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Update

House passes bill postponing Section 89's implementation

WASHINGTON—The House of Representatives late last week passed legislation that would delay implementation of Section 89 for one year but also would delay the development of regulations employers need to comply with the controversial law.

The broad Treasury Department and Postal Service appropriations bill approved by the House contains an amendment that would bar the Treasury Department from using any funds to en-

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Antitrust suits in peril

Judge indicates he will dismiss case

By JUDY GREENWALD and STACY ADLER

SAN FRANCISCO—A U.S. District Court judge intends to dismiss the massive antitrust litigation pending in federal court against 31 insurance industry defendants, according to a preliminary opinion issued last week to parties in the case.

Judge William W. Schwarzer's proposed memorandum and order, which is designed to focus the scheduled Sept. 15 oral arguments in the case, states that at this point he intends to:

- Grant the defendants' motion to dismiss on the grounds that their activities were protected under the limited antitrust exemption contained in the McCarran-Ferguson Act (*BI*, Jan. 9).
- Grant the defendants' motion to dismiss on the "state action" doctrine, which provides immunity from antitrust laws if the anticompetitive restraint of trade reflects a state policy and if the state actively supervises any private anticompetitive conduct.
- Dismiss the global conspiracy charge, which alleged that U.S. insurers and certain insurance trade groups conspired with foreign reinsurers to restrict coverage available under general liability insurance policies.
- Dismiss the foreign defendants from the case on the basis of comity—a reciprocal respect for foreign law.

Proposed California antitrust guidelines could have a chilling effect on traditional insurance industry practices. Page 33.

Judge Schwarzer, however, does say in the memorandum that the attorneys general do have the standing to bring the action.

At the Sept. 15 oral arguments, the state attorneys general will be permitted to argue why Judge Schwarzer's intended rulings would be incorrect. As a result of that hearing, the judge could scrap his whole memorandum, or it could form the basis for his final order.

Judge Schwarzer is presiding over the antitrust lawsuits filed by 19 state attorneys general that have been consolidated in U.S. District Court in San Francisco, along with several private lawsuits alleging antitrust violations by insurance industry defendants.

The suits allege that the defendants—including major U.S. insurance companies, five reinsurance companies, the Insurance Services Office Inc. and several London-based underwriters—engaged in a boycott involving approval of ISO's commercial general liability insurance form.

Specifically, the suits contend that the defendants conspired to manipulate the U.S. commercial liability insurance market and that ISO was forced to rewrite its CGL form to exclude coverage for pollution and to include a retroactive date in the claims-made version of

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HMO bidding helps city control medical costs

By MARK A. HOFMANN

MILWAUKEE—Competitive bidding by health maintenance organizations, a utilization review program and participation in an employer-supported group that negotiates hospital fees are credited with helping the city of Milwaukee hold its 1988 health care costs to only about $100,000 more than it paid two years earlier.

All facets of Milwaukee's health-care program for 27,259 employees, retirees and dependents will be subject to competitive bidding beginning this year, says Florence Dukes, Milwaukee's director of employee benefits administration.

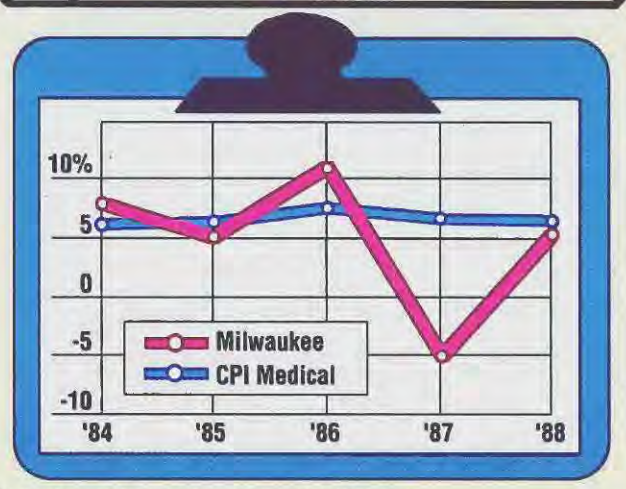
After reducing its employee and retiree health care expenditures by 4.8% in 1987, the city in 1988 held its health care cost inflation to a full point below the 6.5% inflation level of the medical care component of the Consumer Price Index in 1988.

Milwaukee's health care costs rose only 5.5% to $25.2 million in 1988 from $23.9 million in 1987. And, the city's 1988 health care costs are only 0.4%, or $100,000, more than what the city paid in 1986.

The city began controlling its health care costs in 1987, after implementing utilization review and negotiating hospital rates for its basic indemnity health care plan (*BI*, April 4, 1988).

Holding the line in Milwaukee

With the aid of an aggressive cost containment strategy, the city of Milwaukee has held its employee health care cost increases below that of the medical care component of the Consumer Price Index.



Source: Bureau of Labor Statistics and the City of Milwaukee

John Hall

To further control health care costs in 1988, the city last year for the first time let competitive bids for health maintenance organization contracts and encouraged health care plan participants to enroll in HMOs, Ms. Dukes explained.

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ABA panel seeks policy language covering pollution

By JUDY GREENWALD

NEW YORK—A new American Bar Assn. subcommittee that includes representatives from all aspects of the insurance industry is attempting to develop commercial general liability insurance policy language to cover sudden and accidental pollution incidents.

However, some of those involved—including the subcommittee chairman—already are concerned that the subcommittee may not obtain the cooperation of the Insurance Services Office Inc., which issues standardized policy forms on behalf of its insurance company members.

Any subcommittee proposal could be rejected by ISO, preventing it from becoming standard policy language.

The ABA Subcommittee on Revision to the CGL Policy includes attorneys representing insurers and reinsurers, insurance brokers, the academic community, regulators and policyholders.

In addition, a representative from the Risk & Insurance Management Society Inc. is serving as a consultant to the subcommittee.

An ISO representative has been asked to serve in a similar capacity. Asked if ISO would do so, an ISO spokeswoman said, "We plan to cooperate, but we are not members of the committee."

This is the first time that a broad-based group of insurance experts has been assembled to draft insurance policy language.

The 12-member subcommittee operates under the ABA's Toxic and Hazardous Substances and Environmental Law Committee, which is part of the association's Tort & Insurance Practice Section.

The subcommittee, which held its first full meeting earlier this month, faces a difficult challenge, acknowledge its members and other observers: It must develop policy language that will not only satisfy its own diverse membership, but also prove acceptable to both insurers and policyholders.

However, "there seems to be a good deal of goodwill on the committee," said Dennis R. Connolly, a senior vp and attorney with Johnson & Higgins in New York and a member of the panel.

As to whether or not a subcommittee proposal is likely to be accepted in the marketplace, Mr. Connolly admitted, "I think that may be a problem." But, he added that if the subcommittee proposes usable policy language, "there is a good chance that market pressures will lead to its use."

Insurers have been reluctant to offer coverage for sudden and accidental pollution incidents because they say courts have expanded prior policy language to include all types of pollution, even those incidents that insurers classify as "gradual" pollution.

ISO officials pointed out during testimony last year before a National Assn. of Insurance Commissioners committee that "we've reached the conclusion that" attempting to distinguish be-

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NEWSPAPER

Paxton's failure blamed on 'inept' management Page 2

New PBGC chief seeks curb on 'follow-on' pension plans Page 3

Update

House OKs Section 89 delay

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force or implement Section 89 until Oct. 1, 1990. Section 89 currently is scheduled to go into effect Oct. 1, 1989.

The purpose of the amendment is to give Congress more time to address problems created by Section 89, according to Rep. Mickey Edwards, R-Okla., who sponsored the amendment.

However, some benefits lobbyists worry that the amendment could be counterproductive and actually add to employers' Section 89 woes. They note that the Senate already has passed Section 89 reform legislation, while the House Ways and Means Committee has given its tentative approval to a reform measure (*BI,* July 17).

Both the Senate and Ways and Means Committee Section 89 reform bills generally call for a Jan. 1, 1990, effective date for Section 89(a), which sets non-discrimination tests for health care benefit plans. The Senate bill sets an effective date for Section 89(k)—which governs how employers must document their plans—of three months after the Treasury Department issues rules or Jan. 1, 1991, whichever is sooner.

However, if Congress approves the appropriations bill, the Treasury Department for much of next year could not develop rules to help employers comply with a new Section 89 statute. As a result, a Section 89 statute could go into effect with the department having little or no time to develop rules.

Exxon takes oil spill charge

NEW YORK—The upper layers of Exxon Corp.'s liability insurance program may not respond to claims arising from the March oil spill in Alaska's Prince William Sound.

Exxon last week reported an $850 million aftertax loss in the second quarter for anticipated cleanup costs, though that amount does not include potential liability from 140 spill-related lawsuits.

Exxon's liability insurance will cover only $400 million of the estimated $1.3 billion cost to clean up the 10 million gallon oil spill and settle uncontested claims, the company says.

An Exxon spokeswoman declined to discuss the company's insurance program but confirmed Exxon has coverage for the spill "in excess of $400 million."

Exxon purchases $400 million in pollution liability insurance from the International Tanker Indemnity Assn., a Bermuda protection and indemnity club. Exxon then purchases $100 million of general liability insurance in the Scandinavian insurance market. This coverage is subject to a $200 million deductible. London market insurers then write $200 million of general liability coverage excess of $700 million (*BI,* June 26; April 3).

But London sources say Exxon's Scandanavian and London general liability policies may exclude coverage for third-party claims and pollution resulting from collisions.

Exxon took a $30 million charge in the first quarter to account for repairs to the Exxon Valdez and loss of cargo (*BI,* May 1).

Meanwhile, the Alaska attorney general says he will not bring criminal charges against Exxon or Alyeska Pipeline Service Co., a consortium of oil companies, for their roles in the spill. But, an FBI investigation continues.

KAL insured for Libya jet crash

LONDON—Korean Air Lines has at least $500 million of liability insurance and $35 million of hull insurance to cover losses stemming from the crash of a KAL DC-10 jetliner last week in Tripoli.

Early reports said 78 of 182 passengers and crew aboard the jet and four people on the ground were killed when the jet undershot a runway in rough weather and plowed through cars and houses. The pilot of the jetliner, registration number HL7328, reported engine failure.

KAL, which renewed its hull and liability coverage on May 15, purchases its aviation insurance from Oriental Fire & Marine Insurance Co. Ltd. of Seoul. KAL carries at least $500 million of liability insurance and possibly up to $1 billion.

Slightly less than 50% of the hull and liability insurance is reinsured in the London market through Lloyd's of London broker Nicholson Chamberlain Colls Ltd. The reinsurance is led in the London insurance company market by The Orion Insurance Co. P.L.C. and at Lloyd's by underwriter Barry Coleman, London sources confirm.

St. Louis-based McDonnell Douglas Corp., which manufactured the DC-10, carries up to $1 billion of aviation product liability insurance placed worldwide.

Mentor liquidators turned down

NEW ORLEANS—The entire 5th U.S. Circuit Court of Appeals will not rehear the appeal by the liquidators of Mentor Insurance Co. of a lower court ruling dismissing the liquidators' racketeering complaint filed in U.S. federal court.

A three-judge panel of the court had earlier upheld a lower court ruling dismissing the liquidators' suit against Mentor's parent company, Ocean Drilling & Exploration Co., and others. The case was dismissed on the grounds that a U.S. court is an inconvenient forum for the litigation and that a trial in Bermuda is favored for both private and public interests (*BI,* July 24; July 3).

The order denying the rehearing petition noted no member of the panel that decided the case nor any active sitting judge on the 5th Circuit requested a poll to determine if the case should be reheard.

Liquidator Charles Kempe said that he and joint liquidator Michael Arnold are "considering all other options," declining to say whether they will seek U.S. Supreme Court review of the ruling.

Medicare benefit cuts eyed

WASHINGTON—Many employer-sponsored retiree health care plans would have to pay slightly higher claims than anticipated under the expanded Medicare program under a proposal to reduce Medicare benefits.

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Paxton's failure blamed on 'inept' management

By DOUGLAS McLEOD

HARRISBURG, Pa.—The Pennsylvania Insurance Department is liquidating Paxton National Insurance Co. after charging that the insurer filed false financial statements, intentionally suppressed loss reserves and suffered from "inept and chaotic" management.

Commonwealth Court Judge Emil Narick Sr. signed a liquidation order for Paxton on Wednesday with the insurer's consent. The Insurance Department had filed a petition to liquidate Harrisburg, Pa.-based Paxton last month.

Paxton's 1988 annual statement reported total policyholder surplus of $150,405, leaving it $2.1 million short of the minimum capital and surplus required by state law, according to the liquidation petition.

Separately, the Delaware Insurance Department has filed a liquidation petition against Remco Insurance Co., a Delaware-domiciled subsidiary of Paxton. A hearing on the petition is scheduled for Aug. 9, a spokeswoman for the Delaware department said.

Paxton and Remco are owned by Harrisburg-based Dauphin Management Corp., which in turn is owned by Thorofare Holding Corp. of Thorofare, N.J. Thorofare's main shareholders include Irwin C. Keightly Jr. and Robert E. Osmundsen, who also served as Paxton's president and executive vp, respectively.

Messrs. Keightly and Osmundsen both declined to comment on the Pennsylvania department's action.

S. Walter Foulkrod III, a Harrisburg lawyer representing Paxton, conceded that Paxton is insolvent but denied the Pennsylvania department's allegations of mismanagement.

"This was a management that was as concerned about what was going on as the liquidator," Mr. Foulkrod said.

The liquidation order is the latest—and apparently final—turn in Paxton's troubled recent history. The insurer has changed hands in the midst of financial difficulties twice since 1984.

Thorofare acquired Paxton and Remco in December 1986 from Pacific Imperial Management Inc., a holding company owned by California insurance agent Russell E. March.

Eighteen months earlier, Paxton had been suspended from doing business after the Pennsylvania department refused to allow the insurer credit for a loss portfolio reinsurance deal. The portfolio transfer—which Paxton had not cleared with state regulators as required by a supervision order then in effect—was necessary to keep Paxton from reporting a surplus impairment (*BI,* July 29, 1985).

Mr. March, in turn, had acquired Paxton in No-

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Outwaite settlement

Fireman's Fund agrees to runoff policy cap

By CAROLYN ALDRED

LONDON—Lloyd's of London underwriter Richard Outhwaite's liability for an unlimited runoff reinsurance policy he wrote for Fireman's Fund Insurance Co. will be capped under a settlement.

Mr. Outhwaite's syndicates could pay about $55 million in claims before their 50% share of the unlimited runoff policy is capped, sources say.

R.H.M. Outhwaite (Underwriting Agencies) Ltd. would not comment on the specific terms of the settlement.

The Outhwaite agency announced July 24 that "a settlement of the dispute between syndicates 317/661 and the Fireman's Fund in connection with the runoff reinsurance policy has been reached. The settlement, the terms of which are to remain confidential between the parties, has the effect of limiting the liability of syndicates 317/661."

Fireman's Fund agreed to a similar settlement earlier this year with Merrett Underwriting Agency Management Ltd., whose syndicates wrote the other 50% of the policy.

The runoff policy in question actually is a retrocession of a runoff reinsurance policy Fireman's Fund wrote for Lloyd's syndicate 210, managed by R.W. Surge & Co. in 1974. The policy—retroceded to Outhwaite and Merrett in 1981—covers losses arising from syndicate 210's 1969 and prior underwriting years for an unlimited amount excess of $35 million.

Outhwaite syndicates 317/661 will pay Fireman's Fund under a complex formula to cover an undisclosed amount of claims already incurred by the insurer, according to sources. In addition, Outhwaite syndicates will cover any future claims up to a specified limit, whereupon Fireman's Fund will reassume all liability for the con-

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Legislators wary of McCarran reform

By JERRY GEISEL

WASHINGTON—Several congressmen say that more evidence is needed before they will believe that the insurance industry's limited immunity from federal antitrust laws provided by the McCarran-Ferguson Act hurts consumers.

At the first congressional hearing this year on the possible reform of the McCarran-Ferguson Act, several members of the House Economic and Commercial Law Subcommittee appeared skeptical that any changes are needed in the 1945 law, which also leaves primary regulation of the insurance industry with the states.

A strong case must be made that McCarran-Ferguson has created problems in the insurance market before any changes are made to the law, said Rep. Chuck Douglas, R-N.H.

"You have to prove that there is a problem. You have to provide the evidence," he said, directing his comments at backers of McCarran-Ferguson repeal.

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- Sen. Robert Kasten says he has strong support for his latest federal product liability reform measure. **PAGE 6**
- This week's editorial opposes giving employees equal representation in the management of employer-funded pension plans. **PAGE 8**
- Governments will pay the largest share for environmental cleanups in the year 2000, actuaries predict. **PAGE 13**
- Most benefit managers earn more than $50,000 in annual cash compensation, a survey shows. **PAGE 14**
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- A dialogue is needed to solve industry problems, says broker C. Richard Peterson in Speaking Out. **PAGE 21**
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Howden trial

Grob admits to secret company ownership

By STACY SHAPIRO

LONDON—The former chairman of Alexander Howden Group Ltd. admits that he and three other former Howden directors secretly owned offshore trusts from which they benefitted and also secretly owned offshore reinsurance companies that transacted business with Howden.

Mr. Grob

However, former Howden Chairman Kenneth V. Grob testified in court earlier this month that he believed the trusts were funded by money that the former Howden directors received legitimately through personal investments and management services.

It wasn't until the British Department of Trade and Industry in January 1983 investigated the alleged misappropriation of $55 million from Howden by the four former directors in 1983 that Mr. Grob says he learned that some of the money in the trusts came directly from Howden.

And, Mr. Grob says that the offshore reinsurance companies, which reinsured Howden underwriting units and Howden-managed Lloyd's of London syndicates, were set up to benefit Howden and engage in business that the companies could not have transacted had shareholders known the companies were owned by Howden directors.

The Crown Prosecution, which has charged Mr. Grob with 27 counts of theft, receipt of stolen goods, false accounting and issuing false statements, charged in court that Mr. Grob is lying.

Crown Prosecutor Michael Hill accused Mr. Grob of fabricating "nonsense," being "deceitful" and telling a "thumping great lie" to the judge and jury hearing the charges against Mr. Grob in Southwark Crown Court.

Mr. Grob denied Mr. Hill's allegations.

"What you say is a nonsense," said Mr. Grob. "I never in all my years spent moneys I had not made on the stock market."

On the witness stand earlier this month, Mr. Grob reiterated that he is not guilty of the charges he faces. And to prove his innocence, he told the jury that he cooperated "in every possible way" with the Department of Trade and Industry inquiry into the alleged misappropriations at Howden.

And although Mr. Grob admits he left England in August 1985 to live in France and Switzerland, he said: "I was not trying to avoid this (English) jurisdiction. . . .I told my attorneys that if ever I was needed, I would return (to England)."

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Mary Herlehy

The village of Palatine plans to fight for reversal of a $16 million personal injury award, of which it owes $13.85 million.

Municipality underinsured for record award

By STACY ADLER

PALATINE, Ill.—The village of Palatine's liability insurance will not fully cover its share of a $16 million damage award to a man paralyzed in a bicycling accident.

Municipal liability experts say the $13.85 million to be paid by Palatine, a Chicago suburb, likely is the largest amount ever paid by a municipality in a personal injury case, though municipalities have been hit with larger property damage judgments.

Brad Johnson, executive director of the Public Risk Management Assn. in Arlington, Va., said Palatine's share of the verdict is "probably" the largest of its kind in the nation.

"This is definitely the largest such award in the state of Illinois," noted attorney James Demos of Demos & Burke in Chicago, who represented Michael McDermott, the injured bicyclist.

At the time of the 1984 accident, Palatine had $10 million in general liability coverage from the Intergovernmental Risk Management Agency, a self-insurance pool composed of 46 Northeastern Illinois municipalities. The coverage included a $1,000 deductible.

However, Palatine has no other insurance to cover the remaining $3.85 million it owes Mr. McDermott.

If the entire award is upheld on appeal, Palatine will have to tap its general revenues or seek a bond issue to cover the remaining $3.85 million of the award, said Skip Leonard, assistant manager

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Workers comp scholar urges broader benefits

By STACY ADLER

BOSTON—Workers compensation laws nationwide must be modified to provide claimants expanded coverage in order to create the comprehensive system that was envisioned when it was first developed, according to a leading workers compensation expert.

Laws in many states must be changed to provide work comp coverage for, among other things, all injuries suffered during the course of employment—not just those sustained in accidents—and mental health claims, said Professor Arthur Larson of Duke University Law School in Durham, N.C.

The nation's most respected student of workers compensation law also outlined some new theories of liability that are developing in workers compensation law at the annual convention of the Assn. of Trial Lawyers of America in Boston July 15-22.

Approximately 2,750 attorneys gathered at the convention to exchange litigation notes. More than 63,000 attorneys belong to the ATLA.

While there have been some improvements in workers comp law nationwide over the last 40 years, the system is not perfect, said Mr. Larson, who has authored the foremost analysis of workers compensation law.

"I would like to see workers compensation do a complete job so that it doesn't have to be supplemented," Mr. Larson said.

Among the changes in workers

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PBGC director looking to curb follow-on plans

By JERRY GEISEL

WASHINGTON—Legislation ultimately may be necessary to curb what the new executive director of the Pension Benefit Guaranty Corp. says is the latest corporate abuse of the PBGC's insurance program—"follow-on" pension plans.

Mr. Lockhart

James B. Lockhart III, who was appointed PBGC chief this month, says the agency is very concerned about recent court decisions that affirmed the right of employers to establish "follow-on" plans after terminating hugely underfunded pension plans and shifting the liabilities to the PBGC.

In May, a federal appeals court in New York ruled that the PBGC had no right to try to return to LTV Corp. $2 billion in liabilities from three previously terminated pension plans. The PBGC's move to restore LTV's plans to the company came after LTV established new follow-on plans.

And, earlier this month, a federal district court judge in Pittsburgh gave interim approval for Wheeling-Pittsburgh Steel Corp. to establish new follow-on plans. In 1985, Wheeling-Pittsburgh terminated several underfunded pension plans, leaving the PBGC with $500 million in plan liabilities (*BI*, April 29, 1985).

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Brokerage found liable in coverage dispute

By JUDY GREENWALD

ANNAPOLIS, Md.—Broker Tanenbaum-Harber Co. of New York must pay a beverage company $2.3 million in a business interruption coverage dispute involving a 1985 fire at an Illinois racetrack, a jury ruled.

Walter L. Harris, Tanenbaum-Harber's president, said the brokerage plans to appeal the verdict.

The July 20 decision by a Prince George's County Circuit Court jury in Upper Marlboro, Md., is the latest in a series of legal developments involving losses suffered by Service America Corp. of Stamford, Conn., in the July 1985 fire at the Arlington Park Racetrack in Arlington Heights, Ill. (*BI*, Aug. 5, 1985).

Service America operated a track food concession.

Shortly before the two-week trial, Hartford Insurance Group, which had written business interruption coverage for Service America, agreed to pay $3 million to settle the dispute, said Donna S. Mangold, an attorney with Washington, D.C.-based Cooter & Gell, which represents Service America.

Hartford denied liability in the case. "Both parties felt that a compromise solution was preferable to a new trial, and the Hartford is pleased that the matter was concluded in a satisfactory manner," said a Hartford spokesman. He said that the litigation "involved complicated factual issues concerning the intent of the Hartford and the expectations and beliefs of Service America Corp."

The crux of the dispute is whether the $5 million in business interruption coverage purchased by Cheverly, Md.-based Allegheny Beverage Corp., which at the time was Service America's parent company, included unscheduled locations. Service America's Arlington Park operations were not named in Allegheny's all-risk policy.

A binder had stated that coverage was for all locations, though the policy cited only scheduled locations.

Allegheny argued in its original suit that it intended to cover all locations—whether or not scheduled—and asked that either Tanenbaum or Hartford be held liable for Service America's losses from the Arlington Park fire.

During a trial in 1987, Judge Robert Woods agreed with Allegheny and instructed the jury to decide who was at fault—Hartford or Tanenbaum-Harber—and for how much. The jury then decided Hartford was liable for $4.5 million in damages (*BI*, July 25, 1988; July 27, 1987).

However, Hartford appealed that decision, and the Maryland Court of Special Appeals ruled that Judge Woods should never have given those instructions because of evidence that could have exonerated both defendants. A new trial was ordered in the case.

Ms. Mangold noted that Service America, which was spun off from Allegheny since the original trial and proceeded with the litigation on its own, now expects to receive a total of $5.3 million between the jury award and the Hartford settlement, even though the policy had a $5 million limit.

"We really got 110% of what we were going after," she said.

Mr. Harris, however, said Tanenbaum-Harber plans to appeal the decision to the Maryland Court of Special Appeals.

"We think there were many errors made at the trial, which we think will give us grounds to appeal the case," said Mr. Harris, who added he is confident the appeal will be successful.

Mr. Harris said Tanenbaum-Harber's errors and omissions coverage is written by a CIGNA Corp. unit. The brokerage has "more than adequate" insurance to cover the verdict if upheld, he said, but would not elaborate. ■

Paxton liquidation

Continued from page 2

vember 1984 after losses had impaired the insurer's surplus and Paxton had been placed under state supervision.

After the 1986 change of control, Thorofare contributed $1.5 million in capital to Paxton through Dauphin Management, and the Pennsylvania department lifted its suspension order.

In 1987, Paxton reported gross written premiums of $4.5 million, consisting mainly of commercial auto coverages. Net premiums totaled $4 million and policyholder surplus amounted to $3.5 million at year-end 1987.

By year-end 1988, gross premium volume had jumped to $12.3 million and net premiums increased to $8.2 million, while reported surplus dwindled to $150,405.

On Feb. 13, the Pennsylvania department issued a new supervision order against Paxton after reviewing its Sept. 30, 1988, quarterly statement and concluding that adverse loss development had probably rendered the insurer technically insolvent.

An amended supervision order was entered two months later, adding allegations of improper reserving and record keeping.

The Insurance Department finally filed its liquidation petition June 19, noting that Paxton's own 1988 annual report showed the insurer to be $2.1 million short of minimum statutory surplus requirements.

The liquidation petition also contained allegations of intentional underreserving and other improper actions by Paxton's management.

During a March 17 meeting between Paxton and Pennsylvania Insurance Department officials, a Paxton representative said the insurer retained only 31 cents of each dollar of non-standard auto liability premium to pay claims, the petition says.

Industry experience indicates that non-standard auto insurance losses typically exceed that amount, while state law requires reserves equaling at least 60% of earned premiums for auto liability business, the petition says.

Over several months last year, Paxton also delayed making substantial additions to its reserves and failed to establish any expense reserves for at least nine asbestos claim files, the Insurance Department petition alleges.

Over several months last year, Paxton also delayed making substantial additions to its reserves and failed to establish any expense reserves for at least nine asbestos claim files, the Insurance Department alleged.

The petition also cited two internal Paxton memos in which Michael Reif, a former assistant vp for claims, told former Paxton Vp John Hines that the insurer had failed to properly reserve for claims.

In a memo dated July 25, 1988, Mr. Reif reported that Paxton was "holding back" reserve increases totaling $3.3 million and that reserve increases of $556,300 were being held back for Remco.

The memo also states that "we have been holding back payments on new business as per instructions from Irv (Keightly). As of today these payments total $141,755.11 in claims payments and $26,815.52 in expense payments.

"When claimants or insureds call and ask for their check, at that time the check is issued. The same thing applies to all deferred payments. That is, we don't pay until someone calls and asks for the check."

The memo goes on to say: "We all know that reserve increases have been held back because of surplus concerns from December 1986 to the present time. I have tried to put our reserve and payment posture into concise form so that everyone concerned is aware of the situation."

In December 1986, Mr. Hines had "arbitrarily" reduced the reserves on 46 claim files by more than $1 million, the Insurance Department charged in its petition.

Paxton's management knew of the alleged improper reserving and record keeping, according to the petition, which also charged that the insurer's directors and officers knowingly filed a false quarterly financial statement for the third quarter of 1988 and a false 1988 annual statement.

Paxton also failed to collect premiums from Dauphin Management, which manages both Paxton and Remco, the petition alleged.

As of the date of the liquidation petition, Paxton had failed to provide a loss reserve analysis and business plan required by the Feb. 13 supervision order, the Insurance Department charged.

At the beginning of June, Paxton also had a negative cash balance and was unable to mail claim checks totaling $204,693, the petition says.

During the roughly four months that Paxton was under the department's supervision, its management "demonstrated a consistent pattern of willful failure to cooperate with the Insurance Department" and showed a "pattern of inept and chaotic management," the petition charges.

While conceding that Paxton is insolvent, Mr. Foulkrod, the insurer's lawyer, denied the charges leveled against Paxton's management.

Specifically, Mr. Foulkrod denied that Paxton officials deliberately held back reserves, calling the charge "misleading."

In its answer to the liquidation petition, Paxton had noted, for example, that while it retained only 31 cents of each dollar of non-standard auto liability insurance premiums, it also ceded 70% of this business to a treaty reinsurer.

Paxton also denied in its answer "that any inferences may be drawn" from Mr. Reif's memos about reserve adequacy, and denied that Mr. Hines arbitrarily reduced reserves.

Mr. Foulkrod also denied that Dauphin Management owes premiums to Paxton, maintaining that Paxton still owes a "substantial" amount to Dauphin in management and other fees.

He also labeled the Insurance Department's charge that Paxton filed false financial statements as "preposterous."

"If somebody were going to file a false statement, why would they do so showing an impaired capital and surplus?" Mr. Foulkrod asked.

Meanwhile, the Delaware Insurance Department is seeking to liquidate Remco, whose surplus the department contends was impaired by $700,000 at year-end 1988. The impairment results in part from $944,679 in unrecoverable reinsurance from Paxton, according to Peter O. Jamison III, a Delaware deputy attorney general.

For 1988, Remco reported gross written premiums of $68,701, net written premiums of $44,684 and policyholder surplus of $3 million.

Remco also primarily wrote commercial auto insurance business. ■

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Small firms' pension hurdles studied

WASHINGTON—Small employers face many barriers that deter them from providing pension plans to their employees, a new study reports.

The upfront financial commitment, as well as continued expenses, are just two factors preventing small companies from setting up pension plans, according to "Pension Policy and Small Employers: At What Price Coverage?"

The policy study was conducted by the Employee Benefit Research Institute, a Washington, D.C.-based benefits think tank.

For example, only 43% of full-time employees working for companies with fewer than 100 employees are covered by pension plans, compared with 91% of full-time employees in medium-sized and large firms, EBRI reports.

Many small employers said a major reason they did not offer a plan is because they felt it was unaffordable, EBRI noted, citing a study on small businesses by the National Federation of Independent Business, a Washington-based trade group.

The financial commitment involved in offering a pension plan can be significant, EBRI noted. The variable costs include start-up fees, plan administration, and possible plan amendments and revisions.

Continuing plan expenses can include investment management fees, audit fees, bookkeeping costs, legal expenses, and internal administration and related staff compensation costs.

Fees from the Internal Revenue Service hit small employers especially hard. The IRS charges employers with fewer than 100 participants $400 to start a pension plan. And, rulings for plan amendments, and funding methods can cost between $50 and $1,000.

Small employers, like their larger counterparts, also have faced a barrage of legislative and regulatory changes that have discouraged them from offering pension programs, the EBRI study adds.

Benefit beat

For example, small employers responding to the NFIB survey cited by EBRI reported "changing and complex regulations, too much cost, red tape, and (the) hassle to start one, (as well as the) administrative costs to keep one" as reasons for not starting a pension plan.

The NFIB study, which surveyed approximately 1,400 employers with fewer than 100 employees, found that 48% of plan sponsors said government regulation was difficult to handle, while another 15% had problems with administrative costs, EBRI noted.

In fact, complex and changing regulations were reported as the cause for 35% of plan terminations in the NFIB study.

While larger companies often have the resources to stay on top of the latest regulatory changes affecting pension plans, that task may be too costly a burden for smaller firms, an EBRI spokeswoman said.

And, the cost of hiring outside consultants would boost pension costs even more, she added.

Other reasons small employers cite for not offering pension plans include:

- Lower-income employees are more interested in higher pay rather than provisions for a pension plan.
- In high-turnover industries, workers are not interested in pension plans because they do not stay on the job long enough to vest in the benefit.

Indeed, workers at small companies tend to stay on the job for a shorter time than at large firms, EBRI reports.

For example, an earlier EBRI study reported that job tenure at small firms—those with between 25 and 99 employees—averaged 5.3 years, compared with six years at companies with between 100 and 499 employees and 6.8 years at companies with between 500 and 999 employees. Employees' average stay in companies with more than 1,000 employees was 8.9 years.

- Some federal laws are especially burdensome for small employers with pension plans.

For example, small company pension plans are much more likely to be considered "top heavy" than large plans because the ratio of owners to employees in the plan is likely to be higher. A top-heavy plan, under rules governed by the Tax Equity and Fiscal Responsibility Act of 1982, is one in which a disproportionate share of the benefits go to company officers.

Plans that are considered top-heavy have to provide faster vesting schedules and less restrictive Social Security integration schedules to assure that non-executive workers receive a fair share of the benefits.

- There is a lack of accurate information about pension plans.

Many small employers are not aware of the variety of pension plan options and don't know where to go with their questions.

The NFIB survey found that companies that depended on accountants or insurance agents for pension information were less likely to offer pension plans than those companies that turned to financial planners, trade associations,or other business or investment consultants.

The survey found that insurance agents that advise small employers may not be as well-informed about pension plans or may not promote pension plans because the plans may not be especially profitable products.

EBRI drew from four previous studies to compile its findings. The four surveys are: "The NFIB Survey on Small Businesses," "The Survey From the Small Business Administration/Internal Revenue Service Match of Corporate Tax Returns With Employment Data," "The Census Bureau 1984 Survey of Income and Program Participation" and "The Current Population Survey" from both May 1979 and May 1983.

Copies of "Pension Policy and Small Employers: At What Price Coverage?" are available from EBRI, P.O. Box 4866, Hampden Station, Baltimore, Md. 21211; or call 301-338-6946. The cost is $39.95, plus $3.95 shipping.

—By Adrienne C. Locke

Xerox ESOP

Xerox Corp. has created an employee stock ownership plan, in part to replace the company's contributions to its existing 401(k) plan.

The ESOP will be implemented with the issuance of 9 million shares of a new Series B convertible stock worth $785 million. The shares, to be owned individually by employees and by the ESOP trust, will give about 57,000 employees up to 10% ownership of the company, which will be the largest single block of voting shares.

A spokesman for Stamford, Conn.-based Xerox said a 15-year loan used to purchase the stock will be repaid primarily through dividends the company will pay the ESOP on the preferred stock and through the Jan. 1, 1990, termination of company contributions to a 401(k) savings plan.

The existing 401(k) plan will remain, but Xerox will stop matching employee contributions at the rate of 25 cents on the dollar.

Salaried employees of Xerox Business Products & Systems, Crum & Forster Inc., Xerox Credit Corp., Xerox Financial Services as well as employees of the parent company will be eligible to participate in the ESOP.

Employees will be permitted to vote the preferred shares they are allocated, but won't be able to cash them in until they leave the company.

Allocation of shares will be based primarily on employees' salaries, according to the spokesman.

—By Michael Schachner

Manufacturer's ESOP

Square D Co. plans to set up an employee stock ownership plan on Jan. 1, 1990, to replace the company's 50% cash match to an existing 401(k) plan with contributions of convertible preferred stock.

Participation in the company's 401(k) plan will be required for employees to receive shares in the ESOP, which will be tied to employee contributions.

Employees of the Palatine, Ill.-based electrical equipment manufacturer will now receive stock equal to the first 2.75% of the maximum 4% of salary they now are eligible to defer to the 401(k) savings plan. Shares will be released quarterly to individual accounts, said a spokesman.

The ESOP plans to borrow $125 million over 15 years to purchase some 1.7 million shares of a new issue of preferred stock. The spokesman said no lender has yet been chosen.

The ESOP will give about 8,500 Square D employees who participate in the 401(k) plan approximately 7% ownership in the company.

And, all 18,000 Square D employees in the United States—even those who do not participate in the 401(k) plan—will receive shares of stock as part of a new profit-sharing plan.

Beginning next year, each employee will initially receive $100 worth of stock.

Employees will then be granted additional shares annually based on Square D's earnings.

If earnings increase 5% to 9% during a fiscal year, employees will receive stock valued at $125. Employees will receive stock valued at $250 if profits increase 10% to 14%; stock valued at $375 for a profit increase of 15% to 19%; and stock valued at $500 if Square D earnings increase by 20% or more.

—By Michael Schachner

Product liability reform bill

Kasten says new proposal has 'strongest support' ever

By ADRIENNE C. LOCKE

WASHINGTON—Sen. Robert Kasten, R-Wis., says he has strong support for his latest federal product liability reform measure, improving the proposal's chances of passage.

Among other things, Sen. Kasten's new bill, S. 1400, would eliminate joint and several liability for non-economic damages in product liability cases; make it more difficult for a plaintiff to recover punitive damages; place time limits on when a product liability suit can be filed based on the age of a product; and would give wholesalers and distributors new protection against product liability suits.

Sen. Kasten's introduction of his legislation last week comes on the heels of the introduction of similar product liability reform legislation last month in the House by Rep. Tom Luken, D-Ohio (*BI,* June 26).

"There is something wrong with a system that discourages the production of safe products for children. . .life-saving vaccines or keeps state-of-the-art medical products off the market," Sen. Kasten said last week.

"The product liability system has become a hindrance to progress in the United States of America," he added.

At a press conference with two of the bill's co-sponsors—Sen. John D. Rockefeller IV, D-W.Va., and Sen. John Danforth, R-Mo.—Sen. Kasten said he was optimistic that this bill will be passed even though his other product liability proposals have never gained Senate approval.

This bill "has the strongest support we have had" since he first sponsored product liability legislation in 1981, Sen. Kasten says.

The bill has 18 co-sponsors at introduction, 10 of whom are members of the Senate Commerce Committee, the first stop for the bill.

"I believe we will have more co-sponsors within the next couple of weeks as the full effort continues to go forward," Sen. Kasten predicted.

Sen. Rockefeller described the legislation as a "fair and balanced bill" that "does not limit the rights of injured parties to receive fair compensation."

In addition, he said, the legislation will make the outcome of product liability claims more predictable, stabilize legal fees and reduce the cost of product liability litigation.

Sen. Danforth referred to the current tort litigation system as a "lottery system that benefits only one group of people—trial lawyers."

"We pay more for our product-liability system than anyone else in the world," Sen. Danforth added.

Although Sen. Kasten and his co-sponsors say they are confident that the bill will pass, others are doubtful.

"The chances of the bill being passed are still pretty slim," says Tom O'Day, associate vp-federal affairs in the Washington, D.C., office of the Alliance of American Insurers.

The bill will face strong opposition from consumer groups and from some members of Congress, he explained.

In addition, the delay in introducing the legislation in this session of Congress also could hurt the bill's chances, according to Mr. O'Day.

The bill was not introduced until last week because time was needed to gain additional support, Sen. Kasten said, adding that he hopes the added support will allow the bill to be passed quickly by the Commerce Committee.

Other supporters of the legislation, however, believe that its July introduction will not hurt its chances.

Liberty Mahshigian, co-counsel with the Product Liability Alliance, a Washington, D.C.-based coalition that supports the enactment of federal product liability reform legislation, believes there is still enough time for the bill to be approved by Congress.

The Kasten bill is very similar to the Luken proposal now pending in the House.

However, one major difference is that the Kasten legislation would eliminate the application of joint and several liability to non-economic damages, while the Luken proposal does not contain any provisions limiting joint and several liability.

Other provisions in the Kasten bill would:

- Permit punitive damages only if there is clear and convincing evidence of negligence by the manufacturer or product seller.

A defendant also could request that the amount of punitive damages be determined separately at a second trial.

- Encourage attempts at settlement before the action reaches trial. Either party would be able to make a settlement offer.

If the defendant rejects an offer and a subsequent verdict is for an amount greater than the settlement offer, the defendant also would be required to pay the plaintiff's legal fees.

If the plaintiff rejects a settlement offer and a subsequent award is less that the settlement offer, the defendant's legal fees would be subtracted from the award.

- Allow any voluntary alternative dispute resolution procedures used in a state to be used as a means of resolving the suit. If a party refuses alternative dispute resolution and the verdict goes against that party, it would be required to pay all legal fees.
- Shield a manufacturer from liability if a claimant was under the influence of an intoxicating drug or alcohol and that condition was at least 50% responsible for the accident.
- Bar punitive damage awards for injuries involving drugs and medical devices that are approved by the Federal Drug Administration or aircraft that have been certified by the Federal Aviation Administration.
- Reduce the amount of a product liability award by the amount of workers compensation benefits a plaintiff receives.
- Generally limit the time during which a suit must be filed to within two years of discovering an injury or its cause.

In addition, the legislation generally would bar product liability suits involving capital goods products that are more than 25 years old.

- Make product sellers only responsible for harm caused by their own negligence. They would be responsible for a manufacturer's negligence only if the manufacturer could not be brought to trial or did not have the funds to pay an award. ■

The tort reform bill introduced by Sen. Robert Kasten has 18 co-sponsors

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Opinions

Unsound pension proposal

AS MUCH AS WE BELIEVE in seeking employees' opinions on management decisions, we cannot support the recent proposal to give employees equal representation in the management of employer-funded pension plans.

An amendment to a budget reconciliation bill approved by the House Education and Labor Committee would do just that by calling for defined benefit and defined contribution pension plan assets to be controlled by a new "joint board of trustees," composed of an equal number of employer and employee representatives (*BI*, July 24).

There are several good reasons why this is a lousy idea.

Above all is the Employee Retirement Income Security Act, which assures employees that pension plan assets will be prudently invested and benefits will be protected.

Under this 1974 federal law, once an employer creates a defined benefit pension plan, that employer is on the hook to deliver the promised benefit, regardless of how well or poorly the pension plan assets are invested. And, trustees of defined contribution plans bear a fiduciary responsibility for the investment of assets.

Employees involved in the management of pension funds could be driven by interests other than the income of the plan, such as low-yielding but socially desirable investments. If the investments of a defined benefit plan went sour, the employer would simply have to cover the loss.

Second, implementing joint employee-employer management of pension plans would be an administrative nightmare. Who is going to select the employees to serve on these new boards? Will there be elections? Who will pay for the cost of these elections? Will employees have adequate information about candidates to make informed decisions?

Third, if employers were forced to set up these joint boards of trustees to manage pension plans, we predict that they would simply terminate their pension plans.

Employers already are beginning to think that compliance with federal regulations governing pension plans is more trouble than the employee benefit is worth. Saddle employers with a new joint board of employees and employers to oversee pension plans and employers may well decide to simply gross up employees' salaries and let each employee save for his or her own retirement.

The demise of employer-sponsored pension plans would be to the detriment of employees and employers.

Many employees simply would lack the discipline to save as much for their retirement as is set aside under pension plans. In addition, individual retirement savings do not enjoy the same tax breaks as employer-sponsored plans. Furthermore, we doubt many employees would be as successful in investing their own savings as employers are with the clout of large pools of money and highly savvy investment advisers.

And, if employees lose defined benefit plans, they would assume the investment risk in saving for retirement.

Without defined benefit plans, employers would lose a powerful incentive for employee loyalty to the company. Turnover would likely increase.

While we reject requiring employers to share management of pension plans with employees, we do think there is merit in inviting some employee representation in the management of pension funds.

Employers would be wise to appoint at least one employee representative to the pension plan committee on a voluntary basis. Such employee involvement would help improve communications about the operation of the pension plan and the management of its assets. It would help show employees that employers aren't hiding anything from them in the management of these plans.

As regards defined contribution plans, rather than establish a joint board of employer and employee representatives, employers should give employees a choice among several options for investing their individual balances—as many companies already do.

Employers with sole investment discretion over defined contribution plans can tend to be too conservative, recognizing not only their potential fiduciary liability under federal pension law for mismanagement of these funds, but also out of concern for the varying needs of plan participants. An employer recognizes that in any given year retiring employees would prefer a small return on their fund balance to a loss.

Giving employees a choice of investment options for their defined contribution plan balances will allow younger employees with many more years to work to be more aggressive in their investment decisions and will permit employees nearing retirement to be more conservative.

Letters

Section 89 reform veils mandated benefit threat

To the editor: Benefit managers and group insurance consultants in unison are hailing Section 89 reforms as the best thing since sliced bread. It looks like Congress has conned us again.

Sen. Edward Kennedy, D-Mass., has proposed legislation over the last several years that would require that all employers provide medical insurance to their employees. His legislation has run into a great deal of opposition. It is my opinion that those congressmen who agree with the Kennedy mandated benefits bill are behind the changes to Section 89.

The original Section 89 legislation is an administrative nightmare. However, this legislation does not dictate to business how much they are to contribute to medical benefits. It also does not tell business that they must provide a minimum level of benefits. The new legislation does dictate to business the amount of money that they must contribute toward coverage. There is also vague wording on a minimum benefit level. These changes represent two of the three cornerstones of the Kennedy legislation. The only thing missing is the mandatory element.

Congress is pulling the wool over our eyes —and we are applauding them for it.

Mark A. Mitchell
U.S. Benefit Consultants
Marietta, Ga.

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Captive runs at full steam

TAMPA, Fla.—Despite a softening property/casualty insurance market, at least one captive insurer not only is keeping its members but is adding to its ranks.

As of mid-July, Energy Insurance Mutual Ltd., a Barbados-domiciled captive for gas and electric utilities, had 60 members, up 11 since the first of the year.

In addition, 15 of the captive's 18 charter members on July 1 renewed their memberships. The other three are expected to follow suit when their membership is up for renewal later this year.

In fact, the 3-year-old captive only has lost one member since its inception in July 1986.

Gene L. Weaver, general manager of EIM since early 1988, said that the member left when it was acquired by another company.

"We feel our members have been very loyal. There have been a lot of pressures on them to go elsewhere," Mr. Weaver said.

One of the chief reasons for the captive's lack of turnover is risk managers' vivid memories of the mid-1980s, said Thomas A. Nunnelly, EIM's chairman.

EIM provides excess general liability and excess directors and officers liability insurance for losses in excess of $25 million. To purchase the excess D&O coverage, a member must purchase at least $25 million in excess general liability coverage. Members must maintain a minimum of $10 million in underlying D&O coverage and may self-fund no more than $15 million of that underlying D&O coverage.

The maximum limit available for any one policy is $50 million. The total maximum available for both excess D&O and excess general liability is $75 million per policyholder.

Mr. Nunnelly said that the lack of D&O insurance for electric utilities during the hard market of the mid-1980s spurred the creation of EIM. Many electric utilities had lost their D&O coverage because of their reliance on nuclear power to generate electricity, he said. Insurers were reluctant to indemnify officers of companies that were using nuclear energy sources.

A steering committee representing electric utilities began exploring the possibility of forming a captive in 1985. The risk managers involved thought an industry captive was "the way to go," he said.

The resulting insurer, Energy Insurance Mutual, was domiciled in Barbados and began issuing policies in July 1986, he said.

EIM moved a branch office ashore in 1988 after it became the first insurer licensed under Florida's industrial captive law, Mr. Weaver said.

Despite setting up its branch office in Tampa, EIM remains domiciled in Barbados, Mr. Nunnelly said, adding that there are no plans to redomicile in the United States.

Mr. Weaver pointed out that EIM has twice distributed dividends to policyholders in the past 18 months. The first distribution, declared in March 1988, represented 10% of surplus and totaled more than $12.6 million. The second, declared earlier this year, represents 15% of surplus and amounted to about $19.6 million.

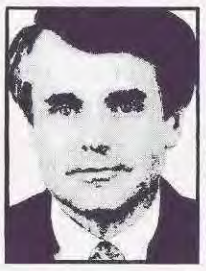
After the most recent distribution on June 30, EIM's assets stood at $197 million and its surplus at $117.9 million, Mr. Weaver said. The captive is carrying approximately $40 million in reserves for losses, he added.

Neither Mr. Weaver nor Mr. Nunnelly think that the current soft market conditions will sink EIM. "One of our major goals is to build a market for the long haul," Mr. Weaver said.

—By Mark A. Hofmann

At issue

Do you support federal legislation establishing uniform product liability standards?



Bill Gavin
vp-risk management
The Hertz Corp.,
Park Ridge, N.J.

I would support federal legislation only as it pertains to product liability. There has to be some central focal point, and if we don't have a better avenue to take, perhaps we should have some minimum standards for legislative uniformity.

William L. Mather
administrator-risk management
The Gillette Co.,
Boston

I do support the development of federal product liability laws, primarily because, for a manufacturer that sells products across the country, it would be much simpler to deal with a single set of federal regulations, rather than a multiplicity of state regulations that might often be in conflict with each other.

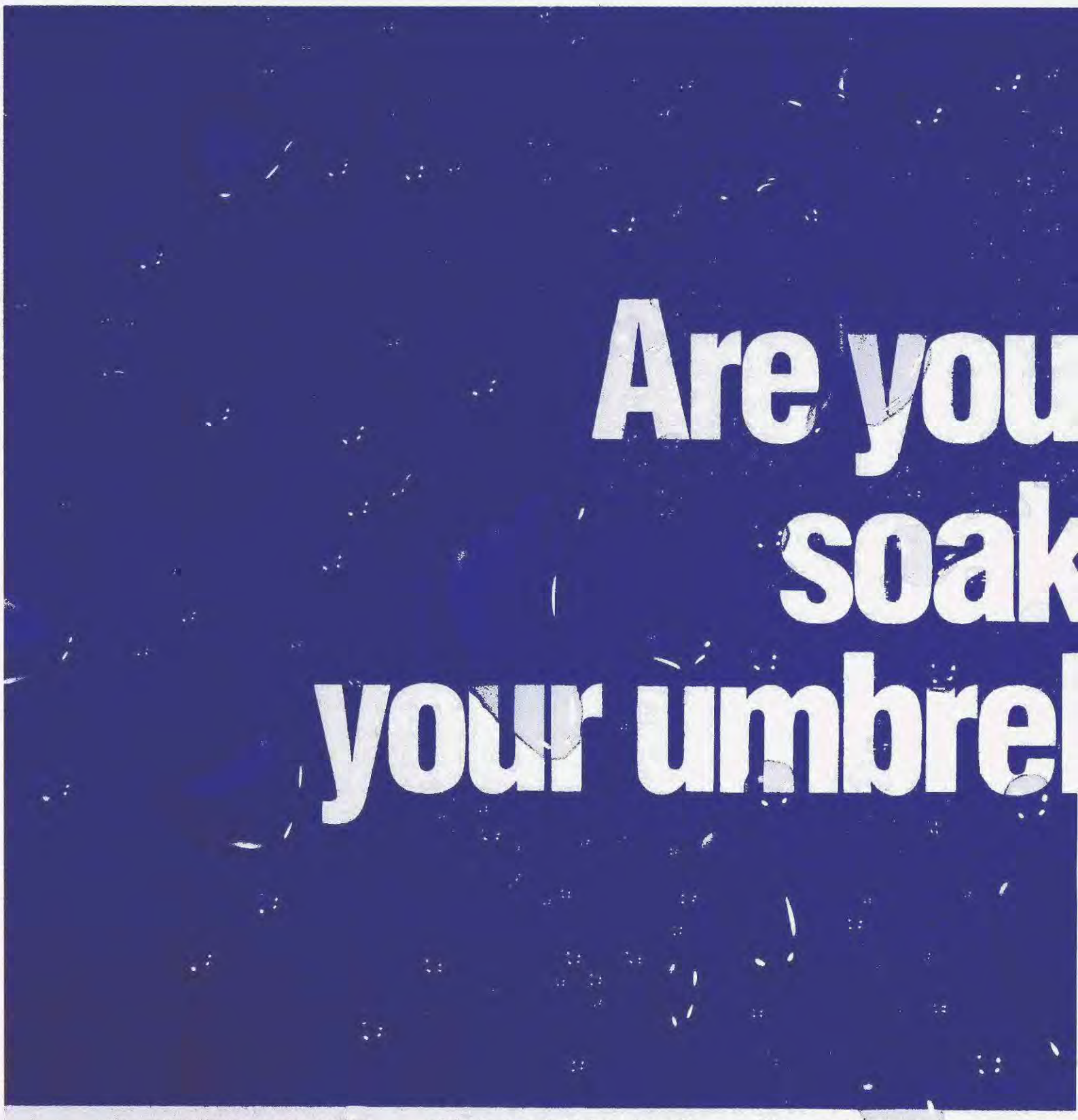
Terry R. Moulder
pension and risk manager
Teleflex Inc.,
Limerick, Pa.

Establishment of a uniform set of rules would help reduce the complications of and costs associated with multistate product liability litigation. As society becomes increasingly mobile, a national common law should help restore a better balance between the rights of individual plaintiffs and the encouragement of interstate trade.

Jacqueline D. Brown
risk manager
Washington Metropolitan Area Transit Authority,
Washington, D.C.

No. If the Consumer Product Safety Act is an indication of the method by which the federal government legislates product liability, then I can envision that standards would tend to increase the exposure base dramatically. Federal standards will also impair states' rights and the individual's right of recovery and may put small businesses out of business.

Compiled by Christine Woolsey



An umbrella program is only a piece of paper if it doesn't protect you when the claims come.
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Phillips promotes David Casselberry

David W. Casselberry, 31, has been promoted to assistant treasurer at Phillips Petroleum Co. in Bartlesville, Okla. In this newly created position, Mr. Casselberry will continue his responsibilities as director of risk management, overseeing risk management for the petroleum company with responsibility for Phillips' worldwide insurance program. He reports to James J. Mulva, vp and treasurer. Mr. Casselberry joined Phillips Coal Co., a subsidiary of Phillips Petroleum, in 1979 and held various engineering and financial evaluation posts before joining the treasury staff in 1984. He was named director of risk management in 1988. Mr. Casselberry holds a bachelor of science degree in engineering from the Colorado School of Mines in Golden and a master of business administration degree from Southern Methodist University in Dallas.

Coming & goings: buyers

* * *

Jean M. Pittler named risk management program director for Government Employees Insurance Co. in Washington, D.C. In this newly created position, she is responsible for the administration, coordination and management of GEICO's risk management program, property/casualty insurance and the development of a loss control and prevention program for the insurer and all subsidiaries. She reports to William G. Griswold, vp of GEICO's home office underwriting division. Previously, Ms. Pittler was a commercial account broker in the Washington, D.C., area. She holds a bachelor of arts degree from Goucher College in Baltimore and is a member of the Potomac Chapter of the Risk & Insurance Management Society.

* * *

Jan H. Folta promoted to vp of staff/management operations for the Syracuse, N.Y., operations center of MONY Financial Services. In this newly created position, she is responsible for all human resource activities, including employee benefits, at the Syracuse center. She reports to Gordon E. Perry, vice chairman and head of MONY's insurance operations. Ms. Folta joined MONY in 1973 in the human resources department. In 1980 she was named director of human resources. Ms. Folta was named assistant vp in 1985, and vp-human resources/business operations the following year. In 1986, she also was named vp of staff operations for MONY's Purchase, N.Y., facility. Ms. Folta holds a bachelor of arts degree in psychology and sociology from Hartwick College in Oneonta, N.Y. In addition, she is a member of the American Society of Personnel Administrators.

* * *

Patricia S. Poston, 32, named risk management coordinator at Ryder System Inc. in Miami. In this position she oversees bonds and assists Ryder Risk Management Administrator Linda Zingsheim, to whom she reports. Ms. Poston replaces **Clara Cummings**, who left Ryder. Prior to joining the transportation rental and insurance services firm, Ms. Poston was an administrative assistant at Insurance & Risk Management Inc. in Miami. She attended New York City Community College of Applied Arts and Sciences in Brooklyn.

Several appointments were also made at Ryder System's workers compensation claims subsidiary, Ryder Services Corp.:

Lynn S. Abrams, 37, named manager-workers compensation claims at Ryder Services in Miami. In this newly created position she conducts large claim reviews and assists in the implementation of cost containment programs. She reports to Susan L. Drake, senior manager-workers compensation. Previously, she was branch manager-work comp for McDonnell Douglas Corp. in St. Louis. She holds a bachelor of science degree in education from the University of Missouri in Columbia.

Rosa M. Rodriguez, 26, named workers compensation systems analyst for Ryder Services in Miami. In this position she is responsible for providing daily support for workers compensation claims administration software and hardware, as well as producing regular and ad hoc reports for operations management. She replaces **Luci Johnson**, who left the company, and reports to Ms. Drake. Previously Ms. Rodriguez served as a supervisor of data processing for CG Data Corp. in Miami. She received a bachelor of science degree from the University of Miami.

Eileen D. Smyth, 40, named office manager of Ryder Services' Pinebrook, N.J. office. In this position she manages the Northeast regional claims office, which administers claims from 11 states. She replaces **Shirley E. Holley**, who was transferred to the position of supervisor-workers compensation claims. Ms. Smyth also reports to Ms. Drake. Prior to joining Ryder Services, Ms. Smyth was a supervisor of workers compensation claims for CNA Financial Corp. in Parsippany, N.J. She attended Montclair State College in Upper Montclair, N.J. In addition, she holds a paralegal certificate from Caldwell College in Caldwell, N.J.

Mark C. Goldacker, 30, named supervisor-workers compensation claims in Ryder Services' Pinebrook, N.J. office. In this newly created position he supervises claims for the Northeast regional claims office, handling claims from 11 states. He reports to Ms. Drake. Mr. Goldacker had been a work comp claims officer with Transamerica Insurance Co. in Philadelphia. He holds an associate degree in business administration from Montgomery County Community College in Blue Bell, Pa.

Darlene S. Fry, 55, named office manager of Ryder Services' Orange, Calif., office. In this position she manages the Western regional claims office, which administers claims for six states. She replaces **Mindy York**, who left the company, and reports to Ms. Drake. Prior to joining Ryder, Ms. Fry was a workers compensation claims supervisor with Comco Management Inc. in El Monte, Calif. She attended the University of Toledo in Toledo, Ohio. In addition, she holds the California Self-Insurance Certification.

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Milwaukee

Continued from page 1

Before the city entered into its competitive bidding process last July, the city's eight HMOs had sought premium increases averaging about 12%, Ms. Dukes said. But, through competitive bidding, increases were held to about 7%, she said.

Milwaukee's HMOs are Aetna Choice Healthcare Plan; Compcare Health Services; Family Health Plan; Maxicare Health Plans Inc.; Metlife HealthCare Network-Wisconsin; PrimeCare Health Plans Inc.; Samaritan Health Plan; and Wisconsin Health Organization.

In an attempt to achieve long-term savings, "this year, we're going to have competitive bidding once again for HMOs," Ms. Dukes said.

And, because of the success of the competitive bidding program in helping contain health care costs, all facets of Milwaukee's employee health benefit program—including utilization review and third-party administrator contracts—will be subject to competitive bidding this year, she pointed out.

"The competitive bidding process really worked well for us," said Ms. Dukes, estimating that it will save Milwaukee almost $1.1 million this year.

"We really feel that the bidding procedure offers the city the best hope for cost-containment in 1990 and beyond," Ms. Dukes commented.

Charles Stanfield, a consultant with William M. Mercer Meidinger Hansen Inc. in Milwaukee, is designing the city's request-for-proposal program for its TPA and UR contracts.

Although the city last year did not repeat its 1987 cost-cutting performance, the rate at which Milwaukee's health care costs are rising "is still quite low" compared with other employers' health care cost experience, according to Stephen C. MacGill, a consultant with A. Foster Higgins & Co. Inc. in Chicago.

Employers' health care costs in 1988 rose an average of 15% to 20%, with some employers paying increases as high as 35% to 40% (*BI*, Dec. 19, 1988).

Milwaukee took action to control its health care plan costs after health care cost increases had outpaced the CPI's medical care component.

Milwuakee's health care costs amounted to $19.9 million in 1983 and increased 8% to $21.5 million in 1984; 5.1% to $22.6 million in 1985; and 11.1% to $25.1 million in 1986.

During the same period, the medical care component of the CPI rose 6.2% in 1984; 6.3% in 1985; and 7.5% in 1986.

The overall CPI rose 4.3% in 1984; 3.6% in 1985; and 1.9% in 1986.

The Milwaukee area has a relatively high rate of HMO penetration, Mercer's Mr. Stanfield pointed out.

Perhaps as many as 40% of Milwaukee-area residents belong to HMOs, he commented.

The city's high rate of HMO participation has "created a price-sensitive market," in which "almost all providers are part of one or more HMOs," according to Mr. Stanfield.

The city actively encourages its health care plan participants to join an HMO, pointing out that HMO coverage entails no copayments, no deductibles and no aggregate cap on benefits.

"We hoped with a wide variety of HMOs, they'd choose one," Ms. Dukes said.

Enrollment in HMOs by active employees has increased to 73.4% in 1989, up from 67.5% in 1988, Ms. Dukes said.

About 16,600 of the city's active employees, retirees and their dependents are enrolled in HMOs, she said.

Full-time employees in 20 union employee groups currently are not required to make HMO premium contributions.

However, they are limited to selecting HMO coverage from the three HMOs with the lowest premiums: Wisconsin Health Organization, Prime Care and Samaritan. Individual monthly premiums range from $83.41 at WHO to $94.44 at Samaritan.

But, under a pilot program that the city hopes to extend to unionized employees, the amount Milwaukee pays to all HMOs for approximately 1,000 management non-union employees is capped at 105% of the lowest premium charged by an HMO.

That contribution is a maximum of $87.48 for single coverage and $246.69 for family coverage.

The highest individual HMO premium among the eight serving Milwaukee employees is $99.88 a month, charged by Metlife, and the highest family premium is $264.52, charged by Aetna Choice.

Retiree HMO premium contributions vary widely by age and previous union membership, according to Ms. Dukes.

Retirees also are limited to selecting an HMO from the three least expensive.

Health care plan participants' copayments for services provided by HMO providers also vary, she said.

Milwaukee's other 10,659 health care plan participants—which are almost evenly split between active employees and retirees and their dependents—participate in the city's self-funded basic indemnity plan, for which Milwaukee does not purchase any stop-loss insurance.

"Out of the basic plan, 5,235 of the enrollees are retirees or their dependents," Ms. Dukes commented.

While there has been a slight increase in the number of retirees who have chosen HMOs—1,150 in 1989 compared with 1,122 in 1988—"there is not a discernable trend toward HMOs among retirees," Ms. Dukes said.

As a result, "we are concerned that our basic plan population is more illness-prone than our HMO population, which is younger and healthier," she said.

To discourage adverse selection, the city requires management and non-union employees enrolled in the basic indemnity plan to make monthly premium contributions that generally are greater than HMO premium contributions, according to Ms. Dukes.

'The competitive bidding process really worked well for us,' says Ms. Dukes, estimating that it will save Milwaukee almost $1.1 million this year. 'The bidding procedure offers the city the best hope for cost-containment in 1990 and beyond.'

Management and non-union employees pay $91.68 per month for family coverage under the indemnity plan and $48.69 per month for individual coverage, Ms. Dukes said.

These premium contributions for the basic plan increased by roughly 12% in 1989 from 1988, Ms. Dukes said.

However, union employees currently do not have to contribute to indemnity plan coverage premiums.

Retiree indemnity plan premium contributions also vary widely but generally are higher than contributions toward HMOs, according to Ms. Dukes.

The indemnity plan pays 80% of the cost of services, but lifetime benefits are capped at $250,000. While there is no deductible for basic services, such as physician visits, there is a $50 deductible for major medical coverage

Madison, Wis.-based Physicians Service Insurance Corp. has administered the basic indemnity plan since January 1988, when it replaced Blue Cross of Wisconsin Inc.

Milwaukee also has sought to contain medical costs through utilization review.

UR, along with medical case management, saved Milwaukee $642,000 last year, Ms. Dukes estimated.

The city's utilization review is administered by the Arlington Heights, Ill., office of Intracorp, a Wayne, Pa.-based subsidiary of CIGNA Corp.

Intracorp also administers UR for mental health inpatient services, Ms. Dukes said.

There currently is no UR system for outpatient mental health, but the city plans to implement such a program by 1990, according to Ms. Dukes.

The city also has realized savings through its participation in the Health Care Network of Greater Milwaukee, a health care coalition, Ms. Dukes pointed out.

In 1988, participation in the health care network saved Milwaukee more than $1.2 million, Ms. Dukes said.

The group, which consists of about 100 Milwaukee-area employers, negotiates fees with hospitals in a four-county area.

The hospitals charge what amounts to a per diem payment for basic services, although the amount paid varies from hospital to hospital. The health-care plans represented in the network currently cover about 125,000 lives.

The network, which is managed by San Diego-based CCN Inc., a health-care management firm, began operating in mid-1987.

Ms. Dukes' predecessor, Charles W. Morton, estimated in early 1988 that during the second half of 1987, the city had saved $400,000 in hospital costs through its participation.

Mercer's Mr. Stanfield agreed that the Health Care Network has served to hold down hospitalization costs.

It "further precipitated competition," forcing hospitals that are not part of the network to keep a close eye on their prices, Mr. Stanfield said.

The health care network's members include Allen-Bradley Co., a subsidiary of Pittsburgh-based Rockwell International Corp.; the Milwaukee Journal and Sentinel newspapers; First Wisconsin Bank; and Briggs & Stratton Corp., a Wauwatosa, Wis.-based engine manufacturer.

Ms. Dukes stressed that the success of the city of Milwaukee's health care cost-containment efforts has resulted from cooperation between the city and its employees.

The city negotiated implementation of the various cost-containment strategies with its public-employee unions, according to Ms. Dukes.

And, Milwaukee "is in the process of negotiating several new steps" with its employee unions to hold down health care costs Ms. Dukes said.

However, because the negotiations are ongoing, Ms. Dukes declined to specify the nature of those proposals.

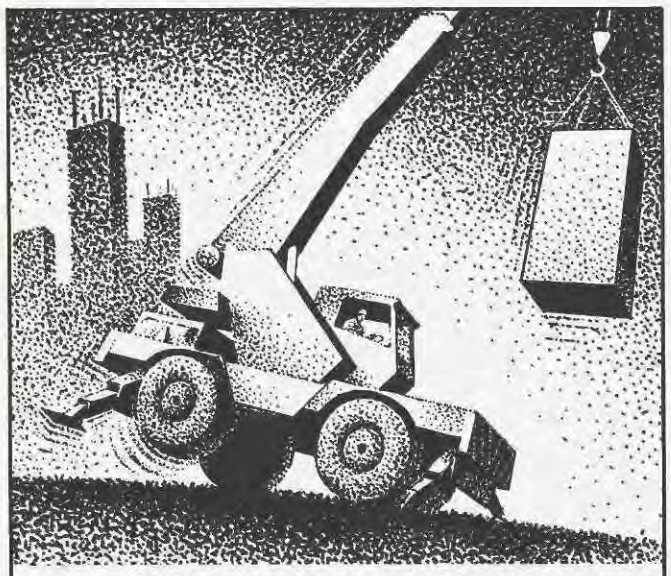
Because the city was up-front with its union employees, "generally speaking, employees have taken cost containment in stride," Ms. Dukes said.

Persuading employees to accept cost containment measures involves a good deal of human relations skill, according to Foster Higgins' Mr. MacGill.

For example, an employer must be prepared to deal with the problems that stem from canceling a contract with an HMO that an employee has grown to trust, Mr. MacGill said.

But, Mercer's Mr. Stanfield cautioned that cost-containment strategies cannot be set in stone. "Cost savings in the health care area are sometimes one-time or two-time opportunities.

For employers to sustain savings over longer periods of times requires vigilance and flexibility to incorporate alternative opportunities," he said. ■



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Governments to fund cleanups: Survey

By MONIQUE PARSONS

Federal, state and local governments will pay the largest percentage of environmental cleanup costs in the year 2000, predict U.S. and Canadian casualty actuaries.

In addition, current federal cleanup programs, like the Superfund program, will be inadequate to finance the cleanup of abandoned hazardous waste sites and will have to be supported by higher taxes, the actuaries forecast in a recent survey.

The "Environmental Risk Survey," a forecast of risks in the year 2000, was conducted by the American Academy of Actuaries, the Canadian Institute of Actuaries, the Casualty Actuarial Society, the Conference of Actuaries in Public Practice and the Society of Actuaries. Of the 1,200 casualty actuaries who received surveys, 332—or 27.7%—responded.

Hazardous chemical waste likely will be the most expensive environmental risk by the year 2000, 56% of the respondents said.

Other environmental risks likely to be the most expensive, according to respondents, are: global problems such as rain forest or ozone depletion, named by 22.6%; radioactive wastes, named by 11.1%; agricultural contamination of underground water supplies, named by 3.6%; "sick office syndrome," named by 1.5%; oil spills, named by 1.2%; and genetic engineering problems, named by 0.6%.

Federal, state and provincial governments will pick up most of the bill for environmental cleanup costs, forecast 55% of the respondents.

Twenty-four percent of respondents believe that consumers will pay the bulk of pollution cleanup costs by the turn of the century. Only 11% expect insurers to pay the bulk of the costs.

And, 1.5% said risk retention groups will shoulder most of the cost, while 8% of respondents predict other means will be tapped to pay cleanup costs.

Most of the respondents—95%—also said that various regulatory programs, like Superfund, will be incapable of covering the costs of cleaning abandoned hazardous waste sites in the year 2000.

"First, we estimate that 30% to 60% of the money from Superfund has been used in litigation," said Robert Brown, president-elect of the Canadian Institute of Actuaries. "That's not going to clean up any tanks. Second, the aim of the money Superfund has is only going to touch the tip of the iceberg."

A majority of the respondents—64%—said pollution cleanup of abandoned hazardous waste sites will most likely be funded through additional taxes. Twenty-three percent said private industry will pick up where Superfund leaves off, 6% said insurers will cover cleanup costs and 7% said other means will be used to fund such programs.

An overwhelming majority of respondents predicted that the insurance industry will be no more likely to write pollution coverage at the end of the century than it is now: 36% predicted that "insurers will have the same attitudes in the year 2000 as they do today regarding pollution"; 34% predicted insurers will be even less likely to write pollution coverage than they currently are; and 30% predicted that insurers will be more likely to write pollution coverage than they now are.

Most survey respondents—64%—attributed the insurance industry's reluctance to write pollution coverage to "broad court interpretation of insurance contracts."

For example, judges have interpreted "sudden and accidental" pollution liability coverage more broadly than the insurers that wrote the policy, Mr. Brown said.

" 'Sudden and accidental' has been construed as encompassing a gradual leak in an underground tank," Mr. Brown said. "Until the judges achieve a level plateau in their interpretation, we'll write clearly in the contract what we're not going to cover."

In addition, the survey found that:

- 62% of the respondents said employers will continue to rely on workers compensation to protect themselves from the growing liability arising from occupational disease hazards—like radon gas and sick building syndrome—in the year 2000. while 21% predict that employers will increasingly retrofit their offices to minimize these risks.
- 81% of the actuaries surveyed believe that property/casualty insurers will be unable to cover claims generated by a major earthquake.

However, in the event of any natural disaster—including a major earthquake, droughts or storms—insurerance will continue to be the primary mechanism used to pay resulting claims, predicted 50% of the respondents.

Another 30% said higher taxes would cover costs.

The survey was conducted both to "raise consciousness" about the actuarial profession, which is marking its 100th anniversary in North America, and to "point out that actuaries can be involved' in environmental risk management. Mr. Brown said.

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The survey, "Environmental Risk Survey," is available free of charge by contacting Elizabeth Kelley at Edelman Public Relations, 1420 K St. N.W., 8th Floor, Washington, D.C. 20005-2401; 202-371-0200.

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Benefit managers' compensation

Survey shows most earn more than $50,000 in salaries and bonuses

By JERRY GEISEL

NEW YORK—Most benefit managers earn more than $50,000 in annual cash compensation, according to a new survey.

Some 73% of surveyed benefit managers in 1987 earned more than $50,000 in cash compensation, which includes salary and bonus, while 34% earned more than $70,000 and 10% collected more than $100,000.

The largest percentage of the surveyed benefit managers—25%—earned compensation of between $50,000 and $59,999 in 1987, while another 18% earned between $40,000 and $49,999.

In addition, 15% of surveyed benefit managers reported compensation of between $60,000 and $69,999, while 14% earned between $80,000 and $99,999. And, 10% of respondents reported earning between $70,000 and $79,999. Eight percent reported compensation of between $30,000 and $39,999, while 1% of the benefit managers surveyed reported less than $30,000 in compensation.

How much benefit managers earn is reported in a newly released survey by Martin E. Segal Co., a New York-based benefits consulting firm.

The survey is based on questionnaires sent late last year to 1,000 benefit managers. Some 223 benefit managers returned the questionnaires for a response rate of 22.3%.

Since the questionnaires were distributed during the fourth quarter of 1988, respondents were asked for year-end compensation data for 1987.

Benefit managers were asked whether their compensation fell within seven different ranges. As a result, the survey does not include information on the average compensation earned by benefit managers.

According to the survey, benefit managers' cash compensation generally increases with the size of the company.

However, because of the small number of responses from benefit managers working for the largest companies, the findings may not be representative of the general population.

For example, responses concerning compensation were received from only nine benefit managers working for companies with more than 100,000 employees.

By contrast, 117 responses, or 53% of surveyed companies, were from benefit managers working for companies with between 1,000 and 9,999 employees.

Of those benefit managers working at companies with more than 100,000 employees, 44% reported 1987 compensation of at least $100,000. Likewise 44% of the surveyed benefit managers working for companies with between 40,000 and 59,999 employees reported 1987 compensation of at least $100,000, while 13% of the benefit managers surveyed working at companies with between 60,000 and 99,000 employees reported compensation of more than $100,000 in 1987.

Only 3% of the benefit managers at companies with between 1,000 and 9,999 employees reported compensation of more than $100,000, while none of the surveyed benefit managers working at companies with fewer than 1,000 employees reported compensation of more than $100,000.

In the company size category in which the largest number of responses were received—companies with between 1,000 and 9,999 employees—32% of the benefit managers reported compensation of between $50,000 and $59,999, while 24% reported compensation of $40,000 to $49,999 and 15% reported compensation of between $60,000 and $69,999.

In addition, 9% of the benefit managers at companies with between 1,000 and 9,999 employees reported 1987 compensation of $80,000 to $99,999, while another 9% of benefit managers at these companies reported compensation of $30,000 to $39,999.

Six percent of benefit managers at companies with between 1,000 and 9,999 employees reported earning between $70,000 and $79,999 in compensation. And, 3% earned less than $30,000.

The survey also reported that the most experienced benefit managers earned the highest salaries.

For example, 50% of benefit managers earning more than $100,000 had at least 20 years of experience in the benefits field, while 17% each had 15 to 19 years of experience, 10 to 14 years of experience and five to nine years of experience.

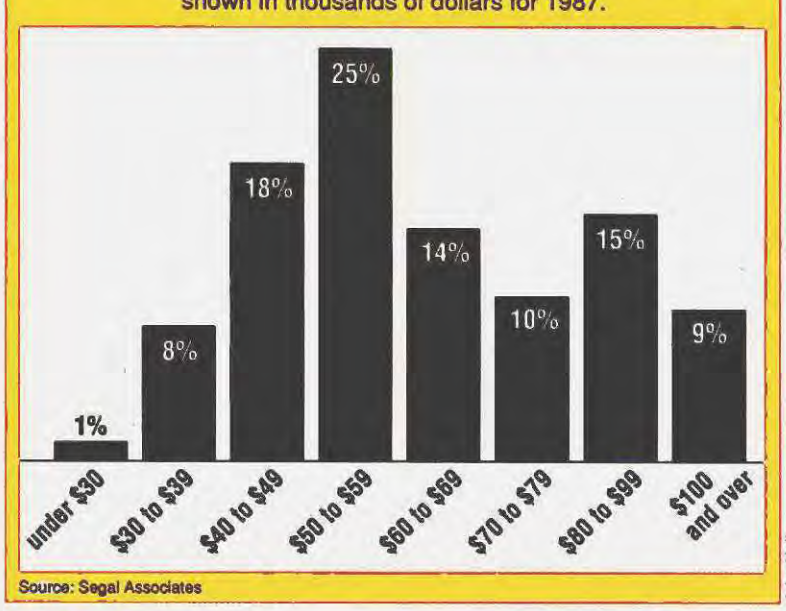
Among benefit managers earning between $70,000 and $99,999, 27% reported at least 20 years of experience, and another 27% reported 15 to 19 years of experience. In addition, 15% reported 10 to 14 years of experience, 27% reported five to nine years of experience and 4% reported less than one year of experience.

Among benefit managers earning between $50,000 and $69,999, 17% reported more than 20 years of experience; 19% reported 15 years to 19 years of experience; 24% reported 10 years to 14 years of experience; 21% reported five to nine years of experience; 17% reported one to four years of experience; and 4% reported less than one year of experience.

On the other hand, none of the benefit managers earning between $30,000 and $49,999 had more than 20 years of experience, while only 9% had as much as 15 years of experience. Some 35% had 10 to 14 years of experience, and another 35% had five to nine years of experience, 17% had from one year to four years of experience and 4% had less than one year of experience.

Benefit manager compensation

Distribution of total cash compensation among benefit managers shown in thousands of dollars for 1987.



Source: Segal Associates

John Hall

Other survey findings include:

- Seventy-one percent of benefit managers earning at least $100,000 had a graduate degree, compared with 44% of benefit managers earning between $70,000 and $99,999, 42% of those earning between $50,000 and $69,999 and 35% of the benefit managers earning between $30,000 and $49,999.

Overall, 91% of the surveyed benefit managers had an undergraduate degree, while 43% held a graduate degree.

- Eighty-two percent of the surveyed benefit managers said they had responsibilities involving their companies' defined benefit pension plans, while 78% reported responsibilities for 401(k) salary reduction plans and 61% had responsibilities for other defined contribution plans.

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Free single copies of the "1988 Survey of Benefit Managers," are available from Mary Feldman, Martin E. Segal Co., 730 Fifth Ave., New York, N.Y. 10019; 212-586-5600.

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Benefits outlook promising: Survey

By JERRY GEISEL

Employee benefit managers are bullish on the future of their profession.

Some 70% of benefit managers responding to a survey by Martin E. Segal Co., a New York-based benefit consulting firm, described the future of the benefits field as "very bright," while 23% said the future will be "moderately bright."

Most benefit managers say the plethora of legislation and regulations from Washington has boosted the importance of their jobs and will continue to do so in the future.

In fact, 61% of the respondents said that benefits legislation and regulation will have a positive effect on their profession in the future.

"Respondents most often said that increased government regulation not only provided more responsibilities for employee benefits departments, but added emphasis and credibility to their function in the corporation," the survey said.

Not all benefit managers, though, believe the continuing welter of legislation and regulations bode well for the field. Twenty-eight percent of benefit managers said that legislation will have a negative impact on the employee benefits field.

These "respondents were particularly concerned with the increasing complexity and a decrease in opportunities for creative and imaginative employee benefits planning," according to the survey.

To cope with the demands of legislative and regulatory changes in Washington as well as other problems, employers are boosting the size of their employee benefit departments, the survey showed.

For example, 51% of benefit managers said additional staff members were added to their departments between 1986 and 1988, while 30% said their staff size remained the same, and 2% did not respond.

The other 17% reported a decrease in staff size between 1986 and 1988.

Larger employers were more likely to add new staffers to their benefits departments than smaller firms, according to the survey.

For example, employers with between 60,000 and 99,999 employees added an average of 5.8 staffers between 1986 and 1988, while companies with more than 100,000 employees added an average of 5.6 staffers during this two-year period. In addition, employers with between 40,000 and 59,999 employees added an average of 5.4 staffers to their benefits department between 1986 and 1988.

By contrast, employers with fewer than 1,000 employees and companies with between 10,000 and 19,999 employees each added an average of only 1.6 employees to their benefits departments. In addition, companies with between 1,000 and 9,999 employees added an average of 2.6 staffers to their benefits departments, while companies with between 20,000 and 39,999 employees added an average of 3.1 staffers.

"We see firms creating positions that did not exist five years ago. There are so many more headaches, such as problems caused by legislation, as well the problem of rising health care costs," said Stewart Lawrence, a senior vp in Segal's New York office.

"When benefit managers say they need more staff, they now often get those additional staffers," Mr. Lawrence added.

Hiring, at least at the larger companies, is likely to continue.

For example, 59% of benefit managers at companies with between 40,000 and 59,999 employees expect the size of their staffs to increase within the next two years.

In addition, 44% of the benefit managers at companies with more than 100,000 employees expect staffs to continue to grow, as did 40% of benefit managers at companies with between 1,000 and 9,999 employees, 38% of managers at companies with between 10,000 and 19,999 employees and 36% of benefit managers at companies with between 20,000 and 39,999 employees.

But smaller companies are less likely to add staff to their benefits departments during the next two years, according to the survey.

Only 11% of benefit managers at companies with fewer than 1,000 employees expect their departments to grow in the next two years.

Not surprisingly, the largest employers also have the biggest benefit departments.

For example, benefit managers at companies with between 40,000 and 59,999 employees reported an average of 23.5 staffers in their benefits departments, while companies with more than 100,000 employees reported an average of 21.1 benefits staffers, and companies with between 60,000 and 99,999 employees reported an average of 20.4 staffers.

On the other hand, benefit managers at companies with fewer than 1,000 employees reported an average of 5.9 staffers in their benefits departments, while companies with between 1,000 and 9,999 employees reported 11.1 benefits staffers, and companies with between 10,000 and 19,999 employees reported 11.3 staffers.

Regardless of company size, an overwhelming percentage of benefit managers said their benefits budget —including both administrative costs and the cost of premiums and/or self-insured claims—increased between 1986 and 1988.

For example, 100% of benefits managers at companies with between 40,000 and 59,999 employees said their benefits budgets increased during the last two years. In addition, at least 86% of benefit managers at companies with more than 100,000 employees reported an increase in their benefits budget during the last two years.

Among benefit managers at companies with fewer than 1,000 employees, 78% said benefits budgets rose during the last two years, while 11% of these employers reported a budget decrease and 11% said the budget remained the same.

In addition, 82% of benefit managers at companies with between 1,000 and 9,999 employees said their benefits budgets climbed between 1986 and 1988, while 10% said their budgets remained the same and 8% said their benefit budgets decreased.

Rising health care costs are benefits managers' most important concern, with 91% of surveyed managers citing health care cost inflation as "very important."

Other issues cited as very important by benefits managers include:

- Health care cost management, 88%.
- Benefit design and coordination, 86%.
- Regulatory and statutory changes, 79%.
- Section 89 compliance, 75%.
- Employee benefit communication, 74%.
- Compliance with federal benefits laws and regulations; 65%.
- Administrative management, 55%.
- Post-employment health care benefits, 53%. ■

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Association-sponsored programs grow

21% of surveyed groups offering plans

By CHRISTINE WOOLSEY

Association-sponsored property/casualty insurance programs are increasing in popularity, according to a survey.

The "1989 Association Sponsored Property and Casualty Insurance Program Survey Report," conducted by The Wyatt Co., shows that while association-sponsored programs are not a new phenomenon, more associations have recently established such programs.

"Today every association executive has at least thought about this" type of insurance arrangement to his or her group's members, said Edgar W. Armstrong, a consultant in the Washington, D.C., office of Wyatt, which conducted the survey for the American Society of Assn. Executives.

And, he pointed out, executives should take advantage of the coverage bargains that can be negotiated for association members in the current soft property/casualty insurance market.

"We're less than a year away from another hard market," Mr. Armstrong predicted.

Approximately 21% of the 864 associations that responded to the survey indicated offering one or more sponsored property/casualty insurance programs, Wyatt and the ASAE found.

And among those, nearly 15% of survey respondents reported that their programs were 20 or more years old, while 61.5% had offered programs for nearly 10 years.

On the other hand, nearly 11% of the associations offering programs began their programs in 1988 and another 6.3% established their programs in 1987. In all 35.1% of the respondents offering programs have established their programs in the past five years.

Wyatt attributes part of the renewed interest in association-sponsored insurance programs to the 1986 amendments to the Risk Retention Act, which allow associations to form risk retention groups and risk purchasing groups to insure liability risks of association members.

In addition, the softening of the commercial insurance marketplace has encouraged underwriters to be more receptive to association-sponsored program arrangements, Wyatt notes.

However, the survey found that most associations began offering programs during hard market periods, which Wyatt says suggests that the programs are established in response to availability and/or affordability problems.

The decision to sponsor an insurance program does not correspond with the size of the association in terms of income, the survey notes.

For example, 15.4% of surveyed associations with $500,000 or less in income sponsor insurance programs, while 18.1% of the associations with $500,000 to $1 million in income have organized an insurance program.

In addition, 28.1% of the associations with $1 million to $1.5 million in income sponsor programs, as do 18.4% of the associations with $1.5 to $2 million in income, 30.6% of the associations with $2 million to $2.5 million in income, 20% of the groups with $2.5 million to $3 million in income, 24.6% of the associations with $3 million to $10 million in income and 14.8% of the associations with more than $10 million in income.

Associations with members in the retail and wholesale trade industries are most likely to sponsor insurance programs. Forty percent of these surveyed groups offered insurance programs to members.

Insurance programs also were sponsored by 36.7% of the construction associations, 27.4% of the health care associations, 26.4% of the services industry associations, 25% of the financial services associations, 22% of the energy and natural resources trade associations, and 21.4% of the utilities associations.

The associations least likely to offer insurance programs included non-profit organization associations, of which only 12.4% offered programs; manufacturing associations, of which only 15.1% offered insurance programs; and insurance and real estate associations, of which only 16.5% offered insurance programs.

Overall, an average of 28.8% of eligible members participate in their associations' insurance programs, the survey shows.

The highest participation rate is found in financial services industry associations, where an average of 53.4% of eligible members participate in association insurance programs. The lowest participation rate is in manufacturing associations, where only an average 20.3% of members participate.

By far, the most common type of association insurance program is a program in which coverage is underwritten by a commercial insurer. Some 73.5% of the associations surveyed that sponsor a program offer a program that is written by a commercial insurer.

The commercial insurers most active in association-sponsored programs, according to Wyatt, are CNA Financial Corp.; Fireman's Fund Corp.; Dodson Insurance Group, parent of Casualty Reciprocal Exchange; CIGNA Corp.; The St. Paul Cos. Inc.; Hartford Insurance Group; and Kansas Bankers Surety Co.

Commercially insured programs are attractive to associations because the associations generally are able to sponsor such programs without significant investment of either personnel time or member money, Wyatt notes.

However, the survey reports, associations generally do not exercise much control over these programs.

Conversely, group captive insurance companies and self-insurance pools, each offered by 13.8% of the respondents offering insurance programs to members, require significant association staff involvement, Wyatt points out.

Associations with large memberships and large annual incomes—mainly those with members involved in general services and utility operations—are most likely to offer group captives to their members, the study reports. Associations for non-profit organizations, especially public entities, are most likely to form self-insurance pools.

Of the remaining respondents, 31.5% offered a program jointly sponsored by the association and an insurance agent, 5% offered risk purchasing group arrange-

Continued on next page

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Continued from previous page
ments, while 2% had formed risk retention groups.

The totals do not equal 100% because some associations offer more than one type of risk financing program to their members.

The type and prevalence of coverages varied by membership activity, according to the survey.

For example, associations composed of manufacturers are most interested in offering broad packages of basic property/casualty insurance, including general liability, umbrella liability and workers compensation coverages.

Errors and omissions coverage is most popular with associations that have members involved in the insurance and real estate, utilities, financial and general services industries, the study revealed.

This may reflect the difficulties those industry groups have had in obtaining professional liability insurance during the last hard insurance market, the survey reported.

Directors and officers liability coverage was most commonly offered by associations representing utilities and financial services companies.

According to the survey, association insurance programs generated an average of $7.3 million in premium volume.

Interestingly, the amount of premium generated by a program had little correlation with the amount of income reported by the sponsoring association.

For example, programs sponsored by associations with less than $500,000 in total income generated an average of $11.1 million in annual premiums, while groups

D&O coverage was most commonly offered to utilities and financial services companies.

with $2 million to $2.5 million in income generated average premiums of $5.9 million and associations with more than $10 million in income generated $7.5 million in average premiums.

Captive and self-insurance pools generated the highest average premium volumes: $9.8 million and $7.1 million respectively.

Programs sponsored by an agent produced an average of $5.9 million in annual premium volume; purchasing group programs generated an average of $5.1 million in premiums; programs written by commercial insurers generated an average of $4.9 million in premiums; and risk retention groups generated an average of $2.8 million in premiums.

The coverages that produced the largest average annual premium volumes per program were E&O and workers compensation insurance, generating $6.7 million and $5.7 million respectively, the study reported.

Directors and officers liability generated an average of $2.7 million in premiums per program, while general liability insurance produced an average of $2.4 million in premiums per program.

In addition, the survey noted that an insurance program's direct cost to an association in terms of dollars and staff time commitment is minimal.

For example, 61% of respondents offering insurance programs indicated that the annual program cost to the association came to less than $10,000, and 64% said less than 25% of one staff member's time is used to oversee the sponsored program.

And, association-sponsored insurance programs can be quite profitable for associations. According to the survey, insurance programs generated an average of $190,000 in annual income to the sponsoring associations.

Nearly 75% of all respondents received some form of remuneration for sponsorship of their insurance programs. Expense reimbursement was the most popular form of remuneration, followed by management fees, royalties, commissions, dividends and profit sharing.

The association insurance program study, which was conducted this year for the first time, has drawn overwhelming interest from association executives, Mr. Armstrong said, adding that the Washington, D.C.-based ASAE may seek to conduct the survey annually or biannually.

•

Copies of the survey are available to ASAE members for $20 and to non-members for $30 from ASAE Public Relations, 1575 Eye St. N.W., Washington, D.C. 20005; 202-626-2798.

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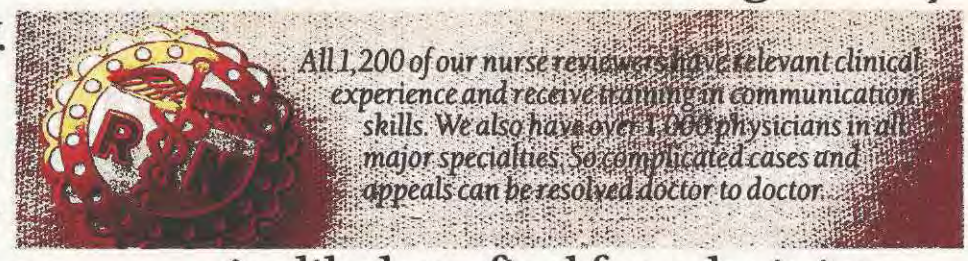

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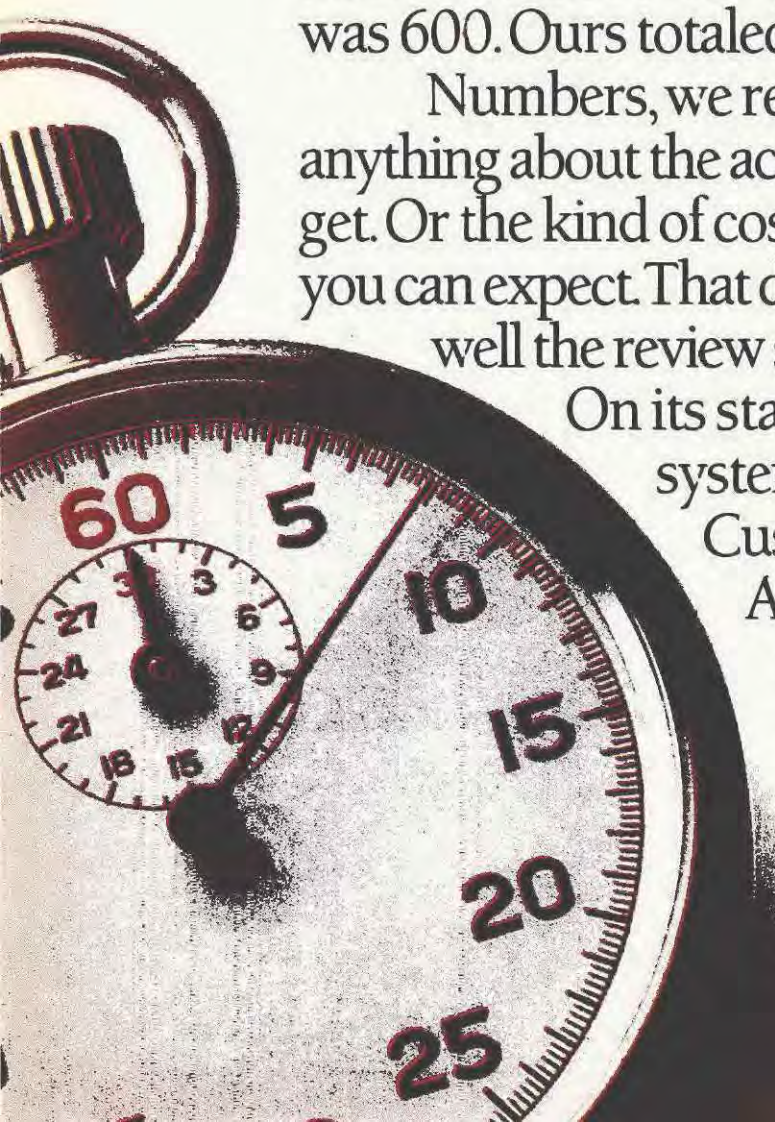
We have enough nurses to complete 100 percent of reviews within one working day. Incoming



phone calls are answered within 30 seconds 90 percent of the time even during peak periods. Written notification of review decisions is sent within two working days.

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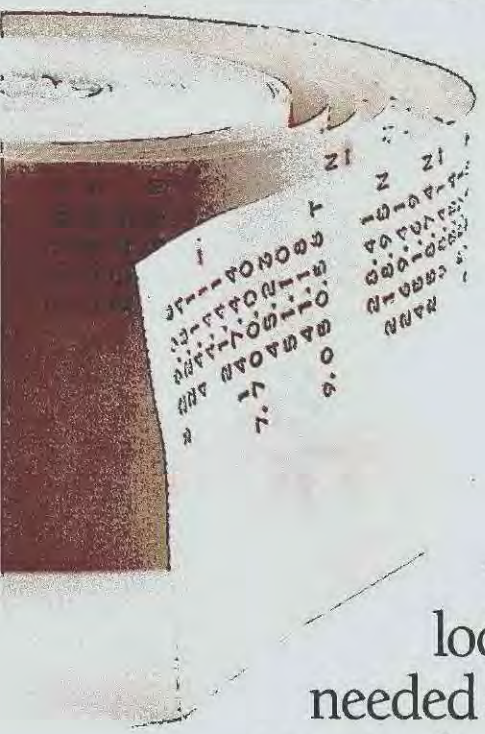

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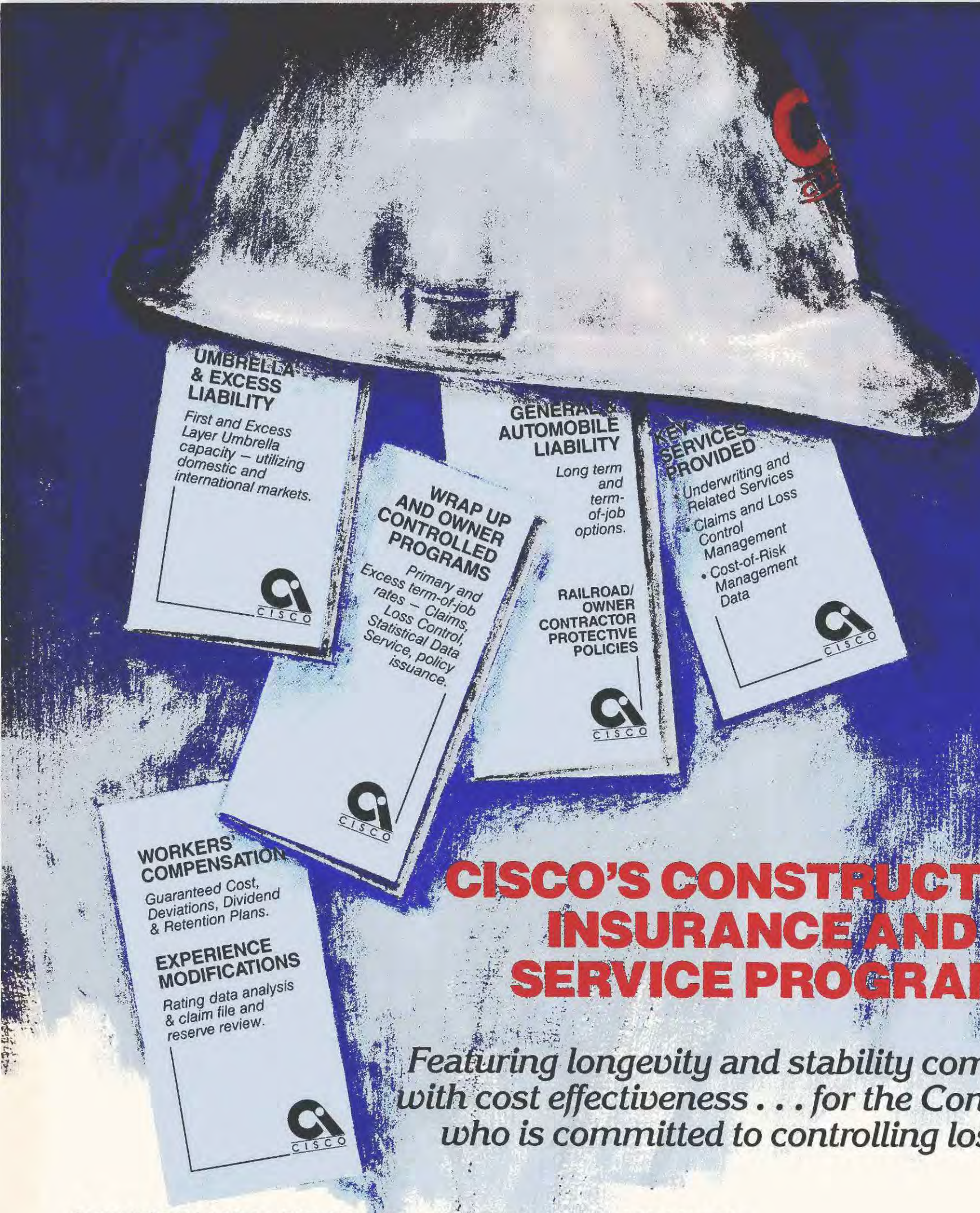

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NAIB faces reality

Dialogue sought to solve problems of brokers, buyers

By C. Richard Peterson

Speaking out

AS NEWLY ELECTED president of the National Assn. of Insurance Brokers, I spoke before the NAIB's board at the association's annual meeting in early June (*BI*, June 12). In that speech, I challenged the NAIB to constructively address the serious issues facing the insurance industry at large and brokers and agents in particular.

I then set out my personal goals and objectives for the association. These will form the cornerstone of what I expect to be a pro-active NAIB posture during my 12-month term as president.

H. Felix Kloman of the Tillinghast division of Towers, Perrin, Forster & Crosby Inc. later took issue with my remarks in a Perspective column (*BI*, July 10). I found his commentary to be both ironic and curious.

An underlying objective of my NAIB speech was to provide a dialogue and exchange of views among members about the myriad problems that we face as brokers, that our clients face as buyers of insurance and related services and that insurance companies face as providers of coverage. I strongly believe that we must address the reality of these problems.

Only by embarking upon an open and constructive discussion will we begin the process of finding viable solutions.

Furthermore, since Mr. Kloman, in effect, pursues the very exchange of views I am espousing, I find it ironic and curious that he seems to be relying on press reports as the basis of his commentary.

Mr. Kloman was not present at the NAIB meeting, nor apparently has he sought to read the text of the speech. Consequently, he has missed both the context of my remarks and some important points that I believe are worth clarifying.

When people's money is at stake, their interest in the economics of our industry wanes. Risk managers and individual consumers do not base their corporate or personal budgets on economic theory. They simply want to know if insurance coverage will be available and how much it will cost.

I agree with Mr. Kloman that our difficulties cannot be remedied through advertising campaigns. And I did not call for such a campaign.

What I suggested was a relevant, fact-based communications program aimed at educating the public about the nature of insurance and its role in our economy and our society. We should communicate the basics of our business starting with the question of what is insurance and how does it work? We might also point out that importance of insurance to the continued economic growth of our country.

In my view, insurance has moved from risk sharing to cost sharing. In the process, the premium transaction is looking more and more like a tax to many people, especially in the personal lines area.

A message pointing out the distinction between taxes and insurance premiums may be both timely and informative.

The public's perception of the insurance industry is negative. Brokers share in the image problem. We believe we have an obligation to help the public better understand the broker's role.

To not pursue this effort through the communications media is short-sighted.

In my speech, I referred to the Federal Reserve Bank as an example of a system that seems to work efficiently for the banking industry. The Federal Reserve provides both stabilizers of monetary policy and a methodology for self-regulation in a quasi-private environment.

Pointing to this example in the context of the insurance industry, my question before the NAIB was: "Is there a comparable system for the insurance industry that can bring about cyclical stability while allowing a measure of self-regulation?" The driving force behind my question is the seemingly uncontrollable insurance cycles and the toll these cycles take on all of us—buyers, brokers and underwriters.

To look for possible answers the NAIB, as announced earlier this month, has appointed the consulting firm of Hamilton, Rabinowitz & Alschuler Inc. to study the issues and recommend courses of action (*BI*, July 17).

Basic economic law holds that price in a free market tends to be determined by supply and demand. Since the demand for insurance is relatively stable, the erratic price swings that we are experiencing must be the result of changes occurring in supply, or the capacity to write insurance coverage.

Since historical statistics tend to support this view, more thought should be given to the nature and ease by which investment capital enters and exits the insurance marketplace.

At the same time, it may also be advisable to raise the standards for insurance licensing to provide a more careful monitoring of who is investing in the insurance industry and if those investors are financially able to sustain their investments during soft market cycles.

Unlike other industries, the insurance industry has no built-in stabilizers to smooth its cycles. Investment is easily made and withdrawn.

The resulting volatility, especially at the beginning of a cycle change, creates a view that insurance is a system that is at best flawed, if not totally irrational.

When people's money is at stake, their interest in the economics of our industry wanes. Risk managers and individual consumers do not base their corporate or personal budgets on economic theory. They simply want to know if insurance coverage will be available and how much it will cost. They are asking for reasonable time frames for the coverage at realistic price levels. And they want to know that the insurance coverage will be there to protect them at the time of loss.

Public confidence in a system that cannot be predicted or even understood continues to erode. Perhaps a Federal Reserve-type system could help change this environment by bringing about a measure of stability and predictability to insurance.

The current system of insurance delivery, coupled with the unpredictable cycle, does not provide for much certainty.

Consequently, public confidence in a system that cannot be predicted or even understood continues to erode. Perhaps a Federal Reserve-type system could help change this environment by bringing about a measure of stability and predictability to insurance.

In Mr. Kloman's commentary, he implies that insurance brokers are in "lock step" with the insurance companies on policy issues. This is not the case. Brokers represent the interests of their clients, the buyers of insurance products and services. In this regard, the NAIB has consistently maintained an open mind on insurance issues and, as a result, has often found itself on opposing sides of insurance companies. The record speaks for itself:

- The NAIB has publicly supported the federal Risk Retention Act.
- We felt, and said, that the Insurance Services Office Inc.'s proposed commercial general liability form was an unfair restriction of coverage.
- We have been open to debate of the McCarran-Ferguson Act and even conducted a comprehensive study in 1987 titled, "The McCarran-Ferguson Act: Marketplace Impact of Proposals for Change."
- We followed that with a 1989 report that called for swift regulatory action to take bankrupt insurers out of the marketplace.

These are only a few examples of issues where the NAIB has found itself differing in whole, or in part, from the views publicly held by insurance companies.

As of the question of ethics in the insurance brokering community, I believe that time is right for discussion.

Ethics are not a checklist of right or wrong behavior, but an attitude that we, as brokers, project in all of our personal and professional relationships.

I have proposed that the insurance brokerage industry, through the NAIB, adopt a formal code of fair practices. This code would articulate how our industry will operate in the future as it matures, expands and changes.

Other professional service industries—including accountants, lawyers and bankers—have such defined standards.

We, as the insurance brokerage industry, also need such standards by which we can be measured by our clients, measured by society and measured by one another.

As brokers, we are in a fiercely competitive environment and are highly visible players in the overall insurance industry. None of us is immune from criticism, productive or otherwise, from observers of our industry.

The NAIB is the proper forum for brokers to consider and debate national issues that affect our clients and our companies.

This debate shapes positions, and I believe it is our responsibility to publicly state these positions when we have the consensus of the members of the association.

I fully expect the NAIB to be challenged, from time to time, for the positions that it takes. And I encourage such responsible differences of opinion as long as the accompanying dialogue will be thoughtful, productive and contribute to a spirit of finding meaningful solutions to the many problems that beset the insurance industry.

C. Richard Peterson is executive vp at New York-based Fred S. James & Co. Inc. and is also president of the National Assn. of Insurance Brokers.

Airport shops face special risks

By The Insurance Institute of America

A.R.M. exercises

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 material, detailing how the standard methods of valuing and preventing possible losses also are applicable to unusual exposures, is drawn from a recent national examination in ARM 54-Essentials of Risk Management Risk Control.

Q: Air Host Inc. operates restaurants and gift shops in several major airports in the United States and Europe, using its own personnel and occupying rented space. Air Host's risk management professional recognizes that hostage takings or other violent incidents at an airport may cause Air Host to suffer a variety of losses because of such violence or military responses to terrorist actions, either of which may close an airport.

Describe how to properly evaluate the losses Air Host Inc. may suffer from such an incident resulting from exposure to:

- Property loss.
- Net income loss.
- Liability loss (including contractual liability).

Before an incident occurs at any particular airport, what actions, if any, could Air Host take to minimize the severity of following types of losses it might suffer in such an incident:

- Property loss.
- Net income loss.
- Liability loss (including contractual liability).

A: Properly evaluating potential losses requires, in each case, first defining a proper valuation standard and then gathering the information needed to apply that standard.

- For property losses, the most appropriate evaluation standard probably is replacement cost (although actual cash value would be appropriate if Air Host did not intend to replace its property after a severe loss). Applying the standards would require data on replacement costs in relevant markets and, for actual cash value, on accumulated depreciation from Air Host's accounting records.
- Potential net income losses are equal to the decrease in revenues (less non-continuing expenses) plus any increased "extra" expenses for each day Air Host's operations may be partially or fully shut down at a given airport at peak season. Data to apply this valuation standard should come from Air Host's own accounting records, projections of business activity, and its own (or comparable firms') loss experience to indicate the degree and duration of shutdowns from hostage or terrorist incidents.
- Such incidents may obligate Air Host to pay workers compensation claims to its own employees, verdicts and negotiated settlements to any injured members of the public and payments to airports or other organizations to whom it may be contractually obligated despite any shutdowns. Beyond these payments, Air Host also may incur costs for investigating and defending legal claims. To properly estimate all these outlays, Air Host should refer to its own and similar firms' loss experience, pertinent workers compensation statutes and the provisions of its contracts with airports and others.

To answer the second part of the question, it should be noted that, in general, loss control actions may be taken either before or after a loss-causing event and may reduce loss frequency, loss severity or both. Only those pre-event actions that would reduce the severity of Air Host's losses, regardless of the effects these actions also may have on loss frequency, are appropriate answers to this question.

- Developing and practicing emergency response plans at each of its locations would help Air Host reduce all types of its losses from terrorist incidents. Beyond such plans, reducing the amount of its property (particularly high-valued items at especially vulnerable airports) should cut property loss severity.
- To maintain its net income, the company needs contingency plans for resuming operations quickly (perhaps in temporary substitute facilities) and for minimizing its continuing and extra expenses. Furthermore, Air Host may be able modify its leases to suspend its rental payments to airports when an entire facility, or the portion used by Air Host, is unusable for any reason.
- Air Host should train its personnel to deal empathetically with members of the public during any terrorist incident while treating their possible injuries and avoiding any invasions of their legal rights. Air Host also may be able to modify its utility contracts and leases to reduce its contractual obligations to continue payments during any shutdowns.

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.

An affordable gold mine for newcomers

"101 Ways to Cut Your Business Insurance Costs without Sacrificing Protection"
By William S. McIntyre IV and Jack P. Gibson
Published by McGraw-Hill Book Co., 1221 Ave. of the Americas, New York, N.Y. 10020
$19.98

By Kevin M. Quinley

Books & ideas

The sum of $19.98 won't buy you much these days. It may get you:

- Two compact discs.
- 5% of your registration fee for the next Risk & Insurance Management Society conference.
- Two hours of parking space time in New York City.

It will also buy you the best little practical risk management manual around for business owners, risk managers and insurance purchasers. William S. McIntyre IV and Jack P. Gibson, authors of "101 Ways to Cut Your Business Insurance Costs Without Sacrificing Protection," have hit a grand-slam home run. In fewer than 200 pages, they give a smorgasbord of handy tips for trimming business insurance costs.

Messrs. McIntyre and Gibson are with the International Risk Management Institute of Dallas. Their consulting expertise and combined experience in insurance make them risk management E.F. Huttons—when they talk, I listen.

The writers address the major types of property and casualty insurance bought by all businesses, with separate chapters on: automobile insurance, commercial general liability, umbrella coverage, workers compensation and property insurance. They devote individual sections to: experience rating, insurance industry relationships, claims, risk financing, insurance bidding and general recommendations.

The authors are ambitious. Their preface states that the book will function "as your personal insurance interpreter." It reveals "tricks of the trade" used to calculate your organization's premiums. The authors stress the importance of getting to know the underwriter personally on more sensitive coverage areas. They advocate some clever ideas to prevent 11th-hour cancellations or non-renewals from insurers.

They are up to the minute, with sections discussing the pros and cons of captives and risk retention groups. "101 Ways" is wary of claims-made coverage, but it offers a handy checklist of considerations for companies contemplating this transition.

"101 Ways" is eminently readable. Each chapter stands alone, chock-full of useful ideas on trimming costs. The book has an excellent, albeit concise, risk management glossary. It also contains handy appendices on claims-made coverage, 10 important coverage considerations and evaluating insurer solvency. These are like a second helping of dessert—you don't expect it, but like it anyway.

This reviewer has a habit of using a yellow highlighter to mark useful portions of books being reviewed. After I finished "101 Ways" and flipped through the pages, the book looked like it had jaundice.

Each chapter gives a brief preface on the topic, then lists concrete suggestions for cutting premiums. Given today's obsession with lists, Mr. McIntyre and Mr. Gibson's risk management tips should find a receptive audience.

This is an excellent do-it-yourself risk management guide that offers a buffet of ideas from which risk managers can pick and choose.

Among their cost-cutting tips:

- Consider deductibles on liability as well as property policies.
- Prepare and verify premium audits.
- Don't over-bid your insurance account too often.

Before this review turns into a mash note, the book does have minor flaws. Experienced risk managers won't learn much new from the book. It is best suited to small-business owners and risk managers with beginning to moderate experience. It's easy to forget that many businesses, (perhaps most), lack full-time risk managers. For those companies, "101 Ways" fills a void.

Messrs. McIntyre and Gibson avoid discussing group health or employee benefit costs, though this is a growing line-item in any business' insurance budget.

Not all of the 101 suggestions are on cutting costs, but rather on broadening coverage or picking a better insurance broker. That's fine, but the book title is a little misleading. A minor quibble, admittedly. Also, a disproportionate number of the author's examples are from the construction industry. Maybe that's a big slice of IRMI's clientele.

This reviewer's recommendation: Forgo the compact discs and don't park your car in Manhattan. Instead, hail a cab, and on the way, read "101 Ways to Cut Your Business Insurance Costs." Few investments of $19.98 will repay you as handsomely.

Kevin M. Quinley is claims manager for MEDMARC Insurance Co. and Hamilton Resources Corp., both of Fairfax, Va. Mr. Quinley holds the Chartered Property & Casualty Underwriter and Associate in Risk Management designations.

Coming & goings: industry

Corroon & Black unit names Hogan CEO

Robert J. Hogan Jr. has been promoted to chief executive officer of Corroon & Black/Stump, Harvey & Cook Inc. of Baltimore, a unit of Corroon & Black Corp.

Mr. Hogan, who began his insurance career in 1977, joined Corroon & Black in 1986. Most recently, Mr. Hogan was executive vp of Corroon & Black of Illinois Inc.

He succeeds Edward F. Pugh, CEO of Corroon & Black Inc. of Washington, D.C., who had also served as CEO of the Baltimore profit center.

In other agent/broker changes:

Robert J. Molinaro appointed senior vp and western group marketing director of Fred S. James & Co. in Irvine, Calif.

Joyce M. Miyada and **Lisa Smith** named vps of King & Neel Inc. of Honolulu.

Cary G. Smith appointed president of Hilb, Rogal & Hamilton Co. of Tidewater in Norfolk, Va.

Kenn R. Allen promoted to vp and chief operating officer of Meadowbrook Insurance Agency in Southfield, Mich.

Reinsurance

John M. Kwaak joined U.S. RE Corp. of New York as senior vp. Most recently, Mr. Kwaak was a vp of Cole, Booth, Potter Inc.

General Reinsurance Corp. of Stamford, Conn., announced the following promotions to vp: **Anthony J. Anastanio**, **Richard S. Patronik** and **Suzanne A. Turner** in Stamford; **James D. Doe** in Atlanta; and **Temple C. Stark** in Dallas.

Jack T. Speckman joined StellaRe Management Corp. of Tarrytown, N.Y., as vp and claims manager.

Kevin D. Davidson promoted to vp of American Re-Insurance Co.'s facultative property division in New York.

Isaac Mashitz and **Donald L. Madsen** named vps at North American Reinsurance Corp. of New York.

Kenneth J. Rutkowsky joined newly formed J.L. Kelley Princeton Inc. of Franklin Lakes, N.J., as president. Most recently, Mr. Rutkowsky was executive vp of American Treaty Management Corp.

Excess/surplus

Mark Aragona joined Crump E&S Group of New York as senior vp. Previously, Mr. Aragona was senior vp and director of Stewart Smith East Inc.

Other suppliers

Stanley A. Roberts named a principal of Milliman & Robertson Inc. of Seattle.

Barry S. Blecher, **Richard B. Cornwell**, **Peter W. Rutherford** and **John S. Westervelt** named partners at benefit consultant Kwasha Lipton of Fort Lee, N.J. Also, **Mary Elizabeth Ampe**, **Jeffrey A. Croyle**, **Patricia A. Rotello** and **Karen S. Salinaro** named principals.

Ralph J. Braskett joined Grubbs & Co. Inc. in Silver Spring, Md., as vp and consulting actuary. Most recently, Mr. Braskett was a chief actuary with Hirshfeld, Stern, Moyer & Ross.

David K. Barton joined third-party administrator INSCOR of Dallas as vp and chief operating officer. Most recently, Mr. Barton was vp-sales of Control Data Benefit Services.

Monna Burns named president of Corporate Claims Services Inc. of Columbus, Ohio, a third-party administrator.

Richard V. Bevan, a vp of benefit consultant TPF&C in New York, a division of Towers, Perrin, Forster & Crosby Inc., appointed communication practice leader.

Thomas M. Dant joined Alexander & Alexander Consulting Group Inc. in Los Angeles as vp and actuarial practice leader. Previously, Mr. Dant was a national practice leader with Peat Marwick Main & Co. ■

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There's more to selling a home these days than meets the eye. "Beware of the buyer" sums it up. Hidden structural damage, contract errors, environmental problems, financial difficulties. All part of a heavier burden of disclosure imposed by the courts on today's real estate professional.

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Lloyd's calls for reports of misconduct

By CAROLYN ALDRED

London

LONDON—Lloyd's of London members who work in the market must report any incidents of market misconduct under a bylaw passed by the Council of Lloyd's this month.

The new regulation imposes "a general duty on any person. . .to report all instances of misconduct, other than those which it is reasonable to regard as being of a minor nature."

The misconduct "is to be reported promptly to the Deputy Chairman and Chief Executive of the Society (of Lloyd's)," the rule says.

Misconduct also may be reported to the managers of the brokers' or underwriting agents' departments at Lloyd's, said Chief Executive Alan Lord.

The duty "applies to a person who either knows of any actual or proposed misconduct or believes, or has reason to believe, that such misconduct is likely to occur or to have occurred," the rule states.

The bylaw is a product of Lloyd's efforts to strengthen its self-regulation standards.

According to Lloyd's, a person is guilty of misconduct if:

- He or she contravenes or fails to observe any Lloyd's regulation.
- Conducts himself in a manner that "is detrimental to the interests of Lloyd's policyholders, the society, members of Lloyd's, brokers underwriting agents or others doing business at Lloyd's."
- Conducts any insurance business "in a discreditable manner or with a lack of good faith."
- Conducts himself or herself "in any manner which is dishonorable or disgraceful or improper."

Contingency fees

The British government is proposing to introduce a limited contingency fee system to allow English lawyers to accept civil legal cases on a "no win, no fee" basis.

Britain's senior legal officer, the Lord High Chancellor Lord Mackay, plans to introduce "speculative action" into the English and Welsh legal system, similar to the type of conditional fee arrangement currently used under Scottish law.

But Lord Mackay rejects adoption of the contingency fee system commonly used in the United States, whereby lawyers accept a percentage of any damages awarded to their clients.

The proposals are outlined in a White Paper titled "Legal Services: A Framework for the Future."

Under the proposals, clients will be able to negotiate with lawyers the payment of a fee on the basis of a successful outcome.

"The Government also accepts that it would be reasonable for a lawyer who represents a client on this basis to balance the risk of losing the case. . .by charging at a higher rate than would have been appropriate but for the conditional factor," the White Paper states.

However, government consultation with the legal profession prior to publication of the White Paper showed a "clear consensus that it would not be right in principle, and would be likely to have a number of undesirable side-effects, for a lawyer to be permitted to undertake a case in return for some percentage of whatever damages might be received," the document notes.

"That form of contingency fee system was also thought likely to create an unacceptable degree of conflict of interest between the lawyer and his client, which could result in his being unable to give the client or the court advice of the required degree of impartiality," the proposal adds.

Therefore, the government "proposes that power be given to the Lord Chancellor to prescribe by. . .legislation, after consultation with the profession, the maximum amount by which a lawyer's costs can be increased when he is working for a conditional fee. That increase will be expressed as a moderate percentage of the normal costs," the White Paper recommends.

Meanwhile, there will be no change in the English rules that govern payment of legal and court costs, which usually result in the losing party paying the costs of both parties to the litigation.

Daycare tax

A proposal to eliminate a workplace daycare center user tax failed in the House of Commons earlier this month.

The proposed amendment to a government finance bill would have prevented Britain's Inland Revenue from taxing employees who use employer-subsidized workplace nurseries or daycare facilities.

"There seems to be an inconsistency in the government's thinking on workplace child care," said Alen Mathewson, chairman of the Workplace Nurseries Campaign.

Government "ministers concerned about the impact on the economy of skills and labor shortages have been urging employers to establish child care. But their failure to support this amendment. . .must raise questions for employers and parents about how seriously the government is committed to promoting workplace child care," he noted.

The Workplace Nurseries Campaign was formed to lobby for the abolition of the tax paid by parents on the cost of their child's care in workplace nurseries. The campaign is sponsored by employers, trade unions and parents.

The campaign estimates that there are about 100 workplace daycare facilities in the United Kingdom, mainly run by the public sector in hospitals, local administrative authorities and colleges. Only about 20 commercial companies provide child care facilities for employees, observers estimate (*BI*, Nov. 21, 1988).

However, Thorpe Park, an amusement and recreation park outside London, this month opened a workplace daycare center for up to 38 children.

New Minet unit

London broker Minet Holdings P.L.C. has formed a new holding company to "spearhead future development plans" in Europe, Chairman Ray Pettitt announced earlier this month.

Minet Europe (Holdings) Ltd. will be headed by Mr. Pettitt as chairman and Ian Fox as managing director. Mr. Fox also is managing director of Minet Insurance Brokers (International) Ltd.

Other directors of Minet Europe will include Bryan Hayes, chairman of Minet Reinsurance Brokers International Ltd.; Michael Pix, senior executive director of J.H. Minet & Co. Ltd.; Derek Cooper, managing director-continental Europe, of Minet International Professional Indemnity Ltd.; V. Desai, group finance director of Minet Group Services; Michael Brown, Minet Group legal adviser and company secretary; and Graham Hudson, director of Minet Insurance Brokers (U.K.) Ltd.

Legal advice offered

British architectural firms now may obtain subsidized legal advice as part of the professional indemnity insurance plan offered through the Royal Institute of British Architects and Lloyd's broker Lowndes Lambert Group Ltd.

RIBA Insurance Agency Ltd. has retained London law firm Fishburn Boxer to assist "in situations where a (policyholder) is concerned about a possible claim for damages being made as a result of an existing problem," RIBA announced this month.

The law firm also will advise policyholders on risk avoidance and how to avoid future claims.

A special unit has been formed at Fishburn Boxer that will charge RIBA members maximum fees of 65 pounds ($105.30) plus 15% Value Added Tax per hour, partner Clive Boxer said.

The offer of subsidized legal advice is one of several improvements made to the insurance plan, which currently has 1,300 architectural firms as members, said Ray Cecil, a senior partner of architectural firm Cecil Denny Highton and a member of RIBA's Council.

Other changes include:

- A special policy for "part-time" architects who work on their own time in order to build their own practice.
- A runoff policy that applies when an architectural firm is wound up.

The RIBA Professional Indemnity Insurance Plan, which is underwritten by Lloyd's of London underwriters and several British insurance companies, was put together in 1985 "at a time when there was a terrible hiatus in the professional indemnity insurance marketplace," said David Davies, a vp of RIBA.

Meanwhile, a recent survey of 3,000 architects commissioned by RIBA revealed insurance and risk management is not well understood in the profession, said Mr. Cecil.

For example, the survey indicated that:

- Risk management "is not generally understood by architects, who seem to have little idea about the preventative or pro-active approach the application of risk management involves."
- Architects "have a low perception of differences in cover available."
- Insurers settle claims too readily out of court. "An architect is not necessarily entirely satisfied with this as the claim can still harm his/her reputation."
- More than half of the architects surveyed had changed their insurers in the last 10 years—most often, to reduce premiums.

Comings & goings

Richard A. Dalzell is succeeding John Robins as group finance director of Willis Faber P.L.C. Mr. Dalzell joined Willis Faber as deputy finance director in March 1988. Mr. Robins, who is the director responsible for Willis Consulting Group, will continue to head Willis' management services and group systems operations.

Robin R. Snook has been appointed managing director of Employers Reinsurance Ltd. Mr. Snook previously was deputy general manager of The Mercantile & General Reinsurance Co. P.L.C.

Igor Best-Devereux has been appointed deputy chairman of the marine and energy division of Alexander Howden Ltd. Mr. Best-Devereux previously was managing director of Anistics Ltd., another London-based subsidiary of Alexander & Alexander Services Inc.

Alan Punter has been appointed managing director and **Deborah Durkin** has been appointed deputy managing director of Anistics Ltd.

Tony Funnell has been appointed deputy general manager of the Institute of London Underwriters, which represents the London company marine insurance market.

A.J. Archer & Co. Ltd. has appointed **Anthony Pitt** underwriter of non-marine Lloyd's of London syndicate 544. Mr. Pitt succeeds Derek Dolling-Baker, who is stepping down as underwriter due to a recent illness. Mr. Dolling-Baker will continue as deputy underwriter.

Lloyd's of London underwriter **Bryan Kellett** has been elected president of the Insurance Institute of London. **Roger Taylor**, group executive director of the Sun Alliance and London Insurance P.L.C., was elected deputy president. Both men will hold office for one year beginning Oct. 2.

London-based financial and professional indemnity insurance broker Special Risk Services Ltd. has appointed **Mary Otto** to lead the company's reinsurance division. Previously, Ms. Otto was senior vp and director of reinsurance with AMBAC Indemnity Corp. of New York, a subsidiary of Citibank. ■

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PBGC chief

Continued from page 3

While the PBGC still hopes to prevail in the courts in its battles against LTV and Wheeling-Pittsburgh, a legislative solution to follow-on plans may be necessary, he said in an interview with *Business Insurance*.

"If we have more trouble in the courts on follow-on plans, we may have to go back to Congress" for legislative relief, he said.

Mr. Lockhart also commented that:

- Major pension reform legislation that Congress enacted in 1987 has, as intended, discouraged employers from terminating underfunded pension plans.
- Legislation proposed by several members of Congress to bar or make it virtually impossible for employers to recover surplus assets from terminated overfunded plans would have a damaging effect on defined benefit pension plans.
- Asset transfers from overfunded pension plans to special accounts to pay for retiree health care liabilities should be allowed as long as a sufficient cushion or reserve—after the transfer—remains in the pension plan.

Mr. Lockhart, 43, is the eighth person to head the PBGC since Congress created the agency as part of the Employee Retirement Income Security Act of 1974. He took over the helm of the PBGC this month after the resignation of Kathleen P. Utgoff (*BI*, May 8), who will be joining the Washington, D.C., law firm of Groom & Nordberg as an economist.

Mr. Lockhart is the first executive of a major insurance broker to direct the PBGC. Since 1983, Mr. Lockhart served as treasurer of Alexander & Alexander Services Inc. in New York, where, among other things, he was chairman of A&A's benefit funds' investment committee. He also was chairman of TIFCO Inc., A&A's insurance premium financing unit, prior to its sale last year to Transamerica Financial Corp.

Mr. Lockhart also served as an assistant treasurer with Gulf Oil Corp. in Pittsburgh.

The new director has a bachelor of arts degree from Yale University of New Haven, Conn., and a master of business administration degree from Harvard University's School of Business in Cambridge, Mass.

Mr. Lockhart comes to the PBGC a year and a half after the agency's biggest legislative success: the December 1987 passage of a sweeping measure known as the Pension Protection Act (*BI*, Dec. 28, 1987). That law, among other things, sets a variable rate premium structure under which premiums that employers pay the PBGC depend on the funding levels of their pension plans.

In addition, the law requires companies to make more frequent contributions to their pension plans, and it closed certain loopholes in federal law that made it relatively easy and inexpensive for companies to terminate underfunded pension plans and shift the liabilities to the PBGC.

Without that law in place, Mr. Lockhart believes, the PBGC by now likely would have been hit with big pension claims.

The 1987 law, he notes, has made it harder for companies to terminate underfunded plans.

Still, the PBGC faces other problems that could stand in the way of Mr. Lockhart's goal of reducing the PBGC's multibillion-dollar deficit and keeping the PBGC's premium rates stable.

The biggest immediate problem confronting Mr. Lockhart and the PBGC—with at least $2 billion and possibly much more at stake—is the attempt by LTV Corp. to establish new follow-on pension plans.

"Most other PBGC problems pale in comparison to the LTV issue," Mr. Lockhart said.

In January 1987, the PBGC terminated three LTV pension plans after LTV, which filed for protection from creditors in July 1986 under Chapter 11 of the Federal Bankruptcy Act, said it could no longer afford to fund the plans.

However, in September 1987, the PBGC attempted to force LTV to take back the terminated plans and their $2 billion in liabilities after LTV, as part of a collective bargaining agreement with the United Steel Workers of America union, established a new pension program to provide certain non-guaranteed benefits that were lost by plan participants when the plans were terminated (*BI*, Sept. 28, 1987).

While the PBGC charged that the new follow-on plans were an illegal continuation of the terminated plans, the 2nd U.S. Circuit Court of Appeals disagreed, explaining that there was no evidence that Congress ever intended the establishment of new pension programs to be grounds for the restoration of already terminated plans (*BI*, May 22).

If LTV ultimately prevails, other companies are likely to try a similar strategy, Mr. Lockhart said.

Such a strategy, pension observers have said, would be appealing for some companies. Financially troubled companies could jettison their underfunded plans, transfer what ultimately could be billions of dollars in liabilities to the PBGC and then establish new low-cost pension programs to provide non-PBGC guaranteed benefits.

Mr. Lockhart describes such a strategy as abusive and clearly not what Congress intended when it established the PBGC to protect workers' and retirees' basic pension benefits.

Mr. Lockhart says he intends to do whatever he can to get the word out to employers contemplating follow-on plans that the agency will vigorously oppose such arrangements.

"We do not approve of follow-on plans that are abusive. . .that replicate the previous plan," he said.

For now, the PBGC is fighting its battle against follow-on plans in court. Next month, for example, the PBGC expects to decide whether or not to ask the U.S. Supreme Court to review the LTV decision, he said.

However, if courts uphold follow-on arrangements that the PBGC considers abusive, Mr. Lockhart says the agency is prepared to go to Congress for legislation to curb the problem.

"It is our thought to address this problem in the courts," but the agency is prepared, down the road, to seek legislation if necessary, he said.

On the other side of the pension ledger, Mr. Lockhart says he is concerned about legislation that is starting to wind its way through Congress to restrict the ability of an employer to recover surplus assets from a terminated overfunded pension plan.

If a reversion ban became law, employers would be much less likely to establish new pension plans or continue funding existing plans beyond the absolute minimum that is required, Mr. Lockhart said.

Over the long haul, a reversion ban "is a real threat to the defined benefit pension plan system and the PBGC, he said.

For example, if companies skimped on pension funding, their pension plans might lack sufficient assets to pay promised benefits if the plans suffered investment losses and the company failed, observers note. Then, the PBGC would be stuck with the company's pension liabilities.

Mr. Lockhart says the PBGC, in theory, would not object to allowing employers to transfer a portion of surplus pension assets—without having to terminate the plan—into special funds to pay for retiree health care benefits.

However, the PBGC would insist that certain safeguards be met, such as requiring that a very healthy funding cushion remain in the pension plan after an asset transfer, he said.

Asset transfers, though, are a very narrow approach toward dealing with retiree health care issues and the problem needs to be examined in a much broader context, Mr. Lockhart said. ■

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Bad-faith suits a necessity: Hunter

By STACY ADLER

BOSTON—State regulators are so "notoriously weak" at policing the insurance industry that bad-faith lawsuits against insurers are necessary to protect policyholders, consumer advocate J. Robert Hunter says.

"In a few years, bad-faith law has done more to police abusive insurance practices than a decade of regulation," Mr. Hunter told attorneys attending the annual Assn. of Trial Lawyers of America convention earlier this month in Boston.

"Insurance companies have been getting away with a lot for a long time," said Mr. Hunter, president of the Alexandria, Va.-based National Insurance Consumer Organization. "There are (insurance companies) whose sole purpose in life is to rip off people."

He explained that "insurance companies make money by denying a claim or even delaying payment of a claim. It is a monumental cash-flow game."

But now the tide is changing through the filing of bad-faith lawsuits against insurers, he said. "We finally have begun to find ways to make them tremble a little bit."

Mr. Hunter blasted state insurance regulators for failing to adequately police the claims-handling practices of the insurance industry.

"It is bad enough the regulators don't know which companies are insolvent. They certainly don't know the ones guilty of bad-faith claims handling," he said.

"State insurance departments have historically been the buffer between insurer greed and the wallet of the customer," he said. "Yet, for many years, there has been, in effect, no protection in most states," he said.

Plaintiffs' attorneys who file bad-faith lawsuits against insurance companies are "the only thing standing between consumers and abusive (claims handling) practices," according to Mr. Hunter.

Therefore, it is "incumbent" on plaintiffs' attorneys "to fight to keep insurance bad faith in its place," Mr. Hunter pointed out.

Mr. Hunter told the attorneys they "must fight because the states won't. Very rarely does the state go to bat for an injured victim of bad faith," according to Mr. Hunter.

The lack of insurance regulation can be seen from the fact that only one-third of the state insurance departments nationwide have written procedures for handling consumer complaints, he said.

Furthermore, if an insurance regulator is asked the average time its takes insurers in his state to pay claims, "he will look at you as though you've asked him something about Einstein's theory of relativity," he said.

Mr. Hunter said part of the reason that state insurance departments fail to adequately police the industry is that they are underfunded and understaffed.

But, he also said part of the problem is that half of the insurance commissioners come from or subsequently go to work at insurance companies. "So you can't expect them to be too tough," he quipped.

The necessity of insurance makes it the equivalent of a "public utility, but it is regulated as if it is some kind of private free enterprise," he pointed out.

Mr. Hunter commented that one insurance executive, when asked about possible federal regulation of the industry, replied: "I would rather be regulated by 50 monkeys than King Kong."

"Fifty monkeys indeed is what they've got," Mr. Hunter said.

Work comp laws

Continued from page 3

compensation law that he would like to see, most of which would expand coverage for workers, are:

- The elimination of the word "accidental" in most state workers compensation statutes.

Some states require an injury be caused by a work-related "accident."

Mr. Larson said the term accident arose out of courts "misreading" state work comp statutes. Most statutes say they cover work-related injuries caused "by accident," which means unintended or unexpected, he said. Somehow courts changed the statutes to mean "by an accident" and then proceeded to demand "Where is the accident?" Mr. Larson said

The result of this is thousands of cases where courts struggle to determine what is usual exertion and what is not, as if intentionally lifting a slightly heavier load than usual turns that activity into "an accident," he said.

This kind of "absurd" result was never intended by the original drafters of the workers compensation statutes and must be eliminated, Mr. Larson said.

In 1950, Mr. Larson said: "This unfortunate phrase should be scrapped. Its contribution to compensation law has been all bad."

But, today, most states still use the word "accident" in their workers compensation statutes.

In fact, only six states have deleted the word from their workers compensation statutes: Rhode Island in 1949; Minnesota in 1953; Pennsylvania in 1972; Maine in 1973; South Dakota in 1975; and Colorado in 1985.

"If these states have successfully deleted the word, I don't see why the others can't," Mr. Larson said.

- The expansion of work comp coverage for mental injuries caused by job-related stress.

"There is no question that these kind of injuries should be covered —they are as real as any other," he said. "A disabling mental injury is as real as a physical injury."

"There is no excuse for still excluding mental-mental cases," Mr. Larson said referring to mental injuries caused by job-related stress. "These kind of injuries are as real as any other," he said.

"Furthermore, the nerves are part of the physical structure of the body," he added.

Only 26 states currently accept these "mental-mental" injuries in some degree he said.

Of these, 10 require that the stress that causes the injury be unusual, six require that the injury be caused by a sudden stimulus and Massachusetts requires a "series of stressful incidents."

- The elimination of workers compensation exemptions for small businesses.

Mr. Larson said the exemption in some state workers compensation statutes for small businesses should be abolished because it no longer is an administrative problem for small business.

All but 14 states nationwide have eliminated this clause, according to Mr. Larson. Therefore, it is feasible for all states to eliminate the small firm exemption, he said.

Currently, nine states exempt employers with fewer than three employees from their workers compensation statutes; two states exempt employers with fewer than four employees; and three states exempt employers with fewer than five employees, he explained.

- Creation in all states of workers compensation coverage for farm laborers.

Only 14 states currently mandate that farm laborers receive the same workers compensation benefits as other workers.

In addition, 25 states provide reduced benefits for farm laborers, he said.

But the remaining states offer no workers compensation coverage for farm laborers, he said.

"It is no longer an excuse that this presents administrative problems," Mr. Larson said. "If 14 states can make it work, I don't see why the rest can't."

'There is no excuse for still excluding mental-mental cases,' contends Arthur Larson of Duke University, referring to mental injuries caused by job-related stress. 'These kind of injuries are as real as any other.'

- Requiring that workers comp pay for claimants' attorneys fees in addition to claimants' benefits so that awards are not reduced.

The original drafters of workers compensation statutes believed that the system would be self-sufficient and that claimants would not need lawyers, he explained.

To date, 36 states and the District of Columbia have added clauses that provide that attorneys fees be added on to a claimant's workers compensation award, he said.

However, in the remaining states claimants are still being penalized, Mr. Larson said.

Mr. Larson has drafted a model act for the Council of State Governments to add legal fees to work comp benefits.

- Prohibiting employers in all states from firing employees for filing a workers compensation claim.

One of the most recent problems in today's workers compensation environment is the incidence of employers that fire employees for filing workers compensation claims, according to Mr. Larson.

An employer was first found guilty of firing an employee for filing a workers compensation claim in 1979.

"It is odd to me that this was so long in coming," Mr. Larson observed.

This action is illegal in 34 states, according to Mr. Larson.

Twenty states have enacted anti-retaliation statutes that make it illegal for an employer to fire an employee for filing a workers compensation claim, Mr. Larson said.

This action is illegal in 11 more states through judicial decisions, he said.

And, both statute and case law bars this activity in three more states, he said.

However, in some states, this type of statute or judicial decision has been deemed to violate the concept of employment at will, Mr. Larson explained.

"These statutes are a disgrace to the states they come from," Mr. Larson asserted. "There is no conceivable excuse for denying remedy here," he said.

"All the remaining states should take care of this problem by statute without delay," Mr. Larson urged.

Mr. Larson also pointed out areas where workers comp law has been expanded over the past 40 years in favor of claimants.

Among the most recent expansion of workers comp law is the development of new theories of liability under workers compensation, he noted.

Because many workers compensation statutes cover injuries "arising out of or occurring in the course of employment," workers may be covered for work-related injuries that occur outside the workplace, Mr. Larson said.

For example, the injuries a worker suffered when he was burned after a pilot light in his bath ignited paint thinner that remained on his body from activities at work were found compensable under workers compensation.

Similarly, the injuries a butcher shop employee suffered when an arrow struck him in his eye while he stood on company property were found compensable, even though the nature of the injury was not in anyway related to his employment.

"There is a very strong trend in favor of accepting" these types of injuries, Mr. Larson said.

Another emerging theory is that if an employee reinjures or causes further injury to an injury that was work-related, he is covered under workers compensation, even if the succeeding injury is not work-related, Mr. Larson explained.

"There is a considerable amount of activity" in this area, he said.

In addition, if an employee injures himself at a recreational activity during his lunch hour or at an employer-sponsored activity, he may be covered under workers compensation, he said.

Similarly, traveling employees may be covered for injuries that occur outside of their work day, Mr. Larson said.

For example, the family of a truck driver killed when he was shot during an eight-hour layover was compensated, he said.

Mr. Larson also pointed out that all states have eliminated provisions in their workers compensation statutes barring coverage for workers involved in "hazardous employment."

As early as 1950, Mr. Larson urged that the clauses in many state workers comp statutes barring workers comp coverage for employees with hazardous jobs "should be junked without delay."

It took nearly 40 years, but the last state with such a limitation—Wyoming—extended workers comp coverage to workers with hazardous jobs in 1987.

Mr. Larson said these hazardous employment limitations were often inconsistent and nonsensical.

For example, in Wyoming, dude ranching was considered hazardous but regular ranching was not. And, in Louisiana, working in a hotel was considered hazardous, but working in a motel was not.

"There isn't any mystery about the solutions" to the problems now plaguing the workers compensation system, Mr. Larson concluded. "In every instance there are already states operating under the suggested changes," he pointed out.

"The system is now about 80 years old, it can no longer be argued that we don't know" whether these suggested changes will work, he asserted.

"Workers compensation is a lot better than it was 40 years ago," Mr. Larson said. "It is a system we can all be proud of." ■

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Panel studies pitfalls of toxic waste case

By STACY ADLER

BOSTON—Seven children have contracted leukemia in a small Massachusetts town. It is suspected that chemicals leaking from a nearby fertilizer plant contaminated the water and caused the children's disease.

Should a plaintiffs' attorney accept the case?

How would such a case be litigated?

Would punitive damages be awarded if it were shown that the fertilizer company knew it was polluting the water?

These are just some of the questions a 13-member panel composed of plaintiffs' and defense attorneys, law professors, a doctor, a consumer activist and an insurance professional grappled with during a forum at the Assn. of Trial Lawyers of America annual convention earlier this month.

The first stumbling block for the attorneys on the panel was whether or not they would take on the hypothetical case.

Attorney Robert L. Habush estimated it could cost $25,000 just to do a preliminary investigation to decide if the case is worthy of litigating.

Mr. Habush is incoming secretary of the Roscoe Pound Foundation, which sponsored the forum. Established in 1956, the Roscoe Pound Foundation is an educational organization that sponsors debates on pressing legal issues.

Other attorneys on the panel agreed with Mr. Habush. "There are many cases that are not brought in America because attorneys cannot afford it," said Joan Claybrook, president of Public Citizen, a Washington, D.C.-based consumer organization linked with Ralph Nader.

Panel moderator Charles Nesson, a professor at Harvard Law School in Cambridge, Mass., suggested that the attorneys might seek the help of a venture capitalist willing to give them money in return for a percentage of any award or settlement received.

But all of the attorneys on the panel said this would be unethical.

"It is against the cannon of ethics," said Professor George L. Priest of Yale Law School in New Haven, Conn.

"I don't think a lawsuit is a marketable commodity," agreed attorney Robert Martin of Martin, Pringle, Oliver, Wallace & Swartz in Wichita, Kan.

Assuming that a wealthy plaintiffs' attorney had enough money to conduct the investigation and to represent the families of the seven children who contracted leukemia, there are still many other obstacles to be overcome.

Since a majority of the panelists were plaintiffs' attorneys, the panel focused on ways defense counsel might try to make litigating such a case difficult. For example, some plaintiffs' attorneys believed the counsel representing the hypothetical Grow Co., the manufacturer that allowed chemicals to seep into the water, would try to stretch out the case.

This is what several of the plaintiffs' attorneys called "bleeding" the plaintiff to death.

Defense attorney C. Barry Montgomery of Williams & Montgomery in Chicago said this type of toxic tort case could be stretched to last six years in a Cook County court.

Another tactic that defense counsel for Grow Co. might attempt is to sell off the small subsidiary in Massachusetts in order to shield the parent company's assets.

Although the plaintiffs' attorneys believed they still might be able to pierce the corporate veil and collect from the parent company, they pointed out that selling the Massachusetts subsidiary would present other problems.

For example, it would be difficult to get documents from the company's new parent since it was not named in the lawsuit.

Finally, panel members were asked how much in punitive damages they would award if it was shown during the trial that Grow Co. knew it was polluting the environment.

Professor Priest said he favors punitive damages that are a modest multiple of the compensatory damages.

Consumer activist Ms. Claybrook said she would award 5% of the parent company's annual revenues, which in this hypothetical case would be a $20 million award.

Andrea Goldstein, president of DES Massachusetts, a plaintiffs' organization, was even more generous. Ms. Goldstein said she would award 4% to 8% of the parent company's annual revenues—for every year the company has been in business.

Most of the panelists, however, agreed with former ATLA President Bill Wagner's assessment. Mr. Wagner said he would "try to hurt them a little, but not too much."

However, Mr. Wagner, a plaintiffs' attorney with Wagner, Cunningham, Vaughan, & McLaughlin in Tampa, Fla., said in some cases "the corporate death penalty is a good idea."

It is sometimes necessary to put corporations "in fear of their economic life," he said.

Other members of the panel were: attorney Earl L. Neal of Chicago; Dr. Jimmie Gleason, chairman of the committee on professional liability at the American College of Obstetricians-Gynecologists in Washington, D.C.; Tom Demetrio of Corboy & Demetrio in Chicago; William Bailey, chairman of the advisory panel on legal issues to the Insurance Information Institute in New York; and Stuart Taylor, senior editor of the American Lawyer Newspaper Group in New York. ■

Legal cowboy wrangles with corporate polluters

By STACY ADLER

BOSTON—The manner in which corporate America pollutes the environment is criminal, says a prominent plaintiffs' attorney.

Americans are in the choke hold of a corporate state that is "killing the mother earth," said attorney Gerry Spence.

"Our earth is dying as we are in its womb," said Mr. Spence, a Jackson Hole, Wyo., attorney who perhaps is best known for representing Karen Silkwood in her famous radiation contamination case.

Mr. Spence issued a call to arms to plaintiffs' attorneys to become involved in toxic waste litigation involving corporate polluters.

Trial attorneys must take on toxic waste cases because "we have to do it. We're the only ones left," said Mr. Spence, who reinforced his "cowboy" image by wearing a suede fringed jacket, blue jeans and a turquoise-buckled belt.

Mr. Spence noted that the Exxon Valdez oil spill was "the greatest thing to happen to this country in a long time."

"Suddenly we've started to become aware of the huge damage being done in this country by our overlords, corporate America," Mr. Spence explained.

Then, pounding his fist against the lectern, Mr. Spence decried: "But there were not five people out of 250 million who gathered under the Exxon Tower to shake their fists and say, 'God damn you!' "

Similarly, no one protested at Manville Corp. when Americans learned that it knew of the dangers of asbestos for 40 years, Mr. Spence alleged.

And, no one protested the use of Agent Orange, a defoliant used in the Vietnam War that has been linked to cancer, he said.

"It wasn't until Exxon came along and we saw little seals covered in oil that we became disgruntled," Mr. Spence said.

But, even then there was no formal protest at Exxon's headquarters, Mr. Spence said, adding that the reason Americans did not protest the Exxon oil spill is because they "value things more than people."

Mr. Spence

American consumers are being brain-washed by television commercials to value objects more than life, he charged.

"This country spends more money on advertising than on all forms of education combined," Mr. Spence said. "By the time our children are 18 years of age, they will have viewed 300,000 television commercials.

"The television networks are the most powerful tool known to man—more powerful than the atomic bomb," he continued. "The media, controlled by corporations, has turned us all into perfect consumers who put things above the earth.

"We must take back the airwaves—they belong to us," he urged.

Mr. Spence said he is doing his share to help solve America's environmental problems.

He currently is representing a group called Earth First in Phoenix, Ariz. The group's goal, according to Mr. Spence, is to preserve nature in order to save humanity.

Three members of the group are in jail in Phoenix for allegedly cutting some power lines that were running through a forest. ■

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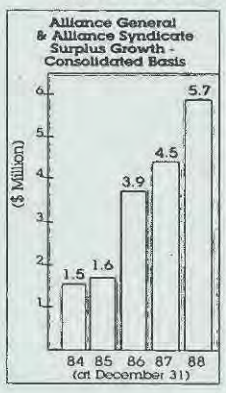

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ABA task force

Continued from page 1
tween sudden and accidental pollution and gradual pollution "is doomed in many fact situations to continued misinterpretation by the courts" (*BI,* Nov. 14, 1988).

Under the current commercial general liability insurance form, which was approved for use in most states in 1986, pollution coverage is provided for products/completed operations exposures, but all pollution coverage for premises and ongoing operations exposures is specifically excluded.

In addition, ISO last year proposed excluding all pollution-related losses from the CGL form through an endorsement. However, ISO proposed another endorsement that would have extended coverage for pollution losses—except for cleanup costs and emissions from waste facilities and underground storage tanks—under a separate aggregate limit.

ISO's proposals were put on hold in November after risk managers and brokers criticized them as another attempt by ISO to limit coverage for consumers.

In December, RIMS and ISO said they were willing to accept a compromise worked out by an NAIC subgroup.

The agreement allows ISO to offer as options to the CGL form two endorsements: one that deletes pollution coverage from products and completed operations coverage and another that allows a buyback of limited pollution coverage with a separate coverage limit (*BI,* Dec. 19, 1988).

Jon Harkavy, director of governmental affairs for RIMS and a consultant to the ABA subcommittee, said RIMS played a role in the creation of the ABA subcommittee.

RIMS felt that before it "signed off" on the second round of modifications to the CGL form that a "more pro-active" stance on the issue of pollution coverage should be taken.

Currently, policyholders must "look at what ISO proposes, and then you operate from there," Mr. Harkavy said.

At the same time, said Mr. Harkavy, "We're not unmindful of the fact we want this thing to be marketable."

"The interest of the NAIC in a nutshell is in seeing that the coverage is available," commented David B. Simmons, general counsel of the NAIC and a member of the ABA subcommittee.

Mr. Simmons stressed, however, that he is not serving as the NAIC's official spokesman on the subcommittee. "There is no formal participation of the NAIC."

While the subcommittee members are optimistic that the group can draft policy language acceptable to insurers and policyholders, Chairman Mark F. Rosenberg does express some concern that ISO will not cooperate with the subcommittee.

"I'm concerned about how much cooperation we're going to be getting from them," said Mr. Rosenberg, a policyholder attorney with Sullivan & Cromwell in New York.

The subcommittee so far has been unable to obtain either ISO documents or oral testimony concerning ISO's own efforts to develop policy language, though ISO has sent the subcommittee some background material consisting of the standard CGL policy form and background materials, Mr. Rosenberg said.

Although an ISO representative has been invited to work as a consultant to the subcommittee, no one from ISO attended the panel's first meeting, Mr. Rosenberg said. He added that he understood ISO is having some difficulty finding the appropriate person to send to the subcommittee's meetings.

Mr. Rosenberg said that "at the very least" he hopes ISO will comment on the result of the subcommittee's efforts. "I think that they will," he said.

ISO's endorsement of any recommendations issued by the subcommittee is crucial, Mr. Rosenberg noted. While individual insurers conceivably could insert the subcommittee's recommendations into their own policy forms, "it certainly can't go in the standard form without ISO, that's for sure."

Referring to the additional information requested by the subcommittee, an ISO spokeswoman noted that ISO does not "furnish proprietary information. ISO has proprietary information we do not give to anybody," she said.

"We gave them the information that we felt was appropriate and we could give them," she said.

RIMS' Mr. Harkavy commented that he was "somewhat disappointed at the lack of ISO involvement."

Conceivably, he said, the NAIC could put pressure on ISO to approve the subcommittee's results. Mr. Harkavy added, however, that he hopes ISO will become more actively involved in the subcommittee's activities.

"I'm hoping they want to become part of the solution, and not the problem," he said.

'We're not unmindful of the fact we want this thing to be marketable,' says RIMS' Mr. Harkavy.

The subcommittee, which has scheduled its next full meeting for Oct. 4, hopes to emerge with a proposal by the end of the year, though it has no set deadline, said Mr. Rosenberg.

He noted that subgroups of the subcommittee are now working on two different approaches to the problem of providing sudden and accidental pollution coverage.

One group, he said, is taking a named peril approach, whereby specific perils for which pollution coverage would be offered are named. The other group, he said, is attempting to develop language that elaborates on the particular kinds of sudden and accidental events that would be covered.

Subcommittee members say that while a goal of developing policy language guaranteed to eliminate any coverage disputes is unattainable, it is feasible to create language that will lead to a minimal amount of coverage litigation while simultaneously offering policyholders the coverage they desire.

Ideally, the subcommittee's efforts will result in language "that helps everyone understand what they're buying, selling and construing in court" rather than having a "mishmash of 50 different exclusions out there," said subcommittee member Ronald E. Bailey, an attorney with Portland, Ore.-based Bullivant, Houser, Bailey, Pendergrass & Hoffman, which represents insurers.

"There's some skepticism that we can do it, yet it's probably worth a try," Mr. Bailey commented.

"I think that any approach is likely to wind up in the courts," said the NAIC's Mr. Simmons. "It's never going to be 100%."

Once that is recognized, "It's a matter of removing the ambiguity as much as possible from any contract language."

The subcommittee's purpose, said Mr. Simmons, is to develop language that is as clear as possible, so that insurers can calculate their risk and policyholders in turn know what protection they are buying.

"I think it's a very feasible project," he said.

An ABA-endorsed provision for pollution coverage "has to be influential," said Mr. Simmons. "I think that to a certain extent, the example of the committee and its efforts to draft the language may in and of itself provide an incentive for (insurers) to get back into the market," he said.

Also optimistic is subcommittee member Jay M. Barber of Atlanta-based Decker & Hallman, which represents insurers.

"There won't ever be a perfect document, I don't think," but he added that he thought the subcommittee "will be successful."

The subcommittee's effort is "multipartisan," pointed out William H. Black Jr. of Philadelphia-based Hecker Brown Sherry & Johnson, which generally represents insurers. He added that he does not know if anything like this has been tried before in the insurance industry.

"I think it's a somewhat different approach that may attract some attention both from policyholders and from insurers," Mr. Black said, though he added that "I don't know how optimistic I am that insurers or policyholders will give a hoot."

Chances are good, given the makeup and experience of the subcommittee's members, that "it will come up with something that is worth looking at, worth considering seriously," Mr. Black said.

Whether what emerges is actually used will be up to insurers and policyholders, he said. "I think it's got to depend to some extent on whether insurers want to get involved in any aspect of insurance for pollution," he said.

"So far," he added, "I've been very encouraged by the apparent understanding of members that various points of view need to have addressed. There's been a very encouraging exchange of ideas so far."

"I think there are good prospects" of developing a provision, said subcommittee member Kenneth S. Abraham, a law professor at the University of Virginia Law School in Charlottesville.

"I think there are a number of ways that we could draft a proposal of one sort or another that would not increase litigation," he said, adding that the question is whether a proposal will be accepted by ISO and policyholders.

Mr. Rosenberg, however, said he believes gaining marketwide approval for any subcommittee proposal may actually be less of a problem than coming up with the proposal to begin with.

One of the factors the subcommittee will keep in mind as it tries to draft language will be its marketability, said Mr. Rosenberg, noting the insurance company representation on the subcommittee. ■

Outhwaite settlement

Continued from page 1
tract.

Joseph W. Brown Jr., president and chief operating officer of Fireman's Fund, was not available for comment.

Syndicates managed by Merrett, which wrote the other 50% of the Fireman's Fund runoff policy, settled a dispute surrounding their portion of the policy earlier this year, a Merrett spokesman confirmed.

Merrett-managed syndicates 418/417, which wrote 37.5% of the runoff policy, and syndicate 421, which wrote 12.5%, "negotiated a cap, or maximum that we can be asked to pay, and we have agreed to make substantial payments according to an agreed timetable," according to Merrett's annual report.

The Merrett annual report also noted that a premium charged to the syndicates' 1985 underwriting year—which still remains open—of $19 million was paid for a financial reinsurance policy.

The policy, "which gives potential recoveries in the period 1990 to 1994 of $24.4 million, was purchased specifically to ameliorate to some extent the overall cost of settlement of a specific runoff contract," the report notes.

Although the Outhwaite agency would not comment specifically on the latest settlement, Edward Bloxham, the agency's chief executive, believes "similar settlements would prove possible with those Lloyd's syndicates where disputes currently exist."

Mr. Outhwaite currently is disputing claims from several runoff reinsurance policies he wrote to cover liabilities arising from past underwriting years of other Lloyd's syndicates and insurance companies.

Mr. Outhwaite wrote a total of about 50 such policies, many without an aggregate cap.

Members of his syndicates' 1982 underwriting year now face hundreds of millions of dollars in losses on the policies.

Moreover, Mr. Outhwaite cannot close his syndicates' 1982 underwriting year because future liabilities cannot be adequately assessed.

As a result of the uncertain amount of liability members face, Lloyd's appointed a senior British trial lawyer to act as a conciliator in an attempt to resolve disputes surrounding the policies (*BI,* June 19).

Edward Bloxham, chief executive of R.H.M. Outhwaite (Underwriting Agencies) Ltd., believes that 'similar settlements would prove possible with those Lloyd's syndicates where disputes currently exist.'

However, further settlements likely will progress slowly, market observers predict.

So far, only three ceding syndicates have indicated that they wish to pursue settlement talks through the Lloyd's conciliation service, a Lloyd's spokesman said.

Meanwhile, Mr. Outhwaite still is not paying claims filed under one policy, even though an arbitration panel determined that the policy is valid (*BI,* July 3).

And, oral arbitration hearings scheduled for this month in another dispute have been postponed to late October, an Outhwaite spokesman confirmed.

The arbitration panel will rule on the validity of a runoff reinsurance policy covering liabilities for past underwriting years of syndicate 90, managed by Pulbrook Underwriting Management Ltd., a subsidiary of Merrett Holdings P.L.C.

Outhwaite, which is disputing the policy on grounds of non-disclosure, reinsured 50% of syndicate 90's liabilities from the 1974 and previous underwriting years excess of $27 million.

Syndicate 727, managed by S.A. Meacock & Co., which reinsured another 20% of syndicate 90's runoff, also is disputing the policy on the grounds of non-disclosure, confirmed Meacock Assistant Underwriter Alec Taylor.

According to Pulbrook's annual report, claims and estimated liabilities owed by Outhwaite and Meacock under the unlimited runoff policy total $94.6 million.

However, the Meacock syndicate is not taking part in the arbitration process, according to Mr. Taylor, who would not comment on whether the Meacock syndicate wrote any other runoff policies.

Syndicate 90 has retained most of the remaining 30% of its liabilities from 1974 and prior underwriting years.

The Outhwaite agency also could face problems on other fronts.

For example, members of Outhwaite's 1982 underwriting year likely will file suit over the runoff reinsurance debacle by the end of the year, says a lawyer representing Outhwaite members.

Current standstill agreements between members and their agents over the Outhwaite situation expire in December.

If these agreements are not extended, then "Outhwaite members must file litigation in order to protect their position," explained Stuart Beare, a partner with the London law firm of Richards Butler.

Mr. Beare is advising the Outhwaite 1982 members' committee, which represents about 800 members on Outhwaite's 1982 underwriting year.

In addition, at least one members' agent has cancelled a sub-agency agreement with the Outhwaite agency and withdrawn members from syndicate 317/661 for the 1990 underwriting year.

Roger Sedgwick Rough, a director of Murray Lawrence Member's Agency Ltd., confirmed that he wrote to members on July 4 informing them of the agency's decision to remove them from the Outhwaite syndicate.

Mr. Sedgwick Rough, whose agency represents 20 members of syndicates 317/661, would not comment on the reason for removing the members.

Another members' agency also has indicated plans to remove members from the Outhwaite syndicate, an Outhwaite spokesman confirmed, but he would not identify the agency. ■

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Business Insurance

Grob testimony

Continued from page 3

Mr. Grob also said that when he was arrested in France in 1987 by French and English police, he knew that he could fight extradition and delay criminal proceedings against him for at least three years. "But I wanted to return immediately," he said.

Mr. Grob and former Lloyd's underwriter Ian Posgate have been on trial since early May for their parts in the alleged misappropriation of Howden and Lloyd's syndicate underwriting funds (*BI*, May 8).

Mr. Posgate is charged with conspiring with Mr. Grob and former Howden Directors Ronald Comery, Allan Page and Jack Carpenter to defraud Howden, subsidiaries and members of Lloyd's syndicates by transferring sums of money belonging to Howden and the syndicates to offshore companies controlled by the four Howden directors.

Mr. Posgate and Mr. Grob both pleaded not guilty.

Mr. Carpenter, who had been on trial with Messrs. Grob and Posgate, was released from court earlier this month by Justice MacNeill for medical reasons.

Mr. Comery died in a car crash in 1987. Mr. Page is terminally ill and has not been charged.

Mr. Grob, now 68, sat in the witness box for more than two weeks, defending his actions for the first time in public since he abruptly resigned from Howden in 1982 during the special value audit by Alexander & Alexander Services Inc., which had acquired the British broker earlier that year.

As a result of a past stroke, Mr. Grob told the jury that his short-term memory was virtually non-existent, though his long-term memory still is intact.

'In reality they (the offshore companies) were set up for Howden purposes,' says former Howden Chairman Kenneth V. Grob. 'If it was known that Howden directors owned them, then they couldn't have their raison d'etre.'

Mr. Grob testified that he joined Lloyd's broker Swann & Everett at age 16 and became chairman in 1956, by which time he and Mr. Comery were buying family-owned stock in the company. Eventually, they owned 90% of the brokerage through family trusts, but they owned only between 60% and 70% of the company at the time it merged with the publicly owned Howden in 1966, said Mr. Grob.

By 1970, Mr. Grob became executive chairman of the Howden group. "My role as I saw it was to lead the company, be responsible for the day-to-day actions, be responsible for the executives reporting to me, protect the shareholders and head board meetings," he told the jury.

In 1974, Mr. Grob said he set up Alexander Howden Financial Services Ltd., which handled Howden's accounting and legal activities. That division included former Howden Finance Director Allan Page and former Howden Secretary Malcolm Reynolds, who handled the group's legal affairs.

By the mid-1970s, Mr. Grob confirmed he had set up personal offshore trusts in Liechtenstein to handle his personal investments, particularly his stock market portfolio from which he said he made much of his fortune. His financial affairs were handled by the Banque du Rhone et de la Tamise S.A. in Geneva, Switzerland, a Howden subsidiary, he said.

Mr. Grob said he believed that he had done nothing dishonest by setting up a trust in Liechtenstein, known as a Bloomer anstalt, or by subsequently establishing Gambit Holdings S.A. in Panama, which was created on the advice of his long-standing bankers at the Banque du Rhone, he said.

In 1978 and 1979, Messrs. Grob, Page, Comery and Carpenter used their personal funds to set up two other Liechtenstein companies, namely an insurance company known as Southern Reinsurance A.G. and a broker named Zephyr Reinsurance Brokers Co. Ltd. S.A., Mr. Grob confirmed.

The companies were owned by the four men's personal trusts although their shareholdings were not disclosed to the rest of the Howden board or to shareholders, he said.

Mr. Grob confirmed that he never asked Mr. Reynolds or anyone else whether he and the other three Howden directors should disclose their shareholdings in the companies to the Howden board.

But, "in reality they (the offshore companies) were set up for Howden purposes," Mr. Grob testified. "If it was known that Howden directors owned them, then they couldn't have their raison d'etre."

Among other things, the offshore companies paid sums to clients for various transactions, Mr. Grob testified, though he did not elaborate.

"I didn't think SRAG was a material factor to be disclosed to shareholders. I didn't think so then and I don't think so now."

Mr. Grob confirmed that SRAG's "entire income" came only from Howden business. "But the benefit was to Howden to have" financing available offshore that Howden could tap, he said. "It was my belief that the surplus of SRAG would be used for Howden purposes, which was the case. All sorts was paid out—you could say dividends—to the anstalts."

But the dividends were used mainly for Howden purposes, said Mr. Grob.

"And for personal enrichment?" asked Crown prosecutor Mr. Hill.

"Yes," conceded Mr. Grob.

However, Mr. Grob said he was not involved in the financial "mechanics" of SRAG. All financial arrangements were handled by Mr. Page, he said.

By 1979, Mr. Grob said he and the other directors realized that the Banque du Rhone was losing money and causing other headaches for Howden, which owned the bank.

The directors then decided to sell the bank and had found a South African buyer, but he dropped out of the sale, Mr. Grob confirmed. So, in late 1979, Messrs. Grob, Comery, Banque du Rhone Chairman Mario Benbassat—and possibly Mr. Page—decided at a meeting at Mr. Grob's French villa to form a purchasing syndicate to buy the bank, Mr. Grob testified.

The funds would initially come from the members of the purchasing syndicate, but would be reimbursed by "the balances"—or profits—from quota-share reinsurance business placed by Lloyd's syndicates managed by Mr. Posgate with a reinsurer owned by the Howden directors, said Mr. Grob.

The four former Howden directors then formed Southern International Reinsurance S.A. in Panama to reinsure Howden underwriting companies and Mr. Posgate's syndicate and to buy the bank, according to Mr. Grob.

Coincidentally, the week before it was decided to buy the bank, Banque du Rhone officials also suggested that four Panamanian trusts be set up to replace the four directors' Liechtenstein trusts, Mr. Grob testified.

Following the meeting at the villa, Mr. Grob said he asked Mr. Posgate and Mr. Carpenter to join the syndicate purchasing the bank.

Mr. Grob also said that while Mr. Posgate did not necessarily have to know that the money to fund the purchase of the bank would come from profits on his syndicates' quota-share reinsurance transactions with SIR, "he did know."

Mr. Posgate has maintained that he did not know he belonged to the syndicate or that a portion of the reinsurance premiums paid to SIR by his syndicates were going to be used to purchase the bank, according to Richard DuCann, Mr. Posgate's attorney.

SIR was incorporated in Panama on March 14, 1980, with a capitalization of $1 million and was designed to write reinsurance for Howden underwriting companies and Mr. Posgate's syndicates, as well as to buy the Banque du Rhone, according to Mr. Grob.

It also was intended to replace SRAG's role in making payments offshore on behalf of Howden, said Mr. Grob.

Soon after SIR was incorporated, a Howden underwriting subsidiary faced $8.5 million of future losses from a U.S. risk, so it was decided to reinsure the loss to SIR, according to Mr. Grob. As a result, the capital of SIR had to be increased to $3 million from $1 million, he said.

The additional $2 million was to come from the surplus of SRAG, which the four Howden directors had set up in Liechtenstein with their own funds, said Mr. Grob.

Mr. Grob said he told Mr. Page to transfer the surplus from SRAG to increase in SIR's capital.

However, the SRAG account was overdrawn at the time, so there would not have been any surplus, said Mr. Hill, the prosecutor. Mr. Hill showed the court a telex from Mr. Page to the Banque du Rhone showing that $2 million was transferred from Alexander Howden Insurance Brokers Ltd.'s bank account to SRAG to capitalize SIR.

The money to capitalize SIR came from the surplus of SRAG, Mr. Grob reiterated.

"But SRAG doesn't have a surplus," said Mr. Hill.

"That's your speculation," said Mr. Grob.

"The whole thing is a nonsense. . . .and a sham," said Mr. Hill.

"What you say is a nonsense," said Mr. Grob.

SIR until mid-1982 paid dividends to the four ex-Howden directors, Mr. Grob said. The dividends were approved by members of the Howden board, who knew that SIR existed but not that SIR was owned by the four ex-Howden directors, he testified.

"People in the know would have expected a proper payment be made to the company (SIR)" to do its work, said Mr. Grob.

"You kept (your shareholding) a secret," countered Mr. Hill. "It was dishonest."

"No sir, I don't accept that at all," said Mr. Grob. The shareholding in SIR by the four directors "had to be kept secret. . . .it was in no way dishonest."

"You expected those not in the know to believe your word that wholly separate shareholders of SIR needed a payment to do their work?" asked Mr. Hill.

"That's right," said Mr. Grob.

"It's a thumping great lie. It was a sham to show that SIR wasn't run by you," said Mr. Hill.

"The dividend was not a sham. It was a dividend for the capital put up by the four trusts," replied Mr. Grob.

Also, SIR paid 50,000 pounds ($81,300 at current exchange rates) to Western Financial Services, which was a company set up by the four ex-Howden directors for their retirement, confirmed Mr. Grob, explaining that the amount represented a management fee.

"What management?" asked Mr. Hill.

"Whatever there was at the time," said Mr. Grob. "I cannot tell you today what management Western Financial Services was handling on behalf of its shareholders."

Meanwhile, in 1980 the four ex-Howden directors needed $2.5 million for the first installment to purchase the first 51% of the Banque du Rhone.

The money would later be reimbursed by income from SIR's transactions with Mr. Posgate's syndicates, according to Mr. Grob.

Mr. Grob said he gave instructions to Mr. Page to debit Mr. Grob's trusts for his share of the $2.5 million. Mr. Grob told the court that at the time he believed that the money—more than $619,000—came from his trusts.

However, court documents show that the money was transferred from Howden underwriting agencies and Mr. Posgate's syndicates into an account at the Banque du Rhone, known as SNA Re Captive account, and then directly to the four directors' Panamanian trusts, said Mr. Hill.

Mr. Grob said he only learned that Mr. Page had taken this "improper" action when the Department of Trade and Industry began investigating the alleged Howden misappropriations. Had he known that this transaction had taken place, he said he would have "found a new finance director" and reversed the transaction.

"Did you ask Mr. Page what happened?" asked Mr. Hill.

"By 1983, Mr. Page was in no position to give a rational answer to anything," said Mr. Grob. "He was a sick man whose mind didn't function normally."

Mr. Hill produced bank statements for Mr. Grob's trusts in Liechtenstein and Panama, which showed that both trusts were overdrawn at the time the money was deposited by SNAC.

However, Mr. Grob stated that he would have expected the Banque du Rhone to have credited the account with the money and use his other sufficient funds at the bank as collateral.

But, Mr. Grob claims that he never looked at the balances of his account to see whether it was overdrawn nor did he ask where the money came from because he said he believed it would have come from the bank as an automatic loan.

"All documentation would have shown you that it came from an outside source," said Mr. Hill.

"No sir. It could show it came as a credit line from the bank," said Mr. Grob.

The trial continued late last week with Mr. Posgate taking the witness stand. ■

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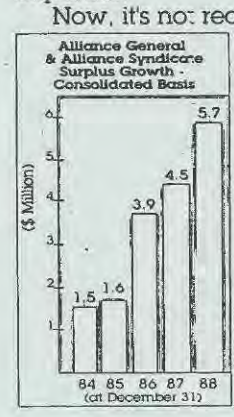

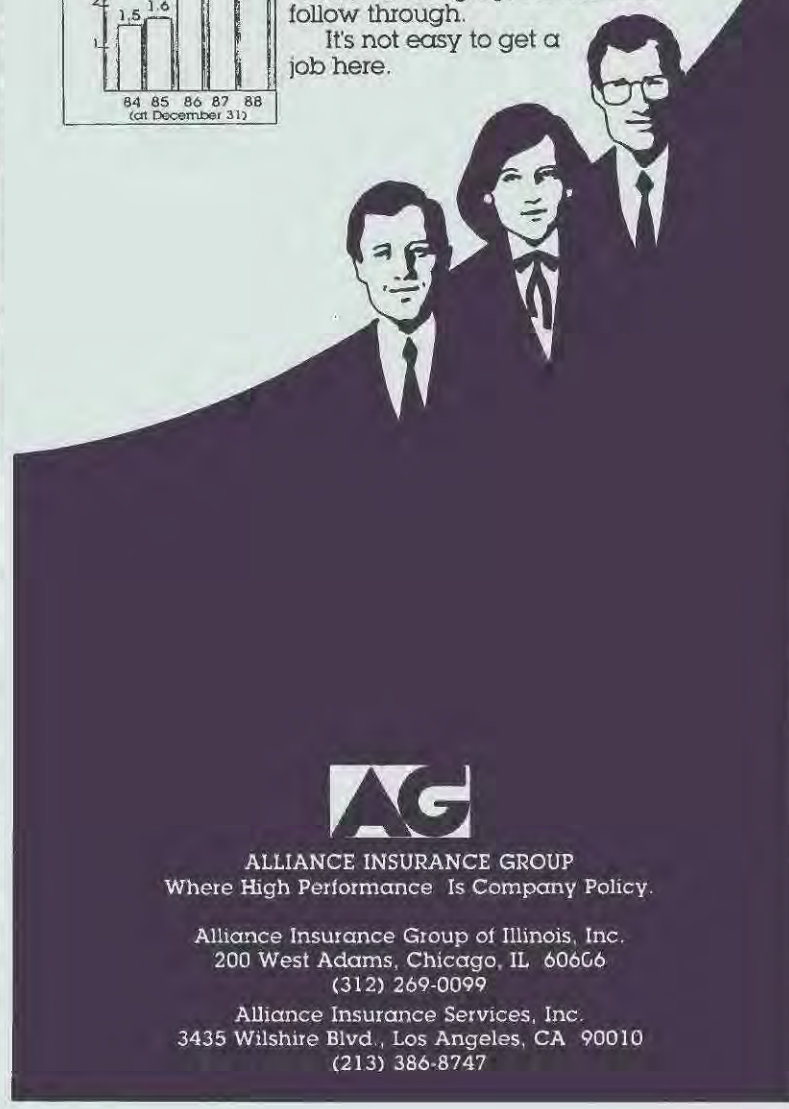

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Sub-total 23,959

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N.J. auto insurance proposals in jeopardy

TRENTON, N.J.—Two proposed New Jersey constitutional amendments that would, among other things, roll back commercial and personal auto insurance rates to 20% below 1987 levels face an uncertain future.

The state Senate and Gov. Thomas H. Kean must approve by Aug. 6 placing the proposed amendments before voters on the November ballot.

However, a spokesman for the Senate majority leader says the Senate does not support dealing with the state's high auto insurance rates through constitutional amendments.

The Assembly on July 10 approved Assembly Concurrent Resolution 140, a proposed constitutional amendment sponsored by Assemblyman Robert Franks, R-Union County, that would require insurers to roll back auto insurance rates to 20% below 1987 levels.

The amendment also calls for implementation of the Michigan Verbal Threshold plan, a no-fault insurance plan under which an auto insurance policyholder's rates would be reduced in exchange for a waiver of the right to file a third-party lawsuit against any motorist.

Meanwhile, Assemblyman Michael Adubato, D-Essex, proposed A.C.R. 142, which also calls for the 20% auto insurance rate rollback.

A.C.R. 142, though, also would eliminate the $152 annual auto insurance premium surcharge that all motorists in the state must pay to support the state's joint underwriting association, which has a $3 billion deficit.

Instead, the measure would require insurance companies to finance the deficit.

But, "there is a very strong sense in the Senate expressed by Senate Majority Leader John Lynch (D-Middlesex) not to tamper with the state constitution in order to address current issues of the day, but rather to do it legislatively," said Sen. Lynch's spokesman.

The Assembly, meanwhile, voted 73-0 to reject a bill supported by U.S. Rep. Jim Courter, R.-Hackettstown, a gubernatorial candidate, that would have established open rating for auto insurance in an attempt to foster more competition and lower rates.

The measure also would have repealed the state's insurance company excess profits law.

Another bill in the Assembly supported by U.S. Rep. James Florio, D-Pine Hill, another gubernatorial hopeful, would have eliminated the auto insurance JUA and the $152 annual surcharge on motorists.

However, the Florio-backed bill never reached the Assembly floor for a vote because it was tie-barred with the Courter bill, meaning both the Assembly and the Senate would have had to pass both bills and Gov. Kean would have had to sign both bills for them to appear on the November ballot as binding referenda.

The Senate had approved the tie-barred referenda on June 29 by a 23-15 vote.

For many years, New Jersey motorists have paid among the highest auto insurance rates in the nation. The average auto insurance policy premium in 1988 was about $1,000.

—By Michael Schachner

Health insurer closes

MIDDLEBURG HEIGHTS, Ohio —Emerald Life Co. of America, a provider of indemnity group health insurance in the Cleveland and Youngstown areas of Ohio, will cease doing business Sept. 1.

Around the states

Co-owners Emerald Life Services Inc. of Middleburg Heights, Ohio, and Central Benefits Blue Cross Blue Shield of Columbus, Ohio, decided to discontinue operations after the insurer's capital and surplus fell below statutory levels.

Emerald Life reported 1988 capital and surplus of $2 million—$500,000 short of Department of Insurance requirements—and operating losses totaling $1.7 million.

Since 1986, Emerald Life has sold indemnity health insurance plans to employers that subscribed to Emerald Health Network, a preferred provider organization subsidiary of Emerald Life Services. Emerald Life currently maintains 6,500 employer contracts covering about 15,000 employees and their dependents.

Subject to approval, Emerald Life Services will sell all existing contracts to Central Benefits, according to Risk Percy, vp-planning with Central Benefits.

—By Michael Schachner

Liquidation hearing

TRENTON, N.J.—A state Superior Court judge will decide on Aug. 14 whether to liquidate Foundation Health Plan of New Jersey.

Judge Harry A. Margolis in April had placed the 32,000-member health maintenance organization into rehabilitation under the receivership of New Jersey Insurance Commissioner Kenneth D. Merin (*BI*, May 15).

At the time of the rehabilitation order, Foundation had $11.1 million in liabilities and $5.4 million in total assets.

If the judge orders Foundation closed, the Short Hills-based HMO would close and its assets would be "sold to pay creditors," according to the Insurance Department. However, until the court approves the liquidation, "Foundation will continue to provide coverage," the department said.

The department, in a recent letter, has advised employers with Foundation subscribers to make alternative coverage arrangements.

HMO of New Jersey, CoMED HMO and Prudential Insurance Co. of America all have agreed to provide coverage for Foundation subscribers "regardless of their medical condition," the department's letter said.

—By Collin Nash

Illinois work comp

SPRINGFIELD, Ill.—A legislative proposal to revamp the Illinois workers compensation system was stymied by plaintiffs' attorneys in the waning days of the General Assembly's regular session.

Plaintiffs' attorneys were concerned because the legislation did not specify the role of legal counsel in a voluntary binding arbitration process to streamline work comp settlements, observers say.

After opposition to the bill was voiced to the Democratic leader of the state's General Assembly, the reform package was not called for a vote.

Gov. James Thompson said in a statement that he was "disappointed" that the General Assembly did not get an opportunity to consider the legislation, which stemmed from months of negotiations.

"When the General Assembly returns to session this fall, legislators should act quickly to enact this legislation to speed the delivery of benefits to injured workers," he said.

In the meantime, Gov. Thompson plans to implement a few of the proposed workers compensation changes administratively, including appointing an advisory committee to review day-to-day operations of the Illinois Industrial Commission, according to Jeffrey Miller, the governor's chief of staff.

Other measures called for in the stalled proposal included: additional training for arbitrators and commissioners; additional arbitrators to help reduce a 2,000-case backlog; and improved data collection procedures.

"There are early indications that (the workers comp legislation) will be resolved in the fall veto session," said Carol Cain Hughes, manager of workers compensation and unemployment compensation for the Illinois State Chamber of Commerce in Chicago.

—By Meg Fletcher

Texas board appointee

AUSTIN, Texas—Jo Ann Howard, an Austin attorney, is the newest member of the Texas State Board of Insurance.

Gov. Bill Clements earlier this month named Ms. Howard to fill the remaining vacancy on the three-member board.

She joins two other recent appointees, Chairman Paul Wrotenberry and board member Richard Reynolds (*BI*, May 1).

Ms. Howard, who will serve through Jan. 31, 1991, is filling the unexpired term of former board member David Thornberry. Mr. Thornberry and former chairman Edwin J. Smith resigned from the agency earlier this year following an investigation into charges that the board was mismanaged.

The agency came under fire after the collapse of Dallas-based National County Mutual Fire Insurance Co. last October (*BI*, Nov. 7, 1988).

Board member James L. Nelson left the board when his term expired earlier this year.

Ms. Howard is an associate with Clark, Thomas, Winters & Newton in Austin.

—By Michael Bradford

Comp benefits raised

OLYMPIA, Wash.—Maximum workers compensation benefits for injured workers in Washington state increased by 3.6% on July 1.

The benefit increase, based on the state's latest cost-of-living adjustment, was contained in legislation passed last year, according to the state Department of Labor & Industries.

The maximum monthly benefit for injured workers increased to $1,713 per month from $1,652 for injuries occurring on or after July 1, 1988. The maximum monthly benefit for injuries before that date rose to $1,284 from $1,239.

The 1988 legislation set the maximum benefit at 100% of the state's average wage for injuries on or after July 1, 1988. The prior law limited benefits for injuries before July 1, 1988, to 75% of the average wage.

Washington's average yearly wage in 1988 was $20,556, up from $19,828 in 1987, the department reported.

—By Glenn Huntley

Medical malpractice

WASHINGTON—Non-economic damages in medical malpractice cases generally would be capped at $250,000 under legislation introduced in the District of Columbia City Council.

However, the legislation proposed last month would allow a judge to grant larger awards under special circumstances, such as the gross disfigurement of a plaintiff.

The $250,000 cap on non-economic damages would be adjusted annually to match increases in the Consumer Price Index.

Other provisions in the legislation would:

- Allow evidence of collateral sources of income, such as a plaintiff's health insurance or disability payments, to be introduced at trials.
- Allow, at the request of the plaintiff or defendant, periodic payments of that portion of an award exceeding $200,000.
- Require the plaintiffs' attorney to do a preliminary investigation, with certification from an outside expert approved by the court, to establish that grounds for malpractice may exist, before filing a case.

The proposal comes amid soaring medical malpractice insurance costs for physicians in the nation's capital.

During the last nine years, average medical malpractice insurance premiums have increased 430% for physicians in the District of Columbia, according to testimony presented by the Medical Society of the District of Columbia, a 3,800-member trade group.

Soaring insurance costs are forcing doctors to pass those costs onto patients said Dr. Daniel Ein, a physician who testified before the district's Committee on Human Services on behalf of the Health Care Access Coalition.

For example, 13% of physicians responding to a survey by the Medical Society of the District of Columbia said the cost of malpractice insurance increased the charge of delivering a baby by $1,000, while 70% said that the price per delivery increased by at least $500.

—By Adrienne C. Locke

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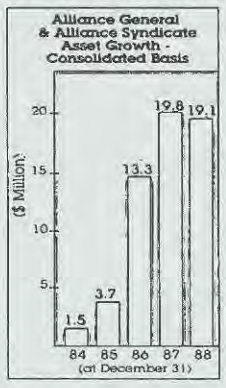

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Proposition 103 challenged, obeyed

Insurer seeks to let commercial auto policies lapse

By GLENN HUNTLEY

LOS ANGELES—A judge will hear arguments this week in an insurer's suit that contends that Proposition 103's restrictions on an insurer's ability to cancel or not renew automobile insurance policies does not apply to commercial auto policies.

The lawsuit, filed in Los Angeles County Superior Court by Omaha, Neb.-based National Indemnity Co., seeks to overturn a California Department of Insurance ruling that the insurer has failed to comply with Proposition 103 by issuing non-renewal notices to commercial auto policyholders.

However, Judge Robert Weil, finding "the existence of good cause" in the insurer's arguments, has stayed the department's order and has scheduled an hearing for Friday on the matter.

As a result, National Indemnity, a unit of Berkshire Hathaway Inc., is allowed to continue to decline to renew commercial auto policies.

Insurance Commissioner Roxani Gillespie in April ruled that National Indemnity was violating Proposition 103 by failing to renew commercial auto policies.

The commissioner ordered the company to rescind non-renewal notices it had sent to policyholders and not to issue any further non-renewal notices except in cases allowed by Proposition 103.

Proposition 103, approved by California voters in November, states an insurer can refuse to renew an "automobile insurance policy" under only three circumstances:

- Non-payment of premium.
- Fraud or material misrepresentation affecting the policy or the policyholder.
- A substantial increase in the insured hazard (*BI*, May 8; Nov. 14, 1988).

National Indemnity notified the state Insurance Department last October that it would withdraw from the state's commercial automobile insurance market by not renewing existing commercial auto insurance policies and refusing to write new policies, said Forrest Krutter, the insurer's legal counsel.

National Indemnity decided to withdraw from the commercial auto insurance market because the insurer was unsure of the possible ramifications of Proposition 103 and felt it would be easier to withdraw from the market before the public even voted on the initiative, Mr. Krutter said.

National Indemnity had about 300 commercial auto policies in effect in California when it decided to pull out of the market last fall, he said. Its policies represented less than 0.3% of the commercial auto market in California.

National Indemnity writes insurance for long-haul trucking, long-haul charter buses, logging, sand and gravel operations, limousines, ambulances and other commercial motor vehicle operations.

Other insurers writing commercial motor vehicle coverage have complied with Proposition 103's auto insurance renewal provision and are renewing existing commercial and private passenger policies, according to the Insurance Department.

For example, State Farm Insurance Cos. of Bloomington, Ill., has not taken a position on the non-renewal issue but continues to renew commercial auto insurance policies in California, said Pete Ingham, State Farm's general counsel.

State Farm was the seventh-largest writer of commercial auto liability insurance last year, with about 3.4% of the market, according to A.M. Best Co. State Farm was the third-largest writer of commercial auto physical damage insurance in 1988, with about 4.5% of the market.

Judge Weil has scheduled a hearing Friday on the commercial auto controversy.

Travelers Corp. of Hartford, Conn., stopped writing new commercial auto policies in California following passage of Proposition 103, but has renewed existing commercial policies, a Travelers spokesman said. "It's not a concern," he said. Proposition 103's auto insurance renewal provision "is not an issue we're involved with," he said.

Travelers in 1988 was the 17th-largest writer of commercial auto liability insurance in 1988, with about 2% of then market, according to Best. Travelers was the 28th-largest writer of commercial auto physical damage insurance last year, with about 1% of the market.

In addition, the Insurance Department announced last week that 46 insurers are voluntarily rolling back insurance "charges" for commercial automobile liability and physical damage insurance by 20% to comply with Proposition 103's rate rollback requirements (see related story). Commercial auto insurance ranks among the lines of commercial coverage for which insurers are most often voluntarily rolling back charges, the department says.

Meanwhile, the National Assn. of Independent Insurers supports National Indemnity's position on the renewal issue, though it has not yet entered the court case.

However, if Judge Weil rules against the insurer, the NAII probably will offer to help National Indemnity appeal the decision and possibly file an amicus curiae brief on National Indemnity's behalf, said John Crosby, the NAII's senior vp and general counsel.

In its lawsuit, filed in May, National Indemnity argues that:

- Sections of Proposition 103 other than the non-renewal provision refer to a definition of "automobile insurance" that includes private passenger policies only. However, the non-renewal provision of the law did not refer to that definition.

"The term, once given a definition, should be carried throughout the initiative consistently," Mr. Krutter said.

- National Indemnity chose not to renew commercial auto insurance policies as part of its complete withdrawal from the commercial motor vehicle market in California, which is allowed under state law.

In the California Supreme Court's May decision upholding most of Proposition 103, the court noted that the initiative did not repeal an insurer's right under state law to withdraw from a line of coverage after notifying the insurance commissioner, the suit noted.

- Application of the non-renewal provision to commercial automobile policies would cause "unintended anomalies and hazards."

For instance, the suit noted, Proposition 103 would not allow cancellation of a commercial auto policy even in a case when continuation of coverage would threaten the insurer's solvency. This situation was not foreseen by the drafters of the proposition because the provision was never intended to apply to commercial automobile insurance, according to the insurer's suit.

Also, restrictions on non-renewals have highway safety implications. National Indemnity argues that "the insurer's ability to non-renew or cancel commercial policies permits them to induce commercial insureds to adopt safety measures."

- Application of the non-renewal provision to commercial auto policies issued before the law's effective date violates the federal and state constitutions.

While the state Supreme Court in upholding the non-renewal provision rejected that argument, National Indemnity "wishes to preserve the argument for future review by asserting it here," the suit notes.

While Judge Weil's May 30 ruling in the case allows National Indemnity to decline to renew commercial auto insurance policies, the judge also ruled that National Indemnity must offer four-month interim policies to commercial motor vehicle policyholders that are denied renewals by the company and cannot find coverage after making "reasonable efforts to secure new insurance."

Interim policies also must be extended an additional four months at policyholders' request if the court has not ruled on the suit within 14 days of the policies' expiration.

Judge Weil ordered National Indemnity to mail notices of the interim coverage along with non-renewal notices beginning June 2.

However, "nobody has even taken us up on the court's offer" of temporary coverage, Mr. Krutter said. ■

Some insurers comply with Prop. 103 cuts

SAN FRANCISCO—More than 200 property/casualty insurers are voluntarily cutting insurance "charges" for hundreds of lines of commercial and personal insurance in accordance with Proposition 103, according to the California Department of Insurance.

The 230 insurers are rolling back charges in 641 commercial lines of coverage and 193 personal lines of coverage to 20% below November 1987 levels, the department reports.

The department is interpreting the term charges in Proposition 103 to mean premiums, according to Milo Pearson, chief of the department's rate regulation division.

But, while some insurers are slashing premiums, the insurers and lines involved are generally small and probably represent only a tiny fraction of the state's property/casualty insurance market, Mr. Pearson noted.

"In terms of premium volume, it's anyone's guess," he said.

In addition, more than 440 insurers submitted filings by June 3 asking to maintain current rates or charge higher rates for nearly 4,000 lines of coverage.

"The department is reviewing these filings. We are preparing to hold public hearings and issue decisions on them," Insurance Commissioner Roxani Gillespie said.

Major insurers—including Hartford, Conn.-based Aetna Life & Casualty Co.; Hartford Group Inc. of Hartford, Conn.; Bloomington, Ill.-based State Farm Insurance Cos.; and The Travelers Corp. of Hartford, Conn.—reported last month that they had filed for relief from insurance premium rollbacks in nearly all personal and commercial lines of coverage they write (*BI*, June 12).

On the commercial side, insurers most often are rolling back premiums for inland marine insurance; 99 insurers are voluntarily rolling back charges for that line, according to the department.

Other commercial lines for which many insurers are rolling back premiums include: fire, 76 insurers; aircraft insurance, 59 insurers; and automobile liability and physical damage, 46 insurers.

State regulators also confirmed that 39 insurers were already charging rates in 90 commercial lines and 21 personal lines that were at or below the mandated rollback levels. The commercial lines for which insurers most often have reduced premiums below the rollback levels are fire and allied lines, inland marine, and burglary and theft.

In addition, a few insurers did not file rate relief applications or affidavits stating their rates met Proposition 103's rollback provision, Mr. Pearson said. The department is investigating and will order immediate rollbacks by any insurer that has not filed documentation for a particular line, he said.

Although Proposition 103 was approved by voters in November after an expensive initiative campaign that focused on private passenger automobile insurance, only 16 insurers have voluntarily rolled back personal auto insurance premiums, the department said.

Proposition 103, among other things, mandated insurance charge rollbacks for most property/casualty lines. The California Supreme Court ruled in May that insurers could seek rate relief if the reduced insurance charges would deny them a reasonable rate of return on their business.

Under Proposition 103, the rollbacks are effective for policies issued or renewed on or after Nov. 8, 1988. Insurers are required to refund the difference to policyholders if higher premiums have been charged since Nov. 8.

—By Glenn Huntley

Insurers sue to block Nevada rollback

RENO, Nev.—Eight property/casualty insurers are seeking declarative and injunctive relief from a Nevada law that rolls back personal and commercial automobile liability insurance "charges."

In a lawsuit filed July 17 against Insurance Commissioner David Gates in U.S. District Court in Reno, the insurers charge that the law violates the due process and other clauses of the U.S. Constitution.

The Nevada law, signed July 6 by Gov. Bob Miller, requires that beginning Oct. 1 insurers issuing or renewing personal and commercial auto liability policies in the state roll back their "charges" to 15% below July 1988 levels. Insurers then are required to freeze their charges at these levels for one year. However, insurers can receive permission to charge rates higher than the rollback levels if they are substantially threatened with insolvency (*BI*, July 3).

The new law also prohibits insurers from canceling or not renewing auto liability policies in effect on Oct. 1 in order to avoid the rollback and freeze.

The insurers charge that the law violates their rights to due process because it does not provide the insurance commissioner with the regulatory means to avoid "confiscatory results" from the rollback and freeze, court papers say.

Specifically, the Nevada law violates the insurers' right to due process because it "imposes the rate rollback, reduction and freeze on insurers without any opportunity for a prior hearing," the suit charges.

Under the law, the commissioner cannot grant general rate adjustments, but instead must grant rate adjustments on a "case-by-case basis under a 'substantially threatened with insolvency' standard," the suit says.

The law also does not specify by when the commissioner must render a decision on an insurer's application for a rate increase, and insurers have no protection from losing premium income during the rate application process, according to the suit.

In addition, the Nevada law violates the "takings clause" of the U.S. Constitution because the rollback and freeze deprive insurers "of property and other rights," the suit says.

The law also violates the "contracts clause" of the U.S. Constitution because it prohibits insurers from canceling or non-renewing auto liability policies in order to avoid the rollback and freeze, the suit says.

Insurers participating in the suit are: Allstate Insurance Co. of Northbrook, Ill.; Farmers Insurance Exchange of Los Angeles; Guaranty National Insurance Co. of Englewood, Colo.; Nationwide Mutual Insurance Co. of Columbus, Ohio; Northland Insurance Co. of Mendota Heights, Minn.; SAFECO Insurance Co. of Seattle; State Farm Mutual Automobile Insurance Co. of Bloomington, Ill.; and United Services Automobile Assn. of San Antonio, Texas.

The Los Angeles law offices of Skadden, Arps, Slate, Meagher & Flom represent all of the insurers except Farmers, which is represented by Woodburn, Wedge, Blakey & Jeppson in Reno, Nev.

The Nevada Insurance Department has not yet filed a response to the suit. Mr. Gates could not be reached for comment.

California antitrust rules could change practices

By GLENN HUNTLEY

SAN FRANCISCO—Insurance industry antitrust guidelines proposed by the California attorney general's office could have a chilling effect on traditional insurance industry practices in the state, observers contend.

The guidelines could, among other things, inhibit brokers' ability to put together excess insurance programs, force surplus lines insurers to obtain prior approval of rates from the California Department of Insurance and restrict insurers from sharing historical, current and prospective pricing data to determine rates.

But, even if the attorney general adopts the guidelines, California courts would not be bound to rule in line with his interpretation of how state antitrust law applies to the insurance industry, observers note.

The 83-page document, currently being circulated for public review by California Attorney General John Van de Kamp, is intended to provide practical guidance to insurers, brokers and others in the insurance industry that were made subject to California's antitrust law, the Cartwright Act, by Proposition 103 (*BI*, May 8; Nov. 14, 1988).

A disclaimer notes the guidelines are "limited to statements of general application" and suggests that insurers seek legal counsel concerning any specific situations.

"These guidelines are not intended to set forth the legal rules that the attorney general would urge upon a court but only those standards by which he intends to exercise his prosecutorial discretion," it states.

While some insurer attorneys credit Mr. Van de Kamp's staff for thoroughly covering how the state's antitrust law would apply to the insurance industry, they also charge that the guidelines reveal the attorney general's lack of understanding about the insurance industry.

"We think the attorney general has made a good jab at it, but in no way does it represent our interpretation of antitrust law," said John Crosby, senior vp and general counsel of the National Assn. of Independent Insurers in Des Plaines, Ill.

Several insurer attorneys, also noting that the guidelines take a strong pro-consumer stance, criticized the guidelines as a political move by Mr. Van de Kamp, who has indicated he will run for governor next year.

"This is quite a political piece for the prospective governor," said Jonathan Bank, an insurer attorney and partner with Buchalter Nemer Fields & Younger in Los Angeles.

The rules present no cause for "immediate panic" by risk managers, but they raise concern about excess insurance programs and joint underwriting arrangements, said Jon Harkavy, director of governmental affairs for the Risk & Insurance Management Society Inc. in New York. "Where the risk manager could be concerned is applying these guidelines during a hard market."

RIMS has sent a letter to its California chapter presidents alerting them to the guidelines.

For example, the draft states that brokers "should limit communications with underwriters so as not to facilitate the forging of illegal agreements" when assembling excess insurance programs.

"In general, brokers' communications with excess insurers should be limited to matters pertaining to general market conditions and to specific matters pertaining to the risk presented—the underwriting or marketing positions of competing insurers should not be disclosed," the guidelines warn.

The RIMS letter, however, points out that "the antitrust ramifications posed by this broad language on the broker, insurer and excess insurer may create problems for the risk manager in obtaining coverage which will follow form."

The guidelines may have "the detrimental impact of spawning 'coverage gap' litigation and broker E&O disputes in the future," RIMS warns.

The suggestion that brokers would further anti-competitive acts by working with insurers when assembling excess insurance programs shows ignorance about the insurance process, said Richard Bouhan, executive director of the National Assn. of Professional Surplus Lines Offices Ltd. in Kansas City, Mo.

"The whole thing seems to assume the broker is merely a purchasing agent for the insured. That's a very simplistic view," Mr. Bouhan said, noting that brokers need to disclose information about price and forms to insurers when structuring excess insurance programs. If brokers are discouraged from communicating with insurers, "the broker loses and the consumer loses," he said.

Mr. Harkavy said another concern for risk managers is a statement in the guidelines indicating that surplus lines insurers must comply with provisions of Proposition 103 that mandate a prior approval rating system beginning this November and that call for a rollback in most property/casualty insurance "charges" to 20% below November 1987 levels.

Rate regulation of surplus lines insurers would defeat the purpose of a non-admitted market, he said. "You don't go to surplus lines unless there is a problem" with obtaining coverage in the admitted market, where rates are regulated, he noted.

Although the reference in the antitrust guidelines to rate regulation of surplus lines is surprising, it may not carry much weight, said NAPSLO's Mr. Bouhan.

Rate regulation is "really not within the purview of the antitrust guidelines. I'm not sure the attorney general even plays a role" in rate regulation under the state insurance code, Mr. Bouhan said.

For insurers, possible restrictions spelled out in the guidelines pertaining to the sharing of historical, current and prospective pricing information is particularly troubling, said the NAII's Mr. Crosby.

The draft guidelines caution insurers about sharing historical, current and prospective pricing data, allocated and unallocated loss adjustment expense data and data on premium and investment income, noting that "such information facilitates enforcement of cartels and stimulates interdependent pricing."

These provisions could be a hardship on smaller insurers, in particular, said David Hauge, an attorney with Knapp, Petersen & Clark in Los Angeles.

The guidelines also may set up an interesting dilemma for insurers, said Lorraine B. Moura, an insurer attorney in the San Francisco office of Buchalter Nemer Fields & Younger. The guidelines warn that insurers should not be aware of pricing data compiled by competitors, while Proposition 103 requires insurers to file data to support rates, she said.

"It's a real paradox," Ms. Moura said. "I don't know how you prove you didn't review the information."

The draft guidelines also state that:

- Joint underwriting activities, including self-insurance pools and joint participation on excess insurance contracts, represent "a significant potential for anti-competitive effects."

To prove that insurers are not violating antitrust laws, the joint underwriting arrangement must result in "pro-competitive benefits," like providing coverage or services that would otherwise not be available.

"It could put a chill on joint underwriting pools that could affect the insurance consumer," RIMS' Mr. Harkavy said.

- Bundling of different types of insurance coverages into one package may be illegal if it forces the buyer to purchase coverages that have no demand separately.
- While reinsurance can be procompetitive, "the structure of joint reinsurance would aggravate the anti-competitive potential of any conspiracy among reinsurers."

The guidelines "demonstrate a very aggressive posture and is overexpansive in respect to the applicability of antitrust laws and too limiting in respects to the defenses available to antitrust clients," said Robert Mitchell, an attorney with the San Francisco law firm Adams, Duque & Hazeltine, which represents the Reinsurance Assn. of America in the massive federal antitrust litigation against the insurance industry (see story, page 1).

The RAA is still reviewing the document.

One insurer attorney believes the guidelines will be adopted by the attorney general.

Lawrence Trent, an insurer attorney with Buchalter Nemer Fields & Younger in Los Angeles, observed that the attorney general's staffers have "thought out their positions" and are unlikely to make significant changes to the guidelines.

But, some attorneys pointed out that California courts would not necessarily rule in line with Mr. Van de Kamp's interpretation of the antitrust law if the attorney general prosecutes insurers or brokers under the guidelines.

"I'm not sure of the binding effect even when they are final. No matter what they come up with, it still is only their enforcement notice," said Barbara A. Goode, an attorney with Fisher & Hurst in San Francisco and counsel for the Western Assn. of Insurance Brokers.

And, if the attorney general overzealously brings cases under the guidelines, then courts likely will rule against him, Ms. Moura predicted.

The NAII and the AIA plan to file written comments on the draft guidelines.

Other industry groups, the California Department of Insurance and many insurers would only comment that they were reviewing the document and would present comments to the attorney general later.

State Farm Insurance Cos. of Bloomington, Ill., expects little change in its operations if the attorney general adopts the guidelines, said Pete Ingham, State Farm's legal counsel.

However, Mr. Ingham said it is difficult to assess now how the insurer would have to alter any of its procedures to avoid violating antitrust law as interpreted under the proposed guidelines.

Los Angeles-based Transamerica Corp. circulated its own antitrust guidelines internally following passage of Proposition 103, a spokesman said. "I would think ours are more stringent" than the attorney general's guidelines, he said.

Written comments on the draft guidelines will be accepted until "at least Aug. 11," a state Department of Justice spokesman said.

Comments can be sent to Attorney General John Van de Kamp, attention Deputy Attorney General Jesse W. Markham, 350 McAllister St., Room 6000, San Francisco, Calif. 94102. ■

Update

Medicare benefit cuts eyed

Continued from page 2

Under the proposal, tentatively approved last week by the House Ways and Means Committee, next year's cap on a senior citizen's out-of-pocket physician expenses under Medicare Part B would be raised to $1,500 from the scheduled $1,370 limit.

And, the new prescription drug benefit, now scheduled to start in 1991, would pay 50% of Medicare beneficiaries' out-of-pocket expenses exceeding $800 rather than $600.

The proposal also would make participation voluntary in the expanded Medicare program, but only if beneficiaries agree to drop coverage under Part B.

But, congressional staffers estimate that less than 1% of the 33 million Medicare beneficiaries would give up Part B because of the valuable coverage for physicians' services that the program offers.

Beneficiaries who do give up Part B would be unlikely to receive more coverage from employer-sponsored retiree health plans, consultants say. Typically, such programs reduce hospital and physician benefits by the Medicare benefits a retiree is eligible for rather than Medicare benefits actually received. And, some plans make participation in Medicare Part B a condition of coverage.

The proposal approved by the House panel last week also would slash the Medicare surtax retirees must begin paying in 1989 to $11.25 from $22.50 per $150 of federal tax liability, up to an $800 maximum. But, as a result, a retiree would have to have a much higher income under the proposal than under current law before reaching the $800 surtax cap.

Saunders convicted of fraud

PHILADELPHIA—A federal jury has convicted Jonathan P. Saunders of more than two dozen fraud charges stemming from his operation of North American Fire & Casualty Co. and Commercial Inland & Marine Indemnity Co., both purportedly based in St. Kitts, British West Indies.

Mr. Saunders faces a maximum of 165 years in prison and $6.75 million in fines, according to Assistant U.S. Attorney Paul L. Gray.

The jury convicted Mr. Saunders Tuesday of 19 counts of mail fraud, one count of wire fraud, two counts of bank fraud and five counts of interstate transportation of money obtained by fraud, Mr. Gray said.

U.S. District Judge Robert S. Kelly revoked Mr. Saunders' bail and remanded him to the custody of U.S. marshals after the verdict. No date had been set last week for sentencing.

An indictment filed last December charged that Mr. Saunders:

- Fraudulently misrepresented the finances of North American Fire and Commercial Inland to state insurance departments, insurance brokers and prospective policyholders.
- Tried to open a trust account for Commercial Inland at a Bryn Mawr, Pa., bank using a worthless $5 million cashier's check drawn on a non-existent St. Kitts bank.
- Passed insufficiently funded checks drawn on Commercial Inland's account to buy U.S. treasury bonds and stock in Chock Full O' Nuts Corp.
- Received premiums totaling $194,656.82 from five agencies between September 1987 and January 1988 for Commercial Inland policies.

Mr. Saunders pleaded no contest to the charges in March but later withdrew the plea and demanded a trial (*BI*, Oct. 3, 1988).

ACIC, Commonwealth settle

NEW YORK—American Centennial Insurance Co. has settled a group of reinsurance disputes with Commonwealth Insurance Co. of Vancouver, Canada, a unit of The Home Insurance Co.

The settlement calls for the termination of "all pending arbitration and litigation" between Commonwealth, ACIC and ACIC's former parent company, Beneficial Corp.

Officials of Home and ACIC and lawyers familiar with the settlement either could not be reached or declined to provide further details, citing a confidentiality agreement.

Commonwealth—which reinsured ACIC from 1977 to 1983—was involved in arbitration proceedings with ACIC over reinsurance recoverables on business produced by two former ACIC managing general agents, The Underwriters Inc. of Parsippany, N.J., and Barrett Treaty Corp. of Huntington, N.Y. (*BI*, June 6, 1988).

Commonwealth had earlier sued Beneficial, ACIC's former parent, over the Barrett business and sued ACIC directly over The Underwriters business (*BI*, Sept. 21, 1987; Aug. 3, 1987). Commonwealth charged that it was defrauded in various ways on both books.

ACIC's total reinsurance recoverables from Commonwealth were estimated at $60 million.

Briefly noted

Transit Casualty Co.'s receiver has filed a $1 billion racketeering suit against Clarendon Insurance Co. