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update

Mandated waste cleanups not 'damages,' court rules

RICHMOND, Va.—Costs for cleaning up hazardous waste sites to comply with governmental directives are not "damages" under general liability insurance policies and therefore are not covered, a federal appeals court says.

The 4th U.S. Circuit Court of Appeals ruled July 6 that Middletown, Ohio-based Armco Inc. cannot recover cleanup and other re-

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House advances variable-rate PBGC premium

By JERRY GEISEL

WASHINGTON—All employers would pay almost twice the current termination insurance premium to the Pension Benefit Guaranty Corp. and companies with underfunded pension plans would have to rapidly improve funding under recommendations being considered by the House Ways and Means Committee.

Those recommendations, hammered out by the Ways and Means Oversight Subcommittee, would establish a limited variable-rate PBGC premium structure.

Under the proposal, the annual base premium would be set at $15 per plan participant, while the maximum premium—to be paid by companies with the poorest funded plans—would be $50 per participant.

Under an earlier Reagan administration proposal, companies with well-funded plans would pay only the current annual PBGC premium of $8.50 per participant while those with poorly funded plans could pay as much as $100 (*BI*, March 23).

In addition, under the subcommittee's proposal, companies would have—in some cases—as little as three years to fund pension liabilities. Companies currently have 30 years in which to amortize their pension debt.

Like the administration proposal, the committee's proposal would make an employer and all of its affiliates jointly and severally liable for funding shortfalls in each unit's defined benefit pension plans.

But, unlike the administration proposal and much to the disappointment of benefit experts, the subcommit-

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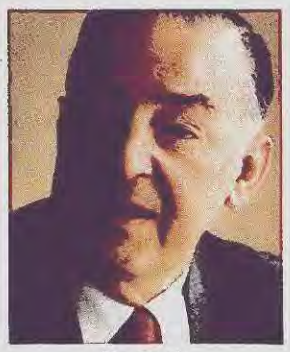
5 ex-Howden officials face criminal charges

By CAROLYN ALDRED

LONDON—After almost five years, the scandals at Alexander Howden Group P.L.C. are moving into the criminal courts.

In dramatic, simultaneous police raids in Britain and France last week, fraud squad officers arrested five former officials of Howden and its affiliates, including flamboyant former Lloyd's underwriter Ian R. Posgate, in connection with the transfer of "millions of pounds" from Howden and its subsidiaries prior to 1982.



Mr. Grob

Four of the men—including Mr. Posgate, another former Lloyd's underwriter and two former Howden executives—were arrested in Britain on July 15 and were charged with fraud the next day in connection with the purchase of a Swiss bank with funds allegedly diverted from Howden and subsidiaries.

A fifth man, former Howden Chairman Kenneth V. Grob, is being held in Nice, France, on charges that he stole more than $1 million. His extradition to Britain will be sought as soon as possible, and his case will then be joined with those of the other four men, officials said.

The four men charged at London's Guildhall Magistrate's Court on Wednesday included Mr. Posgate, Lloyd's most dynamic and successful underwriter of the late '70s and early '80s who was dubbed "Goldfinger" in the London market.

Also appearing in the dock were Colin Hart, former underwriter for Lloyd's syndicates managed by L.E. Hart Associates Ltd., which Howden acquired in 1976; Alan J. Page, formerly chief financial officer at Howden; and Jack H. Carpenter, a former Howden director.

The arrests follow almost five years of investigation into the so-called Howden affair, which first came to light in 1982 after Alexander & Alexander Services Inc. acquired Howden.

The news of the arrests last week stunned the Lloyd's market. After years of investigation, many people thought criminal charges would never be brought in the scandal.

One Lloyd's underwriter, who did not wish to be identified, said he was very surprised when he heard the news but was pleased that action was being taken that could finally put the case to rest one way or another.

A Howden spokesman stressed that the criminal charges are related to events at Howden before A&A acquired the London company in 1982. And, Robert Moore, senior vp of A&A, said: "We think that it is very important that the current events be seen in the context of the last five years. We, as an American company, taking over a U.K. company, found a lot to fix. We've devoted millions of dollars and years of work to making it better. We feel very gratified having created a company as strong and viable as Howden is today.

"Finally after years of taking our lumps, we are now in a position to say, 'Let the facts speak for themselves.' "

Mr. Posgate, 55, was charged with conspiring between Oct. 1, 1979, and Sept. 1, 1982, "together with Messrs. Grob, Carpenter and Page to defraud the Alexander Howden Group of Companies and its associates and subsidiary companies by

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Health pool proposal

Employers charge assessments unfair

By DEBORAH SHALOWITZ

WASHINGTON—A resurrected congressional proposal that would allow states to require employers to subsidize state health insurance pools for the uninsurable is expected to narrowly pass a key House committee.

A similar proposal died in a joint conference committee last year over concerns about the benefits the pools would provide, but the current proposal has been modified in an effort to prevent similar concerns from arising this year.

The legislation would allow states to assess all insured and self-insured employers with 20 or more employees to fund any losses incurred by health insurance pools for the uninsurable (*BI*, July 6).

Employers that do not participate in the state risk pools would be assessed 5% of their gross annual wages.

States also could assess health insurers, or maintain existing programs that only assess health insurers to cover costs, according to the proposal.

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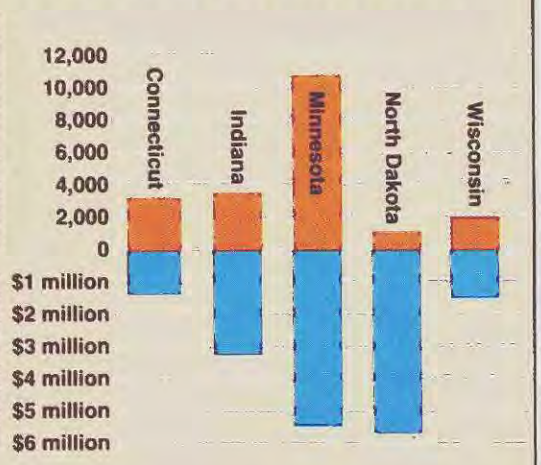
State health insurance pools' beneficiaries and losses*



* Number of beneficiaries as of May 1, 1986, (Aug. 1, 1986, for Connecticut). Losses are for calendar year 1985.

Source: Employee Benefit Research Institute.

Ex-Transit MGA alleges collusion

By DOUGLAS McLEOD

DALLAS—A former managing general agent for Transit Casualty Co. is suing Transit's liquidator, several former Transit directors and others, charging they are responsible for the insurer's collapse.

In a complex series of pleadings, Carlos I. Miro and his agency, Miro & Associates Risk Management Inc. of Dallas, allege Transit directors conspired to drain the insurer's surplus through a series of dividend payments to its parent company and to conceal Transit's poor financial condition with reinsurance contracts that were canceled before Transit entered receivership.

The alleged conspiracy was intended to allow Transit's parent, Beneficial Standard Corp. of Los Angeles, to complete a liquidation of real estate and other assets unencumbered by any regulatory action against Transit, the pleadings charge.

BSC was liquidated and its assets—including Transit stock—were distributed to shareholders in May 1985. Transit—with current liabilities estimated at more than $500 million—was ordered liquidated in Missouri in December 1985. Guaranty fund assessments through Dec. 31, 1986, to pay Transit claims totaled $111.5 million.

Transit's liquidator, Missouri Insurance Director Louis R. Crist, last week filed a motion to dismiss the Miro pleadings on the grounds that they were improperly filed.

A judge's ruling on the motion was expected by today.

Separately, Transit's liquidator has prepared its own suit against Transit directors, charging negligence in the management of the MGA programs and in the payment of dividends to BSC.

The lawsuit, which has not yet been filed, has been shown to National Union Fire Insurance Co. of Pittsburgh, Pa., which wrote directors and officers liability coverage with a $15 million limit for Transit, according to Charles Patterson, a lawyer with Lillick,

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Fear of product liability litigation prompts Monsanto to cease production of asbestos-replacement fiber
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update

Cleanup not covered: Court

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sponse costs from Maryland Casualty Co. arising from litigation over a hazardous-waste site in Kansas City, Mo.

The court ruled that such costs were not "damages" within the meaning of a CGL policy. It also found that Maryland Casualty, which insured Armco from 1966 until June 1, 1983, did not owe Armco a defense in the litigation.

The decision by the 4th Circuit affirmed a decision handed down last September by a U.S. District Court judge in Baltimore (*BI*, Sept. 8, 1986).

The litigation arose from a lawsuit by the federal government under the Resource Conservation and Recovery Act of 1976 and the Superfund Act against owners of the Missouri waste storage facility and various waste generators, including Armco.

An attorney for Armco called the decision "incorrect" and said the company will ask the appellate court to rehear the case.

PBGC to appeal LTV ruling

NEW YORK—The Pension Benefit Guaranty Corp. will appeal a bankruptcy court ruling last week that allows Dallas-based LTV Corp. to set up a new pension program to replace supplementary benefits participants lost when LTV filed bankruptcy last year.

PBGC officials say that LTV's action violates the Employee Retirement Income Security Act and, if allowed to stand, could lead to the collapse of the PBGC insurance program.

U.S. Bankruptcy Judge Burton Lifland in New York approved a tentative labor and benefit pact between the United Steel Workers union and LTV, which, among other things, restores nearly all pension benefits to participants that the PBGC did not guarantee when the agency took over the plans.

Many LTV retirees' benefits were reduced when the PBGC terminated LTV pension plans following LTV's filing for Chapter 11 reorganization last year and assumed their $2.3 billion in unfunded liabilities. The PBGC guarantees only basic pension benefits and not certain supplementary benefits.

LTV praised Judge Lifland's ruling as providing relief to the company's retirees.

But, the PBGC said the ruling would give employers a financial incentive to terminate underfunded plans and set up new supplementary plans. "This would result in payment by the PBGC, rather than by the company, of a major portion of the cost of the company's on-going retirement program. This result is completely at odds with the statute's (ERISA) purpose," said PBGC Executive Director Kathleen P. Utgoff. "For PBGC to undertake such tasks would be a financial transformation of its historic role and would involve massive additional costs that would threaten the survival of the termination insurance program."

The PBGC says it will appeal the ruling to a U.S. District Court and, if necessary, to the Supreme Court.

$95 million Bendectin award

WASHINGTON—Merrell Dow Pharmaceuticals Inc. will appeal a $95 million jury award to a boy whose birth defects were attributed to his mother's use of the anti-nausea drug Bendectin.

A six-person jury last week awarded 8-year-old Sekou Ealy $20 million in compensatory damages and $75 million in punitive damages following a trial in U.S. District Court in the District of Columbia. Sekou was born with deformed elbows and hands.

The verdict is the largest award in a Bendectin case and one of the largest ever in a product liability action. The previous largest award in a Bendectin case was a $2 million judgment by a state court in Philadelphia in January, which Cincinnati-based Merrell Dow is appealing (*BI*, Jan. 26).

A spokesman for Cincinnati-based Merrell Dow, a unit of Dow Chemical Corp., said it was "incredible" that the jury found that Bendectin caused the child's problems and that the damages awarded were "grossly excessive."

A Merrell Dow spokesman declined to comment on specifics of the company's insurance coverage except to say it had a complex program that is a combination of insurance and self-insurance.

However, Merrell Dow does have primary product liability insurance written by Dow's Dorinco Reinsurance Co. and excess insurance placed primarily with Lloyd's of London underwriters.

Merrell Dow manufactured Bendectin from 1956 until 1983. The company recently was found not liable for the birth defects of two children whose mothers used Bendectin (*BI*, July 6). Overall, the company has won 13 of 17 trials.

New York passes D&O bill

ALBANY, N.Y.—A bill that would permit shareholders to limit their directors' liability, which is modeled after amendments to the Delaware General Corporation Law enacted in June 1986, awaits Gov. Mario Cuomo's signature.

The New York legislation is essentially the same as Delaware's in protecting directors from liability except when they act illegally or in bad faith, said a spokesman for Sen. Richard Schermerhorn, R-Cornwall, who sponsored the bill (*BI*, June 23, 1986).

However, the New York legislation differs, said the spokesman, in that it further protects directors by stating they can take corporations' short- and long-term interests into account "without limitation" in dealing with takeover attempts.

Another bill that expands the current indemnification provisions for directors of non-profit corporations, also sponsored by Sen. Schermerhorn, also is awaiting the governor's signature. The changes are in accordance with those enacted for directors of business corporations last year.

A spokesman for Gov. Cuomo would not comment as to whether he plans to sign either bill.

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Captives sue Hall, RBH over premium diversion

By DOUGLAS McLEOD

NEW YORK—Two captive insurers are suing Frank B. Hall & Co. Inc., Rollins Burdick Hunter Co. and several other brokers and individuals, charging that they participated in a conspiracy to divert premiums from the captives.

The lawsuit, alleging violations of the federal Racketeer Influenced and Corrupt Organizations Act, charges that a former Hall employee and the captives' former treasurer were part of a scheme to embezzle $1.1 million from Philan Insurance Ltd. and Benodet Insurance Ltd., both based in the Cayman Islands.

To produce a stream of premiums from which money could be diverted, the defendants induced the captives to "accept reinsurance risks far in excess of Philan and Benodet's capacity to prudently accept such risks," the complaint alleges.

The two captives already have paid or incurred losses of $5 million on the reinsurance business and may pay more than $70 million in additional losses and expenses, the complaint says.

Insurers ceding business to the captives included Union Indemnity Insurance Co. of New York, a former Hall unit now being liquidated by the New York Insurance Department; and Insurance Corp. of Ireland, which was taken over by the Irish government in 1985 when ICI's parent company, Allied Irish Banks Inc., discovered "major losses" for 1984 (*BI*, March 25, 1985).

The ICI business represented retrocessions of risks originally underwritten by Mission Insurance Co., now being liquidated by the California Insurance Department, one brokerage source said.

Philan and Benodet also were significant reinsurers of syndicates on the Insurance Exchange of the Americas in Miami, according to IEA's 1985 annual statement. The IEA business is not mentioned in the captives' lawsuit, however.

Michael Brown, a lawyer with the New York firm of Ohrenstein & Brown, representing Philan and Benodet, refused to provide details of the captives' financial status.

An official of the captives' current manager, Marsh & McLennan (Cayman Islands) Ltd., also would not comment.

Mr. Brown did say that the captives have ceased writing new and renewal business but are not in liquidation.

Mr. Brown also declined to comment on the captives' current owner, though sources familiar with the captives report that Philan and Benodet were originally formed by Bridgton Distributing Co. Inc., a construction supply firm in Providence, R.I., formerly controlled by Arthur and David Milot.

The Milot brothers have since sold Bridgton and related companies to a Braintree, Mass., building supply firm, but Philan and Benodet were not included in that sale, sources familiar with the transactions say.

Arthur Milot also declined to comment about the two captives.

The lawsuit, filed last month in U.S. District Court for the Southern District of New York, names:

- Hall, Frank B. Hall Re of New York Inc., Frank B. Hall Re International Inc., Frank B. Hall Re de Mexico

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E-Ferol maker, distributor indicted for safety violations

By MEG FLETCHER

ST. LOUIS—A drug manufacturer, distributor and three executives face criminal charges of misrepresenting the safety and effectiveness of an intravenous vitamin E supplement that is blamed for the deaths of dozens of infants and injuries to several more in 1983 and 1984.

However, neither their July 7 indictment nor any conviction is expected to cost the corporate defendants any insurance coverage in more than 100 civil cases related to the drug's effects, most of which have been settled.

Arraigned in federal court last week were Carter-Glogau Laboratories Inc. of Glendale, Ariz., a former pharmaceutical manufacturing subsidiary of Twinsburg, Ohio-based Revco D.S. Inc., and Ronald M. Carter Sr., its former president.

Also arraigned were O'Neal, Jones & Feldman Inc. of Maryland Heights, Mo., a former pharmaceutical distributing subsidiary of Dyson-Kissner-Moran Corp. of New York; Larry K. Hiland, O'Neal's former president and chief executive officer; and James B. Madison, O'Neal's former executive vp of operations.

The Justice Department's indictment charges that Revco's Carter-Glogau unit manufactured and shipped 40,000 vials of the drug from November 1983 to April 1984 without testing the safety and effectiveness of the drug for its recommended uses.

O'Neal, Jones & Feldman distributed about 26,000 vials to neonatologists and hospitals nationwide, according to the indictment.

E-Ferol primarily was given to premature infants to treat retrolental fibroplasia—a disease that can result in blindness—and vitamin E deficiencies.

According to the indictment, Carter-Glogau's Mr. Carter wrote in a 1982 memo: "If we make some attempt to solubilize the vitamin E and use the wrong proportions and kill a few infants, we'd have some serious problems."

Despite reports of deaths and severe reactions linked to the drug's use as early as January 1984, the defendants continued until April 1984 to tell medical professionals that E-Ferol was safe, the indictment alleges.

In a January 1984 memo cited in the indictment, Mr. Madison of O'Neal, Jones & Feldman said that E-Ferol sales had generated $50,000 of business in the first two months and that the company had "just scratched the surface." He estimated that annual sales would be $1.5 million.

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Fear of suits kills 'safe' Monsanto fiber

By STEPHEN TARNOFF

ST. LOUIS—Monsanto Co. will not market a "phosphate fiber" asbestos substitute it has developed because of the adverse "litigation climate" in the United States.

St. Louis-based Monsanto decided earlier this month not to market the patented product, which would have had limited product applications, despite its studies that indicate the product is safe, according to company officials.

"The decision to terminate this program was based on the litigation climate that exists in the United States today," said a notice posted at the company earlier this month.

"Regrettably this has led Monsanto to conclude that we are not prepared to accept the potential product liability risks associated with marketing this reinforcing fiber, no matter how safe it may be," the notice informed company employees.

"It was not the general concern about the safety of the product but with the further expansion or misapplication of law that certainly weighed heavily in reaching that decision," emphasized William Blase, Monsanto's assistant general counsel.

A Monsanto spokesman said that defending even non-meritorious suits would be very costly, although it was not determined who potential plaintiffs might be. "I don't think anybody could have quantified it to that point," he said.

The company's concerns over potential litigation if the phosphate fiber were marketed —even though officials believe the product is safe—are well-founded, according to Robert E. Toth, Monsanto's risk manager.

"We manufacture many, many perfectly safe products today and we are still facing litigation over these products, even though they have been proven to be safe."

The availability and cost of product liability insurance for the new product "was not a factor" in the company's decision to terminate the program, according to Mr. Toth.

"As you know, with any major corporation, when we buy product liability insurance, we don't buy it for a single product," he noted. Product liability insurance covers all of a policyholder's products, he said.

"The cost of buying insurance was not a significant factor in the decision that we

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Prevalence of selected cost-containment features
(By percent of employees covered)

Source: Department of Labor survey

Workers pay more health costs: Survey

By ALISON KITTRELL

WASHINGTON—Group health insurance benefits still are provided to virtually all employees at medium-sized and large U.S. companies, but workers are being asked to share more of the costs, according to a recent government survey.

"Employee Benefits in Medium and Large Firms, 1986," the eighth in a series of surveys by the U.S. Department of Labor's Bureau of Labor Statistics, shows that health care benefits are provided to 95% of the 4.3 million employees at the 1,308 companies nationwide covered in the survey.

"Virtually all of the participants in health care plans were covered for the major categories of medical care, such as hospital room and board, care by physicians and surgeons, diagnostic X-ray and laboratory work, prescription drugs and private duty nursing," the survey points out.

"Unlike most other employee benefits, there were few differences in health care provisions among employee groups," such as salaried and hourly workers, the survey adds.

Other key findings reported in the latest survey include:

- Almost all participants in employer-provided health care plans had coverage for hospitalization and most had first-dollar coverage, though the percentage of workers that had to pay part a portion of their hospital costs is increasing.
- Employees also are being asked to pay more of the costs of their medical expenses, both under basic benefit plans, which covered 75% of plan participants for surgical costs, and major medical benefits, which covered 82% of participants for a wide range of medical costs both in and out of the hospital.
- The percentage of employees who had to contribute to the cost of their health insurance coverage rose sharply in 1986.
- In the interest of cost-containment, employers increasingly are covering less-costly alternatives to hospitalization and including other plan design features, such as second surgical opinion programs, that are designed to hold down expenses (see chart).

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IEA and Cadillac settle dispute

By MICHAEL BRADFORD

MIAMI—A $3.2 million settlement reached by the Insurance Exchange of the Americas and Cadillac Insurance Co. earlier this month is only the first hurdle the exchange must clear in its attempt to resolve several disputes involving IEA syndicates over loss-riddled reinsurance treaties.

