sites nationwide.

Santa Clara County Superior Court Judge Eugene M. Premo ruled that the costs incurred by FMC under the Comprehensive Environmental Response, Compensation & Liability Act, better known as the Superfund Act, are insurable "damages" under its CGL policies.

FMC's CGL policies, like those of most CGL policyholders, stipulate that they will "pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages."

Specifically rejecting contrary rulings by federal appellate courts, Judge Premo said the term "damages" in the CGL policies should be given an ordinary, dictionary definition that would encompass government-mandated cleanup costs.

Insurers argued that the term "damages" should be given a legal definition that would only include damages incurred by a policyholder in a court of law, not government-mandated cleanup costs.

FMC successfully argued that this was too technical a definition of the word damages.

The meaning of the term damages has been a source of contention between policyholders and insurers in dozens of state and federal courts nationwide.

To date, the courts still are divided on the issue,

though the only three federal appellate court decisions on the "damages" issue have favored insurers. However, a vast majority of the state courts that have ruled on this issue have favored policyholders.

Now, FMC attorneys say Judge Premo's decision could indicate that the tide is turning in favor of policyholders.

"This ruling comes on the heels of three or four other similar rulings and indicates that the argument that 'damages' has a special, esoteric meaning is a sham," said FMC attorney Eugene Anderson of Anderson, Russell, Kill & Olick in New York.

"The tide has turned," he said, explaining that policyholders more often are winning this argument at the state court level.

FMC attorney David Steuber agreed, saying the FMC decision "demonstrates a trend that policyholders are winning in this area."

Mr. Anderson and Mr. Steuber, with the Los Angeles firm of Paul, Hastings, Janofsky & Walker, both predicted that the FMC decision would be persuasive to other courts hearing similar pollution coverage litigation.

However, insurer attorney Timothy Russell of Drinker Biddle & Reath in Washington, D.C., said it was unclear what impact the "poorly reasoned" decision would have.

"The FMC court dwelled on the notion that 'damages' should not have a technical, legal meaning; but 'damages' is, after all, a legal term," said Mr. Russell, who represented insurers that have since been dismissed from the FMC case.

"It is totally fair and appropriate to question what meaning 'damages' has in a legal context," he said.

Roger Warin, an insurer attorney with Steptoe & *Continued on page 29*

Health plan costs top 10% of pay: Study

By JERRY GEISEL

WASHINGTON—The average cost of family medical care coverage will hit \$3,000 per employee in 1989 if health care inflation does not subside.

Last year, employer and employee contributions for family comprehensive medical coverage climbed 11.9% to \$2,700, up from \$2,412 in 1987, according to a just-released survey by The Wyatt Co.

"It is an alarming cost. It means that for many employees, medical care coverage well exceeds 10% of compensation," said Lance Tane, a consultant in Wyatt's New York office and chairman of Wyatt's group/flex practice.

In view of the enormous costs involved, employers now should rethink their benefit plan design, he said.

"Is the purpose of a medical plan to pay for ordinary expenses or is it only to pay for significant, unanticipated expenses that cause hardship?" he asked. If companies believe that it is the latter, then a closer, more strategic look at how their plans are de-

signed is needed, Mr. Tane said.

Costs also are soaring for individual and employee-and-spouse health care coverage.

For example, employer and employee contributions for individual coverage jumped 14.3% to \$1,056 in 1988 from \$924 in 1987. And, during the same period, employer and employee contributions for employee-and-spouse comprehensive medical care coverage shot up 11.7% to \$2,292 from \$2,052.

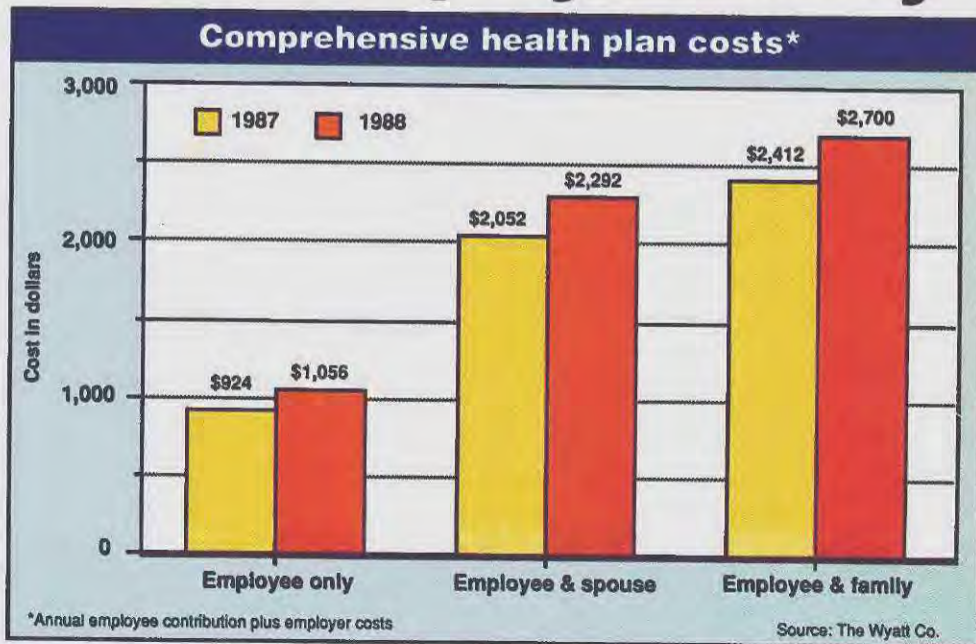
Faced with skyrocketing medical costs, employers are shifting more group health care expenses to employees.

For example, among a core group of 376 employers surveyed by Wyatt in both 1988 and 1986, 16% last year required employees to pay at least \$75 a month toward the cost of the premium for comprehensive medical care coverage, up from 9% in 1986.

On the other hand, employees paid less than \$10 a month toward the premium at just 2% of the core group employers last year, down from 9% in 1986.

At the same time, employers are stepping up implementation of medical care cost con-

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Home Insurance Co. must cover Uniroyal for share of Agent Orange settlement: Court Page 3

Plaintiffs and insurer defendants in antitrust suit join to oppose five reinsurers' motion to dismiss Page 3

Update

IRS gives employers W-2 relief

Continued from previous page
penses paid or incurred in 1988.

The W-2 reporting requirement had been tucked into a technical corrections bill passed by Congress late last year. That gave employers little time to comply.

"The relief notice is late, but very welcome news to employers," said David Sugar, a consultant with Hewitt Associates in Lincolnshire, Ill.

Lloyd's capacity static for '89

LONDON—Premium capacity at Lloyd's of London this year will be about 11 billion pounds (\$20 billion), the same as in 1988.

This is the first year since 1970 that the 300-year-old insurance market's underwriting capacity has not increased.

The market's announcement follows a record number of resignations of underwriting members. About 1,750 members resigned last year, compared with 489 in 1987, Lloyd's confirmed.

However, at least 970 new members join Lloyd's this month, and more than 3,800 existing members have increased their underwriting capacity. There will be about 31,300 Lloyd's members in 1989, down from 32,080 in 1988.

Meanwhile, a record 31 new syndicates begin underwriting this year, of which 28 will write non-marine business. Of the market's 407 syndicates, there are 183 non-marine syndicates, 135 marine, 4 aviation, 37 motor and eight life.

Industry's combined ratio rises

NEW YORK—The property/casualty insurance industry's combined ratio deteriorated to 105.4% in 1988 from 104.5% in 1987 as underwriting losses soared, according to A.M. Best Co.

Underwriting losses in 1988 surged 17.7% to \$11.3 billion from \$9.6 billion in 1987, said Sean F. Mooney, senior vp and economist at the Insurance Information Institute in New York, which released the preliminary data.

Net premiums written increased 3.9% to \$198.9 billion in 1988 from \$191.5 billion in 1987. Net premiums written in 1987 were 8.7% higher than the \$176.1 billion net premiums reported in 1986.

Investment income last year increased 13.3% to \$27.2 billion from \$24 billion in 1987. Pretax operating income increased 8.3% to \$15.6 billion from \$14.4 billion in 1987.

But, aftertax income dropped 2.8% to \$14 billion from \$14.4 billion in 1987. Pretax and aftertax income were both \$14.4 billion in 1987 because capital gains offset taxes, Mr. Mooney noted.

Policyholder surplus in 1988 increased 11.5% to \$116 billion from \$104 billion. The rate of return on capital dropped to 12.1% from 13.2% in 1987.

Texas antitrust case jurisdiction

AUSTIN, Texas—Travis County District Judge Peter Lowry will hear arguments Friday on whether the Texas State Board of Insurance should have primary jurisdiction in the antitrust litigation filed in state court by the state's attorney general against property/casualty insurance industry defendants.

Defendants contend in court filings that the State Board of Insurance should have primary jurisdiction in the Texas suit, which charges them with violating the Texas Free Enterprise & Antitrust Act of 1983 and the Texas Deceptive Trade Practices Act (BI, Nov. 7, 1988). The defendants argue that the board has regulatory authority over the insurers and therefore should determine whether the attorney general's allegations have merit.

The attorney general argues the case belongs in state court.

Allegations in the Texas suit are similar to those in the combined federal court suit filed by 18 other state attorneys general. Numerous defendants are named in both suits (BI, March 28, 1988).

Reliance investigation denied

NEW YORK—Reliance Group Holdings Inc. last week denied published reports that it is under federal investigation for stock fraud.

The Washington Post reported Dec. 30, 1988, that Reliance and the company's chairman, Saul P. Steinberg, were engaged in an illegal "stock parking" scheme with Drexel Burnham Lambert Inc.

The Post reported that Steinberg attempted to evade New York insurance laws—which prohibit insurers from owning stock in bankrupt organizations—by "parking" Wickes Co. stock with Drexel in March 1984. Reliance had bought 10.4% of Wickes, which was in Chapter 11 bankruptcy proceedings at the time.

Stock parking is a scheme in which a stockholder tries to hide ownership of stocks by placing them with another party and agreeing to buy them back at a later date.

"Purchases of Wickes common stock were in full compliance with all insurance and other regulatory requirements," said Reliance in a prepared statement. "The U.S. Attorney's office has explored all facets of those transactions and both Reliance and the company's chairman, Saul P. Steinberg, have been advised that they are not targets of the government's investigation."

Payments made for train crash

LONDON—The British Railways Board will make bereavement payments of 10,000 pounds (\$18,230) to the survivors of the 34 victims of December's railway disaster in London.

The statutory minimum bereavement payment under Britain's Fatal Accidents Act of 1976 is 3,500 pounds (\$6,380).

In many cases this payment, which does not include loss of income support, will be only part of the overall settlements, the state-owned railway said last week.

British Rail conceded liability the day of the accident, in which three commuter trains collided (BI, Dec. 19, 1988).

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Blood bank not negligent in AIDS case: Texas jury

By MICHAEL BRADFORD

DENTON, Texas—A Texas District Court jury has denied \$5 million in damages claimed by the wife of a man who died after receiving a transfusion of AIDS-tainted blood that was provided by a blood bank.

Allen Weed, an attorney with the Dallas firm of Shank, Irwin, Conant, Lipsky & Casterline, said last week he would decide after a judgment has been entered whether to appeal the jury's decision not to hold The Blood Center at Wadley negligent in the case.

Mr. Weed's client, Patty Jo Baker and her family, sued the Denton, Texas, blood center for negligence in failing to screen donors for conditions that could have indicated the presence of the acquired immune deficiency syndrome virus.

Ms. Baker's 56-year-old husband, George, died in June 1986 after contracting AIDS as the result of a blood transfusion he received with blood from the Wadley center during an operation in 1984.

The jury in the case, which was heard in state district court in Denton County, ruled last month that the center was not negligent in providing the contaminated blood for transfusion. Attorneys for the defendant argued that blood banks have been required by the Federal Drug Administration to test their supplies for the AIDS virus only since the spring of 1985.

The case is the first of its kind to go to trial in Texas.

The outcome of the case is the opposite of a decision handed down late last year in Northern California. There, a jury ruled that the Irwin Memorial Blood Bank in San Francisco acted negligently in supplying

AIDS-tainted blood for an infant's transfusion (BI, Dec. 12, 1988).

The child, who is still alive, received the transfusion in 1983.

In that case, the jury awarded \$750,000 to the 5-year-old and his family.

Attorneys say hundreds of similar cases are pending nationwide in courts of all levels. Many are filed in San Francisco and in most cases the plaintiffs claim they were stricken with the virus after receiving contaminated blood in transfusions prior to the spring of 1985.

Estimates indicate that around 1,000 people in the United States who received transfusions between 1978—when the virus was first identified—and the time mandated screening began in 1985 have developed AIDS (BI, Jan. 25, 1988). Although the outcomes differed, in both the California and Texas cases the issue of testing was critical to the juries' decisions.

"We established that he died of AIDS as a result of that transfusion," Mr. Weed said of Ms. Baker's husband. "The issue became whether Wadley was negligent in failing to screen or test the blood he got."

Even though there was no requirement for blood banks to screen for the AIDS virus before 1985, "our claim was there were other things that could have been done. There was some other testing that would have given the potential for identifying people with AIDS," according to Mr. Weed.

The suit charged that the Wadley center was negligent in its failure to use "available surrogate tests

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New directory of HMOs/PPOs is available

Extra copies of the *Business Insurance* 1988-1989 Directory of HMOs and PPOs are available.

This second annual directory issue on HMOs and PPOs was sent in December to all subscribers to *BI* as a 53rd issue of 1988.

The 1988-1989 HMO/PPO directory issue contains information on 402 health maintenance organizations and 673 preferred provider organizations, and it is the most comprehensive and easy-to-use directory of managed health care delivery systems published.

The issue also contains articles assessing HMOs and PPOs and spotlighting trends in the marketplace. Also, *Business Insurance* ranks the Top 10 general service HMOs and PPOs in the country.

If you are not a subscriber and would like to request a copy, or would like additional copies, please write Jack Kennedy, *Business Insurance*, Single Copy Sales, 965 E. Jefferson Ave., Detroit, Mich. 48207-3185; or call 313-446-1609.

Copies of the HMO/PPO directory cost \$25 each, plus postage.

EC threatens suit over product law

By CAROLYN ALDRED

BRUSSELS, Belgium—The European Commission is threatening to sue Britain and Italy unless both countries remove loopholes favoring defendants in their product liability laws within three months.

The commission also warns that it will sue nine other European Community member nations if the countries do not enact legislation implementing the EC's product liability directive within the next few months.

The product liability directive, passed by the European Council in July 1985, was due to be implemented throughout the European Community by July 31, 1988. However, only the United Kingdom, Italy and Greece had enacted legislation implementing the directive—which imposes strict liability on manufacturers—by the deadline (BI, July 11, 1988).

France, West Germany, Belgium, The Netherlands, Luxembourg, Denmark, Ireland, Spain and Portugal have yet to pass legislation enacting the directive.

The directive, when enacted in all EC nations, will move the burden of proof in product liability litigation to the producer of a product from the consumer. Currently, most European Community member nations require consumers to prove negligence on the part of the manufacturer to obtain compensation for a product-related injury.

However, the EC will sue Britain and Italy for enacting versions of the directive that hold producers to liability standards not as great as that intended by the EC unless the laws are amended, said Hans Tachner, a divisional director

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✓ The outcome of litigation contemplated by Lloyd's members against their agents over huge underwriting losses could outline the legal duties that are owed Lloyd's members. **PAGE 10**

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✓ In Ask a Casualty Actuary, Richard Sherman of Coopers & Lybrand examines guidelines for reflecting loss reserves on financial statements. **PAGE 19**

✓ Retiree health benefits should have demanded corporate America's attention long ago, says William Sharkey of CIGNA Corp. in Speaking Out. **PAGE 20**

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Antitrust suit strategy

Defendants urge dismissal citing McCarran-Ferguson

By JUDY GREENWALD

NEW YORK—The massive antitrust litigation against the insurance industry would come to a quick end if U.S. District Court Judge William W. Schwarzer accepts the "McCarran-Ferguson" motion to dismiss the case.

The motion, which was one of several filed by industry defendants last month, seeks summary judgment on behalf of all the defendants on the grounds that, contrary to claims in the consolidated antitrust suits, the industry defendants did not engage in a boycott (*BI*, Dec. 19, 1988).

A boycott would void the immunity from federal antitrust laws otherwise provided in the McCarran-Ferguson Act.

"We think it has merit. Whether Judge Schwarzer thinks it has merit remains to be seen," commented defense attorney Robert Schiff of Fisher & Hurst in San Francisco, who is representing reinsurance intermediary Thomas A. Greene & Co. in the litigation.

U.S. District Court Judge William Schwarzer is presiding over the consolidated antitrust cases in U.S. District Court in San

Francisco. The cases include the actions brought by 18 state attorneys general and 20 private plaintiffs.

Another defense attorney, who preferred not to be identified, commented, "I think we have an excellent chance of success."

"I think that Judge Schwarzer fully thinks that this case may be ripe for adjudication quickly, and without a lot of legal expense and waste," the attorney added.

But Jesse W. Markham Jr., a deputy attorney general for California, one of the plaintiff states, believes the McCarran motion, along with the others filed by defendants, will not be granted.

"They really seem to me to lack merit," he said.

Mr. Markham and several defense attorneys say they believe Judge Schwarzer directed them to, in effect, assume for the moment all the allegations of fact included in the antitrust suit are correct and to address solely the legal merits of the case in the motions filed.

Other defendants, however, disagree and have decided to file motions disputing the allegations themselves (see related story).

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Plaintiffs, defendants join to fight reinsurers' request

By JUDY GREENWALD

SAN FRANCISCO—In an ironic twist, several insurance industry defendants are joining forces with state attorneys general in fighting dismissal motions filed by five reinsurance defendants in the massive insurance industry antitrust litigation.

A difference in legal strategy is dividing some of the 31 insurance industry defendants in the antitrust lawsuits brought in federal court by 18 state attorneys general.

The five reinsurers are seeking to be dismissed from the litigation, claiming that there is little if any evidence linking them to the alleged antitrust conspiracy among insurance industry defendants.

The five reinsurers seeking dismissal on these grounds are: Constitution Reinsurance Co., Mercantile & General Reinsurance Co. of America, Winterthur Swiss Insurance Co., Prudential Reinsurance Co. and North American Reinsurance Co.

In response to the motions, Aetna Casualty & Surety Co., another defendant, filed a statement with the U.S. District Court in San Francisco, asking Judge William Schwarzer to "defer consideration" of the

motions for now.

The reinsurers' motions could generate "time-consuming disputes" that would "draw attention and energy away from the broader, potentially dispositive legal motions," the Aetna statement said.

A joint letter sent to U.S. District Court in San Francisco by Hartford Insurance Group and Allstate Insurance Co. makes the same request.

And a Dec. 30 letter to the court written by Thomas Greene, a deputy attorney general for California, on behalf of the plaintiffs cites the statements by the three insurers in asking that the motion be stricken for now and reintroduced "at an appropriate time."

Consideration of the motion, Mr. Greene said, would extend the discovery process.

Meanwhile, two other reinsurance industry defendants—General Reinsurance Corp. and the Reinsurance Assn. of America—submitted statements to the court saying, in effect, that while they do not feel the judge wanted the other reinsurers' motions to be made, they would like to be included in the motions if they are considered.

The source of the dispute is the ambiguity

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Liability coverage for capsized ferries written locally

By CAROLYN ALDRED and LAUREL WENTZ

RIO DE JANEIRO, Brazil—A Brazilian tourist boat that capsized off the coast of Rio de Janeiro on New Year's Eve killing more than 100 people has maximum liability insurance of 92 million cruzaos (\$122,912 at current exchange rates).

And, two other ferries that capsized and sank last week in unrelated incidents were likely to be insured in their local insurance markets.

The Brazilian boat's liability coverage, as well as hull insurance of 85 million cruzaos (\$113,636), is placed with the Sao Paulo, Brazil-based insurer Cia Paulista de Seguros, a spokesman for the company confirmed.

Reinsurance is placed with Rio de Janeiro-based Instituto de Resseguros do Brasil, he added.

The 100-foot boat, Bateau Mouche IV, capsized and sank shortly before midnight at the entrance to the bay of Rio de Janeiro en route to a New Year's fireworks display on Rio's Copacabana Beach, reports say.

The State of Rio has suspended operations of the Itatiaia Turismo tour agency, which operated the vessel, and Sol e Mar Co., the boat's owner, pending an investigation, news reports say.

At least 149 people were aboard the vessel, including the crew and

Continued on next page

Home to appeal ruling in Agent Orange case

By DOUGLAS McLEOD

NEW YORK—The Home Insurance Co. will appeal a federal judge's ruling that it must pay Uniroyal Inc. \$12 million in costs arising from the 1984 class-action settlement of Vietnam veterans' claims against Agent Orange producers.

In an insurance coverage dispute that has been pending since 1984, U.S. District Judge Jack B. Weinstein last month granted summary judgment in favor of Uniroyal, which had sought to recover its \$9 million share of the \$180 million Agent Orange settlement, along with about \$3 million in defense costs (*BI*, May 14, 1984).

Among other things, Judge Weinstein ruled that Uniroyal's numerous shipments of Agent Orange to the U.S. Air Force be-

tween 1966 and 1968 constituted a single occurrence under each of two general liability policies written by Home.

The judge also found that coverage should be apportioned between the two policies based on the volume of dioxin-tainted Agent Orange shipped during the two policy periods.

In addition, Judge Weinstein rejected Home's argument that claims by veterans exposed to the toxic defoliant during the Vietnam War were excluded by the Uniroyal policies' war risk exclusion.

Home will appeal Judge Weinstein's order to the 2nd Circuit U.S. Court of Appeals, according to Sheila L. Birnbaum, a lawyer with Skadden, Arps, Slate, Meagher & Flom in New York, representing the insurer.

Separately, Diamond Shamrock

Chemical Co. and several of its insurers presented closing arguments last month in a trial to determine the extent of Diamond Shamrock's coverage for Agent Orange-related liabilities.

Diamond Shamrock is seeking indemnification from Aetna Casualty & Surety Co. and other insurers for its \$21.6 million share of the Agent Orange class-action settlement, along with coverage for cleanup costs and other claims related to a dioxin-contaminated plant site in Newark, N.J., where the company produced the herbicide (*BI*, June 27, 1988).

Issues to be decided by a judge in New Jersey Superior Court in Morristown include the number of occurrences the Agent Orange claims represent and how coverage should be apportioned among Diamond

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Prudential has right to sue for negligence: Magistrate

By STACY ADLER

BOSTON—The Prudential Insurance Corp. of America has the right to sue four asbestos producers for negligence in failing to warn of the dangers of the deadly substance used in its Prudential Center in Boston, a federal magistrate has ruled.

