JULY 30, 1990

Business Insurance®

Reporting weekly for corporate risk, employee benefit and financial executives / $2.00 a copy; $75 a year

Update

Federal appellate court allows offsets by Reserve's reinsurers

CHICAGO—A federal appeals court has affirmed a lower court order allowing reinsurers of the defunct Reserve Insurance Co. to offset amounts Reserve owed them against amounts they owe the insurer's estate.

In a widely awaited ruling on offsets, a panel of the 7th U.S. Circuit Court of Appeals upheld a 1985 federal court decision that allowed members of a reinsurance pool to offset the roughly $550,000 Reserve owed the pool against

Continued on next page

Proposal would expand COBRA

By JERRY GEISEL

WASHINGTON—Employers would have to extend COBRA health care continuation coverage for up to 15 years—at least five times longer than now required—under a proposal being drafted by a member of the House Ways and Means Committee.

The bill would apply to dependents of former employees who were at least 50 years old when they became COBRA beneficiaries. Those dependents would be able to receive COBRA coverage until they became eligible for Medicare at age 65 or obtained coverage through another employer health plan.

Federal law now requires most employers to extend COBRA coverage for up to three years—regardless of the dependent's age—in the event of the death of an employee or a marital separation or divorce.

And in some selected cases, the bill would require employers to extend coverage for more than 15 years.

While the proposal was drafted by Rep. Barbara Kennelly, D-Conn., it was expected to be introduced either late last week or at least before the August recess this week by Rep. Marcy Kaptur. D-Ohio

As now written, the bill would permit children of a beneficiary who was eligible for the expanded COBRA coverage to retain the coverage until age 23.

A seven-year-old son of a woman who received COBRA coverage at age 50, therefore, could keep COBRA coverage for up to 16 years.

Congressional staffers say the proposal reflects Rep. Kennelly's long-standing interest in trying to reduce gaps in benefit coverage that are especially harmful to women.

Rep. Kennelly was one of the key backers of the Retirement Equity Act, a 1984 federal law that liberalized participation and eligibility rules in the Employee Retirement Income Security Act of 1974 to make it easier for younger women to earn a pension benefit.

A congressional staffer noted that the COBRA proposal is intended to help particularly older women who now have the most problems obtaining affordable health care coverage when their COBRA benefits run out.

"These are often low-income people in dire economic straits who are least likely to be able to afford private coverage," the staffer said.

In addition, private health care coverage may not be available at any price for older women who have pre-existing medical conditions, the staffer said.

Business lobbyists, though, are outraged. While they say they are

Continued on page 22

Claims-reported clause affirmed

By JOANNE WOJCIK

LOS ANGELES—A recent California appellate court decision enforcing the terms of a claims-made and reported professional liability policy brings the state more closely in line with other jurisdictions, attorneys say.

In a defeat for policyholders, the California Court of Appeal for the 2nd District ruled that Pacific Employers Insurance Co. of Los Angeles can deny coverage under a claims-made and reported errors and omissions liability policy for a claim that was made during the policy period but reported only after the policy expired.

"The law around the country is consistent with this ruling," said Pacific Employers attorney Bradley W. Jacks of Bronson, Bronson & McKinnon in Los Angeles.

The July 2 decision represents the mainstream interpretation of claims-made and reported coverage, agreed Tom Brunner, an insurer attorney with Wiley, Rein & Fielding in Washington, D.C.

With this ruling, the court "has validated the claims-made and reported form," said R. Gaylord Smith, an insurer attorney with Lewis, D'Amato, Brisbois & Bisgaard in San Diego.

Policyholder attorneys criticized the Pacific Employers ruling as too severe.

"Denying coverage because somebody is late is draconian. The penalty far outweighs the breach," said Eugene Anderson of Anderson, Kill, Olick & Oshinsky in New York.

The decision is especially significant because three earlier California appellate rulings—none of which is still on the books—effectively had transformed claims-made policies into occurrence policies by allowing the policyholder to report claims after the end of the policy period.

This ruling also marks the first time a state appeals court refused to require an insurer to show prejudice to deny coverage when notice of a claim was given late.

Under a long-standing California case law principle known as the notice-prejudice rule, insurers have been prohibited from denying coverage because of late notice unless they can prove the late notice inhibited their ability to defend against the claim.

Two state appeals courts previously declined to enforce claims-made and reported policies.

In *Brown-Spaulding & Associates Inc. vs. International Surplus Lines Insurance Co.*, the court found that the restrictive nature of claims-made and reported policies

Continued on page 4

Retiree health plan changes

Twenty-three percent of companies planning to change their retiree health care plans in 1990 intend to limit benefits to a fixed-dollar amount, compared with only 1% that said they would take this approach a year ago.

Increase contribution requirements: 68%
Require higher deductibles: 33%
Decrease benefits: 25%
Implement fixed-dollar benefits: 23%
Offer flexible benefits: 8%
Increase benefits: 6%
Terminate plan: 5%
Other steps: 20%

Source: A. Foster Higgins

BI/CYNTHIA WATSON

Employers target retiree health costs

Seek to limit contributions

By JERRY GEISEL

NEW YORK—Employer interest is surging in controlling retiree health care costs and liabilities by limiting company contributions to retiree plans.

Twenty-three percent of employers that plan to change their retiree medical programs this year intend to adopt new defined contribution plans that will set fixed-dollar limits for company contributions, according to a new survey by New York-based consultant A. Foster Higgins & Co. Inc.

That figure marks a dramatic change from the last two years: Between 1988 and 1989, just 1% of employers that changed their retiree medical plans adopted a defined contribution-type program, according to the "Retiree Health Care Benefits Survey—1989."

Foster Higgins says the proposed Financial Accounting Standards Board rules requiring employers to recognize their retiree health care costs and liabilities on their financial statements are a major reason employers are considering new ways of better controlling costs.

Employers also are boosting deductibles and requiring retirees to contribute more toward premiums, the survey of 1,100 employers found.

But few companies are terminating retiree health care plans, whose

Continued on page 11

Walbrook may seek to commute liabilities

By STACY SHAPIRO

LONDON—Commuting the liabilities of Walbrook Insurance Co. Ltd. could result in full payment of claims to Walbrook policyholders, while tapping the British guaranty fund could result in up to 90% payment of each policyholder claim against six insolvent affiliated insurers owned by London United Investments P.L.C.

Walbrook, which continues to pay claims against it in full, stopped underwriting in March, when the other six LUI insurers ceased paying claims (*BI*, April 2).

Collectively, the seven insurers could owe as much as 2 billion pounds ($3.6 billion) over a 25-year period or mainly long-tail U.S. liability insurance contracts, according to the court-appointed administrators of LUI.

The insurers' total assets to pay these claims are not yet known, though reinsurance recoveries are expected to total 1 billion pounds to 1.25 billion pounds ($1.8 billion to $2.3 billion).

All the LUI insurance companies participated at one time or another on a line slip written by LUI subsidiary H.S. Weavers (Underwriting) Agencies Ltd.,

Continued on page 29

NEWSPAPER

California sues 4 companies under toxic notification law
Page 14

Rhode Island employers hail work comp reform law
Page 3

National Union to appeal $49 million bad-faith award
Page 2

Update

Court OKs Reserve offset

Continued from previous page
about $750,000 the pool owed Reserve's liquidator (*BI*, Nov. 6, 1989).

Under a complex application of the offset principle, the reinsurers were ordered to pay the liquidator a net total of $201,677.

The appeals panel also affirmed the lower court's rejection of a claim by the liquidator for unearned premiums allegedly due the Reserve estate because of the pool manager's "wrongful" cancellation of Reserve policies on the eve of the insurer's insolvency. The liquidator claimed that the transfer of these unearned premiums to other members of the pool constituted a "voidable preference" under rules governing the liquidation.

Reserve's liquidator will not appeal the 7th Circuit ruling, said Daniel Guberman, deputy chief general counsel with the Illinois Insurance Department's Office of the Special Deputy, which is overseeing Reserve's liquidation.

The ruling is the second such loss for liquidators: A California Court of Appeals panel last year similarly allowed offsets to reinsurers of the insolvent Mission Insurance Group (*BI*, Jan. 8).

The liquidator of Mission has appealed the decision to the California Supreme Court.

Tobacco firms lose label ruling

TRENTON, N.J.—Health warnings on cigarette packages do not protect tobacco companies from personal injury suits charging them with failure to warn consumers and misrepresentation, the New Jersey Supreme Court has ruled.

This ruling runs counter to five federal appeals court rulings and one state supreme court ruling since 1966, when federal law required warning labels on cigarettes, said Brown & Williamson Tobacco Co. attorney Jay Cohen, with Paul, Weiss, Rifkind, Wharton & Garrison in New York.

The New Jersey ruling stems from a suit by Claire Dewey, who claimed her husband died in 1980 of lung cancer caused by smoking cigarettes made by Brown & Williamson, R.J. Reynolds Tobacco Co., R.J. Reynolds Industries Inc. and American Brands Inc.

The decision supports the "risk-utility" test for design defects, which would hold manufacturers liable for damages arising from the use of a product that presents more risks than benefits, said plaintiffs' attorney Marc Z. Edell, with Budd, Larner, Gross, Rosenbaum, Greenberg & Sade in Short Hills, N.J.

In a separate case, the Massachusetts Supreme Judicial Court in Boston allowed the plaintiffs to name as a defendant Store 24 Inc., a Waltham, Mass.-based convenience store that they charge illegally sold cigarettes to minors, who allegedly now are unable to quit smoking.

No other courts are known to have allowed retailers to be named in tobacco liability suits, said Brad Krevor, executive director of Group Against Smoking Pollution in Boston.

Lilly sued over anti-depressant

RIVERHEAD, N.Y.—Four personal injury lawsuits filed against Eli Lilly & Co. seeking a total of $250 million in punitive damages as well as compensatory damages charge that the company's widely publicized anti-depressant drug Prozac triggers suicidal thinking.

Three suits seeking a total of $150 million in punitive damages plus unspecified compensatory damages were filed last week in state court in Louisville by the widows of three employees of Louisville-based Standard Gravure Corp. shot to death in 1989 by a company employee.

An autopsy of the gunman, Joseph T. Wesbecker, who also killed four others and injured 13 before killing himself, revealed therapeutic levels of Prozac in his system, said plaintiffs' attorney B. Hume Morris, a partner of Morris, Hawkins & Dutton in Louisville.

But a Lilly spokesman said reports noted that Mr. Wesbecker had "a lengthy history" of suicide attempts and homicidal tendencies before taking Prozac, which Lilly began marketing in 1988.

In a suit seeking $50 million in compensatory damages and $100 million in punitive damages that was filed earlier this month in New York State Supreme Court in Riverhead, Rhonda L. Hala charges that the Indianapolis-based pharmaceutical company failed to adequately test the drug and negligently claimed it was safe. Ms. Hala has attempted suicide several times while taking Prozac, her lawyers say.

A Lilly spokeswoman would not comment on the Hala suit.

Lilly representatives would not discuss the company's insurance.

Leonard L. Finz P.C., a New York law firm representing Ms. Hala, estimated Lilly's gross sales from Prozac, the company's sales leader, will exceed $500 million this year.

Updates continue on page 30

Errors and omissions

• Andrew F. Giffin previously was chief counsel in the Pennsylvania Insurance Department and first deputy commissioner in Massachusetts. His former positions were misstated in the July 9 issue.

• Due to a compilation error by the National Conference of Insurance Guaranty Funds, a chart in the July 16 issue outlining the most costly insurance company insolvencies overstated guaranty fund assessments resulting from the 1988 collapse of Consumers Indemnity Co. Assessments to date have totaled about $4 million.

• J. Patrick Gallagher has been named president and chief operating officer of Arthur J. Gallagher & Co. A story in the July 23 issue incorrectly stated Mr. Gallagher's new title. Chairman Robert E. Gallagher remains the brokerage's chief executive officer.

• The chart of most popular risk management information systems in the July 23 issue failed to include two products, GAB Business Services Inc.'s Claims Management Reporting system and ESIS Inc.'s CRIS-CIGNA Risk Information Services system. A revised chart appears on page 30.

• A story in the July 23 issue incorrectly referred to an Upjohn Co. waste site in Mountainview, Calif. The site is in Puerto Rico.

National Union to appeal $49 million bad-faith award

By LOUISE KERTESZ

SANTA CLARA, Calif.—National Union Fire Insurance Co. of Pittsburgh, Pa., will appeal a $49 million bad-faith jury award for—among other things—failing to inform an insolvent policyholder it had insurance covering claims by six investors for their losses.

The American International Group Inc. subsidiary next month also will ask the presiding judge in the case to deny a request the plaintiffs' attorney says she will make to apply the verdict to about 1,200 other investors in Technical Equities Corp., which was an investment and real estate firm.

The plaintiffs' attorney says she will seek an order that, based on the bad-faith ruling in favor of the six investors, National Union pay approximately $107 million in additional damages to the other 1,200 investors to cover their losses and related expenses.

The plaintiffs claim that amount represents losses not covered by settlements with a group of accountants, banks, lawyers and stock brokers that the investors sued over their involvement in the collapse of Technical Equities.

The more than 1,200 investors in Technical Equities stock, real estate partnerships and short-term notes lost about $150 million because of fraudulent activities by Technical Equities executives that led to the firm's collapse. Several of the executives have been convicted on criminal fraud charges in connection with the firm's demise, including former Chairman Harry Stern.

Although the same judge ruled in underlying litigation that an unspecified portion of the investors' losses are covered by Technical Equities' directors and officers liability and comprehensive general liability insurance, the bankruptcy court overseeing the Technical Equities case has not determined how much of the coverage is available to respond to investors' claims, observed plaintiffs' attorney Marie Seth Weiner, who is with Cotchett & Illston of Burlingame, Calif.

To avoid protracted action in bankruptcy court, the investors instead will ask Santa Clara County Superior Court Judge Conrad L.

Continued on page 13

Ex-insurance exec ordered to pay examiner

Defamation award fought

By DOUGLAS McLEOD

PHILADELPHIA—Former insurance executive Louis Mazzella is challenging an arbitration panel's $75,000 defamation award to a state insurance examiner Mr. Mazzella accused of conspiring to destroy his company.

Mr. Mazzella, former owner of the defunct Colonial Assurance Co. of Elkins Park, Pa., sued Robert Savitsky in 1986, charging that the Pennsylvania Insurance Department examiner and others conspired to take over Colonial and force it into liquidation.

After a federal judge dismissed the complaint, Mr. Savitsky sued Mr. Mazzella for allegedly filing a groundless and defamatory lawsuit and last month was awarded $20,000 in actual damages and $55,000 in punitive damages.

Mr. Mazzella has appealed the arbitration panel's decision. Under federal rules governing such arbitrations, the case will be reargued in federal court in Philadelphia as if the arbitration had not taken place, according to Jay M. Starr, Mr. Mazzella's Philadelphia-based attorney.

Attorneys for both sides say they know of no other case in which an examiner has won damages from the owner of a defunct insurance company after being unsuccessfully sued by the owner over regulatory actions arising from an examination.

"I've never seen such a case, and I've been handling cases for 25 years," said Malcolm H. Waldron Jr., Mr. Savitsky's attorney in Philadelphia.

Some industry observers favor expanding examiners' legal rights in such cases.

State laws—including Pennsylvania statutes—generally grant examiners immunity from suit except in cases of illegal acts or willful misconduct by the examiner, notes Albert B. Lewis, a partner with the New York law firm of Bower &

Continued on page 17

Former Transit MGA calls receiver's allegations unfair

By DOUGLAS McLEOD

CHICAGO—Former Transit Casualty Co. managing general agent Richard E. Foss says Transit's receiver is unfairly blaming him for the insurer's spectacular demise.

In congressional testimony earlier this year, Transit Special Deputy Receiver J. Burleigh Arnold blasted National Underwriting Agency Inc., an MGA headed by Mr. Foss, for allegedly binding Transit as a fronting insurer on huge amounts of loss-plagued liability business with little regard for Transit's profitability (*BI*, March 19).

Mr. Foss declined to respond to the charges at the time, but he has since circulated to brokers a rebuttal to Mr. Arnold's testimony in which he complains that NUA has been unjustly singled out.

"As often happens when events turn sour, a scapegoat is sought to shoulder the blame. In this case, for reasons best known to him, Mr. Arnold has sought to lay the blame (for) the Transit debacle on NUA's doorstep," Mr. Foss says in his statement.

"NUA, however, resents being tarred with this brush, denies any form of malfeasance and strongly reiterates that throughout its relationship with Transit, it conducted its business operations with a high degree of professionalism and integrity," the statement adds.

"I cannot continue my business with a stain on my name," Mr. Foss explained in an interview. "I'm trying to clear my name."

Mr. Foss now heads Geneva Underwriting Management Inc., a syndicate manager on the Illinois

Continued on page 16

Inside

Departments

Vol.24, No.31—*Business Insurance* (ISSN 0007-6864) is published weekly by Crain Communications Inc, 740 N. Rush St., Chicago, Ill. 60611-2590. Second-class postage is paid at Chicago, Ill., and at additional mailing offices. Postmaster: Send address changes to *Business Insurance*, Circulation Department, 965 E. Jefferson Ave., Detroit, Mich. 48207; 800-992-9970 or 313-446-1611.

Risk Manager of the Year judges

10 to assess nominees

CHICAGO—Ten judges, representing a broad spectrum of risk management and insurance industry experts, will select the 1991 *Business Insurance* Risk Manager of the Year and Risk Management Honor Roll.

Business Insurance's annual recognition of excellence in risk management is based on the 10 judges' assessments of the risk managers' accomplishments as detailed in nominating statements. The candidate receiving the highest collective score will be named the 1991 Risk Manager of the Year.

As many as five other risk managers can be named to the 1991 Risk Management Honor Roll, at the judges' discretion.

Nominating forms are now available from the Chicago editorial office of *Business Insurance*.

The 10 judges include the 1990 Risk Manager of the Year, three members of the 1990 Risk Management Honor Roll, two insurance company executives, two brokerage executives, a risk management consultant and an insurance professor.

Judging the nominations for the 14th annual *Business Insurance* risk management awards will be:

- Ronald E. Compton, president and director of Aetna Life & Casualty Co. in Hartford, Conn. Mr. Compton is serving on the panel for a second year, representing a stock insurance company.
- John F. Doetzer, president of Consolidated Insurance Center Inc. in Baltimore. This is Mr. Doetzer's second year as a judge, representing a regional broker.

Continued on page 12

Mr. Compton
Aetna Life & Casualty Co.

Mr. Doetzer
Consolidated Insurance Center

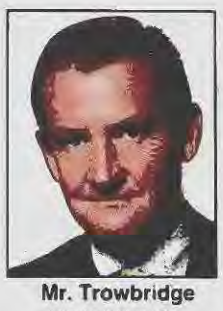
Mr. Gaunt
Georgia State University

Mr. Kloman
Tillinghast

Mr. Quern
Rollins Burdick Hunter Co.

Ms. Johnson
UMMSS

Mr. Oaks
Tennessee Farmers Co-op



Mr. Trowbridge
Atlantic Mutual Cos.

Mr. Wilder
The Wall Disney Co.

Mr. Zuckerman
Thomas Jefferson University

Rhode Island employers hail comp reform

By JUDY GREENWALD

PROVIDENCE, R.I.—Rhode Island business leaders say a comprehensive package of workers compensation bills signed into law earlier this month will cut employers' costs while simultaneously reforming a troubled system.

But insurance trade groups say the package, which begins to take effect Sept. 1, is likely to increase workers comp costs, not reduce them.

Meanwhile, a provision in the legislation will postpone an Aug. 22 hearing on an 86.2% average workers comp insurance rate hike proposed by the National Council on Compensation Insurance. No new date has been set.

Two-thirds of the $217 million in workers comp premiums generated last year in Rhode Island are now underwritten in the assigned risk pool. In addition, 90% of the state's employers now purchase work comp coverage in the residual market.

The problems in the Rhode Island workers comp market are attributable to grossly inadequate rates and difficulties employers and insurers encounter in having injured workers return to work after they recover, explained Peter Burton, director of government, consumer and industry affairs for the NCCI's New England region, based in Windsor, Conn.

The workers comp package was signed into law by Gov. Edward DiPrete July 11 after it was unanimously approved by the state Assembly and was passed by the Senate by a 46-1 vote.

The compromise bill was hammered out between labor and business groups, both of whom supported the legislation. Efforts leading to the passage of the package included a march of business leaders

Continued on page 27

Souter's nomination may aid risk managers

By JERRY GEISEL

WASHINGTON—Legal and insurance experts are hoping that conservative U.S. Supreme Court nominee David H. Souter could support decisions beneficial to risk management.

But, observers still are scouring decisions rendered by Mr. Souter, 50, who was an associate justice on the New Hampshire Supreme Court from 1983 until his appointment to the 1st U.S. Circuit Court of Appeals in April.

Previously, Mr. Souter was an associate justice for the Superior Court of New Hampshire from 1978 to 1983. He was the state's attorney general from 1976 to 1978.

As a conservative jurist, Mr. Souter might be inclined to limit defendants' liability in tort cases, said Peter Lefkin, an assistant vp of Fireman's Fund Insurance Co. in Washington, D.C.

"One of the problems we have had is liberal activist judges who have expanded the doctrines of tort liability far beyond anything that was contemplated in the past. Someone as conservative as this judge would not be out there trying to expand doctrines of liability," Mr. Lefkin said.

AP/Wide World Photos

David Souter

Victor Schwartz, a partner with the Washington, D.C., law firm of Crowell & Moring and author of a widely used text on tort law, said Mr. Souter probably often ruled on common law cases involving product liability, medical malpractice and punitive damages as a New Hampshire Supreme Court justice.

"Judge Souter will bring a lot of experience to the court in these areas," he said. "He will know a lot about punitive damages, and that could be helpful."

But, being a conservative jurist could pull Mr. Souter in two directions on, for example, whether high punitive damage awards are unconstitutional, legal experts say.

Mr. Schwartz said that Mr. Souter, as a conservative, would be less likely to be a judicial activist and therefore may not be inclined to change the current system of punitive damages.

But, if Mr. Souter concludes that high court intervention is appropriate, he might be inclined to support limits on those awards, Mr. Schwartz said.

Mr. Souter was nominated to replace Justice William Brennan Jr. One of Justice Brennan's best known majority opinions was in *New York Times vs. Sullivan*, a 1964 case limiting the liability of the media. In that case, the justices ruled a public figure had to prove actual malice to win a libel judgment. ■

BASF insurance adequate to cover Ohio plant blast

By ADRIENNE C. LOCKE and CAROLYN ALDRED

CINCINNATI—BASF Corp. has adequate insurance to cover $25 million in property and business interruption losses resulting from an explosion that heavily damaged its Cincinnati chemical manufacturing plant.

BASF also has workers compensation coverage from Ohio's monopolistic state fund to fully cover workers compensation claims by the 71 workers injured and the family of one worker killed in the July 19 blast.

The blast occurred while workers at the plant—which produces coatings for metal containers, including food cans—were using solvents that produce flammable vapors to clean a reactor that produces resins, according to the Cincinnati fire department.

An Occupational Safety and Health Administration official said the agency is investigating other potential causes.

"From the damage that I saw, I'd say 80% of the complex suffered heavy structural damage or was destroyed," said Cincinnati Fire Division Chief William A. Miller.

The production plant and some administrative buildings in the complex were destroyed, said a spokesman for West German chemical conglomerate BASF AG of Ludwigshafen, West Germany, the parent company of Parsippany, N.J.-based BASF Corp.

The company has not decided whether to rebuild the plant, he said.

Other U.S. and European BASF facilities can fill existing orders, thus limiting business interruption losses, the spokesman said.

BASF's U.S. property and business interruption insurance is led jointly by Hartford, Conn.-based Industrial Risk Insurers and Gerling-Konzern Insurance A.G. of Cologne, West Germany, both of which have a 25% share, said Dietmar Nowak, a member of Gerling's board.

Other U.S. insurers fill out of the coverage, he said.

IRI and Gerling estimate property and business interruption losses from the explosion will total about $25 million.

Mr. Nowak and a BASF AG spokesman could not say how much of the loss represented property loss compared with business interruption losses.

A spokesman for IRI would not comment.

Continued on page 30

A huge fireball exploded over the BASF chemical plant in Cincinnati on July 19. One worker was killed and 71 were injured.

Claims-made

Continued from page 1

violates public policy (*BI*, Jan. 16,1989).

And, in *Village Escrow Co. vs. National Union Insurance Co. of Pittsburgh, Pa.*, another court held that an insurer cannot deny coverage under a claims-made policy unless the insurer can show late notice prejudiced its ability to defend (*BI*, July 25, 1988).

The Brown-Spaulding and Village Escrow rulings have been decertified by the California Supreme Court, making them ineffective as precedents.

In addition, a July 1987 ruling by the 9th U.S. Circuit Court of Appeals in San Francisco in another case involving National Union stated that California policyholders are not bound by claims-made policy provisions requiring them to notify the insurer of a claim within the policy period unless the insurers' interest would be impaired.

But the court later vacated the ruling after National Union and other insurers settled the dispute (*BI*, Oct. 19, 1987; Aug. 31, 1987).

Policyholder attorneys say the Pacific Employers ruling is surprising because it runs contrary to the California appellate court's traditional liberal, pro-policyholder interpretation of insurance policies.

"The Brown-Spaulding and Village Escrow decisions were more consistent with California case law," said Mr. Anderson.

"The notice-prejudice rule should apply across the board," agreed Village Escrow attorney Terence McGaughey of Tremaine, Shank, Stroud & Robbins in Los Angeles.

In its ruling on Pacific Employers, a CIGNA Corp. unit, the appellate court did not apply the so-called notice-prejudice rule, saying the rule was inappropriate in the context of a claims-made insurance policy.

It is unclear whether the decision will be appealed. The attorney for the policyholder did not return phone calls.

However, it is unlikely the California Supreme Court would reverse the ruling on appeal, said Mr. Smith, who represented National Union in the Village Escrow case.

Because the Supreme Court decertified the two earlier pro-policyholder decisions and asked the appellate court to rule on this issue, the "court is sending a message that this is a result of which it approves," he said.

'The notice-prejudice rule should apply across the board,' says attorney Terence McGaughey.

"The majority of jurisdictions recognize that the notice-prejudice rule has no logical application to claims-made policies," noted Royal Oakes, an insurer attorney with Barger & Wolen in Los Angeles.

"Any other result would emasculate the whole idea of a claims-made policy, which is to provide low-cost insurance based on an insurer's confidence that claims won't filter in after a policy expires," he added.

The Pacific Employers decision "repudiates some of the odd notions suggested in some of the earlier cases," agreed Mr. Brunner.

"It is a very carefully thought-out opinion that says as restrictive as this (claims-made, claims-reported) policy is, it doesn't violate public policy," said Jeffrey Kurtock, the attorney for ISLIC in the Brown-Spaulding case.

He added that the ruling gives insurers more certainty about the scope of claims-made coverage they've written. Previously, insurers "didn't know if they could close their books" on professional liability policies written in California, said Mr. Kurtock, who is with Lewis, D'Amato, Brisbois & Bisgaard in San Francisco.

More certainty about how their policies will be interpreted by the California courts should increase the availability of E&O insurance in California.

The Pacific Employers case stems from a dispute in which the widow of an insurance agent was denied coverage for claims made against her husband's estate because they were reported to the insurer after the policy expired.

The agent, Richard Rausch, was covered by a $5 million E&O policy underwritten by Pacific Employers from May 15, 1981, to May 15, 1983. After Mr. Rausch died on Nov. 5, 1982, nine former clients sued his estate for alleged fraud, seeking a total of more than $700,000.

Mrs. Rausch tendered the Pacific Employers policy to Kenneth A. Krekorian of Newman, Aaronson, Krekorian & Vanaman, the attorney handling the estate.

Mr. Krekorian, however, failed to notify Pacific Employers about the lawsuits filed by Mr. Rausch's clients within the policy period.

Subsequently, Mrs. Rausch hired another attorney to provide notice to Pacific Employers of the claims. This attorney gave notice on Feb. 14, 1984, more than a year after the policy had expired.

Pacific Employers subsequently denied coverage on the grounds that while the claims by the clients were made during the policy period, they were not reported until after the policy expired.

The Pacific Employers policy required the insurer "to pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of any claim made against the insured and reported to the company during the policy period."

Mrs. Rausch sued Pacific Employers in October 1985, challenging the denial of coverage.

The trial court in October 1989 ruled in favor of Mrs. Rausch, saying that Pacific had to prove "actual prejudice resulting from receipt of notice of otherwise covered claims beyond the termination of the insurance policy issued."

However, the appellate court reversed the trial court, ruling Pacific did not have to prove prejudice to deny a claim due to late notice. "The effect of applying the 'notice-prejudice rule'. . .would convert (Pacific Employers') claims-made policy into an occurrence policy," the court said. "In the absence of actual prejudice from late reporting, which also defeats coverage under an occurrence policy, all negligence during the policy period would be covered."

The court also said that even though the result of this ruling "is coverage more restrictive than that provided by the basic types of professional liability insurance policies," this was, in fact, the type of coverage that Mr. Rausch had purchased.

The court said claims-made and reported policies do not violate public policy because policyholders can choose to purchase less restrictive occurrence coverage.

Finally, the court concluded that Mrs. Rausch failed to give notice of the clients' claims against her husband's estate "as soon as practicable," which was required by the Pacific Employers policy. The court said that Mrs. Rausch could have given notice to Pacific at the same time that she tendered the policy to the attorney handling her husband's estate.

But because Mrs. Rausch failed to give timely notice, the appellate court ruled that Pacific Employers could deny coverage without having to show prejudice.

•

Pacific Employers Insurance Co. vs. Superior Court of Los Angeles County, California Court of Appeal, 2nd Appellate District, No. B046562.

Effective Claims Management is more than a fist full of dollars

It takes dollars to pay claims, but it also requires smart management to run an effective Claims Division.

RELIANCE NATIONAL'S professional Claims Division is built on integrity and prudent claims management. Our specialists have years of experience in claims assessments. We follow a special brand of quality in achieving our goals; minimizing allocated expenses and obtaining advantageous settlements.