The inactive IEA still must come to terms with several other ceding insurers and at least one broker that refuses to surrender premiums to insolvent syndicates.

But the IEA may be close to reaching a settlement with a second ceding insurer, according to officials with the exchange and the Florida Insurance Department.

And, as the IEA moves to reopen on Sept. 1 as a market writing only surplus lines insurance, an Insurance Department official says the department is finalizing its plans to rehabilitate at least some of the IEA's insolvent syndicates.

Reinsurance business assumed by IEA syndicates from Detroit-based Cadillac and several other insurers resulted in such heavy losses that the IEA was forced to close earlier this year (*BI*, Feb. 16).

As a result of the losses, seven of the 15 formerly active syndicates have been placed in rehabilitation. Those syndicates are Syndicate One Inc., Syndicate Two Inc., Syndicate Three Inc., Syndicate Four Inc., RAM Syndicate Inc., Hispano American Insurance Syndicate Ltd. Inc. and AIB Syndicate Inc.

Since the exchange was shuttered, officials at the IEA and the Insurance Department have been attempting to rescind or commute the troubled treaties.

IEA President Nicholas Cross is bound by a confidentiality agreement not to discuss specifics of the Cadillac settlement, but he did say that all 15 syndicates participated in the settlement and that the agreement does not trigger the IEA's guaranty fund, which currently stands at about $13 million.

Ernest Solomon, Cadillac's president, said the settlement ends all IEA obligations to the insurer and its affiliate, United Fire Insurance Co. in Des Plaines, Ill.

In a suit filed earlier this year, Cadillac sought $5.1 million in claims payments and $5 million more in punitive damages from the syndicates. Cadillac charged the syndi-

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Illinois' captive law tied to existing code

By LAURA MAZZUCA

CHICAGO—Illinois is within weeks of having its own captive insurance company law, joining the growing number of states that find the alternative to traditional insurance coverage an undeniable reality.

The bill, which was passed unanimously in both the House and the Senate this month, is expected to be signed into law within a week or two by Gov. James R. Thompson.

Effective immediately upon ratification, the bill will make Illinois the first large industrial state to adopt legislation specifically authorizing captive insurers.

The bill was introduced by Rep. John Cullerton, D-Chicago, and hammered out by Chicago law firm Hopkins & Sutter in close cooperation with the Illinois Insurance Department. The 62-page document is a far cry from the nine-page captive law in Vermont, currently the U.S. domicile of choice for captive insurers.

Captive insurer laws are in place in Colorado, Delaware, Florida, Hawaii, Tennessee, Vermont and Virginia. A bill is active in New Jersey, but a Rhode Island captive bill is considered by experts to be dead.

Unlike the legislation in Vermont, Delaware and Hawaii, the Illinois bill is closely tied to the existing state Insurance Code, particularly regarding formation. For instance, the minimum surplus required for all captives formed in Illinois is $2 million, the same as for any insurer. In Vermont, the minimum capitalization for single-parent captives is $250,000, the minimum for industrial captives is $500,000 and the minimum for association captives is $750,000.

An industrial captive is owned by several companies that are not members of an association while an association captive is formed by members of a business or trade association.

But the bill's drafters are touting its domestication clause as particularly attractive to offshore captives desiring to "come home." Under the bill's modification of the Insurance Code's Sections 180 to 186, existing offshore or foreign insurers may change their domicile to Illinois by adopting resolutions and obtaining approval from the director of insurance.

Most states do not have special provisions on domestication, and rely instead on general corporate statutes to cover the process, said Tomas M. Russell, senior

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Treaty modification saves Eurobond holders millions

By JUDY GREENWALD

NEW YORK—Insurance company portfolio managers are heaving sighs of relief over the Treasury Department's decision to modify an earlier decision to unilaterally terminate a tax treaty between the United States and the Netherlands Antilles.

While it would not have threatened any insurer's solvency, terminating the treaty conceivably could have cost insurers millions of dollars in Eurobond losses.

Eurobonds are bonds denominated in U.S. dollars or other currencies and sold outside the country whose currency is used.

"It was a big relief," said Tim Holt, a portfolio manager at Aetna Life & Casualty Co. in Hartford, Conn. Had the Treasury gone through with its plan, Aetna could have lost $15 million to $20 million, he said.

The 39-year-old treaty with the Netherlands Antilles provided that Eurobonds issued through this group of islands by U.S. corporate affiliates were exempt from a 30% withholding tax.

To prevent certain abuses of the treaty, the Treasury Department announced last month that it planned to unilaterally cancel the treaty, which meant that bonds issued before

July 1984 would be subject to the 30% tax.

The withholding tax was eliminated in July 1984, so only Eurobonds issued through the Netherlands Antilles before that date would have been affected by cancellation of the treaty.

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Bermuda court to hear Pinnacle appeal

By ROGER SCOTTON

HAMILTON, Bermuda—Pinnacle Reinsurance Co.'s appeal of a Bermuda Supreme Court ruling against it will be heard by the Court of Appeal in its next session, likely to be held in November.

Pinnacle is appealing a May 1 ruling denying its request for a declaratory judgment that the liquidators of Mentor Insurance Ltd. do not have standing to sue Pinnacle in U.S. District Court in Louisiana (*BI*, May 11).

The Court of Appeal in Bermuda last week rejected pleadings by Pinnacle that the appeal be heard this month.

The court also heard, but did not rule on, a contention by Pinnacle that it had discovered new evidence that the permanent liquidators were not vested with the assets of Mentor in the order appointing them. Therefore, Pinnacle contends, they do have the power to sue on behalf of Mentor.

The provisional liquidators had been vested with this power.

The liquidators' attorney argued that such evidence could not be introduced at the appeal stage.

Sir Alastair Blair-Kerr, president of the three-man Appeal Court, ruled that the appeal hearing be held over.

As a result of Pinnacle's contention that the permanent liquidators' appointment did not include vesting them with the assets of Mentor, Supreme Court Justice Gerald Collett ordered the liquidators not to seek new vesting authority without giving Pinnacle and Mentor Holding Co., Mentor's Bermuda-based parent company, prior notice.

Pinnacle, a unit of Lloyd's of London broker C.E. Heath, is one of 11 defendants named by the liquidators in the Louisiana suit. The suit charges that Pinnacle, Mentor's ultimate parent company Ocean Drilling & Exploration Co. and certain ODECO and Mentor officers and directors conspired to conceal Mentor's true financial condition through the use of reinsurance contracts (*BI*, March 24). The suit seeks to recover damages equal to Mentor's insolvency, estimated at $500 million.

Meanwhile, Mentor's liquidators have told the federal court that the state's choice-of-law rules do not allow the suit to be heard under Bermuda law.

ODECO, which denies the allegations and has filed a motion to have the suit dismissed, also argues that because the alleged scheme took place in Bermuda, and because Mentor was a Bermuda-based company and its liquidators appointed by a Bermuda court, the suit should be heard under Bermuda rather than U.S. law.

ODECO also has claimed that under Bermudian law, Mentor liquidators Charles Kempe and Michael Arnold lack the required legal standing to bring an action that belongs not to Mentor, but to its creditors.

But the liquidators' lawyer, Michael Murphy of the New York firm of Lord, Day & Lord, argued in a court memorandum filed this month that if ODECO's assertion is right, "The word should now go out to all those with a propensity to form an offshore corporation in an English Commonwealth jurisdiction and use that offshore corporation as a vehicle for their wrongdoing in the U.S."

Under ODECO's logic, the memorandum says, the wrongdoers may hide behind the shield of their offshore company and immunize themselves from the consequences of their acts.

Claiming that Louisiana law must prevail, Mr. Murphy asserted that Mentor was controlled from New Orleans, that it had no functioning board of directors and that minutes were fabricated from Mentor board meetings that never took place.

He maintained that the negotiation and formation of Mentor's excess-of-loss contracts was centered in Louisiana and that activities concerning a cover-up of the alleged fraudulent scheme took place in New Orleans in the executive suite of ODECO's headquarters on Canal Street.

Under conflict of law principles, the law of the state with "the most significant relationship with the dispute" should be applied, Mr. Murphy said.

His memorandum says that legal guidelines on the issue recommend an "interest analysis" based on consideration of the place of injury, place of conduct, domicile of the parties and the place of the center of the relationship among the parties.

Seven of the defendants named in the liquidators' suit, he says, are located in Louisiana, and Mentor itself, though incorporated in Bermuda, was formed as an "exempt" company—one that is free from Bermudian ownership requirements because its business arises and occurs outside of Bermuda.

His court memorandum states: "This state (Louisiana) has an overwhelming interest and policy in deterring tortious conduct committed in this state by anybody, and in particular, by Louisiana residents. To apply ODECO's version of English/Bermudian law and thereby immunize such conduct on the ground that the plaintiffs represent a Bermudian victim of that conduct, would be to turn that state policy on its head."

The memorandum was accompanied by an affidavit on the nature of Bermudian exempted companies. The affidavit was written by Bala Nadarajah, the former legal adviser to Bermuda's insurance regulators who now works for the Washington, D.C.-based law firm of Hanson, O'Brien, Birney & Butler. ■

Thanks to modern medicine, he'll now be able to outlive his savings.

Advancements in medicine are helping Americans live longer than ever. But not everyone is financially prepared for a longer life.

Particularly retirees who end up needing expensive long-term care. Currently, that's 6 million people. That number should be 14 million by the year 2020.

Personal savings are seldom enough to pay the costs of retirement health care. And Medicare and Medicaid are only a partial solution. Companies with retirement health care benefits also face the problem of unfunded future liabilities.

Additional solutions must be found to address this retirement health care cost issue that will eventually affect every person, company and institution in our country. Ideas that go beyond traditional products.

At NWNL Group, we're developing an employee benefit program called LifeScope® that would provide for a person's retirement and working years. What makes the LifeScope Program unique is its comprehensive approach to providing benefits. It is more than life insurance and a nursing home policy.

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To find out more about NWNL Group and the LifeScope Program, contact Ginny Patrick, NWNL Group, Box 20, Minneapolis, MN 55440 or call (612) 372-5784. Because now is the time to begin solving the problems of providing health care in the future.

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Sources for statistics: Employee Benefit Research Institute, 1985; National Underwriter, 1986.

opinions

New PBGC proposal not perfect

RECOMMENDATIONS made by the House Ways and Means Oversight Subcommittee are good medicine for the nation's pension ills, but several changes would make the subcommittee's formula even more effective.

In a key recommendation, the subcommittee proposes a variable-rate termination insurance premium structure under which Pension Benefit Guaranty Corp. premiums will be based on the financial condition of an employer's pension plan. Employers with pension plans that are at least 10% overfunded would pay a base annual premium of $15 per plan participant. Other plans also would pay $15 per plan participant, plus a special funding charge of $5.50 per $1,000 of underfunding up to a maximum annual PBGC premium of $50.

This variable-rate approach—admittedly a limited one—is a more equitable way to meet the PBGC's growing revenue needs than simply raising the current flat premium paid by all employers. If premiums have to be raised, the burden should fall most heavily on the less-funded plans because they pose the greatest risk to the PBGC insurance program. And, basing premiums on risk, is, after all, a basic element of insurance.

But the subcommittee's premium range of $15 to $50 is much too narrow to give employers with poorly funded plans enough of an economic incentive to improve plan funding. We prefer the Reagan administration approach, under which the PBGC premium would range from $8.50 to $100.

The subcommittee recommendations also would require employers to fund their pension liabilities much more rapidly compared with current law.

No doubt faster amortization of pension liabilities will put financial pressure on some employers and may cause some companies to be more prudent about boosting benefits. And that's as it should be. If companies can't afford to fund benefits in a reasonable amount of time, then they shouldn't increase benefits in the first place.

When some companies are terminating pension plans with virtually no assets to pay for tens of millions of dollars in benefits, it is clear that funding rules must be tightened.

Other subcommittee recommendations would reduce the number of times a company could receive a funding waiver from the Internal Revenue Service and make those waivers more difficult to obtain. In addition, filing for bankruptcy under Chapter 11 proceedings no longer would be an avenue for employers to dump pension liabilities onto the PBGC.

At the same time, financially distressed companies that received permission to terminate underfunded plans would be 100% liable to the PBGC for guaranteed benefits compared with the current 75% liability cap.

By reducing waiver opportunities and making it harder for companies to shed underfunded plans, more employers will realize that pension benefits are indeed long-term commitments and are not something that can be promised when times are good and then shed when conditions change.

Other subcommittee recommendations, though, must be overhauled. Unlike the Reagan administration, the subcommittee would not allow employers to remove excess assets from pension plans and transfer those assets to special trusts to pay for current retirees' health care benefits. Indeed, the subcommittee would not allow employers—for any reason—to take out surplus assets from ongoing plans. Plans would have to be terminated, as is the case now, to recover excess pension assets.

We fail to see how anyone's interest is served by forcing companies to terminate defined benefit pension plans to recover excess assets. It is in everyone's interest to encourage employers to maintain their current pension programs by allowing them to remove extra assets as long as a healthy cushion remains.

And we strongly oppose the subcommittee recommendation to boost the excise tax on reversions to 20% from 10%. That 10% tax was just put in place by the 1986 tax law. By again raising the tax, the subcommittee could encourage more terminations by employers that fear the excise tax will just keep going up.

letters

Reports of insurance crisis are exaggerated

To the editor: I have been in this business for 38 years and, reflecting on the current crises, things could be worse.

On the plus side, the insurance buying public benefited from the highly competitive business conditions, especially when insurers commenced "cash-flow" underwriting. During my tenure, only twice have policyholders been forced to face constricted capacity and increased premiums, and both cycles were rather short-lived. We hear of all sorts of horror stories, but premiums now are coming down again.

The public also has benefited from broader coverages. I can recall a time when it was not possible for the average policyholder to obtain a multiple-peril policy or even replacement-cost insurance. Due to innovation by certain insurers and competition, the insured had perhaps the cheapest, broadest coverages available. When prices were down, nobody complained that their premiums were too low.

On the negative side, insurers have not always acted responsibly, although an understanding of how the business operates will lead one to the conclusion that the fortunes of primary insurers are too often regulated by forces beyond their control. Reinsurers far removed from the local scene have a tremendous effect on insurers.

Insurance companies also are in many cases owned, controlled or operated by management that has little or no experience in the industry. Too many are lawyers or financial people who feel insurance is nothing more than a quasi-banking operation rather than one of transfer of risk.

A prominent president of an insurance company, on learning of a large fire loss, remarked: "The account was a bad loan."

While I have praised insurers, many recently have lost the initiative to be innovative, preferring to operate with the "lemming theory," following the leader to suicide.

There is little doubt that insurance company management in recent times has been motivated by greed and has taken on a "public-be-damned" attitude, which has backfired. We are now witnessing pressure from consumer groups, insurance commissioners and, belatedly, state legislatures.

Regrettably all of these forces are going to hinder competition within the industry, which will only benefit the very large insurers. These companies welcome a distribution system where they will be guaranteed a profit and are not bothered by competition from the small insurers that cannot afford the expense inherent with the multiplicity of onerous insurance code regulation.

H.P. Schlander
Pasadena, Calif.

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Boycott mandatory health benefit supporters

To the editor: Chrysler Corp.'s and American Airlines' endorsement of the Kennedy bill providing for mandatory employer-provided health insurance is unbelievable (*BI*, June 29). How can any businessman or woman believe in mandated benefits in a free enterprise system?

My wife and I own a small retail corporation. She questioned, "What can we do?"

I answered, saying: "The first thing we can do is not trade our station wagon for a Dodge Caravan—as we had planned to do—and be certain that when we fly, we do not fly American."

Tom Williams
Director-Human Resources
Greenheck Fan Corp.
Schofield, Wis.

business insurance®

Reporting weekly for corporate risk, employee benefit and financial executives

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IEA settlement

Continued from page 3

cates with mismanagement and fraud in connection with treaty reinsurance they wrote covering taxicab risks in California and Chicago (*BI*, March 2).

Mr. Solomon said he settled for less than the $5 million in actual damages he had sought because about $2 million in expected liability claims never materialized.

"I'm happy with the settlement," Mr. Solomon said. "I'll not pursue my legal action further."

He said $1.3 million of the settlement will be paid in cash by the eight syndicates not in rehabilitation. Those syndicates are Administrative Management Services Ltd. Inc.; W.F. Poe Syndicate Inc.; B.G.H. Syndicate Inc.; American Royal Syndicate Inc.; Pacific Insurance Syndicate Inc., formerly Miami Savings Insurance Syndicate Inc.; First Investors Syndicate Inc.; First Inter-Continent Insurance Syndicate Inc.; and Usher Syndicate Ltd.

The remaining $1.9 million of the settlement between the IEA and Cadillac will be in the form of a letter of credit from the seven syndicates in rehabilitation.

Mr. Solomon said $2.9 million of the settlement is earmarked for paying claims related to Cadillac's book of business ceded to exchange syndicates.

The $2.9 million also allows Mr. Solomon to retire a letter of credit of the same value that he had established on his personal funds to pay those claims.

He said United Fire, which faces $450,000 in claims related to the exchange treaty, would receive $300,000 of the settlement. United Fire will pay claims due now and invest the remainder of the settlement to pay future claims.

With the Cadillac settlement behind it, the IEA is continuing negotiations with other insurers seeking payment of reinsurance claims.

For example, a settlement with Forum Insurance Co. of Schaumburg, Ill., is close, exchange and Insurance Department officials say. Forum ceded a book of long-haul trucking business produced by Will Darrah & Associates of Myrtle Beach, S.C., to exchange syndicates.

The exchange reported a total of $1.4 million in reinsurance payable to Forum on paid and unpaid losses and unearned premiums for 1985, according to the IEA's annual statement.

But Forum reported $4.7 million in unearned premiums and reinsurance recoverable from the exchange for the same period, according to figures published by A.M. Best Co.

Mr. Cross said the exchange has discussed a settlement with Forum regarding the underwriting members not in rehabilitation.

Robert E. Sheridan, senior attorney with the Florida Insurance Department, said the remaining syndicates are close to hammering out an agreement with the insurer.

Of the syndicates in rehabilitation, the only syndicate to which Forum did not cede business was Syndicate Four.

Mr. Sheridan said Forum was scheduled to begin auditing figures last week compiled by the department and the IEA regarding losses connected to the trucking risks.

"If they're satisfied, we probably will commute that treaty very shortly," Mr. Sheridan said.

In addition, arbitration is scheduled for mid-August regarding a reinsurance treaty dispute involving a book of automobile business ceded by International Bankers Insurance Co. of Coral Gables, Fla., to IEA syndicates, Mr. Cross noted.

The exchange reported $2 million in unearned premiums and reinsurance payable to International Bankers in 1985, while International Bankers reported $8.3 million in reinsurance recoverable from IEA syndicates in 1985, according to figures published by A.M. Best.

Another reinsurance treaty dispute that still must be resolved involves reinsurance recoverable reported by Dependable Insurance Co. of Jacksonville, Fla., related to Puerto Rican auto risks.

Dependable reported more than $4.6 million in reinsurance recoverable from the IEA, while the exchange reported $582,174 in unearned premiums and reinsurance payable to Dependable at year-end 1985.

This business was ceded to AIB Syndicate, B.G.H. Syndicate, Hispano American, Administrative Management Services, RAM Syndicate and Syndicates One, Two, and Three, according to J. Lloyd West, executive vp at Dependable.

Mr. West said talks about business Dependable ceded are on hold while the Insurance Department firms up plans for rehabilitating the seven insolvent syndicates.

Smaller amounts are sought from the IEA by Protective Casualty Insurance Co. of Baton Rouge, La. and Angelina Casualty Co. of Lufkin, Texas.

According to A.M. Best, at year-end 1985 Protective Casualty reported $3.8 million in reinsurance recoverable from AMS, and Angelina reported $2.9 million in reinsurance recoverable from IEA syndicates.

The business ceded by two insurers is "all part of the same bag" and represents minor problems, according to Mr. Cross.

The IEA must also come to terms with exchange broker Triton Insurance Brokers Ltd. of London.

While Mr. Cross did not have specific figures, he said Triton owes unpaid premiums on treaty reinsurance business written by exchange syndicates.

"That is the subject of fairly heated debate," he said. "We are still reconciling our figures with theirs."

"At issue are the rights and responsibilities of brokers on the exchange," said Larry Bonner, an attorney with the Miami firm of Greer, Homer, Cope & Bonner, which is representing Triton. "Is it their responsibility to pay premiums to syndicates under rehabilitation with no ability to pay claims?"

Mr. Bonner also could not provide specifics on the premiums held by Triton, but he said the broker estimates claims owed by the syndicates are greater than the amount of unpaid premiums.

Mr. Bonner said the IEA filed suit in the U.S. District Court for the Southern District of Florida seeking payment of the premiums but dropped the case and is now appealing to the court to submit the dispute to arbitration.

Mr. Cross said a proposed agreement with Triton calls for the broker to place the premiums in a trust on behalf of the exchange once it is determined how much is owed.

Meanwhile, Mr. Sheridan of the Insurance Department said it may not be much longer before the department's rehabilitation plans for the seven financially impaired syndicates are solidified. "I think we're finally to a point where we are going to be able to solve several of these problems."

He added that "it may well be that by the end of the month we'll have a situation where we feel we are taking a turn towards rehabilitation."

While Mr. Sheridan acknowledged that some of the syndicates in rehabilitation may operate again if owners are willing to invest additional capital, he also observed that "there is a possibility that one or two may not make it. They may have to be liquidated."

He would not reveal which syndicates could be headed for liquidation. ■

Health care pools

Continued from page 1

With mounting opposition from business groups, it will be a "tough, close vote at the full committee," said a legislative aide for Rep. Fortney "Pete" Stark, D-Calif., who introduced the proposal.

"We're very much afraid that it will" pass the full Ways and Means Committee, said Mark Ugoretz, executive director of the ERISA Industry Committee, a Washington-based group many of the nation's largest employers.

"We haven't counted votes," said an aide to Rep. J.J. Pickle, D-Texas. "But traditionally, it's been a fairly narrowly contested" debate.

Business lobbying groups are mounting a major campaign to fight the proposal, which was approved last week by the House Ways and Means Health Subcommittee as part of Medicare legislation and sent on to the full Ways and Means Committee.

Among other arguments, business groups contend that if states are allowed to force self-insured employers to participate in state risk pools, that could open the door to allowing states to force these employers to comply with a myriad of other state benefit mandates. They say this could result because the legislation could be viewed as negating the pre-emption clause in the Employee Retirement Income Security Act, which precludes states from regulating self-funded benefit plans.

Business groups also argue that based on the experience of existing state health care insurance pools, it would be difficult to establish premiums that would cover the costs of the pools because those costs cannot be accurately estimated (see chart, page 1).

However, the Health Insurance Assn. of America, a Washington-based trade group whose 335 members sell about 85% of health insurance in force today, supports the proposal, as do public interest groups fighting diseases.

The HIAA, which contends that the cost of covering the uninsurable should be spread over as large a group as possible, is lobbying to make formation of state risk pools mandatory, instead of voluntary.

The current risk pool proposal is similar to one that died in a conference committee last year after last-minute squabbling erupted among conferees over whether the pools would be allowed to provide abortion benefits (*BI*, Sept. 29, 1986).

The current proposal leaves up to each individual state the coverage that will be provided.

But in an effort to avoid a repeat of last year's scenario in the joint conference committee, a provision exempting all church organizations from participating in state health insurance risk pools was added, according to Rep. Stark's aide.

The pooling arrangement outlined in the Stark proposal would be designed like many of the individual state pool programs, and the approximately one dozen existing state health insurance risk pools would be allowed to maintain their current pooling arrangements.

Under the Stark proposal:

- Any state resident ineligible for Medicare or Medicaid who cannot buy private insurance could buy insurance from the pool.
- Premiums could not exceed 150% of the average individual standard risk policy premium charged in the state for comparable coverage.

Coverage provided by the pool would be typical of the coverage provided by large employer plans.

But the pool also would:

- Limit annual out-of-pocket expenses to $2,000 for individuals and $4,000 for families.
- Impose a lifetime expense limit of not less than $500,000.
- Offer a choice of deductibles, not to exceed $1,000 per person.
- Establish a six-month waiting period for people with a pre-existing medical condition.
- Cover the purchase and repair of durable medical equipment.

In a last-ditch effort to sway legislators, a coalition of groups—the Assn. of Private Pension & Welfare Plans, the U.S. Chamber of Commerce, ERIC, the National Assn. of Manufacturers and the Self-Insurance Institute of America—sent a letter to Ways and Means Committee members last month "strongly" urging them to reject the proposal.

Business lobbyists argue that it is just patently unfair to assess employers for health coverage of the uninsured when many already provide health insurance benefits to their employees.

Opponents of the provision also say the costs of risk pools cannot be accurately estimated, pointing out that the costs of existing state health insurance pools vary widely.

Citing the potential for new state regulation of self-funded benefit plans, the coalition warned in its letter: "Such legislation actually would mean that 46% of all existing health plans covering tens of million of workers and dependents would have to be substantially rewritten to conform to more than 680 separate state mandated benefit laws."

In the letter, the coalition outlined three other major objections to the proposal:

- Federal legislation is unnecessary.

"States already have all the authority they need to establish and finance a risk pool," the letter said.

- The risk pool proposal would set up a "patchwork quilt national health insurance program with 50 different standards of coverage."
- The risk pool proposal does not provide "even minimal fiscal restraints," such as requiring second opinions and pre-certification reviews and limiting hospital stays.

Typically, the state pools require that participants pay premiums and share costs through, for example, deductibles and copayments. There are limits on annual out-of-pocket expenses for covered services and limits on lifetime expenses.

Premiums range from a low of 125% of the average premium rates for individual and group standard risks in the state for comparable coverage to a high of 400%.

For example, Connecticut has a premium floor of 125% and a premium ceiling of 250% of the average group premium rate charged by health insurers in the state.

When premiums do not cover the pool's expenses, costs are usually shared by health care insurers, including health care service plans and health maintenance organizations authorized to issue insurance in the state.

These concerns generally are assessed in proportion to their share of the health care insurance market in the state.

Generally, the insurers are allowed to deduct their assessments from the premium taxes they owe the state.

According to the Employee Benefit Research Institute, a Washington-based think tank, the premiums generated by some state health insurance pools do not finance even half the total costs incurred by the pools, while in other states, premiums completely cover the costs.

For example, in Minnesota, premiums covered 43% of the expenses of the state's pool for uninsurable individuals in 1983.

However, premiums have covered nearly all of the health care expenses incurred by the state health care insurance pools in Connecticut and Florida. ■

Oregon governor to sign tort, insurance reform bills

SALEM, Ore.—Gov. Neil Goldschmidt is expected to sign a handful of insurance-related bills—including major tort reform measures—passed by the Oregon Legislature.

Every politician in the state would be "stunned" if Gov. Goldschmidt, a Democrat, vetoed S.B. 323, which contains most of the tort reforms, says Eric Carlson, administrator of the Senate Judiciary Committee.

According to Mr. Carlson, S.B. 323 would:

- Cap non-economic damages at $500,000.
- Abolish joint liability for non-economic damages.
- Apply joint and several liability for economic damages only when the defendant is determined to be 15% or more at fault.

Defendants found to be less than 15% at fault would be held responsible only for their proportion of damages. However, defendants in hazardous waste and pollution cases would be held to the standards of joint and several liability regardless of the percentage at which they are at fault.

- Enable courts under certain conditions to deduct from jury awards collateral source benefits, such as workers compensation or group health benefits.
- Require plaintiffs seeking punitive damages to make a prima facie case before evidence of the defendant's financial condition would be admitted.

Punitive damages, which under current law are awarded only in the face of a "preponderance of evidence," would be awarded under this bill only after plaintiffs produce "clear and convincing evidence."

- Hold unpaid directors, officers and board members of non-profit and government organizations liable only for gross negligence and intentional acts.
- Raise the standard of proof in liquor liability cases. Under the bill, plaintiffs would be required to show "clear and convincing evidence" that an establishment served liquor to someone that was already visibly intoxicated.

If signed, the bill would become law Sept. 27 and will apply to all claims filed on or after that date.

Another bill awaiting the governor's approval would raise the maximum amount of money plaintiffs may receive in suits against any public entity.

Plaintiffs would be able to receive up to $200,000 per person and $500,000 per incident. Currently, plaintiffs are able to receive $100,000 per person and $300,000 per incident.

Some insurance reform provisions also were passed by the legislature.

For example, under S.B. 323, an insurer would have to receive approval from the insurance commissioner to raise or lower rates for any line of commercial liability insurance by more than 15%.

The insurance commissioner also would have to receive 60 days' notice before an insurer could withdraw from any line of commercial liability insurance. Insurers could cancel commercial liability policies only under certain conditions, and then must give policyholders 30 days' notice.

Insurers' reporting requirements would be increased "dramatically," Mr. Carlson notes.

Meanwhile, the Oregon House has sent to the governor a workers compensation bill designed to reduce employers' costs.

The goal is to cut by 20% the $500 million that Oregon employers annually pay in workers compensation premiums, primarily by reducing injured workers' options and by streamlining administration of the system, according to a spokeswoman for the Workers Compensation Division of the Department of Insurance and Finance.

If signed, H.B. 2900 would:

- Reduce to 180 days from one year the time limit for a worker to appeal a decision on a workers compensation claim.

The bill also requires an appeal hearing within 90 days of a request. The lag time now is six to nine months, the spokeswoman said.

- Restrict the claims process by limiting the kinds of claims that can be reopened and limit the scope of review.
- Reduce the number of workers eligible for vocational assistance by limiting training and job placement services to workers with no transferable skills.

In addition, the bill would establish a program in which the state subsidizes an employer's workers compensation disability premium if he hires a worker who was injured elsewhere.

- Reduce to three from five the number of attending physicians an injured worker can consult during the lifetime of a claim.
- Revise and standardize guidelines for determining the level of a worker's unscheduled or permanent total disability.

In related action, Gov. Goldschmidt signed another bill—H.B. 3381—placing administration of the state's workers compensation system under the insurance commissioner as of July 1. The insurance commissioner previously had been responsible only for workers compensation rate making, the spokeswoman said.

H.B. 2900 also gave the commissioner expanded authority in rate-making matters, she added.

around the states

IRIS access denied

HELENA, Mont.—The Montana Supreme Court has upheld the state insurance commissioner's authority to deny public access to insurer financial data reported through the National Assn. of Insurance Commissioners' Insurance Regulatory Information System.

"Given the availability of other comparable information and the preliminary, subjective nature of the IRIS reports, we hold that the demands of individual privacy outweigh the merits of public disclosure," the court said in a decision earlier this month.

The decision overturned a district court ruling that gave Joseph M. Belth, a Bloomington, Ind., professor of insurance and editor of The Insurance Forum magazine, access to the information. The district court also ordered state Insurance Commissioner Andrea Bennett to provide access to all IRIS documents in her possession.

In appealing the district court's decision, Commissioner Bennett raised the issue of whether the state government can usurp an insurer's right to privacy and whether public disclosure of IRIS information denies an insurer due process.

"The Supreme Court opinion noted that the NAIC's IRIS reports are confidential and intended only for regulatory use," the NAIC said in a statement.

"The court found the insurers' privacy expectations to be reasonable and a constitutionally protected interest," the statement continued.

The court ruled, "We do not find that (public) benefit would outweigh the demands of individual privacy." In addition, the court noted that final reports on the state's examinations of insurers are publicly available.

Ms. Bennett said she was happy with the decision because it takes technical skill to properly interpret IRIS information.

Mr. Belth, who is a professor of insurance at Indiana University, said insurance consumers' right to know regulators' statistical and analytical reports on insurers' financial status outweighs the NAIC's concerns. However, he acknowledged that publishing an insurer's troubled status probably would cause policyholders to flee the company.

Mr. Belth is awaiting the outcome of a similar case filed in the District of Columbia.

The Montana high court's decision, which interprets Montana law, cannot be appealed.

Bank bill veto

CARSON CITY, Nev.—Gov. Richard Bryan has vetoed a bill that would have allowed financial institutions chartered in Nevada to sell insurance and to lease banking space to independent agents.

Under S.B. 252, banks, savings and loans, thrift companies and credit unions would have been able to form separate corporations to sell insurance. However, they would not have been permitted to commingle their insurance and banking products.

In addition, the bill would have enabled financial institutions to lease part of their banking space to independent insurance agents. However, they would have been required to charge a flat annual leasing fee and could not have based the fee on the volume of business or profits of the agent, "making them just landlords," explained a spokesman for the Nevada Legislature.

Industry associations throughout the state urged the governor to veto the bill for the protection of consumers, said Jack Barriage, executive vp of the Nevada Independent Insurance Agents.

The bill passed the Assembly by a vote of 26-15. The state's Senate passed the bill on a voice vote after it moved through a conference committee.

The bill was vetoed June 30.

Punitive damages

AUSTIN, Texas—The Texas Supreme Court ruled last week that punitive damages can be awarded in wrongful termination cases under workers compensation law.

The court upheld a 1985 jury award of $167,464 in actual damages and $175,000 in punitive damages to Loretta Caille, who had charged management at Azar Nut Co. of El Paso fired her for filing a workers compensation claim.

Ms. Caille received a $9,000 payment from Azar Nut's workers compensation insurer for hand and head injuries she sustained when a file cabinet fell on her. Shortly after the payment she was fired, her attorney said. Management claimed during the 1985 trial that her termination was because of problems with her work unrelated to the workers comp claim.

Neither officials at Azar Nut nor the company's attorneys could be reached for comment. ■

London reinsurance rates leveling on renewal: Study

By CAROLYN ALDRED

LONDON—Reinsurance rates and ceding commissions leveled during Jan. 1 renewals, according to a recent Reinsurance Offices Assn. survey.

In particular, "it would appear that the rather drastic number of reductions in levels of treaty reinsurance commission and fairly widespread rate increases for excess-of-loss business have slowed down compared with the previous two years," said a statement from the ROA.

The survey is based on the responses from about 40 ROA members, including major reinsurers such as Munich Reinsurance Cos. (U.K.) Ltd. and Swiss Reinsurance Co. (U.K.). Ltd., said a spokesman for the association.

The survey showed that rates for non-proportional reinsurance remained fairly static during the year-end renewal season, compared with the rate increases that were rampant during Jan. 1, 1986, renewals.

Specifically, the ROA survey showed:

- For short-tail liability business renewed at the end of last year, rates for 75.4% of the 1,591 contracts surveyed were unchanged, while rates for 19.1% of the contracts increased and rates for 5.5% decreased. This compares with rate increases for 78.8% of the 1,590 contracts surveyed in the Jan. 1, 1986, renewal season.
- For long-tail liability business, reinsurers made no rate changes on 58% of the 4,537 contracts in the survey, compared with increased rates for 81.4% of the contracts surveyed in the previous year. In addition, rates increased for only 38.3% of the contracts, while rates dropped for 3.7% of the contracts surveyed.
- Rates remained the same at year-end for slightly more than half—51.3%—of the 3,133 non-proportional aviation treaties surveyed, while rates increased for 48.3% of the contracts. This compares with increased rates for a staggering 99.1% of contracts covered by the 1986 renewal season survey.
- For marine non-proportional business, rates for almost half of the 17,027 contracts surveyed—48.9%—did not change, while rates for 43.8% increased and rates for 7.3% decreased. During the previous renewal season, rates rose for 79.9% of the contracts surveyed.
- For the 8,222 London market excess-of-loss contracts surveyed, rates for 50.8% increased, while rates for 41.6% remained level and rates for 7.6% dropped. Rates had been increased for 94.9% of the LMX contracts surveyed the previous year's renewals.
- For fire business, 48.9% of the 18,389 surveyed contracts maintained 1986 rates, rates were increased for 44.8% and rates were cut for 6.2%. The previous year, rates rose for 88.7% of the surveyed contracts.

The number of reinsurers refusing to write certain lines of coverage remained stable between the two renewal seasons, the survey shows.

For example, 23 ROA member reinsurers are not writing North American liability risks for manufacturing operations in 1987, the same number as in 1986.

However, it is not clear from the ROA survey if the companies refusing to write this business this year were the same companies that refused to write North American liability business last year.

The survey also shows that ceding commission rates, which had decreased in previous years, generally held steady during Jan. 1, 1987, renewals.

Specifically, the survey shows:

- For short-tail liability contracts, 85.3% showed no change in ceding commissions from 1986. Commission rates dropped for 2.4% of the contracts and increased for 2.2%. In 1986, commission rates for 39.3% of the contracts decreased.
- For long-tail liability, there was no change in commissions for 82.2% of the contracts, while commissions for 14.3% decreased and commissions for 3.5% increased. Commissions for 41% of long-tail liability contacts decreased in 1986.
- For aviation business, almost all—94.7%—of the contracts surveyed maintained the same commission rates. No contracts were renewed with higher commissions.
- Some 93.6% of the marine contracts surveyed were renewed at the same commission rates, while commissions for only 1.1% of contacts increased and 5.3% decreased. Commissions were cut on 34.5% of the marine contracts during 1986 renewals.
- For fire business, 88.1% of the 4,125 contracts were renewed with no changes in commissions, while commissions decreased for 9.1% and increased for 2.7%. The previous year, commissions were cut for 39.9% of fire contracts renewed. ■

Employee Benefits Communications Conference

On August 3 & 4 an influential group of employee benefit executives will meet to explore issues critical to their professional responsibilities. The annual Business Insurance Conference provides an opportunity to gain valuable insight into communicating benefits to employees.

Speakers

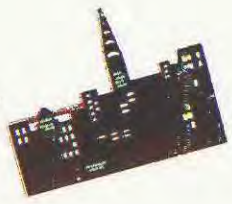
Jim Biggerstaff
Manager, Compensation & Benefits
PEARL HEALTH SERVICES
Tax Reform and 401K

Catherine A. Corse
Employee Benefits Officer
BARNETT BANKS INC.
Communicating COBRA

Laura Fairman
Director, Product Research & Development
Group Insurance Marketing
METROPOLITAN LIFE INSURANCE COMPANY
PANELIST: *Triple Options*

Victoria George
Benefits Specialist
Benefit Planning Department
BANKAMERICA CORPORATION
PANELIST: *Utilization Review*

Sally Gottlieb
Flex Plan Coordinator
PACIFIC GAS & ELECTRIC COMPANY
CASE STUDY: *Total Benefit Programs*



Alfred Hayes
Director, Human Resources
SONY CORPORATION OF AMERICA
CASE STUDY: *Computer Communications*

Jeffrey Horn
Principal
TOWERS, PERRIN, FORSTER & CROSBY
CASE STUDY: *Total Benefit Programs*

Alfred Malecki
Publisher
BUSINESS INSURANCE
EBC AWARDS

H. L. Marchant
Principal
WILLIAM M.MERCER-MEIDINGER-HANSEN,INC
CASE STUDY: *Interactive Video*

Kathryn J. McIntyre, A.R.M.
Editor
BUSINESS INSURANCE
OPENING REMARKS

Arnold Milstein, MD
President
NATIONAL MEDICAL AUDIT
PANELIST: *Utilization Review*

Agenda

Keynote Address ***Monday, August 3***
Influence — Elaina Zuker, President of Success Strategies, sets the tone for the 1987 EBC Conference. Effective communication possesses a powerful ability to influence. Communicators sometimes get lost in a maze of glitz and glitter, worrying too much about deadlines and production values. Employee benefits communicators may also get bogged down by legislative and health care cost control requirements. But no communicator should ever lose sight of the impact communication has ... its potential to influence attitudes, choices and response. Ms. Zuker will walk you through six influence styles — discover an approach that can get you results.

Communicating COBRA
COBRA Simplified — Creative ways of communicating COBRA to employees and keeping paper work down to a minimum. Find out how one company took the sting out of COBRA.

Triple Options
The Challenge — Communicating indemnity plans, HMO and PPO options to employees. The challenge begins with devising a plan that keeps information overload to a minimum and ends with effective communication that still defines the parameters of employees' choices.

EBC Awards Luncheon
Achievement — Recognizing outstanding communications programs, Alfred Malecki, Publisher, Business Insurance, presents the 15th Annual EBC Awards. Also shown will be the first place a-v winner.

Research — Techniques
Inspiration — Developments in consumer research and statistical techniques inspire a new management strategy that identifies employee satisfaction with benefits and their direct relation to corporate benefit costs.

Case Studies
Informal workshops, presented as concurrents, give you the opportunity to attend all sessions.

Flexible Benefits — A Total Program
Innovative — Pacific Gas & Electric Company's benefits program, "Flex," is a 1986 award-winning example of a total communications effort, effectively communicating flexible benefit options. They've taken the complexity out of choice. Their innovative approach incorporated input from their employees.

Interactive Videos
Creative Technology — When is it appropriate? This case study of the Ford Motor Company will cover the evaluation process that confirmed the use of interactive videos, the strategy for implementing this communication program, and examples of the technology used: touch screen, digital audio and video disc.

EBC
• conference •

John Parkington, PhD
Director, Organization Research
& Analysis Services
THE WYATT COMPANY
Research

Timothy Stentiford
Consultant
HEWITT ASSOCIATES
CASE STUDY: *Computer Communications*

I. B. Wallman
Employee Benefits department,
Employee Relations Staff
FORD MOTOR COMPANY
CASE STUDY: *Interactive Video*

Herb Zeltner
President
HERBERT ZELTNER CONSULTING INC.
You Be The Judge

Edward J. Zeman
Director, Employee Services
THE LONG ISLAND RAILROAD
PANELIST: *Triple Options*

Elaina Zuker
President
SUCCESS STRATEGIES
KEYNOTE: Influence In Communication

The BI Conference opens Sunday, August 2, with registration check-in and a cocktail reception from 5-7pm. Sessions begin Monday, August 3 at 8:30am. The conference adjourns Tuesday, August 4 at 4:30pm.

The cost is **$650.** A 10% discount is offered to additional registrants from the same company. The fee includes sessions, workbook, educational materials, and scheduled functions.

Payment required with registration. All registrations will be confirmed.

Cancellations must be received in writing. A refund will be made on cancellations received prior to July 1. A **$100** service charge will apply to cancellations received after July 1. No refund will be made on cancellations received less than 5 business days prior to the conference. If your plans change, you may substitute the name of another person from your company without penalty.

To register, complete the form and send it with your payment to:

Business Insurance, Communication Services Department,
220 E. 42nd St., Suite 930, New York City, NY 10017
For information call: Barbara Dalton, Registrar, at (212)210-0780.

Hotel Accommodations

We have set aside a limited block of rooms at a special rate of **$130 single/$150 double,** at the Grand Hyatt Hotel in New York City. These rates are available to Conference Registrants only, and will be honored until July 13.

You must mention the *Business Insurance Benefits Conference* when making your reservations. Hotel cards will be included with your Conference Registration Confirmation. Or call the Grand Hyatt Hotel at **(212)850-5900**; or toll free at **(800)228-9000.**

Travel Arrangements

We have arranged for discounted airline tickets to New York City from almost every location in the U.S. Contact Travel Technology Group at **800/524-4442.** You must mention the *Business Insurance Benefits Conference* to take advantage of these low rates with no restrictions.

Awards Luncheon

A luncheon ticket is included with your Conference registration. A limited number of additional seats are available for the EBC Awards Presentation Luncheon. Additional tickets are **$60** each, available on a first come-first serve-basis; **reservations required.** Contact Registrar.

Computer Communication
The Cutting Edge — Why Sony Corporation opted for computer communication and how they combined market trends with technological innovations to implement state-of-the-art interactive computer communication vehicles. This case study walks you through personalized benefits and provides scenarios for combining benefit options.

Case Studies ***Tuesday, August 4***
All three case studies [illegible]eated.

You Be The Judge
A-V Excellence — Prese[illegible] annually, this energetic session presents audio-visual programs submitted to the EBC Competition. You be the judge — see what other industry professionals are doing in this medium.

Luncheon
A final opportunity to gather with industry leaders and peers.

Utilization Review
Performance — The nature of utilization review demands peak performance. This session provides an examination of operations, key findings on performance levels and a look at how one benefits department performs this communications task.

Tax Reform & 401k
Issues and Ideas — Better marketing is essential to communicating tax reform and 401k, especially to lower paid employees. Find out how humor and a promotional contest got attention and boosted participation.

Adjournment
Until next year ...

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BI 6/22

Certain factors look attractive to D&O underwriters: Broker

By KATHRYN J. McINTYRE

KEY BISCAYNE, Fla.—What kind of directors and officers liability risk does an insurer want to write?

Gary K. Brown, director of the Energy Division of Alexander & Alexander Inc., describes the preferred D&O risk as a corporation:

- With a sound financial condition, supported by credible audited historical information.
- With a proven management track record and controls.
- With a sound board of directors.
- With adequate internal controls and audit committees.
- With a proven track record and product performance and, ideally, not tending toward the experimental or exotic.
- With well-defined product lines; not a conglomerate.
- In a stable and growing industry.
- Publicly held vs. closely held.
- Not involved in significant merger and acquisition activity.
- Interested in long-term relationships with insurers.

Mr. Brown, who is in the Baltimore office of A&A, gave these tips during a Utility Risk Management Seminar in Key Biscayne, Fla., sponsored by Stone & Webster Management Consultants Inc.

The D&O market started to settle in 1987, after the upheaval in 1985, caused by the withdrawal of reinsurance support for D&O insurance, Mr. Brown said.

"Underwriters started to see profits" in 1987, he observed. And, new D&O facilities began to operate (*BI*, April 13; July 6).

Mr. Brown estimated that there is $165 million in D&O limits available from conventional commercial insurance companies and $225 million in limits available from alternative markets. "That's with getting all the players to play," he noted.

In addition, prices are now about 10% less than last year, Mr. Brown said, but he reminded the audience that is off 1,000% price increases. Deductibles and retentions also have stabilized, Mr. Brown said.

While some characteristics of a corporation may not be subject to change, there are ways to endear a risk to an underwriter, Mr. Brown suggested. He advised risk managers to:

- Market a D&O risk at least three to four months before renewal.
- Make oral presentations to underwriters as often as possible, to make sure they understand the business. This is especially important if there is any bad publicity about the company.
- Include senior people in meetings with underwriters.
- Develop relationships with and among the chief financial officer, the underwriter and legal counsel. ■

Stokdyk named risk manager at Toyota Motor Sales U.S.A.

comings & goings: buyers

John E. Stokdyk, 55, has been named national risk manager at Toyota Motor Sales U.S.A. Inc. in Torrance, Calif. In this position he will oversee risk management, property/casualty insurance, loss control and operation of Toyota Motor Insurance Corp., a Vermont-based captive insurer with $3.1 million in gross written premiums in 1986. Mr. Stokdyk replaces **Gwen Wamsley**, who left the company to form a risk management consultant, Evergreen Risk Management Services of Hawthorne, Calif. He reports to Douglas M. West, associate legal counsel. Prior to joining Toyota, Mr. Stokdyk served as corporate director of insurance at Lear Siegler Inc. in Santa Monica, Calif. Prior to that, he was president and chief executive officer of Wichita, Kan.-based Travel Air Insurance Co. He received a bachelor of arts degree in economics from Yale University in New Haven, Conn., and a master of business administration degree from Harvard University in Cambridge, Mass. Mr. Stokdyk holds the Chartered Property & Casualty Underwriter designation and is a deputy member of the Risk & Insurance Management Society.

Mr. Stokdyk

* * *

Robert Anderson, 43, has been named vp of health, safety and environment at Manville Corp. in Denver. In this position he will oversee corporate medical health and safety programs, as well as environmental programs dealing with air and water pollution and waste disposal. He also will continue his responsibilities as corporate medical director, the post he held prior to this appointment. As medical director, Dr. Anderson was responsible for the development and maintenance of Manville's Environmental, Safety and Health Information Management System, a fully automated occupational health surveillance system. He replaces **William B. Reitze**, who retired from the company after 19 years, and reports to S. Rollins Heath Jr., executive vp, finance and administration. Prior to joining Manville in 1982, Dr. Anderson was corporate medical director at Air Canada in Montreal and, prior to that, served as vp of health and environmental services for Trans World Airlines Inc. in Kansas City, Kan. He received a bachelor of science degree in applied mathematics from Michigan State University in East Lansing, his doctorate in medicine from George Washington School of Medicine in Washington, D.C., and a master of public health degree from the University of Texas School of Public Health in Houston. He is a member of the American Medical Assn. and the American Occupational Health Assn.

Mr. Anderson

* * *

Thomas L. Morin, 45, has been named corporate director of benefits at Maytag Corp. in Newton, Iowa. In this newly created position, he oversees all welfare plans at Maytag, including plan design and administration. He reports to William Foust, vp-corporate human relations. Previously, Mr. Morin served as manager of employee benefits at The Trane Co. in La Crosse, Wis. Prior to that he worked for Prudential Insurance Co. of America. He received a bachelor of science degree in business from Eastern Illinois University in Charleston. He is a member of the International Foundation of Employee Benefit Plans.

Mr. Morin

* * *

Constance A. Clayton, 43, has been named director of risk management for the Southeastern Pennsylvania Transportation Authority in Philadelphia. In this position, she oversees all property/casualty exposures and coordinates insurance and and self-insurance programs. She replaces **William M. Boone**, who has been appointed director-risk management at MEDIQ Inc. in Pennsauken, N.J. She reports to James Kilcur, general counsel. Prior to this appointment, Ms. Clayton served as risk manager for the city of Philadelphia and served as risk manager for Keystone Foods Corp. in Bryn Mawr, Pa. She received a bachelor of science degree in business administration from St. Joseph's University in Philadelphia. Ms. Clayton is a past president of the Delaware Valley Chapter of the Risk & Insurance Management Society and serves on its local board.

* * *

L. Wayne Chisholm, 53, has been named director of casualty/risk management services at the Wisconsin Hospital Assn. Shared Services Program in Madison. In this newly created position, he oversees services for hospitals that participate in WHA's liability insurance plan, which provides comprehensive general and professional liability coverage for its members. He reports to Michael R. Shoys, senior vp. Previously Mr. Chisholm was vp of risk services for Jardine Emett & Chandler Inc. in San Francisco. Prior to that he was marketing coordinator with Scott Wetzel Services Inc. Mr. Chisholm received a bachelor of science degree in business from the University of Illinois at Urbana.

* * *

Lidia Lopez, 26, has been named workers compensation coordinator at Ryder System Inc. in Miami. In this newly created position she assists and reports to Susan L. Drake, manager-workers compensation claims. Ms. Lopez is responsible for inputting claims data into Ryder's claims information system. Prior to this promotion, Ms. Lopez served as workers compensation clerk. She attended Miami-Dade Community College in Miami.

●

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

Boiler inspection costs up: Broker

By KATHRYN J. McINTYRE

'It's a good idea to get a quote' for inspection services on an unbundled basis, advises Michael R. McDermott, president of Alexander Howden Ltd., noting, however, the marketplace for boiler and machinery for utilities is going soft.

KEY BISCAYNE, Fla.—The cost of inspection services is escalating in relation to the overall boiler and machinery insurance premium for utilities, according to one broker.

"It's a good idea to get a quote" for inspection services on an unbundled basis, advises Michael R. McDermott, president of Alexander Howden Ltd. in Toronto.

Overall, however, the marketplace for boiler and machinery insurance for utilities is going soft this year after a "very difficult" market in 1986, he said.

A specialist in utility risks, Mr. McDermott spoke at a Utility Risk Management Seminar held in Key Biscayne, Fla., late last month. The seminar was sponsored by Stone & Webster Management Consultants Inc. in New York.

The leading markets for boiler and machinery insurance for utilities, according to Mr. McDermott and later confirmed by the insurers, are: The Hartford Steam Boiler Inspection & Insurance Co.; Allendale Mutual Insurance Co., Arkwright-Boston Insurance Co. and Protection Mutual Insurance Co., members of the Factory Mutual System; Industrial Risk Insurers; California Union Insurance Co., a CIGNA Corp. unit; Royal Special Risk—a division of Royal Insurance Co.; Continental Insurance Co. and The Home Group Inc.

"There are others," Mr. McDermott said later, "but these come on pretty strong."

Insurers that will sell inspection services to utilities, but do not write boiler and machinery insurance for utilities include Zurich-American Insurance Group, Kemper Corp. and Travelers Corp., Mr. McDermott said.

The three insurers confirmed they do sell inspection services independent of insurance, but with different degrees of enthusiasm. The three insurers also said they would write boiler and machinery insurance for utilities.

On selling inspection services independent of insurance, Zurich-American said it is "very selective, if we do it at all." Travelers' Constitution State Service Co. occasionally provides engineering services without Travelers writing the insurance, a spokesman said.

But, Kemper's National Loss Control Service Corp. said it sells inspection services domestically and internationally.

The Home also has sold its engineering services to utilities without insurance, Mr. McDermott said.

A spokeswoman for The Home said "services are used in conjunction with insurance programs," but would not elaborate.

Boiler and machinery insurance covers sudden and accidental breakdowns to boilers and fired vessels, unfired vessels, refrigerating systems, auxiliary piping, engines, pumps and compressors, fans and blowers, turbines, electrical generators, motors, transformers and miscellaneous electrical apparatus, noted William J. Collins, director of client services with Stone & Webster.

A breakdown, generally, is defined as "a sudden and accidental breakdown of the object, or a part thereof, which manifests itself at the time of its occurrence by physical damage to the object that necessitates repair or replacement of the object or part thereof," he added.

"The state of the art" in boiler and machinery insurance is to purchase a comprehensive policy, which defines the terms "object" to include various types boilers, fired vessels and metal unfired vessels, Mr. Collins said. This replaces the need to list every type of covered object, he said.

To help underwriters assess engineering reports to underwrite boiler and machinery insurance, Howden created Independent Engineering Services in London a little over a year ago, said Mr. McDermott. The firm works exclusively for Lloyd's underwriters and is paid by the underwriters.

Alexander Howden Ltd. in Toronto is the reinsurance broker for the utility industry mutual insurance company Utility Services Insurance Co. in Bermuda. Howden replaced Sedgwick Group last year when Mr. McDermott moved from Sedgwick's Canadian-based wholesale operation to Howden.

The reinsurance program is led in London and supported by underwriters at Lloyd's of London, American Reinsurance Co., Swiss Reinsurance Co., Munich Reinsurance Co. and in Australia, Mr. McDermott said.

USICO, which was founded in 1970 to write boiler and machinery insurance, writes up to $50 million in boiler and machinery limits and up to $50 million of all-risk property insurance.

USICO has 20 members and also participates as a reinsurer on policies for 14 other utilities, according to Edward I. Inderbitzin, manager of corporate insurance and risk management at Potomac Electric Power Corp. in Washington, D.C., and a member of the insurance advisory group to USICO.

The company writes almost $12 million in gross premiums annually and is managed in Bermuda by Stone & Webster Management Services Ltd., under the direction of the USICO board. ■

In 1914, when the Panama Canal was finally carved out, A

Two oceans joined at Panama. Men had dreamed of it for centuries. But it wasn't until 1904 that engineers began successfully carving out the dream from the land. Three years later, chief engineer George W. Goethals led the way. It took over $352 million and ten years to complete. And when the first ship steamed through the canal, Allendale had been setting a steady course for 79 years.

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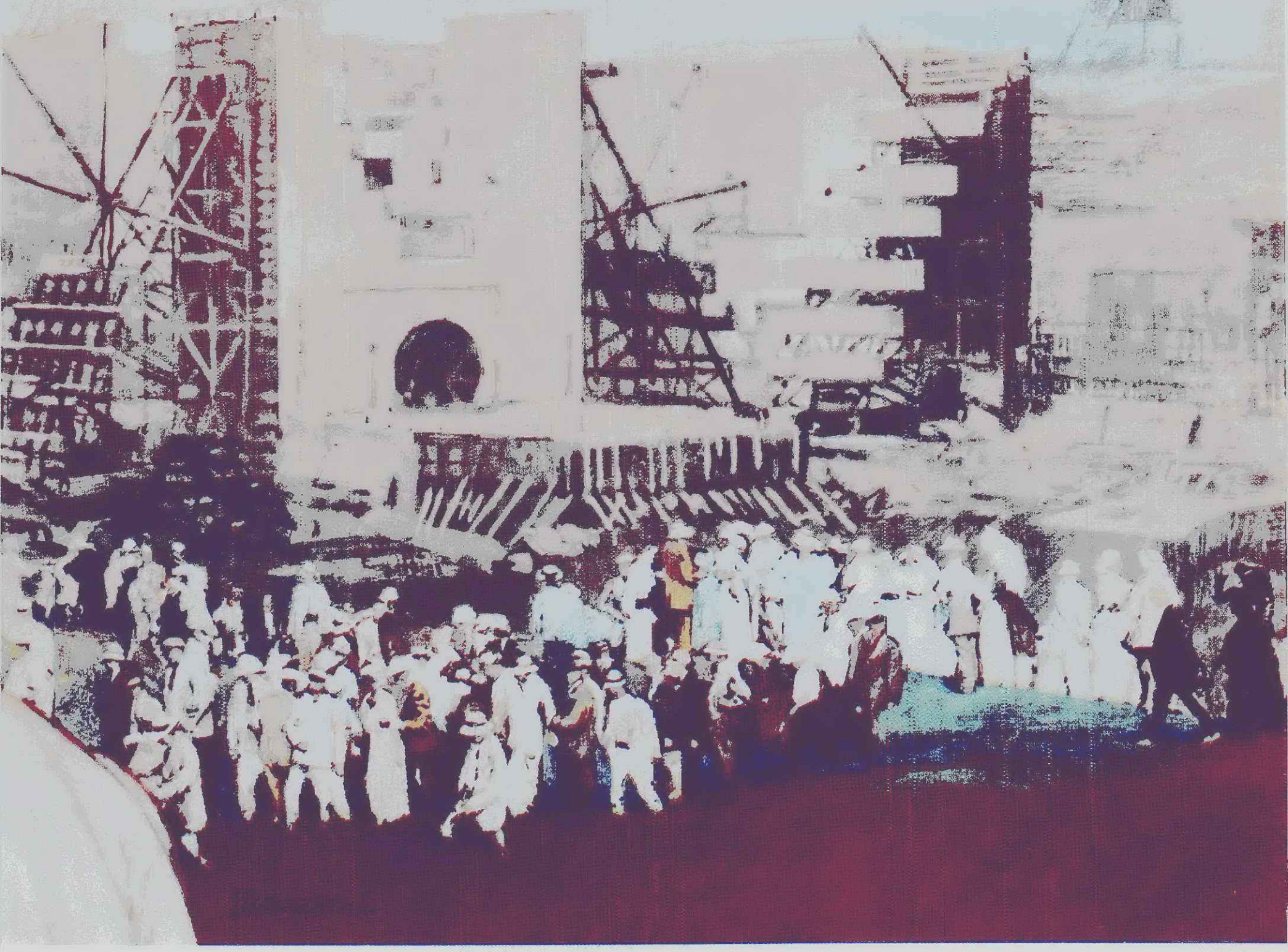

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ASBESTOS LITIGATION

Ruling foils insurers that 'run for cover, not coverage'

By John E. Heintz

IT HAS BEEN 10 YEARS since Insurance Co. of North America sued Forty-Eight Insulations Inc. in an effort to avoid covering asbestos-related bodily injury claims.

Since then, policyholders and insurers have spent hundreds of millions of dollars litigating the same basic issues in numerous courts across the country.

Each case has focused on primarily two questions:

- Which policies must respond to an asbestos-related bodily injury claim—those in effect at the time an asbestos-related disease is manifested, or all those in effect from first exposure on?
- What is the extent or scope of an insurer's obligations when its policy is triggered?

Fourteen state and federal courts have rendered decisions addressing these questions. Each of these decisions gave the policyholders all or most of the coverage they sought. As the number of decisions in favor of policyholders mounted, some insurers recognized that continued litigation likely would prove fruitless and settled with their policyholders.

But many insurers refused to accept what appeared inevitable and continued their efforts to avoid coverage. These insurers argued that past cases did not address certain defenses to coverage, were based on incomplete records or resulted from a flawed analysis of both policy language and the law.

Frequently these insurers raised new and—many felt—specious arguments against coverage, as old ones failed to do the job. They also forced their policyholders to engage in repetitive, costly and, ultimately, unnecessary litigation to secure the coverage rights to which so many courts had said they were entitled.

The latest of the asbestos coverage decisions—Judge Ira A. Brown's decision in the California Superior Court case *In re Asbestos Insurance Coverage Cases*—should put an end to the insurers' inclination, as one court described it, to "run for cover, not coverage." That case—one of the largest in the history of American jurisprudence—gave more than 50 American and London market insurers every opportunity to prove their cases against coverage (*BI*, June 1).

The parties produced hundreds of thousands of documents and took more than 1,000 depositions. They engaged in a 15-month trial during which they developed a comprehensive record on the medical aspects of asbestos-related injuries, on the drafting history of the standard form general liability policies used by the insurance industry since the 1940s and sold to thousands of policyholders, and on the course of dealings between policyholders and their insurers.

After all was said and done, Judge Brown's decision not only confirmed the validity of prior decisions, but provided what many describe as the broadest coverage result of all: Judge Brown ruled that the insuring language did not restrict coverage to the period during which either inhalation of asbestos or the emergence of a detectable bodily injury occurred. He rejected the insurers' contradictory contentions that the standard policies were intended and understood to be limited on either an exposure-only or manifestation-only basis.