U.S. Magistrate Robert B. Collings upheld the legal grounds for a lawsuit filed by Prudential for the costs of removing the unwanted substance from the Prudential Center.

The Prudential lawsuit, which was filed in May 1985, is believed to have been the first lawsuit filed by a private corporation seeking recovery for asbestos property damage (*BI*, July 8, 1985). Until the Prudential lawsuit, asbestos property damage lawsuits had been filed by school districts and municipalities.

Prudential is suing four asbestos producers for \$75 million in compensatory damages for the costs of detecting, monitoring, and removing most, if not all, asbestos from its Boston building.

However, the magistrate threw out Prudential's claim for \$100 million in punitive damages, saying it cannot be allowed under Massachusetts law. Punitive

damages can only be awarded in Massachusetts if expressly provided for in a statute, he ruled.

Prudential says the asbestos producers were negligent in failing to warn of the dangers of asbestos, which it claims is causing actual property damage to its building.

In order to successfully sue for negligence, which is a tort theory, Prudential must show actual property damage—not just economic loss.

The asbestos producers challenged the lawsuit saying they should not be held liable for negligence. The producers argued that removal of asbestos should be viewed as a business cost rather than actual property damage, because the asbestos products never failed to perform their fireproofing function.

However, the magistrate ruled, based on allegations in Prudential's suit, that there is support for the company's contention that the asbestos in its building is causing actual property damage.

As a result, Prudential can proceed with its negligence lawsuit against the asbestos producers.

"It can be inferred that the asbestos has purportedly contaminated the mechanical equipment, lights and

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Wal-Mart

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Wal-Mart operates a chain of hundreds of discount stores nationwide and reported nearly \$16 billion of sales in 1988.

In the case, Andrew Carrizales sued Wal-Mart in May 1987 claiming he suffered back injuries that required surgery after he slipped and fell on an oily substance in the Sulphur Springs, Texas, Wal-Mart store in September 1986.

Plaintiff's attorney Wallace Craig of Wallace Craig & Associates in Fort Worth subpoenaed Mr. Walton to testify in the case on March 23 and June 3, 1988, court papers say.

Each time, Wal-Mart filed a writ of mandamus with the 2nd State Court of Appeals and the Texas Supreme Court challenging the subpoenas, but the motions were denied, Mr. Craig said. However, Mr. Walton never appeared. And, after each missed court appearance, Judge John Street of the 352nd District Court in

Tarrant County set a new date for his appearance.

On June 7, Mr. Craig filed for six sanctions against Wal-Mart, including requests that the defense: not be allowed to introduce evidence about Mr. Carrizales' criminal record; be barred from introducing evidence of the plaintiff's activities since he sustained his injuries; and pay Mr. Carrizales \$50,000 per day increasing at 10% at 10-day intervals for each day Mr. Walton failed to appear commencing June 6.

In July, Mr. Craig reached an agreement with defense attorneys to take Mr. Walton's deposition at Wal-Mart headquarters in Bentonville, Ark., on Aug. 8. However, Mr. Walton did not show up for the deposition.

Judge Street on Nov. 18 ordered Wal-Mart to produce Mr. Walton on Nov. 28 or Wal-Mart would face a \$10,000 monetary sanction. The judge ruled the sanction would double each day Mr. Walton did not appear, and that after eight days Wal-Mart would face a \$1 million sanction for

each day Mr. Walton did not appear.

Again, Mr. Walton did not appear. Judge Street on Dec. 12 rendered a default judgment in favor of the plaintiff on the liability issue and dismissed the sanctions Mr. Craig asked the court to impose against Wal-Mart. The jury awarded Mr. Carrizales \$35,658 in damages.

Mr. Walton finally gave his deposition Dec. 15.

Judge Street leveled \$11.5 million in sanctions against Wal-Mart on Dec. 29.

Mr. Craig said Mr. Walton's attorneys told him that Mr. Walton—who is an avid quail hunter—was "bird hunting" between Nov. 28 and Dec. 15.

"They seemed to be afraid that Mr. Walton was going to be abused in court," he said. "But I was very nice to him and he was very cordial" when Mr. Walton, who turns 71 in March, finally gave his deposition.

Industry experts are surprised at the amount of the sanctions.

"I think it's a freak award," said

Fred Fisher, a risk management consultant with Fisher Associates in Torrance, Calif.

Mr. Fisher said he was unaware of previous sanctions for late testimony that approached this figure.

Tom Brunner, a defense attorney for insurers with the Washington, D.C., law firm Wiley, Rein & Fielding also was surprised.

"Most courts are reluctant to order the deposition of high-ranking executives in cases like this," Mr. Brunner added. "But, if the court allows it, the executive is stuck."

Robert Rhoads, general counsel for Wal-Mart, would not comment.

However, Mr. Rhoads said Wal-Mart was "leaving the door open to consider all options."

Carol Swanda, another attorney with Wallace Craig & Associates, would not comment on whether Wal-Mart and Mr. Carrizales are attempting to negotiate a settlement.

She also would not comment on the contingency agreement arranged with Mr. Carrizales.

Mr. Rhoads would not say whether Wal-Mart planned to appeal Judge Street's ruling on either the sanction or the liability award.

Wal-Mart has until Jan. 28 to appeal Judge Street's sanctions.

Mr. Rhoads also refused to comment on Wal-Mart's insurance.

Dan A. Bailey, an attorney specializing in directors and officers liability insurance with the law firm Arter & Hadden in Columbus, Ohio, said he doubted whether the \$11.5 million in sanctions against Wal-Mart would be covered by any type of D&O policy anyway.

"Every D&O policy I've seen clearly excludes fines, sanctions and penalties imposed by law," said Mr. Bailey in an interview.

Attorney John Morrison with Althamer & Gray in Chicago, who specializes in D&O cases for insurers, concurred with Mr. Bailey.

"The language of most D&O policies does not include losses due to fines and sanctions unless otherwise noted," he said.

D&O policies also state that a claim must be brought against a director or an officer, pointed out Ken Wollner, a risk management consultant with The Wyatt Co. of Chicago. In the Wal-Mart case, Mr. Walton was not a named defendant, and therefore D&O coverage would not respond, Mr. Wollner said.

Mr. Walton's failure to appear until December also could jeopardize Wal-Mart's general liability coverage—if any—for the liability award, according to experts.

Mr. Brunner noted that most CGL policies obligate policyholders to give testimony in liability cases.

Mr. Fisher said CGL policies also typically do not cover sanctions because of intentional act exclusions and punitive damage exemptions.

Judge Street, who won his appointment to the court in the November 1984 general election, lost his seat to a Republican in the 1988 election when all Democratic judges that were opposed lost their seats. ■

Ferry disasters

Continued from previous page
a samba band, when it capsized and sank, reports say.

However, both the boat's owner and operator last week denied allegations that the boat was overcrowded, claiming the vessel was licensed to carry 150 people.

Most of the passengers were Brazilian, though a few foreign tourists are reported to have been on board.

Survivors swam to shore or were rescued by other boats also heading to watch the fireworks display.

In another ferry disaster on New Year's Day, 79 people died when a local ferry capsized in Amatique Bay off the coast of Guatemala.

The Rufino Barrios II capsized and sank while being towed by a Guatemalan Navy vessel after the ferry ran out of fuel.

News reports claim the boat was severely overloaded, and it capsized after passengers panicked when the Navy tug boat pulled sharply on the tow line.

The ferry captain, who was arrested and charged with negligent homicide after the accident, claims Navy crew aboard the towing vessel was drunk, according to news reports last week.

The Guatemalan embassy in London was unable to provide further information about the ferry or its owners, and calls to Guatemala were unanswered. However, sources in London say the ferry is likely to be insured in the Guatemalan market.

In addition, a domestic ferry that capsized and sank last week off the coast of the Philippines killing at least 40 people also is unlikely to have any insurance coverage outside the local insurance market, London market sources say.

Jem II capsized in stormy waters off Tamblas Island 180 miles southeast of Manila with more than 140 passengers on board. Twelve people still are missing. ■

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3 employers introduce LTC programs

Three more employers are offering group long-term health care insurance to their employees.

About 8,000 active salaried employees, their spouses and parents are eligible to purchase LTC coverage under a group plan General Foods Corp. of White Plains, N.Y., will begin offering April 1.

In addition, the Army & Air Force Exchange Service of Dallas will begin offering an LTC plan on April 1 to its active employees and retirees. The service, which operates food and clothing stores on U.S. military bases domestically and abroad, employs about 23,000 civilians worldwide, all of whom are eligible for the coverage. In addition, the employees' spouses and parents and 10,000 retirees and their spouses are eligible for the new LTC program.

And, the South Carolina Retirement Systems, which manages retirement plans for state employees and retirees, began offering its employees and retirees an LTC plan on Jan. 1. About 127,000 public employees and spouses and 27,000 retirees and their spouses are eligible for coverage through South Carolina Retirement Systems.

All three plans are underwritten by Aetna Life Insurance Co., a unit of Aetna Life & Casualty Co. of Hartford, Conn.

Plan enrollees pay the entire premium under each of the plans.

Benefits under each plan can be used to pay for nursing home care or home care provided by medical professionals or family members giving custodial care. The enrollee must require assistance in at least two activities of daily living—such as walking, eating or dressing—to qualify for benefits.

Both the General Foods and the Army & Air Force Exchange plans offer active employees four benefit options in \$20 increments from \$40 to \$100 per day for nursing home care. Home care benefits under those two plans are half those for nursing home care.

The lifetime maximum benefit is \$36,500 for each \$20 of daily nursing home care benefits purchased by General Foods and the Army & Air Force Exchange plan enrollees. The maximum home care benefit is half the nursing home care benefit.

The South Carolina Retirement System program provides benefits in \$10 increments from \$30 to \$100 per day for nursing home care. The benefits are half for home care.

The lifetime benefit maximum is \$18,250 per \$10 benefit purchased for nursing home care and half that for home care.

The cost of coverage for General Foods enrollees for \$40 of daily coverage, for example, is \$5.20 monthly at age 30, \$8.12 at age 40, and \$15.52 at age 50.

For \$40 of daily coverage under the Army & Air Force Exchange plan, enrollees pay \$4.64 monthly at age 30, \$7.20 monthly at age 40 and \$13.76 monthly at age 50.

Under the South Carolina Retirement System plan, for each \$10 daily benefit level enrollees pay \$1.25 monthly at age 30, \$1.40 monthly at age 40 and \$3.76 monthly at age 50.

All three plans include a 90-day waiting period before benefits are paid.

General Foods, unlike the other two employers, also offers a return of contribution feature that returns all money paid into the plan to beneficiaries if an active employee or spouse dies without receiving a paid benefit. If retirees die before filing a claim, the returned amount is decreased by 10% for each year since retirement.

Alaska was the first state to sponsor long-term care coverage for its public retirees in 1987, and the Ohio Retirement Systems offers similar coverage (*BI*, July 25, 1988; Sept. 14, 1987; March 16, 1987). About 100

Benefit beat

employers now offer LTC benefits.

Health care costs

Baxter Healthcare Corp. has stabilized its employee health care costs over the past two years and projects lower cost increases in 1989 than those expected for other employers because it took a dose of its own recommended employee health care cost-cutting medicine.

Baxter, a Deerfield, Ill., manufacturer and marketer of health care products with 35,000 employees, contained its health care costs through a variety of measures—including implementing case management and utilization review programs.

Baxter's group health care benefit costs per employee fell 3.6% in 1987 to \$1,665 from \$1,727 in 1986, according to Herbert E. Walker, vp of compensation and benefits.

In 1988, Baxter's health care costs crept up 2% to \$1,699, he said.

While the preliminary estimates for 1989 indicate increases of about 8% to 10% in benefit costs, the increases are far less than the minimum of 20% premium increases for indemnity plans nationwide and 15% to 30% increases for health maintenance organizations (*BI*, Dec. 19, 1988).

Health Data Institute, a Baxter company that collects and analyzes health care cost and utilization data, recommended the health care cost

containment program changes two years ago.

But, Baxter also cut the number of health maintenance organizations it offered employees to 13 in 1988, from 137 in 1986. The surviving HMOs generally were larger organizations that emphasized cost controls, he said.

"We wanted to minimize situations where the HMO gets into trouble financially and winds up trying to pass extraordinary cost increases on to us through increased rates," Mr. Walker explained.

In addition, Baxter employees can select one of three options under the company's self-insured indemnity plans that vary in annual deductibles and out-of-pocket maximums.

Enrollees can choose a \$200 deductible and \$2,000 out-of-pocket maximum per year, a \$300 deduct-

ible with \$3,000 out-of-pocket maximum and a \$400 deductible with a \$4,000 maximum.

After the deductibles, the plan pays 80% of a plan enrollee's health care costs up to the yearly maximum and 100% of health care costs exceeding the enrollee's yearly out-of-pocket maximum.

Baxter also allots its employees \$900 of "flex dollars" annually to reduce their premiums. Employees can use any leftover flex dollars to pay for uncovered health care costs or dependent care if the employees opt for single coverage. Employees also can take leftover amounts in cash.

Made any benefit changes? Write Glenn Huntley, Business Insurance, 6404 Wilshire Blvd., Los Angeles, Calif. 90048; 213-651-3710.



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At issue

Should banks be allowed to sell insurance?



John Brouch
Director-risk
management
American
National
Can Co.,
Chicago

No, I don't believe they should. Banks don't have the expertise and should leave it to the brokers and direct writers. However, there should be some machinery in place to regulate the banks if they do sell insurance.



Ralph Perry
Vp-risk
management
Amfac Inc.,
San Francisco

Yes, it could help restore the insurance industry's image, which is lousy. Bankers have developed an image of being helpful to customers in their banking needs. There is a trust that has been built up and it would carry over to the insurance industry.



Steve Cataldo
Risk manager
Trammell
Crow Co.,
Dallas

Technically there is a conflict because they have a captive audience on the lending side. In the 1980s banks have gotten too unmanageable. They need to manage their banking affairs before they get into anything else.



Eldrich Carr
Manager-risk
management
The
Goodyear
Tire &
Rubber Co.,
Akron, Ohio

Many insurers currently acknowledge that they are only a banking operation, having moved away from acceptance of risk transfer. Therefore, it seems proper that banks be allowed to provide a risk transfer vehicle if it is a more efficient system. Further, it might facilitate the risk manager's examination of all of the financial vehicles and trade-offs available in dealing with the cost of risk.

Compiled by Christine Woolsey

Comings & goings: buyers

GM names Maddock new risk manager

R. Paul Maddock, 40, named director of risk management for General Motors Corp. in Detroit. In this position he oversees worldwide insurance cover-

ages for the automaker. In addition, he was named to the board of directors of GM subsidiary Motors Insurance Corp., which underwrites several classes of property/casualty insurance. Mr. Maddock replaces **Wayne N. Morrison**, who left the company, and reports to John Finnegan, assistant treasurer. Mr. Maddock, who joined GM in 1982, most recently served as director-property and liability risks. Prior to joining GM he was a staff attorney for the Machinery & Allied Products Institute in Washington, D.C. He holds a bachelor of arts degree in history and psychology from Brigham Young University in Provo, Utah, and a doctor of law degree from George Washington University in Washington, D.C.



Mr. Maddock

Mr. Maddock replaces **Wayne N. Morrison**, who left the company, and reports to John Finnegan, assistant treasurer. Mr. Maddock, who joined GM in 1982, most recently served as director-property and liability risks. Prior to joining GM he was a staff attorney for the Machinery & Allied Products Institute in Washington, D.C. He holds a bachelor of arts degree in history and psychology from Brigham Young University in Provo, Utah, and a doctor of law degree from George Washington University in Washington, D.C.

Roger L. Sims, 47, named director of employee benefits for the New York Department of Civil Service in Albany. In this position he administers New York state's health insurance program as well as other employee benefits for state employees and retirees. He replaces **Charles Barnes**, who assumed another position in the employee benefits division, and reports to Paul Puccio, deputy commissioner for program services. Previously Mr. Sims served as director of benefits and compensation for Pay 'N Save Inc. in Seattle. He holds a bachelor of science degree in risk and insurance management as well as a master of business administration degree from the University of Washington in Seattle. In addition, Mr. Sims is certified as an arbitrator on the employee benefits claims panel of the American Arbitration Assn.

Dennis Owen named vp of risk management for Landstar System Inc. in Madisonville, Ky. In this newly created position he is responsible for property/casualty insurance, claims administration, alternative risk financing, loss control and employee benefits for the trucking company. He reports to Robert Wheaton, executive vp and chief financial officer. Previously Mr. Owen served as director of risk management at Ligon Nationwide Inc. in Madisonville. Prior to his position at Ligon he was general counsel with Brand Insulations Inc. in Chicago. Mr. Owen holds a bachelor of science degree in personnel management from Northern Illinois University in DeKalb and a doctor of law degree from Loyola University of Chicago. In addition, Mr. Owen is a member of the American Bar Assn. and a deputy member of the Risk & Insurance Management Society.

We'd like to report on staff changes in your company's risk management, safety and employee benefits departments. Just drop a note to Paul Winston, Copy Editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590, or call 312-649-5442. Please send a photograph, too.

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Opinions

Who's fooling whom?

ASSESSMENTS OF THE amount of competition in the property/casualty insurance market today are as varied as the descriptions of the proverbial elephant by blind men, as our "1989 Renewal Report" last week revealed.

Brokers and risk managers report primary and excess property and casualty insurance rate reductions far larger than primary property and casualty insurers are willing to admit they are offering.

Risk managers and brokers report property rates are being cut 25% to 40% and general liability rates are going down 10% to 40%.

But insurers contend that property rates are being cut only 5% to 20% and that renewal rates for most lines of liability insurance are fairly stable.

Meanwhile, some leaders in the reinsurance marketplace are saying they are seriously concerned about the amount of competition in their market while others maintain that competitive pressures are not dangerously cutthroat.

About the only marketplace that agrees on its state is the surplus lines market. Almost everyone in the surplus lines market reports losing business to primary insurers that are cutting rates more than the surplus lines market is willing to do to

hold business.

With all this disagreement, one could conclude that somebody must be kidding somebody—or themselves—about the amount of competition in the property/casualty insurance marketplace.

We suspect, but cannot prove, that insurers and reinsurers who are downplaying the amount of the rate cutting in the market are suffering from a combination of misleading management reports and wishful thinking.

We've heard enough reports from brokers about branch offices hiding rate cuts from upper management by miscoding risks that we believe top insurance company management is not fully aware of the extent of rate cutting.

Furthermore, it's all too easy for branch office insurance company management and top management to convince themselves that the accounts they are cutting rates for are really the superior accounts that deserve the price breaks while "the other guy" is the one writing all the underpriced business.

We also suspect that overall property/casualty insurers are going to regret their 1989 underwriting decisions.

Letters

State should receive punitive damages

To the editor: There currently is much discussion about excessive awards for punitive damages. Apparently, the Supreme Court will soon address this issue.

However, little attention has been given to the matter of who should be the beneficiary of such punishment. A successful plaintiff receives payment for economic loss and for pain and suffering. Plaintiffs' attorneys receive a large percentage of such payments.

What need then is there for both plaintiff and attorney to receive still another award? Should not awards for punishment go to the state? As long as attorneys receive a percentage of punitive damage awards, such awards will be excessive.

Surely, if punishment is appropriate, monies so awarded could be put to infinitely better use by the state to provide the mechanics to improve or correct adverse conditions that cause claims in the first place.

David L. Holmgren
Senior Vp
The Lofberg Cos.
Teaneck, N.J.

PPOs can provide best of both worlds

To the editor: Paul Katz's Perspective article, "PPOs Must Adjust to Market Realities" expresses a disenchantment with preferred provider organizations (BI, Dec. 19, 1988). Why he expected PPOs to be a "white knight" is curious. Certainly no PPO executive I know ever did.

Perhaps, like some consultants to the industry, he promised too much to restive benefit managers who were anxious to embrace any prospect of savings. When savings were less than expected those same benefit managers chewed out the advisers that touted the programs.

Let's get one thing straight: There are

no "miracle" managed care plans. But the market votes with its feet and today, employers and employees nationwide are choosing PPOs as their managed care option. PPOs retain the best features of traditional health plans while incorporating managed care concepts. This is the trade off purchasers are looking for. Where health care is concerned, employers and employees alike want value, and that means good health is not compromised by overriding cost-cutting concerns.

As Ralph Pollock, president of the Connecticut Business Coalition, has said: "A PPO removes the nagging concern that there is an incentive not to treat in a health plan like an HMO. In a PPO there is incentive to give care. However, that makes employers worry about the presence of very strong utilization review to guard against providing too much care."

These utilization review programs have been incorporated into PPO programs that—coupled with careful selection of providers, data collection and analysis—are enabling PPOs to maintain quality at the same time they control costs.

PPOs are just a few years old and are still evolving. They struggle with the same problems that led to many HMO failures in recent years. Employees are still largely insulated from the cost of care. Providers still do not always provide appropriate services at the lowest cost. Insurers and employers do not always build in the incentives that can make these programs work.

It is naive to expect any organization—whether an HMO or PPO—to reshape and redirect the nation's monolithic and enormous health care and insurance systems overnight.

Mr. Katz cites Kaiser Foundation Health Plan Inc. as a successful example of managed care. But Kaiser took decades to create its system and to raise a generation of practitioners who can practice comfortably with it. It is important to remember that programs like Kaiser operate apart from the traditional health care system.

PPOs function as an option within the system—a system that patients want, one with which employers are comfortable and one that agents and brokers know how to sell.

PPOs are continually evolving. There are many PPOs that have paid providers on fixed-fee schedules or per diems since the early 1980s. Others have limited panel size, drawing on accumulated data to choose providers that are most cost effective. Mr. Katz does allude to this by mentioning the exclusive provider orga-

nization. But that product could not have been sold even three years ago.

Since that time, PPOs have gained enough experience with their provider panels to know who practices quality, cost-effective medicine and who does not. Purchasers have taken the first cautionary steps of limiting access and providing employees with incentives and disincentives. The market is ready for EPOs.

PPO executives by and large have recognized the realities of the market since the beginning. Big panels and open access was what employers wanted and that is what they got. Now, savvy purchasers realize that smaller panels and tight utilization review is better and PPOs are adjusting to meet that need.

Not all PPOs will be able to adjust and survive, nor will all HMOs or other managed care programs. Those that do will offer the best of both worlds to purchasers and patients: quality care at a reasonable price. And that, ultimately, is what the market wants.