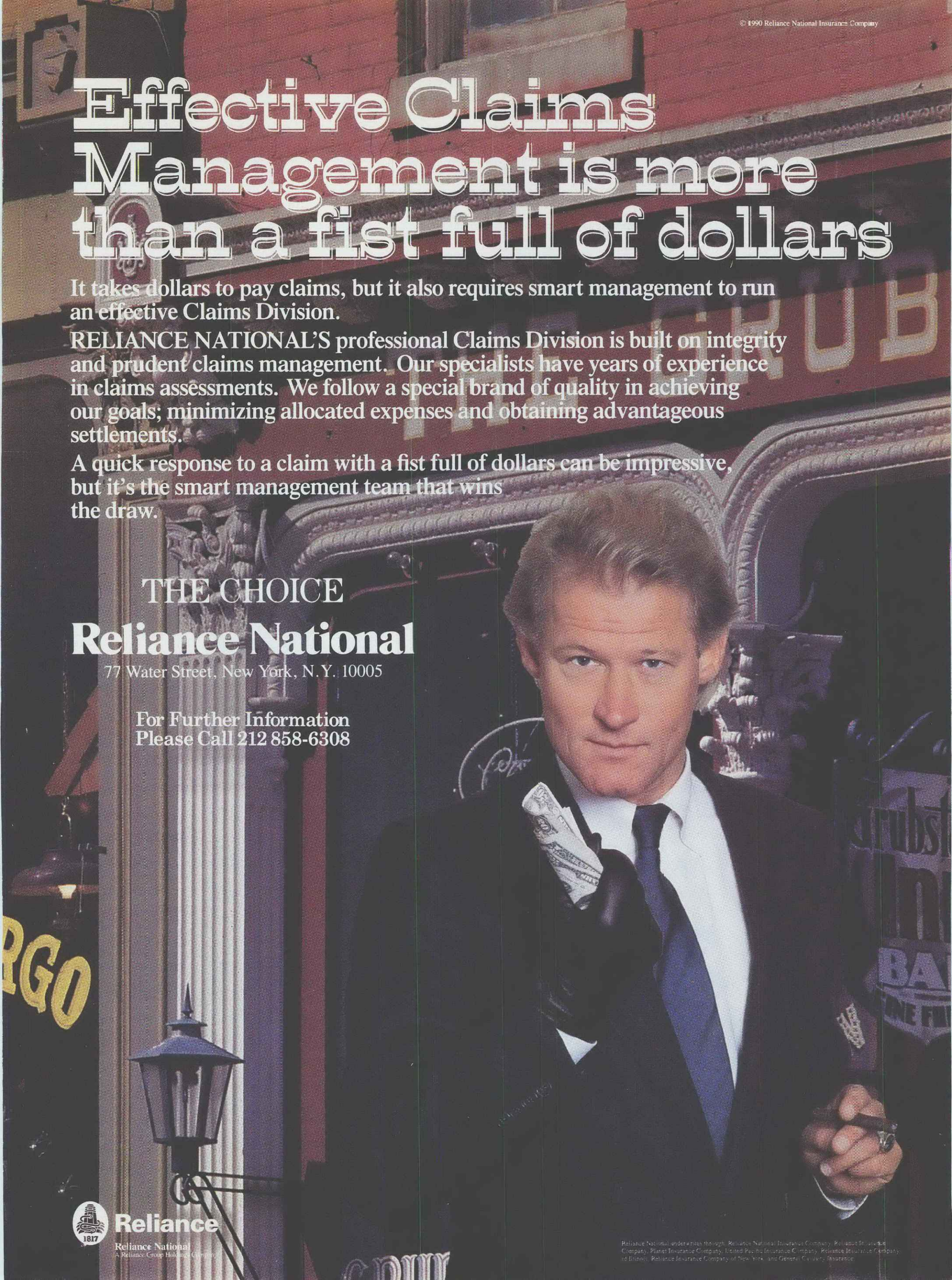
A quick response to a claim with a fist full of dollars can be impressive, but it's the smart management team that wins the draw.

THE CHOICE

Reliance National

77 Water Street, New York, N.Y. 10005

For Further Information
Please Call 212 858-6308



Reliance

1817

Reliance National
A Reliance Group Holdings Company

Retired NBA players score more benefits

Benefit beat

Retired members of the National Basketball Players Assn. will receive an annual cash benefit to obtain medical care coverage until age 50 under a new agreement with the National Basketball Assn.

NBA retirees also will receive an additional cash benefit under the plan.

The benefits will be paid by an annuity fund financed by an 8% carveout of the revenues the league sets aside annually to pay players' salaries. The cash benefits end at age 50, when retirees are eligible for benefits under the NBA defined contribution pension plan.

Under an amendment reached July 23 to the collective bargaining agreement between the league and the players association, a retired player who is at least 30 years old will receive the cash benefits one year after retirement. Younger retirees must wait until age 30.

Under the plan, NBA retirees will receive a $4,000 annual cash benefit designed to help pay premiums for personal health insurance policies as well as cover deductibles and copayments, explained Charles Grantham, executive director of the NBPA.

Retirees who do not use all of the $4,000 may deposit the remaining amount in an interest-bearing account established by the NBA, Mr. Grantham said. The left-over amount and accumulated interest will be available to the retiree the following year in addition to the $4,000 cash benefit.

Any left-over funds in a retiree's account when he reaches age 50 will be distributed in a lump sum.

Retirees also will receive a separate cash benefit—which will not be tied to retiree health care—under the plan based on a formula that takes into account:

- The number of years he was in the league.
- His age.
- His salary at retirement.
- The amount of revenue the league contributes to the fund.

For example, a player who retires at age 27 after playing four years and is earning $500,000 would receive an annual cash benefit of about $20,000 beginning at age 30, an NBA spokesman said.

To finance the annuity that will pay the medical and cash benefits, all 27 NBA teams must contribute a portion of the revenues they receive from the league to pay players' salaries. The annuity fund will be jointly administered by the league and the players association.

Currently, NBA teams receive 53% of league revenues to pay salaries. Under the new plan, 45% of league revenues will go toward salaries and 8% will be contributed to the annuity fund.

Based on its projections, the league would contribute about $56 million to the annuity fund during the 1990-91 season; $60 million in 1991-92; $63.8 million in 1992-93; and $68 million in 1993-94.

"At a time when NBA gross revenues have increased beyond expectation, this provided a unique opportunity to keep our eyes on the prize—long-term financial security and family medical protection," Mr. Grantham said. "This plan will provide our players with security during the most critical time of their lives: from retirement from the NBA to age 50."

"This is a landmark agreement," said NBA Commissioner David J. Stern.

The agreement is subject to approval by the U.S. District Court in Newark, N.J., which oversees the antitrust agreement between the league and the players.

—By Michael Schachner

Hysterectomy study

Blue Cross & Blue Shield of Illinois is asking hospitals in the state to tighten their guidelines in an effort to reduce the number of hysterectomies after a study found that up to nearly one-third of those operations may be unnecessary.

A study of 5,844 hysterectomies performed on BC/BS of Illinois patients from 1987 to 1989 found that only 10% of them were based on diagnoses of malignancies, said Dr. Arnold L. Widen, vp and medical director for the association.

"What's particularly alarming is the high rate of hysterectomies involving women of childbearing age with no signs of malignancy—30% in our study," he said.

"By no means am I saying all those hysterectomies are unnecessary, but it raises the issue" that many may be, "particularly because it's such a common operation," Dr. Widen said.

After Caesarean sections, hysterectomies—which cost $10,000 on average—are the most common surgery performed today, Dr. Widen said. Eliminating the one-third of all hysterectomies that BC/BS of Illinois considers questionable would save the insurer nearly $16 million annually, he said.

Alternatives—including less complex surgery, medication and hormonal treatments—should be considered before resorting to a hysterectomy, he said. And patients should more often question physicians about their options, he said.

—By Christine Woolsey

Mental health costs

Psychotherapy that targets patients' specific symptoms rather than their entire psychological makeup will lower medical costs, says a Biodyne Institute study on Medicaid recipients in Hawaii.

Biodyne reported a "substantial drop in medical usage costs" by mental health patients after they received about six months of the "targeted" therapy.

But Hawaii health officials question the cost-effectiveness of such treatment.

The four-year, $5.5 million clinical research study, called the Hawaii Medicaid Project, was conducted by San Francisco-based Biodyne, a mental health research firm, and sponsored by the U.S. Health Care Financing Administration.

As part of the study, 437 Medicaid patients received six months of targeted therapy.

Traditional mental health therapy provided by most Medicaid programs attempts to understand a patient's entire psychological profile and provide appropriate treatment for all diagnosed disorders, said Biodyne Chairman and President Nicholas Cummings.

Targeted therapy focuses on the one disorder impairing behavior at that particular time, Dr. Cum-

Continued on next page

Continued from previous page

mings explained.

The study found that medical expenses in the first year following targeted psychological treatment dropped $627 on average, or 18%, for Medicaid patients.

In contrast, the study found that medical costs for about 16,000 Medicaid patients who received other types of mental health therapy increased $115 on average in the year following treatment.

The study also observed that targeted therapy reduced the cost of treating many chronic diseases for 395 Medicaid patients and patients who were federal employees.

Combined, those chronic ailments—such as respiratory disease, diabetes, hypertension and ischemic heart disease—afflict 39% of the U.S. population, Biodyne notes.

Among the patients with chronic diseases who received targeted mental health therapy, medical costs dropped $552 each on average in the year following therapy, the report says.

Costs for patients with chronic health problems who did not receive targeted mental health treatment increased $697 on average the year following their mental health treatment, the report found.

"Therefore, if such a large percentage of the U.S. population suffers from one of these conditions, it is possible to extrapolate that the application of targeted, focussed interventions can have a dramatic effect on the governments' health care costs overall," the report concluded.

However, health officials reject the 177-page study and are asking Biodyne "to revise it," said Conroy Chow, planning officer for the Hawaii Department of Human Services, which administers the Medicaid program in the state.

Mr. Chow said that although targeted mental health therapy may cut medical costs per patient, there are no aggregate savings after paying for the costs of mental therapy and implementing the program.

The state would be spending an estimated $1.4 million to save $275,250, "and that is not cost effective from the state's point of view," Mr. Chow said.

While this data was not included in the original study, Dr. Cummings said in an interview that the aggregate medical cost for the 437 patients receiving the "targeted" therapy was $1.34 million the year before therapy and $978,000 in the year after therapy. Targeted therapy sessions cost the Medicaid program about $195,500, resulting in an approximate aggregate savings of $166,500 to the state.

In a 14-page response to the state's concerns about the study, dated July 16, Biodyne agrees to conduct additional accounting research.

Another stumbling block in incorporating the targeted therapy method into the state Medicaid system would be attracting enough patients to make it cost-effective, Mr. Chow said.

However, Dr. Cummings said this problem could be corrected by mandating targeted mental health therapy.

Dr. Cummings said he has received more positive than negative response to the report.

For example, most primary care physicians are "delighted" with the results because they would prefer to refer "worried sick" patients to a psychologist than to continue to treat them, Dr. Cummings said.

Meanwhile, the Ohio Medicaid program implemented the Ohio Biodyne Mental Health and Substance Abuse Treatment Program on July 1. The program is expected to save the state $1.6 million in medical claims in its first year, Ohio administrative services officials said.

—By Sam Cristy

At issue

Are you happy with your risk management information system?

Charles E. Rizzo
Corporate risk manager
Scripps Howard Inc., Cincinnati, Ohio

We formulated our own in-house RMIS back in 1985. It wasn't really a cost issue; we just wanted to tackle it on our own. It's been upgraded when necessary and in each successive year it's gotten better and better. Most everything we do is on our computer. We've very pleased with it and we think it's on par with other risk management information systems.

Yolanda Romero Moore
Workers compensation administrator
Thomas Jefferson University, Philadelphia

Very much so. We used to have a self-made data system, created by a non-insurance person, which didn't collect sufficient data about loss runs. Now we have real management tools we can work with to help us place our excess insurance, track workers compensation claims and identify trends.

Donald G. Wylin
Risk management coordinator
Harper Grace Hospitals, Detroit

Yes. We're able to do all sorts of loss runs and 'what-if' situations. And it gives us the data we need in a few minutes, not a few days. Any organization that has significant loss concerns has to have an RMIS with finance and loss control functions.

Don Dukate
Risk manager
Circle K Corp., Phoenix

I believe our system is performing as expected and is very cost-effective. We've had an RMIS since 1981. We are upgrading our system to greatly enhance our response time. We now report all claims via an 800 number to our RMIS vendor. This gives us online access to claim reports within minutes, reduces reporting time lag and speeds our loss notices to adjusters.

Compiled by Christine Woolsey

Opinions

COBRA proposal flawed

THE LATEST PROPOSAL to extend COBRA health care coverage to dependents of former employees is well-intentioned but certainly not palatable to employers.

Rep. Marcy Kaptur, D-Ohio, is expected to introduce legislation to require employers to extend coverage to dependents of former employees who were at least 50 years old when they became COBRA beneficiaries. Those dependents would be able to receive the coverage until they became eligible for Medicare at age 65 or obtained coverage through another employer health plan, according to the draft of the legislation (see story, page 1).

Federal law now requires most employers to extend COBRA coverage for up to three years—regardless of the dependent's age—in the event of the employee's death, a marital separation or divorce.

Rep. Barbara Kennelly, D-Conn., who has drafted the proposal, is most concerned about access to health insurance for older women, especially those with an illness.

Her concerns are well-founded. The cost of individual health insurance for an older woman with a health condition is certainly prohibitive. We recently saw a premium hike to $367 from $247 per month for a 55-year-old woman in the Chicago area with a health condition.

Extending the coverage this way also probably would not be terribly expensive for employers collectively since most people who purchase COBRA coverage are former employees and they generally buy coverage for less than 12 months (*BI*, June 4).

However, when considering the cost of this proposal, the cost to a single small employer also must be analyzed. For a smaller employer, providing health insurance to a COBRA beneficiary for 15 years at 102% of the group plan premium could be quite expensive.

Equally important is the public policy issue raised by the proposal. When does an employer's responsibility to a former employee—and in this case, his or her dependents—end? Requiring employers to assume the responsibility for making health care affordable to former employees' dependents for 15 years—and, in some cases, longer—certainly is unreasonable.

While the goal of this proposal is meritorious, the method is not.

This proposal to expand COBRA coverage once again begs the question: What national policy should be adopted to assure that all Americans have access to affordable health care?

Letters

Businesses should determine family leave

To the editor: In the past your publication has generally reflected the position of business in the many editorials you have written opposing government mandates. But you missed the mark in your July 9 opinion piece, "Family Leaves Are Necessary," citing family leave legislation as "rather modest as mandates go."

The issue is not about family/medical leave as a business practice. According to a recent survey by the Illinois State Chamber of Commerce, some 50% of our members offer such a leave and we are supportive of that business decision. But that's the point: It's a business decision to make and should not be imposed upon business by government.

In the same survey we also asked what employers would do if such a mandate became law. The responses included: require employees to pay more for benefits; eliminate or decrease other benefits; and hire fewer employees.

The majority of Illinois Chamber members are small businesses with fewer than 100 employees. And, many of these have fewer than 50 employees. Most of these small employers operate on a zero-to-slim profit margin and they would classify such a mandate as "excessive," rather than modest. They're poised to grow, but weary of all the government paperwork, regulations and mandates already imposed on employers.

The mandate in both the federal legislation, H.R. 770, or in a similar state bill awaiting the governor's signature in Illinois, S.B. 1501, is the type of mandate that will force employers to stay small and to cause others to close up altogether.

Mandated family/medical leave has both direct and hidden costs, including the hiring and training of replacement workers, or the overtime costs involved in filing for those on leave. And, because of the 1988 changes to the Illinois Unemployment Insurance Act, this type of mandate in Illinois is expected to result in unemployment insurance charges once the temporary worker is laid off after the permanent employee returns. The Illinois legislation also allows such leave to be taken on an intermittent basis, which could increase the administrative burden attached to this benefit.

We believe a stand against mandated benefits is one that supports employee benefit choices, collective bargaining, workplace flexibility, manageable unemployment insurance costs, job growth and small employer growth. There are only so many benefit dollars to go around.

The pages of *BI* are filled with stories about flexible benefit programs being created. These programs would be in jeopardy if the government begins to dictate what benefits employers should offer their employers.

Carol Hughes
Director-Workers Compensation
and Unemployment Insurance
Illinois State Chamber of Commerce
Springfield, Ill.

* * *

To the editor: I don't want to be an employer anymore. My husband and I have been running a small business since 1971 and our employees have numbered from three to as many as 135. The more the government interferes in business policy, the less enthusiastic we feel about running a company because we no longer can do what is best in accordance with sound business practices.

We have offered all the benefits from paid leave to health insurance to unpaid leave because it was good policy and the marketplace demanded it. However, each time an employee was granted a leave of absence for maternity purposes, the employee decided not to return to work. In each case we were notified at the end of the leave period when we expected the employee back on the job.

This is why I object to the mandating of job guarantees and the continuation of paid insurance such as that being proposed by some members of Congress. A company, especially a small one, is never guaranteed that a new contract will come in or that the current one will be renewed.

Considering the current economic climate and business downturns in some sectors, this is not the time for Congress to mandate employee benefits. The more they do so, the more individuals like us will back away from starting the small businesses that employ the majority of America today.

Elizabeth A. Pronko
Vp-Administration
PE Systems Inc.
Alexandria, Va.

* * *

To the editor: The July 9 editorial, "Family Leaves Are Necessary," begs for a reply. Your characterization of the family leave bill as "rather modest as mandates go" leads me to wonder if you also believe it is possible to be a "little bit

Continued on page 10

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

Business Insurance®
Reporting weekly for corporate risk, employee benefit and financial executives

Publisher: Alfred Malecki *(New York)*

Associate Publisher/Editor: Kathryn J. McIntyre, A.R.M. *(Chicago)*
Managing Editor: James M. Burcke *(Chicago)*
Senior Editor: Jerry Geisel *(Washington)*
Assistant Managing Editor: Dave Lenckus *(Chicago)*
CHICAGO: Jeanne M. Bartels *(Graphics Editor)*, Karen Brown *(Assistant to the Editor)*, Linda J. Collins *(Agent/Broker Editor)*, Meg Fletcher, A.R.M. *(Associate Editor)*, Sara J. Harty *(Editorial Assistant)*, Mark A. Hofmann *(Associate Editor)*, Colleen Johnson *(Copy Editor)*, Nancy Johnson *(Copy Editor)*, Marilou Jones *(Directory Editor)*, Laura Mazzuca *(Agent/Broker Topics Associate Editor)*, Roger Schillerstrom *(Editorial Cartoonist)*, Deborah Shalowitz *(Associate Editor)*, Timothy Stanton *(Copy Editor)*, Paul Winston *(Copy Desk Chief)*, Christine Woolsey *(Associate Editor)*
DALLAS: Michael Bradford *(Associate Editor)*
LONDON: Stacy Shapiro *(International Editor)*, Carolyn Aldred *(Associate Editor)*
LOS ANGELES: Joanne Wojcik *(Bureau Chief)*, Louise Kertesz *(Associate Editor)*
NEW YORK: Douglas McLeod *(Bureau Chief)*, Stacy Adler *(Associate Editor)*, Judy Greenwald *(Associate Editor)*, Collin Nash *(Editorial Assistant)*, Michael Schachner *(Associate Editor)*
WASHINGTON: Adrienne C. Locke *(Associate Editor)*

Advertising Director: Martin J. Ross *(New York)*
Midwest Sales Manager: Robert L. Niesse *(Chicago)*
CHICAGO: Deborah D. Neale *(District Manager)*, Margaret Hikido *(District Manager/ Classified Sales)*, Elmer Kerstowske *(Production Manager)*
NEW YORK: Charles A. Horvath *(District Manager)*, Jack Forrest *(District Manager)*, Kathryn Premetz *(District Manager)*, Cynthia Bykowski *(District Manager)*
LOS ANGELES: Michael J. Sharpe *(Western Advertising Manager)*

Director of Communications: Ronnie I. Drachman *(New York)*
Promotion Manager: Michele Pierson *(New York)*

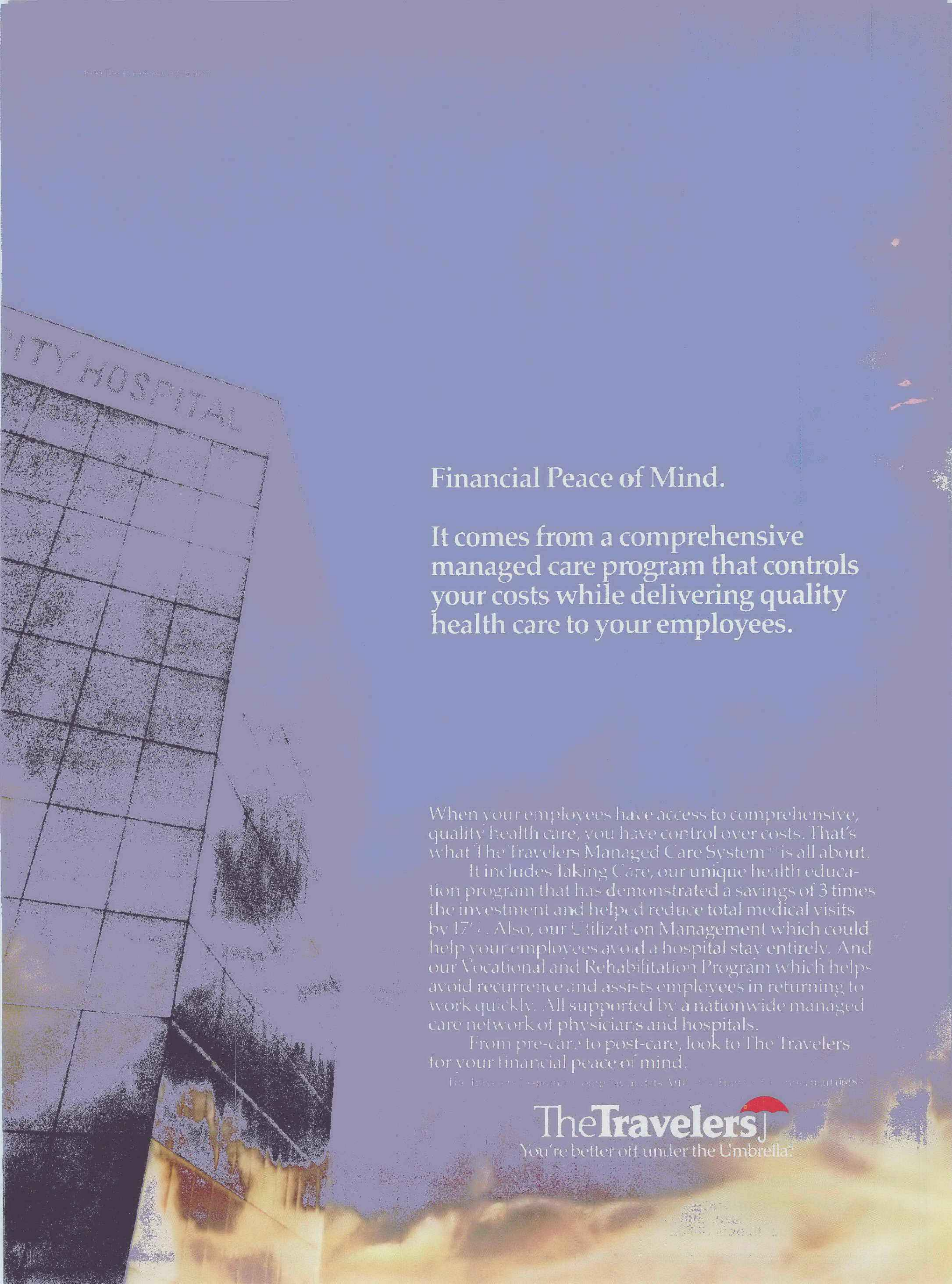
EDITORIAL: Chicago: 312-649-5398; Dallas: 214-363-1066; London: 71-404-4228; Los Angeles: 213-651-3710; New York: 212-210-0140; Washington: 202-662-7200
ADVERTISING: New York: 212-210-0228; Chicago: 312-649-5276; Los Angeles: 213-651-3710
COMMUNICATIONS: New York: 212-210-0132
CIRCULATION: Detroit: 313-446-1611

Published by Crain Communications Inc., Chicago

G.D. CRAIN JR. Founder (1885-1973)
MRS. G.D. CRAIN Chairman
S.R. BERNSTEIN Chairman-executive committee
RANCE CRAIN President
KEITH E. CRAIN Vice chairman
MARY KAY CRAIN Treasurer
MERRILEE P. CRAIN Secretary
WILLIAM A. MORROW Executive Vp-operations
WILLIAM STRONG Vice president-circulation
ROBERT C. ADAMS Vice president-production
H.L. STEVENSON Corporate editor
PENELOPE A. GEISMAR Corporate communications mgr.

Published weekly at 740 Rush St., Chicago, Ill. 60611, Telex 6871241, Fax 312/280-3174, Cable CRAINCOM. Offices: 220 E. 42nd St., New York, N.Y. 10017, Telex 640207, Fax 212/210-0704, CRAIN COM NYK; 1 Northpark, East Suite 114, 8950 N. Central Expressway, Dallas, Texas, 75231, Fax 214/696-1936; Suite 814, National Press Building, Washington, D.C. 20045, Fax 202/638-3155; 6404 Wilshire Blvd., Los Angeles, Calif. 90048, Fax 213/655-8157; 20-22 Bedford Row, London WC1R 4EB, England, Fax 71/430-2176. $2.00 a copy. $75 a year in U.S. Canada and all other foreign add $32 for surface mail. Europe and Middle East only add $88 for air delivery. First-class mail to U. S., add $77; to Canada add $87. Bermuda only, $157 per year expedited delivery. SHEILA GORMLEY, circulation manager. LISA RIVERS, fulfillment director. Four weeks' notice required for change of address. Send subscription correspondence to Circulation Department, Business Insurance, 965 E. Jefferson Ave., Detroit, Mich., 48207, or phone 800-992-9970 or 313-446-1611, Fax 313/446-1650. Microfilm copies are available from University Microfilms, 300 Zeeb Road, Ann Arbor, Mich. 48013. Microfiche copies available: Bell & Howell, Micro Photo Division, Old Mansfield Road, Wooster, Ohio 44691. Portions of the editorial content of this issue are available for reprint or reproduction in other media. For information and rates to reproduce in general circulation media, contact: ART MERTZ, The Crain Syndicate, 740 Rush St., Chicago, Ill. 60611, 312-649-5303. For reprints or reprint permission contact: Reprint Department, Business Insurance, 220 E. 42nd St., New York, N.Y. 10017, 212-210-0229, Fax 212/210-0704.

VBPA Member of Business Publications Audit of Circulation ABP



CITY HOSPITAL
Financial Peace of Mind.
It comes from a comprehensive managed care program that controls your costs while delivering quality health care to your employees.
When your employees have access to comprehensive, quality health care, you have control over costs. That's what The Travelers Managed Care System℠ is all about.
It includes Taking Care, our unique health education program that has demonstrated a savings of 3 times the investment and helped reduce total medical visits by 17%. Also, our Utilization Management which could help your employees avoid a hospital stay entirely. And our Vocational and Rehabilitation Program which helps avoid recurrence and assists employees in returning to work quickly. All supported by a nationwide managed care network of physicians and hospitals.
From pre-care to post-care, look to The Travelers for your financial peace of mind.
TheTravelers
You're better off under the Umbrella.

Hartz names risk management director

Thomas D. Lewison, 48, has been named corporate director of risk management of Hartz Group Inc. in New York. In this newly created position he is responsible for all corporate property/casualty insurance, employee benefits, safety and security programs. Mr. Lewison reports to Curtis Schwartz, executive vp-finance. Prior to joining Hartz Group Inc.—which is the parent company of Hartz Mountain Industries Inc., Hartz Mountain Corp., the Village Voice newspaper, and Harmon Publishing Co. Inc.—in January, Mr. Lewison served as chief operating officer of ICI Mutual Insurance Co. in Washington, D.C., an association captive for the mutual fund industry. He also has served as director-risk management for pharmaceutical manufacturer Rorer Group Inc. in Fort Washington, Pa., and as corporate risk manager for chemical producer Degussa Corp. in Ridgefield Park, N.J. Mr. Lewison holds a bachelor's degree in business administration from New York University in New York City. In addition, he holds a property/casualty certificate from The College of Insurance in New York. Mr. Lewison is a member of the New Jersey Chapter of the Risk & Insurance Management Society.

Mr. Lewison

* * *

Richard R. Cote, 47, has been named senior risk manager of Ryder System Inc. in Miami. In this newly created position, Mr. Cote is responsible for property insurance and self-insurance, loss prevention, surety bonds, risk management for international operations, workers compensation self-insurance, aviation hull insurance and insurance compliance for aviation lessees. He reports to W.M. McDonald, group director-risk management. Mr. Cote, who most recently was Ryder's risk manager, joined the transportation company in 1976. Before that, he was an assistant vp-underwriting at General Insurance Co. in Miami Beach, Fla. Mr. Cote holds a bachelor's degree in business administration from the University of Miami. In addition, he is a deputy member of the Risk & Insurance Management Society and is a past president of the South Florida Chapter of RIMS.

Comings & goings: buyers

In another appointment at Ryder: **James H. Herald**, 42, has assumed additional duties following the retirement of risk manager **Albert G. Dege**. Mr. Herald, who retains his title of risk manager, now has responsibility for general liability, automobile and workers compensation insurance, environmental issues and fiduciary liability insurance. He also will administer all retrospectively rated insurance plans. He reports to Mr. Cote, senior risk manager. Mr. Herald, who joined Ryder in April, previously was supervisor of corporate risk management at Harris Corp., a communications and electronics firm in Melbourne, Fla. He holds a bachelor's degree in international finance from Georgetown University in Washington, D.C., and a master's degree in international management from the American Graduate School of International Management, Thunderbird Campus, in Glendale, Ariz.

Also at Ryder System: **Marjorie E. Serralles** was named financial manager. She replaces **Mary K. Ging**, who transferred to Ryder's treasury department. Ms. Serralles is responsible for financial analysis of self-insured plans and alternative risk financing plans, and is controller for workers compensation claims. She reports to Mr. McDonald, group director-risk management. Ms. Serralles, who joined Ryder in 1984 as a senior financial analyst, most recently served as manager of financial projects in Ryder's insurance division. Prior to joining Ryder, she was an accountant at Price Waterhouse in Miami. She holds a bachelor's degree in business administration from Georgetown University in Washington, D.C., and a master's degree in business administration from the University of Miami. Ms. Serralles is a member of the American Institute of Certified Public Accountants.

* * *

Janet M. McCabe, 32, named casualty risk manager of W.R. Grace & Co. in New York. She is responsible for Grace's domestic casualty, directors and officers liability, and fiduciary liability insurance programs. Ms. McCabe replaces **Patricia R. Pisarski**, who left the company, and reports to Jeffrey M. Posner, assistant vp and director of corporate risk management. Prior to joining Grace, Ms. McCabe was manager of benefits and insurance at Simplicity Pattern Co. Inc. in New York. Ms. McCabe holds a bachelor's degree in business management from the University of Massachusetts in Amherst. She currently is working toward completion of the Chartered Property & Casualty Underwriter designation.