Judge Brown found nothing in the voluminous record concerning the drafting history of the standard form or the parties' course of dealings to indicate that the drafters or the parties intended any restrictions not evident from the restricted plain meaning of the policy. He rejected the insurers' efforts to restrict coverage to either exposure or manifestation by reliance on medical evidence.

Judge Brown also found the language controlling the scope of an insurer's obligations to be plain and unambiguous. That language, he ruled, requires an insurer whose policy is triggered to pay all liabilities a policyholder incurs with respect to an asbestos-related claim. If the policy carries a duty to defend, the insurer is required to pay all defense costs as well.

By basing his decision on the plain meaning of the standard policy language and by finding that the extensive evidence before him confirmed that the parties did not intend a different meaning, Judge Brown implicitly found the insurers' restrictive readings of their policies to be unreasonable. Thus, his thorough 107-page effort has not only given

speaking out

policyholders their most convincing victory yet, but finally should put to rest many worn-out insurer contentions and defenses.

While the California decision is unlikely to affect asbestos coverage for many other policyholders because of prior decisions and settlements, it should have a significant impact on coverage litigation concerning toxic tort and hazardous-waste liability because it addresses fundamental issues common to all coverage disputes.

Coming as it does at the close of one chapter and the early stages of another, the decision should prompt the insurance industry to take a hard look at its past handling of coverage disputes and to fashion a more realistic approach for future cases by accepting certain indisputable facts. These would include at least the following five propositions:

- Virtually all of the thousands of liability policies sold to companies, large or small, over the last 40 years either are standard form policies or contain language functionally identical to standard form policies drafted by the insurance industry.

In the California litigation, many insurers sought to avoid construction of ambiguous policy provisions in favor of coverage by making claims about the source of policy language that they could not substantiate. They argued that the virtually identical language, found in thousands of policies, coincidentally resulted from thousands of one-on-one negotiations with policyholders.

The policyholders were thus compelled to establish what was obvious at the outset—that the industry's standard forms are the source of the essential insuring language in thousands of liability policies. Insurers should not again assert that disputed policy language was mutually drafted unless they can clearly document such a claim.

- Insurance industry drafting committees left behind a comprehensive record of their work on standard comprehensive general liability policies.

Participants in the drafting process have now supplemented that record by giving extensive testimony in the California case. That record and testimony contains detailed accounts of the drafters' discussions, their analysis of underwriting problems and objectives, their consideration of alternative policy language and their reasons for adopting the language contained in the various standard forms used since the 1940s. As such, the drafting history record teaches a great deal about what the policies cover and do not cover.

Not surprisingly, the insurers in California sought to prevent consideration of this evidence, but their objections may have only served to highlight the significance of the evidence. In light of the court's reliance on the drafting history to reject insurer contentions, it would be foolhardy for insurers to pretend in other litigation that this history does not exist or is irrelevant to the coverage disputes now confronting them.

- The drafters of the standard form policy developed broad, unrestricted and flexible language.

As Judge Brown concluded after his review of the draft history, the drafters "of necessity and purposely. . . adopted language with an inherent flexibility and interpretability in uncontemplated situations."

Simply because the insurers and their policyholders may not have anticipated new types of liability claims when contracting for insurance does not deprive policyholders of coverage. Insurers thus should resist arguing that a policyholder's liabilities for such claims as hazardous-waste clean-ups are not covered because they could not have been anticipated before the enactment of the statutes under which such claims are made.

- Courts will not accept a "restriction" on coverage that has no basis in policy language, particularly when similar restrictions were considered and rejected by the drafters of the standard form.

Judge Brown observed that the drafters' consideration and rejection of language that was apparently intended to limit coverage on either an exposure or manifestation basis confirmed his conclusion that the standard language contained no such limitations.

Judge Brown's rejection of the "exposure" and "manifestation" theories based on both the plain meaning of the policy and the drafters' rejection of more restrictive language should put an end to insurers' efforts to read those restrictions into the policy. More generally and more importantly, it also should cause insurers considerable pause before they boldly assert that the standard form was not intended to cover certain types of liability when such an intent is nowhere apparent on the face of the policy or in the drafting history. And they certainly should refrain from positions that are contrary to the drafting record.

Thus, for example, the insurers should reassess their argument that CGL policies were intended to cover only liabilities arising out of "legal" claims, and not those arising out of claims that they characterize as equitable ones. Neither the standard policy language nor the drafting history reflects such a distinction.

- Forcing each policyholder to re-litigate issues already resolved against the insurance industry in other coverage litigation inevitably backfires.

In the California case, some insurers continued to press the manifestation position even though it had been rejected in 12 of the 13 previous asbestos coverage decisions. The theory had been adopted in the 13th case in large part because the policyholder sought that result. Insurers gain little, from either a legal or business perspective, by continuing to argue a point so clearly rejected by so many courts.

These propositions may not be easy for many insurers to swallow because their acceptance also will mean acceptance of substantial coverage obligations. But the insurers that persisted to the bitter end in California paid a heavy cost—in legal fees, in ultimate liability and in credibility in and out of court—because they ignored reality.

The insurers should ask themselves whether they want to look back 10 years from now only to find that they learned nothing from their experience with asbestos claims, and that they repeated their mistakes in other coverage litigation.

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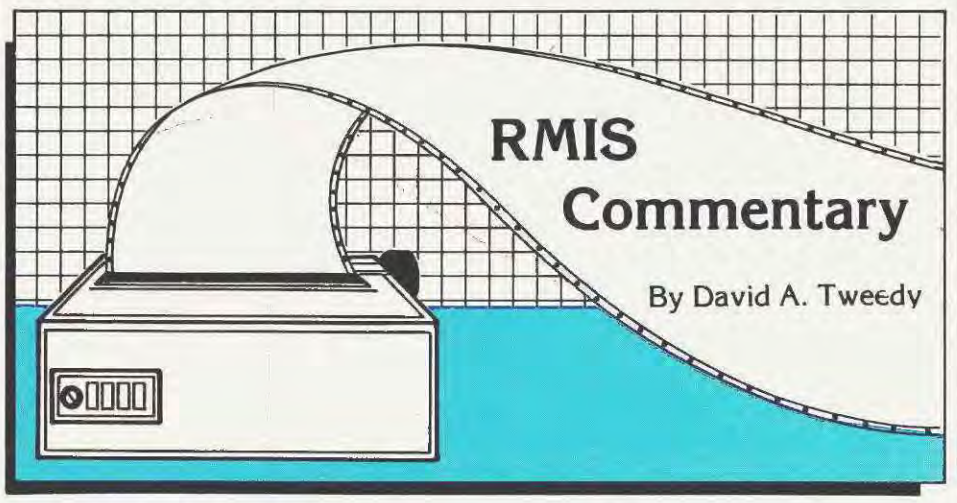
perspective

Communicating with execs



FURNISHING senior management with quick, concise and precise information is a major goal of all risk managers. Yet, it also can be a frustrating and sometimes unattainable goal at that.

However, through the use of well-designed risk management information systems, a risk manager can effectively communicate with and advise senior management. Considering that risk managers, as holders of staff positions, are forced to convince operating personnel of the logic of each of their recommendations, the control and understanding of information can be a vital tool.

Although many risk management information systems are developed as electronic record-keeping devices—used to assemble claims and other information—we have seen many risk managers use their power to communicate with senior management personnel to positively affect the decision process. Rather than being delayed by an inability to obtain timely information or extract key information from the mass of data available to the risk manager, the RMIS allows the risk manager to be an actual part of decision making.

How does the risk manager use the system in this fashion? There are five principal system considerations to accomplish this goal, including: data extraction, timeliness, "relational" ability, visual support and report brevity.

Proper use of these attributes can help a manager do better risk management.

✔ Data extraction.

The ability to sift out key information from the mass of data available to the risk manager is one of the best reasons to obtain and control an RMIS. Key data becomes available when the day-to-day, mundane matters of tracking information is turned over to an automated computer system. Not only does this allow additional time, but it provides easy access to data, enabling the user to understand its implications. The result is that key data is more readily available.

Because senior management has so many different tasks demanding time and attention, the ability to see and transmit key data is critical to the risk manager's attempts to influence corporate behavior. Such information must be meaningful.

According to Richard Betterley, president of Betterley Risk Consultants Inc., "often, risk management professionals become accustomed to presenting information in familiar terms. Discussing cost in terms of premium, rates and the like is easy, but may not be as meaningful to senior management. Expressing costs, losses, lost production and medical expense in terms of costs per unit sold, per employee, per dollar of sales and others, can be much more effective."

✔ Timeliness.

Generally, data is available; it is merely a question of obtaining it in a timely manner and relating it to other corporate activities. This is where a risk management department-controlled RMIS can have such a large advantage over traditional insurer-supplied systems.

Senior management operates in two concurrent time spans: the short term (what happened last month?) and the long term (where will we be in five years?). Answers to short-term questions can usually be obtained through a system controlled by the risk manager, one that is interactive.

As we well know, when senior management wants answers, it usually wants them now. Being unable to provide those answers creates frustration and causes the risk manager to be branded as "unhelpful." Unfortunately, having rapid access to out-of-date information is almost as bad.

Frequently, we have seen risk managers report information to senior executives that is so badly out of date that it is immediately discounted if not completely rejected. The risk manager had no better information, but in this case found that poor information was almost as bad as none at all.

Those of us who practice risk management understand that having information that is too raw can be as damaging as having no information at all. However, it is better to have control over such information and present it either with cautionary notes (or not release it at all), than to provide information that is so badly out of date as to be unusable.

There is an important danger in using raw claims information. For example, initial reserves for reported claims can be very inaccurate. Incurred-but-not-reported claims are subject to guesswork for all but the largest organizations and over- or underreserving of claims is commonplace. An RMIS may help you develop trending information, but be cautious in its use.

Timeliness has an additional benefit: Since so much of the value of an RMIS can be in its use in helping control frequent losses such as workers compensation or product liability claims, the ability to quickly obtain and distribute information about claims frequency is a valuable deterrent when properly used. Managers in a position to affect loss control, for example, often reject risk managers' advice on the basis that "those losses occurred before I was the plant manager; since I have changed things around here, the information doesn't apply to me." Timely extraction, analysis and distribution of data can avoid these objections.

✔ "Relational" ability.

"Relational" ability with regard to risk management information systems, and particularly with regard to the development of appropriate reports to senior management, refers to the correlation of risk management data with general corporate operating data, yielding information that relates the former to the latter. An example would be the development of relationships between the number of product units sold to the number of product liability claims, or the number of motor vehicle accidents to total number of fleet vehicles.

The use of such relational data is extremely powerful for the risk manager, allowing him or her to more effectively influence corporate decision making.

The challenge for designers of risk management information systems—whether they be risk managers, consultants or system vendors (or, in the best situation, as a team)—is to determine what reports are most meaningful for the individual organization. Using off-the-shelf reports is usually a mistake, since they suffer from the same problem as insurance company or self-insurance service providers: They do not highlight the most critical information and, therefore, are difficult to use. It is incumbent upon the RMIS designers to seek out and define those key bits of information that give an accurate, easy-to-understand picture of risk management at the organization. Selecting poor indicators is almost as bad as having inaccurate data, rendering the system less than useful.

As an example, we have seen RMIS reports designed to indicate the relationship between workers compensation claims frequency and dollars of payroll. When the company suffered through an across-the-board payroll cut for manufacturing workers, the relational data became flawed. If the report had been structured around man-hours worked, the data relationships would have remained valid.

Often, relationships that appear to be valid become flawed due to changes in industry practice. For example, hospitals used to be able to analyze frequencies leading to potential malpractice claims by measuring them against total patient days. As health care industry practices changed and more outpatient services were provided, the number of patient days—measured as overnight stays—became skewed, rendering the historical data less useful.

Since it is difficult to predict the future, developing ideal relational information that is completely reliable is impossible. Sometimes, changes in business practices will require a re-thinking of the system. Then, the necessity to have a broad data base containing information that is not readily useful now—but may be in the future—is important.

Thus, we urge clients to capture general risk management information that may be useful at some later point (*BI*, Jan. 20, 1986).

✔ Visual support.

It is easy to be impressed by the graphic support capabilities of various systems. Graphs are great ways of displaying information, particularly in terms of trends. However, don't make the mistake of designing a package of reports that depends on graphic support and does not provide underlying, more detailed information.

Usually, the "gee whiz" aspects of graphics wear thin after a few months, and risk managers and senior management begin to ask questions about the information. If the underlying information is not defined with sufficient detail, you and senior management may be disappointed.

✔ Report brevity.

Do not bury the boss with reams of paper! This is a sure-fire way to discourage interest in system output. Rather, a goal should be to respond to requests with one-page summaries. If more backup information is needed, then provide the detail.

We have stressed the necessity of the ability of an RMIS to produce a variety of reports—from simple one-pagers to voluminous detailed documents. Senior management, however, is usually interested in knowing the bottom line quickly.

Reporting accurately and effectively to senior management is tricky, with each manager having different interests. Using an RMIS that is inherently flexible can help you respond to the different demands of individuals. Properly structured and presented, reports can be a powerful means of communicating risk management information. Each user is different, though, so make certain that they are custom-designed, or at least modified for your needs.

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Health plans

Continued from page 3

• Some 71% of health care plan participants had dental coverage in 1986, down slightly from 1985. Vision care was provided to 40% of plan participants, and 20% of participants had hearing care benefits.

• Mental health coverage was provided for virtually all health plan participants, but in most cases coverage for mental health care services was more restrictive than that offered for other illnesses.

• About 75% of the plan participants could continue their employer-provided health care coverage into retirement, while coverage could be continued following a layoff for about half of the employees.

(This survey was conducted before the health care provisions of the Consolidated Omnibus Budget Reconciliation Act began to take effect last year. COBRA requires employers to continue coverage for employees who are laid off or terminated and for the widowed and divorced spouses and dependents of employees).

• Self-funded health insurance plans continued to grow in 1986, as did the popularity of health maintenance organizations and preferred provider organizations.

Overall, the survey shows that employees are being asked to pay a greater portion of the health care costs.

For example, the authors note: "For a majority of employees, insurance covers all initial hospital room expenses; however, a growing minority must pay part of the first-dollar costs."

The percentage of employees whose hospitalization coverage is provided through a major medical plan, which typically requires payment of a deductible and coinsurance, rose to 35% in 1986 from 33% in 1985, 28% in 1984 and 19% in 1983.

And, of the 64% of employees covered by basic hospitalization coverage, which generally do not require a deductible or coinsurance payments, 14% must pay a portion of their hospital costs, either a specified amount per admission or a portion of their first day's expenses.

Some 75% of the plan participants had basic coverage for surgical costs in 1986. More than 80% of these employees were enrolled in plans in which payment is based on "usual and customary" charges, up from 75% in 1985 and 69% in 1984.

Most of these surgical care plans pay 100% of reasonable and customary charges, but 12% of the employees were covered by surgical plans that paid only between 80% and 85% of the charges or imposed an overall dollar limit on surgical payments.

Major medical plans, which the survey defines as health plans that cover many categories of care, were provided to 82% of the employees at surveyed companies, a decrease from 92% in 1983. The authors say the drop is due to an increase in employees opting for coverage through health maintenance organizations.

The most-common major medical plan deductible, applied to 44% of the plan participants, was $100. That has been the most-common deductible amount since the BLS began conducting the survey in 1979. However, in 1986, 36% of participants were required to pay a deductible of $150 or more, up from 29% in 1985, 21% in 1984 and 12% in 1983.

Some 86% of the major medical plan participants were in plans that required employees to pay a 20% coinsurance payment; 81% of these employees were covered by plans that paid 100% of covered expenses when the employee's out-of-pocket expenses reached a certain limit.

The survey authors point out that the prevalence of such limits on employee's out-of-pocket expenses has increased each year since 1979, when less than half of the major medical plan participants were enrolled in plans with stop-loss features.

The percentage of employees whose coverage was fully paid by their employer dropped significantly to 54% in 1986 from 61% in 1985 and 72% in 1980.

Thirty-five percent of the employees also had dependent care coverage fully paid by their employers, down from 42% in 1985 and 51% in 1980.

"The long-term decline in fully employer-financed health insurance coverage is at least in part due to the increased cost of medical care," the survey authors say.

In cases where the employee contribution for health care coverage could be identified separately from employee contributions for

Continued on next page

Health benefits

Continued from page 3

other benefits, employee contributions averaged $13 a month for individual coverage and $41 for family coverage.

These are increases of 6% for individual coverage and 8% for family coverage over 1985, the authors note, and parallel "the 7.5% increase in the medical care component of the Consumer Price Index for All Urban Consumers in 1986."

However, the survey also showed that 14% of employees required to contribute to the cost of their health care coverage could do so on a pretax basis, such as through a flexible spending account.

Cost-containment provisions of employer-sponsored health insurance plans also continue to grow in popularity among employers, according to the survey.

In an effort to cut costs, employers are encouraging employees to use less-expensive alternatives to hospitalization. For example, 70% of plan participants now receive coverage for treatment in extended care facilities, up from 67% in 1985; 66% are covered for home health care services, up from 56% in 1985; and 31% now have coverage for hospice care, up from 23% in 1985.

Pre-admission testing provisions applied to about half the plan participants in both 1986 and 1985. But, the percentage of participants covered by a plan that paid for second surgical opinions rose to 57% in 1986 from 50% in 1985. And, in 1986, 60% of those participants were in plans that provided incentives for obtaining a second surgical opinion.

In addition, 28% of the plan participants in 1986 received higher reimbursement or paid lower deductibles for surgery performed at an outpatient center. Similar economic incentives were offered to 12% of participants for childbirth at a birthing center rather than a hospital and 7% were given higher benefit payments for using generic prescription drugs.

Plans covering 10% of employees prohibited or limited non-emergency weekend hospital admissions, while 9% of employees had to pay separate deductibles for hospital admissions and 2% were given incentives to audit their hospital bills.

Dental coverage was offered to 71% of medical plan participants surveyed in 1986, down slightly from 1985.

Sixty-three percent of employees with dental coverage must pay a deductible, the most common of which is $50 annually, required by plans covering 26% of the employees. Likewise, 86% of employees with dental coverage were subject to an annual maximum benefit, the most common of which is the $1,000 maximum specified by plans covering 42% of the surveyed workers.

Fifty-eight percent of employees with dental coverage also had coverage for orthodontic expenses, at least for dependent children.

While the percentage of employees with dental coverage dropped, the popularity of other less-traditional benefits continues to grow, according to the survey.

For example, 40% of health insurance participants had coverage for vision care in 1986, up from 35% in 1985 and only 18% in 1979. And, hearing care was available to 20% in 1986, up from 17% in 1985.

Coverage for treatment of alcoholism rose to 70% in 1986 from 68% in 1985. Coverage for treatment of drug abuse has grown each year to 66% in 1986 from 37% in 1982, when statistics on the coverage first were gathered.

Virtually all the plans also provided coverage for mental health care, although few plans provided the same level of benefits for psychiatric care as for other illnesses. For example, 99% of the health plan participants had coverage for inpatient mental health care, but only 37% had the same level of benefits for these services as for other health care services. And, 97% had coverage for outpatient mental health care, but only 6% had the same level of coverage.

Most commonly, plans imposed more restrictive limits on dollar amounts or days of coverage for mental health care, or they required employees to pay 50% of the charges instead of 20%.

Finally, the survey showed that "employer-provided health care through independent health plans has gained equal footing with commercial insurance policies and Blue Cross/Blue Shield plans."

The survey defined independent health plans as self-funded plans, HMOs and PPOs.

"The rise in coverage of independent health plans with basic hospital benefits is largely due to the growing importance of health maintenance organizations," the survey authors noted.

The percentage of health plan participants covered by HMOs grew dramatically to 13% in 1986 from 7% in 1985. PPOs provided coverage for 1% of participants in 1986, the first year PPO enrollment was studied by the BLS.

Some 45% of major medical plan participants were covered by a self-funded plan in 1986, up from 38% in 1985. And, self-funded basic health benefits covered 29% of participants in 1986.

Commercial insurance and Blue Cross-Blue Shield plans now cover about half the medical plan participants; in 1980, they covered five out of every six. However, the survey authors point out that many employers with self-funded plans purchase commercial stop-loss coverage.

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Copies of the survey, "Employee Benefits in Medium and Large Firms, 1986," are available for $5 each from either the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, or the Bureau of Labor Statistics Publication Sales Office, P.O. Box 2145, Chicago, Ill. 60690. Request stock number 029-001-02927-6.

Defined benefit plans still dominate

By ALISON KITTRELL

WASHINGTON—Defined benefit pension plans are the dominant retirement plans for employees at medium-size and large U.S. companies, but "other sources of retirement income, such as savings plans," are "growing in importance," a recent survey shows.

Some 75% of the 4.3 million employees at companies surveyed by the U.S. Labor Department's Bureau of Labor Statistics were covered by defined benefit pension plans in 1986, and employers completely fund the plans covering 94% of those workers.

However, 60% of the employees at surveyed companies participated in at least one defined contribution plan, point out the authors of "Employee Benefits in Medium and Large Firms, 1986."

Some 89% of the employees at the companies surveyed belong to some sort of employer-sponsored retirement plan: either a defined benefit plan, a defined contribution plan or both.

For 72% of the employees belonging to defined benefit plans, pension benefits are based on earnings: An employee's benefit is expressed as a percentage of his or her annual earnings multiplied by years of service.

For 79% of those with earnings-based formulas, the percentage was based on earnings in the final years of employment, while benefits for the rest of these employees are based on career earnings.

Most of those employees whose benefits were not based on a percentage of earnings were enrolled in plans that promised benefits equal to a dollar amount for each year of service. Such flat-amount plans covered about 25% of the pension plan participants surveyed, continuing a decline from 32% in 1981.

Blue-collar workers were more likely to be covered by flat-amount plans, the survey showed: Almost half of the blue-collar employees at surveyed companies were in such plans, compared with only 5% of the professional and administrative workers.

Virtually all—or 98%—of the employees covered by defined benefit pension plans could retire before the normal retirement age of 65 and receive immediate, reduced pension benefits. The most common age at which an employee can opt for early retirement is age 55.

On the other hand, "Employees who continue on the job after age 65 rarely receive private pension payments before retirement," the survey authors say. "Moreover, postponed retirement is rarely fully reflected in the size of the pension benefit."

Still, 40% of the defined benefit plan participants were members of pension plans that credited employees for service after age 65.

Most defined benefit plans—62% —have provisions under which plan benefits are offset by Social Security benefits.

On average, defined benefit pension plans replaced about 28% of the final year's earnings for employees who retired in 1986 at salaries of between $20,000 and $40,000.

Income replacement rates rose dramatically with years of service. For example, a defined benefit plan would replace an average of 18.9% of final year earnings for an employee making $25,000 after 20 years of service. The income replacement rate for this employee rises to 34.4% after 40 years of service.

Benefit formulas for current retirees have been increased at least once between 1981 and 1985 for 35% of the employees covered by defined benefit plans, the survey says. Forty-six percent of the workers whose benefits were increased received one benefit increase during that period; 24% received two increases; 9% received three increases; 22% received four increases; and less than 1% received five or more benefit increases.

The most popular form of vesting in defined benefit plans is 10-year cliff vesting, provided to 69% of the employees enrolled in defined benefit plans.

Some 70% of the white-collar workers and 50% of the blue-collar workers at the surveyed companies participated in at least one defined contribution plan, including retirement plans and capital accumulation plans.

Participation in defined contribution plans is increasing, the survey showed. For example, 30% participated in employee stock ownership plans in 1986, up from 24% in 1985. In addition, 22% participated in profit-sharing plans in 1986, up from 18% a year earlier.

Thirty-one percent of employees surveyed participated in salary-reduction plans with 401(k) or 403(b) features in 1986.

Two-thirds of those participants were enrolled in savings and thrift plans, into which employees could contribute up to a certain percentage of salary, with the employer matching at least part of the employee contribution. The most common employer contribution in 1986 was 50% of the employee contribution, up to 6% of salary.

White-collar workers were more likely to participate in savings and thrift plans: Overall, 28% of all employees surveyed were members of such plans, but 38% of the white-collar workers participated in these plans, compared with only 17% of blue-collar workers.

Ninety percent of the savings and thrift plan participants could decide among more than one investment option for their own contributions. However, only half could make investment choices regarding employer contributions.

Eighty-two percent of the participants in savings and thrift plans could withdraw employers contributions prior to retirement, disability or termination of employment. Fifty-six percent of the employees could withdraw employer contributions for any reason, though they may suffer a penalty, while 28% could only withdraw employer contributions in case of a hardship. ■

Disability benefits widespread: Study

By ALISON KITTRELL

WASHINGTON—About half of all employees at medium and large companies have short-term sickness and accident insurance and long-term disability insurance, according to a recent survey by the U.S. Department of Labor.

Other employees get short-term protection through paid sick leave and long-term protection through immediate disability pension benefits, note the authors of "Employee Benefits in Medium and Large Firms, 1986," the eighth annual survey by the U.S. Department of Labor's Bureau of Labor Statistics.

About half the 4.3 million employees surveyed have sickness and accident insurance; for about 80% of them, the benefit is paid totally by the employer. Most of the 20% who have to pay for the coverage pay between $2 and $3 a month.

Unlike paid sick leave, sickness and accident insurance rarely pays the full salary of an ailing worker.

The study notes sickness and accident benefits rarely equal a worker's full salary.

White-collar workers with sickness and accident insurance were more likely to have plans that replaced a percent of earnings, while blue-collar workers were likely to be in plans that paid a flat dollar amount per week, regardless of earnings.

Also unlike paid sick leave, sickness and accident insurance usually requires employees to be out of work for a short period—most often one to seven days—before benefits are paid. However, the waiting period may be shortened or eliminated for workers who are involved in an accident or hospitalized.

Long-term disability insurance is designed to replace the income of employees who are sick or injured for long periods of time. Usually, LTD coverage begins when sick leave or sickness and accident insurance ends and continues until the employee no longer is disabled or reaches retirement age.

LTD coverage for those injured after age 60 usually continues for five years or to age 70, whichever is earlier.

LTD insurance covered 48% of the employees surveyed, and 20% were required to pay part of the cost of the coverage. Most paid a set amount—typically 20 cents to 40 cents—per $100 of covered earnings.

Under most of the LTD plans covered in the survey, benefits equaled 50% to 60% of the employee's monthly pay. And, most of these plans had a maximum limit for monthly benefits. The maximums ranged from less than $1,000 to more than $10,000, but the most common were $3,000 and $5,000.

However, 25% of the LTD participants were in plans in which the benefit was not a percentage of salary.

These plans used a variety of benefit formulas, such as a set dollar amount, a variable percentage of earnings or a benefit that varied based on the disability.

Some 70% of the LTD participants were in plans that placed some type of ceiling on the income that could be paid to an employee during a specific disability period.

Fourteen percent of the participants were in LTD plans that paid survivor benefits after the death of a disabled employee. The most common survivor benefit was a lump-sum payment, usually three times the monthly LTD benefit.

Finally, 37% of the LTD plan participants were in plans that had separate limits for benefits paid in the case of mental illness.

In most cases, benefits were paid for only 24 months unless the employee was institutionalized. A few plans limited the duration of benefits regardless of whether the employee was institutionalized, or paid benefits only if the employee was institutionalized. ■

PBGC proposal

Continued from page 1

tee recommendations do not allow employers to remove surplus assets —for any reason—from their pension plans.

A pension plan would have to be terminated for an employer to recover surplus assets, as is now the case.

And, in such terminations, the current 10% excise tax on reversions generally would be doubled to 20% under the subcommittee proposal.

Under other subcommittee recommendations, many of which are similar to those made by the administration:

- Financially distressed companies no longer could dump their pension liabilities onto the PBGC by filing for reorganization under the federal bankruptcy laws.

In addition, financially distressed companies that are allowed to terminate their plans would have a greater liability to the PBGC.

- Companies would have greater difficulty obtaining waivers of their required minimum pension plan contributions from the Internal Revenue Service.

Employers also would be required to notify employees that they had applied for a funding waiver—which could cause morale problems, experts say.

- Employers would have to make minimum contributions to their pension plans within 2½ months after the close of the plan year, compared with the current 8½-month standard.

These recommendations, along with those of the administration, are the starting points of what could become the most comprehensive congressional overhaul of pension plan rules since the Employee Retirement Income Security Act of 1974.

While the subcommittee and administration proposals differ in a number of areas, they share a common theme: strengthening the financial base of the PBGC, which is struggling under the burden of a $4 billion deficit. Both proposals also would make the PBGC less vulnerable to future massive pension claims by requiring companies to improve their pension plan funding.

"There is a consensus that some action has to be taken to shore up the PBGC finances and to modify rules that allow a minority of firms that underfund their plans to pass on their liabilities to the PBGC and to employers that fund the PBGC through the payment of termination insurance premiums," said Frank McArdle, educational director of the Employee Benefit Research Institute.

The EBRI is a Washington, D.C.-based non-profit public policy research organization.

"This continued deterioration (of the PBGC) is a direct result of the termination of progressively and more seriously underfunded pension plans," said Ways and Means Oversight Subcommittee Chairman Rep. J.J. Pickle, D-Texas, and Ranking Minority Member Richard Schulze, R-Pa., in a letter to Ways and Means Committee Chairman Dan Rostenkowski, D-Ill.

'There is a consensus that some action has to be taken to shore up the PBGC finances and to modify rules that allow a minority of firms that underfund their plans to pass on their liabilities to the PBGC,' says Frank McArdle.

"Without legislatively mandated pension funding reforms, this trend can be expected to continue," the letter to Rep. Rostenkowski said.

"This trend, by a relative few employers, toward maintaining increasingly underfunded pension plans. . .threatens the solvency of the PBGC. . .and unfairly shifts that burden to the vast majority of employers who operate well-funded pension plans," added Reps. Pickle and Schulze.

While the final shape of legislation is far from certain, observers say there is a bipartisan consensus that the PBGC premium structure must be changed and that plan funding must be improved significantly.

"I have a tremendous sense that Congress is going to do something on PBGC premiums and plan funding," probably as part of a budget reconciliation bill, said Edward J. Davey, vp with Johnson & Higgins in New York.

"The large liabilities that have been dumped on the PBGC are propelling this drive," Mr. Davey said.

Indeed, shortcomings in current pension rules have become readily apparent to members of Congress and the administration.

For example, one LTV Corp. pension plan terminated last year had about $230 million in unfunded liabilities and just $7,700 in assets.

Yet, LTV—which later terminated several other pension plans resulting in a $2.3 billion loss for the PBGC—broke no pension funding rules and paid the same PBGC premium rate as companies that maintained overfunded pension plans.

While benefit experts do not agree with all the details in the subcommittee and administration proposals, they say it is time to change the rules to improve plan funding and thus improve the security of the nation's pension system.

"Everyone recognizes that changes are in order. Better pension plan funding is in the national interest," said Frederick Rumack, director of taxes and legal services at Buck Consultants Inc. in New York.

For employers with well- or overfunded pension plans that have no intention of terminating those pension plans, the most significant recommendation made by the subcommittee is the establishment of a variable-rate PBGC structure.

Under that recommendation, the base premium would be $15 per plan participant for plans that are at least 10% overfunded. Plans that are less than 110% funded would pay, in addition to the basic premium, a funding charge of $5.50 per $1,000 of underfunding. An employer's overall premium would be capped at $50.

However, plans with fewer than 100 participants would pay only the $15 premium.

The Reagan administration's proposal calls for setting the base premium at $8.50 for plans whose vested pension obligations are overfunded by at least 25%. The premium would be indexed to the annual average increase in national wages.

Also under the administration proposal, plans that are less than 125% funded would also face a funding charge of $6 per $1,000 of underfunding.

The PBGC would have authority under the administration's proposal to adjust this funding charge —up or down—by as much as 50% every three years if claims experience proved better or worse than expected.

The subcommittee proposal does not call for indexing nor does it give the PBGC authority to adjust the funding charge.

The Reagan administration proposal calls for a maximum PBGC premium of $100, which would be indexed to 150% of the average annual increase in national wages.

The administration proposal—with its range in PBGC premiums of $8.50 to $100—is much more a true variable rate structure than the subcommittee recommendation with its premium range of $15 to $50.

"The subcommittee recommendation is much less of a variable rate than we proposed," said PBGC Executive Director Kathleen P. Utgoff. "It does not provide the same incentive for employers to responsibly fund their pension plans as our proposal."

Still, Ms. Utgoff acknowledges, the subcommittee's variable rate premium recommendation is a step in the right direction in encouraging better plan funding.

The subcommittee is recommending a higher base premium but lower funding charges and a lower maximum premium in response to lobbying by those with poorly funded plans who would be hit with the highest premiums, sources say.

Some employers, though, say it is unfair to raise the base premium so much for companies with well-funded plans, while lowering funding charges and the maximum premium.

"It would have been fairer to set the maximum premium higher and the funding charge higher since those with the greatest risk (to the PBGC) would pay the most," said Christopher Bone, a consulting actuary with Actuarial Sciences Associates Inc., an American Telephone & Telegraph Co. subsidiary in Piscataway, N.J. Mr. Bone also is a member of the Coalition for Retirement Income Security, an ad-hoc group of employers lobbying for a variable PBGC premium structure.

But many employers support the committee recommendation not to index premiums to wage increases or give the PBGC authority to adjust funding charges.

"Indexing is irrational," asserted Mark Ugoretz, executive director of the ERISA Industry Committee, a Washington-based benefits lobbying organization representing large employers. "It transfers authority (to set premiums) from Congress to a quasi-federal agency."

To improve pension plan funding, the subcommittee would set a new amortization schedule to pay off liabilities that is more rapid than the 30 years companies generally now have to amortize pension liabilities.

For example, the speed at which new liabilities—those created after June 30, 1987—would have to be amortized would be based on the funding level of a plan.

Under this schedule:

- Pension plans that are less than 50% funded would have to amortize new liabilities in three years.
- Plans that are between 50% and 70% funded would have to amortize new liabilities over five years.
- Plans that are more than 70% funded would have 15 years to amortize new liabilities.

A similar rapid amortization schedule would be established to fund old liabilities, though that schedule would not take effect until 1991.

In addition, special transitional funding rules would be established for the financially hard-pressed steel industry. Full details are not yet available.

Unlike the administration proposal, and much to the disappointment of benefit experts, the subcommittee recommendations would not allow the withdrawal of surplus assets from overfunded pension plans.

Plans would have to be terminated to recover excess assets, as is now the case.

By contrast, the administration proposed that excess assets—those assets exceeding 125% of pension liabilities—could be transferred tax-free to special trusts to pay for current retirees' health benefits or to underfunded defined benefit plans (*BI*, Feb. 23).

The administration also would allow surplus pension assets to be withdrawn for any purpose, as long as a company did not have an underfunded plan.

However, such general purpose withdrawals would be subject to a 10% excise tax.

While not only preventing companies from removing excess assets from on-going plans, the subcommittee recommendations also would double the excise tax on reversions to 20%. However, the excise tax would be 10% if the reversion were shifted to an underfunded plan.

Subcommittee members are saying that "easier access to excess pension assets is not something that should be further encouraged," noted EBRI's Mr. McArdle.

Other experts are outraged that the subcommittee wants to double the excise tax on reversions to 20%, noting that the 10% excise tax has just been put in place by the Tax Reform Act of 1986.

"The ink is hardly dry on the 10% excise tax," said Dick Raskin, a consultant with The Wyatt Co. in New York. "Does this mean that in two years the excise tax will be 40%?"

Also, the subcommittee proposal would require any company terminating an overfunded plan that also had an underfunded plan to contribute to the underfunded plan over a three-year period an amount equal to the reversion or an amount needed to bring the plan to a 25% overfunded level, whichever is less.

While restricting the termination of underfunded plans, such as in Chapter 11 bankruptcy proceedings, terminations of underfunded plans by financially distressed companies still would be allowed:

- If a company were in Chapter 7 bankruptcy liquidation.
- If the PBGC determined that an employer's pension costs became unreasonable as a result of a declining workforce.
- If the PBGC found that the employer is unable to pay its debts when due and is unable to continue in business.

However, a financially distressed employer would be fully liable to the PBGC for unfunded guaranteed benefits, up from the 75% liability cap under current law.

In addition, companies seeking funding waivers would first have to prove that their financial difficulties were of a temporary rather than a longstanding nature.

In addition, the maximum number of funding waivers that could be granted over a 15-year period would be reduced to three from five. ■

Ex-Howden execs arrested

Continued from page 1

falsely representing that a syndicate of purchasers for Banque du Rhone de la Tamise of Geneva comprised individuals and/or entities independent of the Alexander Howden Group."

Mr. Hart, 53, was charged with conspiring between Jan. 1, 1974, and May 31, 1977, "with Messrs. Grob, Carpenter and Page to defraud members of syndicates 502/64 and 868/35 at Lloyd's by affecting the transfer of funds belonging to members of the syndicates to the Banque du Rhone."

Mr. Page, 68, and Mr. Carpenter, 66, were charged with both offenses. Mr. Page and Mr. Carpenter are retired. Mr. Page is seriously ill, and Mr. Carpenter has undergone major heart surgery in recent years.

Mr. Posgate

All four men were released on 100,000 pounds bail ($161,000) and are scheduled to appear in court on Oct. 13. All intend to plead not guilty to the charges at that hearing.

As a condition of the bail, the men had to surrender their passports and promise not to contact, either directly or indirectly, Mario Benbassat, Elihou Zilkha and another person identified only as Mr. Zuffery, who are believed to be important witnesses. The three men, all of whom live in Geneva, are former directors of the Banque du Rhone.

The three-month adjournment of the case is believed to be necessary to allow time for the extradition of Mr. Grob.

The four defendants sat together in the dock in the London court last week as the charges were read. Mr. Carpenter shook his head slowly as the others sat motionlessly. Friends and relatives filled the back of the small courtroom.

Authorities in London, including Lloyd's and the Department of Trade and Industry in conjunction with the City of London's Fraud Squad, began investigating affairs at Howden after a fair-value audit of Howden conducted by A&A in July 1982 revealed accounting "irregularities."

On Sept. 20, 1982, A&A filed two lawsuits against five ex-Howden employees, including Mr. Posgate, the powerful underwriter for Howden-managed marine syndicates 126 and 127 at Lloyd's and a member of the Committee at Lloyd's, Mr. Grob, Mr. Page and Mr. Carpenter. A fifth defendant in the civil litigation, Ronald C. Comery, another former Howden director, has since died.

The first suit, in which A&A was the sole plaintiff, sought "damages for fraud and/or misrepresentation and/or negligent misstatement" during the Howden acquisition.

The second suit, which included Howden subsidiaries as plaintiffs, sought damages from a "dishonest scheme" in which the five defendants allegedly used Howden funds for their personal gain.

The suit alleged that at least $56 million in funds from Howden companies and Howden-managed Lloyd's syndicates were filtered through three companies, two owned by Messrs. Grob, Page, Comery and Carpenter—the so-called "Gang of Four"—and a third owned by the four men and Mr. Posgate.

A third lawsuit was later filed by Howden subsidiary Alexander Howden (Underwriting) Ltd. in London's High Court in November 1983 that demanded Mr. Hart return more than $1.83 million to members of Syndicates 502/64 and 868/35, which were managed by Howden.

Howden—which filed the suit on behalf of syndicate members—claimed the money was "unlawfully diverted from and/or not returned to members" between 1974 and 1979 (*BI*, Dec. 5, 1983). The suit alleged the money was filtered into accounts at the Banque du Rhone for the personal use of Mr. Hart and "others."

In April 1984, A&A agreed to drop all claims against Messrs. Grob, Page, Carpenter and Comery after the return of certain Howden assets. The suit against Mr. Hart was settled in November 1986.

A&A settled its suit against Mr. Posgate in January for an undisclosed sum (*BI*, Jan. 19).

The criminal charges filed this week follow two years to the month the expulsion from Lloyd's of Messrs. Grob, Comery and Carpenter following an internal Lloyd's disciplinary investigation (*BI*, July 22, 1985). At the same time, Mr. Posgate was suspended from Lloyd's for six months after an appellate hearing overturned Lloyd's decision to also expel him.

Lloyd's disciplinary proceedings against Mr. Page were dropped because he was ill.

Lloyd's also expelled Mr. Benbassat, former managing director of the Banque du Rhone.

In October 1986, Lloyd's expelled Mr. Hart for, among other things, allegedly misappropriating syndicate funds.

If the cases come to trial, the issues at the criminal trial will be different from those involved in the Lloyd's proceedings and the civil litigation.

Members of the London market are now speculating whether criminal action will be taken against other former Lloyd's members linked to other market scandals.

It was initial investigations into the Howden Affair in 1982 that led to the discovery of an unconnected affair involving losses of millions of pounds from syndicates managed by PCW Underwriting Agencies Ltd. A $138 million settlement offer by Lloyd's to help bail out members of the syndicates was accepted last month by more than 98% of PCW members (*BI*, July 13).

Investigations by the fraud squad and the Department of Trade and Industry into the PCW scandal are continuing, sources confirmed last week.

Former PCW Chairman Peter Dixon, who now lives in the United States, was expelled by Lloyd's and fined 1 million pounds ($1.61 million) in November 1985 for his role in the alleged misappropriation of PCW funds.

In April 1986, Peter Cameron-Webb, another former PCW chairman, agreed to pay 1.5 million pounds ($2.4 million) to PCW's replacement managing agency (*BI*, April 13).

However, neither man has been charged by the British police, despite public complaints in the past by Lloyd's Chairman Peter Miller of the lack of criminal proceedings. ■

E-Ferol maker faces criminal charges

Continued from page 2

The 25-count indictment charges each defendant with one count of conspiracy to commit mail and wire fraud and conspiracy to violate federal drug regulations.

It also charges them with multiple counts of: mail fraud through letters to hospitals, wire fraud through telephone conversations with medical professionals and "substantive" violations of federal drug regulations for marketing a new drug without approval and for introducing a misbranded drug into interstate commerce.

Each defendant faces a maximum penalty of $142,000 in fines. Messrs. Carter, Hiland and Madison also face up to 101 years in prison.

Carter-Glogau, Mr. Madison and Mr. Hiland all plan to plead innocent to the charges, their attorneys said last week. Spokesmen for the other defendants did not return telephone calls.

A Justice Department spokeswoman said a recent U.S. Supreme Court ruling that narrows the use of the federal mail fraud statute should not hurt this case. "We are confident that the charges will stand," she said.

The Justice Department's investigation into E-Ferol "is a pretty forceful action by the government showing that they will not countenance illegal action by a drug manufacturer that violates drug laws," said John Pinney, a partner with Graydon, Head & Ritchey in Cincinnati. He represented seven plaintiffs in civil lawsuits against some of the defendants, which have been settled.

Revco said in a statement that it was studying the allegations. The company also said that the maximum potential fines "do not impact Revco financially."

Revco emphasized that the product was withdrawn voluntarily from the marketplace in 1984 after some of the hospitals using it claimed adverse reactions.

E-Ferol is linked with the deaths of between 30 and 40 infants and injuries to several others, which resulted in more than 100 civil lawsuits. However, no case is known by Revco to have gone to trial, and most have been settled.

Insurers for all defendants have paid out $20 million to $40 million to settle the claims, according to sources close to the litigation.

Revco, which had named Carter-Glogau on its policy, has settled all but six of 115 civil cases, said Jack Staph, Revco's vp, general counsel and secretary. He declined to comment on the amount of money paid out in settlements but confirmed that Revco's $150 million in product liability insurance was more than sufficient.

The primary layer of Revco's insurance program was underwritten by United Insurance Co. Ltd., a Cayman Islands-based insurer owned by captives of major corporations and managed by a Reiss Organization unit.

However, two of Revco's major excess insurers that wrote coverage on an admitted basis—Transit Casualty Co. and Midland Insurance Co.—since have been declared insolvent and currently are in liquidation. Transit Casualty is being liquidated in Missouri while Midland is being liquidated in New York.

Revco believes a substantial portion of the settlement costs is recoverable from the Ohio insurance guaranty fund, and possibly Arizona's or other guaranty funds as well, Mr. Staph said.

Generally, guaranty funds cover claims filed by residents of their states, although it depends on state regulations and policy wording. Revco is based in Ohio, where the guaranty fund covers claims to $300,000, while Carter-Glogau was based in Arizona, whose fund covers claims to $100,000.

James E. Lane, administrator of the Ohio Insurance Guaranty Assn., said it would be "highly unlikely" that an insurer would

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Howden scandal surfaced in 1982

September 1981: Alexander & Alexander Services Inc. announces the acquisition of Lloyd's of London broker Alexander Howden Group P.L.C. for $299.9 million in stock and cash (*BI*, Sept. 28, 1981).

July 1982: A&A conducts a fair-value audit of Howden following rumors that millions of pounds in Howden underwriting funds are missing. Howden Chairman Kenneth V. Grob resigns from the A&A board for "unrelated" reasons (*BI*, Aug. 2, 1982).

August 1982: A&A makes a secret deal with Mr. Grob, former Howden Chief Financial Officer Alan J. Page and former Howden directors Ronald C. Comery and Jack H. Carpenter to recover assets they allegedly diverted from Howden for their own gain. Mr. Grob steps down as Howden chairman.

September 1982: A&A budgets $35 million to cover shortfalls at Howden subsidiary Sphere Drake Insurance Co. Ltd. (*BI*, Sept. 6, 1982).

Later in the month, A&A files suit against Messrs. Grob, Page, Comery and Carpenter and Ian R. Posgate, underwriter for several Lloyd's syndicates managed by Howden, alleging they misused $56 million of Howden assets through an elaborate scheme that dated back to 1975 (*BI*, Sept. 27, 1982).

Among other allegations, A&A charges that Messrs. Grob, Page, Comery and Carpenter—the so-called "Gang of Four"—diverted Howden funds to Panamanian companies they secretly owned and the Banque du Rhone et la Tamise, a Swiss bank the four men and Mr. Posgate secretly acquired from Howden.

A&A says it canceled its heretofore secret agreement with Messrs. Grob, Page, Comery and Carpenter because they misrepresented the value of the diverted assets. At the same time, Howden fires Mr. Posgate, widely regarded as the most successful underwriter at Lloyd's.

October 1982: Mr. Posgate sues Alexander Howden (Underwriting) Ltd., a Howden unit that he had headed, alleging he was illegally fired (*BI*, Oct. 18, 1982).

January 1983: Mr. Posgate is suspended from underwriting by Lloyd's (*BI*, Jan. 31, 1983). Two months later, he is suspended from his seat on the Council of Lloyd's (*BI*, March 28, 1983).

April 1984: A&A drops its litigation against Messrs. Grob, Page, Comery and Carpenter in exchange for the recovery of an additional $1.6 million in Howden assets, including a Renoir painting and Mr. Grob's London townhouse. The recoveries brought to $29 million the amount of missing Howden assets recovered.

However, A&A continues to press its suit against Mr. Posgate (*BI*, April 23, 1984).

August 1984: A London High Court judge rules that Mr. Page and Mr. Carpenter cannot resign from Lloyd's to escape facing disciplinary proceedings (*BI*, Aug. 13, 1984).

February 1985: The Council of Lloyd's reprimands Mr. Posgate and Lloyd's underwriter Mark Denby for allegedly transferring the proceeds of reinsurance policies principally funded by Howden-managed syndicates to syndicates managed by Posgate & Denby (Agencies) Ltd., a Lloyd's underwriting agency headed by Mr. Posgate and Mr. Denby (*BI*, Feb. 18, 1985).

May 1985: Mr. Posgate appeals the decision of a Lloyd's disciplinary committee, which found him guilty of accepting gifts from Mr. Grob and Mr. Comery, including a Pissarro painting, that were allegedly intended to influence Mr. Posgate's underwriting decisions.

Mr. Posgate also was found guilty of failing to admit that he and other Howden directors owned shares in the Banque du Rhone (*BI*, May 13, 1985).

July 1985: Lloyd's expels Messrs. Grob, Comery and Carpenter and Mario Benbassat, former managing director of the Banque du Rhone, for their roles in the misappropriation of assets from Howden. In addition, Lloyd's recommends that Mr. Posgate be expelled, but the sentence is reduced on appeal to two six-month suspensions to be served consecutively. Disciplinary proceedings against Mr. Page are dropped because he is ill.

Among other findings, Lloyd's charges that Messrs. Grob, Comery and Carpenter bought the Banque du Rhone by misappropriating Howden funds—including funds from Mr. Posgate's syndicates and Sphere Drake—through reinsurance transactions (*BI*, July 22, 1985).

December 1985: Mr. Posgate announces he hopes to return to Lloyd's as an underwriter for a syndicate managed by R.L. Glover & Co. (Underwriting Agencies) Ltd. when his suspension expires in January 1986 (*BI*, Dec. 23, 1985).

In addition, two Howden units settle for $19 million a lawsuit filed by about 300 members of Mr. Posgate's syndicates that charged the syndicates were mismanaged (*BI*, Dec. 30, 1985).

February 1986: The Council of Lloyd's rejects Mr. Posgate's application to return as an underwriter on the grounds that he is "unsuitable" to be a Lloyd's underwriter. Mr. Posgate appeals.

July 1986: A former House of Lord's judge upholds Lloyd's decision to ban Mr. Posgate from underwriting (*BI*, July 14, 1986).

October 1986: Lloyd's expels former Lloyd's underwriter Colin Hart and fines him more than $250,000 for a variety of alleged offenses—including the misappropriation of syndicate funds—that occurred when he was underwriter for syndicates managed by L.E. Hart Associates Ltd., which has been a Howden subsidiary since 1976 (*BI*, Oct. 20, 1986).

January 1987: A&A settles for an undisclosed sum its 1982 lawsuit against Mr. Posgate, who agrees to drop his unfair dismissal suit against A&A, marking the end of all civil litigation involving A&A's acquisition of Howden (*BI*, Jan. 19).

July 1987: Messrs. Posgate, Grob, Page, Carpenter and Hart are arrested on fraud charges.

Also, the Securities and Exchange Commission notifies A&A that it completed its investigation of A&A's handling of the Howden acquisition, begun in 1983, and found no basis for taking action against the company.

Monsanto

Continued from page 3

made," he added.

Mr. Toth noted that Monsanto has product liability coverage with the London market and that it also participates in Cayman Islands-based A.C.E. Insurance Co. Ltd. and Barbados-based X.L. Insurance Co. Ltd., but did not say how much coverage the company has.

A.C.E. writes up to $140 million in limits excess of $100 million while X.L. writes up to $75 million excess of $25 million.

Two months ago, Monsanto announced the "successful start-up" of a facility in St. Louis to develop and produce the phosphate fiber.

The Monsanto spokesman said the phosphate fiber was being developed for limited uses as a replacement for asbestos. For example, the phosphate fiber would have been used as a component of motor vehicle brake shoes.

In addition to being a replacement for asbestos, the product also would have had applications in adhesives, coatings and sealants, according to Monsanto.

The product could have generated about $100 million in revenues annually by 1992. "It was not a big market but could have been profitable," the spokesman added. "It had a niche application."

However, recent newspaper reports questioning the safety of asbestos substitutes "muddied the water for all fibers," causing management to reconsider the project and ultimately to stop development, the spokesman noted.

"Those stories raised the flag for Monsanto to rethink the whole project," he said.

Monsanto conducted toxicity and health studies that showed the fiber was broken down in the lungs, according to the spokesman.

"It looked like it was going to be a safe product. Interim toxicity reports were very favorable."

He added that he was unaware of any other product that Monsanto had pulled from the market or stopped developing because of fears of product liability litigation.

However, the company did seriously consider limiting the marketing of another fiber product that, among other things, was used as a flame retardant fabric for children's sleepware. Consumers had confused Monsanto's product with another manufacturer's product that had been linked to cancer.

"We questioned whether to continue with the product" for use in the sleepware, he said, adding that the product was not withdrawn. "It's the only other product we seriously questioned based on the litigation potential."

Analysts speculate that another factor that may have influenced Monsanto is that the company has been a defendant in several major product liability cases.

For example:

- In January 1986, Monsanto subsidiary G.D. Searle & Co. stopped selling of two popular intrauterine devices, including the "Cu-7," in the United States, because of the rising costs of defending itself in product liability suits (*BI*, Feb. 10, 1986). The company, still faces about 490 cases.
- Monsanto was one of seven defendants in litigation brought by Vietnam War veterans exposed to the herbicide Agent Orange. Under a $180 million settlement, Monsanto agreed to pay 45.5%, or $81.9 million (*BI*, May 14, 1984).
- Monsanto is a co-defendant in litigation arising out of a 1979 tank car derailment in Sturgeon, Mo. In one of the actions, 129 plaintiffs are seeking nearly $900 million in actual and punitive damages.
- Last December, Monsanto was hit with a $108 million damage award to the family of a worker who died allegedly because of his exposure to benzene at a Monsanto plant in Texas. Recently, the judge ordered a new trial in the case (*BI*, Dec. 22, 1986).

"They are probably more gunshy" than other companies might be, said James H. Wilbur, an analyst with Smith Barney, Upham Harris & Co. Inc. in New York.

Garo Armen, with Dean Witter Reynolds Inc. in New York said that $100 million in revenues from a potential product is "worth looking at but not taking a lot of risk with. . . .I wouldn't be surprised if they were on the conservative side in making such a move."

However, the Monsanto spokesman said the company did not base its decision on the fact that the company is involved in product liability litigation. Rather, that litigation is "indicative of the current climate we live in," he said.

Monsanto's decision to stop development of phosphate fiber because of potential product liability problems is not the first time a company has taken such a step, although there is little hard data available on the extent that this has occurred.

Many of those fighting for changes in product liability laws have warned that increasing litigation and insurance costs fueled by many more product liability suits have caused companies to withdraw products from the market or to stop development of new ones.

A study by the Conference Board, an information service for business executives, reported this year that about 12% of 232 corporations surveyed decided not to invest in new products or services because of liability concerns.

A spokesman for the National Assn. of Manufacturers in Washington said that some firms have pulled a variety of products from the market—including drugs, vaccines and medical equipment—because of product liability risks.

Peter Reuter, a senior economist at the Rand Corp.'s Institute for Civil Justice, said it is possible some companies have changed their approach to determining their product liability risks.

Previously, studies showing that a product poses no adverse health effects would have been enough to assure a company that it would not face product liability problems after it is marketed, he said.

However, under a strict liability system in which companies have been held liable for the adverse health effects caused by products late in their market life, a company might be less willing to develop or market a product.

The Monsanto spokesman added that the phosphate fiber was patented Monsanto technology and that the company could sell the technology. ■

update

Insurer ordered to pay law firm

SAN DIEGO—A federal court jury in San Diego has ordered National Union Fire Insurance Co. of Pittsburgh, Pa., to pay more than $1 million in legal fees it owed a Los Angeles law firm hired to defend a policyholder involved in a bank closing.

National Union, a unit of American International Group Inc., approved the law firm of Steven Stanwyck as defense counsel for Douglas E. Patty, chairman of the Heritage Bank of Orange County, which was declared insolvent and closed in 1984.

However, the insurer sued Mr. Stanwyck, charging that his legal fees were unreasonable and excessive and demanding that he return fees already paid (*BI*, Oct. 6, 1986).

Mr. Stanwyck filed a compulsory counterclaim seeking the $1.09 million in fees, contending that they were reasonable and specifically authorized by National Union. The jury unanimously agreed and awarded the Stanwyck firm $1.06 million.

Mr. Stanwyck also has filed suit in Los Angeles seeking an additional $100 million from National Union, AIG and their legal counsel for bad faith, improper conduct and punitive damages.

National Union had insured Heritage Bank for $20 million under a three-year D&O policy written in 1980, said Michael Dawe, an Orange County attorney who represented Mr. Patty. However, National Union would not confirm this.

Insurer backs insolvent HMO

TALLAHASSEE, Fla.—An insurer that wrote a solvency policy for a health maintenance organization placed into receivership last week will provide funds to keep the HMO operating until July 31.

State Mutual Life Insurance Co. of Worcester, Mass., will provide funds to United American HealthCare Inc. of Lake Worth, Fla., based on coverage it wrote that guaranteed payment of all of the HMO's bills, claims and amounts needed to continue providing health care services for the remainder of any month in which the HMO might be declared insolvent.

United American HealthCare was declared insolvent and placed under supervision last week by Leon County Circuit Court Judge J. Lewis Hall, said an Insurance Department spokeswoman.

The department said it is seeking a buyer for the insolvent HMO, but if none is found buy July 31, United American will be liquidated. The HMO provided services to 11,000 members.

Owned primarily by First American Bank of Lake Worth, the HMO has about $700,000 in assets and $4.3 million in liabilities.

In another action last Wednesday, Sunshine Health Plan Inc. of South Daytona Beach, Fla., was ordered by the Leon County Circuit Court to show cause at a Sept. 11 hearing why it should not be placed into receivorship.

The HMO, which has 13,000 members, has $1.2 million in assets and $1.9 million in liabilities.

Ohio liquidates HMO

COLUMBUS, Ohio—The Ohio Insurance Department is liquidating WellCare Healthplan, a Youngstown-area health maintenance organization, following court approval earlier this month.

The HMO has $1.8 million in liabilities, most of which are payments due providers, and $68,455 in assets, a department spokesman said. The number of WellCare's subscribers enrolled both in group plans and individually dwindled to about 90 from 2,000 as its financial difficulties became publicly known, the spokesman noted.

WellCare members who paid their July premiums will be covered through July 31 under a reinsurance agreement with North American Life Assurance Co., according to the terms of the liquidation.

Starting in August, Blue Cross & Blue Shield of Ohio will provide uninterrupted coverage to WellCare's subscribers, regardless of pre-existing conditions, the department said.

WellCare is the third HMO to become insolvent in Ohio, and the second one this year, according to the department spokesman.

Railroad liable for dioxin claim

ST. LOUIS—Norfolk & Western Railway Co. cannot recover for claims against it from its co-defendants in a dioxin contamination case, a Missouri appellate court ruled last week.

The decision, which upheld a lower court's ruling, stems from the January 1979 rupture of a tank car containing a wood preservative and a small quantity of dioxin, a toxic chemical, in Sturgeon, Mo.

Railroad workers involved in the cleanup accepted a $7 million settlement in 1982 from the railroad's co-defendants: General American Transportation Co., and its GATX Corp. subsidiary, Dresser Industries Inc.—which were involved in manufacture of the tanker—and Monsanto Co., which produced the dioxin.

A jury in Madison County, Ill., awarded the employees $58 million from the railroad, but that award was overturned by an Illinois appellate court (*BI*, Oct. 15, 1984).

The employees refiled the lawsuit in St. Louis Circuit Court, where they settled with the railroad for $15.8 million in 1986, according to a railroad attorney.

A related lawsuit pressed by Sturgeon residents is being heard in St. Clair County Circuit Court in Illinois.

Briefly noted

Washington state insurance regulators attribute about $2 million of the $11 million **insolvency of Life Insurance Co. of America**, of Bellevue, Wash., to business written for a multiemployer trust called Pacific Multi-Industry Trust. The trust, made up mostly of small Southern California businesses, dissolved in February when regulators placed LICA in receivership. . . .Congressional conferees agreed on an **omnibus banking bill** containing a moratorium that would prohibit federal regulators until March 1, 1988, from granting banks broader authority in the insurance, real estate and securities industries (*BI*, April 6).

Captives sue Hall, RBH

Continued from page 2

S.A., Frank B. Hall Re (Latin America) Inc. and Frank B. Hall Re Southeast Inc.

- Keough-Kirby Associates Inc., a broker based in Woonsocket, R.I.; and Keough-Kirby Re Ltd. of New York.
- Leonard Smith, a former Hall vp and a former senior vp of Keough-Kirby Re, and his wife, Carol Smith.
- Stephen Maloney, former treasurer of Philan and Benodet, and his wife, Margorie T. Maloney.
- Monroe Birnberg, former president of Union Indemnity, and Douglas L. King, Union's former chairman.
- RBH and Rollins Burdick Hunter (Bermuda) Ltd.
- Fielding Juggins Money & Stewart Ltd. and C. Howard Ltd., both London brokers.
- Touche Ross & Co. and Ernst & Whinney, auditors of Philan and Benodet between 1981 and 1984.

In early 1983, Mr. Smith, then a Hall vp, convinced Philan and Benodet to use Hall as their broker, underwriting manager and consultant, according to the complaint.

During the course of the year, however, Mr. Smith, Hall and other defendants developed the alleged plan to divert reinsurance premiums, the suit alleges.

Mr. Smith and Hall "solicited the assistance" of RBH (Bermuda) to obtain a shell company to accept premiums on behalf of the two captives, according to the complaint, which identifies the shell company eventually used as Mansion Management Services Ltd. of Bermuda.

Mansion was wholly owned by RBH (Bermuda) and began operating in early 1983 "solely for the purpose of siphoning off premium rightfully belonging to Philan and Benodet," the complaint charges.

Mansion—which performed no services for the two captives and acted "without appropriate authorization" from either reinsurer—diverted 9% of the premiums owed to Philan and Benodet, the suit alleges.

The money went into bank accounts maintained for the benefit of Mr. and Mrs. Smith and Mr. and Mrs. Maloney, while Mansion retained 1% for itself, the suit says.

Meanwhile, Mr. Smith and Hall also advised Philan and Benodet to accept a large volume of reinsurance risks, which generated increased commissions for Hall and "served as a source of funds to be illegally diverted to Smith and Maloney," according to the complaint.

The alleged conspiracy was expanded in November 1984, when Keough-Kirby formed a reinsurance unit, Keough-Kirby Re, which took over some brokerage and underwriting consultant duties performed by Hall, the suit says.

Mr. Maloney was given a minority shareholding in Keough-Kirby Re—an act of "commercial bribery" by Keough-Kirby, according to the suit.

Mr. Smith left Hall to become senior vp of Keough-Kirby Re. He and the reinsurance unit then conspired with Mr. Maloney, Mr. Birnberg and Mr. King to use Island Corporate Services Ltd., based in the Cayman Islands, to accept premiums on behalf of the two captives.

Keough-Kirby, through its reinsurance unit and Mr. Smith, was mainly responsible for forming Island, which was used, like Mansion, to divert premiums to the personal bank accounts of the Smiths, the Maloneys and Mr. Birnberg, the complaint charges.

C. Howard Ltd. also participated in the alleged scheme by diverting premiums directly to accounts maintained for the benefit of the Maloneys, the suit says.

The defendants—with the exception of Touche Ross and Ernst & Whinney—concealed the alleged conspiracy "through regular and constant falsification over a period of years of records and reports as to reinsurance premiums and coverages," the captives allege.

Hall, Mr. Birnberg and Mr. King aided the alleged conspiracy by allowing Union Indemnity's records to be inaccurate and misleading and by disguising Union's insolvency, the suit charges.

Philan and Benodet did not discover the "carefully premeditated" fraud until Union Indemnity was ordered liquidated, at which point the captives were in a state of "near ruination," the complaint says.

The RICO charge against all the defendants except the accounting firms cites more than $70 million in actual damages resulting from the captives' reinsurance assumptions, and seeks treble damages of $210 million.

The complaint also levels charges of fraud and breach of fiduciary duty against Hall and its subsidiaries, Keough-Kirby and its reinsurance unit, and RBH and RBH (Bermuda).

Other charges include fraud and embezzlement against all the defendants except the accounting firms; negligence against Hall and its subsidiaries; and negligent hiring against Hall and Keough-Kirby.

The suit seeks indemnification of claims paid by Philan and Benodet from all the defendants except the accounting firms.

Touche Ross is charged with accountant malpractice and negligence in its 1983 and 1984 audits of the captives and in its alleged failure to discover Union Indemnity's problems as auditor for that insurance company.

Ernst & Whinney is charged with accountant malpractice in its 1981, 1982 and 1983 audits of Philan and Benodet.

In a statement earlier this month, Hall said the charges are "without merit." The statement noted that Hall "intends to vigorously defend this action and believes that it will not have a materially adverse effect on Hall's financial condition."

An RBH official said last week that he had not read the complaint and could not comment.

Mr. King called the conspiracy charges "ridiculous" and questioned why Hall would conspire with a competitor, RBH. He also denied that Union Indemnity's records were intentionally misleading.

"It's possible that one or two or three people were sour apples, but that doesn't make Hall guilty of anything," Mr. King said.

Mr. Birnberg, Mr. Smith, Mr. Maloney and officials of Keough-Kirby could not be reached. ■

E-Ferol dispute

Continued from page 33

attempt to recover indemnity payments after they have been made alleging that the policyholder's intentional acts voided the insurance contract.

"The defense of an intentional act is not being actively asserted at this time," Mr. Lane also said.

Revco's Mr. Staph said that no insurer has raised any issues to deny coverage on the basis of an intentional act.

Ohio's guaranty fund has paid all Transit-related claims in the case and are now discussing Midland-related claims with Revco, Mr. Lane said, declining to comment on details of the agreement.

Earlier this year, the Ohio guaranty fund demanded that Arizona's guaranty fund participate in settling some claims, said Daryl Geller, the Arizona fund's claims administrator. The Arizona fund has hired an attorney to review the matter, he said.

E-Ferol's distributor, O'Neal, Jones, had primary liability insurance underwritten by National Union Fire Insurance Co. of Pittsburgh, Pa. Limits were $1 million per occurrence/$3 million annual aggregate in each of the two policies that spanned 1983 to 1984, according to court papers filed in a coverage dispute.

The Justice Department's investigation into E-Ferol 'is a pretty forceful action by the government showing that they will not countenance illegal action by a drug manufacturer that violates drug laws,' said John Pinney, a partner with the Cincinnati law firm of Graydon, Head & Ritchey.

Insurers in O'Neal, Jones' $150 million umbrella liability program during the two policy years that spanned 1983 to 1984 were led by Highlands Insurance Co. of Houston, which provided $10 million in excess coverage. Hartford Accident & Indemnity Insurance Co. of Hartford, Conn., wrote $5 million excess of $10 million.

Participating in the third layer of $45 million excess of $15 million were: New England Reinsurance Corp. of Boston; Los Angeles-based Landmark Insurance Co.; Prudential Reinsurance Co. of Newark, N.J.; and Midland.

Aetna Casualty & Surety Co. of Hartford, Conn., wrote $15 million excess of $60 million. Other insurers participated in higher layers creating $150 million in limits.

National Union currently is seeking a declaratory judgment in New York Supreme Court of New York County on how to interpret coverage, naming O'Neal, Jones as well as its excess insurers.

The central issue is the number of occurrences, which National Union says is one. National Union also contends that defense costs are included in policy limits.

Insurers participating in the $45 million excess of $15 million layer contend that E-Ferol claims, if covered, constitute separate occurrences in each of two policy periods so that underlying aggregates should be triggered in each of two policy years, said Michael Gorelick, an attorney with Abrams & Martin in New York, which represents excess insurer Landmark.

The premature infants' deaths and injuries related to E-Ferol prompted the U.S. Food and Drug Administration to further define requirements for marketing a drug that has not specifically been given new drug approval. Drugs identical to those previously approved could be marketed only if they are equivalent "in directions, patient group, administration, purpose and dosage," according to an FDA spokeswoman.

E-Ferol was one of more than 5,000 drugs that were allowed to be distributed for use before clearing the FDA's usual drug testing procedures because of an FDA policy that allowed the sale of drugs that were similar to drugs marketed before 1962.

However, the Justice Department contends that E—Ferol was a new drug and, therefore, could not be distributed without receiving specific FDA approval.

In addition, the FDA established regulations requiring that adverse reactions must be reported for such identical drugs that had not yet been specifically approved. ■

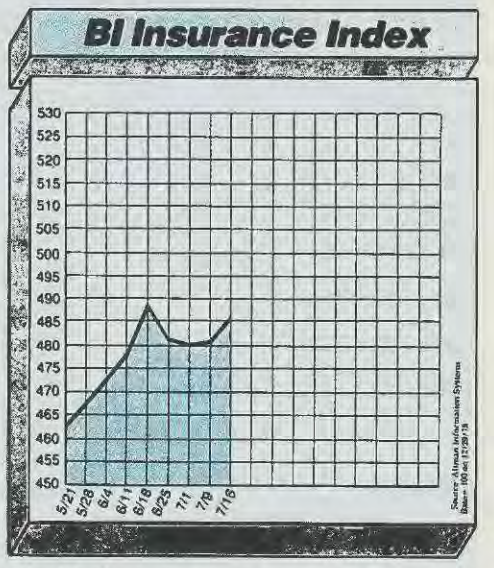
BI Industry Stock Report

July 16, 1987 — 7/10/87 thru 7/16/87

Brokers		Price	% Chg.	P/E	$ Div.	% Yld.	High	Low	Vol.(000)
Alexander & Alexander Svcs	NYSE	25.63	-1.4	30.5	1.00	3.9	25.88	25.50	895.7
Baldwin & Lyons Inc	OTC	20.00	0.0	8.4	0.20	1.0	21.50	20.00	0.6
Corroon & Black Corp	NYSE	31.38	3.3	14.6	0.84	2.7	31.38	30.25	250.9
Gallagher Arthur J & Co	OTC	20.25	1.2	15.6	0.40	2.0	20.25	19.75	108.0
Hall Frank B & Co Inc	NYSE	12.63	-6.5	0.0	0.00	0.0	13.25	12.50	296.4
Marsh & Mclennan Cos Inc	NYSE	62.00	0.2	16.9	2.40	3.9	63.50	62.00	743.6
Poe & Assoc Inc	OTC	12.25	0.0	15.5	0.40	3.3	12.25	12.25	20.0
AGENTS/BROKERS	AVERAGE			15.4		3.1			
Conglomerates & Holding Cos.									
Berkley W R Corp	OTC	24.75	0.0	8.4	0.28	1.1	25.00	24.50	556.2
Berkshire Hathaway Inc Del	OTC	3610.00	3.1	119.9	0.00	0.0	3610.00*	3470.00	1.1
CIGNA Corp	NYSE	64.50	-0.4	9.2	2.80	4.3	65.25	64.50	1,342.5
CNA Finl Corp (CNA)	NYSE	51.75	-0.7	11.8	0.00	0.0	52.50	51.75	259.3
General Re Corp	NYSE	51.50	0.0	15.8	1.00	1.9	52.00	50.88	2,311.2
ITT (Hartford Group)	NYSE	61.88	3.1	15.9	1.00	1.6	62.00	59.88	3,735.7
Sears Roebuck & Co. (Allstate)	NYSE	51.13	2.0	13.3	2.00	3.9	51.38	50.25	3,401.2
Transamerica Corp (Occidental)	NYSE	41.50	-2.1	9.3	1.76	4.2	44.00*	40.50	2,699.8
CONGLOMERATES/HOLDING COS.	AVERAGE			66.1		0.2			
Insurers									
Acceptance Ins Hldgs Inc	OTC	12.50	13.6	6.9	0.00	0.0	12.50*	11.25	42.7
Aetna Life & Cas Co	NYSE	59.63	0.6	9.1	2.76	4.6	59.75	58.63	3,001.6
American General Corp	NYSE	40.00	-0.3	10.7	1.25	3.1	40.25	39.63	1,094.9
Amern Heritage Life Invt Co	NYSE	32.00	-0.8	16.2	0.96	3.0	32.06	32.00	31.0
American Indty Finl Corp	OTC	15.25	-1.6	0.0	1.12	7.3	15.25	14.75	22.4
American Intl Group Inc	NYSE	68.88	-1.1	15.2	0.25	0.4	69.38	68.50	1,208.5
Aneco Reins Ltd	OTC	2.25	-14.3	0.0	0.00	0.0	2.63	2.25	62.3
Avemco Corp	NYSE	24.00	3.2	17.4	0.28	1.2	24.25	22.63	89.4
Business Mens Assurn Co Amer	OTC	44.75	11.2	0.0	1.10	2.5	44.75*	41.00	408.4
Chubb Corp	NYSE	61.75	0.0	9.8	1.68	2.7	62.13	61.63	496.0
Aon Corp	NYSE	27.50	2.3	9.8	1.20	4.4	27.50*	26.25	499.1
Continental Corp	NYSE	45.88	2.8	10.4	2.60	5.7	46.13	44.63	856.2
Crown Life Ins Co	OTC	270.00	0.0	9.3	6.40	2.4	270.00	270.00	1.0
Durham Corp	OTC	33.25	0.4	19.6	0.92	2.8	33.25	33.25	6.3
Farmers Group Inc	OTC	43.50	3.6	13.7	1.20	2.8	43.50	42.00	620.2
Fairmont Finl Inc	AMEX	17.63	0.0	9.9	0.00	0.0	0.00	0.00	0.0
Fireman Fd Corp	NYSE	35.75	-0.7	12.3	0.40	1.1	36.50	35.75	556.9
Fremont Gen Corp	OTC	16.13	3.2	0.0	0.60	3.7	16.13	15.25	262.9
Great West Life Assurn Co	OTC	700.00	0.0	14.4	18.00	2.6	0.00	0.00	0.0
Home Group Inc	AMEX	19.13	0.0	4.9	0.20	1.0	19.13	18.88	479.5
Hanover Ins Co	OTC	34.50	0.0	8.3	0.36	1.0	34.75	33.75	58.7
Harleysville Group Inc	OTC	16.63	2.3	5.2	0.40	2.4	16.63	16.25	27.4
Hartford Steam Boiler Insptn	OTC	30.00	-3.2	13.0	1.00	3.3	30.75	30.00	73.4
Kans City Life Ins	OTC	30.50	6.1	11.7	0.96	3.1	30.50	29.00	56.8
Kemper Corp	OTC	32.13	2.8	11.1	0.60	1.9	32.13	31.00	1,353.6
Liberty Corp S C	NYSE	41.75	5.7	15.0	0.72	1.7	41.75	39.25	30.3
Lincoln Natl Corp Ind	NYSE	50.75	1.8	10.7	2.16	4.3	50.75	49.75	219.7
Mission Ins Group Inc	PAC	1.63	0.0	0.0	0.00	0.0	4.38	0.69	5.6
Monumental Corp	OTC	55.63	0.0	18.8	0.00	0.0	55.63	55.63	1.1
Nac Re Corp	OTC	25.00	2.0	32.9	0.00	0.0	25.00	24.50	33.6
Nobel Ins Ltd	OTC	13.00	2.0	9.8	0.37	2.8	13.00	12.50	25.7
Northwestern Natl Life Ins	OTC	28.00	2.8	8.0	0.96	3.4	28.50	27.38	186.4
Ohio Cas Corp	OTC	43.75	-2.8	12.4	1.68	3.8	45.00	43.75	291.0
Old Rep Intl Corp	OTC	30.25	0.8	10.8	0.80	2.6	30.63	30.25	121.0
Orion Cap Corp	NYSE	23.50	-2.1	0.0	0.76	3.2	23.88	23.25	86.5
Protective Corp	OTC	15.00	4.3	12.2	0.70	4.7	15.13	14.88	209.1
Provident Life & Acc Ins Co	OTC	21.63	4.2	11.9	0.84	3.9	21.63	20.88	241.4
Reliance Group Hldgs Inc	NYSE	10.00	-2.4	11.1	0.16	1.6	10.25	10.00*	142.9
St Paul Cos Inc	OTC	48.25	3.2	11.2	1.76	3.6	48.50	46.75	647.4
SAFECO Corp	OTC	30.75	3.4	11.4	0.96	3.1	30.75	29.50	1,770.0
Scor U S Corp	OTC	12.25	0.0	14.6	0.00	0.0	12.25	12.00	302.3
Seibels Bruce Group Inc	OTC	15.38	-0.8	96.1	0.80	5.2	15.50	15.25	93.4
Selective Ins Group Inc	OTC	26.00	0.5	10.0	0.92	3.5	26.00	25.88	64.6
Statesman Group Inc	OTC	5.25	6.3	0.0	0.05	1.0	5.25	4.94	160.2
Tokio Marine & Fire Ins Co	OTC	72.00	0.0	80.9	0.19	0.3	72.00	72.00	13.5
Torchmark Corp	NYSE	28.50	0.9	10.2	1.20	4.2	28.50	28.25	853.0
Travelers Corp	NYSE	44.63	-0.3	9.5	2.28	5.1	45.25	44.63	1,787.0
Trenwick Group Inc	OTC	13.00	-5.5	22.0	0.00	0.0	14.00	13.00*	16.8
United Fire & Cas Co	OTC	29.50	-0.8	9.4	0.96	3.3	30.50	29.25	6.9
United States Fid & Gty Co	NYSE	39.88	0.0	9.6	2.48	6.2	40.25	39.88	1,049.8
Unum Corp	NYSE	23.75	-1.0	0.0	0.40	1.7	24.00	23.63	886.8
Uslife Corp	NYSE	38.50	2.3	9.9	1.20	3.1	38.50	37.50	119.1
Washington Natl Corp	NYSE	31.75	-4.5	16.4	1.08	3.4	33.13	31.63	80.8
Zenith Natl Ins Corp	OTC	22.00	2.3	12.7	0.80	3.6	22.50	21.00	200.6
INSURANCE COMPANIES	AVERAGE			12.2		2.7			

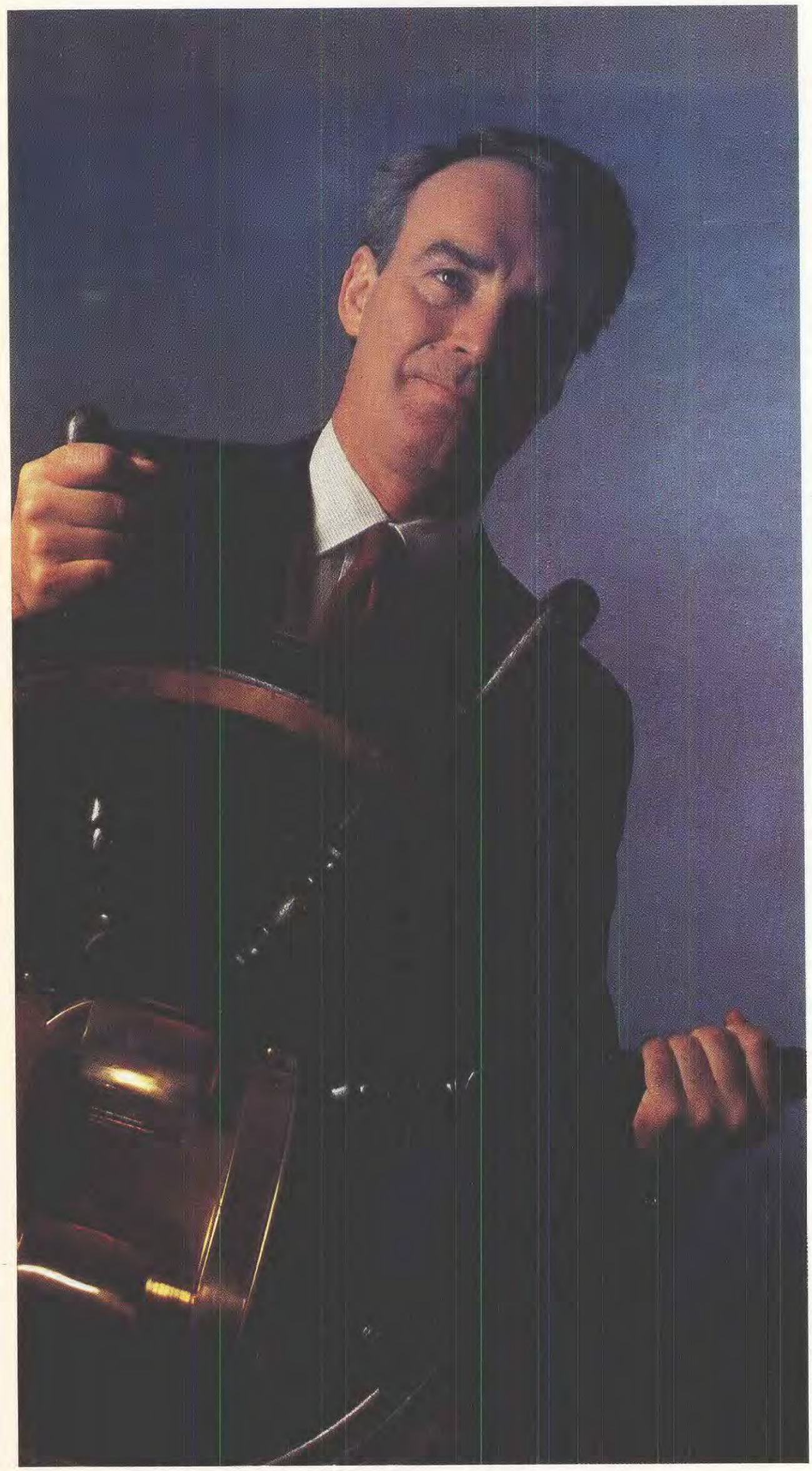
System design: Altman Information Systems

BI Insurance Index



The *Business Insurance* stock index climbed 3.9 points to 485.1 on July 16, up from 481.2 on July 9. A total of 32 stocks posted gains, 18 fell and 14 remain unchanged. Advancing issues were led by: Acceptance Insurance Holdings Inc., up 13.6%; Business Men's Assurance Co. of America, up 11.2%; Statesman Group Inc., up 6.3%; and Kansas City Life Insurance Co., up 6.1%. Declining issues were led by: Aneco Reinsurance Co. Ltd., down 14.3%; Frank B. Hall & Co. Inc., down 6.5%; Trenwick Group Inc., down 5.5%; and Washington National Corp., down 4.5%. The *BI* index climbed 0.8% for the week, trailing other market indicators: The Dow Jones 30 Industrials rose 1.9%, while the NYSE composite rose 1.5% and Standard & Poor's 500 index jumped 1.7%.

Take Charge.



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