Lynn O. Dowling
President
American Assn. of Preferred
Provider Organizations
Washington, D.C.

Punitive damages reduce misconduct

To the editor: I wish to offer a rebuttal to your editorial concerning punitive damages, "Rebalancing the Scales" (BI, Dec. 19, 1988). Thanks to "punitive damages" no one can abuse the free marketplace by fraudulent or malicious conduct without the risk of being punished severely. Punitive damages are a non-bureaucratic, non-tax supported way of bringing a wrongdoer to account, thereby deterring offensive commercial behavior.

In my law practice, I deal with horror stories every day. I see families hounded by collection agencies to pay medical bills that insurance companies should have paid. One such victim became so distraught she attempted suicide; another had his wheelchair repossessed because the insurer failed to make payments; in another case, senior citizens were duped out of millions in health care benefits. And what about the manufacturer that puts a dangerous product on the market to harm or kill someone for the sake of profit and then secretly hides the damaging evidence? In the recent case that the U.S. Supreme Court will review, court records reveal that the defendant ordered

Continued on page 24

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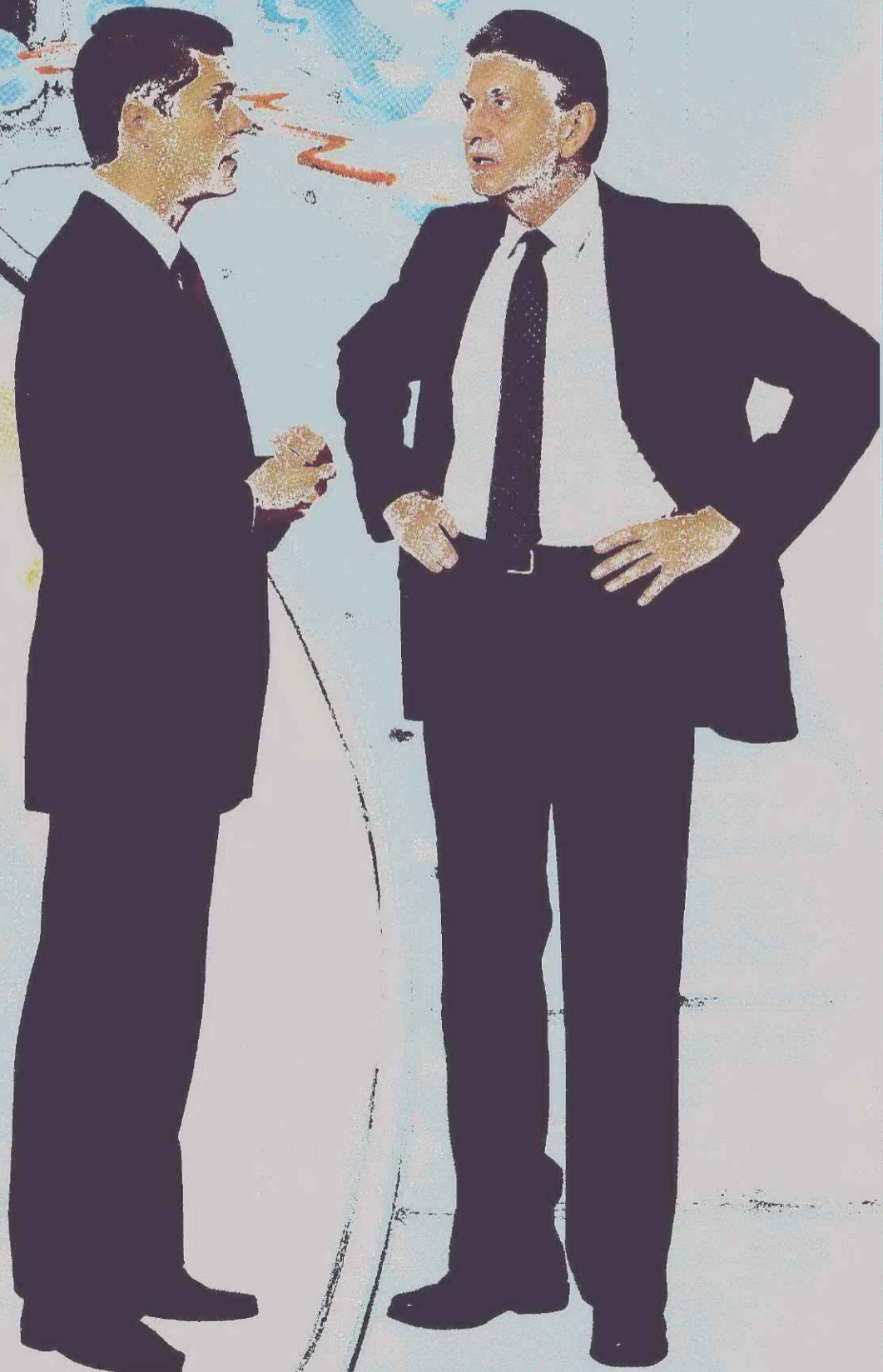
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Suits may define Lloyd's agents' duties

By CAROLYN ALDRED

LONDON—The outcome of breach of duty litigation contemplated by hundreds of Lloyd's of London members against various Lloyd's organizations over huge underwriting losses could clearly outline the legal duties that members' agents and managing agencies owe Lloyd's members.

And, if this litigation is successful, it could trigger more litigation by other members facing underwriting losses.

For example, about 460 members of syndicate 317/661, underwritten by Richard Outhwaite and managed by RHM Outhwaite (Underwriting Agencies) Ltd., are considering whether to seek indemnification for hundreds of millions of dollars of losses the syndicate faces from the 1982 underwriting year.

In addition, about 470 members of syndicate 553, managed by CJW (Underwriting Agents) Ltd., plan to begin legal proceedings against CJW and their members' agents this year if they are not indemnified for losses incurred in the 1984 underwriting year.

In all, about 1,452 CJW members face losses of at least 70 million pounds (\$127.6 million at current exchange rates) from the 1984 underwriting year, mainly due to U.S. casualty business underwritten by former Lloyd's underwriter Cyril J. Warrilow in the early 1980s.

Meanwhile, lawyers are trying to expedite litigation already begun by nearly 60 members of syndicates formerly managed by Oakeley Vaughan (Underwriting Agencies) Ltd., who are seeking indemnification from the Corporation of Lloyd's for more than 20 million pounds (\$36.5 million) of losses.

The outcome of this case could more clearly define the duties that the Corporation of Lloyd's owes Lloyd's members, observers say.

New underwriting agency agreements passed by the Council of Lloyd's late last year and the introduction of self-regulatory rules at Lloyd's more clearly define the duties that Lloyd's members' agents and managing agencies owe members, who—under the Lloyd's policy of unlimited liability—pledge all of their resources as security.

However, the extent of the underwriting agencies' duties to members so far has not been determined judicially, lawyers agree.

Consequently, the first court decision in a suit filed by members over underwriting losses likely will set landmark definitions and could have a major impact on Lloyd's and its underwriting agencies.

"No case has yet been decided regarding the question of duties owed (to Lloyd's members) so the first decision will be a landmark," said a spokesman for the London law firm Elborne Mitchell & Co.

All Lloyd's members must join Lloyd's through a members' agent, whose prime role is to manage a member's Lloyd's affairs.

A members' agent advises members about which syndicates to join and how much to invest in each; monitors the premium income written by each syndicate its members join; handles any changes in the members' underwriting limits; and deals with the administration of the members' investments at Lloyd's.

Managing agencies are the firms responsible for managing the syndicates at Lloyd's.

New agency agreements, passed late last year by the Council of Lloyd's and effective as of Jan. 1, 1990, define more clearly the distinction between the duties of members' agents to members and managing agents' duties to mem-

bers.

Under the new regulations, members will have a contractual relationship both with their members' agency and the managing agencies that manage each syndicate in which a member participates.

However, members currently sign a contract only with their members' agency, making the members' agent contractually responsible to members for the actual underwriting and conduct of insurance business, even though members' agents do not undertake these activities.

Because of this practice, a group of about 460 members is investigating the possibility of taking legal action against members' agents who placed them on syndicate 317/661, managed by RHM

Outhwaite (Underwriting Agencies) Ltd. in 1982.

The 1,614 members of syndicate 317/661 during the 1982 underwriting year will have to pay a total of 85.4 million pounds (\$155.7 million at current exchange rates) to cover estimated underwriting losses of 263.3 million pounds (\$480 million), primarily stemming from runoff reinsurance policies Mr. Outhwaite wrote in 1981 and 1982 (BI, Oct. 24, 1988).

Members likely will await the outcome of several arbitrations currently under way between Outhwaite and syndicates that ceded reinsurance to syndicate 317/661 before deciding whether to commence legal proceedings, said a spokesman for Richards Butler, the London law firm representing the members.

Mr. Outhwaite is disputing at least nine of the more than 30 runoff reinsurance contracts he wrote in late 1981 and 1982, claiming the ceding syndicates did not disclose adequate information about the risk.

However, both of the arbitrations decided so far have gone against Outhwaite (BI, Nov. 28, 1988; Oct. 24, 1988).

Although a legal report commissioned by 102 members' agents last year concluded that any litigation against Outhwaite alleging breach of duty would probably not succeed, further legal opinion has advised that action against members' agents could be more successful.

Stuart Boyd, a leading trial lawyer commissioned by the Corporation of Lloyd's to review the Outhwaite report, which was prepared

by the London law firm Freshfields, concluded that Freshfields was limited in its terms of reference.

Freshfields was "asked to consider whether Outhwaites were in breach of duty or breach of contract but . . . not asked to consider the liability of any other person or firm or corporate body whose conduct might have been open to criticism," said Mr. Boyd in his review.

In particular, Mr. Boyd pointed out that the legal principles concerning an underwriting agent's duty to its members "are not yet clearly established."

However, "it is reasonably well established that where there is no contract between the principal and the sub-agent (the underwriting agent), the intermediate agent (i.e.

Continued on next page



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Continued from previous page
the members' agent) is liable to his principal for the acts or omissions of the sub-agent," Mr. Boyd said.

"That being so, the members' agents would clearly be liable for the acts and omissions of Outhwaites. . . on the grounds that the members' agents themselves owed a duty to their names, and that the acts and omissions of Outhwaites have put the members' agents in breach of that duty," he said.

In addition, about 460 of the Outhwaite syndicate members commissioned London law firm Richards Butler to investigate the chances of successful litigation to recover losses.

"Richards Butler and leading counsel advise that under the law of agency, proof of breach of duty on the part of Outhwaites would result in indirect names having a proven claim for breach of duty against their members' agent," according to a letter sent late last year to members of the Outhwaite

1982 Names Assn.

In addition, Freshfields is "of the opinion that there appears to have been a breach of the 20% underwriting limit of syndicate 661. Overwriting should have been controlled by Lloyd's and was not. The possibility of names having a case against Lloyd's in this connection should be kept under review," noted Names Assn. Chairman Peter Nutting in the letter.

The association plans "either to pursue the names case in arbitration or court proceedings or to press Lloyd's to take the appropriate initiative to resolve the matter," Mr. Nutting wrote.

Regarding the Warrilow syndicate, a majority of the 200 members of Warrilow syndicate 553 who met last month voted to "seek an indemnity" for all losses on the 1984 year from CJW (Underwriting Agencies) and members' agents.

Estimated losses to members of the syndicate during the 1984 underwriting year, arising primarily

**The Oakeley
Vaughan case could
more clearly define
the duties Lloyd's
owes members.**

from U.S. casualty reinsurance or from coverage written under the binding authority of U.S. Lloyd's correspondents, total at least 71 million pounds (\$129.4 million at current exchange rates) (BI, May 23, 1988).

Meanwhile, the 1984 account is still open because of uncertainties regarding future liabilities.

Members voted to commence legal proceedings against CJW and their members' agents if the "indemnity is not forthcoming or is inadequate."

So far, about 470 Warrilow members have subscribed to a

Names Committee that commissioned accounting firm Peat Marwick Mcintock and law firm Elborne Mitchell to investigate the losses, said Tom Benyon, chairman of the committee.

Reports prepared by the two firms will be mailed to members this month, according to Mr. Benyon.

Meanwhile, in a summary of the reports handed to members at the December meeting, the Warrilow Steering Committee—chaired by Mr. Benyon—alleges that:

• An internal Lloyd's report produced in 1984 illustrates concern that "CJW was not competent to manage the syndicate."

• The reserving policies of syndicate 553 were inadequate. Mr. Benyon states in his summary of the reports that "it would appear that the syndicate's reserving policy was, surprisingly, the same for both the short- and long-tail accounts."

• Between 1978 and 1983 "the

syndicate consistently overwrote its premium income limits and was accordingly in breach of Lloyd's regulations."

• The rapid expansion of the syndicate to a capacity of 31.9 million pounds in 1984 from 900,000 pounds in 1978 "was not marked by the employment of additional and suitably experienced staff to deal with the syndicate's U.S. casualty business nor by the creation or development of suitable management systems to monitor and control the business being written."

The report states that until November 1984 Mr. Warrilow was the only full-time director of CJW.

According to Mr. Benyon, Elborne Mitchell has "advised that the syndicate was seriously mismanaged by CJW to such an extent that it amounted to negligence giving rise to a cause of action in tort."

However, no allegations of mismanagement are directed to the agency's current management team, which was brought in by Lloyd's during 1984, Mr. Benyon noted at the meeting.

In addition, Elborne Mitchell advises that the members' agents legally are liable to members "in respect of the acts or defaults of CJW if breach of duty by CJW (is) established," Mr. Benyon noted in the summary report.

The members' agents also are liable for any failure to "exercise reasonable skill and care" arising from their contractual and fiduciary duties to investigate syndicate 553 prior to placing members on the syndicate and to continue to monitor its performance, the report contends.

Mr. Benyon has written to John Shipton and Michael Payne, joint chairmen of the Warrilow Members' Agents' Committee, seeking a meeting.

Officials of that committee could not be reached for comment.

Meanwhile, lawyers are trying to expedite litigation already commenced by members stemming from losses sustained by syndicates formerly managed by Oakeley Vaughan (Underwriting) Ltd.

About 60 members of the syndicates are suing the Corporation of Lloyd's, alleging that Lloyd's failed to prevent the syndicates from overwriting their premium capacity.

In addition, Lloyd's is suing 10 members' agencies and Oakeley Vaughan auditors, seeking a declaration that the agencies and the auditors should be held liable to the members suing Lloyd's "for breach of a written contract of duty as agent or sub-agent responsible for the underwriting of syndicates" formerly managed by Oakeley Vaughan (BI, Feb. 15, 1988).

Although a trial date is not expected before the fall of 1990 because of the difficulty in obtaining court time, Elborne Mitchell, the law firm representing the members, is "considering making an application to the court for an expedited date on the grounds that the syndicates accounts have not closed. . . and that names continue to receive cash calls which, in several instances, they are unable to meet."

An application for an early trial hearing will be made later this month, said an Elborne Mitchell spokesman. The law firm hopes to obtain a trial date later this year or early 1990, he added.

The central issue of the litigation the members have filed against Lloyd's is the question of the duties the Corporation of Lloyd's owes to members, according to a recent letter sent by Mr. Benyon to Mr. Mitchell.

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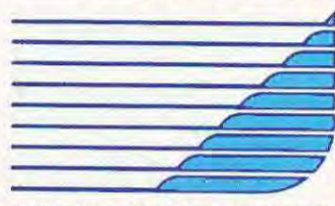
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3 countries may pay claims from air show crash

By HERBERT FROMME

BONN, West Germany—The Italian government's liability for deaths and injuries from the crash of military aircraft during an air show at a U.S. Air Force base in West Germany last August may be far less than originally anticipated.

The West German, U.S. and Italian governments now are negotiating the payment of claims, according to the Koblenz Defense Cost Office, a department of the West German tax authorities that is handling a portion of the claims.

Seventy spectators were killed and hundreds of others were injured in the accident (BI, Sept. 5).

The Koblenz Defense Cost Office—called Amt fuer Verteidigungslasten in German—estimates that the total cost of third-party liability claims stemming from the accident will range between 100 million deutsche marks and 300 million deutsche marks (between \$56.6 million and \$169.7 million), a spokesman for the Defense Cost Office said.

The United States may be held liable for a portion of the loss under the North Atlantic Treaty Organization Status of Forces Agreement because it organized the air show, the spokesman said.

If the United States shares responsibility for the loss, then under the terms of the NATO agreement it would pay 40% of the losses, the Italian government would pay 40% and the West German government would pay 20%, the spokesman said.

If the three governments decide that the United States is not responsible for losses, then the Italian government would pay 75% of the losses and the West German government would pay 25% of the claims, under the terms of the agreement, the Defense Cost Office spokesman said.

If the United States shares responsibility for the loss, the Italian government would pay only 40% of all losses.

West German civil aviation lawyers first believed after the Aug. 28 crash that the Italian government would be responsible under West German civilian aviation law for all losses because an Italian military aircraft plowed into the crowd at Ramstein Air Base in West Germany.

The Italian air force has liability insurance with limits of 2 billion lira (\$1.4 million) per aircraft with Milan Insurance, a member of Consortio Italiano Assicurazione Aeronautice, the Italian aviation insurance pool.

U.S. and West German authorities have not completed their investigation of the crash and cannot say how many of the 10 Italian jets performing aerobatic maneuvers were involved in the loss.

During the maneuvers, one Italian jet collided with two other Italian jets and hurtled into the crowd of spectators. The other two aircraft crashed away from the spectators.

Settlement of all the claims arising out of the Ramstein air show disaster is far from complete.

The West German government is handling all claims from the disaster, with the Koblenz Defense Cost Office handling claims exceeding 5,000 deutsche marks (\$2,828) and the Kaiserslautern branch of the Defense Cost Office handling smaller claims.

The office has received a total of 1,270 third-party liability claims. About two-thirds of the claims are "indirect claims," such as claims by employers who continued to pay wages to employees who missed work because of injuries suffered at the show and from health insurers who paid the cost of hospital treatments for those injured in the incident, the spokesman pointed out.

"Among the 1,270 claimants are 400 direct victims of the crash," he said.

The office had paid only 5.4 million deutsche marks (\$3.1 million) by Dec. 2, and those payments represent only advances on future settlements, including funeral expenses.

The advances range from 10,000 deutsche marks to 15,000 deutsche marks (\$5,657 to \$8,485) to each injured individual every three months.

In addition, the office is reimbursing hospital and other medical costs.

Relatives of those who were killed already have received compensation for funeral costs and regular maintenance payments, according to the Defense Cost Office. West German law does not allow claims for loss of companionship.

Also, no compensation will be paid in lump sums, and no bargaining for the sums involved is allowed.

Compensation is based on regular maintenance payments that are universally used in West German alimony and maintenance settlements. These amounts are established by the country's highest court, the Bundesgerichtshof.

Included in the compensation formula is the level of state pension benefits the victim would have received. But since the procedure for calculating the pension benefits takes roughly six months, no compensation settlements have so far been finalized for the bereaved.

The Defense Cost Office is under no legal obligation to pay before the precise sums have been fixed, the spokesman said.

Injured persons now are filing their detailed claims for compensation, including loss of income and pain and suffering, he said. No settlements have been reported so far.

West German life and accident insurers also have received claims stemming from the accident. These insurers have not yet tabulated their losses from the accident.

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EXEL Ltd. names Kevany president, CEO

Michael J. Kevany has been named chairman and chief executive officer of X.L. Insurance Co. Ltd. of Bridgetown, Barbados, and president and CEO of EXEL Ltd., X.L.'s parent company.

Mr. Kevany succeeds Ian Heap as chairman and CEO of X.L. and as president and CEO of EXEL. Mr. Heap will remain as chairman of EXEL. Brian O'Hara also remains as president of X.L.

Most recently, Mr. Kevany was president-special risk services of Philadelphia-based CIGNA Corp. He joined CIGNA in 1977 as vp and branch manager in New York.

Prior to joining CIGNA, Mr. Kevany held a variety of positions in his 20 years with Royal Insurance Co. of New York.

In other insurer changes:

Russell E. Leatherby named president of UniCARE Financial Corp. of Irvine, Calif. He succeeds Ralph W. Leatherby, who remains chairman and chief executive officer.

At New York-based Continental Corp., **George S. Zacharkow** and **Wayne H. Fisher** appointed senior vps and **Robert F. Mastroberti** appointed vp-field operations for the Agency & Brokerage Group.

Paul Mattera and **David A. King** named vps of Liberty Mutual Insurance Co. of Boston.

Robert J. Ott, D.D.S., named president and chief executive officer of Delta Dental Plan of New Jersey Inc. in Parsippany. He succeeds Joseph Pollack, D.D.S., who will continue as chairman.

Francis W. Rivelli named resident vp of Bituminous Insurance Cos. in Rock Island, Ill., a subsidiary of Old Republic International Corp. of Chicago.

Lary K. Rand appointed vp-standard markets for the commercial insurance division of Aetna Life & Casualty Co. of Hartford, Conn.

Leo J. Coleman named chairman and chief executive officer of the workers compensation operations of Farmington, Conn.-based Orion Capital Corp., which include Employee Benefits Insurance Co. and EBI Indemnity Co.

Elliott P. Gleason promoted to senior vp of Design Professionals Insurance Co. in Monterey, Calif., a unit of Employee Benefits Insurance Co.

Edward A. Wiegner joined Progressive Casualty Insurance Co. of Mayfield Heights, Ohio, as executive vp and chief financial officer. In his most recent position, Mr. Wiegner was senior vp and chief financial officer at Household International Inc.

Reinsurance

Edward F. Schwenzfeier appointed vp-facultative education & training of the facultative division of Princeton, N.J.-based American Re-Insurance Co.

Jean-Marie Nessi and **Dominique Maurin** named executive vp and vp, respectively, of Ancienne Mutuelle Reassurance of Paris.

Chairman **Patrick Peugeot** named chief executive officer of SCOR U.S. Corp. of New York. Mr. Peugeot also is chairman and chief executive officer of SCOR Paris.

Gerard A. Anaszewicz appointed vp of National Reinsurance Corp. of Stamford, Conn.

Michael J. Wybar promoted to executive vp of Sullivan Payne Co. in Seattle. Mr. Wybar will be based in the Philadelphia office.

Agents/brokers

Michael P. Cahill appointed senior vp and director-national energy division for the Los Angeles office of Alexander & Alexander of California Inc., a unit of Alexander

Comings & goings: industry

& Alexander Services Inc.

David R. Hoskins joined Andreini & Co. of San Mateo, Calif., as senior vp. Mr. Hoskins previously was president and chief executive officer of Crump E&S of California Insurance Services, now called S.J. Petrakis Insurance Services Inc., an affiliate of Crump E&S Group.

At Jardine Emmett & Chandler Inc., **Jeffery G. McKinley** appointed senior vp in San Francisco and **Edward A. Schwarz** promoted to chairman of the Phoenix office.

Robert M. Bryant named vp-governmental programs division of Markel Service Inc. Mr. Bryant

was president of Special Risks Inc., which Markel purchased earlier this year.

Other suppliers

R. Jane Hill appointed president of Risk Management Services in Short Hills, N.J., a division of Fred S. James & Co. Inc. where she also is a corporate vp. Ms. Hill is based in Nashville, Tenn.

Coopers & Lybrand's Actuarial, Benefits & Compensation Group of Detroit announced the following appointments: **Jerry Halperin** promoted to vice chairman; **Jack Forstadt** named national director-health and welfare consulting

practice; and **Iris Goldfein** named partner-in-charge of the Chicago office.



Ms. Hill

of Counties.

Ken E. Polk joined Buck Consultants Inc. of New York as manager of its Dallas office. Mr. Polk previously was a principal and manager of the Dallas office of William M. Mercer Meidinger Hansen Inc. of New York.

Richard D. Stover named a

principal of William M. Mercer Meidinger Hansen Inc. of New York. Mr. Stover is based in the Morristown, N.J., office.

Richard L. Skinner named president of Independent Benefit Plans Inc. of Beech Grove, Ind. Mr. Skinner succeeds W.B. Davenport, the founder and president, who will continue with the firm as a consultant.

Jenifer Cline promoted to vp-operations for Parkside Health Management Corp. of Park Ridge, Ill. Also, **Barbara J. Flewellyn** joined Parkside as director-operations for the Ohio region and will be based in the Cleveland office. In her most recent position, Ms. Flewellyn was director for the Health Enhancement Center of University Hospitals of Cleveland.



Aon forms new RBH holding company

Chicago-based Aon Corp. has restructured its brokerage operations and has formed a new holding company for four brokerage and consulting operations, including Rollins Burdick Hunter Co., the seventh-largest U.S. broker.

"Over the last few years the fundamental strengths of Rollins Burdick Hunter's retail brokerage business have grown substantially," explained Patrick G. Ryan, chairman and CEO of Rollins Burdick Hunter Group and president and CEO of Aon Corp.

"Our growth has been enhanced by significant diversification including expansion into employee benefit consulting, reinsurance and affinity group operations," he said. "This restructuring enables us to continue our basic teamwork strategy while emphasizing and focus-

Markets

ing on the strengths of four distinct services arms for the 1990s," Mr. Ryan said.

The newly formed Rollins Burdick Hunter Group comprises:

- Rollins Burdick Hunter Co., the nation's seventh-largest commercial insurance broker. Arthur F. Quern, chairman, president and chief executive officer of RBH, will continue to head the brokerage.

- The newly created Rollins Specialty Group Inc., which combines several existing operations to focus on brokerage services for financial institutions, associations and affinity groups. Michael D. Rice has been named president and CEO of Rollins Specialty Group. Pre-

viously, Mr. Rice was senior vp of Rollins Burdick Hunter Co.

- Miller, Mason & Dickenson Inc., an employee benefits consultant. President and CEO Daniel T. Cox will continue to head MM&D.

- Aon Risk Services Inc., which specializes in reinsurance brokerage through Aon Reinsurance Agency—formerly known as Reinsurance Agency Inc.—and Cole, Booth, Potter Inc. Michael D. O'Halleran has been appointed president and CEO of Aon Risk Services and is in charge of developing its long-range growth strategy.

Mr. O'Halleran joined Aon in November 1987, leaving Thomas A.

Greene & Co. Inc., an Alexander & Alexander Services Inc. unit.

When asked about any non-compete agreement, Mr. Ryan said that in the year since Mr. O'Halleran left the A&A unit, "A&A has not come to me with any suggestion that they are concerned in any way with what he is doing for us. So these non-compete covenants are a non-issue."

Paul R. Davies is president of Aon Reinsurance Agency and Cole, Booth & Potter Inc.

Captive manager

A new management firm has been organized to manage Vermont-based and other captive insurance companies.

Northern States Management Inc. in Waterbury Center, Vt., can

provide a full range of services to captives, including general consulting, management and reinsurance placement, said John J. Middleton, Northern States' president and chief executive officer.

Prior to establishing Northern States, Mr. Middleton was chief operating officer of Vermont Insurance Management Inc., a captive management company in Montpelier. He also was president of Hospital Underwriting Group, Tennessee-based captive.

For more information, contact Mr. Middleton at P.O. Box 160, Waterbury Center, Vt. 05677; 802-244-8607.

ALTA expands

ALTA Health Strategies Inc., a managed care company in Salt Lake City, has opened new preferred provider networks in Ohio/Northern Kentucky, California, Arizona and New Mexico.

The company, which currently has operational provider networks in seven states and serves more than 2 million people nationwide, also plans to expand its PPO network to Colorado and Texas this year.

ALTA Health Strategies also provides claims administration, utilization review and health data analysis.

For more information contact Carole L. Kennedy, senior-vp for managed care programs, at ALTA Health Strategies Inc., 2614 South 1935 West, Salt Lake City, Utah 84119; 801-973-7300.

Met Life expands

New York-based Metropolitan Life Insurance Co. is opening three new regional defined contribution service centers.

The new offices for the defined contribution record keeping services, known as METRORECORDS, are in New York, San Francisco and East Hanover, N.J.

"The regional service centers provide the kind of administrative and record keeping services that were previously available only in our New York home office," explained Jim Logan, vp-savings and retirement plan services.

"In addition to these new facilities, we plan to open more offices as our business continues to expand," Mr. Logan said.

The New York office will be run by Lois Snitkoff. Prior to joining Met Life, Ms. Snitkoff was responsible for technical aspects of defined contributions services as a vp at Citibank in New York, a unit of Citicorp.

The San Francisco and East Hanover, N.J., offices will be run by Serge Boccassini. Previously, Mr. Boccassini was director of all new business for Met Life's defined contribution clients.

For more information, contact Ms. Snitkoff at 1 Madison Ave., New York, N.Y. 10010; 212-578-6273; or Mr. Boccassini at 72 Eagle Rock Road, East Hanover, N.J. 07936; 201-515-1562.

James International

New York-based Fred S. James & Co. Inc. has entered into a cooperative business agreement with one of Japan's leading insurance agencies.

Under the agreement, James will serve as a general insurance resource and adviser to Ginsen Co. Ltd. of Tokyo, a subsidiary of the Sumitomo Bank of Japan.

James will provide a full range of insurance brokerage services to clients of Ginsen and the Sumitomo Bank with U.S. operations.

For clients who have risks out-

Continued on next page

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U.K. bill would hike insurance costs: CBI

By CAROLYN ALDRED

LONDON—The Confederation of British Industry, the United Kingdom's most influential trade organization, is urging members of Parliament to reject a government proposal it says will raise employers' liability and third-party insurance premiums by about 16%.

Under the proposed legislation, the government would reclaim from insurers and injured persons any state-sponsored aid received by an injured person who receives a liability or employers' liability claim payment.

Currently half of any social security benefits payment to an injured person is deducted from a claim payment made by an insurer and retained by the insurer. The injured person retains the other half of the social security benefit.

If insurers and injured persons are forced to reimburse the state for state-paid benefits, employers liability and third-

London

party liability insurance costs would increase by 60 million pounds per year (\$109.4 million at current exchange rate), according to the CBI.

The government proposal is included in a new social security bill, which is due to be debated in the House of Commons for the second time on Jan. 10.

In the United Kingdom, all employers must purchase insurance covering all employees for injuries. In addition, motorists must purchase third-party liability coverage.

Injured persons often receive social security payments before their claims against employers or third-parties are paid.

"All compulsory third-party and employer liability insurance will go up as a result of the government (plan) to claw

back benefits," said Dick Eberlie, the CBI's deputy director of employment affairs.

Insurers will likely raise rates to cover not only the cost of refunds to the government but also the increased cost of administration under the plan and the increase in damage awards that likely will result, said the CBI.

Injured parties seeking damages likely will press for higher awards to compensate for the 50% of benefits they would be required to repay the government under the proposal, according to the Assn. of British Insurers.

Outhwaite losses reduced

The recent jury decision against Shell Oil Co. in its pollution coverage case will reduce by millions of pounds the massive underwriting losses faced by members of Lloyd's of London.

Continued on next page

Markets

Continued from previous page
side of the United States, James will provide brokerage services through Sedgwick Group P.L.C., James' London-based parent company.

"Working with Ginsen opens new doors of opportunity for James among Japanese companies," said Jonathan M. Chettle, managing director of James International.

"Our clients and all Japanese companies are rapidly expanding overseas, especially in the United States," said Takeshi Fujiki, general manager of Ginsen's international division.

Name changes

The New York Cooperative Insurance Assn. has changed its name to the New York Insurance Alliance Inc. The association includes 54 New York-domiciled property/casualty insurance companies.

The Remedy Co., the Dallas-based subsidiary of Lindsey & Newson Claims Services Inc., has changed its name to American Health & Rehabilitation Services.

Mergers/acquisitions

Financial Guardian of Kansas Inc. and Kline Insurance Agency of Hutchinson, Kan. have merged.

New York-based Continental Corp. has signed a letter of intent with Tokio Marine & Fire Insurance Ltd., a Japanese insurer, to sell 40% of Continental's wholly owned subsidiary, First Insurance Co. of Hawaii.

Detroit-based Michigan Mutual Insurance Co. has agreed to acquire a one-third interest in Facultative Managers Corp. of Norwalk, Conn. Fremont Indemnity Co. of Los Angeles will retain a one-third ownership in the company. The remaining one-third ownership is held by senior officers.

Lindsey & Newson Inc. of Tyler, Texas, has acquired Bill Tassin Claims Service Inc. in Lafayette, La.

New Offices

Interstate Service Insurance Co. and Interstate Service Insurance Agency Inc. have relocated to 7720 Rivers Edge Drive, Columbus, Ohio 43235; 800-876-7483.

Webber Consulting Group Inc. has relocated to 630 Colonial Park Drive, Suite 200, Roswell, Ga. 30075; 404-641-1868; 800-562-2242.

Turner Insurance & Bonding Co. Inc. has relocated to 2601 Bell Road, Montgomery, Ala. 36117; 205-244-0004; 800-828-8015.

National Claims Service Inc. of Richmond, Va., has opened a new office at 1315 Glenburnie Road, Suite C12, New Bern, N.C. 28561; 919-637-2600. ■

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Continued from previous page
don syndicate 317/661 underwritten by Richard Outhwaite if the ruling is not overturned.

Syndicate 317/661 had set aside about 8 million pounds (\$14.6 million at current exchange rate) to cover losses if Shell won its coverage battle.

Shell, however, lost its demand for coverage in the first pollution coverage jury trial to be concluded in the United States. The jury told Shell that it cannot claim pollution clean-up costs from any of its 260 comprehensive general liability insurers (*BI*, Dec. 26, 1988).

Shell is appealing the decision.

The 1,614 members of the syndicate's 1982 underwriting year were told last year that they must pay a total of at least 85.4 million pounds

(\$155.7 million) to cover estimated underwriting losses of 263.3 million pounds (\$480 million), about 15% of which stem from run-off reinsurance policies that underwriter Richard Outhwaite wrote in 1981 and 1982 (*BI*, Oct. 24, 1988).

Of the 263.3 million pounds in reserves for the 1981 and 1982 account years, about 40 million pounds (\$77.9 million)—including the 8 million pounds set aside for Shell—are earmarked to cover all pollution-related claims from the United States, said a spokesman for R.H.M. Outhwaite (Underwriting Agencies) Ltd., the syndicate's managing agency.

London's role after 1992

Most British insurance and rein-

surance company executives believe that London's position as the major European insurance center is threatened by the changes likely to follow the 1992 removal of trade barriers in the European Community, according to a recent survey.

Twenty-seven percent of chief executive officers polled by accounting firm Ernst & Whinney think London's prominence is threatened, 54% expect London's position to be slightly threatened and 18% believe the changes present no threat.

British underwriting and brokerage companies are analyzing how to prepare for 1992.

While 60% of the 122 companies surveyed have begun their analysis, only 5% have put plans into operation, the survey found. Another

5% of the respondents have determined a strategy, which has not yet been acted upon, and 24% of the respondents have a partially determined strategy.

But, 63% say they do not have sufficient information to determine a strategy for 1992.

Forty-five percent of the respondents believe that their key goal when the trade barriers are lifted must be to refocus on a broader, European market rather than on their companies' traditional markets, while 44% of the respondents consider the most important objective is to become an established niche player.

Companies proposing to trade in other EC countries will adopt one or more methods, the survey found. For example, 53% of U.K. com-

panies will adopt cooperation agreements with companies in other countries; 42% will make acquisitions; 21% plan to develop existing representation; 15% will merge with other companies; and 15% will launch new operations.

IIE syndicate sale

London United Investments (Holdings) P.L.C., parent company of H.S. Weavers (Underwriting) Agencies Ltd., plans to acquire CalFed Insurance Syndicate Inc. on the Illinois Insurance Exchange for \$12.7 million.

The IIE syndicate is managed by LUI subsidiary LUI Management Inc., which also manages IIE syndicate LUI Insurance Syndicate Inc.

The two syndicates write excess liability insurance for large risks as well as primary and excess property coverages.

Each syndicate wrote \$12.5 million in gross premiums in the first nine months of 1988 (*BI*, Aug. 29, 1988).

The CalFed syndicate was sold by Los Angeles-based CalFed Inc., which also owns Anglo-American Insurance Co. Ltd., one of the two insurers on the Weavers underwriting stamp.

"The acquisition will give the London United Group a much stronger presence on the Illinois Insurance Exchange, which should enable both syndicates to write an increased amount of business as well as having a greater say in the running of the Illinois Insurance Exchange," said a statement issued by LUI in London.

Richard Foss, president of LUI Management Inc., said that with the sale, the two syndicates will start to write small liability accounts on an occurrence basis, something Cal-Fed had not wanted to do.

Prominent lawyer dies

Donald O'May, one of London's leading insurance and maritime lawyers, died on Dec. 30 at age 61.

Mr. O'May joined the London law firm Ince & Co. in 1951 and became a partner in 1954.

At the time of his death, Mr. O'May was chairman of the steering committee of the European Users' Council of the London Court of International Arbitration; a member of the Commercial Court Users' Committee; and a member of the Technical and Clauses Committee of the Institute of London Underwriters.

Mr. O'May also was working on the last stages of a book on marine insurance.

Comings & goings

Chris Head has been appointed managing director and **Roy White** has been appointed a director of the Professional Indemnity & Financial Institutions Group of Sedgwick Associated Risks Ltd. Mr. Head moved to The Sedgwick Group P.L.C. unit from Hogg Robinson & Gardner Mountain P.L.C. Mr. White is rejoining Sedgwick from C.T. Bowring & Co. Ltd.

Gordon Sanders has joined Sedgwick Ltd., a unit of the Sedgwick Group, as senior consultant to a new research and development planning committee. Mr. Sanders previously was senior risk management consultant at London accounting firm Peat Marwick McLintock.

David Meachem joined Price Forbes Ltd., the reinsurance brokering subsidiary of Sedgwick Group, as a director with responsibility for casualty and special risks. Mr. Meachem was a partner in London broker Anthony Popple & Co. before its acquisition by PWS Holdings P.L.C. Most recently, Mr. Meachem worked as a consultant with Robert Fleming Insurance Brokers Ltd. ■

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ASK A CASUALTY ACTUARY

Reflecting loss reserves on financial statements

Q Our corporation self-insures up to fairly high retentions a number of its casualty exposures. Should we or should we not reflect loss reserves for casualty claims on our financial statements? My understanding is that current practices vary widely with respect to this issue. What is your opinion?

A You are correct when you say that current practices vary widely. Some corporations do not carry any liability on their books for self-insured casualty claims, while others set up an amount equal to the total of the claims adjuster's case reserve estimates. Still others carry an additional amount beyond the actual case reserves to reflect adverse development of the case reserves and other corporations also include an additional provision for incurred-but-not-reported claims. Each of these practices is not uncommon, although it is difficult to say how widespread each one is. It should be recognized, however, that much of this variation in practice is due to differences in facts and circumstances among different companies, rather than to differences of opinion in interpreting current accounting and actuarial standards.

There has been a tendency over time for more and more corporations to establish accruals for self-insured losses. This is due in large part to the trend toward higher retentions and the greater availability of accurate loss data on which to base the magnitude of the accrual.

From an actuarial standpoint, the most relevant pronouncement on this issue is contained in the report of the American Academy of Actuaries Task Force on Self-Insured Trust Funds. While this document was developed for hospital liability self-insurance, it also applies to private corporations and public entities.

The task force report clearly requires—from an actuarial perspective—that a liability should be established that makes a provision not only for individual claim reserves, but also for adverse development on those claims reserves as well as for IBNR claims and for adverse fluctuations in reserves. In other words, provision should be made not only for the unexpected value of such liabilities, but also for the possibility that random fluctuations will cause the ultimate cost of claims to exceed the expected value.

Not uncommonly, actuaries interpret this to require that the reserve should be carried at a confidence level higher than that of the expected value, whether 70%, 90% or higher. However, the present value of future investment income is allowed as an offset to the entire reserve to be established. This is in contrast to accounting standards, which generally do not allow either discounting or reserves carried at a confidence level much higher than the expected value.

Let's take a look at the various arguments that are commonly made to support each of the above-mentioned positions on this issue from an accounting perspective.

The notion that self-insurance reserves are altogether unnecessary is based on the idea that the magnitude of such reserves, if established, would not be material to the financial statements. While this is not infrequently the case, it has become less and less likely in recent years because of increasing retentions and the long-tail nature of many of the

claims subject to high retentions.

The notion that accruals for self-insurance liabilities are unnecessary conflicts with the general principle of conservatism that is fundamental to accounting.

The issue of materiality only becomes relevant in the context of an independent CPA firm issuing an opinion on a set of financial statements. Often in the past, the auditing firm has not made an issue of the non-accrual for self-insured losses because the amount of such an accrual would not have material impact on net income or net worth (but that does not necessarily mean that non-accrual is the proper treatment according to accounting principles). More recently, however, as retentions have risen, it has become much less likely that the amounts involved would not be material.

From an accounting standpoint, the key pronouncement on this issue is Financial Accounting Standards Board Statement No. 5.

FASB 5 states, "An estimated loss from a loss contingency shall be accrued by a charge to income if both of the following conditions are met: one, information available prior to issuance of the financial statements indicates that it is probable that an asset had been impaired or a liability had been incurred at the date of the financial statements. It is implicit in this condition that it must be probable that one or more future events will

The notion that accruals for self-insurance liabilities are unnecessary conflicts with the general principle of conservatism that is fundamental to accounting.

occur confirming the fact of the loss; two, the amount of the loss can be reasonably estimated."

FASB 5 stipulates two conditions:

- It is probable that a liability has been incurred.
- The amount of loss can be reasonably estimated.

The first condition depends on the likelihood that a loss has been incurred. If that probability is "remote"; i.e., the chance of the future event or events occurring is "slight," then no accrual is needed. If that probability is "reasonably possible"—which is defined as "more than remote but less than likely"—then no accrual is needed, but disclosure is required if the amount is material.

"The disclosure shall indicate the nature of the contingency and shall give an estimate of the possible loss or range of loss or state that such an estimate cannot be made," according to FASB 5. If that likelihood is "probable"—i.e., "likely to occur"—then the first condition has been met.

With respect to the first condition (that it is probable a liability has been incurred), a number of observations may be made:

- For known, uncontested claims, it would appear that this condition has been satisfied. For example, most workers compensation claims are of this type.
- For known, contested claims, which is often the case with liability claims, it could be open to question as to whether this first condition has been satisfied. Accounting standards require advice from an attorney (who will be guided by American Bar Assn. rules) in classifying any one loss as either likely, reasonably possible or remote.
- For unknown claims (i.e., IBNR claims)—where the event that will give rise to the claim has already occurred but where the corporation or claims administrator has not yet been notified—the fact that the claim hasn't been reported yet but every other event that would establish that a liability exists has occurred, suggests that IBNR claims meet this first condition.

In fact, paragraph 35 of FASB 5 states: "Accrual may be appropriate for litigation, claims or

assessments whose underlying cause is an event occurring on or before the date of an enterprise's financial statements even if the enterprise does not become aware of the existence or the possibility of the lawsuit, claim or assessment until after the date of the financial statements."

With respect to the second condition (that the amount of loss can be reasonably estimated), frequently a reserve isn't established because it is claimed that the size of the liability cannot be reasonably estimated. What is usually the case, however, is that the size of the reserve can be estimated within a broad range (e.g., \$1 million-\$5 million).

The fact that the range is often broad is usually cited as support for the idea that the reserve cannot be reasonably estimated. However, paragraph 39 of FASB 5 makes it clear that the simple fact that "the range of possible loss is wide" does not demonstrate that the amount of the loss cannot be reasonably estimated. In the range cited above, it is fairly certain that the liability is at least \$1 million and, therefore, a reserve of at least that magnitude should be established (provided that the first condition of FASB 5 is also met).

Interpretation 14 of FASB 5 provides a number of clarifications that are important here.

First, it states that the second condition of FASB 5 "does not delay accrual of a loss until only a single amount can be reasonably estimated. To the contrary," when the first condition is met, "and information available indicates that the estimated amount of loss is within a range of amounts, it follows that some amount of loss has occurred and can be reasonably estimated."

Interpretation 14 also states, "When some amount within the range appears at the time to be a better estimate than any other amount within the range, that amount shall be accrued. When no amount within the range is a better estimate than any other amount, however, the minimum amount in the range shall be accrued."

Generally Accepted Accounting Principles also require a disclosure of the range of values and that the booked amount represents the minimum.

Paragraphs 4, 5 and 6 of Interpretation 14 describe examples that are so relevant to your question that I will quote them in their entirety:

"As an example, assume that an enterprise is involved in litigation at the close of its fiscal year ending Dec. 31, 1976, and information available

Continued on next page

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Mr. Sherman

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

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

Coping with retiree health care costs

By William H. Sharkey Jr.

RETIREE HEALTH BENEFITS have suddenly emerged as the most controversial, misunderstood issue to face corporate America this decade. Current notoriety aside—and with the advantage of hindsight—it is an issue that should have demanded, but never got, our corporate attention at least a generation ago.

Pushing the benefits issue to the forefront is a set of proposed accounting standards that will force companies to reckon and post as a debit the cost of their current and future retiree health benefits. A draft version of the standards is due out in the near future from the Financial Accounting Standards Board, with a final version to be phased in in late 1991.

The "day of reckoning" for retiree health benefits has been long overdue. Look deeper at the issue and you see a problem that has been growing steadily over the past decade: How to pay for and provide cost-effective benefits to more and more retired employees as health care costs continue to spiral upward and as workers retire earlier and earlier.

Such reckoning is foreign in corporate America. Most companies providing such benefits do so on a comfortable pay-as-you-go basis, without estimating, posting as a debit or setting aside funds for the health needs of their current and future retirees. And, in fairness to employers, the lack of tax incentives in large part has helped perpetuate this head-in-the-sand system.

The consequences of this system have been enormous. America's overall corporate liability for retiree health benefits is estimated to be as high as \$2 trillion. Put that unfunded liability on the corporate balance sheet—as FASB will require—and you can understand all the corporate uproar.

Clearly, the FASB rules will force a change in the popular pay-as-you-go system—a change most unpopular with employers.

But before shooting the messenger of this bad news, take a closer look at

the problem driving the issue. The persistent spiral of health care costs and the just-as-persistent greying of the baby boom generation continue to push up the cost of retiree health benefits.

Ultimately, that cost will be too high for many companies. Furthermore, the judicial trend of making companies honor their retiree obligations is rendering that reality inescapable.

As that reality becomes clearer, many companies will eventually change the retiree health benefit system. FASB is merely accelerating this change. But, changing the system will be difficult and corporate options are few.

Some companies may consider eliminating benefits for current employees in order to eliminate their

provides its own set of challenges. Benefit systems will have to be overhauled to sort out employees who qualify for retiree benefits from those who don't. Then, projecting medical and administrative costs 30 years hence for those employees also will be difficult.

To better address this issue, companies must now begin to decide how to more aggressively manage their retiree health care costs. Better cost management today will shape the extent of retiree health obligations in the future. Beset by health care inflation, many companies already have begun to try to control these costs. Some are making very tough decisions.

In today's competitive environment, companies are torn between the

Since some HMOs and managed care programs would require retirees to change physicians and hospitals in the approved HMO or other program, companies need to sensitively communicate this change. Employers will need to better describe advantages of quality medical services delivered through managed care programs.

Younger employees—tomorrow's retirees—have found managed care programs to be an effective, cost-saving system of quality health care. A key attraction in some managed care programs has been the freedom of choice that gives people access—at a cost—to physicians outside the network.

Those of us in the health insurance industry are working to make these programs more sensitive to the needs of retirees, those about to retire and employees far from retirement.

In addition to controlling costs, these new programs must, among other essential elements, address employees' needs for long-term care, adult day care and home health services that allow people to stay healthy and independent as long as possible.

Once effective benefit programs are built and sensitively communicated, more precise estimates of retiree health care liabilities can be produced. And finally, work can begin on building assets to meet those liabilities, even though investing today to pay for retiree health care in the future is not as attractive as investing in tax-favored pension plans.

And a new retiree health benefits system can work. Even with the tremendous demographic and economic forces in play, if employers and employees work together they can create a workable benefits system—a system that will help employers control their health benefits liability and protect retirees from the financial ruin of a serious illness.

William H. Sharkey Jr. is vp-marketing for CIGNA Corp.'s Employee Benefits Group in Bloomfield, Conn.

Speaking out

future obligations for retirees. This could force a substantial reverse cost shifting from the private to the public sector. And, in this worst case scenario, all of us, both corporate entities and private citizens, will pay in the form of taxes for the inevitable increased use of Medicare.

More important, no company can afford the social impact of such a drastic step. Most Americans want to stay financially independent. But strip them of their health benefits and in many cases you strip them of that independence. You would also strip many companies of their morale and ultimately their productivity.

Another bad option is to hinge corporate hopes and actions on a tax break from Congress to help accumulate the needed assets. In this deficit-plagued era, such a Congressional move would be unlikely.

Even so, a tax break won't make the liability vanish. Under the corporate tax structure, a company with a \$10 million liability would only get a 38% tax reduction. That leaves a \$6.2 million liability. So, there still will be considerable numbers to reckon with.

Even reckoning this liability

interests of their employees and those of their shareholders. On an emotional level, companies still want to be the paternalistic provider of benefits; fiscally, they can't.

Part of the solution to the retiree benefits dilemma involves greater cost sharing between employer and employee through higher deductibles and larger copayments for medical services and prescriptions. Some companies are creating a sliding scale of retiree benefits, using length of service to determine the level of benefit.

But, it's important that employees know that they will have to pay a greater share of their medical benefits. Employees need enough notice to factor the additional cost of health benefits into their current expenses and their retirement plans.

Another important element in the solution is for companies to continue to control health care costs through health maintenance organizations and other integrated managed care programs. It's true that most older people today have built long relationships with their physicians and local hospitals and have been resistant to changing physicians.

Self-insured loss reserves

Continued from previous page

indicates that an unfavorable outcome is probable. Subsequently, after a trial on the issues, a verdict unfavorable to the enterprise is handed down but the amount of damages remains unresolved at the time the financial statements are issued. Although the enterprise is unable to estimate the exact amount of loss, its reasonable estimate at the time is that the judgment will be for not less than \$3 million or more than \$9 million. No amount in that range appears at the time to be a better estimate than any other amount. FASB Statement No. 5 requires: accrual of the \$3 million at Dec. 31, 1976; disclosure of the nature of the contingency and the exposure to an additional amount of loss up to \$6 million; and possibly disclosure of the amount of the accrual.

"The same answer would result under the example. . . above, if it is probable that a verdict will be unfavorable even though the trial has not been completed before the financial statements are issued. In that situation, (the first condition) would be met because information available to the

enterprise indicates that an unfavorable verdict is probable. An assessment that the range of loss is between \$3 million and \$9 million would meet (the second condition). If no single amount in that range is a better estimate than any other amount, FASB Statement No. 5 requires an accrual of \$3 million at Dec. 31, 1976, disclosure of the nature of the contingency and the exposure up to \$6 million and possibly disclosure of the amount of the accrual. Note, however, that if the enterprise had assessed the verdict differently—e.g., that an unfavorable verdict was not probable but was only reasonably possible—the (first condition) would not have been met and no amount of loss would be accrued but the nature of the contingency and any amount of loss that is reasonably possible would be disclosed.

"Assume that in the examples given. . . above, (the first condition) has been met and a reasonable estimate of loss is a range between \$3 million and \$9 million but a loss of \$4 million is a better estimate than any other amount in that range. In that situation, FASB Statement No. 5 requires: accrual of \$4 million; disclosure of the nature of the

contingency and the exposure to an additional loss of up to \$5 million; and possibly disclosure of the amount of the accrual."

In some instances, it may be appropriate to argue that it cannot be shown that the liability will fall within a stated range. The actuary's ability to estimate the required amounts depends on the quality and availability of data and the nature of the type of exposure (loss). Some circumstances make it inherently impossible to estimate the magnitude of the liability with any degree of accuracy. In other circumstances—for example, when dealing with good data for a significant volume of claims—the law of large numbers applies and accurate estimation is clearly possible.

In the final analysis, each situation must be judged by the facts at hand in determining whether or how much of a reserve should be established for self-insured loss and the appropriate disclosures to be made. You should work very closely with your internal financial people and your independent auditor or consulting actuary in determining what is appropriate for your company's situation.

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EC directive

Continued from page 2
for the EC in Brussels.

The United Kingdom changed the wording of the directive's optional developmental risk defense—also known as the state-of-the-art defense—when it implemented the product liability legislation in its Consumer Protection Act in 1987 (BI, June 15, 1987).

The wording of the developmental risk defense in the EC directive states that a producer is not liable if "the state of scientific and technical knowledge at the relevant time was not such as to enable the existence of the defect to be discovered."

This is interpreted to mean that a producer is liable for a defective product if anyone, anywhere in the world, could have realized the existence of the defect.

The wording incorporated into the British law states that a producer is not liable if "the state of scientific and technical knowledge at the relevant time was not such that a producer of products of the same description as the product in question might be expected to have discovered the defect if it had existed in his product while they were under his control."

Under the British law, a producer is liable only if it was possible for another manufacturer of the same product to have detected the defect.

The British law's wording "goes too far. It reintroduces the status of having to prove negligence—that the producer who was responsible was acting below the status of his profession," said Mr. Tachner.

The British law is "much more in favor of industry and is a contradiction of the (EC's) intent of the directive," he added.

Italy's product liability law also broadens producers' defenses beyond that permitted by the EC directive.

For example, the EC directive states that a producer cannot be held liable if a product is produced according to mandatory standards laid down by government authorities. The Italian law does not specify that the mandatory norms must be issued by government authorities. Thus, under the Italian law, production of an item according to industry norms could be used as a defense by producers, said Mr. Tachner.

The EC plans to issue a formal notice to both countries this month, warning them to amend their laws within three months or the commission will take the matter to the European Court of Justice, he said.

Meanwhile, the commission this month is writing to the nine countries that have not adopted the product liability directive to remind them that the implementation date was more than five months ago. Countries that do not pass legislation within three months will receive a second warning that the EC will commence legal action in the European Court of Justice.

Although the European Court of Justice cannot impose fines or other punitive measures, being sued by the commission damages a member state's political prestige and is not welcomed, said Mr. Tachner.

"I'm very hopeful that in the next three to four months the majority of member states will finish putting through the necessary legislation," he added. ■

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Around the states

Connecticut OKs hike in workers comp rates

HARTFORD, Conn.—Connecticut employers this year will pay about \$65 million more in workers compensation insurance premiums than they paid in 1988 following an Insurance Department decision to allow an average 10.7% workers comp insurance rate increase.

The National Council on Compensation Insurance had sought a 25.5% rate increase, which would have increased employers work comp premiums by \$150 million, said Toby Doyle, legal counsel for the Insurance Department.

At a Nov. 15 public hearing—the first ever held in the state on a workers compensation issue—contractors and other employers objected to the NCCI proposal, Mr. Doyle said.

The new rates, which took effect Jan. 1, will mean an average increase in workers comp rates of 14.2% for manufacturers, 15.7% for contractors and 4.9% for all other industries, according to Mr. Doyle.

In his Dec. 2 decision, Insurance Commissioner Peter F. Kelly noted that 7.83% of the NCCI's 25.5% requested rate increase should be rejected because NCCI rates do not take into account insurers' investment income.

In addition, Commissioner Kelly noted that 6.9% of the NCCI's requested rate hike represented expected increases in the cost of claims and was not justified.

The NCCI agreed to the department's rate increase on Dec. 22.

—By Laura Mazzuca

Texas work comp bill

AUSTIN, Texas—Rep. Richard A. Smith will introduce H.B. 1 with recommendations for reform of the Texas workers compensation system when the Texas Legislature convenes Tuesday.

Rep. Smith, R-Bryan, will introduce the bill that will include 90% to 95% of the recommendations released by the Joint Select Committee on Workers Compensation Insurance in December, according to a spokesman at his Austin office.

The bill will call for:

- Changing the state's Industrial Accident Board to have as many as nine part-time members with an executive director, rather than the current three full-time members.
- Allowing some businesses in the state to self-insure their workers comp risks, a practice currently barred in Texas.
- Elimination of trial de novo, the right of an injured worker to appeal to a state court jury, which is not allowed to consider evidence previously heard by the Industrial Accident Board. "We would like to keep the final decision-making authority within the Industrial Accident Board," said the spokesman.

The intent of the bill is not to eliminate a worker's access to the court, he said. But, the proposed legislation calls for a "substantial evidence standard" that would only allow an appeal if there is evidence that would discount the findings of the IAB, he explained.

—By Michael Bradford

Illinois tax dispute

SPRINGFIELD, Ill.—An estimated \$56 million in disputed premium tax payments held in a protest fund since 1985 will be immediately deposited into the Illinois General Revenue Fund following a court-ordered settlement, according to a spokesman for Illinois Attorney General Neil F. Hartigan.

The protest fund was established four years ago when New York-based Metropolitan Life Insurance Co. and 27 other out-of-state insurers sued the Illinois Department of Insurance. The companies disputed the constitutionality of an Illinois statute imposing a special 2% premium tax on all policies written in Illinois by property/casualty and life/health insurers headquartered in other states.

The 2% tax is levied in addition to other premium taxes the insurers owe.

The companies had alleged the tax unfairly discriminated against out-of-state companies, the spokesman said.

Under the terms of a court-ordered agreement imposed by Sangamon County Circuit Court Judge Simon L. Friedman last week, the 28 insurers agreed to release the \$56 million in accumulated taxes and continue paying the 2% premium tax.

The insurance companies will honor the agreement as long as the tax is not increased and "there are not material changes made in the statute by the legislature in intervening years," according to the settlement documents.

William S. Hanley of the Springfield law firm of Sorling, Northrup, Hanna, Cullen & Cochran and counsel for the insurance companies, would not comment on the settlement terms.

To be exempt from the special premium tax, an insurance company must:

- Be incorporated in Illinois.
- Maintain headquarters in Illinois.
- Locate officers in Illinois.
- Conduct underwriting operations in Illinois.
- Maintain appropriate records in Illinois.

—By Kari Berman

Texas rehabilitations

AUSTIN, Texas—Management changes at the Texas State Board of Insurance and additional financial examiners are partly responsible for a recent spurt in the number of Texas insurers placed in rehabilitation, according to the regulatory agency.

A board spokeswoman pointed out that the 20 insurers placed in rehabilitation during the first four months of fiscal year 1989 compares with 17 targeted during the whole fiscal year 1988.

State law prohibits the board from releasing the names of insurers in rehabilitation and the spokeswoman could not provide a breakdown of the size of the companies or the types of business they write.

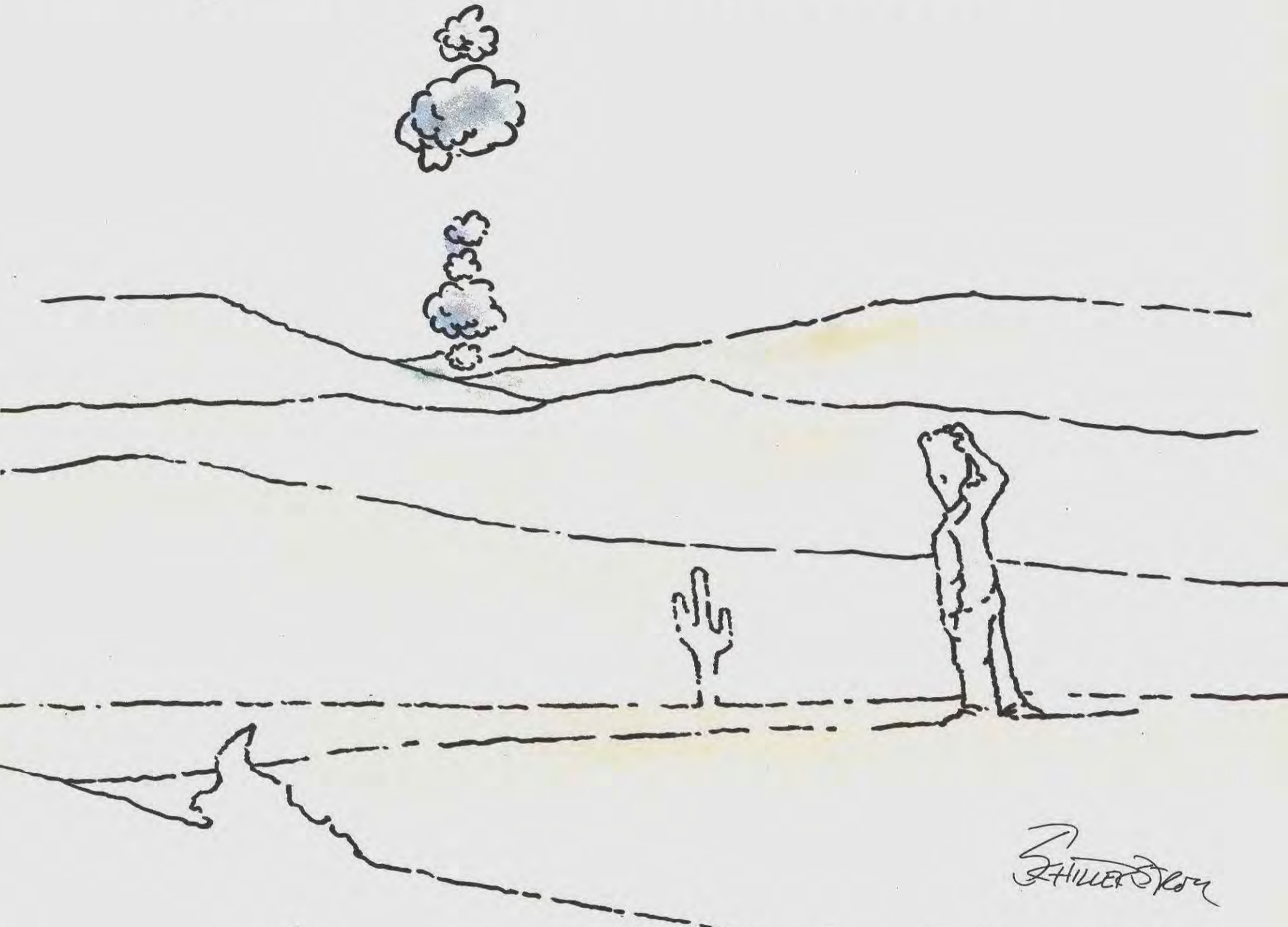
Recent personnel changes at the board include the appointment of Deputy Commissioner Nick Williams to direct a "management information systems division," which acts as an early-warning system to alert regulators when an insurer is headed for financial trouble (BI, Dec. 12, 1988).

James Odiome, who held the positions of chief liquidator and head of the board's financial division, was previously in charge of monitoring the financial health of insurers. He resigned after being removed as head of finance.

Insurance Commissioner Doyce Lee resigned late last year amid criticism of agency management. He was replaced by Deputy Commissioner A.W. "Woody" Pogue (BI, Dec. 26, 1988).

—By Michael Bradford

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Prudential suit

Continued from page 3
ceilings upon which it rests," said the magistrate.

Prudential also claimed there was actual property damage because the intrinsic value of its building was diminished by the presence of asbestos.

"Based upon these allegations, and the inferences which may properly be drawn therefrom, the plaintiff's second amended complaint can be read to allege property damage rather than purely economic loss," concluded the magistrate. "The plaintiff should be allowed to proceed in its tort claim."

Furthermore, the court said: "Although the 1st Circuit has not spoken on this issue, there is federal case law which permits tort recovery in analogous asbestos property damage suits."

And, the magistrate noted, "Other courts have recognized the right to recover under negligence theories in asbestos property damage cases."

Prudential is suing Turner & Newall P.L.C., a Manchester, England-based asbestos producer; Turner & Newall Ltd., also of Manchester; Armstrong World Industries Inc. of Lancaster, Pa.; and AC&S Co., also of Lancaster.

Originally, the lawsuit also named W.R. Grace & Co. of New

York; Celotex Corp. of Tampa, Fla.; Dana Corp. of Toledo, Ohio; and Keene Corp. of New York.

These producers were dismissed in Prudential's second amended complaint because the lawsuit was narrowed to include only one building to which these asbestos producers did not supply products.

The case sparked some controversy when it was filed because Prudential Reinsurance Co., a subsidiary of Prudential, is known to have reinsured the liability insurance for at least one of the asbestos producers named in the suit.

Prudential Reinsures Armstrong's risks, said Prudential attorney Peter T. Enslein of Ashcraft & Gerel in Washington, D.C.

That means that any recovery to the company will be reduced by Prudential Re's cost of any award.

Prudential is a mutual insurer, owned by its policyholders.

The initial rulings from Magistrate Collings represent some of the earliest federal court rulings on asbestos property damage in commercial buildings.

Attorneys say only a dozen or so courts have addressed the issues associated with asbestos in commercial buildings.

Magistrate Collings' rulings "reinforce the principles other courts have accepted," said Prudential attorney Mr. Enslein.

Courts nationwide are virtually unanimous in their belief that as-

bestos in buildings constitutes property damage, he said.

The most influential decision to date on the subject came down last fall when San Mateo County Superior Court Judge Ira A. Brown Jr., who is presiding over the coordinated asbestos coverage cases in San Francisco, ruled asbestos in buildings constitutes property damage (BI, Sept. 12, 1988; Sept. 5, 1988).

Industry observers say if building owners are successful in proving that asbestos in buildings constitutes property damage, this type of litigation could surpass in size and scope the asbestos bodily injury litigation.

These rulings "are important to buildings' owners—they tell them they do have recourse" when they discover asbestos in their buildings, said Mr. Enslein.

In addition to ruling that Prudential has the right to sue the four asbestos producers for negligence, Magistrate Collings made several other significant rulings Dec. 12.

The magistrate ruled that:

- The asbestos producers are not liable under the theory of strict liability, under which manufacturers can be held responsible for any and all defects in their products.

- However, the magistrate noted that Prudential can proceed with its claims for breach of express and implied warranty against the asbestos producers.

- Prudential's claims against the asbestos producers for fraud and conspiracy lack the specificity required by the law.

However, the magistrate did allow one specific fraud claim to stand. He allowed Prudential to proceed with its claim that Andrew C. Richardson, the commodity manager of Armstrong Contracting, a unit of AC&S, misrepresented the durability and appropriateness of its asbestos products.

Mr. Richardson allegedly "assured Prudential that Sprayed Limpet Asbestos when used with an overspray... was durable and therefore appropriate for the use contemplated by Prudential." Pru-

dential says it relied on this representation, which was allegedly false and known to be false by the producer at the time it was made.

- Prudential's claim against the asbestos producers for unfair and deceptive business practices is not valid because the Massachusetts law titled "Deceptive Sales Practices" under which Prudential brought its claim was enacted in 1972, 10 years after the asbestos producers sold their products to Prudential.

Discovery in the case has been going on for several years. Magistrate Collings is expected to rule on several discovery-related motions later this year.

A jury trial is expected to begin in 1990.

Prudential Insurance Co. of America vs. Turner & Newall P.L.C., Turner & Newall Ltd., AC&S Inc., Armstrong World Industries Inc.; U.S. District Court for the District of Massachusetts, No. 85-2179-H.

Blood bank wins AIDS suit

Continued from page 2
that identify donors at an increased risk for AIDS."

The papers state that tests such as the "T-Cell test, lymphopenia test or hepatitis B-Core antibody tests" could have screened out "potentially AIDS-infected donors."

Mr. Weed said, "A high ratio of people who get the AIDS virus, long before they show symptoms, have an inverted T-Cell ratio."

However, Billie Bellengee, an attorney with the Dallas law firm Cowles & Thompson, who represented the blood center, disagreed.

"Those are not tests for AIDS. There was no study or literature that said those tests were appropriate for screening for AIDS," Ms. Bellengee said of the charges that Wadley could have used tests like the T-Cell test.

Prior to the spring of 1985, the blood center among other things asked in writing and orally each potential donor whether that person had symptoms of AIDS, she said. Also, donors received handouts describing AIDS symptoms and warning those in the high-risk categories not to donate blood, said Ms. Bellengee.

The center required each donor to sign a card that indicated the person had read the AIDS information, she said.

"The jury realized that when anybody gets AIDS, it is a terrible thing. But there was nothing that could have been done to prevent it" in this case, Ms. Bellengee said.

In winning the California case in December, plaintiff's attorney Michael James Moriarty also argued that Irwin failed to test the blood that was tainted with the virus.

In attempting to prove the Texas case, Mr. Weed said he ran into trouble when it became evident that the Wadley center was following the procedures of most other blood banks in the country.

"Our problem, more than anything, was that the blood banking industry as a whole was sitting on their hands," said Mr. Weed. "Wadley was not doing any less and certainly not any more than many others in the country."

After the decision in California, Mr. Moriarty said he expected that courts hearing similar cases against other blood banks would hold the facilities liable for the quality of their blood supplies from February 1983 forward.

But he said last week, "I'm very surprised they didn't win it," referring to the plaintiffs in the Texas

case. Mr. Moriarty maintains that, "Each case will have to pivot on its own facts" and he doesn't expect the decision in Texas to harm plaintiffs' chances in any similar cases that may be filed against blood banks.

Mr. Moriarty also said attorneys won't be dissuaded from filing similar suits against blood banks in the future. "I wouldn't think that any attorney (in a similar case) would back off because of the decision in Texas," he said.

Gilbert Clark, executive director of the American Assn. of Blood Banks in Arlington, Va., said, "When these cases go before a jury, every jury is going to react differently. And every judge is different in these cases."

Mr. Clark said there are "too many variables in these cases to say that one will impact the other."

He added that he doesn't believe the outcome of other cases will affect jury decisions because a jury involved in such a case "is not even supposed to know such things."

However, Mr. Clark said such suits are having an impact on the cost of professional liability insurance for blood banks.

The association dropped the liability insurance program it provided for its 60 blood bank members after Cincinnati-based Great American Insurance Co. in September 1987 raised its rates to \$3 per donation from 65 cents per donation and changed the coverage basis from occurrence to claims-made. The coverage was for \$1 million per occurrence.

The AABB last year attempted to form a risk retention group in Illinois. However, many members decided to self-insure or purchase coverage from Medical Insurance Exchange Co. in Oakland, Calif. (BI, Jan. 25, 1988).

Ms. Bellengee confirmed that the Wadley blood center does have insurance but would not give details of the coverage.

Mr. Weed said an award to the plaintiff would have been covered by the facility's professional liability coverage. He pointed out that such awards are covered by professional liability coverage because "most states have legislated that blood is not a product because it is not produced or enhanced by a blood bank. It is broken down into its separate factors."

Therefore, blood centers are considered service centers and are not subject to state product liability laws, he explained.

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Letters

Continued from page 8
its manager to do away with a competitor by stating, "Put (him) out of business. Do whatever it takes. Squish him like a bug."

Every state has a legitimate interest in deterring such fraudulent, malicious or oppressive conduct. No one should believe that punitive damages are awarded willy-nilly, nor are they that commonplace. A jury decides the punishment in the first instance but then the trial judge reviews the punishment and decides whether it is excessive. After that, appellate courts have the power to reduce the punishment if it is excessive. No punitive damage award survives all that scrutiny unless the punishment was well-deserved and fair.

Most state courts presently consider many factors when judging the excessiveness of punitive damages. These include: the reprehensibility of the conduct; whether the

conduct was an isolated act or a pattern of conduct; the wealth of the defendant; the amount necessary to have the desired deterrent effect; whether unwarranted profits were made; whether corrective action has been taken; and any other mitigating or aggravating circumstance.

This case-by-case review makes much more sense than an arbitrary maximum cap. For example, an arbitrary cap of \$5 million in punitive damages could actually make fraudulent activities pay for a wrongdoing that reaps \$20 million of unwarranted profits through a fraudulent scheme.

Who is the group that, for years, has been trying to dismantle this "punishment" for egregious civil wrongdoing? Why it's none other than the wrongdoers themselves!

William M. Shernoff
Shernoff, Scott & Bidart
Claremont, Calif.

Enrollees charge doctor incentives impair HMO care

By KARI BERMAN

PHILADELPHIA—A class-action lawsuit attacks the basic primary physician reimbursement practices of health maintenance organizations.

Six former enrollees in a health maintenance organization operated by U.S. Healthcare Inc. charge in a class-action suit that U.S. Healthcare encourages its primary physicians to provide inadequate services to enrollees.

The suit, filed last month in U.S. District Court for the Eastern District of Pennsylvania, charges Blue Bell, Pa.-based U.S. Healthcare and its subsidiaries with violations of the Racketeer Influenced and Corrupt Organizations act for false advertising and failure to disclose its physician compensation practices. The suit seeks unspecified damages and legal fees.

Damages may be trebled against defendants found guilty of RICO violations.

A U.S. Healthcare spokesman said: "The company believes that these claims are false and that the lawsuit is without merit. U.S. Healthcare provides cost-effective, quality health benefits, approved and regulated by state and federal agencies, all in accord with applicable law."

The suit was filed by six former enrollees of U.S. Healthcare's Pennsylvania operation.

All current and former members of U.S. Healthcare-affiliated HMOs since 1982 are included in the class action, which was certified Dec. 27.

U.S. Healthcare, which is the fifth-largest general service HMO based on number of enrollees, operates HMOs in six states and provides medical care for an estimated 900,000 enrollees and dependents in employer groups.

U.S. Healthcare is an independent practice association, a type of HMO that contracts with independent physicians or small, single specialty physician groups.

According to the complaint, U.S. Healthcare offered financial incentives to its primary physicians to discourage them from referring patients to specialized physicians and recommending hospital care.

HMOs typically operate under what is known as a "gatekeeper system": Each member is assigned a primary physician who administers treatment and makes referrals to specialists and arranges any needed hospital services.

According to the complaint, U.S. Healthcare maintains a "Comprehensive Referral Fund," against which all specialist and hospital care costs are charged.

However, to minimize use of this fund, U.S. Healthcare created a "Comprehensive Referral Fund Incentive" that entitled the HMO's primary physicians to a pro rata share in any surplus in the CRF at year-end, the complaint says.

And, under the incentive program, if a primary physician exceeds his or her CRF allotment, then funds to cover specialist charges and hospital costs are taken out of the physician's personal retainer fee, the complaint said.

The plaintiffs also charge that U.S. Healthcare further compromised the level of medical care delivered to its members by offering "bonus" payments to primary physicians as rewards for treating patients on an outpatient basis rather than in a hospital.

"The CRF feature of defendants' HMO plans was intended by defendants to create and has created a financial incentive for primary physicians to minimize referrals of members for treatment by specialists and at hospitals," the complaint stated.

"Through the above-described CRF arrangement and otherwise, defendants have undermined and compromised the independent medical judgment of primary physicians, thereby resulting in a substantial diminution in the quality and comprehensiveness of health care services available through the plans to plaintiffs and the class as a whole," the complaint says.

U.S. Healthcare's reimbursement arrangement is typical of HMOs.

"Practically all HMOs in the country have some form of incentive pool from which doctors receive funds at the end of the year," said Mark Joffe, associate counsel with the Group Health Assn. of America in Washington, D.C., an HMO trade group.

"It is an incentive for curbing unnecessary care, not for encouraging compromise care," he said.

Barabra Hammer, a consultant with Hewitt Associates in Rowayton, Conn., said: "In a capitation plan, it is typical for doctors to be paid out of a reimbursement fund and bonus pool. Although this has been a question of debate, we find that the key to maintaining quality care is in the pricing.

"If the pricing of an HMO is fair, then doctors are not worried about using all of the funds," she said. "Problems arise when prices are too low."

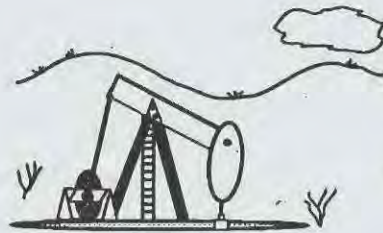
The suit also seeks an injunction to stop all U.S. Healthcare ads, charging that the HMO's advertisements of 100% coverage for hospitalization, surgery and specialist care misrepresent the extent of services readily available.

"The promotional efforts of defendants constitute a systematic and continuous scheme to misrepresent and conceal the true nature of the services available to members under the HMO plans. . . . The promotional materials have been uniform in their misleading and fraudulent failure to disclose any information whatsoever about the existence or operation of the CRF," the suit charges.

"We are going to go all out on this because we believe that the public has a right to know exactly what it is getting for the money," said plaintiffs' attorney David Berger, who is with the Philadelphia law firm Berger & Montague.

Mr. Berger and Philip Salkin, who is with the Lansdale, Pa., law firm of Pearlstine/Salkin Associates, are lead plaintiffs' counsel.

"They are led to believe that they will receive unending coverage when in fact the HMO will do everything to avoid paying for it," Mr. Berger said.



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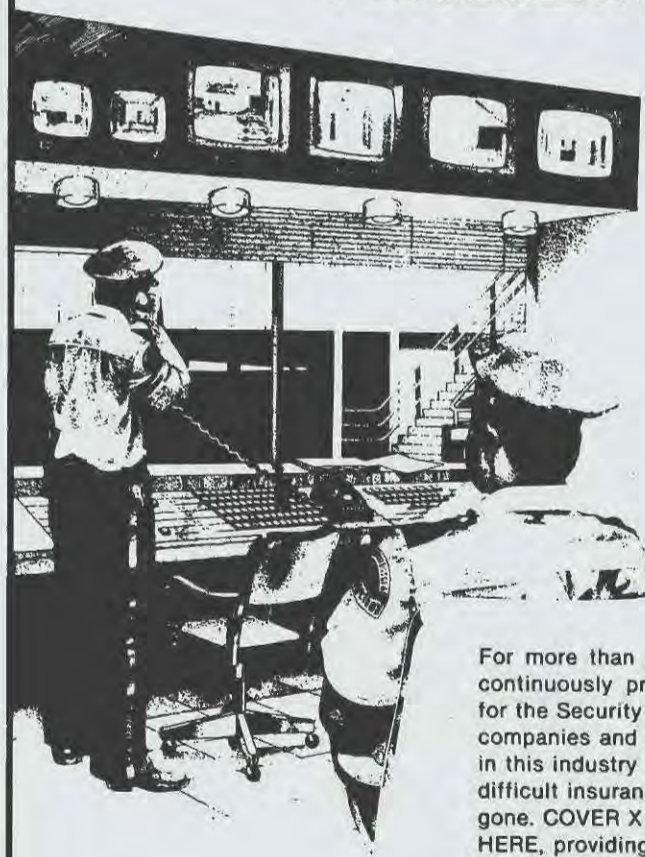
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'Practically all HMOs in the country have some form of incentive pool from which doctors receive funds,' says GHAA's Mr. Joffe.

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Business Insurance Circulation Breakdown*
Commercial Consumers

Administrative:	
CEO's Presidents and Owners	2,621
Vice-Presidents, General Managers and Other Administrative Personnel	3,657
Financial:	
Chief Financial Officers and Vice-presidents of Finance	2,993
Secretaries, Treasurers, controllers and other Financial Personnel	4,454
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	10,994
Sub-total	24,719
Associations	477
Government, Unions and Educational Institutions	979
Commercial Consumers	
Sub-total	26,175
Insurance Agents and Brokers	10,557
Insurance Companies	7,380
Actuaries, Consultants, Attorneys, Adjusters, Appraisers and Third Party Administrators	3,843
Others Allied to the Field	2,991
TOTAL	50,946

* Source: Business/Occupational breakdown of qualified circulation, May 30, 1988 issue, as submitted to BPA for June 1988 BPA Publisher's Statement.

Antitrust suits

Continued from page 3

While the industry defendants filed several motions, none were filed by the attorneys general from the 18 states who brought the federal actions (*BI*, Dec. 26, 1988).

Responses to all the motions filed are due by April 28. Replies will be due on June 16 and a hearing is scheduled for July 7.

The antitrust suits brought by the state attorneys general charge that industry defendants engaged in a boycott involving approval of the Insurance Services Office Inc.'s proposed commercial general liability forms.

Specifically, the suits contend that the defendants conspired to manipulate the U.S. commercial liability insurance market and that the Insurance Services Office Inc. was forced to rewrite its commercial general liability form to exclude coverage for pollution and to include a retroactive date in its claims-made form.

Further, the suits allege that the

defendants sought to eliminate occurrence-based general liability insurance and to include defense costs within excess liability insurance policy limits.

But the McCarran-Ferguson motion contends that plaintiffs' efforts to invoke the boycott charge "is in direct conflict with the intent of McCarran—to defer to state regulation permitting cooperative industry action on rates and forms."

"The development of standardized policy forms necessarily involves discussion and cooperative action as to the terms and conditions of coverage that should be included or excluded," says the motion.

Other arguments presented in the so-called McCarran motion to dismiss are:

- The defendants' involvement with the CGL policy forms constitute the "business of insurance," which is exempted by McCarran-Ferguson from antitrust scrutiny.

- The defendants' conduct was regulated by state law. All 18 plaintiff states, notes the motion, "have at rel-

evant times permitted insurance companies and ISO to cooperate in developing insurance policy forms."

- The boycott exception to McCarran-Ferguson does not apply to the development of standardized policy forms. An agreement on policy terms is not a boycott, says the motion.

The defendants allegedly sought changes in the CGL forms by threatening reinsurance would not be provided on the forms unless the changes were made.

But only an absolute refusal to sell insurance or reinsurance, not just a refusal to deal except on certain coverage terms, would be considered a boycott, says the motion.

- Acceptance of the boycott theory would, in fact, undermine McCarran-Ferguson because the act authorizes state-regulated cooperation in developing standardized policy forms.

"Of necessity... the process of developing a proposed form must include discussion of whether the form would receive market acceptance," states the motion. "Statements by primary insurers and reinsurers about their willingness or unwillingness to accept particular terms are a part of this process."

- McCarran-Ferguson recognizes the primacy of state insurance regulation.

"This case is a prime example of how application of the federal antitrust laws would frustrate state regulation," says the motion.

"The cooperative development of standardized policy forms is an activity permitted by each of the 18 plaintiff states and by the additional

states where named private plaintiffs reside," says the suit.

The industry defendants also filed a "state action" motion on Dec. 16, which encompassed some related arguments. This motion focused on state regulators' activities in relation to approval of the forms. Its main arguments are:

- The defendants' conduct was not a prohibited restraint of trade.

"None of these forms was available for use until approved by the relevant states," states the motion. "Federal antitrust law is directed at restraints of trade, not at regulatory decisions."

- Plaintiffs' injuries, if any, were not caused by the defendants, said the motion, "because such injury could only result from the ultimate approval of the forms by the relevant states. State approval was the essential precondition to their use in the marketplace."

- The defendants' role in the form-making process was exempt from antitrust laws under the state action doctrine. This doctrine provides immunity from antitrust laws if the anticompetitive restraint reflects a state policy, and if the state actively supervises any private anticompetitive conduct, says the motion.

Both of these conditions were fulfilled, claims the motion.

First, "The insurance regulatory structure in each Relevant State reflects a 'clearly articulated and affirmative expressed' policy to displace competition, to permit collective form-making and to substitute regulation with respect to insurance policy forms."

And second, the states actively supervised the defendants' conduct. "The Relevant States' active consideration of the CGL forms reflects their probing and intense involvement in assessing the particular provisions of the ISO CGL forms," says the motion.

Another motion filed solely by the reinsurer defendants states there are no grounds for the suit because there is no direct relationship between them and the plaintiffs.

"As described in the complaints, the direct impact of the alleged conduct in the reinsurance and retrocessional reinsurance markets would be felt by primary insurers and reinsurers, not by plaintiffs," says the motion.

"Plaintiffs here are neither competitors nor customers of any of the reinsurer defendants," says the motion.

"They do not participate in the market in which those defendants participate, and were not the parties purportedly coerced by the reinsurance conspiracies alleged."

A narrower motion filed by foreign reinsurer defendants in the case states the complaints against them should be dismissed because of their foreign base.

The foreign defendants, including Robin A.G. Jackson, Merrett Underwriting Agency Management Ltd., Murray Lawrence & Partners and 16 others, "submit that their foreign nationality, the foreign situs of the alleged conduct and its immediate effects and the foreign location of the markets in which they operate combine to compel dismissal."

Reinsurers' motion

Continued from page 3

of Judge Schwarzer's statements at a June 23 status hearing and confusion as to whether he intended to instruct the defendants to focus solely on the case's legal arguments, rather than on the factual allegations supporting those arguments.

"I think there is a disagreement," said Eugene F. Bannigan of New York-based Lord Day & Lord, Barrett Smith, who is representing North American Re.

"I think it's a legitimate disagreement based on what the judge said. It's a question of interpretation." None of the parties, he added, "is acting in an unreasonable way."

"The judge will sort this out," Mr. Bannigan said. "Nobody's screaming and yelling."

Lewis A. Kaplan of New York-based Paul, Weiss, Rifkind, Wharton & Garrison, who represents Constitution Re, defended the motion. "It is certainly my view that the motion is meritorious."

Mr. Kaplan added that like any attorney, he wishes to maximize his client's chances for dismissal and that the motion was "fully consistent" with the guidelines established by the judge.

Allstate attorney Alan H. Silberman of Chicago-based Sonnenschein, Carlin, Nath & Rosenthal commented: "There is a difference of opinion as to what Judge Schwarzer wanted in this round of motions, and rather than simply go blindly along assuming one side or the other was right, the appropriate thing to do was to put it in front of the judge."

Mr. Silberman said it was his understanding that the judge wanted the motions to be based on legal principles.

Referring to the letter sent by Allstate and Hartford asking that the motion not be considered, he said: "Simply put, the point of the letter is to make it clear to the court no one is trying to disregard his orders, but he has to decide whether this is the time for (the motions) or not."

No one, he stressed, is questioning the validity of the motions themselves, just whether the judge wants to entertain them at this time.

"There is no great fight," Mr. Silberman said. "If anything, it's a matter of the mutual respect I think we all have for the court and the process."

"It's not a big deal," said a Hartford spokesman. "We have no problems" with the motions themselves.

But, the spokesman added, "Our feeling is that the battle has been joined on these grounds, the legal grounds, and let's take it from there." The reinsurers' motions bring facts into the picture, "and we feel it's premature."

"It's a question of strategy, that's what it is," he said.

The joint motion submitted by Constitution Re, M&G and Winter-

thur said the facts concerning the companies "are not in dispute. On their face, they show only lawful and innocuous conduct."

"The movants are defendants in this antitrust litigation because they all were members of a trade association, CRC and Winterthur participated in a meeting of a committee of that association, and all three acquiesced in having that association send a letter" to ISO.

The motion should be granted, it states, "because there is no evidence—either direct or circumstantial—which would permit a jury to find, or to infer, that any of these three defendants was a party to any illegal agreement in violation of the federal antitrust laws."

A separate motion submitted by Prudential Re also calls for its dismissal as a defendant because of a lack of evidence.

"Although hundreds of pre-complaint depositions... have been taken in this action, and many thousands of documents have been collected and reviewed by the State, there exists no evidence suggesting that Prudential Re 'knowingly participated' in any agreement in restraint of trade, or had a 'conscious commitment' to a common scheme designed to achieve an unlawful objective," states the motion.

North American Re's motion also states that there is no evidence against it.

"NARE respectfully submits that the record is devoid of any evidence from which a trier of fact could reasonably conclude that plaintiff's allegations have the slightest merit," states the motion.

"Indeed, as we demonstrate, the facts developed by plaintiffs in their own two-year investigation conclusively establish that NARE was not a participant in any conspiracy to 'boycott' or 'threaten to boycott' 1984 Insurance Services Office (commercial general liability) forms.

"Yet, in spite of this, plaintiffs, for reasons which are not apparent, have chosen to include NARE in a complaint which is not grounded in fact or warranted by existing law."

In its statement to the court, General Re states that it "has not filed a similar motion directed at the merits of plaintiffs' claims because we understood based on the Court's initial status conference on June 23, 1988, that the Court desired that such motions should not be made before motions on threshold legal issues (such as the applicability of the McCarran-Ferguson Act to plaintiffs' complaints) be added."

However, the statement adds that it "fully supports" the motions, and that "in the event the Court does consider at this time the 'no conspiracy' motions filed today, Gen Re joins such motions."

The RAA makes a similar request in its statement to the court. ■

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Benefit costs

Continued from page 1
tainment techniques.

For example, the use of such cost-management techniques as coverage for hospice care, home health care, precertification of hospital stays and wellness programs all have expanded during the last several years.

These findings are contained in the latest group benefits survey, which is conducted biennially by Wyatt's Research and Information Center in Washington, D.C.

Wyatt's latest group survey polled 2,271 employers. The survey data base includes detailed information on group health care plans covering about 5 million salaried workers. Similar, but less extensive data also was obtained for plans covering about 5 million hourly workers.

The survey also includes comparative information on core groups of employers. A group of 376 companies were surveyed in the 1988 and 1986 surveys, while 170 companies were surveyed in the 1988, 1986 and 1984 surveys.

"Such core group analyses provide a valuable way to identify actual, programmatic changes as group benefit programs expand, mature and change in response to the social, legal and legislative environment," Wyatt notes.

Increasing medical costs pose difficult questions for employers and society, according to Wyatt.

"By having rich and expensive medical plans, you have an increasing share of the compensation pie being devoted to sickness than for salary. Is that the way we want to go as a society?" Mr. Tane asks.

"How much of our resources do we invest in medical care? How much of our resources should be used to pay for the cost of premature infants compared, for example, to improving educational opportunities?" Mr. Tane added.

In view of these soaring costs, companies must ask themselves if their group health care plans are meeting corporate objectives, Mr. Tane said.

Already, employees are being asked to pay more of their own medical expenses, according to the survey.

For example, among the core group of 170 employers with comprehensive medical plans,

71% imposed a deductible of more than \$100 in 1988, compared with 59% in 1986 and 45% in 1984.

On the other hand, the percentage of employers with deductibles of less than \$100 fell to 1% last year, down from 7% in 1986 and 21% in 1984.

In addition, employers imposing a \$100 deductible declined to 28% in 1988, down from 34% in both 1986 and 1984.

While deductibles are rising, Mr. Tane believes companies should be considering even higher deductibles—perhaps as much as \$1,000—or linking deductible levels to salary, a practice that has been adopted by a handful of companies.

"When employees have a direct economic stake (through higher deductibles) in controlling health care costs, they tend to be better consumers of health care services," Mr. Tane said.

Dental plan deductibles also are climbing, according to the survey.

For example, among the core employer group, 29% last year imposed dental plan deductibles of less than \$50 for individual coverage, down from 32% in 1986 and 35% in 1984.

On the other hand, in 1988, 7% of employers imposed a dental plan deductible of between \$100 and \$200, compared with 5% in 1986 and 3% in 1984. Just 4% imposed a \$200 deductible in 1988, compared with 1% in 1986 and none in 1984.

Aside from paying higher deductibles, employees also are being asked to contribute to the cost of their group health care premium.

For example, among a core group of 170 employers, 73% last year required employees to pay a portion of the premium for family coverage, up from 63% in 1986 and 44% in 1984.

By contrast, employees are less likely to contribute toward the cost of other, less expensive group benefit programs.

For example, among the core group, 51% required contributions toward retiree health care plans last year, compared with 50% in 1986 and 49% in 1984; 53% offered contributory dental family care programs, up from 52% in 1986 and 31% in 1984; 41% required employee contributions toward long-term disability premiums, unchanged from 1986 and 1984; and

30% required employee contributions toward group life insurance premiums, up from 17% in 1986 and 21% in 1984.

While the level of cost sharing is increasing at companies, employers still pick up most of the premium.

For example, just 12% of employers require employees to pay more than 50% of the premium for family medical coverage, while 81% of employers require employees to pay between 1% and 50% of the cost. And, in 9% of the plans the employer pays the entire cost.

For other types of benefits, employees are even less likely to pick up most of the premium costs.

For example, for family dental coverage, the employer pays 100% of the premium in 23% of the plans, while in 55% of plans, the employee pays between 1% and 50% of the premium and in 14% employees pay between 51% and 99% of the premium. In 8% of family dental plans, the employee pays 100% of the premium.

In the area of cost management, the Wyatt survey shows that several techniques have stabilized at high levels.

For example, more than 84% of employers in the core group last year used preadmission testing, compared with 83% in 1986 and 87% in 1984.

Other popular cost management techniques used by employers include:

- Second surgical opinions, used by 81% of employers in 1988, 83% in 1986 and 54% in 1984.

- Ambulatory surgical facilities, used by 89% of employers in both 1988 and 1986 and 81% in 1984.

- Home health care, used by 77% of employers in 1988, up from 70% in 1986 and 68% in 1984.

The popularity of other cost management techniques has soared. For example, 66% of employers in the core group last year offered coverage for hospice care, compared with 52% in 1986 and 39% in 1984, while 61% of employers required precertification of hospital stays, up from 31% in 1986 and just 17% in 1984.

However, some cost management techniques are being discarded by employers.

For example, last year, 36% of employers in the core group offered coverage for annual physicals, down from 41% in 1986, but up

from 18% in 1984.

Mr. Tane says that there is increasing evidence from the medical community that annual physicals are not necessary and that special screening programs designed to spot specific medical problems, such as high blood pressure, may be more cost-effective.

In the area of flexible benefit plans, the survey found that 19% of companies last year offered some type of flex program.

However, the percentage of employers offering a flexible benefit program varied considerably by industry.

For example, 31% of employers in the financial services sector offered a flex plan, compared with 24% of health care employers and 19% of employers in service industries. Just 16% of manufacturers and 11% of employers in the wholesale/retail trade industry offered flex plans.

Flex plans have become especially popular in the financial services industry because of an effort to meet the varying benefit needs of a diverse workforce, Mr. Tane noted.

Other survey findings include:

- Just 42% of employers provide medical care coverage and 35% provide life insurance coverage to part-time employees.

The low percentage of part-time employees covered by major benefit programs could spell problems for employers trying to pass Section 89 non-discrimination tests. Under Section 89, which took effect Jan. 1, employees working at least 17.5 hours per week must be counted when running the tests.

- Just 14% of employers have done any type of actuarial evaluation or forecasting of costs to determine what their future retiree medical care liabilities might be.

However, some 20% of employers said they plan to reduce their retiree health care plan liabilities based on recent court decisions that have said that companies—in certain situations—may cut back retiree health care benefits.

Copies of the 1988 "Survey of Health and Welfare Plans Covering Salaried Employees of U.S. Employers," are available from any local Wyatt office or from Wyatt's Research and Information Center, 1850 M St. N.W., Suite 400, Washington, D.C. 20036; 202-887-4600. The cost is \$500, but copies are free to survey participants.

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Alternatives

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Superfund case

Continued from page 1

Johnson in Washington, D.C., said Judge Premo's ruling was faulty because "he reads the policies as though the word 'damages' is not there."

"The word 'damages' in the context of an insurance policy is talking about lawsuits," added Mr. Warin, who did not represent any insurers in the FMC case. "Insurance policies protect people against lawsuits."

American International Group Inc. attorney Victor Rabinowitz criticized the ruling because the judge failed to consider that FMC is a large, national corporation and therefore a sophisticated insurance buyer capable of understanding legal definitions.

"It is ironic that FMC is analogized to a 'reasonably prudent lay person' when in fact it is an insurer," said Mr. Rabinowitz, an attorney with Buchalter, Nemer, Fields & Younger in Los Angeles.

FMC owns a captive insurance company in Bermuda, FMC Insurance Co., that writes general liability coverage for FMC nationwide.

Mr. Rabinowitz said AIG is considering appealing the decision.

Mr. Russell also criticized Judge Premo for failing to consider that FMC is a sophisticated insurance buyer.

"The court ignored that fact that FMC has batteries of attorneys and brokers at its beck and call. Very large, sophisticated insurance buyers know very well that they are buying a legal document," he said.

However, FMC attorney Mr. Steuber said, "California law has no large, sophisticated buyer exception" to the rule that all insurance policies should be given their plain meaning.

Thomas W. Brunner, an insurer attorney with Wiley, Rein & Fielding in Washington, D.C., also criticized Judge Premo's ruling.

"The judge did not recognize... that liability insurance is designed to apply to traditional tort liability" not government-mandated cleanups, said Mr. Brunner, who did not represent any insurers involved in the FMC case.

FMC, which manufactures agricultural chemicals among other products, sued 174 of its primary and excess insurers on Nov. 13, 1987, seeking coverage for the cost of cleaning up 46 polluted sites in 22 states and indemnification of thousands of personal injury claims (BI, Feb. 9, 1987).

The insurers, which include New York-based AIG; Crum & Forster Inc. of Morristown, N.J.; CIGNA Corp. of Philadelphia; and many Lloyd's of London syndicates, wrote primary and excess general liability coverage for FMC from 1960 until 1986.

Judge Premo's Jan. 3 ruling stems from a request by insurers

that he decide the sole issue of whether response, inspection and cleanup costs incurred by FMC under federal and state environmental legislation constitute insurable "damages."

The insurers argued that government-mandated cleanup costs are not insurable because they are equitable or injunctive in nature. The insurers maintain that only damages awarded by a court are insurable.

FMC, on the other hand, maintained that its insurance policies should be construed broadly to give the term "damages" a common meaning. They said the difference between equitable damages and legal damages is too technical.

Noting that there are no California appellate court decisions on this issue, Judge Premo said, "The court is fully aware of the critical importance of this issue."

The first California appellate court case on the insurability of government-mandated cleanup costs will begin in February with a trial between Aerojet-General Corp. of La Jolla, Calif., and 55 of its general liability insurers in San Francisco (BI, Nov. 7, 1988).

"It appears inevitable that an appellate court applying California law will soon speak to this issue," said Judge Premo.

In addition, Judge Premo noted that the 9th U.S. Circuit Court of Appeals, which includes California, has not ruled on the issue.

However, the 9th Circuit may soon decide to review a U.S. District Court decision that Hartford Accident & Indemnity Co. must reimburse Intel Corp. of Santa Clara, Calif., for the costs incurred in a government-mandated hazardous waste cleanup (BI, June 27, 1988).

To date, three U.S. Circuit Courts of Appeal have issued rulings stating that government-mandated cleanup costs are not insurable.

Judge Premo analyzed all three of these decisions and said he was "troubled by their lack of reasoned support for their holdings."

In fact, Judge Premo's decision could have an impact outside of the FMC case because of his biting criticism of the three federal appellate decisions, attorneys say.

For example, looking at the 4th U.S. Circuit Court of Appeals decision in *Maryland Casualty Co. vs. Armco Inc.*, in which the court held that in an insurance context a "legal, technical" definition of the word "damages" should apply, Judge Premo said the court "gives no reason for this."

Judge Premo also criticized the 8th U.S. Circuit Court of Appeals ruling in *Continental Insurance Cos. vs. Northeastern Pharmaceutical & Chemical Co.*, because that court based its decision on the flawed *Armco* decision.

The 8th Circuit ruled that although outside the insurance con-

text the term "damages" is ambiguous, within the insurance context it is not. As a result, the court gave the word "damages" a narrow, technical definition that did not encompass Superfund cleanup costs (BI, March 7, 1988).

"This court is not persuaded that the very technical meaning of the word 'damages' adopted by *Armco* and its progeny... is in line with California case law requiring that terms in insurance policies be afforded their plain meaning," said Judge Premo.

The judge went on to say that he was more persuaded by other court decisions that stress it makes no difference whether the government cleans a polluted site and sues the responsible party to recover the costs or whether the government simply calls upon the responsible party to clean up the polluted site.

Judge Premo said he could see no reason why insurers that pay for cleanup costs if they are thrust on the policyholder in a lawsuit would refuse to pay when the government simply forces the policyholder to perform the cleanup.

"The carriers have given no policy reason, and the court can perceive none, why the situation should be different if the insured is required by the government to clean up its own site," he said. "It is the same property damage and the same cost to clean up; only the actor is different."

"The granting or non-granting of indemnification under the policy should not depend on the identity of the actor which performs the cleanup operation," he concluded.

Furthermore, Judge Premo denied the insurers' argument that public policy demands that policyholders that pollute the environment be denied coverage.

Insurers said that allowing polluters to use insurance to finance cleanup operations would remove any deterrent to policyholders from generating more pollution.

"The court is not convinced by this argument," said Judge Premo. "As a matter of reality, most of the damage that FMC has now been charged with cleaning up was done by it during a period of time when the scientific community had very little knowledge of the overwhelmingly disastrous effect that this chemical pollution would have."

And, "since CERCLA cleanup costs are limited by statutory definition to the cleanup of abandoned sites, we are not talking about a policy of discouraging future pollution by allowing insurance carriers to avoid payment of these damages," he added.

Judge Premo has issued two other significant rulings in the FMC case:

• On Dec. 9, the judge ruled against FMC's request that insurers should be prohibited from arguing that the pollution exclusion means anything different than

Continued on next page

Update

Humana may buy Maxicare unit

LOUISVILLE, Ky.—Humana Inc., an owner and operator of 83 hospitals nationwide, has signed a letter of intent to acquire Phoenix-based Maxicare Arizona, an independent practice association-model HMO owned by Maxicare Health Plans Inc. of Los Angeles.

The agreement is effective March 1, subject to regulatory approvals and final approval by the companies. Terms were not disclosed.

The acquisition will add 24,000 members to Humana Health Care Plans, the multistate health benefit plan division of Louisville-based Humana. The division currently has 841,000 members in its health maintenance and preferred provider organizations.

The acquisition does not include Maxicare's Tucson-based HMO, Maxicare/Health America Health Plan of Arizona Inc. The group model HMO has about 50,000 members.

Maxicare Health Plans operates HMOs in 13 states, serving 1.3 million members. The firm has been selling or closing unprofitable plans since mid-1988 as part of a restructuring after posting losses of about \$500 million over the last two years (BI, Dec. 12, 1988; Sept. 5, 1988).

AEGIS takes over DOLI

HAMILTON, Bermuda—Associated Electric & Gas Insurance Services Ltd., a utility industry mutual insurer, has assumed the assets and liabilities of Directors & Officers Liability Insurance Ltd., another Bermuda-based mutual that writes D&O coverage for member utilities.

As of Jan. 1, all new D&O policies and renewal policies for DOLI members will be written by AEGIS, the utility captive announced.

The combined companies will have assets of about \$1.2 billion and policyholders surplus of about \$285 million at year-end 1988. Combined 1988 gross written premiums totaled about \$300 million.

Peat Marwick settles thrift suit

SAN FRANCISCO—Accountant Peat Marwick Main & Co. is paying \$9.25 million to settle claims brought by the state of California and 12,500 account holders over the April 1984 collapse of Western Community Moneycenter, a Walnut Creek, Calif., savings and loan.

The firm is covered by an errors and omissions insurance program underwritten mainly by Lloyd's of London syndicates, said Tony Costantini, associate general counsel in Peat Marwick's New York office. All of the settlement is covered by the insurance program, except for a deductible, which he could not disclose.

The state and the account holders sued Peat Marwick in late 1985 for allegedly mishandling the 1982 audit of the thrift.

In its response to the suit, Peat Marwick said that it had complied with applicable auditing standards and alleged that the state had failed to properly regulate Western Community Moneycenter.

Reliance exiting Massachusetts

BOSTON—Massachusetts' Department of Insurance probably will try to prevent Reliance Insurance Co. and two of its units from withdrawing from the state's property/casualty insurance market. Reliance subsidiaries Planet Insurance Co. and United Pacific Insurance Co. also surrendered their licenses.

Company officials said the move, effective Dec. 15, 1988, stemmed from losses in the state's personal automobile insurance market and increasing assessments from Commonwealth Automobile Reinsurers, the state's assigned risk pool. Reliance companies, which wrote \$25.8 million in commercial property/casualty insurance premiums in Massachusetts in 1987, faced CAR assessments of more than \$9 million, a Reliance spokesman said.

Under Massachusetts law, an insurer that withdraws from the personal auto market must withdraw from all other property/casualty markets as well. A spokeswoman for the Massachusetts insurance commissioner said a legal challenge is virtually certain because the state holds an insurer cannot surrender its licenses without prior notice.

Philadelphia-based Reliance is the seventh property/casualty insurer to leave Massachusetts in the past two years. Only six weeks ago, Northbrook, Ill.-based Allstate Insurance Cos. announced that it would cease writing business as of June 30, 1989, because of escalating costs (BI, Nov. 21, 1988). As companies leave the state, the remaining insurers' CAR assessments have increased.

Travelers argues California writ

SAN FRANCISCO—Travelers Corp. contends it did not violate California's Proposition 103 by refusing to renew private auto insurance policies.

In a notice of non-compliance issued against Travelers last month, the California Insurance Department contends that Proposition 103 precludes insurers from canceling or not renewing policies except in cases of fraud, non-payment of premiums or a significant change in the insured risk. The department gave Travelers until Jan. 17 to file a brief in support of its position (BI, Jan. 2).

However, in a hearing last week, Kent Keller of the Los Angeles firm of Barger & Wolen, who represents the insurer, told regulators that Travelers was within the law because the company had notified the state Insurance Department of its intent to withdraw from the California auto insurance market on Nov. 7, 1988—the day before voters approved the controversial law.

Travelers has about 25,000 private auto insurance policyholders in the state, less than 0.5% of the total auto insurance market.

Briefly noted

A Dec. 15 California Supreme Court decision that health plans regulated by the **Employee Retirement Income Security Act of 1974** are exempt from a California law that allows beneficiaries of health plans to sue insurers for delays or denials of claims will be appealed to the U.S. Supreme Court, says plaintiff's attorney William M. Shernoff of Shernoff, Scott & Bidart in Claremont, Calif. (BI, Dec. 26, 1988). . . **Utah Insurance Commissioner Harold Yancey** has been reappointed to serve a second four-year term.

Judge interprets 'sudden' pollution

By STACY ADLER

DETROIT—The word "sudden" in the pollution exclusion clause in comprehensive general liability policies should be given a temporal meaning that would exclude all forms of gradual pollution, a federal judge has ruled.

U.S. District Court Judge John Feikens ruled last month that Troy, Mich.-based Ex-Cell-O Corp. may not be covered for the costs to clean up 12 polluted sites in four states, unless it can prove that the pollution happened quickly.

The pollution exclusion bars coverage for all forms of pollution except those that are "sudden and accidental."

In a suit against its insurers, Ex-Cell-O had argued that the word "sudden" should be interpreted to mean unexpected or unintended.

However, Judge Feikens ruled: "That 'sudden' in the pollution exclusion includes a temporal component of brevity and means brief, momentary or lasting a short time."

"If the drafters had meant 'unexpected and unin-

tended from the standpoint of the insured' it is reasonable to assume that they would have said so explicitly," he said.

Judge Feikens also ruled that Ex-Cell-O, rather than its insurers, has the burden of proving the pollution occurred quickly.

In addition to Wausau Underwriters Insurance Co. of Wausau, Wis., the suit also names: AIU Insurance Co. of New York; American Employers' Insurance Co. of Boston; Highlands Insurance Co. of Houston; Hartford Insurance Group of Boston; and two units of Hartford: First State Insurance Co. of Boston and New England Insurance Co. of Boston.

Earlier, Judge Feikens issued several other key rulings in the Ex-Cell-O case (BI, June 6, 1987).

Most importantly, he ruled that an insurable lawsuit "includes any effort to impose on the policyholders a liability ultimately enforceable by a court."

• *Fireman's Fund Insurance Cos. and American Insurance Co. vs. Ex-Cell-O Corp. et al.*; United States District Court for the Eastern District of Michigan Southern Division, No. 85-71371.

Cleanup costs

Continued from previous page
what they told the insurance commissioner of West Virginia it would mean in 1969 when they sought its approval.

FMC asserts that, at the time the insurers were seeking approval of the pollution exclusion, they told the commissioner it was merely a clarification of existing policy language and not a reduction in coverage.

Judge Premo said FMC's request could not be granted for several legal reasons and because he did not believe that what the insurers said to the commissioner in 1969 was materially different from what they are saying now.

He explained that insurers believed that prior to implementing the pollution exclusion all forms of gradual pollution would be excluded because acts that are expected or intended by policyholders are not insurable.

"The insurers can certainly be said to have understated their position to the commissioner in referring to the exclusion as a clarification, but the court does not believe that (the insurers') acts can be characterized as the sort of dishonesty that would give rise to judicial estoppel," Judge Premo said.

• On Dec. 15, Judge Premo ruled that California law—not Illinois law—should be applied when judging whether FMC provided its insurers with timely notice of its pollution claims.

Insurers argued that Illinois law should be applied because FMC is based in Chicago, and because many of the insurers are located in Illinois.

FMC argued that California had a greater interest in resolution of this litigation, and therefore that its laws should apply. In support of its argument, FMC noted, among other things, that seven of the 46 sites are in California and that at the time many of the insurance contracts were entered into it was based in San Jose, Calif.

While both Illinois and California hold that policyholders have a duty to give timely notice of claims to their insurers, if a policyholder fails to give timely notice of a claim in Illinois, the insurer can deny coverage, whether or not the insurer has been prejudiced or hurt by the late notice.

California, on the other hand, holds insurers can only deny coverage if they have been substantially prejudiced by the policyholder's delay.

Looking at these differences, Judge Premo ruled: "Although Illinois has an interest to protect, it... (appears)

relatively 'less committed' to its law regarding notice requirements than is California."

Judge Premo explained that some Illinois judges have looked at whether an insurer was prejudiced by late notice.

"California's policy, on the other hand, would necessarily be disserved by application of Illinois law, since there would be forfeiture of coverage whether or not the carriers were pre-

judiced by the late notice," he said.

Judge Premo is expected to make many more rulings in the FMC litigation in the coming months.

It is expected that the ultimate question of whether or not FMC has insurance for the tens of millions of dollars of cleanup costs it has incurred will eventually be determined by a jury in a long, fact-specific trial, very similar to the Shell Oil Co. litigation.

Recently, a jury found that Shell had no coverage for a hazardous waste cleanup that has been estimated to cost anywhere from \$1 billion to \$4 billion. The jury found that Shell knew it was polluting the environment (BI, Dec. 26, 1988).

• *FMC Corp. vs. Liberty Mutual Insurance Co. et. al.; Superior Court of California for the County of Santa Clara, No. 643058.*

Agent Orange coverage

Continued from page 3

Shamrock's policies. A ruling is expected this month.

Of the seven Agent Orange manufacturers participating in the class-action settlement, only Uniroyal and Diamond Shamrock are engaged in coverage litigation with their insurers, lawyers involved in the two coverage cases say.

Uniroyal sued Home in U.S. District Court for the Eastern District of New York in Brooklyn after the May 1984 class-action settlement, and the suit remained pending during three years of legal challenges to the settlement by claimants who had opted out of the class. During that time, Uniroyal's board of directors voted to liquidate the company.

The 2nd Circuit U.S. Court of Appeals ultimately affirmed the Agent Orange settlement, and the U.S. Supreme Court later declined to review challenges to the agreement.

Home was Uniroyal's primary general liability insurer from 1965 to 1976, providing per-occurrence and annual aggregate limits ranging from \$2 million to \$10 million over retentions ranging from \$100,000 to \$500,000 during various policy periods.

Following the Agent Orange settlement, Home argued that Uniroyal had failed to meet its burden of proving "actual injuries" to the Agent Orange claimants, and that each spraying of the herbicide in Vietnam constituted a separate occurrence to which a separate deductible should apply.

Home also argued that Uniroyal had no coverage for the class settlement because of the policies' war risk exclusion.

Uniroyal refuted each of Home's contentions, arguing that the war risk exclusion should not apply and that the negligent manufacture of Agent Orange itself constituted a single occurrence under the policies.

The two sides filed cross motions for summary judgment, resulting in Judge Weinstein's Dec. 19 order.

Judge Weinstein rejected Home's argument that Uniroyal had failed to prove actual injuries, ruling that Home is bound to pay settlement and defense costs as long as the occurrence that gave rise to the settlement was covered by the policies.

"Home's contention would place settling defendants in the hopelessly untenable position of having to refute liability in the underlying action until the moment of settlement, and then of turning about face to prove liability in the insurance action," the judge wrote.

"Such a regime would markedly reduce the advantages to the insured of settling: Faced with the choice of defending the tort action vigorously or settling it without hope of insurance reimbursement, insureds would tend to choose the former. Settlements expressly disavowing tort liability—such as the one in Agent Orange—would be discouraged lest the express disavowal operate as a waiver of insurance coverage claims," Judge Weinstein ruled.

"In times of severe pressure on courts overwhelmed with litigation and undersupplied with resources, a rule forcing more cases to trial would be a self-inflicted wound of suicidal import," he concluded.

Home also argued that because the court dismissed separate actions brought by claimants opting out of the class settlement, Uniroyal should have refused to settle with the class.

However, Judge Weinstein noted that the reasonability of a settlement must be judged on the facts known at the time of the settlement, and that the district court had approved the Agent Orange settlement as reasonable.

Judge Weinstein also found fault with Home's position on the number of occurrences involved in the Agent Orange case.

Noting the insurer's argument that each spraying of the defoliant in Vietnam represented an occurrence, the judge observed that "having gone so far it is hard to see why Home did not insist that each of hundreds of thousands of exposures of veterans to the herbicide was a separate occurrence."

"Even under Home's gracious intermediate position," the judge wrote, "there would be considerably more than 20,000 occurrences, each subject to at least a \$100,000 deductible. The result would be that Home owes no coverage payments to Uniroyal."

The judge found no support for Home's contention that the number of occurrences must be determined by the time and place of the ultimate injury.

Citing the policies' definition of "occurrence" as an "accident or a happening or event or a continuous or repeated exposure to conditions which... result in a personal injury," the judge concluded that "the occurrence is not defined to be the injury; the injury is clearly stated to be the result of the occurrence."

However, Judge Weinstein found the occurrence definition to be ambiguous in other ways, noting that the policies' terms "identify a set of possible occurrences, but give little assistance in selecting the proper item from the

set."

Applying New York law, the judge resolved this ambiguity against the insurer, ruling that the occurrence was Uniroyal's delivery of Agent Orange to military depots on the West Coast between 1966 and 1968.

The opinion notes that the deliveries were the last act over which Uniroyal had control, since after delivery the military barred Uniroyal from any involvement in the mixing, transportation or use of Agent Orange.

Judge Weinstein observed that this situation differed from practice in civilian sales contracts, where the seller monitors the use of its product and presumably has some control over the purchaser's conduct.

The judge also ruled that Uniroyal's 110 shipments of Agent Orange over the three years represented a single continuous occurrence under the policies.

The deliveries were "part of a routinized, repetitive process through which a large supply of herbicides was funneled to the military," the opinion says, adding that "the number of deliveries was happenstance, determined by the size of available transportation freight cars and in no way by the military's need for 110 separate 'pieces' of herbicide."

Judge Weinstein also relied on Uniroyal's Agent Orange shipments to determine how coverage under the Home policies would be triggered.

Based on an affidavit submitted by Home's lawyers and other agreed-on facts, Judge Weinstein concluded that "injuries in fact" to Vietnam veterans occurred within about two weeks of their exposure to Agent Orange during wartime spraying operations.

Based on arguments in the coverage litigation and other information drawn from years of hearing Agent Orange proceedings, Judge Weinstein also concluded that the sprayings themselves probably occurred within a week of the arrival of Agent Orange shipments in Vietnam, and that the shipments probably arrived within three months after their delivery to U.S. military stations on the West Coast.

Therefore, the judge found, injuries in fact to Vietnam veterans occurred roughly four months after Uniroyal's delivery of Agent Orange to the Air Force.

Applying this four-month time lag to Uniroyal's delivery schedule, Judge Weinstein ruled that the veterans' injuries triggered two Home policies:

- A policy in force between Feb. 1, 1965, and May 1, 1967, with a per-occurrence and annual aggregate limit of \$6 million over a per-occurrence retention of \$100,000.

- A policy in force between May 1, 1967, and May 1, 1970, with a per-occurrence and annual aggregate limit of \$10 million over a \$100,000 retention.

In apportioning losses between these two policies, Judge Weinstein rejected the triple-trigger theory of liability applied in the 1981 *Keene Corp. vs. Insurance Co. of North America* decision (BI, Oct. 12, 1981), finding instead that "the undisputed facts permit a clean differentiation of injuries between policy periods."

Although Uniroyal had argued that it should be able to choose the policy it preferred, the judge concluded that in theory this approach "could easily be extremely unfair to an insurer who was on the risk for a day but who then is burdened with the entire loss incurred over several years."

Instead, Judge Weinstein noted that Uniroyal's first 23 shipments of Agent Orange—accounting for about 18% of the total gallons sold—resulted in alleged injuries during the first policy period, assuming the four-month lag between the dates of delivery and injury. The other 87 shipments, representing 82% of the total gallons sold, produced the alleged injuries during the second policy period.

The judge therefore apportioned 18% of Uniroyal's \$12.2 million settlement and defense cost claim to the first policy and 82% to the second policy. After applying the two \$100,000 retentions, the first policy should pay \$2.1 million and the second \$9.9 million, the judge ruled.

Judge Weinstein also rejected Home's attempt to apply the war risk exclusion.

"The short answer to Home's argument is that the court has held that the occurrence was the continuous course of deliveries by Uniroyal to the government in the United States. The war risk exclusion is inapplicable to 'occurrences taking place in the United States of America, its territories or possessions, or Canada.' Coverage is therefore not barred by this clause."

Even if the delivery had taken place overseas, however, the exclusion might still be inapplicable, the judge observed.

Pointing to a New Jersey state judge's rejection of the war risk defense in the Diamond Shamrock litigation, Judge Weinstein noted that the exclusion is intended to bar coverage for liabilities arising out of hostile acts in wartime, not those arising from defects in a product which, even when used as intended, injures those using it.

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CEOs see substance abuse as a costly problem: Survey

By ALISON KITTRELL

Substance abuse in the workplace costs employers approximately 1% to 5% of payroll each year, according to more than one-third of top executives responding to a survey.

And, while 81% of the respondents reported their companies had programs to address substance abuse, nearly half of those companies have no mechanism for measuring the effectiveness of their programs.

Executives also expressed dissatisfaction with government substance abuse control efforts, according to the survey by Marsh & McLennan Cos. Inc. and subsidiary William M. Mercer-Meindinger-Hansen Inc.

The survey included responses from 265 chief executive officers of Fortune 1,000 companies, state governors and mayors of large cities.

"Based on our survey results, we estimate that the total annual cost of substance abuse to business and to state and local government organizations is between \$60 billion and \$65 billion," said M&M Chairman Frank J. Tasco.

"This amount assumes added significance when viewed as a figure representing almost one-half of U.S. corporate aftertax profits," which amount to about \$145 billion.

The survey authors extrapolated the nationwide figure from executives' responses to survey questions about the cost of substance abuse as a percentage of payroll, explained Anthony Gajda, a Mercer principal.

Executives responding to the survey were asked to estimate their direct costs of dealing with substance abuse, including absenteeism, health insurance benefits, workers compensation benefits, time taken to handle disciplinary/grievance proceedings and employee recruitment/training/replacement. The costs were expressed as a percentage of payroll.

They also were asked to estimate indirect costs, including reduced productivity, customer dissatisfaction and defective merchandise.

The largest percentage of respondents—37%—estimated the costs at between 1% and 5% of payroll. The next largest group—33%—were unsure of the costs.

In addition, 21% of the respondents said the costs were less than 1% of payroll; 6% estimated the costs at 6% to 10% of payroll; 2% estimated the costs at more than 15% of payroll and 1% estimated costs at 11% to 15% of payroll. Dol-

lar-amount estimates ranged from less than \$1 million to more than \$20 million.

The number of respondents who could not attach a dollar amount to the substance abuse problem did not surprise Mr. Gajda. "I think they (those who were unsure) were being thoughtful. Some people may look at their medical benefit costs but not at the whole picture."

The executives said that substance abuse is most costly to their organizations in terms of increased medical claims, increased absenteeism and decreased productivity.

But despite the heavy toll of substance abuse, employers have not flocked to adopt cost management techniques to attack the problem.

"Only 24% have preferred provider arrangements with substance abuse or alcoholism treatment facilities, although such medical expenses present excellent opportunities for managed care to control costs," the authors note.

And, utilization review is being used by only 37% of the respondents to manage substance abuse cases, the survey found.

The most-common substance abuse programs at the surveyed companies were employee assistance programs, which 85% said they now offer and an additional 10% said they will offer within two years. In addition, 57% said they now offer wellness programs that deal with substance abuse; another 14% plan to offer such a program within two years.

Other substance abuse-related programs include pre-employment drug testing, reported by 50% of the employers; targeted enforcement programs, reported by 33% of the employers; and drug testing for current employees, reported by 29% of the programs.

But, the authors note, "It's also questionable just what goes by the labels of employee assistance and wellness programs. Such descriptions are used for a wide variety of programs, ranging from rudimentary to comprehensive."

Most of the executives—74%—say their company has a formal policy for dealing with substance abuse, and an additional 15% said their company is developing such a policy. Almost all these policies are communicated in writing to employees and spell out disciplinary actions the employer will take and assistance available.

However, the authors note, "Having a policy and making it effective are very different issues." For instance, 48% of the respondents said their organization has no way of systemati-

cally evaluating its programs.

Absenteeism rates were used as a measure by 32% of the respondents; health insurance claims by 29%; disciplinary actions by 26%; on-the-job accidents by 23%; productivity ratings by 14%; and other criteria by 9%.

Commenting on the general scope of substance abuse, 88% of executives said that substance abuse is a "very significant" problem for U.S. employers; in contrast, only 36% say the problem was "very significant" five years ago. And, 81% also said the problem is likely to become worse if additional public funds are not used to combat substance abuse.

M&M also queried human resources officials at the organizations surveyed to get the perspective of those who deal with substance abuse problems on a day-to-day basis.

Some 54% of the human resources respondents estimate that between 6% and 15% of their active employees are substance abusers, and 61% estimate that between 6% and 15% of employees have dependents who are abusers.

Some 58% of human resource officials estimated the absentee rate for substance abusers at two to three times the average, and 17% said it was four to six times the average.

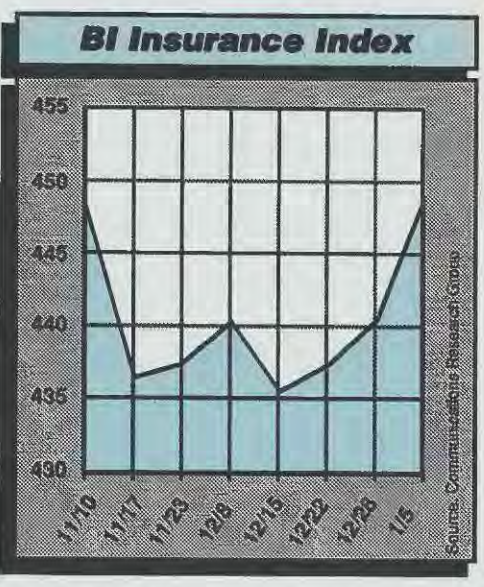
Forty-four percent of the human resource officials said substance abusers had two to three times the average number of workplace accidents, and 10% said the rate for substance abusers was four to six times average.

Overall, the survey respondents were unhappy with government attempts to combat the spread of substance abuse. Some 91% said they were dissatisfied with efforts at the federal and state levels, and 86% said they were dissatisfied with efforts at the local level.

Some 72% of the executives said that the public resources being devoted to solve the problem are inadequate, and 61% said that available resources are not used effectively.

In general, the executives tend to favor education over law enforcement as a way of curbing the abuse of alcohol and drugs. Almost two-thirds—64%—said more public resources should be allocated to education, if there is no increase in available resources.

Copies of the survey, "Substance Abuse in the Workplace," are available free from Dong Kingman Jr., Marsh & McLennan Cos. Inc., 1221 Ave. of the Americas, New York, N.Y. 10020.



The Business Insurance Index begins tracking the stock of selected health maintenance organizations this week. Including the new companies, the BI Index rose 8.4 points to 449 on Jan. 5, from 440.6 on Dec. 28. Advancing issues were led by: HMO America Inc., up 12.8%; Maxicare Health Plans Inc., up 12.5%; and Frank B. Hall & Co. Inc., up 9.1%. The largest losses were posted by: Statesman Group Inc., down 9.1%; Hartford Steam Boiler Inspection & Insurance Co., down 5.1%; and U.S. Healthcare Inc., down 3.2%. The most active issue was: Sears, Roebuck & Co., 2.5 million shares traded. The BI Index gained 1.3% for the period; the Standard & Poor's 500 also gained 1.3%; the New York Stock Exchange Composite grew 1.1%; and the Dow Jones 30 Industrials was up 0.4%.

British Issues

Jan. 5 Companies	Price	P/E	Div. %	Yield	1 Week	
					High-Low	price/price
Comml Union	341	11.0	25.3	7.4	341-336	
Genl Accident	865	8.6	58.0	6.7	865-858	
Gdn Royal Exch	188	10.1	13.1	7.0	190-188	
Royal	392	12.8	30.0	7.7	392-382	
Sun Alliance	999	7.6	54.7	5.5	999-992	

Brokers	Price	P/E	Div. %	Yield	High-Low
Bradstock	213	12.0	9.0	4.2	215-213
CE Health	419	13.3	34.5	8.2	421-419
Hogg Robinson	146	13.5	8.0	5.5	146-137
Lloyd Thompson	190	15.0	8.0	4.2	190-190
PWS Holdings	134	19.2	6.0	3.9	138-134
Sedgwick Grp	237	19.7	16.0	6.8	237-229
Steel Bri Jones	209	18.7	13.3	6.4	210-209
Willis Faber	228	13.7	16.0	7.0	228-224

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

BI Industry Stock Report

JANUARY 5, 1989

12/30/88 THRU 1/5/89

BROKERS	Price	Weekly % change	Year to Date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
				High	Low						
Alexander & Alexander Svcs	23.63	-0.5	0.6	28.13	17.75	135	1.00	4.2	16.2	3.71	6.37
Corroon & Black Corp.	31.13	1.6	0.0	34.75	28.00	296	1.08	3.5	4.7	5.43	5.73
Gallagher Arthur J. & Co.	16.63	2.3	-0.7	19.13	13.88	34	0.48	2.9	11.5	5.16	3.22
Hall Frank B. & Co.	3.00	9.1	4.2	5.50	2.50	144	0.00	0.0	-1.6	0.00	N/A
Hilb, Rogal & Hamilton	15.25	1.7	0.0	15.25	9.75	20	0.00	0.0	12.8	4.60	3.32
Marsh & McLennan Cos. Inc.	55.75	-2.2	-0.9	59.63	45.25	242	2.50	4.5	13.6	6.74	8.27
Poe & Assoc Inc.	8.25	0.0	0.0	9.25	6.75	9	0.40	4.8	9.3	0.27	30.56
BROKERS	AVERAGE	1.7	0.5					2.8	9.5		

CONGLOMERATES & HOLDING COMPANIES	Price	Weekly % change	Year to Date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
				High	Low						
Berkley W.R. Corp.	29.75	0.4	0.8	30.25	23.50	77	0.36	1.2	6.4	17.63	1.69
Berkshire Hathaway Inc. DEL	4675.00	-1.6	33.9	5050.00	2755.00	66	0.00	0.0	18.8	2492.68	1.88
ITT (Hartford Group)	52.00	2.0	3.7	54.88	43.25	788	1.48	2.8	6.8	52.23	1.00
Sears Roebuck & Co. (Allstate)	41.38	1.5	1.2	46.13	32.25	2496	2.00	4.8	10.8	34.74	1.19
CONGLOMERATES	AVERAGE	1.0	6.8					1.7	9.2		

INSURERS/REINSURERS	Price	Weekly % change	Year to Date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
				High	Low						
Aetna Life & Cas Co.	48.00	1.6	1.6	52.50	39.50	669	2.76	5.8	7.9	53.56	0.90
American General Corp.	31.00	3.7	3.7	36.38	27.50	981	1.40	4.5	7.8	28.04	1.11
Amer Heritage Life Invnt	25.25	1.0	-1.9	27.00	24.00	2	1.08	4.3	10.7	20.98	1.20
Amer Indiy Fin'l Corp.	10.25	0.0	-2.4	12.00	8.25	2	0.56	5.5	18.0	15.26	0.67
American Int'l Group	68.50	0.7	1.1	68.75	49.00	920	0.40	0.6	10.1	33.56	2.04
Aon Corp.	27.88	1.4	-0.4	28.75	21.88	385	1.28	4.6	9.1	15.13	1.84
Argonaut Group	45.25	2.8	3.4	49.00	29.50	93	0.00	0.0	6.3	29.19	1.55
AVEMCO Corp.	26.00	3.0	0.5	28.75	17.88	20	0.34	1.3	12.1	7.74	3.36
Baldwin & Lyons Inc.	14.75	1.7	-0.9	16.38	12.13	19	0.20	1.4	6.1	17.57	0.84
Belvedere Corp.	4.63	5.7	2.9	6.00	4.00	15	0.04	0.9	6.8	7.87	0.59
Chandler Insurance	9.75	8.3	5.4	10.25	4.25	87	0.00	0.0	4.7	7.18	1.36
Chubb Corp.	58.88	0.9	1.5	63.38	51.25	265	2.16	3.7	6.7	46.13	1.28
CIGNA Corp.	47.50	0.0	0.8	55.38	42.75	405	2.96	6.2	8.8	49.19	0.97
CNA Fin'l Corp.	59.63	0.2	-1.4	66.13	51.00	107	0.00	0.0	9.4	46.40	1.29
Continental Corp.	32.38	-1.1	0.0	41.63	31.50	547	2.80	8.0	10.4	42.10	0.77
Durham Corp.	32.25	0.8	-2.3	36.75	21.50	8	0.92	2.9	37.5	26.00	1.24
Farmers Group Inc.	74.75	0.0	0.0	74.88	40.50	0	1.44	1.9	17.5	22.02	3.39
Fireman's Fund Corp.	29.00	-0.9	-0.9	33.50	25.75	150	0.50	1.7	126.1	26.17	1.11
Forum Re (Bermuda)	1.63	0.0	0.0	4.00	1.13	0	0.00	0.0	4.5	2.58	0.63
Fremont Gen Corp.	13.13	-2.7	-1.9	13.50	8.75	358	0.60	4.6	8.9	16.24	0.81
Frontier Insurance Group	12.75	2.0	2.0	13.25	6.50	26	0.00	0.0	6.4	5.97	2.14
General Re Corp.	56.50	0.2	1.8	59.38	45.50	503	1.20	2.1	11.5	26.21	2.16
Home Group Inc.	11.75	8.0	6.8	14.38	10.50	333	0.20	1.7	1.4	17.76	0.66
Hanover Ins Co.	26.50	-0.9	-0.9	27.75	20.50	121	0.36	1.4	5.0	25.10	1.06
Harleysville Group Inc.	18.00	1.4	0.0	18.25	13.38	11	0.48	2.7	7.1	16.65	1.08
Hartford Steam Boiler	34.75	-5.1	-5.4	37.25	22.50	171	1.40	4.0	11.9	10.65	3.26
Kans City Life Ins	33.50	-2.9	-2.9	39.50	25.25	12	0.00	0.0	8.7	39.22	0.85

HEALTH MAINTENANCE ORGANIZATIONS	Price	Weekly % change	Year to Date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
				High	Low						
Kemper Corp.	24.13	-1.5	0.5	27.50	20.75	259	0.72	3.0	7.7	26.50	0.91
Lawrence Ins. Group	8.00	0.0	1.5	11.63	4.50	4	0.24	3.0	17.8	2.90	2.76
Liberty Corp. S.C.	37.00	2.8	2.8	47.25	33.88	15	0.80	2.2	12.8	17.40	2.13
Lincoln Nat'l Corp.	43.63	-0.3	-0.8	53.50	40.25	209	2.48	5.7	11.3	36.62	1.19
NAC Re Corp.	31.75	3.3	0.0	31.75	18.50	144	0.00	0.0	14.2	19.92	1.59
Navigators Group	21.00	1.2	5.0	20.75	14.50	6	0.00	0.0	10.2	12.88	1.63
Nobel Ins Ltd.	4.63	0.0	-2.5	9.50	3.75	61	0.42	9.1	-33.1	7.76	0.60
Northwestern Nat'l Life	31.75	2.4	2.0	34.50	22.63	102	1.12	3.5	7.6	35.05	0.91
Ohio Cas Corp.	37.00	4.6	3.5	38.25	32.25	117	1.88	5.1	6.9	27.86	1.33
Old Rep Int'l Corp.	24.63	3.1	2.6	25.88	19.13	159	0.74	3.0	5.8	27.82	0.89
Orion Cap Corp.	16.13	7.5	4.9	17.63	13.13	86	0.76	4.7	5.5	9.34	1.73
Phoenix Re Corp.	9.50	0.0	0.0	11.00	6.75	53	0.00	0.0	5.2	11.08	0.86
Protective Life Corp.	13.00	-1.0	-1.9	15.13	12.25	63	0.70	5.4	15.9	17.25	0.75
Re Capital Corp.	9.38	5.6	2.7	11.75	7.88	11	0.00	0.0	20.8	11.49	0.82
Provident Life & Acc Ins Co.	19.75	3.9	2.6	25.00	15.63	106	0.68	3.4	16.6	21.96	0.90
St. Paul Cos. Inc.	43.25	-0.6	-0.6	51.00	38.25	704	2.00	4.6	6.1	35.83	1.21
SAFECO Corp.	23.63	-0.5	0.0	30.00	22.75	1949	1.08	4.6	7.5	21.39	1.10
SCOR U.S. Corp.	9.00	7.4	-1.4	9.50	6.63	113	0.20	2.2	6.5	9.39	0.96
Selbels Bruce Group Inc.	12.00	6.7	5.4	14.25	11.00	39	0.80	6.7	8.1	12.51	0.96
Selective Ins Group Inc.	22.75	-1.1	-1.1	26.50	19.25	32	1.24	5.5	5.1	19.52	1.17
Statesman Group Inc.	3.06	-9.5	-2.2	5.56	2.75	113	0.05	1.6	-306.0	3.48	0.88
Tokio Marine & Fire Ins	89.00	-1.7	-2.6	98.00	63.25	18	0.22	0.2	53.9	0.00	N/A
Torchmark Corp.	30.38	-1.2	-0.4	33.50	24.50	93	1.20	3.9	9.9	12.24	2.48
Transamerica Corp.	33.63	-1.1									

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