* * *

Bernard C. Knobbe, 30, has been named benefits manager of Chicago Title & Trust Co., a title insurance and trust services firm in Chicago. Mr. Knobbe replaces Norma Nauts, who retired. He is responsible for benefits administration and planning for employees and retirees. Mr. Knobbe reports to LaNette Zimmerman, vp-human resources. Before joining Chicago Title & Trust in June, Mr. Knobbe was assistant manager-benefits planning and analysis for Continental Bank in Chicago. Prior to that, Mr. Knobbe was benefits and insurance plan administrator at Longman Group USA Inc., the holding company for Longman Financial Services Publishing Co., also in Chicago. He holds a bachelor's degree in accounting from Northeast Missouri State University in Kirksville. In addition, Mr. Knobbe is a member of the Chicago Chapter of the International Society of Certified Employee Benefits Specialists and of WEB, the Washington, D.C.-based network of employee benefits professionals.

Mr. Knobbe

* * *

William M. Moser, 32, has been named health and benefits manager of Harleysville Insurance Cos. in Harleysville, Pa. In this newly created position he is responsible for administration of the company's group health, dental, life, disability and pension plans. Mr. Moser reports to Bruce McKelvey, vp-human resources. Mr. Moser, whose most recent title was health and benefits administrator, joined Harleysville Insurance Cos. in 1986 as a personnel administrator. Before that, he was an instructor at North Penn School District, a Lansdale, Pa., middle school. Mr. Moser holds a bachelor's degree in education from the University of Pittsburgh and is pursuing a master's degree in business administration. He also is working toward completion of the Certified Employee Benefits Specialist designation.

* * *

Joanne E. Byrnes, 29, has been named director of insurance at FL Industries Inc. in Livingston, N.J. In this newly created position she is responsible for the thermal systems manufacturer's entire insurance program. Ms. Byrnes, who reports to Ronald Thau, assistant treasurer, joined the company in 1989 and most recently was insurance manager. Previously, she was an insurance coordinator for health care products manufacturer Becton Dickinson & Co. in Franklin Lakes, N.J. She holds a bachelor's degree in business administration from Montclair State College in Upper Montclair, N.J.

* * *

Anne M. Ritter, 32, has been named workers compensation claims manager of ABB Risk Management Services in Rocky Hill, Conn. In this newly created position she is responsible for the administration of insured and self-insured workers compensation claims for Stamford, Conn.-based Asea Brown Boveri Inc., part of electronic engineering group ABB Asea Brown Boveri Ltd. in Zurich, Switzerland. Ms. Ritter reports to Charles J. Salek, managing director, ABB Risk Management Services. Ms. Ritter most recently was a claims account manager at Connecticut Valley Claim Service Co. Inc., also in Rocky Hill. She holds a bachelor's degree in business administration from the State University of New York at Fredonia.

•

We'd like to report on staff changes in your company's risk management, safety and employee benefits departments. Just drop a note to Nancy Johnson, Copy Editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590, or call 312-649-7784. Please send a photograph, too.

Letters

Continued from page 8

pregnant."

Government—state or federal—should not be in the business of dictating an employer's benefit package.

Among other things, this legislation would:

- Cause tremendous hardships on employers, particularly small employers.
- Benefit almost exclusively higher-paid or two-income families, who could afford unpaid leave.
- Result in trade-offs of other benefits that might be considered even more important to employees.
- Mandate continuation of health insurance.
- Result in paid leave legislation—which is the ultimate goal of its proponents—in very short order.

Just one week prior to your editorial, you ran a story entitled "More Employers Tailoring Benefits to Meet Family Needs" (*BI*, July 2). Please re-read it. Changing demographics and a shortage of skilled workers will bring many changes in employers' benefit plans—gradually and voluntarily.

Kathy McKimmie
Vp-Human Resources
Indiana Chamber of Commerce
Indianapolis

Utilization review joint task force, guidelines clarified

To the editor: The article "Self-Monitoring Urged to Let UR Mature" in your June 25 issue needs some clarification regarding comments attributed to Robert A. Picarillo, vp-government affairs for CIGNA Corp. in Bloomfield, Conn., who spoke at the Group Health Assn. of America's recent meeting.

The article says he praised both efforts by the "joint task force" of the American Medical Assn., the American Hospital Assn., the Blue Cross & Blue Shield Assn. and the Health Insurance Assn. of America to set up uniform UR practice guidelines and the establishment of the Utilization Review Accreditation Commission.

The joint task force is actually the Joint Work Group on Health Benefits Administration. The group is currently developing model guidelines for concurrent review. Its membership also includes the American Managed Care & Review Assn. The group's draft of model UR guidelines are under review and will be available to the public later this year.

AMCRA joined the group this spring as a result of the association's participation in the development of national UR standards and URAC.

For a copy of the model UR guidelines when they become available or more information about URAC or the national UR standards, contact Susan Tate, Director of Medical Affairs, AMCRA, 1227 25th St. N.W., Suite 610, Washington, D.C. 20037.

Charles W. Stellar
Executive Vp
American Managed Care
& Review Assn.
Washington, D.C.

Retiree health

Continued from page 1

costs—like health care plans for employees—rose by more than 20% last year. Total retiree medical plan costs in 1989—including employer and retiree contributions—were $2,083 per person, up 20.2% from $1,733 in 1988.

Benefit consultants say rapidly rising interest in defined contribution-type retiree medical programs demonstrates that companies are at last realizing that new approaches are necessary if they want to control costs.

"This is a dramatic change. It shows that management understands that it can't control costs with the open-ended promises of traditional retiree medical plans," said Patricia Wilson, a Foster Higgins principal in Philadelphia.

Under a traditional defined benefit retiree medical plan, an employer provides a fixed set of benefits. For example, a supplementary plan may be designed to ensure that retirees—through a combination of Medicare and the employer-provided benefits—receive the same benefits as active employees.

In addition under a similar approach, a supplementary retiree plan may automatically pick up costs not paid by Medicare, such as Medicare's deductibles and coinsurance requirements.

As a result, plans that are coordinated with Medicare automatically pay more as deductibles and coinsurance limits rise.

"With a defined benefit-type plan, the employer is really saying 'whatever the cost, we will pay.' You give up your ability to manage costs," Ms. Wilson said.

By contrast, with a defined contribution medical plan—similar to a defined contribution pension plan—an employer limits its contribution to a fixed amount.

For example, an employer could make fixed annual contributions to an employee's "account." Upon retirement, the employee could use the balance for health insurance.

The defined contribution approach lets a company "limit its liabilities. Management has the ability to intervene and increase contributions, but it is at the company's discretion," Ms. Wilson said.

Ms. Wilson said proposed FASB rules as well as the now-repealed 1988 Medicare changes have accelerated corporate interest in better controlling retiree health care costs and liabilities.

Under the proposed FASB rules, employers would have to recognize on financial statements retiree health costs and liabilities as they are accrued beginning in 1993.

Employers have said in several surveys that those rules would slash corporate earnings and net worth.

"Employers have slowly learned how retiree health care liabilities were racking up" because of the FASB proposals, Ms. Wilson said.

Concern over retiree health care costs also was fueled by the so-called "maintenance of effort" provision in the now-repealed Medicare Catastrophic Coverage Act of 1988.

Under that act, employers would have had to return to retirees over two years savings they achieved by eliminating benefits duplicated by the expanded Medicare program.

"Employers had to deal with maintenance of effort. They had to determine the nature of their retiree health promise. Gradually, the light went on as to what these plans were costing companies," Ms. Wilson said.

But, drastically overhauling retiree health care programs is just one corporate approach to controlling costs, the survey found.

For example, among the firms intending to change their retiree health care programs this year, 68% said they will boost retiree premium contributions, 33% said they will raise deductibles and 25% said they will decrease benefits.

In addition, 8% of firms said they will start flexible benefit programs for retirees.

While only 6% said they will increase benefits, just 5% said they intend to eliminate retiree health care plans.

"Management still feels an obligation to provide these benefits. Few companies can fathom eliminating their retiree health plans," Ms. Wilson said.

Foster Higgins also found that the retiree portion of corporate health care expenses is growing. Employers reported that retiree costs averaged 15.9% of total company health plan costs last year, up from 13.7% in 1988.

That percentage is expected to rise in the future as more workers retire and life expectancies rise, Ms. Wilson said.

The survey also found that among companies that require retirees to pay a portion of their health care insurance premium, the average monthly contribution for retirees under 65 was $61 for individual coverage and $99 for dependent coverage.

For retirees age 65 and older, the average monthly retiree premium contribution was $39 for individual coverage and $63 for dependent coverage.

Thirty-six percent of employers said they paid the entire premium for individual coverage for retirees under 65, while 20% said the retiree pays the premium and 44% said the premium is shared.

In addition, 26% of employers said they paid the full premium for dependent coverage for retirees under 65, while 26% said the retiree pays the full cost and 48% reported that the cost is shared.

In the case of retirees 65 and older, 47% of employers said they paid the full premium for individual coverage; 17% said the retiree paid the premium; and 37% reported the cost is shared.

For dependent coverage for retirees 65 and older, 34% of employers paid the entire premium, while 24% said the retiree pays all and 42% reported that the premium cost is shared.

•

Copies of "Retiree Health Care Benefits Survey—1989" are available for $100 from A. Foster Higgins & Co. Inc., Survey and Research Services, 212 Carnegie Center, Princeton, N.J. 08543; 609-520-2441. Prepayment is requested.

Nominations

Continued from page 3

• Larry D. Gaunt, professor of risk management and insurance in the College of Business Administration at Georgia State University in Atlanta. This is Mr. Gaunt's first year on the panel, representing the academic community.

• H. Felix Kloman, a vp and principal with Tillinghast, a division of Towers, Perrin, Forster & Crosby Inc. Mr. Kloman, who is based in Stamford, Conn., is serving on the panel for the first time, representing risk management consultants.

• Arthur F. Quern, chairman and president of Rollins Burdick Hunter Co. of Chicago. Mr. Quern is serving on the panel for a second year, representing national insurance brokers.

• Josephine Goode Johnson, executive director of the University of Maryland Medical Service System Self-Insurance Trust and director of its Office of Risk Management. Ms. Johnson was a member of the 1990 Risk Management Honor Roll representing self-insured funds.

• Roger D. Oaks, director of risk management for the Tennessee Farmers Cooperative in LaVergne, Tenn. Mr. Oaks was named to the 1990 Risk Management Honor Roll representing firms with annual sales of less than $300 million.

• Edward K. Trowbridge, chairman and chief executive officer of Atlantic Mutual Cos. in New York. This is Mr. Trowbridge's first year on the panel, representing mutual insurance companies.

• Stephen M. Wilder, director of corporate risk management at The Walt Disney Co. in Burbank, Calif. Mr. Wilder was named Risk Manager of the Year in 1990.

• M. Michael Zuckerman, director of risk management and insurance at Thomas Jefferson University in Philadelphia. Mr. Zuckerman was named to the 1990 Risk Management Honor Roll representing non-profit institutions.

Created by *Business Insurance* in 1977 on the 10th anniversary of the magazine's founding, the Risk Manager of the Year award is designed to honor outstanding professionals in the field.

Beginning in 1981, judges also named a Risk Management Honor Roll to recognize excellence in risk management in different types of organizations.

The candidates are scored on how well they have met 10 established criteria (see box).

After the highest scoring candidate is named the Risk Manager of the Year, the remaining candidates are separated by employment categories:

• Corporations with sales exceeding $300 million.

• Corporations with sales less than $300 million.

• Government entities.

• Tax-exempt or non-profit institutions.

• Financial institutions.

• Self-insurance funds and pools.

The highest-scoring candidate in each of the categories not represented by the Risk Manager of the Year is named to the Risk Management Honor Roll, subject to the judges' discretion.

"Anyone who wants to nominate a risk manager for the Risk Manager of the Year award should request a form now and begin working on it this summer," suggests Associate Publisher/Editor Kathryn J. McIntyre.

"Although the deadline for submitting nominations is Nov. 19, the busy fall travel season makes summer the ideal time to begin working on the nominating statement," added Ms. McIntyre.

The 1991 Risk Manager of the Year and members of the Risk Management Honor Roll will be announced in the April 29, 1991, issue of *Business Insurance*, which will coincide with the 29th annual Risk & Insurance Management Society conference in New Orleans.

Nominations may be made by anyone aware of a candidate's accomplishments: staff, colleagues, a superior, a broker, an underwriter or a consultant. Candidates should be involved in preparing the nominating statement to make it as complete as possible.

In addition to the completed nominating forms outlining accomplishments, each nomination must include a letter from the sponsor nominating the candidate and a letter of endorsement by an executive of the candidate's organization, who may be the candidate's superior or any higher officer. The letter must certify the accuracy of the information submitted in the nomination.

A candidate need not spend full time handling risk management functions, but he or she must be a full-time employee of the organization for which he or she directs the risk management program.

To nominate a candidate for 1991 Risk Manager of the Year, request a nominating form from *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611-2590. ■

Risk Managers of the Year

1990 — Stephan M. Wilder
Director of Corporate Risk Management
The Walt Disney Co.

1989 — Jeffrey W. Pettegrew
Risk Manager and Chief Administrative Officer
Contra Costa County Municipal Risk Management Insurance Authority

1988 — William L. Mather
Administrator of Risk Management
The Gillette Co.

1987 — Edith F. Lichota
Senior Vp
Irving Trust Co.

1986 — Donald Nelson
Director of Risk Management
ARA Services Inc.

1985 — Harold C. Lang
Director of Insurance and Risk Management
Leaseway Transportation Corp.

1984 — Richard M. Inserra
Director of Insurance and Risk Management
American Can Co.

1983 — John A. O'Connell
Executive Director and Risk Manager
Holy Cross Shared Services Inc.

1982 — Eckhart Russell
Risk and Insurance Manager
Alcan Aluminium Ltd.

1981 — Duane E. Allen
Assistant Treasurer
Hanna Mining Co.

1980 — Thomas V. Hallett
Risk Manager
General Motors Corp.

1979 — Edward L. Erickson
Director of Insurance
American Broadcasting Cos. Inc.

1978 — Howard T. Weber
Director of Insurance
Minnesota Mining & Manufacturing Co.

BI/ CYNTHIA WATSON

Risk Management Honor Rolls

1990

Josephine Goode Johnson
Director of Risk Management
University of Maryland Medical Service System
Self-insured funds

Roger D. Oaks
Director of Risk Management
Tennessee Farmers Cooperative
Small Corporation

M. Michael Zuckerman
Director of Risk Management and Insurance
Thomas Jefferson University
Not-for-profit Entity

1989

John A. Lindquist
Risk Manager
Browning-Ferris Industries Inc.
Large Corporation

J. Douglas Higley
Director of the Office of Risk Management
State of Louisiana
Government Entity

1988

Gregory L. Daniels
Director - Risk Management Division
American National Red Cross
Not-for-Profit Entity

Stephen A. Finley
Risk Manager
City of Lakewood, Colo.
Government Entity

Timothy G. Galarnyk
Corporate Safety Engineer and Risk Manager
Lunda Construction Co./Phoenix Steel Inc.
Small Corporation

Edward G. Weiss
Director of Risk Management and Security
First of America Bank Corp.
Financial Institution

1987

Susan M. Werner
Director of Risk Management
Hardee's Food Systems Inc.
Large Corporation

Mark F. Wilson
Corporate Risk Manager
First Mississippi Corp.
Small Corporation

1986

Delmer Ison
Director of Risk Management
Washington Metropolitan Area Transit Authority
Government Entity

William E. Rogers
Director of Community Health Services and Risk Management
Conemaugh Valley Memorial Hospital
Not-fot-Profit Entity

1985

Susan N. Weiner
Executive Director-Division of Risk Management
Dade County Public Schools
Government Entity

Eva F. Goodrich
Manager of Insurance and Risk Management
Cincinnati Electronics Corp.
Small Corporation

1984

Sidney D. Blatt
Risk and Administrative Manager
Holloway Cos.
Small Corporation

Gene Snyder
Administrator - Department of General Services
Risk Management Division
State of Oregon
Government Entity

1983

Jerri Nelson MacMillian
Risk Manager
Aetna Life & Casualty Cos.' Real Estate Investment Department
Large Corporation

Robert L. Sinclair
Risk Manager
Metropolitan Government of Nashville and Davidson County
Government Entity

1982

Spencer J. Traver
Assistant Treasurer
BF Goodrich Co.
Runner-up

Paul B. Harvey
Risk Manager
Ponderosa Homes
Small Corporation

George N. Pierce
Risk Manager
Orange County, Fla.
Government Entity

Gene M. Marsh
Executive Vp - Risk Management
General Conference of Seventh-day Adventists
Not-for-Profit Entity

1981

Robert Bieber
Risk Manager
Westchester County
Government Entity

William Ryan
Insurance and Risk Manager
University of Michigan
Not-for-Profit Entity

BI/CYNTHIA WATSON

Candidates will be rated according to 10 criteria

Ten criteria will be used to score the nominations submitted for the 1991 *Business Insurance* Risk Manager of the Year Award and Risk Management Honor Roll.

The 10 independent judges will score each candidate on a scale of one to 10 according to how well he or she:

• Established and implemented an effective risk management program within the organization.

• Solved one or more major problems for his or her organization.

• Innovatively applies the diverse tools of risk management and insurance.

• Creatively and effectively uses the insurance markets to structure an insurance program that serves the needs of the organization (specifically addressing the types of policies purchased and manuscripted policies, if any, developed).

• Established a workable intelligence system inside and outside the organization, culminating in a flow of information about events and activities that affect the organization's risk management and insurance. (How the risk manager secures information on risks from other departments and the use of risk management information systems are addressed in this criterion.)

• Skillfully performs the functions of management in the overall organization and within the risk management/insurance department. (The functions include planning, organizing, directing and controlling.)

• Achieves the most effective program at the optimum cost over the long term.

• Developed technical expertise in any or all of the broad categories included within risk management, leading to a better managerial grasp of the operations aspects of the job.

• Exhibits an attitude and performs activities fostering the advancement of the risk management profession (such as professional activities, speaking engagements, teaching and related activities).

• Develops in his or her career (as exhibited by job history, including current job description, education, honors and memberships).

Technical Equities

Continued from page 2

Rushing on Aug. 20 to apply the bad-faith ruling to the other 1,200 Technical Equities investors, Ms. Weiner explained.

But, National Union, which is appealing the underlying rulings, will appeal the verdict in the bad-faith suit, according to Archie S. Robinson, a partner with Robinson & Wood Inc. of San Jose, which represents National Union.

Therefore, Judge Rushing should not "extrapolate these results" to all the investors, Mr. Robinson said.

In the bad-faith case, a Santa Clara County Superior Court jury last month awarded $6 million in compensatory damages and $43 million in punitive damages to six investors in Technical Equities, which failed in 1986.

The jury found that National Union fraudulently failed to inform the stockholders that the investors' losses may be covered under the advertising injury clause of the CGL policy that National Union wrote for Technical Equities.

The jury also returned a verdict against National Union on charges of breach of duty of good faith and fair dealing, fraud, negligent misrepresentation, wrongful cancellation of Technical Equities's D&O policy and unfair claims settlement practices.

The jury found in the bad faith case that National Union fraudulently failed to inform the stockholders that the investors' losses may be covered under the advertising injury clause of the CGL policy.

The bad-faith case centers on the actions of National Union since Technical Equities' failure and is just the latest round of litigation that the investors have filed against the insurer and Technical Equities' executives since 1986.

Technical Equities filed for reorganization under Chapter 11 of the U.S. Bankruptcy Code in February 1986.

For two years after Technical Equities originally sought protection from its creditors, investors seeking repayment of their losses filed "hundreds of suits" against the firm, alleging fraud, breach of fiduciary duty and negligence.

Judge Rushing combined all the cases into a "coordinated proceeding" in June 1987 and established a "test case procedure for proceeding with the hundreds of individual actions," court papers say.

Judge Rushing first ruled on Feb. 22, 1988, in a suit filed in 1986 by investors Leonard and Eileen Helfand against National Union and 19 Technical Equities directors and officers, that the entire $30 million in D&O coverage that National Union wrote for Technical Equities management over three years must respond to losses by all investors.

National Union wrote $10 million in annual D&O limits from Aug. 5, 1984, to Aug. 5, 1987, for a total of $30 million in coverage.

The judge ruled all three policies must respond even though National Union had canceled the final year of coverage in June 1986. The judge also ruled defense costs were not included in policy limits.

The next month, a group of Technical Equities accountants, banks and lawyers, as well as two former stock brokers for the plaintiffs, agreed to settle a civil fraud suit "for about $60 million," Ms. Weiner said. The suit—filed in May 1987 by investors Bernard F., Grace L. and James P. McLaughlin —also alleged breach of fiduciary duty, negligent misrepresentation, professional negligence and violation of state corporation code.

Agreeing to the settlement were the accounting firm KMG Main Hurdman of San Jose, which has since merged with Peat Marwick Mitchell & Co.; Security Pacific National Bank in Los Angeles; Bank of the West in San Francisco; the San Jose law firm of Kouns, Marshall, Quinlivan & Severance; New York-based stockbroker Bear Stearns & Co. Inc.; and stockbroker Sutro & Co. in San Francisco.

Ten of the 19 Technical Equities directors and officers also named in the suit agreed to settle by assigning their rights under any insurance policy that could respond to investors' claims against the directors and officers.

On June 23, 1988, a jury ordered six of the Technical Equities directors and officers and Stern Management Associates—a partnership between Mr. Stern, the former chairman of Technical Equities, and another officer—to pay $6 million in compensatory damages for fraud, conspiracy to commit fraud, aiding and abetting a fraud, and acting with malice, oppression or fraud.

And, six days later, the jury ordered three of the defendants, including Mr. Stern, to pay a total of $147 million in punitive damages.

The three executives are appealing the punitive damages award, according to plaintiffs' attorney Ms. Weiner.

On Sept. 12, 1988, under an agreement between the plaintiffs and the 10 defendants who assigned their policy rights to the plaintiffs, Judge Rushing ruled those defendants were responsible for reimbursing the remaining 1,200 investors for their $107 million in losses.

This settlement later permitted the plaintiffs to "go after National Union," Mr. Robinson said. "They're the deep pockets."

About 11 months later, in August 1989, investors Milton and Mildred Chatton filed suit against National Union and 18 Technical Equities directors and officers seeking coverage for their monetary losses and for emotional distress under the advertising injury and bodily injury provisions, respectively, of the firm's CGL policy.

National Union wrote the CGL policy from Oct. 1, 1985, to Oct. 1, 1986.

National Union argued that the policy required that the act leading to the alleged advertising injury be committed during the policy period, which the insurer claims has not been established.

In addition, advertising injury must have an element of "unfair competition," which involves one competitor unfairly gaining an advantage over another, perhaps in an advertising campaign, Mr. Robinson said. He also noted that the bodily injury provision of the CGL policy does not apply to intentional acts.

However, on Feb. 16 of this year, Judge Rushing ruled in favor of the plaintiffs. "When an investor suffers an injury as a result of receiving and relying on materials distributed by the company, the investor is injured as a result of unfair competition," the judge wrote in his ruling.

"There is no dispute that TEC distributed false and misleading annual reports during the period the policies were in effect," he wrote.

Judge Rushing found that there was $1 million aggregate coverage under the advertising injury provision to cover the investors' losses and $1 million of coverage per occurrence with no aggregate for the emotional distress claims.

However, the judge has not yet determined the total damages payable under the CGL policy.

National Union is appealing that decision.

Meanwhile, the $49 million bad-faith jury award rendered against National Union last month stems, in large part, from the discovery of the CGL policy by plaintiffs' attorneys.

The plaintiffs charged in the bad-faith action that, among other things, National Union failed "to disclose the availability of coverage under (a) comprehensive general liability policy" as required by California law.

"National Union wrongfully withheld the existence and identity of the CGL policy from its own insureds. . .as well as from plaintiffs," the suit charged.

Ms. Weiner explained that the requirement of the insurer to inform a policyholder of its coverage is based on California case law and the insurance contract, which implies "a covenant of good faith and fair dealing under California law."

Ms. Weiner explained that it is not entirely clear why Technical Equities was unaware of the existence of the CGL policy, because Technical Equities Senior Vp and Chief Financial Officer Herbert Barovsky, who was "the person in charge of insurance" at the company, has taken the Fifth Amendment in all of the lawsuits filed by the Technical Equities investors.

However, attorneys for the investors believe that "the physical policy," which was bound in October 1985, had not been delivered to the company's brokers before Technical Equities filed for protection from creditors in February 1986, Ms. Weiner said. "We don't know if a copy ever got to the insureds," she said.

Ms. Weiner also said that "a truckload of documents" were removed in January 1986 from the firm's offices.

Mr. Robinson called the bad-faith verdict "erroneous."

He said the judge permitted the investor attorneys "to run amok," whereas defense attorneys "were precluded from showing" that it is neither the practice of insurers nor required by law that insurers inform a policyholder about the existence of coverage.

Besides, Technical Equities' broker, Rollins Burdick Hunter Group of Chicago, did not believe the CGL policy covered the executives' liability, Mr. Robinson said.

But, Ms. Weiner said "there was no evidence" presented at the the trial that RBH believed the CGL policy did not cover the investors' losses.

Ms. Weiner added that evidence was presented in the trial that RBH sent claims to National Union for coverage under the CGL policy.

A spokesman for RBH did not return phone calls.

The jury in the bad-faith suit also found that National Union wrongfully canceled Technical Equities' D&O coverage.

The investors charged that after Technical Equities filed for Chapter 11 reorganization, National Union sent letters to the firm canceling the D&O policy "effective June 20, 1986."

National Union told the company that "there would be no coverage provided under the third policy year. . .despite the fact that the premium for such coverage had previously been paid," the suit said.

But, Mr. Robinson said that the insurer canceled the D&O coverage "at the request and consent of the insured, who were trying to reorganize."

Mr. Robinson also said Judge Rushing's conduct during the four-month bad-faith trial "made it very difficult to show what really happened during settlement negotiations" with investor attorneys, leading to the verdict against National Union on unfair settlement charges.

The plaintiffs charged that they offered to settle the D&O coverage dispute case for $24 million in August 1987, but "no written response to the $24 million settlement demand was ever sent to plaintiffs by defendant National Union or defense counsel."

The special master handling the case did not believe the $24 million demand was reasonable, but Judge Rushing did not allow National Union to show letters from the special master holding the demand was not reasonable, Mr. Robinson said.

While appeals of the several judgments in favor of the plaintiffs are pending, Ms. Weiner stresses that the plaintiffs are seeking only to recover their $107 million in outstanding losses.

However, the plaintiffs have not decided whether they will seek punitive damages in the bad faith litigation. ■

California sues 4 firms under Prop. 65

By JOANNE WOJCIK

LOS ANGELES—Southern California medical and food sterilization firms were caught off guard in July when the state attorney general's office sued four companies under Proposition 65, the state 1986 toxic notification law.

However, the companies—which are accused of not properly informing the public about toxic substances emitted from their plants—should not have been surprised since they had been under investigation for several months and knew they were violating the law, says Edward Weil, deputy attorney general in Oakland.

"The suits were unnecessary," Mr. Weil said. "They could have provided a warning or used the technology" to reduce toxic emissions from the plants, he said.

The suits, filed July 17 in state Superior Court in Los Angeles and Orange counties, allege that the four companies failed to warn an estimated 3 million people that they are being exposed to toxic levels of ethylene oxide, a potent carcinogen that also causes reproductive abnormalities.

Those suits were based on reports the four companies filed with the South Coast Air Quality Management District and the U.S. Environmental Protection Agency.

Named in the suits were:

- Griffith Micro Science Inc. of Vernon, Calif.
- Baxter Healthcare Corp. of Deerfield, Ill., the parent company of Baxter Pharmaseal Division and Bentley Laboratories Inc.
- Botanicals International Inc. in Carson, Calif.
- Vacudyne Inc. of Chicago Heights, Ill., the parent company of Sterilization Services of California Inc. in Anaheim.

Although several of the firms recently cut emissions of ethylene oxide, the suit is seeking penalties for past violations.

"They still were in violation of the law for two years," asserted Mr. Weil. Proposition 65 went into effect in 1988.

In addition, the suits seek an injunction restraining the companies from emitting ethylene oxide in amounts that "pose serious health risks to the public."

If found guilty, the companies could face billions of dollars in penalties.

The maximum fine under Proposition 65 is $2,500 a day for each person who has not received a clear warning about the cancer risks related to exposure.

Proposition 65, which was approved by voters in November 1986, requires businesses with 10 or more employees to issue "clear and reasonable" warnings if they expose employees or the public to any substance that poses a significant risk of cancer or birth defects (*BI*, April 4, 1988; Feb. 29, 1988).

In the most serious violation, the suit charges that Griffith Micro Science exposed nearly 2 million people to ethylene oxide levels up to 100 times higher than acceptable. Proposition 65's limit is two micrograms of the chemical per day over an individual's lifetime.

That company, which operates two plants in Vernon, was one of the first in the region to install scrubbers to reduce emissions, according to Bill FitzGerald, vp-scientific affairs in its Willowbrook, Ill., office.

A scrubber was installed at one plant in 1987 and the company says it plans to install another at its second plant.

Mr. FitzGerald said the company is confused by the suit, with which it has yet to be served.

"Apparently they're not satisfied with the ads we've placed in newspapers" to warn people of the emissions, he said.

Such ads, says Mr. Weil of the attorney general's office, are not sufficient warning.

Proposition 65 stipulates that businesses exposing employees or the public to hazardous materials use the most appropriate of three warning methods: newspaper ads, signs and direct mail.

In the case of the sterilization plants, direct mail would have been more appropriate than newspaper ads since it would be targeted to people living in the affected area, according to Mr. Weil.

Baxter Healthcare also has used newspaper ads to inform the public of their exposure to ethylene oxide since Proposition 65 went into effect, according to a company spokesman.

Baxter operates Baxter Pharmaseal in Irwindale and Bentley Labs in Irvine.

Notices also have appeared on in-plant posters and the company has conducted a companywide education program, the spokesman said.

The companies shouldn't have been surprised by the California lawsuits, says Edward Weil, a deputy attorney general: All four had been under investigation for several months and were violating the toxic notification law knowingly.

Baxter "has been spending a great deal of time and money on notification," he said.

Bentley Labs says it plans to eliminate the use of ethylene oxide by year-end. And since 1984, Baxter Pharmaseal has used an incinerator to turn the gas into carbon dioxide, the spokesman said.

Botanicals International has not posted warnings outside its plant because the company has been closely monitored by the California Air Resources Board and the South Coast Air Quality Management District, said Roger Karrick, an attorney for the company.

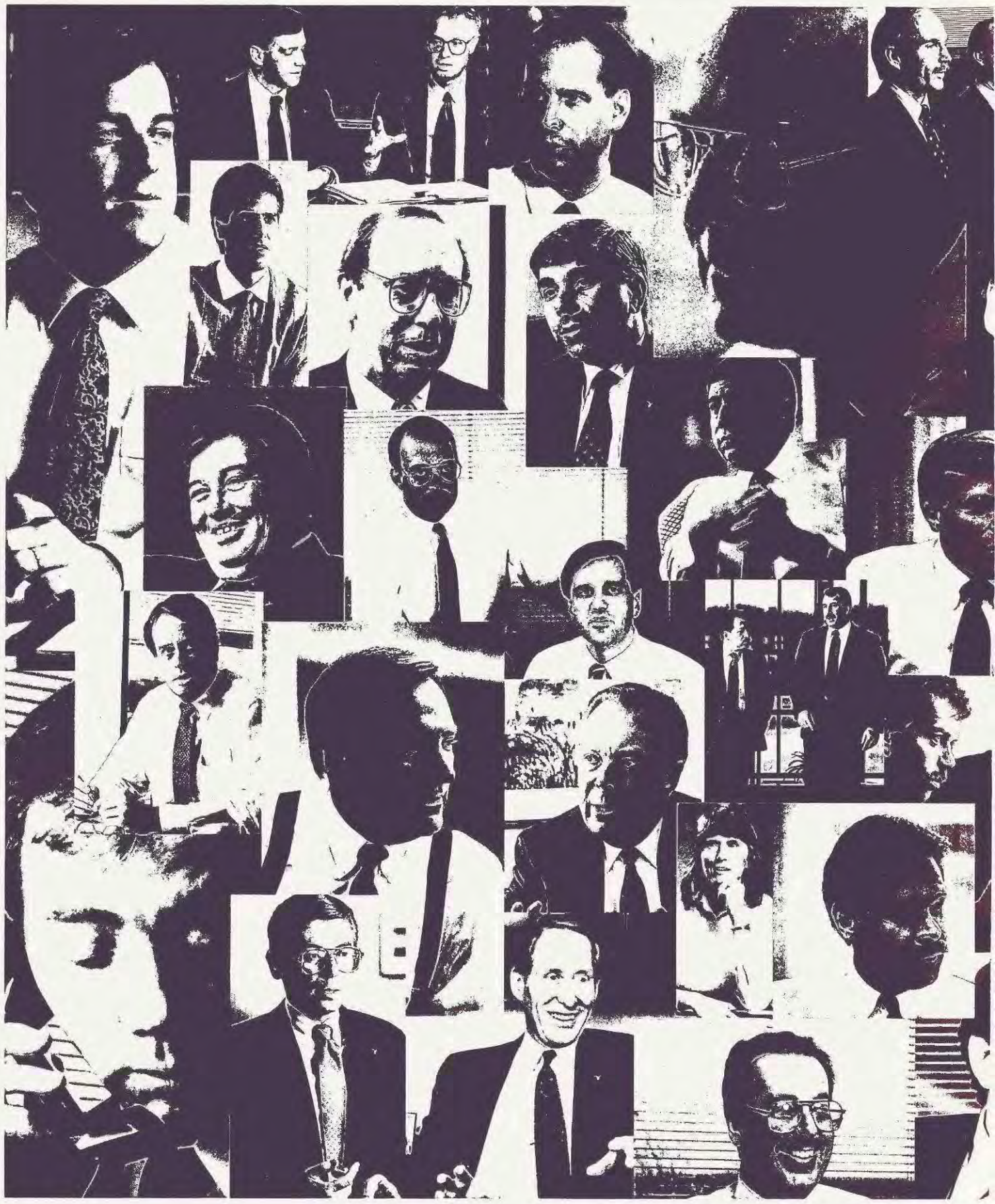
"We currently have a valid permit and have never been cited for a violation," said Mr. Karrick, who is with the Los Angeles firm of Heller, Ehrman, White & McAuliffe.

The company attorney also said he was disappointed that the attorney general announced the suits at a press conference before Botanicals had received a copy of the complaint.

"I think it's grandstanding by a politician," said Mr. Karrick.

California Attorney General John Van de Kamp has "unfairly scared a lot of people," he added.

Officials at Vacudyne, the fourth company named in the suits, did not return phone calls. ■



Early retirement ruling limited in scope

By LOUISE KERTESZ

WASHINGTON—The National Labor Relations Board must reconsider its dismissal of a labor union complaint that the Toledo Blade newspaper is violating labor law by directly offering union workers early retirement incentives without the union's consent, a federal appeals court has ruled.

The U.S. Court of Appeals for the District of Columbia ruled that the newspaper's offer is an unfair labor practice and that the NLRB's dismissal of the union's complaint in June 1989 was "fundamentally inconsistent" with the structure of the Taft-Hartley Act.

The NLRB must now reconsider its dismissal of the union's complaint and take "action consistent with (the) conclusion" reached by the appeals court, the appellate court ruled.

Benefit consultants do not believe that the ruling will have a significant impact on employers since the facts of the case are somewhat unusual and since most employers already work with unions when offering early retirement plans.

However, the consultants observed that the ruling could provide labor with an additional bargaining chip.

The case centers on a clause often found in labor union contracts with newspapers. The clause allows newspapers to negotiate directly with workers over buyouts of their lifetime job guarantees.

Such guarantees are common in the newspaper industry, where management typically has granted lifetime job guarantees to workers in the newspapers' mechanical departments in exchange for the introduction of new technology, said Michael J. Rybicki, a partner with Seyfarth, Shaw, Fairweather & Geraldson in Chicago, a law firm that represents employers in labor/management disputes.

> **'Most employers have taken the position of working with the unions,' says Mr. Golden.**

Collective bargaining agreements covering thousands of newspaper workers across the country allow management to offer the buyouts directly to workers, Mr. Rybicki said.

The clause was contained in the collective bargaining agreements that the Toledo Blade reached with the Toledo Typographical Union, which represents composing room workers, in 1976 and 1979.

But in 1982 contract negotiations, the union at the Toledo Blade refused to include the "direct dealing" clause in a new contract, according to the appeals court decision.

During those negotiations, the newspaper and the union reached an impasse over the issue, so the clause was not included in the contract.

However, the Blade continued to negotiate with individual employees over buyouts without the union's consent.

The union then filed a complaint with the NLRB, arguing that during the contract bargaining sessions, the Blade, "by insisting upon a clause concerning a non-mandatory subject of bargaining, had refused to bargain in good faith," court papers said.

Under labor law, employers may bargain to an impasse only over a mandatory subject of bargaining, such as wages, benefits and work rules.

When an impasse is reached over a mandatory issue, management may lawfully seek to implement the disputed practice and the union may strike.

However, the NLRB dismissed the union's complaint, ruling that the clause allowing management to offer directly to union workers buyouts of their lifetime job guarantees was a mandatory subject of bargaining.

But "the clause upon which the employer went to impasse would, in our view, allow it to prevent the union from playing an important role reserved to it by statute," the appeals court ruled.

"An employer that negotiates directly with an individual employee, without first bargaining with the union, violates" labor law, the court said.

"By allowing the employer to bargain directly with its employees, Toledo Blade's proposal would deprive the union. . .of its central statutory role as their representative in dealing with the employer," the appeals court ruled.

The NLRB may wait to act until the 10th U.S. Circuit Court of Appeals in Denver rules on a similar case, according to an NLRB spokeswoman.

If the NLRB decides to hold to its original position that the "direct dealing" clause is a mandatory bargaining issue, the agency may appeal the matter to the Supreme Court, according to the spokeswoman.

However, it is likely the NLRB will abide by the appeals court ruling "just because of the strong wording," according to Elizabeth Poston, a principal and actuary at William M. Mercer Inc. in Washington, D.C.

The appellate court ruling, though, will not have widespread impact because it involves "a rather narrow set of facts," Ms. Poston said.

"I don't think you'd see similar facts" at many other companies, she said.

The appeals court ruling will "not have much impact," agreed Rich Ostuw, a vp with TPF&C, a division of Towers, Perrin, Forster & Crosby Inc. in Cleveland.

"It's not a widespread employer practice" to deal directly with employees without the union's consent, Mr. Ostuw said.

"Most employers have taken the position of working with the unions," agreed Howard Golden, a partner with Kwasha Lipton in Fort Lee, N.J.

But, if the NLRB reverses its position and holds that it is an unfair labor practice for employers to negotiate directly with employees, it would give unions with a direct dealing clause "increased bargaining leverage" during contract talks, Mr. Rybicki said.

Other employers negotiating with labor unions also might find it difficult to deal directly with unionized employees over other issues "that might be construed as violations" of the prohibition against direct dealing, such as wages tied to individual performance goals, he said.

Officials at the Toledo Blade were unavailable for comment. ■

Foss rebuttal

Continued from page 2

Insurance Exchange.

Mr. Foss also was the target of critical remarks by a House Oversight and Investigations Subcommittee staff member who discussed subcommittee hearings on insurer insolvencies at a meeting of the American Assn. of Managing General Agents earlier this year.

In a letter to Rep. Edward R. Madigan, R-Ill., IIE President James M. Skelton protested the remarks, which he said labeled Mr. Foss a "crook" and questioned the Illinois exchange's integrity because of its association with Mr. Foss.

In a June 15 reply, Rep. Madigan reported that Subcommittee Chairman John D. Dingell, D-Mich., had reviewed the staffer's remarks and found them "inconsistent with the manner in which he conducts the affairs of his committee."

The staffer was reprimanded, according to Rep. Madigan's letter.

Transit was ordered liquidated in late 1985 and is estimated to be insolvent by between $3 billion and $4 billion. Gross losses from NUA's high-risk excess casualty book alone may total $2.4 billion, Mr. Arnold told the Oversight and Investigations Subcommittee in March. Transit was one of several insurance company failures examined by the subcommittee in a report on insolvencies released earlier this year (*BI*, Feb. 26).

NUA, one of the largest of Transit's MGAs, was formed in 1978. It was 37.5% owned by Transit; 37.5% owned by H.S. Weavers (Underwriting) Agencies Ltd., a unit of London United Investments P.L.C.; 20% owned by Mr. Foss; and 5% owned by NUA Secretary Barbara K. Marrs.

The agency bound Transit as a fronting insurer on excess liability business, much of it covering Fortune 500 corporations, and arranged treaty and facultative reinsurance for the risks with scores of reinsurers, including companies on the Weavers line slip, many of which are now being run off.

In his testimony earlier this year, Mr. Arnold generally attacked NUA's underwriting and reinsurance placement practices and charged that the agency was more interested in generating commissions for itself and Weavers than in safeguarding Transit's interests.

Mr. Foss resoundingly denies those allegations in his rebuttal, a copy of which he provided to *Business Insurance*.

For example, Mr. Foss rejects Mr. Arnold's suggestion that NUA exercised little underwriting judgment and underpriced its business, saying this "casts unfair aspersions" on NUA underwriters.

NUA submitted policies to Transit for review and was audited at least annually by Transit reinsurers, Mr. Foss maintains. And, Transit conducted an underwriting and claims audit in 1984 and had "no material complaints" about NUA's operations, he says.

While Mr. Foss concedes that NUA's pricing was "competitive," he says it was not the lowest and that underwriting requirements were "tough." He also accuses Mr. Arnold of misleading the subcommittee in his description of some of NUA's accounts.

While testifying accurately that NUA wrote liability coverage for The Boeing Co. and A.H. Robins Co., Mr. Arnold failed to note that the Boeing coverage excluded aircraft product liability risks and that the Robins coverage excluded liabilities related to the Dalkon Shield intrauterine device, according to Mr. Foss.

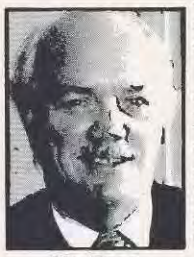
Mr. Foss also disputed Mr. Arnold's estimate of more than $2 billion in losses from the NUA book. The estimate "appears to be a gross exaggeration," Mr. Foss says in his rebuttal, noting that the Transit receivership has refused to grant NUA access to the actuarial report and work papers that ostensibly support this estimate.

Using Mr. Arnold's example of 80 accounts written for Transit by NUA, Mr. Foss says that NUA wrote total limits of $4.1 billion for these accounts. These limits were part of layers with total limits of $22.5 billion, which were excess of underlying coverage of $29.3 billion, Mr. Foss says.

According to Mr. Foss, had the losses on NUA business totaled $2.1 billion, other insurers on the layers on which Transit participated would have sustained $9.8 billion in losses and underlying insurers would have paid some $30 billion if the losses were evenly spread.

Mr. Arnold in an interview last week defended the actuarial estimate of NUA-related losses at $2.4 billion and denied misleading Congress in his testimony regarding NUA's accounts.

"I don't think my testimony was misleading in any way," Mr. Arnold said, adding about the Boeing and Robins accounts that "he's talking about some isolated exclusions that may or may not be there."



Mr. Foss

Mr. Arnold's criticism of NUA's reinsurance placements for Transit also is unfounded and ignores Transit's own role in selecting its reinsurers, Mr. Foss maintains.

For example, prospective treaty reinsurers were screened first by NUA's intermediaries and then by NUA itself, which examined reinsurers' current financial information and A.M. Best Co. ratings, the rebuttal says.

NUA then forwarded lists of reinsurers it deemed acceptable to Transit for the insurer's review and approval, Mr. Foss said.

Mr. Arnold maintains that while Transit in theory was supposed to have a role in approving reinsurers, in practice the placements were handled largely by NUA.

Mr. Arnold's allegations that NUA failed to maintain adequate letters of credit from unauthorized reinsurers and failed to set adequate loss reserves are also unfounded, Mr. Foss contends.

When Transit rescinded NUA's claims handling authority in June 1985, LOCs from alien reinsurers were adequate "and probably only became insufficient (if this is in fact the case) through the failure of the Transit receivership to properly update and monitor claims information," Mr. Foss says.

NUA also properly discharged its claims handling duties under its agency agreement with Transit, he says. However, these duties did not include setting reserves for incurred-but-not-reported losses, which were set internally by Transit, according to Mr. Foss' rebuttal.

However, Mr. Arnold asserts that Mr. Foss is wrong on this point. A section of NUA's agency agreement dealing with the agency's commission structure required NUA to calculate IBNR reserves and submit those figures to Transit for approval, according to Mr. Arnold.

Mr. Foss' contention on the IBNR point "flies in the face of the express language of the contract itself," Mr. Arnold said.

Mr. Foss also sharply disputes Mr. Arnold's charge that NUA had a "parasitic" relationship with Transit and was more interested in garnering commissions for itself than in Transit's underwriting profitably.

Mr. Arnold testified that NUA received a 6% commission on gross premiums written for Transit, with a 7.4% override commission payable to Transit by its reinsurers.

Continued on next page

Continued from previous page

In addition, NUA was to receive a "contingent management fee" equal to 25% of the underwriting profits on business it produced.

But, Mr. Foss maintains, this commission structure provided NUA with an incentive to produce profitable business, as opposed to just generating premium volume without concern for profitability.

"Although our goal was obviously to make money, to suggest that we were 'mercenary' or 'parasitic' not only ignores the facts but is insulting in the extreme," he says in the rebuttal.

Mr. Arnold's testimony also left the false impression that NUA kept the 7.4% override when it actually turned this money over to Transit, Mr. Foss added.

Mr. Foss also says in his rebuttal that lawyers for the Transit receivership have concluded that "absolutely no evidence of wrongdoing by NUA was apparent in its Transit dealings."

The lawyers came to that conclusion after reviewing informal depositions of NUA employees and NUA's "frank and open" responses to a 62-question review of the agency's operations that the lawyers asked NUA to complete last September, Mr. Foss says.

However, a lawyer for the receivership recalls these events somewhat differently. After reviewing NUA's responses and the depositions, Transit lawyers told lawyers for NUA that the receivership was not going to sue NUA "at this time," according to Thomas McCarthy, a partner with the St. Louis law firm of Buechner, McCarthy, Leonard, Kaemmerer, Owen & Laderman, which is representing Transit.

"I don't read that as a clean bill of health," Mr. McCarthy said.

Transit is still considering the possibility of suing NUA and its directors and officers for breach of fiduciary duties, Mr. Arnold pointed out. ■

Defamation award

Continued from page 2

Gardner and a former New York insurance superintendent.

Owners of failing insurance companies, however, have tried to intimidate examiners and impede regulatory action by filing multimillion-dollar lawsuits, Mr. Lewis said.

Such lawsuits—alleging civil rights violations, gross negligence, libel or slander—can cause state attorneys general to defend examiners under a reservation of rights, and can create severe financial problems for the examiners, including damage to their credit ratings, he said.

Mr. Lewis has advocated legislation in New York that would allow an examiner to sue for treble damages in cases where lawsuits alleging that insurance examiners acted illegally have been dismissed or withdrawn.

Colonial, owned by Mr. Mazzella through two holding companies, was ordered into liquidation in March 1984.

A federal grand jury in Philadelphia indicted Mr. Mazzella on mail and wire fraud charges in April 1985 for allegedly diverting $2.4 million in reinsurance premiums owed to Colonial by American Centennial Insurance Co. of Peapack, N.J.

The indictment charged that Mr. Mazzella deposited the premiums in a New York bank account he opened using the forged signatures of two Colonial officers, then falsely told Colonial officials that the reinsurance agreement with American Centennial had been cancelled (*BI*, June 24, 1985).

Prosecutors later withdrew these charges but obtained a new indictment on essentially the same charges in April 1987 (*BI*, May 4, 1987).

Mr. Mazzella pleaded no contest to five mail and wire fraud counts and was sentenced in January 1988 to five years probation. He also agreed to pay $650,000 in restitution to American Centennial and Colonial's liquidator (*BI*, Jan. 25, 1988).

In the period between the two indictments, one of Mr. Mazzella's holding companies, Colonial Investment Co. Inc., filed a civil racketeering suit in U.S. District Court in Philadelphia against Mr. Savitsky and two former Pennsylvania commissioners.

The suit alleged that Mr. Savitsky and two Colonial employees conspired to convert the insurer's assets to their own use, destroy Colonial as a business and defraud the insurer's creditors and stockholders.

Among other things, the complaint charged that Mr. Savitsky—who allegedly was overseeing Colonial's operations during an examination—damaged the insurer by wrongfully interfering with its business relationships with Adriatic Insurance Co., Omaha Indemnity Co., Allstate Insurance Co., Mercantile & General Reinsurance Co. P.L.C. and an unnamed Cayman Islands reinsurer.

Owners of failing insurers have tried to intimidate examiners with lawsuits, says Albert B. Lewis.

The complaint also charged that Mr. Savitsky discriminated against certain Colonial employees.

In addition to alleging violations of the federal Racketeer Influenced and Corrupt Organizations law, Mr. Mazzella accused Mr. Savitsky of tortious interference with contractual relations, civil conspiracy, commercial defamation, fraud and negligence.

On a motion by the Pennsylvania Attorney General's office—which represented Mr. Savitsky and the two former commissioners—U.S. District Judge James Giles dismissed Mr. Mazzella's complaint in November 1987.

Mr. Savitsky then filed a complaint against Mr. Mazzella in the Court of Common Pleas in Philadelphia. The lawsuit was transferred to federal court on a motion by Mr. Mazzella.

Mr. Savitsky's complaint noted that while examining Colonial from November 1981 to March 1984, Mr. Savitsky found not only that the insurer was insolvent but also that it had made illegal investments, written lines of insurance it was not authorized to write, failed to collect premiums from a brokerage controlled by Mr. Mazzella and created a false record of cancellations.

Mr. Savitsky charged that Mr. Mazzella's lawsuit was "wrongful, commenced in a grossly negligent manner and without probable cause" and was intended to injure Mr. Savitsky because he had assisted in Colonial's liquidation.

The suit sought more than $20,000 in damages for the allegedly defamatory accusations in Mr. Mazzella's complaint, along with an unspecified amount of punitive damages.

Mr. Mazzella denied the charges.

Under rules governing claims of less than $100,000 in the Philadelphia federal court, the case was referred to a panel of three court-appointed arbitrators.

The panel last month unanimously awarded Mr. Savitsky $20,000 in actual damages and $55,000 in punitive damages.

Mr. Mazzella has filed an appeal, which under federal rules automatically entitles him to reargue the case in federal court as if the arbitration had not occurred, according to Mr. Starr.

No trial date has been set. ■

Robinson Foundation sets goals

By MARK A. HOFMANN

WESTPORT, Conn.—Trustees of the Angus Robinson Jr. Memorial Foundation hope to raise at least $100,000 in the next year for internships for college students interested in insurance and reinsurance careers.

The foundation was set up in honor of Mr. Robinson, who was president and chief executive officer of Chartwell Reinsurance Co., a unit of Northwestern National Life Insurance Co., and a founder of Trenwick Group Inc. in Bermuda.

Mr. Robinson, considered an innovator in alternative risk financing, died April 15 of cancer at age 43 (*BI*, April 23).

The foundation will be "emblematic" of Mr. Robinson's strong commitment to the idea that "bright people who were not necessarily in the insurance business could be brought into it," said Mark W. Hinkley, senior vp and director of treaty operations at Skandia America Reinsurance Corp. in New York.

"We're pretty optimistic" about meeting the goals, said Brian O'Hara, a foundation trustee and president of X.L. Insurance Co. Ltd. in Bermuda.

'We're pretty optimistic' about meeting the goals, says Brian O'Hara, a foundation trustee.

Mr. O'Hara said that he and other trustees want to raise at least $100,000 during the next year and continue to add to the fund thereafter.

About $15,000 had been received by the middle of last week, according to another trustee, Jacques Q. Bonneau, a senior vp at Trenwick America Reinsurance Corp. in Stamford, Conn.

Between 200 and 250 letters announcing the creation of the foundation were sent to potential supporters in late June.

Trustees have talked to the Independent Reinsurance Underwriters Assn. Inc. of Canton, Ga., about their summer intern program and had preliminary talks with National Assn. of Independent Insurers in Des Plaines, Ill., and the College of Insurance in New York regarding their educational programs, according to Michael H. Hayes, a trustee and executive vp with Stamford, Conn.-based Chartwell.

"We expect other industry organizations to contact us as the foundation reaches grant-making status," he said.

According to trustees, the foundation will emphasize underwriting education, although it will also support students interested in brokerage careers.

Formal scholarship criteria have not been set, but trustees say considerations will include strong academic records, involvement in extracurricular and community activities and financial need.

The Angus Robinson Jr. Memorial Foundation is a non-profit corporation. Donations are tax deductible.

•

For further information, contact the Angus Robinson Jr. Memorial Foundation, 4 Wake Robin Road, Westport, Conn. 06880, 203-454-7360.

Carve out mental benefits

'Resource pool' controls costs, maintains quality

By John D. Fry

Speaking out

MENTAL HEALTH CARE quality, access and cost are some of the most troubling problems in the health care industry today. However, employers can deal with increasing mental health care utilization and costs by carving out mental health benefits from existing health care plans.

Employers utilizing this strategy can deliver mental health benefits through an exclusive provider organization or a limited health plan arrangement.

In a health care industry where double-digit inflation is the norm, mental health care has the dubious distinction of clipping along at even higher rates:

- Mental health costs today comprise 11% to 15% of total health care claims expense, compared with 5% during the early 1980s. And, some firms expend far higher amounts on mental health care; it is not unusual to hear of mental health benefits comprising 25% to 35% of an employer's total claims expense.
- Furthermore, mental health expenses are increasing at two to three times the rate of other types of health care benefits.

Mental health care claims also tend to be very large in absolute terms:

- Total mental health inpatient costs are approaching $1,000 per day in many parts of the country. Combined with long lengths of stay (15 to 30 days), inpatient stays can easily top $20,000.
- Adolescent hospitalization is the fastest growing component of mental health care costs. Adolescent hospitalizations tend to be for very long periods of time—30 to 90 days. Total charges for an adolescent hospitalization are routinely more than $30,000.

Mental health-related prescription drug expenses also are skyrocketing. Prozac, an antidepressant, is widely prescribed and very expensive, costing roughly $50 per month. It is easy to understand why Prozac is so popular: it relieves depression and even has some "desirable" side effects, like weight loss and increased sexual drive. Still, its use is phenomenal: Prozac accounts for nearly 20% of one health care plan's total prescription drug expense.

We may have only seen the tip of the iceberg in demand for mental health services. Demand for service is being positively influenced by:

- The reduction in social stigma for seeking psychiatric and substance abuse care. Psychiatric and substance abuse issues have truly become mainstream, "cover-of-Newsweek" issues in our society.
- There is a tremendous oversupply of mental health care providers. Markets like Austin, Houston and Dallas, Texas; Milwaukee; Phoenix, Ariz.; Salt Lake City; and Los Angeles—to name but a few—have two to four times the number of inpatient beds needed.

The supply of outpatient providers also has grown significantly in recent years. For example, Utah has seven times the number of licensed mental health professionals needed to provide services to residents of the state.

- State mandates that insured health care plans include coverage for mental health conditions are common.

For example, Texas recently enacted legislation requiring that substance abuse treatment be covered just like any other illness. Assuming that 7% of adults are alcoholics or problem drinkers, Texas has about 800,000 adults that need treatment for alcohol abuse. If each case costs $7,500, total costs would be $6 billion. An employer providing health care to 1,000 beneficiaries could incur about $500,000 in alcoholism treatment expenses.

- Employers in some industries must have drug testing programs, which can increase the demand for mental health care. One Northwest employer found 60% of its employees tested positive for illegal drug use. While a rate that high is unusual, a rate of 10% to 20% of employees using illegal drugs is not uncommon.

The results of a study of nearly 19,000 people provide dramatic support to the potential demand for mental health care. The study found that 32% of those interviewed at some point prior to the interview had a diagnosable mental health condition. In addition, 19% had a diagnosable mental health condition in the previous six months, while 15% had a diagnosable condition within a month of the interview.

Generally, about 4% of health plan enrollees use mental health benefits. The results of the study suggest that the current level of mental health care utilization may be but a fraction of the potential utilization.

With all this in mind, health care payers are now taking an active interest in managed mental health care. A recent survey indicated that about 70% of large employers are considering implementing some type of managed mental health care program. Government payers, such as Medicaid programs and the CHAMPUS program covering the military, are contracting for mental health care services in some parts of the country.

Clearly, providing mental health benefits under a traditional fee-for-service indemnity plan leaves the payer exposed to significant liability. Mental health benefits are a natural area for payers to contract for services under an exclusive provider organization or another limited health plan arrangement.

One approach to contracting is a method known as the "resource pool." A number of characteristics of the resource pool can be altered, but here is a general description of the concept:

- The employer pays a predetermined fixed amount per month per employee in return for provision of mental health services. The provides total predictability and stability in terms of mental health care costs.
- This panel of providers delivers services, including both outpatient and inpatient care, under either an EPO or health maintenance organization type of design.
- The panel covers employees in all areas in which the employer has operations. The employer retains the risk for care in other areas and any risk it wants to assume for employees who do not receive care from a panel provider. Typically, out-of-area mental health care utilization is minimal.
- A relative value scale is used that assigns numeric values to units of service by type of service. All services have relative values per unit of service. For example:
  - Stays in psychiatric hospitals may have a value of 5 units per patient day.
  - Stays in a chemical dependency facility may also have a value of 5 units per patient day.
  - Sessions with a psychiatrist, psychologist or a psychiatric social worker may have a value of one unit per 50-minute session.

Obviously, the actual relative values are more complex than this example.

- After the deadline for the receipt of bills for service, the total number of units of service is determined. The capitation fee is divided into the total number of units of service delivered. This division results in a fee per unit of service for that particular month. Each provider then receives payment according to the number of units of service they delivered multiplied by that month's fee per unit of service.
- The fee per unit of service varies from month to month according to the total number of service units delivered in a particular month. If a large volume of services are delivered in a given month for whatever reason, the dollar value per unit of service is relatively small. Conversely, if a small volume of services are delivered, the dollar value of a unit of service is relatively large.
- Panel participants receive reimbursement based on the number of units of service delivered. Additionally, the providers would receive any employee copayment amounts established by the payer.

The resource pool is based on the premise that mental health care providers are the only group that can control mental health care costs and utilization. Because of the subjective nature of diagnosis and treatment, traditional approaches to capitation arrangements that rely on administrative techniques—like preauthorization, case management, etc.—can easily be "gamed." The resource pool places the penalties and rewards for appropriate utilization squarely in the hands of the only group that can really control it: the providers.

The resource pool method has several advantages:

- Utilization and inflation risk is entirely assumed by the provider panel. Appropriate utilization is assured by peer review and social pressure. Each provider receives a report with each month's check that specified how the funds were distributed. The report lists utilization by provider, diagnosis and procedure. This organized method of the exchange of information regarding treatment of particular conditions, combined with the financial incentive for efficient behavior, will produce optimal care for patients.
- Peer and social pressure are effective means to achieve appropriate utilization. The effect of inappropriate utilization is to graphically reduce the payment per unit of service.

For example, a provider who inappropriately hospitalizes his patients is literally taking money from the other providers.

Conversely, providers are motivated to deliver appropriate services to employees because they receive no part of the pool of funds if they deliver no services.

- This system encourages providers to be innovative in the type of treatment prescribed for a particular patient. A common criticism of mental health care is that it is "benefit-driven"—the care delivered is a function of the type of care that is reimbursable. This system can eliminate irrational or less than optimally effective care because it aligns the provider's interest with the ultimate interest of the payer: high-quality, cost-effective care.

Maintaining reasonable mental health care access, quality and cost for employees and dependents needing mental health care is a major challenge for employers. Aggressive management of mental health care benefits can be a substantial help to both payers and patients. The resource pool method of capitating mental health care benefits provides an optimal balance among cost control, access and quality. ■

John D. Fry is a partner with Phase II Consulting, a health care management and economics consulting firm in Salt Lake City.

Proxy battles heat up

Fights for control of corporations a D&O headache

By Anthony J. Falkowski

PROXY FIGHTS ARE not new. Historically, they have played a role in the contest for board seats. But recent changes in the business climate—tightened financing, the passage of state anti-takeover statutes and court-sanctioned anti-takeover defense tactics—have brought the proxy fight to the forefront of the struggle for corporate control.

Those who have closely followed the procedures and outcomes of these contests in recent years conclude that this means of wielding power poses as serious a threat to the security of directors and officers as did the intense merger and acquisition activity of the 1980s. The volatile conditions evidenced by increased shareholder activism and a sharp rise in the number of proxy fights suggests that while the vehicle may be changing, the heightened liability of chief executives and those serving on corporate boards will continue into the 1990s.

Clearly, corporate governance and policy-making are coming under attack. By April of this year, the business community had already seen 18 major proxy battles, many of them rocking the Fortune 500 companies. Several forces in the economic and legal environment have contributed to the rise in proxy fights. The stock of publicly held corporations has increasingly been concentrated in the hands of large institutional shareholders—money managers such as pension and mutual funds and insurance companies—which in 1989 held 43% of U.S. stocks. Large stockholders who become dissatisfied with corporate governance cannot simply sell out, because they would create too adverse an impact on stock price. Instead, they are demonstrating a willingness to become involved in shaping the direction of the company. They are seeking a greater voice, and they want to be heard.

Evidence of this shareholder activism and clout can be found in the letters that such formidable

With the collapse of the junk bond market, many would-be raiders who are unable to borrow enough funds. . .have resurrected an old alternative: the proxy contest for corporate control.

funds as the California Public Employees Retirement System sent to General Motors Corp., suggesting a shareholder representative seat on the board of directors and a role in choosing a successor to Chairman Roger Smith.

In the first quarter of this year alone, institutions or their affiliates had put forward 112 governance proposals at annual meetings—most of which concern confidential voting, shareholder rights plans and referendums on policy decisions.

Of course, there is a significant difference between the intentions of institutional shareholders, who seek changes or representation on the board, and dissident leaders, who use the proxy contest to gain control of the company or to induce a major restructuring, as in the case of Carl Icahn's attempt to force the spinoff of USX Corp.'s steel operation.

However, since the success of dissident challengers usually depends upon enlisting the support of large institutional shareholders, the two groups sometimes fight on the same side. With the collapse of the junk bond market, many would-be raiders who are unable to borrow enough funds to launch a hostile takeover have resurrected an old alternative: the proxy contest for corporate control. Or if a potential acquirer can put forth a cash tender, the proxy battle offers extra leverage by breaking down management's defenses. For instance, a recent Wall Street Journal article attributed the success of Georgia-Pacific Corp.'s bid for Great Northern Nekoosa Corp. to Nekoosa's facing a likely defeat in a shareholder vote at its annual meeting. If a challenger were to succeed through proxy support in replacing a sizable portion of the board with new dissident members, presumably the new board would also look more favorably upon the tender offer.

Not only these economic factors, but also legal realities are increasing the attractiveness of proxy contests. Since a Supreme Court ruling in 1987 opened the way for anti-takeover or anti-shareholder legislation in 39 states, the proxy fight may be the only way for a challenger to get around laws impeding the use of dollars for takeovers. Varying in their severity, these laws are creating situations that invite test-case suits against directors and officers by disgruntled shareholders. On the one hand, studies by the Securities and Exchange Commission and others have shown that, by preventing attractive takeover bids, restrictive laws drag down share price. On the other hand, the most severe statutes, such as Pennsylvania's, can disenfranchise shareholders and expand management's fiduciary duty beyond shareholders to other stakeholders, such as employees and suppliers.

The well-publicized litigation involving Armstrong World Industries Inc., in which allies of the challenging Belzberg family had a vested interest in testing a 1988 Pennsylvania anti-takeover statute, is certainly not unique to that state. The fact that the Belzbergs ultimately gave up their long takeover effort does not negate the expense involved in this protracted legislation. And hours after Pennsylvania's newest anti-takeover statute was signed into law this year, Armstrong's president and chairman, along with certain other directors and officers, were named in another suit challenging its constitutionality.

The clear connection between proxy fights and lawsuits can be seen in the news almost daily. The 1989 Wyatt D&O Liability Study supports this idea that proxy fight litigation-related defense costs are substantial and increasing at a rate of 8% to 10% annually. Wyatt projects that for all D&O claims made in 1989, the average defense costs will be $1.299 million.

Much of the litigation grows out of the proxy process itself. Especially when the vote is close, the losing side often seeks to invalidate the outcome by charging violations of the anti-fraud/proxy rules that are part of the Securities Exchange Act of 1934. Often, dissidents charge management with making false statements or misrepresenting the company's financial performance during the campaign. Management's use of defense mechanisms to ward off or to win a proxy contest is another major source of litigation.

It is these maneuvers which lead to allegations of entrenchment through illegal defenses and acting in self-interest, rather than for any legitimate corporate purpose. The fact that management may spend significant amounts of corporate funds to win a proxy contest adds fuel to these charges.

For example, in *Reidman vs. Niagara*, a suit recently filed in Delaware Chancery Court, a major shareholder of Niagara Exchange Corp. charged that after it had announced a proxy solicitation, the directors of the insurance holding company delayed Niagara's annual meeting so that they could entrench themselves in office by placing a block of company shares in the hands of an ally. Reidman Corp., a Niagara shareholder, also claims that the board breached their fiduciary duty by implementing poison pill, golden parachute, super-majority and staggered-board provisions for no purpose other than entrenchment.

Similarly, an appellate court upheld the ruling of a federal judge in Massachusetts against the board of Norton Co. (*ER Holdings vs. Norton*) that postponing the company's regular annual shareholder meeting with less than 60 days' notice violated company bylaws. As in many other cases, the directors believed their actions were logical and justified. They said a two-month delay was needed to formulate a response and properly explore alternatives to a tender offer of a hostile suitor.

A contentious issue that should continue to bring about numerous suits is that of legal voting shares, such as the voting of Employee Stock Option Plan shares to prevent outside challenges.

The recently publicized struggle in which Kollmorgen Corp. successfully turned back a takeover bid by rival Vernitron Corp. by winning a

The 1989 Wyatt D&O Liability Study supports (the) idea that proxy fight litigation-related defense costs are substantial and increasing at a rate of 8% to 10% annually.

proxy contest is a good example. One of the major issues in the litigation between the two companies was Kollmorgen's controversial $23.2 million sale of preferred stock to an investor group aligned with management. The margin of proxy victory was less than the number of shares in question, and Vernitron claimed that the shares were issued solely to achieve that victory.

Moreover, the suits and countersuits between Avon Products Inc. and dissident shareholder Chartwell Associates shows that the legal battles can continue, even when both sides have supposedly negotiated an agreement to avert a proxy contest. Chartwell, whose members include John P. Rochon, vice chairman of Avon rival Mary Kay Corp., had previously said in SEC filings that Avon shareholders would be best served by the sale of the company. In the settlement, Avon agreed to place two directors nominated by Chartwell on its board and to include them on a committee that will consider ways to maximize shareholder value, while a joint press release spoke of the two parties' agreement to "operate in good faith." Within weeks after the settlement, however, Avon had filed suit charging Chartwell with false and misleading statements under the Securities Exchange Act about its intention to merge Avon with Mary Kay and its purposes for continuing to buy up shares of Avon's common stock.

It's difficult for managers to make policy decisions under unsettled conditions such as these. Perhaps more pertinent to director liability than litigation directly associated with the proxy fight is the charged atmosphere that these struggles create—a fertile environment for subsequent suits against directors and officers. The heated media campaigns that have become an accepted part of proxy solicitation not only promote an adversarial relationship between shareholders and management, but usually raise broad allegations of mismanagement and poor operating profits—possibly questions of integrity—which do not disappear once the contest has been determined.

In fact, the implications of proxy fights for both the company and its management are staggering, regardless of the poor odds of a challenger's winning. The very nature of a proxy contest and the shareholder activism surrounding it spell a

Continued on next page

Good risk management

Firms must apply risk control, risk financing techniques

By The Insurance Institute of America

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

This month's exercise focuses on recognizing potentially poor risk management decisions and critiquing them in ways that lead to more sound risk control and risk financing choices. The following question and answer are drawn from an examination in ARM 54—Essentials of the Risk Management Process.

A.R.M. excercises

Q: Good risk management usually requires that an organization apply both risk control and risk financing techniques to each of its major exposures to accidental loss. In view of this fact, explain why each of the following decisions probably does not constitute good risk management. Answer separately with respect to each decision and do not repeat any answers.

• The owner of a 10-story apartment building already fully retains all physical damage losses to the steam boiler that heats the building. Because the boiler room also contains a spare boiler that could heat the main building until the main boiler is repaired, the apartment operator decides that periodic safety inspections of the main boiler are an unnecessary expense and should be discontinued.

• An aircraft manufacturer decides to rely solely on strictly worded "hold-harmless" agreements from each of its subcontractors for protection against any product liability claims arising out of components manufactured by these subcontractors.

Indemnifying a manufacturer's losses under a hold-harmless agreement is not a primary business activity of most subcontractors; therefore, the manufacturer's own resources, or those of an insurer, generally provide more reliable sources of funds to pay for liability claims.

A: • Discontinuing inspections of the main boiler just because a backup is available ignores such potentially devastating possibilities as:

✔ Inspections of all boilers may be required by law so that failing to inspect any boiler may subject the apartment owner to criminal liability while strengthening the case of any civil plaintiff who may suffer injuries from any boiler explosion.

✔ An explosion of the main boiler may also wreck the spare one if they are situated close together.

• Failure to inspect all boilers may be evidence of such recklessness that the coverage provided by any other property or liability insurance the apartment owner has purchased may be jeopardized.

In contrast, taking care to inspect all boilers tends to greatly reduce and stabilize boiler-related risk financing costs, thus cutting the apartment owner's overall cost of risk related to these boilers.

• A "hold-harmless" agreement, even though it is quite strict in the sense of containing terms highly favorable to the aircraft manufacturer, may well be an unreliable source of risk financing funds for this manufacturer because:

✔ The agreement may not be legally enforceable, perhaps because it is vaguely worded or is contrary to either public policy or a specific statute in the state having jurisdiction.

✔ The manufacturer's subcontractors may be unwilling or financially unable to generate funds to meet the manufacturer's losses that fall within the scope of the hold-harmless agreement, even though these subcontractors may carry apparently adequate contractual liability insurance.

✔ The aircraft manufacturer may suffer a liability claim that falls outside the scope of the hold harmless agreement, especially if any ambiguity in this agreement is construed against the manufacturer as the sole drafter of its terms.

Indemnifying a manufacturer's losses under a hold-harmless agreement is not a primary business activity of most subcontractors; therefore, the manufacturer's own resources, or those of an insurer from whom the manufacturer has purchased appropriate liability insurance, generally provide more reliable sources of funds to pay for liability claims against such a manufacturer. ■

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

Proxy fights

Continued from previous page

reduction or loss of control over policy decisions.

A recent study analyzing 60 proxy contests for seats on the boards of exchange-listed firms during 1978-1985, conducted by Harry and Linda DeAngelo at the University of Michigan's J. Ira Harris Center, found that proxy contests are often followed by the sale or liquidation of the firm. "Less than one-fifth of the sample firms remain independent, publicly held corporations run by the same management team three years after the proxy contest, the study says, concluding that: "The evidence indicates that, once a proxy contest materializes, incumbent management face a serious threat to their tenure."

Many state statutes protecting directors and officers do not cover the very allegations most raised as a result of proxy contests: self interest, gross negligence, fraud and abuse violations.

Management's legitimate and honest decisions, as well as defensive maneuvers designed to help them keep their jobs and the company intact, can imperil them. Once a proxy contest is indicated, it is quite likely that the company, its directors and officers will be sued at some point. Directors or officers who willingly or unwillingly resign from their companies can be left without corporate indemnification, and the new entity or management team has no built-in incentive to take care of them.

Many state statutes protecting directors and officers do not cover the very allegations most raised as a result of proxy contests—self interest, gross negligence, fraud and abuse violations—nor necessarily apply to legal expenses. Therefore, a good directors and officers liability policy may be their only reliable protection.

Managers need the freedom to make decisions affecting the corporation without worrying about jeopardizing their personal assets. If they do lose their positions as a result of proxy fights, they need the ability to move on to other positions with their reputations intact and without worrying about previously made decisions. Before a critical situation arises, risk managers, directors and officers should make certain that they are fully aware of the provisions and exclusions of their D&O insurance by reviewing the policy with qualified legal counsel.

For instance, payment of defense costs on a current basis is an extremely important option given the high cost of legal fees, for it enables a person to wage an effective defense where one's reputation and personal assets are at stake.

It is also important to know that most policies become "runoff" after either a change in the composition of the board of directors or even a change in the right to vote for directors. Runoff policies typically provide directors no coverage for ongoing acts.

Risk managers must be aware of these coverage limitations and have contingency plans to offer continuous, unbroken coverage for directors. The sophistication of the insurer as a specialist in D&O liability, the insurer's capacity and available limits, and the underwriter's willingness to tailor coverage to the company's special needs will make a significant difference in the degree of comfort that directors and officers derive from their insurance protection.

As many observers have pointed out, the proxy process is a healthy, democratic one that addresses what may need changing in a company's policies and/or governance. At the same time, they tend to spawn expensive lawsuits and intensify management's vulnerability. Awareness of exposures is an important first step in implementing policies and procedures to reduce personal liability, such as instituting a shareholders' committee to advise the board. Outside directors also have the ability to ensure that they maintain a truly objective position, independent of officers and aware of shareholder concerns.

Risk managers, directors and officers should make certain that they are fully aware of the provisions and exclusions of their D&O insurance by reviewing the policy with qualified legal counsel.

While the volatility of the climate surrounding proxy fights precludes any certainty of protection, no matter how carefully one proceeds, informed risk managers can play an essential advisory role both prior to and during this crucial period. ■

Anthony J. Falkowski is senior vp of Executive Re Inc. in Hartford, Conn., which reinsures directors and officers liability coverage written by Aetna Casualty & Surety Co.

COBRA

Continued from page 1

sympathetic to the health insurance problems of older women, the lobbyists argue that employers shouldn't have to bear the burden for such a societal problem.

"There is a limit of employer responsibility for people who lack and never have had a direct employment-related connection to a company. This proposal far exceeds that limit," said Mark Ugoretz, executive director of the ERISA Industry Committee, a Washington, D.C.-based benefits lobbying group for large companies.

While COBRA—the Consolidated Omnibus Budget Reconciliation Act of 1985—lets employers charge beneficiaries up to 102% of the group rate for continuation coverage, benefit experts say beneficiaries' claims typically exceed the premiums they pay because those most likely to opt for COBRA coverage are those people who anticipate needing health care services.

Employers typically have been paying between $1.40 and $1.60 in claims for every $1 in COBRA premiums collected, said Mary Lynn Eubanks, a consultant at Hewitt Associates in Lincolnshire, Ill.

Consultants say that gap would widen if coverage were extended for up to 15 years for older beneficiaries.

"As the age of beneficiaries increases, the potential for more claims increases," said Ms. Eubanks.

"The COBRA premium is nowhere near going to cover costs," said William Miner, a consultant with The Wyatt Co. in Chicago.

But Gwen Gampel, president of Congressional Consultants, a Washington, D.C.-based health consulting firm, doubts expanding COBRA eligibility to 15 years for older beneficiaries will significantly raise employers' costs.

Ms. Gampel, who supports the extension of COBRA benefits, said few beneficiaries would opt for COBRA coverage for the full 15 years or anywhere near that long, noting that the proposal would not change the current COBRA provision under which COBRA coverage generally ceases when the beneficiary becomes covered under another employer's health care plan.

While few people would purchase COBRA coverage for 15 years, for those few in need of coverage "it is important and necessary," Ms. Gampel said.

Expanding eligibility would worsen problems employers have in explaining COBRA benefits to those eligible and tracking beneficiaries who do not work for them, consultants and lobbyists say.

"Fifteen years of keeping track of address changes, remarriages, collecting checks—it is not a pretty picture," said Wyatt's Mr. Miner.

Business lobbyists claim that the proposed expansion far exceeds the intent of COBRA: providing temporary coverage until more permanent insurance could be arranged.

"This is far beyond what is fair and reasonable," said James Klein, deputy executive director of the Assn. of Private Pension & Welfare Plans, a benefits lobbying group in Washington, D.C.

"Requiring companies to extend coverage for three years is strict enough. But it seems outrageous for an employer to have to extend coverage for up to 15 years to those who never worked a single day for the firm," Mr. Miner said.

"It makes COBRA virtually a permanent benefit," said Sharon Canner, assistant vp with the National Assn. of Manufacturers in Washington, D.C.

The congressional staffer, though, said a 15-year expansion is reasonable.

If the proposal became law, lobbyists and consultants say, it might presage continued expansion of COBRA.

"What is the magic of age 50 for beneficiaries to get up to 15 years of coverage? Why not age 25 or 35? When will it stop? That is what scares me," Mr. Miner said.

Ms. Gampel, though, doubts that the eligibility age for expanded COBRA coverage would be lowered in the future. "There is some kind of recognition that age 50 is the beginning of old age," she said.

Business groups also maintain that COBRA coverage could be expanded for former employees as easily as coverage for dependents. Currently, employees can obtain only up to 18 months of coverage after they quit or are fired, though coverage is not available in cases where an employee is fired for gross misconduct.

"Once legislators expand COBRA coverage for widows, there is a strong precedent for providing it to everyone until they become eligible for Medicare," said Frank McArdle, a Hewitt consultant in Washington, D.C.

While it's late in the current congressional session for introduction of the bill, business lobbyists warn there is plenty of time for it to pass if employers don't lobby against it.

Business groups say the proposal could surface in a deficit reduction package—known as budget reconciliation legislation—that budget and tax committee members and the White House now are attempting to put together.

"We are always fearful that something like this could be slipped through as part of reconciliation legislation. As a result, we take this proposal very seriously," said Elise Gemeinhardt, manager-public policy with the Washington Business Group on Health, a lobbying group representing large companies.

The original COBRA health care continuation provisions were part of a budget reconciliation law in 1986.

At that time, most employers were unaware that the act would require them to open up their group health care plans to millions of additional people. As a result, they were left scrambling to meet the administrative demands of the law.

"Many people didn't pay attention to the original COBRA legislation. They shouldn't make the same mistake twice," said Henry Saveth, a principal with A. Foster Higgins & Co. Inc. in New York.

Under the 1986 law, some companies had to comply within three months. Similarly, the COBRA expansion proposal as now drafted would take effect for plan years beginning after Dec. 31, 1990. Some observers, though, believe the effective date could be delayed if the proposal is passed very late in the congressional session.

While Rep. Kennelly drafted the proposal, she decided not to introduce the bill because she was too involved in the current negotiations on how to reduce the federal budget deficit, an aide said.

As a result, Rep. Kaptur is expected to step in to introduce the bill.

A congressional staffer said Rep. Kennelly remains committed to the proposal.

Enacting that proposal would mark the second expansion of COBRA in less than a year.

A budget reconciliation bill passed last year included an amendment allowing a beneficiary to keep COBRA coverage—even after becoming covered by another employer's health care plan—if the new plan excludes coverage for the beneficiary's pre-existing medical condition.

That amendment wiped out a provision in the original law allowing employers to cancel COBRA benefits for former employees who receive coverage from a new employer, even if that plan does not cover pre-existing medical conditions. ■

INTERNATIONAL

Poland considers insurance law

By STACY SHAPIRO

WARSAW, Poland—A proposal now before the Polish Parliament could become the first insurance law passed by the new democratically elected governments in Eastern Europe.

The Law (for) Carrying on Insurance Business in Poland, which could be enacted as early as next year, would allow foreign brokers and insurers to operate in Poland.

State-owned insurers would become stock companies and anyone meeting legal requirements would be allowed to form an insurance company under the proposal, which was introduced by the Polish Ministry of Finance.

"One of the intentions of the new law is to encourage foreign insurers to participate in the Polish financial services market," said Wojciech Kostrzewa, insurance adviser to the minister of finance. "It will introduce competition that can only be to the benefit of Polish policyholders and is vital to the restructuring of the Polish economy."

Mr. Kostrzewa recently announced the introduction of the new insurance proposal at the London headquarters of the Assn. of British Insurers.

According to the association, the British Department of Trade and Industry assisted in drafting the Polish legislation, which is modeled after the U.K. Insurance Companies Act and the European Community's insurance directives.

"Poland is the first of the newly democratized countries in Eastern Europe to announce a new insurance law," pointed out ABI Chief Executive Mike Jones.

Since Communist rule began in Poland shortly after World War II, two state-owned companies have dominated the nation's insurance market: the State Insurance Enterprise, known as PZU, which has been the only company authorized to write compulsory classes of insurance such as third-party automobile liability coverage; and Warta Insurance & Reinsurance Co. Ltd., which has been responsible for writing international insurance and reinsurance.

Under Poland's Insurance Act of 1984, Communist authorities allowed new insurance companies to be formed on a cooperative basis by domestic investors.

Despite "concessions toward liberalization," however, that law did not allow new insurance companies to write compulsory classes of business, the ABI said. "The act also decreed that any new insurance company should be at least 51% state-owned."

One new insurer, the Westa Insurance Cooperative, was formed in 1988 to write domestic insurance. According to an internal brochure from Alexander Stenhouse Europe Ltd., Westa now has offices in 42 of Poland's 49 regions and has an agreement with Germany's Colonia Insurance Co. to insure Polish nationals traveling to the West.

The Polish Insurance Act also was amended in May of last year "in what turned out to be one of the last attempts by the Communist government to reform the Polish economy," said the ABI. The amendments allowed the establishment of joint stock—also known as limited liability—companies, in which shareholders' liabilities are limited to their stock investment. The amendments also dropped the requirement for a majority shareholding by the state.

Several insurers, including a company called Polisa, were established after those reforms.

But the proposal now before the Polish Parliament is designed to create a truly Western-style insurance industry.

The proposal would allow any mutual society or joint stock company licensed by the Ministry of Finance to write insurance and reinsurance. A mutual society, which insures the risks of its members, would have to be listed on a court register of societies.

Continued on next page

Pollution liability rules for Antarctica to be considered

By MARIA KIELMAS

Representatives from 25 nations later this year will begin drafting a pollution liability protocol applying to mining activities in Antarctica.

Discussions over whether to add liability provisions to the 1988 Convention on the Regulation of Antarctic Mineral Resource Activities will be part of a conference on comprehensive measures to protect the fragile Antarctic environment, scheduled for Nov. 19 to Dec. 10 in Santiago, Chile.

The protocol, which officials from the 25 nations agree is designed to increase protection of the environment, may set liability limits for certain activities as well as establish a mechanism for assessing and adjudicating claims.

A further aim is to provide funds for immediate cleanup assistance should a party responsible for a pollution incident prove financially incapable of doing so. The fund could be financed by a levy on commercial operations on the continent, like private mining companies, or on some other basis.

"The view is taken that we need more detailed consideration of liability provisions prior to opening the area for mineral development," said a spokesman for the British Foreign Office in London. "There are issues applicable to oil development which are different from hard rock development."

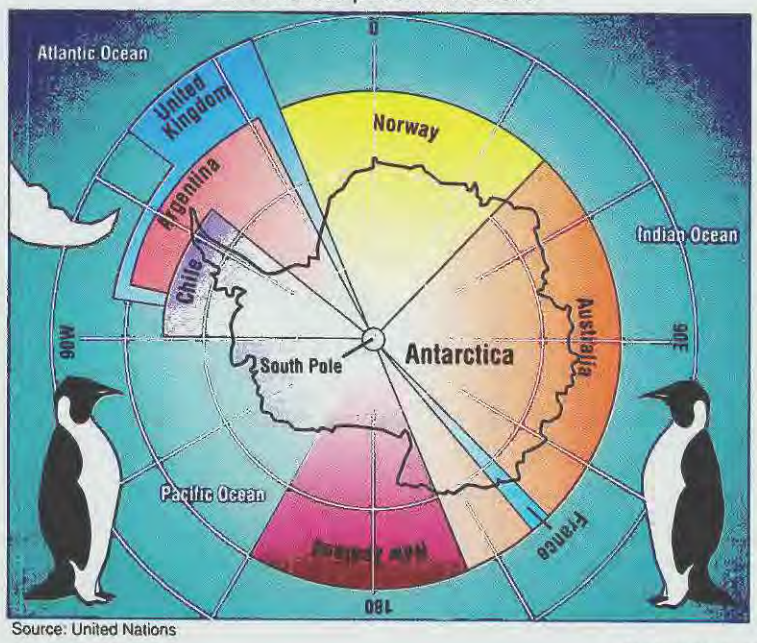
Another question "which remains to be tackled," said the spokesman, is whom the liable parties will indemnify in the absence of a settlement of Antarctic territorial disputes.

Seven nations—Argentina, Chile, Britain, France, Norway, New Zealand and Australia—claim territory on the continent, with the first three nations' claims overlapping (see map). Other than Norway's, all claims extend into the heart of the continent on the basis of the "sector principle," which delineates boundaries as meridian lines drawn from the South Pole to the eastern and western extremities of each country's coastal claim.

Norway disagrees with this principle, and claims inland territory based on the 1911 South Pole expedition by Norwegian explorer Roald Amundsen.

Antarctic territorial claims

Seven nations are claiming territory in Antarctica, which complicates the question of who should be indemnified in case of an Antarctic pollution incident.



Source: United Nations

BI/JOHN SMITHER

In 1961, Britain detached an area south of 60 degrees latitude south from the Falkland Islands dependencies to form the British Antarctic Territory. The aim was to insulate its Antarctic claim from any future settlement with Argentina over the Falklands. International lawyers have argued that this strategy may not hold up if Britain transfers its sovereignty over the Falklands.

The United States and the Soviet Union do not claim Antarctic territory but have reserved the right to do so.

The 1959 Antarctic Treaty, signed by 16 nations including the claimants, froze the territorial claims, banned military bases on the continent and aimed to encourage international scientific cooperation. There are now 25 nations

Continued on next page

Bleak profits foreseen for Lloyd's

By CAROLYN ALDRED

LONDON—Lloyd's of London members face several bleak years, some underwriters warn.

Massive losses in the late 1980s and early this year will produce poor underwriting results for several years and an upturn in rates may still be some years away, they said at the annual Assn. of Lloyd's Members conference.

About 450 names attended the London conference on July 17.

Underwriting accounts, which close after three years according to Lloyd's accounting system, still are suffering from deficiencies in reserves created in previous years, noted Anthony Haynes, chairman of the ALM.

Lloyd's results for 1987, which were released in late June, "do not show" that reserves for past underwriting years were underestimated by nearly 200 million pounds ($364 million), said Mr. Haynes. Without the need for additional reserves, 1987's profits would have been 190 million pounds more ($345.8 million), he estimated.

Noting that the same situation arose with 1986 results, he asked: Are these figures merely aberrations or do "they show that the market is materially underreserved?"

Results from the 1988, 1989 and 1990 underwriting years—which will be announced over the next three years—likely will vary greatly among marine syndicates, depending on the type of business the syndicates wrote, said Stephen Merrett, a leading Lloyd's marine underwriter.

Those specializing in energy business, for instance, likely will suffer losses due to major accidents like the Piper Alpha disaster of 1988 and the Phillips Petroleum Co. plant explosion in Pasadena, Texas, last year, he noted.

Syndicates that wrote much excess-of-loss reinsurance, especially London market excess-of-loss business, also will suffer because of the high volume of catastrophes in recent years, he added.

Mr. Merrett said a "probable" late-1990 contraction in the reinsurance market "may force increases in direct rates." But, he said, any "enthusiasm for underwriters to increase rates is not obvious yet."

Lloyd's members should look closely at the future business plans of syndicates "and try and evaluate how effective those plans will be in a continued difficult market," Mr. Merrett advised.

In the non-marine market, signs also are not very encouraging, according to non-marine underwriter David Robertson.

That market "should show an overall profit in 1988," but "what can I say about 1989?" he asked rhetorically.

Some 220 non-marine catastrophes costing a total of about $12 billion will make 1989 a "poor year," he warned. In addition, he said, "we had a desperately competitive market."

Mr. Robertson said he remains optimistic about the future.

"If we tread carefully in the years ahead there will be good profits to be made," Mr. Robertson said.

As for the aviation market, it was the most profitable market in

Continued on page 25

Premiums up most in Asia, Europe

By CAROLYN ALDRED

ZURICH, Switzerland—Life and non-life insurance premium growth surged in Asia and to some extent in Europe in 1988, while insurance premium volume grew by only 2% in the United States, according to the latest survey of world trends by Swiss Reinsurance Co.

The survey is based on net premium volume reported by direct insurers in countries where overall premium volume exceeds $100 million. Only domestic business is considered for each nation.

The survey is based on 1988 figures—the latest available when the survey was being compiled by the Zurich-based company.

"1988 may be termed an excellent year for insurance," said Swiss Re in its Sigma publication, which presented growth rates adjusted for inflation and differing exchange rates.

"Direct insurers collected ($1.171 trillion) in premiums for both life and non-life business. The real (worldwide) growth rate amounted to 8.6%," compared with 8.5% growth in 1987.

The report called 19.2% premium volume growth in Asian countries and 9.3% in the European Community "dynamic" and noted that "at 2%, the real growth rate of total business in the U.S.A. was clearly below the world average."

According to Swiss Re, the nations with the large premium growth in 1988 were Spain, 34.5%; Taiwan, 23.2%; and Thailand, 21.1%.

Meanwhile, life insurance premium volume continued to grow at a faster rate than non-life insurance. In 1988, life insurance premiums represented 52.6% of total premium volume compared with 51% in 1987.

As for individual spending, the Swiss continued to spend the most per person on private insurance in 1988: $2,324. The Japanese were only $3 per person behind and the Americans were third at $1,751 in per capita premiums.

North America still tops the

Continued on page 25

INTERNATIONAL

Poland

Continued from previous page

To obtain a license from the Ministry of Finance, an insurer or reinsurer must specify in an application:

- Company name, address and classes of insurance to be written.
- The capital at its disposal. However, the proposal does not spell out capitalization requirements for Polish insurers.
- The estimated costs of organizing its administration and agent network.
- The company's organizational structure.
- The qualifications of the people proposed to manage the company.

The application must also be accompanied by a business plan, which should include the company's reinsurance program and its financial projections for the first three years of operation.

The insurer/reinsurer must create reserve capital and technical and insurance reserves "to cover current and future obligations resulting from the insurance (reinsurance) business," the proposal says.

A portion of premiums is to go toward an "insurance guarantee fund," which will be used to pay claims arising from risks for which insurance is mandatory, including third-party auto insurance and agricultural property coverage, but the party at fault did not purchase insurance.

The proposal also would establish two "Insured Persons Protection Funds"—one for life insurance and one for non-life insurance—to pay 100% of all life insurance claims, 90% of all compulsory claims and 50% of all other non-life insurance claims if an insurance company becomes insolvent.

Use of brokers and intermediaries would be allowed under this proposal, though the Ministry of Finance plans to later draft regulations on broker licensing.

Insurers and reinsurers in which there is "foreign financial interest" must also be licensed by the minister of finance. A foreign company could, however, obtain a license if the supervisory authority in its domicile delivers a certificate to the Polish minister of finance.

Premium income could not be transferred out of Poland under the proposed law, though profits could be repatriated with some restrictions.

Foreign insurers would only be allowed to sell policies through qualified principal agents whose registered office or residence is in Poland.

Also, the parent of a licensed foreign insurer must pay a deposit against future obligations, which is equivalent to 25% of the minimum guarantee capital of a licensed company.

The proposed law could allow some restrictions on coverage conditions and rates that would curb competition for compulsory coverages.

Under the proposal, the minister of finance will issue an ordinance that will define the general conditions that must be met by compulsory insurance policies, such as third-party auto and agricultural property risks. ■

GLOBAL BRIEFS

NRG's plan to acquire Victory would place it among Top 20

AMSTERDAM, The Netherlands —Netherlands Reinsurance Group N.V.'s plan to buy reinsurer Victory Insurance Holdings Ltd. of London and its non-U.S. units would push the Amsterdam-based company into the ranks of the 20 largest reinsurers.

NRG plans to pay 122.1 million pounds ($222.2 million) for Victory, which has subsidiaries in Australia and Bermuda and branch offices in Canada, Hong Kong and New Zealand, the companies said.

In 1989, gross premiums for the units being acquired were 224.9 million pounds ($409.3 million) and net premiums of 172.6 million pounds ($314.1 million), evenly split between life and health reinsurance and non-life reinsurance.

Combined consolidated gross premium income of NRG and the Victory units would have been about 650 million pounds ($1.05 billion at appropriate rate) at the end of 1989 and net premiums would have been about 487 million pounds ($784 million), NRG said.

That volume would have placed NRG in the *Business Insurance* rankings of world's 20 largest reinsurers (*BI*, Aug. 28, 1989).

To finance its purchase, the reinsurer—which is 51% owned by Nationale Nederlanden N.V.—proposes to raise 240 million Dutch guilders ($129.8 million) by issuing 120 million new common shares.

Victory, a unit of Legal & General Group P.L.C. of London, will continue to operate under that name after the sale, said NRG.

Legal & General said it will retain Victory U.S.A., which represents a small proportion of Victory's reinsurance business and "is now closed to new business."

Explaining the sale, Joe Palmer, L&G's group chief executive, said: "We concluded that the Victory Group needed to be considerably larger if it were to compete effectively over the longer term with the major international reinsurers."

An NRG statement said the purchase is "expected to lead to a broadening in the range of products offered by the enlarged NRG Group and to a stronger competitive position in the world reinsurance markets."

The sale is conditional upon approval of regulators and shareholders in both companies.

—By Carolyn Aldred

E.C. auto directive

BRUSSELS, Belgium—Under the motor insurance directive passed by the European Council last month, companies meeting criteria in the second non-life insurance directive could insure their auto and truck fleets across European Community borders.

According to the council, several E.C. nations were concerned about protecting accident victims, so the council agreed that "for a transitional period" insurers should hold "sufficient reserves" in each of the E.C. countries where they sell third-party auto insurance to pay for "potential liabilities."

This reserving is to be phased out when the planned framework directive on non-life insurance is adopted and introduced to member states, the council added.

Meanwhile, the council also agreed on the proposed life insurance directive that would have to be approved by the European Parliament before being adopted. Among other things, the directive allows companies to buy group life insurance across E.C. borders.

The directive will allow an E.C. citizen to purchase insurance from "an insurer in any member state on his own initiative and thus enable him to choose from all types of policies available within the community," said Sir Leon Brittan, vp of the European Commission.

—By Stacy Shapiro

Antarctic liability

Continued from previous page

that are consultative parties to the 1959 treaty, which means they have established permanent scientific bases in Antarctica.

However, there are no liability requirements under the 1959 treaty, which is the only legal framework currently in force on the continent.

In 1982, the then-20 consultative parties to the 1959 treaty began negotiations on a minerals convention. The Convention on the Regulation of Antarctic Mineral Resource Activities was signed in 1988.

Article 8 of CRAMRA, titled "Response Action and Liability," states that a party conducting mineral activities and, in certain cases the sponsoring nation, will be held strictly liable for:

- Damage to the Antarctic environment and dependent ecosystems arising from mineral activities, including payment in the event that there is no restoration to the condition before the activity.
- Loss of or impairment to an established use of dependent or associated ecosystems.
- Loss of or damage to property of a third party or loss of life or personal injury of a third party.
- Reimbursement of reasonable costs to whoever incurred them in relation to necessary response action to clean up damage and restore the area to its pre-existing condition.

Only two defenses to this liability are available: unforeseen natural disaster; and military action or terrorism against which no reasonable precautionary measures could have been taken.

Paragraph 7a of the Response Action and Liability article stated that a separate liability protocol would be adopted at a later date.

CRAMRA must be ratified by at least 16 of the 20 consultative parties present at the first negotiations in 1988, including all seven territorial claimants, the United States, the Soviet Union and a minimum of five developing nations.

But, in response to a worldwide public and environmentalist outcry that greeted the presentation of CRAMRA in 1988, two of the territorial claimants—Australia and France—have proposed that Antarctica be declared a wilderness reserve and that mining activity be prohibited.

"The Minerals Convention is now on its last legs," says Jagdish Patel, Antarctica lobbyist for environmental group Greenpeace in London. Greenpeace has called for Antarctica to be declared a world park, with mineral and military activity banned and tourism strictly monitored.

Greenpeace claims no country has taken responsibility for a spate of accidents last year that threatened the Antarctic environment.

For example, the Argentine resupply ship Bahia Paraiso ran aground in January 1989, producing a 7.4-mile diesel oil slick along the Antarctic coast.

The following month, two ships—the British resupply vessel H.M.S. Endurance and the Peruvian ship B.I.C. Humboldt—ran aground and caused oil spills, according to Argentine scientists on the continent.

"Antarctica (territorial claimant) nations have done nothing to help; they are not cleaning up," Mr. Patel said.

A U.S. government official in Washington told *Business Insurance* that protests by environmentalists against CRAMRA along with the subsequent stances taken by Australia and France have delayed discussions on the liability protocol.

The British Foreign Office official said "our view of the situation as it now stands is that what is needed is a means by which decisions can be made if anyone wants to go there (Antarctica) and dig things up."

"In our view, a total ban does not provide that means and, in 20 or 30 years would, in any case, break down," he said.

The U.S. official said the U.S. government currently is formulating its own position on the liability protocol.

He noted that the question of whom should be indemnified for Antarctic pollution incidents can be settled without confronting the territorial claims.

For instance, a commission could be set up under the Minerals Convention—such as the existing Antarctic Minerals Commission—that would include members from all the consultative parties to the convention. "The commission could be the plaintiff" if the Antarctic environment is spoiled, the official explained.

However, no discussions are under way at the moment with the property/casualty insurance industry about the Antarctic liability proposals because the liability protocol is only at a conceptual stage, the U.S. official said.

"But the industry may be able to advise later on a liability fund, limits of liability, who will set up the liability rules and how to evaluate (the financial toll of) environmental damage and damage to wildlife and the ecosystem," the official said.

"The private sector has a lot of valuable experience in (assessing liability in) areas such as space nuclear waste and oil spills, but the problem remains that none of those is really applicable to the Antarctic," he added.

The reason for the difference, according to legal experts, is that the the impact of environmental damage in Antarctica to surrounding ecosystems could be catastrophic and long-reaching and, thus, is as yet unquantifiable.

Another difference is that legal principles that work in uninhabited areas—like space or the deep sea—cannot be applied to an area that has been subject to sovereignty claims for many decades and nearly a decade of human activity.

"This is a case which envisages the cooperation of a large number of countries, insurers, environmentalists and scientists. It's all very challenging," the U.S. official pointed out. ■

Advertiser Index

Issue of July 30

Business Insurance

INTERNATIONAL

Premium growth

Continued from page 23

other major areas of the world for market share with net premium volume of $457.9 billion, or a 39.1% share of the world life and non-life insurance market. Europe is second with a net premium volume of $349 billion and a market share of 29.8%. Asia follows with $322.7 billion and 27.6%.

"Despite the recovery of the U.S. dollar in relation to the currencies of the most important industrial countries, North America was unable to retain its world market share. The loss amounted to about 0.7%," said the Sigma report.

"The insurance industry in Asia —with a real growth rate of 19.2%—has demonstrated the strongest growth. This represents a clear growth acceleration as compared with 1987," said the report.

Among the 10 countries with the highest 1988 growth rates, five were in Southeast Asia: Taiwan, 23.2%; Thailand, 21.1%; Japan, 19.5%; South Korea, 19.2%; and Singapore, 16.6%.

Among the European nations with the greatest growth were Spain, 34.5%, and Portugal, 16.4%. Both nations recently joined the European Community.

"Spain's extraordinary growth, unparalleled in 1988 by any other country in the world, is attributable solely to the strong growth in the life sector (70.2%)" caused by the government creating tax advantages for buying life insurance, according to the report.

Also in Europe, Luxembourg, France, Greece and The Netherlands all reported premium growth rates exceeding 10% in 1988.

However, the insurance markets in West Germany, which reported 8.4% premium growth, Italy, where premium volume rose 7.7%, and the United Kingdom, which reported premium growth of 2.5%, showed "distinctly slower growth than in 1987," the report noted.

Meanwhile, "the share of total business accounted for by non-life business decreased again in 1988 from 49% in 1987 to 47.4%" in 1988, the report notes.

According to Swiss Re, non-life business has continued to decline as a portion of total business during recent years. In 1980 non-life business represented almost 60% of all worldwide insurance premiums.

North America continued to have the largest share of non-life insurance market in 1988 with 48.4% of the world's net premiums, or $268.4 billion. Europe, with net premiums of $179.7 billion, had a 32.4% share of the world non-life insurance market, while Asia, with net premiums of $85.1 billion, had a world share of 15.3%.

•

For a copy of the Sigma report, contact J. Arbacher, Head of Economic Studies, Swiss Reinsurance Co.; P.O. Box 8022; Zurich, Switzerland; 01-208-2543.

Lloyd's fortunes

Continued from page 23

1987 for the third straight year, said aviation underwriter Anthony Hines.

But, he warned, those results will not likely be repeated for 1988, 1989 and 1990.

Despite three straight years of plummeting rates and increasing losses, he advised members to grit their teeth and stay on their aviation syndicates.

"This is a cyclical business and we have reached the bottom of the cycle. If we are to survive, rates are going to have to increase," he said.

Sir Francis Dashwood, a working member and chairman of a Lloyd's members agency, agreed that now is not the time to resign.

Although he expressed surprise that recent catastrophes have not increased rates, he predicted that "1989 and 1990 will be the bottom of the cycle, and it's a mistake to come out of a market when it's at the bottom."

Sir Francis said he is "deeply apprehensive about 1989 and 1990, but I think there will be a tremendous recovery in 1992." ■

Lloyd's urged to expand overseas

By CAROLYN ALDRED

LONDON—Lloyd's of London should now move to expand its business in foreign markets other than the United States and curb its experiments to attract small-risk business, says a stock analyst.

Europe and Asia—other than Japan—will lead insurance growth in the 1990s, predicted Roger Harvey, director of insurance research at Kleinwort Benson Securities, a London brokerage (see story, page 23).

"That is a strong argument for diversification now—not in five years," he said at the annual Assn. of Lloyd's Members meeting July 17.

"There are no grounds for complacency by Lloyd's," he warned, pointing out that U.S., European and Japanese insurers are strong enough to "finance a long period of great competition."

Lloyd's should "concentrate on writing big risks rather than mass risks," Mr. Harvey argued, referring to recent attempts by some syndicates to attract Main Street and personal lines business.

"Bread-and-butter business seems a dangerous route for Lloyd's to go" given the strength of traditional insurers, said Mr. Harvey.

Lloyd's instead should concentrate on large, complex risks and other areas where it has clear advantages, he said.

Elvin Patrick, chairman of Bankside Underwriting Agencies Ltd., agreed that the exchange will not find it easy to write large volumes of small risks on a direct basis without relying on Lloyd's brokers.

He said the experiment in personal lines business should be "handled centrally" and confined to the domestic U.K. market.

Mr. Patrick said he doubts that syndicates have the expertise or resources to compete directly with major insurers. "Lloyd's should not deal direct overseas but should encourage overseas brokers to become Lloyd's brokers," he added.

The market will remain "dependent on brokers," Mr. Patrick said.

He also forecast that multinational brokers will become increasingly "alienated" from the Lloyd's market, while the "smaller, specialist brokers will continue working with Lloyd's."

Meanwhile, several speakers at the conference believed that the ban on Lloyd's brokers owning syndicates has resulted in a marked decline in the amount of business brokers have brought to Lloyd's.

Before the Lloyd's Act of 1982 was enacted, forcing brokers to divest their Lloyd's underwriting agencies, many underwriting agents were owned by Lloyd's brokers.

"Divestment in hindsight was the wrong decision but we were told that we would not get self-regulation without divestment," said Lloyd's non-marine underwriter David Robertson.

"We would like to open up the debate again to see if we could change it, but then the whole of the '82 act would be up for review," he noted.

Mr. Robertson said underwriters were looking at ways of "working much more closely with brokers."

This is known at Lloyd's as "the New Deal," he explained, referring to the new wave of underwriters and brokers seeking to do business with each other.

However, Stephen Merrett, a leading marine underwriter, argued that declining amounts of business probably have more to do with the changing marketplace than divestment.

"The changing market and world has diminished the flow of business into Lloyd's," said Mr. Merrett. To turn that tide, he added, Lloyd's will need to learn to "reflect the needs of our customers."

"I believe we will get a good deal back by working with brokers to get closer to customers," he said. ■

LONDON

Sorema Reinsurance creates London non-marine company

By STACY SHAPIRO and CAROLYN ALDRED

LONDON—Sorema Reinsurance Co. of Paris is setting up a new London company with 30 million pounds ($54.3 million) in capital to write non-marine reinsurance.

Sorema (U.K.) Reinsurance Ltd., which is awaiting Department of Trade and Industry approval, will be headed by Managing Director Nigel Harley, former chairman and chief executive of Continental Reinsurance Corp. in New York.

Five people have joined Sorema U.K., but he says he hopes to recruit more staff members soon.

The new company is being financed by Sorema U.K.'s ultimate parent, the French insurer Groupama, the marketing name for Caisse Centrale de Mutuelle Agricole. Groupama has injected 500 million francs ($90.9 million) of additional capital into Sorema, in part to start up Sorema U.K., the companies announced.

Sorema has also acquired for an undisclosed sum Continental Reinsurance Technical Risk Management and its facultative reinsurance portfolio. CRTRM is a London underwriting unit of Continental Reinsurance Corp.

Under terms of the proposed acquisition, Marcus Corbally, who heads CRTRM, will join Sorema U.K. as its deputy managing director; and his specialist team will be joining him.

A spokesman said Sorema also has overseas units in Copenhagen and Singapore.

Syndicates stop writing

Lloyd's of London syndicates 185 and 87 will stop underwriting at the end of the year following losses stemming from the Piper Alpha oil rig disaster in 1987.

The syndicates, managed by Claremount Underwriting Agency Ltd., are the latest casualties of the Piper Alpha incident, which is costing insurers more than $1.4 billion.

"The reason behind this decision (to stop underwriting) is that there are indications from supporting members' agents that they are not prepared to continue unless there is a change of underwriter for the 1991 account," Claremount Chairman John Oakes said in a letter to syndicate members this month.

"During the last few weeks, we have been trying to find a suitable person to take over as active underwriter of syndicates 185 and 87" to replace Alan Gorsuch "but unfortunately we have been unsuccessful," he added.

Because the syndicates decided to stop writing, their 1988, 1989 and 1990 accounts, which still remain open under Lloyd's three-year accounting system, will be reinsured for an adequate premium into the accounts of syndicate 2, also managed by Claremount, the letter said.

The 1988 account of syndicate 185 is "dominated by the Piper Alpha claim, and the final outcome of this account will depend largely on whether the claim exceeds the (syndicate's reinsurance) program," the letter said.

Meanwhile, for the 1989 and 1990 accounts, "the percentages of both the settled and incurred claims against net premium income are very high. This is because, having paid heavily for an extensive reinsurance program and having declined business for commercial underwriting reasons, the account was left with very little net premium," said the letter.

Mr. Oakes' letter gave no loss estimates and he was not available for comment.

Underwriter banned

The Council of Lloyd's of London has banned Graham John Potter from underwriting at Lloyd's, though he can still remain a member. Mr. Potter has not appealed the sentence.

The former underwriter for syndicate 384, managed by Aragorn Agencies Ltd., resigned in April 1988 after his agency accused him of a serious breach of Lloyd's regulations. That misconduct led to cash calls of syndicate 384 members (*BI*, May 16, 1988).

The agency's charges against Mr. Potter stem from a retrocessional contract covering the liability account of syndicate 553, whose underwriter was Cyril Warrilow. Mr. Warrilow resigned from syndicate 553 in 1987 after his syndicate reported huge U.S. liability losses for the 1984 underwriting year.

According to Aragron's allegations, the retrocessional cover for syndicate 553 was bound in January 1984. However, the premium was too large to incorporate into syndicate 384's 1984 accounts without the syndicate exceeding its premium limits, so Mr. Potter instructed broker Butcher Robinson & Staples Ltd. to withhold the slip for signature until 1985. As a result, the retrocessional contract was effective from March 1984 although the premium was paid by special settlement in 1985.

Lloyd's expelled Mr. Potter from underwriting because:

- He willfully deferred the entry of the reinsurance contract, thereby delaying the submission of the slip to the Policy Signing Office. This led to the premium income not being included in the 1984 underwriting year, which "circumvented" Lloyd's monitoring of premium income limits and solvency.
- He willfully and "without reasonable excuse" prevented syndicate members in 1984 from benefiting from the premiums and the interest on the premiums. ■

The professional marketplace

RATES AND CLOSING TIME:

Rates: *Display classified is $108.50 per column inch, minimum of one inch. Straight classified is $9.00 per line, minimum of 5 lines. Count 34 characters per line (include each space and punctuation as a character). Additional $17.50 charge for all blind box ads. Only those reponses which fit into a business size envelope will be forwarded. Responses are forwarded daily.*

Closing: *Published every Monday. Copy must be in typewritten form by noon Tuesday, 6 days preceding publishing date. No verbal phone copy accepted. Prepayment required for straight advertisements. Mail ads to Margaret Hikido, Classified Advertising, 740 N. Rush St. Chicago, IL 60611. For more information call 312-649-5340. FAX 312-280-3189.*

LOGIC ASSOCIATES, INC.

Risk Management Executive Search Consultants

Celebrating Our 12th Year Of National Service To The Risk Management Community

Telephone 212-227-8000
Fax 212-766-0188

170 Broadway Suite 1208
New York, New York 10038

"The Original and #1 Choice in Risk Management Recruiting"

SENIOR UNDERWRITER WORKER'S COMPENSATION

Progressive Sarasota-based Worker's Compensation carrier seeks experienced underwriter to live and work in beautiful Sarasota, Florida.

Three to four years experience underwriting all types worker's compensation programs. Strong benefit package. Send resume with salary history to:

P.O. Box 1598
Sarasota, FL. 34230-1598
Attn: M. Roberts

TPA SALES

Irvine, California based start-up TPA needs salesperson for self-funded medical plans. Knowledge of re-insurance and regulatory environment required. Light travel within California. Salary plus bonus. Send resume and salary requirements to:

Diana De Wees
WGA INSURANCE SERVICES
P.O. Box 2130
Newport Beach, CA 92658

PRODUCER ACCOUNT EXECUTIVE

Our consulting firm is on retainer with a very select group of brokers who offer serious and unique opportunities in the following vibrant locations:

San Diego
•
Seattle
•
S.E. Florida
•
Los Angeles

For the above locations, our clients will consider proven producers from outside the area.

We also have excellent clients looking for local candidates in the following locations:

Phoenix/Tuscon
•
Chicago
•
Suburban Philadelphia
•
San Francisco Bay Area

Our clients range from privately held firms offering equity possility to national brokers with large resource centers.

They are not like the typical "looky-loos" you may have encountered that just like to talk. These firms invested in a unique retainer program available only to serious firms with specific, aggressive growth plans.

In addition to general commercial producers, we would particularlylike to hear from those with expertise in construction, health care, and marine.

IR Group

Please contact Richard Shoemaker, President, IR Group Companies, 7844 Madison Avenue, Suite 106, Fair Oaks, CA 95628, or call (916) 965-5511 and ask for the Project Leader for the city of interest.

ROLEX

President "Look-A-Like"

An Exact Replica! Gold-tone, Day, Date, Hidden Clasp, Simulated Diamonds, State-of-the-Art Quartz Movement. Easily confused with the real 18K Gold Rolex. Ladies' or men's. Only $39.95 (add $5.00 post/hndlg/insur. In CA, add $2.60 tax). COD-OK. Call 1-800-648-4600 or send check to: AVADIO , 9016 Wilshire Blvd., #828-K, Beverly Hills, CA 90211

Insurance

SAFETY COORDINATOR

Management position to supervise safety for 22 store chain. The successful candidate will be responsible for providing safety management which includes training, risk analysis, managing in-house G.L. small claims, develop safety program, monitor G.L. and Workman's Compensation and serve as liaison with compensation and G.L. carriers.

Successful applicant will have a proven track record in safety education and insurance. B.S. in business administration or health care management preferred.

We offer a competitive salary commensurate with experience and a comprehensive package.

Interested candidates should send resume and salary requirements to:

Eileen Manion
Shoppers Food Warehouse
3129 Pennsy Drive
Landover, MD 20785

SHOPPERS FOOD WAREHOUSE

EOE M/F

INSURANCE MANAGER

AGWAY

Central N.Y. Location

Challenging opportunity to direct insured and self-insured programs. Underwriting and claims required. Finance desired. Excellent benefits.

Send resume and salary requirements in confidence to:

R. Schlote
Agway Inc.
Box 4933
Syracuse, New York 13221
E.O.E.

UNDERWRITER

A successful Austin-based health care company looking for experienced underwriter. 3-5 years experience in Indemnity and HMO underwriting required. The candidate selected must be a Registered Health Underwriter or a Certified Employee Benefits Specialist. Excellent salary and benefit package. Send resume and cover letter with salary requirement to:

Personnel/UW
P.O. Box 9420
Austin, Texas 78766
EOE

HELP WANTED

RISK MANAGER

Responsible for planning, coordinating and controlling a comprehensive program of risk management which minimizes the County's exposure to loss of its income or damage to its physical facilities. Duties include developing comprehensive policies for the County Executive and County Board, implementing loss control/prevention programs and procedures for County Departments, establishing adequate insurance coverage through purchase on the open market, self-insurance and new risk concepts, and ensuring insurance standards for contractors, vendors and lease holders. Ensures that claims processing and adjusting are completed in accordance with policies. Also responsible for employee safety programs, vehicle accident investigation and workers' compensation claims administration.

An evaluation of experience and education will be made and only those who appear to be best qualified will be considered. Minimum qualifications would be a combination of seven to ten years of experience and education in the broad risk management field working in a manager's or assistant manager's position. Government experience as a Risk Manager or Assistant Manager is preferred, Annual salary range minimum $42,523, control point $53,153, maximum $58,469. Competitive benefit package including most benefits paid by the County. This position is in the exempt service.

Interested persons should submit a brief account of education and professional experience to:

Sylvan Leabman, Fiscal and Budget Administrator, **Milwaukee County Department of Administration Courthouse, Room 308, 901 N. Ninth Street, Milwaukee, WI 53233**

Equal Opportunity Employer

REGIONAL MARKETING MANAGER

Rebound, Inc., a national health care corporation specializing in the rehabilitation of traumatic head injuries, is expanding and has an excellent opportunity for an experienced sales and marketing professional based in either Des Moines or Omaha.

Responsibilities will be to:

- Establish a network of contacts, including case managers, physicians, and area medical and insurance professionals;
- Develop marketing plans and programs;
- Increase referrals and build census at our Kansas City facilities.

Qualified candidates will possess a proven record of 3-5 years successful sales experience in a health care industry or working as a case manager. Pre-established network of contacts a definite plus. Rebound offers an excellent compensation package including a base salary plus commissions.

Interested candidates may respond to Amy Stepp, Marketing Director, 1001 NE Independence Ave., Lee's Summit, MO 64063, Fax (816) 525-3670.

EOE

Rebound, Inc.
A HEALTH CARE CORPORATION

PROGRAMS WANTED!

Non-admitted insurance company client seeks MGA book of profitable P&C and/or health business in CA, FL, TX, GA, NC, SC & some others. Send full details (including loss history, present carrier & commission requirements) on confidential basis for prompt reply.

WESTMINSTER/ORIENT CAPITAL CORPORATION
2121 AVE. OF THE STARS
SUITE 629
LOS ANGELES CA 90067
(213) 551-6529 • FAX 551-6622

PREMIUM FINANCING

- * OFFSHORE COMPANIES
- * NON-RATED COMPANIES
- * COMMERCIAL ONLY
- * FLEXIBLE RATES

We specialize in companies which lack sufficient financials to obtain conventional premium financing. Funded Trust Accounts are normally required of non-rated companies, or companies which cannot pass our credit test.

Call or Write:

BIC PREMIUM FINANCE
10420 OLD OLIVE ST RD
P.O. BOX 66967
ST. LOUIS, MO 63166-6967
314-997-3660 or 800-727-4446

HELP WANTED

CAREER OPPORTUNITY
EMPLOYEE BENEFIT ADMINISTRATOR/CONSULTANT

NATIONAL TPA has unique career opportunity for a highly motivated benefits professional with the ability and desire to become a consultant in the employee benefits field. Reporting directly to a top level executive, this position offers exposure to all areas of benefit plan administration and consulting with outstanding potential for growth into top level corporate management.

Candidates must desire to live and work in Michigan and possess the skills to communicate effectively with clients, attorneys and other professional advisors. Five or more years pension experience and the CEBS designation is desirable. Send resume and salary history in confidence to:

Director of Personnel
P.O. Box 88500
Indianapolis, IN 46208

COMMERCIAL P&C PRODUCERS

Production, Production Mgmt., Branch Mgmt. and Agency Mgmt. positions available in S.E. and Mid. Atlantic U.S.A.

If you are presently a commercial P&C Producer and if you have a verifiable production record of at least $150k new business comm. income per year for the last 3 years I would like to talk to you.

I am a Comercial Production and Production Management Headhunter. My clients are all national or regional brokerage houses and blueblood independents who are looking for real talent. So if you are under compensated or un-challenged in your present position I can assist you as I have assisted dozens of other senior producers

Positions will be $100k plus (package) and equity is available in some situations. Absolute descretion is assured.

Call Maurice Burton, Maurice Burton & Co.
(404) 477-2266, Atlanta Georigia
Serving the Brokerage Community since 1979

President, Bank-Owned Insurance Company

Firstar Corporation, an $8 billion Milwaukee-based bank-holding company active in three states, seeks a President for an established, profitable and rapidly growing insurance company. Annual premium volume exceeds $40 million.

The President directs all activities of the agency which interfaces with over 125 holding company bank locations, as well as with a broad network of correspondent banks. The President also directs a captive life company, a title insurance agency, and participates in the direction of brokerage sales thoughout the holding company.

The service lines of the agency include credit life and health, annuities, personal lines, personal life, commercial life and specialized products for financial institutions. An experienced staff of 55 works with over 300 licensed agents in the bank locations.

The Senior Management of Firstar is committed to the continued growth of this successful business. They seek an individual whose marketing and management skills and knowledge of the industry are established. A competitive salary, based on qualifications, and a very attractive incentive with a complete package of corporate benifits accompany the offer.

If you qualify and are interested, plese send your resume and salary history in confidence to:

FIRSTAR
777 E. Wisconsin Avenue, Milwaukee, WI 53202
c/o George A. Graham Jr., First Vice President, Box PIC

NEW PRODUCTS

Guaranteed Conversion System

Turn those P&C files into L&H gold New: Guaranteed Conversion System CSR & Agents team up for profits. Complete system only 49.00 + 2.50 HL. Send check to **JVP INS, PO Box 272, Carbondale IL 62903.** DO IT NOW...

GET RESULTS!

Advertise in the PROFESSIONAL MARKETPLACE

HELP WANTED

SAFETY INSPECTOR
$2,279-$3,054/month

The County of Orange seeks an individual to perform safety inspections and accident investigations, as well as conduct employee safety classes. This individual will be responsible for maintaining statistical records, writing reports and preparing correspondence. Knowledge of state and federal Occupational Safety and Health Act and other laws, codes, and regulations relating to industrial safety and the California Workers Compensation Act is required.

Excellent benefits offered. Call for information and a mailed application (resumes cannot be accepted) or pick up materials in person. Final filing date is Monday, August 6, 1990.

(714) 834-2844
COUNTY OF ORANGE
Personnel Department
10 Civic Center Plaza
Santa Ana, CA 92701

Affirmative Action Employer M/F

GROUP SALES MANAGER

Midwest life and Health insurer has an excellent opportunity for a knowledgeable individual for the newly restructed position of Group Sales Manager.

Continuing growth has led to an expansion of our group sales department. The person in this new position will be responsible for overseeing the daily sales functions for all group products, directing the sales staff, and will participate in strategic planning and product development. This position reports directly to the Vice President of Sales.

To qualify for this key role, the candidate must have hands on supervisory/managerial experience in selling employee welfare programs. A minimum of a bachelors degree as well as strong written and oral skills are also required. Equal opportunity employer. Interested and qualified candidates may submit their resume in confidence, along with salary requirements, to: **Box 2621, Business Insurance, 740 Rush St. Chicago, IL 60611-2590.**

Business Insurance

Circulation Breakdown*

Commercial Consumers

Administrative:
CEO's Presidents, and Owners . 3,291
Vice-Presidents, General Managers and Other Administrative Personnel 3,847

Financial:
Chief Financial Officers and Vice-presidents of Finance 2,382
Secretaries, Treasurers, contollers and other Financial Personnel 3,562

Risk/Employee Benefits:
Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations 11,566

Sub-total 24,648

Associations 539
Government, Unions and Educational Institutions 1,389

Commercial Consumers
Sub-total 26,576

Insurance Agents and Brokers . 10,223
Insurance Companies 7,713
Accountants, Actuaries, Attorneys & Consultants 3,353
Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers 1,115
Others Allied to the Field 2,149

TOTAL 51,129

* Source Business/Occupational breakdown of qualified circulation, November 27, 1989 issue, as submitted to BPA for December 1989 BPA Publisher's Statement.

Rhode Island

Continued from page 3

on the state capitol that was led by Gov. DiPrete.

Insurance trade groups say a provision in the package providing for annual cost-of-living increases for permanent and partially disabled workers will likely increase costs.

But advocates of the package say this provision will be offset by other reforms, including one that cuts benefits to partially disabled workers who cannot demonstrate that they have tried to get a job.

Among other things, provisions in the package:

- Call for the creation of a competitive state fund to write workers compensation risks.
- Extensively overhaul the system that administers the award of workers compensation benefits.
- Create anti-fraud measures to crack down on outside income by disabled workers receiving workers comp benefits.

Business and labor leaders say they are pleased with the workers comp package and are optimistic about its impact on the workers comp system in Rhode Island.

"We feel very strongly that in the long run it will provide great incentives for cost reduction as well as improved efficiency," said Francis J. Holbrook, executive director of the Rhode Island Chamber of Commerce Federation in Providence.

"I think the final legislation is good legislation," said Sheldon Sollosy, president of Manpower Inc. of Providence, who was active in passage of the legislation.

While "it's going to take a few years to work out," there will be cost savings as a result of the legislation, Mr. Sollosy predicted. "I wouldn't have worked so hard if it didn't" result in cost savings, he added.

"I think it will bring us to a point where the burden of workers compensation is shouldered somewhat more equally by both the employee and the employer," said Mark McKenney, an attorney with Providence-based Higgins, Cavanagh & Cooney, which represents employers and insurers in workers comp cases.

"Basically, it gives employers a lot of tools they didn't have available to them before," said George Healy, an attorney with Warwick-based Olenn & Penza, who represents employers in workers comp cases.

The legislation gives employers the ability to bring about premium reductions assuming they are willing to put in the effort to stay on top of claims, Mr. Healy said.

"I think it's a good package for the people we represent," said Edward J. McElroy, president of the Rhode Island AFL-CIO.

But, Mr. McElroy said, the "proof is in the eating," explaining it will take some time before the merits of the legislation can be proven.

However, Roger Messier, owner of Providence-based insurance agency Butler & Messier and named by the governor to the Workers' Compensation Advisory Council created by the legislation, said: "I don't really believe at this point that it will be a cost saver. I think finally it will be a cost stabilizer" that can introduce "some semblance of sanity" into the system.

And, insurance trade group officials are considerably less enthusiastic about the legislation.

The NCCI's Mr. Burton said he cannot precisely measure the effects that the legislation will have on workers comp costs. But, "this bill may add cost to the system rather than reduce cost to the system," he said.

Similarly, Joseph DiGiovanni, vp for the American Insurance Assn. in Boston, said: "We don't think it's going to save anything, and in fact it's going to cost money.

"I think what they ultimately ended up with may satisfy people's political needs," Mr. DiGiovanni said. But, "I'm not sure that over the long term they've really accomplished a whole heck of a lot."

Messrs. Burton and DiGiovanni both criticized provisions in the legislation that will provide annual cost-of-living benefit increases for injured employees. Benefits will rise commensurately with increases in the Consumer Price Index.

The cost-of-living increases will add to workers comp costs, Mr. Burton said, noting there currently are no provisions for such benefit increases.

"The problem is the cost-of-living increases add system costs to a system that's really, from a cost standpoint, out of control at this point," said Mr. DiGiovanni, pointing to insurers' huge rate hike request.

He said the COLA increases should have been capped and that some benefits should have been reduced to compensate for the COLA increases. "You generally try to put some parameters around these kinds of system changes," he said.

The legislation also provides that a partially incapacitated employee who has reached the point of "maximum medical improvement" will receive only 70% of the normal benefits, unless the worker can demonstrate he has unsuccessfully attempted to find a job.

After six years, the partially disabled worker must again prove that he is unemployable for his benefits to continue, in what observers describe as a "gate" provision.

'This bill may add cost to the system rather than reduce cost,' says NCCI's Mr. Burton.

In addition, at that point, the injured worker would no longer be entitled to negotiate a settlement with his employer or insurer, putting the worker at risk of receiving no further benefits.

However, an injured worker who can prove he is unemployable can then continue to receive benefits until he fully recovers, or until his employer can demonstrate he is once again employable.

Mr. Burton said the "gate" provision also could increase system costs. After six years, those injured workers who feel they are not able to return to work are likely to seek counsel and produce additional "frictional" costs to the system, Mr. Burton said.

Mr. DiGiovanni also noted that the gate only will be as effective as the people who administer the system.

Also unhappy with this provision is John Harnett, an attorney with Lovett, Schefrin, Gallogly & Harnett in Providence, who represents employees in workers comp cases.

The provision puts the burden of proof on the employee to show he is unemployable, Mr. Harnett said. Until now, it was up to the employer to prove the employee was marketable, he said. "I don't like the concept," he said.

Furthermore, because both insurers and employees will become a "little skittish" as the six-year mark approaches about whether benefits will be continued, it is likely to encourage settlements, "which is not necessarily a good thing" for a truly injured worker, Mr. Harnett said.

"I think what they did was kind of limited in scope, to just kind of pick on the injured worker," he said.

But Mr. Healy, the employers' attorney, said he believes that 90% of the benefit recipients probably would not be able to get through the "gate," though he added that those who prove they are unemployable should continue to receive benefits.

Another controversial measure in the legislation is the creation of a competitive state workers comp fund, which initially will be funded by a $5 million loan from the state. The fund will function similarly to a mutual insurance company.

Mr. Burton said the fund fails to address the "systematic problems" affecting workers comp in Rhode Island.

"We don't view that as a responsible way to reform the system," said the AIA's Mr. DiGiovanni.

But Mr. Messier, the insurance agent, said that if the state fund can show it "can operate profitably and operate with a reasonable loss ratio. . .it will show the insurance companies that they have to get their act together."

"I think it will bring some insurers back into the voluntary market if it's successful," Mr. Healy said. And at least on paper, there is no reason why the state fund cannot be successful, he said, noting it has proven to be a "tremendous tool" in other states.

Less controversial are measures that call for overhauling workers comp administrative procedures.

Under the current system, claims disputes are first heard by hearing officers for the Department of Workers Compensation. Then, if subsequently appealed, they are heard by the Workers Compensation Commission for trial on a de novo basis, without relying on evidence previously introduced at the departmental hearing.

As a result, claimants knew they had nothing to lose by pursuing the case, Mr. McKenney said.

Under the new structure, disputes first receive a mandatory pretrial hearing by workers comp judges. If the dispute is not resolved at that point, it goes to a trial, but before the same judge who initially heard the case.

Holding both steps in the judicial process before the same judge decreases the likelihood of a different decision and therefore may discourage continuing litigation, Mr. McKenney said.

"It gets that element of greater predictability" that is now missing, Mr. McKenney said. He also noted that the Department of Workers Compensation hearing officers had a reputation among employers for being too lenient.

John Kane, director of Rhode Island's Department of Administration, agreed that this provision "will allow for more efficient handling of cases in the beginning because the judge who hears the first step will also be the judge who hears the subsequent follow-up." This will lead to quicker decisions and put workers into rehabilitation programs more quickly, he said.

Another administrative measure included in the new law permits employees to receive benefit payments for 90 days after filing a claim without the employer accepting liability for the injury.

Under the previous system, the burden was on the employer to file a notice of controversy so it could fight a claim, Mr. McKenney said. Otherwise, an employer was precluded from later fighting a claim on its merits. This led employers to file notices as defensive measures, sometimes even if a claim had not been filed by the employee, which bloated the system.

In some cases, it created a situation in which an employee who had not yet filed a claim found himself in a hearing room with an official ready to offer him money, he said.

Also under the previous system, once a notice of controversy was filed, employers were permitted to cut off benefits to employees, Mr. McKenney noted. Although the cases were theoretically supposed to be heard within 14 days after the notices were filed, because of the volume, they were often not heard for eight to 12 weeks, leaving the employee without benefits for that entire period.

The new system gives the employer time to investigate claims "and won't starve the employee out while waiting to do so," Mr. Healy explained.

The stronger anti-fraud measures in the new law provide that any employee who obtains workers comp benefits fraudulently can be prosecuted for larceny by the state attorney general.

Meanwhile, passage of the law will delay a hearing on the NCCI's workers comp rate increase proposal.

The NCCI is proposing a 123.3% rate increase for insurers that write less than 1% of the voluntary market and for insurers writing assigned risk plan policies. It also is seeking a 28.1% increase in loss cost rates for insurers that write at least 1% of the voluntary market (*BI*, March 19).

A provision in the new law means the rate hearing must be delayed for additional data to be submitted, said Edward Balfour, chief of the property/casualty division at the Rhode Island Department of Business Regulation, which supervises insurance in the state.

The provision calls for regional, as well as state, data to be included in any filing. At present, only state data is submitted in rate filings.

The legislation also provides that rate filings reflect that employers that pay at least $2,000 in annual workers comp premiums receive an experience modification allowance. Current limits vary from $3,000 or $3,500, Mr. Balfour said.

Rhode Island work comp rates were last increased in 1989, including a 32% increase in fully developed rates for the assigned risk plan and a 41% increase in loss cost rates approved for those insurers that write at least 1% of the market. ■

Insurer disputes benefit policyholders

By STACY ADLER

SAN FRANCISCO—If policyholders have a motto when litigating with insurers, it might very well be "divide and conquer."

By fostering disputes between insurers, policyholders can win huge judicial victories, according to insurer attorneys.

For example, insurers received one of their biggest legal defeats in history when a California Superior Court judge handed down a series of broad coverage rulings in a 1987 coordinated asbestos coverage case (*BI*, Sept. 12, 1988; June 1, 1987). The defeats occurred largely because insurers spent more time litigating with each other than with the policyholders, they said.

From the asbestos cases, insurers learned not to fight among themselves, said Jeffrey H. Haney, an insurer attorney with Bishop, Barry, Howe, Haney & Ryder in San Francisco.

Mr. Haney and several other prominent insurer attorneys discussed insurer vs. insurer disputes at a June program in San Francisco sponsored by the Practising Law Institute, the nation's oldest nonprofit legal education group.

Insurers in the San Francisco coordinated asbestos litigation became "myopic," focusing only on when coverage should be triggered and failing to see the big picture, said Mr. Haney, who represented insurers in that case.

"Insurers lost sight of the other issues and spent day and night arguing the trigger issue," agreed Phil Matthews of Hancock, Rothert & Bunshoft in San Francisco.

Some insurers said coverage should be triggered when the claimant manifests an asbestos-related disease, some said coverage should be triggered when the claimant is exposed to asbestos and still others argued the coverage should be triggered when the asbestos injury occurred.

"The insurers divided on date of loss and decided to make that the focus of the case," said Mr. Matthews, who represented insurers in the asbestos litigation.

The result was devastating for insurers: California Superior Court Judge Ira A. Brown Jr. ruled in 1987 that coverage was triggered continuously from the time a claimant is exposed to asbestos until he dies. Infighting among insurers "had a great deal to do with Judge Brown's decision," Mr. Haney said.

"He couldn't help but be affected by the constant discord," Mr. Haney said. "It is human nature."

"The only person who benefits from insurer vs. insurer disputes is the policyholder," he said.

Mr. Matthews agreed: "The policyholder doesn't even have to argue his case. He just has to say, 'Your honor, clearly the policy is ambiguous.' "

If a court finds a policy to be ambiguous, more often than not it will rule against insurers who drafted the murky language.

As a result, policyholders often try to engender disputes between insurers, Mr. Matthews said.

"It is limitless what an insured can gain by taking this approach," Mr. Haney said.

"The best way to help the policyholder out is to sue other insurers," claimed Mitchell Lathrop of Adams, Duque & Hazeltine in San Diego.

"By litigating these disputes, insurers shoot themselves in the foot," Mr. Haney agreed.

Smart insurers will recognize the need to separate insurer vs. insurer disputes from the policyholder litigation, Mr. Haney said.

He recommended that inter-insurer disputes be bifurcated from insurer-policyholder disputes.

And Mr. Matthews recommended that insurers try to keep their disputes "fair and friendly."

Too often these inter-insurer disputes become acrimonious, "like a divorce proceeding," he said.

As a result of past mistakes, insurers have learned a lesson, according to the attorneys.

Many insurers now are attempting not to litigate with each other when litigating with a policyholder, they said.

"Today, when the defense committee (of insurer attorneys) sits down, they say 'let's not fight among ourselves,' " Mr. Haney said. ■

Insider trading

American International Group Inc.: Mary Elizabeth Fajen, director, disposed of by gift 600 shares of common stock at an unreported price per share on April 18 and now directly holds 9,705 shares.

John J. Roberts, director, disposed of by gift 1,000 shares of common stock at an unreported price per share on April 2. Mr. Roberts now directly holds 456,213 shares.

Maureen P. Tully, officer, sold 300 shares of common stock at $102.38 per share on May 31 and no longer holds any shares in the company.

AIG stock was trading at $95 per share on July 20.

Aon Corp.: Harvey N. Medvin, vp, disposed of by gift 800 shares of common stock at an unreported price per share on April 23. Mr. Medvin indirectly acquired by gift 800 shares that same day. In addition, Mr. Medvin exercised an option for 400 shares of common stock at $16.72 per share on May 7. He now directly and indirectly holds 278,940 shares.

Aon stock was trading at $36.50 per share on July 20.

Chubb Corp.: Joseph A. Morein, vp, disposed of by gift 224 shares of common stock at $47.38 per share on June 18 and now directly holds 600 shares.

Chubb stock was trading at $46.88 per share on July 20.

Corroon & Black Corp.: Joseph V. Ambrose, officer and director, indirectly purchased 223 shares of common stock at an unreported price per share on June 11 and now directly and indirectly holds 28,855 shares.

Robert F. Corroon, director, disposed of by gift 300 shares of common stock at an unreported price per share on May 1 and now directly and indirectly holds 145,995 shares.

Marnix L.K. Guillaume, officer, sold 454 shares of common stock at an unreported price per share on July 1 and now directly holds 10,046 shares.

Richard M. Miller, chairman, disposed of by gift 100 shares of common stock at an unreported price per share on April 16. In addition, Mr. Miller disposed of by gift 100 shares of common stock at an unreported price per share on June 25 and now directly and indirectly holds 209,536 common shares.

Corroon & Black stock was trading at $30.75 per share on July 20.

The Hartford Steam Boiler Inspection & Insurance Co.: Wilson W. Wilde, officer and director, exercised an option for 43,900 shares of common stock at between $27.50 and $32.56 per share on June 29. In addition, Mr. Wilde purchased 100 shares of common stock at $57.13 per share on May 9. He now directly and indirectly holds 105,370 shares.

Paul A. Vatter, officer and director, purchased 100 shares of common stock at $57.13 per share on May 9 and now directly and indirectly holds 84,168 shares.

Hartford Steam Boiler stock was trading at $61 per share on July 20.

Hilb, Rogal & Hamilton Corp.: Theodore L. Chandler, shareholder, purchased 5,000 shares of common stock at between $12.87 and $15 per share from April 10 to April 27 and now directly and indirectly holds 22,499 shares.

Thomas B. Leitch, vp, exercised an option for 2,200 shares of common stock at $6 per share on June 6 and now directly holds 31,975 shares.

Hilb, Rogal & Hamilton stock was trading at $16 per share on July 20.

Kemper Corp.: Thomas K. Anderson, officer and director, exercised an option for 5,400 shares of common stock at $19.29 per share on April 5 and now directly and indirectly holds 45,932 shares.

Walter L. White, officer, exercised an option for 7,800 shares of common stock at between $12.88 and $19.29 per share on May 10 and now directly holds 9,824 shares.

Kemper stock was trading at $42 per share on July 20.

Marsh & McLennan Cos. Inc.: J. Michael Bischoff, vp, sold 500 shares of common stock at $79 per share on May 31 and now directly and indirectly holds 5,310 shares.

Richard H. Blum, director, exercised an option for 1,000 new shares of common stock at $33.19 per share on May 25 and now directly and indirectly holds 72,740 shares.

Adele S. Simmons, director, sold 7,000 shares of common stock at $73 per share on May 21 and now directly and indirectly holds 153,299 shares.

Frank J. Tasco, chairman, disposed of by gift 845 shares of common stock at an unreported price per share on April 27 and now directly and indirectly holds 112,027 shares.

Philip L. Wroughton, director, exercised an option for 20,000 shares of common stock at $33.19 per share on May 15 and now directly and indirectly holds 33,397 common shares. M&M stock was trading at $74.63 per share on July 20.

NAC Re Corp.: Ronald L. Bornhuetter, president, sold 10,000 shares of common stock at $33 per share on June 25 and now directly holds 64,249 shares.

Gerald Tsai, director, purchased 250 shares of common stock at $32 per share on May 14 and now directly holds 1,000 shares.

NAC Re stock was trading at $33.75 per share on July 20.

The St. Paul Cos. Inc.: Robert J. Haugh, director, disposed of by gift 1,650 shares of common stock at an unreported price per share on May 2 and now directly and indirectly holds 32,931 shares.

St. Paul stock was trading at $59.50 per share on July 20.

SCOR U.S. Corp.: Francois C. Negrier, director, sold 2,055 shares of common stock at $10 per share of June 27 and now directly holds 7,117 shares.

Richard L. Weiler, officer of subsidiary, sold 1,258 shares of common stock at $10.50 per share on June 11 and now directly holds 5,666 shares.

SCOR U.S. stock was trading at $10.63 per share on July 20.

U.S. Healthcare Inc.: Ellen L. Cass, vp, sold 6,666 shares of common stock at $15.25 per share on May 14 and no longer holds shares in the company.

Hyman R. Kahn, officer and director, disposed of by gift 45,000 shares of common stock at an unreported price per share on May 30 and now directly and indirectly holds 190,582 shares.

Kathleen Lunemann, vp, sold 6,866 shares of common stock at $14 per share on May 4 and no longer holds shares in the company.

Scott Murphy, vp, sold 4,000 shares of common stock at $14.13 per share on May 7 and now directly holds 4,000 common shares.

David B. Soll, director, sold 25,000 shares of common stock at $14.88 per share on May 9 and now directly holds 99,155 shares.

U.S. Healthcare stock was trading at $17.50 per share on July 20.

UNUM Corp.: Donald W. Hartward, director, purchased 300 shares of common stock at $45.15 per share on April 5 and now directly holds 300 shares.

Robert Swiggert, director, purchased 1,000 shares of common stock at an unreported price per share on May 21 and now directly holds 5,098 shares.

UNUM stock was trading at $53 per share on July 20. ●

Insider Trading, prepared by Invest/Net Group Inc. from reports filed by the Securities and Exchange Commission, tracks stock sales and purchases by insurance industry directors and officers.

Walbrook

Continued from page 1

which had been London's largest U.S. casualty underwriter.

Under the plans, policyholders and several major U.S. ceding companies will be asked to commute their policies: accept cash payments based on their known losses and predictions of their unknown losses on Walbrook policies and terminate the insurer's future liabilities to them.

Effectively, it means, "Here's your cash; tear up your policy," said Paul Evans, senior manager at accounting firm Price Waterhouse in London. LUI administrators Colin Bird and Alan Barrett are partners with accountant Price Waterhouse.

These commutations would permit Walbrook to remove liabilities from its books and "financially strengthen" the company, say the administrators of LUI.

The few policyholders of insolvent London United Reinsurance Co. Ltd. in Bermuda and Desert Insurance Co. Ltd. in Bermuda will also be asked to commute their contracts.

Meanwhile, the policyholders of the other four insolvent LUI insurers probably will be paid claims through court-approved schemes of arrangement "in order to provide protection from policyholders seeking winding up," say the administrators.

The four companies are Kingscroft Insurance Co. Ltd., Lime Street Insurance Co. Ltd. and El Paso Insurance Co. Ltd. in the United Kingdom and Mutual Reinsurance Co. Ltd. in Bermuda.

Many policyholders of these four insolvent insurers could receive up to 90% of their claims through these schemes of arrangement combined with some recoveries through the Policyholders Protection Board, the U.K. guaranty fund, according to Mr. Evans. Only individuals in partnerships, not corporate policyholders, would be able to recover from the board, which is financed through a levy on British insurers (*BI*, May 7).

Ceding companies of the four insurers also would not be able to collect from the Policyholders Protection Board.

These proposals, the details of which are yet to be worked out, were unveiled by the administrators at an LUI creditors meeting last week in London. The meeting was described as "quiet" by attendees.

LUI in May was put into court-ordered administration—the British version of U.S. Chapter 11 reorganization—after attempts to raise new capital failed (*BI*, May 28). Appointment of the LUI administrators does not extend to LUI's 30 other subsidiaries, including its seven insurance subsidiaries and Weavers.

However, the administrators are seeking to recover income from LUI assets to pay LUI creditors, which include banks and LUI's own Weavers. The administrators can cajole the LUI directors to sell LUI assets and help in discussions to solve the insurance subsidiaries' problems.

"The approach taken by the administrators has been to seek the protection of LUI's assets, the realization of certain of those assets in the short term and to seek to maximize the value of other assets in the longer term as a means of endeavoring to maximize returns to creditors of LUI," said the administrators' letter to creditors.

LUI's 15 main creditors and 21 minor ones—those owed less than 5,000 pounds ($9,050)—collectively are owed around 39.4 million pounds ($71.3 million), say the LUI administrators. Policyholders of LUI insurance units are not included as creditors.

The largest of the creditors are: Barclays Bank P.L.C., owed 14.9 million pounds ($27 million); Weavers, owed 12.7 million pounds ($23 million); and Royal Bank of Scotland P.L.C., owed 7.1 million pounds ($12.9 million).

A creditors committee including Barclays Bank, Weavers and Royal Bank of Scotland was formed last week.

Trevor Jones, principal of security newsletter Insurance Security Services, who said he represents policyholders owed $1.2 million by LUI insurance subsidiaries, objected that the insurance creditors were not included in the committee.

"They intend to design all of these actions without any involvement with insurance creditors at all," Mr. Jones said.

If insurance creditors aren't given some control over the administration of LUI, he says he would bring legal action.

However, the administrators are inviting major policyholders and ceding companies to form an advisory committee to assist in the scheme of arrangements for Kingscroft, Lime Street, El Paso and Mutual Reinsurance.

Others at the meeting and in the London market approve of the administrators' actions.

"I think the administrators have done a good job," said John Garner, chairman of the Lloyd's of London Insurance Brokers Committee. "It's the best that could have been done."

Mr. Garner would not comment on the apparent failure of an attempt by a brokers' working party —led by Sedgwick Group P.L.C. and Marsh & McLennan Cos. Inc. —to raise money to rescue the insurers. "The brokers' plan has been overtaken" by the administrators' actions, he said.

The brokers, which had considered seeking court-approved schemes of arrangements for all seven insurers, apparently now are satisfied that an orderly runoff of the business will proceed.

Directors of Walbrook—led by Sir Ian Morrow, who was appointed chairman of Walbrook in May—propose the commutations to "strengthen the financial position" of the company, say the administrators, who added they approve of the plans for Walbrook and the other units.

"It is anticipated that a number of leading U.S. insurance companies which have been reinsured by the LUI group, together with other major groups of policyholders, will explore the possibility of commutation" with Walbrook, the administrators said.

Mr. Evans would not identify these policyholders and U.S. ceding companies.

Walbrook, as the leading underwriter on the Weavers line slip, underwrote over the years many professional liability and general liability insurance policies for lawyers, accountants, brokers, hospitals, doctors and many major U.S. corporations.

Among Walbrook's clients are members of the Los Angeles Bar Assn., the New York Bar Assn., the Big Six accounting firms, major American hospitals, doctor-owned mutuals and Fortune 500 companies.

It is anticipated that Walbrook would negotiate with each of its policyholders to arrive at a sum that is fair to both sides to pay known and anticipated losses, according to Mr. Evans. This process could take up to two years, he said.

At the moment, Walbrook is solvent and is paying 100% of all claims, so policyholders would not have to accept less than full payment of known and anticipated claims, London sources agreed.

However, Walbrook cannot collect in full reinsurance claims from the six other insolvent LUI insurance subsidiaries and must anticipate defaults by other non-related reinsurers, stress the administrators.

The advantage of commutation is certainty of at least some payment. Policyholders would receive their claims payments immediately. However, the ultimate cost of future claims could exceed the estimates.

The alternative for policyholders is not to commute their policies and gamble that Walbrook will be around in 25 years to pay claims.

Commutations will have to be worked out with policyholders on an individual basis, which will be a "lot of work," said Mr. Garner of the LIBC. "But policyholders would be very sensible to negotiate" with the administrators, he added.

The plan means, 'Here's your cash; tear up your policy,' says Paul Evans of Price Waterhouse.

Brokers will be working with the administrators to establish the level of claims to be paid to policyholders, Mr. Garner said.

If policyholders commute their Walbrook insurance contracts, the strategy "could lead to an improved net asset position" of the company, say administrators. Walbrook could then pay a dividend to LUI "and it is conceivable that LUI would have a valuable subsidiary," said Mr. Evans.

Administrators say the book value of Walbrook is 54.8 million pounds ($99 million), although they add that it is "uncertain" how much could be recovered from the sale of Walbrook today.

If the commutations do not succeed and Walbrook is put into a court-approved scheme of arrangement, "it is likely that creditors of LUI would not receive further dividends until the outcome of the scheme proposals was known, which could be a long time," the administrators say.

Meanwhile, LUI's administrators told creditors that the directors of the other six insolvent insurers also have plans to pay claims. The six insurers stopped paying claims in March after actuaries from Tillinghast, a division of Towers, Perrin, Forster & Crosby, discovered that the companies' reserves are about 100 million pounds ($181 million) deficient (*BI*, May 7).

The directors of London United Reinsurance and Desert are "also pursuing a strategy of commuting their insurance liabilities," stated the administrators. There are very few claimants of these two companies and these mainly involve ceding company, says Mr. Evans. The amount of claims is considered "negligible."

The directors of Kingscroft, El Paso, Lime Street and Mutual Reinsurance are preparing schemes of arrangement to be approved by the British High Court and "the policyholders of those companies in due course," say the administrators. The schemes allow the orderly runoff of the companies with creditor approval without forcing the companies into liquidation.

"The schemes will be prepared in such a way that advantage can be taken of the Walbrook commutation strategy if policyholders wish to commute with other LUI group companies and are expected to provide for claims of policyholders to be met as they arise, partly in cash and partly by the issuing of loan notes for later settlement," say the administrators.

Mr. Evans could not say what percentage of each claim would be paid to policyholders of these four insurers.

However, many policyholders could be paid up to 90% of their claims against the four insolvent insurers with the help of the U.K. Policyholders Protection Board, added Mr. Evans.

But the policyholders will have to qualify under the Policyholder Protection Act in order to receive this level of claim payment, London sources agree.

The act states that the Policyholder Protection Board has a duty in the event of an insurance company liquidation to pay 90% of all claims to individual policyholders who are not "bodies corporate" that hold valid insurance contracts written in the United Kingdom. These would include individuals in partnerships such as doctors, lawyers and accountants.

The board can also act when a company is insolvent but not in liquidation if "payments to policyholders is the cheaper option" than liquidation, said Mike Jones, chief executive of the Assn. of British Insurers.

The policyholders would be paid from a fund not yet accumulated that would be financed by a maximum 1% levy on all British insurers' non-life insurance premiums. Based on last year's total gross non-life premium volume for ABI members, the maximum levy would be 224 million pounds ($405.4 million).

While the ABI acknowledges the Policyholder Protection Board's role in LUI's affairs, "the cost to general insurance companies should be as small as possible," Mr. Jones said.

Also, a British court may be asked in future to clarify "what constitutes a partnership and what constitutes a U.K. policy," he said.

Overall, however, "things do not look that bad" for policyholders of LUI insurance subsidiaries, Mr. Garner commented.

In an effort to raise money to cover LUI's debts to creditors, the creditors voted unanimously last week to sell within a year some LUI assets for an estimated 20 million pounds ($36.2 million), the LUI administrators say.

The administrators propose selling:

- First Reinsurance Co. of Hartford for around $25 million, says Mr. Evans.

First Re, which is owned by LUI subsidiary JBR Holdings Inc., in May—with the administrators' approval—sold its subsidiary LUI Insurance Syndicate Number Two Inc., which traded on the Illinois Insurance Exchange in Chicago.

- LUI's 35% share in Oland International Companies Inc., a Los Angeles-based brokerage. This holding is valued at around 3.7 million pounds ($6.7 million).
- LUI's 25% share in London-based brokerage ABC Insurance Services Ltd., which owns Lloyd's of London brokerage J. Besso & Co. Ltd. The holding is valued at 300,000 pounds ($543,000).

The administrators are also planning to sell off smaller LUI assets, including a Rolls Royce and two other company cars; paintings, which are being valued by Christie & Co.; a 45,000 pound ($81,450) statue stuck in cement outside LUI's offices on Bermondsey Street in London; and "property in Barbados."

The property in Barbados includes a piece of land and an apartment building owned by an LUI subsidiary, Mr. Evans said.

•

Associate Editor Carolyn Aldred in London contributed to this story.

Reaction to plan mixed in U.S.

By MARK A. HOFMANN

Initial reactions in the United States to the plans for handling the liabilities of Walbrook Insurance Co. Ltd. and other units of London United Investments P.L.C. are mixed.

The proposals contained "no real surprises," said Roger D. Oaks, director of risk management for the Tennessee Farmers Cooperative Inc. in La-Vergne, Tenn., a policyholder of H.S. Weavers Underwriting Ltd., which underwrote on behalf of the LUI insurance units.

Mr. Oaks said that he would like to see "something further" on the details of the commutations proposed by the directors of Walbrook, which was the lead insurer on the Weavers line slip.

Any commutation agreement will have more of an impact on insurers that had been reinsured by LUI units than it would on individual policyholders, said Mark Wilson, corporate risk manager for First Mississippi Corp. in Jackson, Miss.

First Mississippi's policy with Weavers has no commutation clause, he said.

However, it is not necessary for policies to contain a commutation clause for policyholders to agree to commutations with Walbrook.

Robert J. Vairo, chairman and chief executive officer of Basking Ridge, N.J.-based Crum & Forster Inc., units of which are reinsured with LUI, said that Crum & Forster supports the work of the administrators but remains "leery" of the commutation approach.

Crum & Forster has "been very active on the so-called working party" attempting to resolve the Weavers situation, he noted.

He stressed, however, that he thinks "liquidation would not be in the best interests of anyone."

The new proposal "rests largely on a broad-based, successful commutation. We question whether or not a commutation plan could get this done in a timely manner," he said. "It just simply isn't going to work overnight."

Mr. Vairo said Crum & Forster, which currently estimates that it will ultimately be owed about $140 million in reinsurance recoverables from LUI units, would prefer a "funded approach" to the commutation plan.

Under a funded approach, administrators would "marshal all assets of the Weavers companies, including Walbrook, and determine what those assets are and what additional funds are needed" to satisfy creditors, he said.

Then outstanding and anticipated claims would be calculated and a decision made whether there are enough assets to pay current claims in full. If assets were insufficient, current claims could be paid at an amount less than 100 cents on the dollar with the balance paid as funds became available over time, he said. The companies would be in a runoff condition for as long as 25 years, he said.

"That's a more business-like approach" than commutation, he said.

Despite concern over the effectiveness of commutation, Mr. Vairo emphasized, "we are not getting out of the process" and will continue working with the LUI administrators on a resolution.

"We would be willing to serve on a creditors committee," he said.

BASF explosion

Continued from page 3

"We are adequately insured for property damage and liability, with deductibles commensurate to the size of our corporation," a BASF spokeswoman said.

Six of the injured workers remained hospitalized late last week. Four of those injured workers were in serious or critical condition, and two were in fair condition.

Other injured workers have been released from area hospitals after having been treated for cuts, broken bones and burns of various severity.

Workers compensation benefits for the 71 workers injured and the one maintenance worker killed in the blast will be paid by the Ohio Bureau of Workers Compensation, the exclusive state workers compensation fund for all Ohio companies that do not self-insure their workers comp risks.

The state fund fully covers policyholders for their workers compensation risks.

Temporary total disability benefits of 72% of lost wages begin the eighth day an injured worker is off work.

If the worker remains off work due to his injuries for at least 14 days, he receives 72% of lost wages for the first seven days he missed work.

After 12 weeks, injured workers receive 66⅔% of their weekly wages based on an average of their salary over a 12-month period prior to the injury.

However, compensation cannot exceed the weekly average wage in the state of $419 a week.

Compensation continues until the worker is able to return to work or has reached the maximum recovery level.

If the worker has not returned to work by the time he has reached his maximum recovery level, he must apply to the state's workers comp bureau to have the disability reclassified as either permanent partial or permanent total disability to continue receiving workers comp benefits.

Compensation for lost wages for permanent partial injuries is based on the degree of medical impairment.

Compensation for permanent total disability continues at 66⅔%

OSHA may come to a different conclusion about the cause of the blast than the fire department.

of the average weekly wage for the life of the injured worker.

In all situations, full medical benefits continue as long as treatment for the work-related injuries is needed.

If a worker is killed immediately in a work-related accident or dies at a later date as a result of the injuries sustained in the accident, temporary total disability benefits are payable for the life of the qualified beneficiaries.

An allowance for funeral expenses also is included in the benefits.

Gerling also is the lead underwriter of BASF's liability coverage, writing 40% share of the coverage. The rest was placed in the U.S. market, Mr. Nowak said.

Gerling had no estimate of the liability damage but did not expect it to be very large, he said.

The Cincinnati Fire Department believes the explosion occurred when a reactor that was being cleaned with heated solvents as part of routine maintenance did not properly vent the flammable vapors normally created in the process, according to Fire Chief Miller.

"Either through human or mechanical error, the vapors were not vented off," he said.

This resulted in a buildup of pressure within the reactor that triggered the reactor's rupture disk, which is designed to release any vapors within the reactor before the reactor itself explodes, Mr. Miller said.

However, the vapor cloud that was released came into contact with an ignition source and exploded, he said.

An Occupational Safety and Health Administration investigator, though, indicated that the agency may come to a slightly different conclusion.

"We have gathered some evidence that seems to conflict, and we are not sure if we can concur with what they gave as the cause," according to William Murphy, an investigator in OSHA's Cincinnati office.

•

Associate Editor Michael Schachner in New York also contributed to this report.

Products omitted from RMIS chart

The chart of the most popular risk management information systems in the July 23 issue failed to include two products: GAB Business Services Inc.'s Claims Management Reporting System and ESIS Inc.'s CRIS-CIGNA Risk Information Services system. The revised chart appears below.

In addition, ESIS was omitted from the directory of risk management information system vendors in the same issue. Information about the company follows:

ESIS Inc.

1600 Arch St., Philadelphia, Pa. 19103; 215-523-3088; fax: 215-523-3261

Year founded: 1792 (parent company).

Parent company: Insurance Co. of North America/CIGNA Corp.

Software products:

- CRIS-CIGNA Risk Information Services: bundled product; unbundled hardware and software; personal computer compatible with mainframe; year of first installation, 1983; 738 total installations, 373 in risk management departments; functions include providing financial, loss control, claims administration, benefits, legal and actuarial information.
- CAF-CRIS Advanced Functions: $1,000 and up; unbundled hardware and software; personal computer connected to mainframe; first installation, 1981; 35 total installations, all in risk management departments; functions include providing financial, loss control, claims administration, benefits, legal and actuarial information.

Staff: 65 total, 62 professionals.

Clients: 73 total; all risk management department clients; 85% with gross revenues less than $200 million, 3% $500 million-$1 billion, 6% $1 billion-$3.5 billion, 6% exceeding $3.5 billion.

User support: User groups and meetings, telephone assistance available 12 hours per day, on-site training and seminars for clients.

1989 gross revenues: 25% from sale of hardware, 75% from services.

Branch offices: Atlanta; Boston and Quincy, Mass.; Chicago; Irving, San Antonio and Houston, Texas; Los Angeles; New York, Woodbury, Buffalo and Syosset, New York; Rancho Cordova, Orange and San Francisco, Calif.; Grand Rapids, Mich.; Indianapolis; Overland Park, Kan.; Englewood, Colo.; Eden Prairie, Minn.; Redmond, Wash.; Marlton, N.J.; Hartford, Conn.; Charlotte, N.C.; Columbia, Md.; Tampa, Fla.; Bala-Cynwyd, Pa.

Principal officers: Wilson H. Taylor, president/chief executive officer; Caleb L. Fowler, executive vp/president-property/casualty; Dennis Kane, president-special risk division.

Contact: Edward Holleran, president-ESIS/vp-risk management services. ■

RMIS popular among risk managers

System Vendor	Number used by risk managers directly	Year first installed	Average prices[1]	Type of hardware needed
CS Online Corporate Systems	1,855	1978	Varies	mainframe
SISDAT Crawford & Co.	621	1975	$12,000[2]	mainframe
Claims Management Reporting System (CMRS) GAB Business Services Inc.	535	1975	–[2]	mainframe
RISKMASTER Software Series (PC) Tillinghast division of Towers, Perrin, Forster & Crosby Inc.	480	1982	$12,000	personal computer
Sailor On-Line The Travelers Cos.	450	1985	Varies	mainframe
CRIS-CIGNA Risk Information Services Insurance Co. of North America/CIGNA Corp.	373	1983	–[3]	personal computer compatible w/mainframe
OSCAR Hartford Specialty Co.	250	1980	$15,000 per year	personal computer with modem
PCMS/Incident Reporting & Claims Management System Cantor & Co.	180	1985	$10,000	personal computer
SIGMA System (Service Bureau Services) Risk Sciences Group Inc.	135	1978	From $15,000	personal computer with modem

1 Prices are based on first year of service; costs vary according to claim volume, data base size, utilization, access charges and additional services.
2 Bundled product; buyer must purchase claims administration services. 3 Bundled product; buyer must purchase insurance from CIGNA Corp.

Source: Vendor questionnaires & interviews

BI/CYNTHIA WATSON

Update

Manville jurisdiction questioned

NEW YORK—A procedural order transferring jurisdiction over the Manville Corp. bankruptcy does not clarify whether the new judge has the power to amend the company's reorganization plan by consolidating claims by asbestos victims nationwide against the Manville Personal Injury Trust into a class-action lawsuit.

In a July 20 order, U.S. District Judge Charles Brieant in New York, who is in the same district as the bankruptcy court, passed jurisdiction of the Manville bankruptcy to U.S. District Court Judge Jack B. Weinstein in Brooklyn.

Two groups of plaintiffs' attorneys want the 2nd U.S. Circuit Court of Appeals to review Judge Weinstein's suggestion to amend Manville's reorganization plan to create a nationwide class (*BI*, July 16).

When asked whether Judge Brieant's order clarifies Judge Weinstein's power to amend the reorganization plan, trust director Marianna Smith said: "The 2nd Circuit hasn't ruled yet."

Meanwhile, a panel of six federal judges—including Judge Weinstein—is tentatively scheduled to meet in Washington, D.C., on Aug. 10 to discuss national solutions to the multitude of asbestos personal injury lawsuits. The judges have dockets that are overwhelmed with asbestos personal injury litigation.

Federal judges in Cleveland and Tyler, Texas, also have proposed a nationwide class-action to solve the asbestos problem.

Amoco Cadiz award finalized

CHICAGO—Amoco Corp. says it will appeal a Chicago federal judge's ruling that finalizes an earlier order to pay 695 million French francs ($128 million) to French claimants damaged by the 1978 wreck of the supertanker Amoco Cadiz off Brittany.

U.S. District Judge Charles Norgle also ordered Amoco to pay 21.2 million pounds ($38.5 million) to Petroleum Insurance Ltd., a Bermuda-based captive of Royal Dutch-Shell Group, which owned the 68 million gallons of oil spilled in the wreck.

In addition, Judge Norgle rejected a renewed motion by Spanish shipbuilder Astilleros Espanoles S.A.—which built the supertanker and was found liable to Amoco for damages from the wreck because of defective design of the ship—to dismiss it from the case on jurisdictional grounds. A default judgment earlier had been entered against Astilleros, which refused to participate in litigation, claiming the court had no jurisdiction over the firm.

Amoco had $50 million in pollution liability coverage through protection and indemnity club London Steamship Owners' Mutual Insurance Assn. Ltd. About $16.75 million of the policy limits was paid into a fund to cover oil spill claims and, with interest, has grown to about 260 million French francs ($47.9 million), said attorneys for Amoco and the French plaintiffs. Much of the balance of the policy limits has gone to cover Amoco's defense costs, which were included in policy limits.

French plaintiffs have not decided whether to appeal the ruling and seek a higher award, said attorney Ronald Allen, with Curtis, Mallet-Prevost, Colt & Mosle in New York.

Creditors committee approved

NEW YORK—A creditors committee for insolvent Constellation Reinsurance Co. "should facilitate the evaluation of any (commutation) plan and move things along in a more orderly manner," a New York trial court ruled in recognizing the committee.

In the July 13 order, New York Supreme Court Judge Walter M. Shackman rejected the state Insurance Department's argument that there is no statutory basis for formally recognizing the committee.

The judge also denied a motion by the department's Liquidation Bureau to prevent New York law firm Mound, Cotton & Wollan from representing creditors. Regulators wanted the firm removed because it previously represented the liquidation bureau and Constellation Re.

The judge wrote that motion was "apparently precipitated" by a letter from Mound, Cotton attorney James Veach to the court concerning state Comptroller Edward V. Regan's investigation of the bureau (*BI*, Jan. 23). The bureau's "feathers were ruffled by Veach's challenging letter," the judge said in denying the motion.

In that letter, creditors expressed concern about the expense of protracted litigation if Constellation Re were liquidated. The reinsurer was ordered into liquidation in February 1987 (*BI*, Feb. 6, 1989).

Briefly noted

Catastrophe-related insured U.S. property damage totaled $1.4 billion in the first half of 1990, the same as in the first half of 1989, according to the Property Claim Services division of the American Insurance Services Group. However, insured property damage for the year through July 25 totals $1.89 billion, or about a 20% increase from $1.55 million in losses registered during the corresponding period of 1989. . . **Trans-Pacific Insurance Co. (F.S.M.)** of Micronesia, which Texas regulators say illegally wrote pollution liability insurance in the state, is barred from doing business in Texas under a state court's temporary injunction. The judge also found that Trans-Pacific is a successor company to Casualty Assurance Risk Insurance Brokerage Co. of Guam, which was hit with cease-and-desist orders in numerous states, including Texas, starting in 1987. . . .Employers with generous **401(k) salary reduction plans** could be exempt from non-discrimination testing under legislation introduced last week in Congress. . . .Congressional conferees said they would push for quick approval in the House and Senate of **oil spill liability legislation** the conferees approved last week. The bill would require almost all tankers to be equipped with double hulls and would allow states to set oil spill liability levels that exceed those called for by the bill. . . .**International Business Machines Corp.** is setting up the largest mental health care preferred provider organization in the nation. American PsychManagement Inc. will establish the network of 10,000 providers for IBM's 700,000 U.S. employees, retirees and dependents. In addition, IBM will begin to subsidize long-term care benefits for employees, retirees, parents and spouses. . . .The House of Representatives last week failed to override President Bush's veto of a **family and medical leave bill** approved by Congress last month.

Brokerage industry's history features mergers, expansion

By LEONARD M. WILSON

Special to Business Insurance

MERGERS ARE NOTHING IF NOT commonplace in the insurance brokerage industry. Last month's announcement of the proposed merger between Corroon & Black Corp. and Willis Faber P.L.C. fit the mold. Few industries have undergone such extensive restructuring and concentration over the relatively short span of 20 years or so.

When we first began to follow the industry as a security analyst, the consolidation was in its early stages. Public offerings by Alexander & Alexander Services Inc., Frank B. Hall & Co., Fred S. James & Co. and Rollins Burdick Hunter Inc. had a specific goal: Each aimed to transform itself into a major, national entity with common stock as the medium of exchange for acquisitions.

Mr. Wilson

Alexander & Alexander, now the second-largest broker in the world, generated less than $50 million in revenues in 1969, compared with almost $1.3 billion last year. To describe the company as a national broker then required a bit of a stretch. RBH, now clearly in the ranks of the alphabets, posted revenues of about $5 million in 1970, hardly enough to support a single front-line office in today's environment.

Insurance brokerage is a classic example of a service industry. Most service industries are characterized by small business units, usually local in nature, and often highly entrepreneurial in spirit. These attributes are still present in a segment of the industry today. But the emergence of competitors on a national and international scale within insurance brokerage represented a deviation from the stereotype of the service industry.

In the early 1970s, the fledgling alphabet brokers were bent on securing a genuine national presence. Size and geographical spread meant an ability to retain clients, grow the existing book of business and support requisite technical skills demanded by an increasingly sophisticated client base.

The computer was the keystone. Through electronic data processing, it was possible to control networks of 50 or 100 offices spread across North America and other continents. Information systems provided consistent reporting and abetted the concept of centralized financial controls coupled with decentralized operating management. The computer also spawned additional client services and improved productivity.

Data processing, though, was not a small-ticket item. Costs were burdensome, and economies of scale became critical. Notwithstanding the appearance of minicomputers and microcomputers, larger insurance brokers were better situated to stand the ongoing expense of computerization. Thus, concentration was made possible by the computer and, in turn, was driven onward by the cost of designing and upgrading data processing systems.

The merger wave also required a receptive population of private brokers, willing to sell out to the publicly owned brokers. Sellers were motivated by a desire to preserve and liquify their net worth. Often, an entrepreneur recognized that his brokerage firm had reached the limit of growth without greater technical resources.

Rapid expansion through merger was not without a certain amount of discomfort. Sometimes, the marriages proved to be rocky, and quiet divorces were arranged. Entrepreneurs, having come under a corporate umbrella, chafed under the restrictions and formalities of the larger organizations. Most made the adjustment. Investors worried about the ability of acquiring brokers to develop successors to the former owner-entrepreneurs. Given the number of acquisitions, it is remarkable in retrospect how smoothly the integration and transition occurred.

Once the alphabet brokers had consolidated their positions within the United States, logic dictated expansion beyond the U.S. borders. After all, clients had become multinational. Foreign multinationals were entering the country. Indigenous brokerages outside the English-speaking countries promised rapid growth from a low base.

Rapid communications and once again the world-shrinking power of the computer gave impetus to vertical integration of retail, wholesale and reinsurance brokerages. It was an anachronism for an alphabet broker, placing large volumes of business in London, to be represented by independent parties when a telephone call or a five-hour plane ride sufficed to secure coverage. Marsh & McLennan Cos. ushered in the changing order with its stormy acquisition of C.T. Bowring P.L.C. 10 years ago.

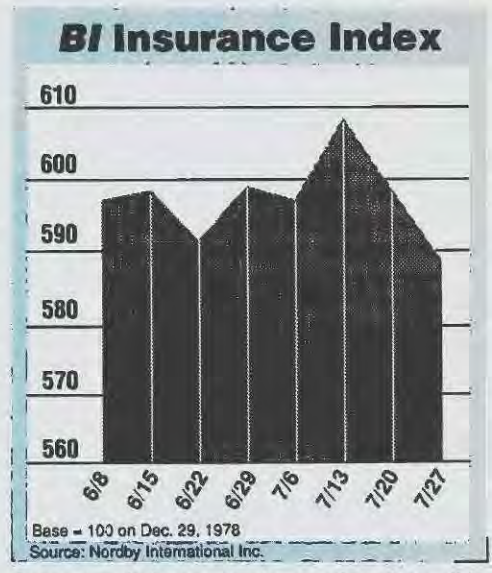
Now, the brokerage industry is substantially restructured. Will mergers be a continuing feature of insurance brokerage? The needs of the alphabet brokers have changed. Typically, the public brokers are where they want to be domestically. Takeovers currently focus on specialties, fill-ins for the few remaining geographical gaps. The tempo of acquisitions has slowed materially, with Corroon & Black the most active of the public brokers in pursuing expansion through acquisition.

In our view, the industry currently has four tiers: international, national, regional-local and specialty. The greatest concentration of industry volume by far is in the hands of the international brokers and, if we had to guess, multinational brokers have the best potential for long-term growth.

Despite 20 years or more of acquisitions, there are still private brokers of consequence that offer enticing targets for possible acquirers. We attended an industry event recently and found ourselves lunching with a group of private brokers. The brokers at that table, only one of perhaps 15 tables, represented our estimate of $120 million to $150 million of commissions, all of it privately controlled.

We suspect that insurance brokerage will become still more concentrated in the 1990s, both within the United States and abroad. Size seems to equate with greater effectiveness in the highly complex areas of insurance brokerage. We do not rule out the possibility of a merger between two of the alphabet brokers even though integration would be formidable. The present disarray of the money center banks argues strongly against any takeovers of insurance brokers for a long time. Further consolidation ought not to prejudice the interests of the investor. More and more, dominating market shares within most industries are closely correlated with high rates of profitability. ■

Leonard M. Wilson is a senior vp with Lazard Asset Management Inc. He is a member of the New York Society of Security Analysts.



Insurance industry stocks continued to slide last week, as the *Business Insurance* Index dropped 9.74 points to 588.78 on July 27, from 598.52 on July 20. Advancing issues were led by Belvedere Corp., up 10.7%; FHP International, up 7.9%; and United Healthcare Corp., up 5.7%. Declining issues followed Seibels Bruce Group, down 15.8%, American Indemnity Financial Corp., down 15.0%; and Lawrence Insurance Group, down 14.5%. The most active issue during the week was Sears, Roebuck & Co. (Allstate) 2.4 million shares traded. The *BI* Index dropped 1.6% for the week; The Standard & Poor's 500 fell 2.3%; the Dow Jones 30 Industrials dropped 2.1%; and the New York Stock Exchange Composite lost 2.2%.

British Issues

July 12 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	505	23.3	28.7	5.7	522—505	
Genl Accident	508	15.5	33.4	6.6	524—508	
Gdn Royal Exch	222	19.4	15.3	6.9	225—222	
Royal	475	25.5	34.0	7.1	483—475	
Sun Alliance	321	11.7	16.7	5.2	330—321	
Brokers						
Bradstock	251	17.7	10.0	4.0	251—251	
CE Heath	487	14.4	34.5	7.1	492—487	
Hogg Group	161	10.6	9.7	6.0	163—161	
Lloyd Thompson	316	19.8	9.7	3.0	318—316	
PWS Holdings	80	12.5	3.3	4.1	82—80	
Sedgwick Grp	227	17.1	16.0	7.0	228—220	
Steel Brrl Jones	275	16.7	14.7	5.3	275—275	
Willis Faber	236	14.8	16.0	6.8	236—232	

Source: Philip Olsen, Insurance Industry Specialist London

BI Industry Stock Report

JULY 23, 1990 THROUGH JULY 27, 1990

BROKERS		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
Alexander & Alexander	NYS	22.38	-2.72	-28.97	34.00	22.38	108	1.00	4.47	17	9.18	2.44
Corroon & Black	NYS	31.50	2.44	-17.65	41.00	28.50	625	1.36	4.32	16	12.73	2.47
Gallagher Arthur J & Co	NYS	22.25	-0.56	-10.10	26.50	21.00	63	0.60	2.70	18	5.33	4.17
Frank B Hall	NYS	3.25	4.00	8.33	4.25	2.50	34	0.00	0.00	-2	-2.80	-1.16
Hilb, Rogal & Hamilton	OTC	16.25	1.56	-12.75	20.63	12.50	203	0.28	1.72	22	4.60	3.53
Marsh & McLennan	NYS	72.75	-2.51	-6.73	89.75	67.00	751	2.60	3.57	17	10.56	6.89
Poe & Associates	OTC	11.50	3.37	-13.21	13.00	8.00	6	0.40	3.48	14	1.93	5.96
BROKERS	AVERAGE		0.8	-11.6					2.9	15		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W R Corp	OTC	42.00	-1.75	0.90	46.50	33.75	405	0.44	1.05	9	25.06	1.68
Berkshire Hathaway Inc	NYS	7075.00	-1.05	-17.97	8900.00	5675.00	1	0.00	0.00	-23	2869.00	2.47
ITT (Hartford Group)	NYS	58.00	-0.43	-3.13	64.50	51.38	1414	1.60	2.76	7	56.33	1.03
Sears (Allstate)	NYS	33.88	-1.81	-12.58	47.25	33.00	2449	2.00	5.90	10	37.75	0.90
CONGLOMERATES	AVERAGE		-1.3	-8.2					2.4	1		
INSURERS/REINSURERS												
Aetna Life & Casualty	NYS	50.38	-3.13	-13.15	62.50	45.25	775	2.76	5.48	9	58.11	0.87
Ambase Corp	NYS	6.63	3.92	-47.52	16.38	5.75	447	0.00	0.00	8	29.08	0.23
American General	NYS	47.75	-0.78	45.80	50.63	28.13	2151	3.20	6.70	11	34.68	1.38
American Heritage	NYS	21.75	-1.14	-23.68	24.63	19.75	5	1.00	4.60	11	22.60	0.96
American Indemnity Fin'l	OTC	4.25	-15.00	-46.88	11.38	4.25	16	0.08	1.88	-1	17.38	0.24
American International	NYS	73.13	-3.78	-13.36	89.63	69.00	1748	0.44	0.60	11	41.92	1.74
Aon Corp	NYS	36.75	0.68	-13.27	43.25	33.38	214	1.52	4.14	10	19.62	1.87
Argonaut Group	OTC	76.88	-0.16	11.62	78.00	60.50	28	1.60	2.08	9	36.83	2.09
AVEMCO Corp	NYS	27.75	-2.63	13.85	30.13	20.38	10	0.40	1.44	20	9.52	2.91
Baldwin & Lyons Inc	OTC	20.75	-2.92	-3.49	24.00	19.25	12	0.28	1.35	7	20.80	1.00
Belvedere Corp	ASE	3.88	10.71	-29.55	5.63	3.38	6	0.04	1.03	-4	8.03	0.48
Chandler Insurance	OTC	8.00	0.00	-31.91	13.25	7.63	79	0.00	0.00	4	9.53	0.84
Chubb Corp (s)	NYS	44.88	-4.27	-53.19	51.38	36.88	1109	1.32	2.94	9	55.49	0.81
CIGNA Corp	NYS	47.13	-2.84	-21.78	66.75	45.25	659	3.04	6.45	11	66.64	0.71
CNA Financial Corp	NYS	77.63	-0.80	-22.38	108.75	68.25	137	0.00	0.00	9	54.87	1.41
Continental Corp	NYS	28.13	1.81	-10.36	38.63	25.75	611	2.60	9.24	11	41.36	0.68
Durham Corp	OTC	28.00	-3.45	-8.94	34.75	28.00	30	0.92	3.29	13	26.32	1.06
Fund American Corp	NYS	35.00	0.36	-0.71	40.75	29.50	849	0.68	1.94	52	32.74	1.07
Fremont General Corp	OTC	16.75	-0.74	-16.77	22.50	14.38	86	0.80	4.78	7	19.09	0.88
Frontier Insurance Group	NYS	27.00	0.00	45.95	33.00	14.13	109	0.00	0.00	12	7.29	3.70
General RE Corp	NYS	83.13	-2.78	-7.64	96.25	72.88	577	1.52	1.83	13	29.04	2.86
Hanover Insurance Co	OTC	24.50	-2.00	-19.67	33.00	22.75	28	0.44	1.80	8	32.03	0.76
Harleysville Group	OTC	25.75	-5.50	-6.36	28.75	21.00	83	0.60	2.33	8	18.94	1.36
Hartford Steam Boiler	NYS	57.38	-5.94	5.76	62.13	48.25	259	1.80	3.14	15	18.94	3.03
Kansas City Life Ins	OTC	36.00	0.00	0.35	36.25	34.50	16	1.12	3.11	10	39.22	0.92
Kemper Corp	NYS	40.63	-3.27	-14.02	51.88	34.00	260	0.92	2.26	10	29.97	1.36
Lawrence Insurance Group	ASE	7.38	-14.49	3.51	9.13	6.50	5	0.36	4.88	13	4.40	1.68
Liberty Corp	NYS	47.13	-5.51	10.88	50.25	35.00	6	0.32	1.95	11	31.82	1.48
Lincoln National	NYS	53.38	-0.93	-12.50	62.88	51.38	203	2.56	4.87	10	49.19	1.09
NAC Re Corp	OTC	31.25	-7.41	-13.79	41.00	28.00	156	0.20	0.64	14	22.81	1.37
Navigators Group	OTC	33.75	0.00	22.73	33.75	25.25	7	0.30	0.00	12	15.22	2.22
Nobel Insurance LTD	OTC	3.13	-3.85	56.25	3.75	1.50	33	0.30	0.00	-2	7.76	0.40
NWNL Companies	NYS	28.63	2.23	-27.53	44.13	25.88	540	1.32	4.61	6	37.50	0.76
Ohio Casualty Corp	OTC	40.88	-1.51	-14.40	52.50	34.75	384	2.32	5.68	11	33.30	1.23
Old Republic Int'l	OTC	24.50	0.00	-4.39	29.00	21.13	150	0.72	2.94	6	30.70	0.80
Orion Capital Corp	NYS	22.25	1.14	-4.30	28.50	16.38	29	0.92	4.13	7	19.72	1.13
Phoenix RE Corp	OTC	10.88	-3.33	-16.35	15.50	8.75	43	0.20	1.84	-15	12.99	0.84
Protective Life Corp	OTC	12.63	-0.98	-11.40	15.88	10.88	169	0.63	5.39	8	14.54	0.87
Provident Life	OTC	23.50	1.62	-9.18	30.13	19.00	255	0.80	3.40	7	23.24	1.01
Re Capital Corp	ASE	14.25	0.88	-1.72	15.25	11.25	14	0.00	0.00	11	14.43	0.99
RLI Insurance Corp	NYS	13.63	2.83	53.52	14.75	8.88	42	0.40	2.94	7	12.42	1.10
St Paul Companies	NYS	60.25	1.26	0.42	63.50	53.00	799	2.40	3.98	7	43.47	1.39
SAFECO Corp	OTC	35.75	-1.72	-10.06	42.38	31.00	897	1.36	3.80	8	24.87	1.44
SCOR U S Corp	NYS	9.63	-9.41	-32.46	14.50	8.38	20	0.20	2.08	12	10.61	0.91
Seibels Bruce Group	OTC	8.00	-15.79	-26.44	13.50	8.38	586	0.80	10.00	-1	13.75	0.58
Selective Ins Group	OTC	15.50	-1.59	-18.95	20.25	15.50	28	1.04	6.71	5	15.72	0.99
Statesman Group Inc	OTC	2.13	3.01	-22.73	3.31	.88	48	0.16	7.53	4	4.19	0.51
Tokio Marine & Fire	OTC	41.00	-11.11	-45.61	78.13	40.75	8	1.04	2.54	-	70.93	0.58
Torchmark Corp	NYS	49.50	-0.25	-13.54	58.75	42.75	202	1.40	2.83	12	13.23	3.74
Transamerica	NYS	37.25	-3.56	-16.53	48.00	33.75	338	1.52	5.15	9	34.63	1.08
Travelers Corp	NYS	28.38	-1.73	-23.05	45.00	25.00	1317	2.40	8.46	7	44.85	-
Trenwick Group Inc	OTC	22.75	-3.19	-6.67	26.88	17.25	52	0.48	2.11	11	16.91	1.35
United Fire & Casualty	OTC	34.75	1.46	5.30	35.00	30.50	15	1.20	3.45	10	22.56	1.54
USF&G Corp	NYS	25.75	-3.29	-13.08	33.88	23.75	798	2.92	11.34	19	22.87	1.13
UNUM Corp	NYS	53.00	0.00	10.99	57.13	35.63	714	0.80	1.51	12	31.20	1.70
USLIFE Corp	NYS	39.00	0.32	-13.81	48.13	34.75	120	1.48	3.79	9	54.34	0.72
Washington National	NYS	21.25	-1.16	-24.78	29.00	19.50	61	1.08	5.08	79	32.90	0.65
USLICO Corp	NYS	21.50	2.38	-9.47	25.13	20.63	30	1.00	4.65	8	27.73	0.78
Zenith National Ins	NYS	14.50	-2.52	-22.67	21.50	13.50	21	0.88	6.07	8	13.81	1.05
INSURERS/REINSURERS	AVERAGE		-2.1	-9.4					3.6	10.6		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	17.00	7.94	-20.00	26.38	14.00	407	0.30	0.00	11	3.54	4.80
HMO America Inc	OTC	7.00	0.00	-9.68	10.63	4.38	135	0.30	0.00	3	1.12	6.25
Pacificare Health Sys	OTC	20.25	-6.90	-22.12	30.38	14.75	151	0.30	0.00	15	6.35	3.19
Safeguard Health Enter	OTC	7.00	-6.67	-17.65	12.50	5.13	23	0.30	0.00	11	2.99	2.34
Sierra Health Services	ASE	7.25	-3.33	-18.31	9.63	5.50	72	0.30	0.00	12	0.62	11.69
United Healthcare Corp	OTC	18.50	5.71	51.02	20.13	7.88	1103	0.30	0.00	23	0.34	54.41
United Medical Corp	ASE	10.13	-6.90	68.75	11.38	5.75	25	0.20	1.98	14	5.70	1.78
U S Healthcare	OTC	19.13	-1.29	34.21	22.25	9.63	0	0.36	1.88	26	3.07	6.23
HMOs	AVERAGE		-1.4	8.3					0.5	16		
ALL COMPANIES	AVERAGE		-1.7	-7.4					3.1	11		

System design: Nordby International Inc.

Don't let your employees take a shower without us.

Or mow the lawn. Or change a light bulb. Or cross the street. The fact is, accidents do happen. And not just to daredevils.

For people under 38, accidents are the leading cause of death. Yet only 17% of adult Americans carry life insurance coverage in excess of $50,000.

Accident insurance, however, represents an affordable way for your employees to obtain additional protection for themselves as well as their families.

Which may be why 60% typically sign up for voluntary accident insurance when it's offered.

But let's talk about you.

While voluntary accident insurance costs your employees very little, it costs you nothing.

Which makes it one of the smartest ways for you to contribute to their financial security. What's more, we have been recognized as the accident insurance leader for years, with a market share that's greater than our next two competitors combined.

To learn more, fax Gordon Murphy, President, CIGNA Special Benefits (215) 523-7915. Just watch your step on the way to the fax machine.

CIGNA Special Benefits Division products are underwritten by Life Insurance Company of North America and other CIGNA companies.

We get paid for results.® CIGNA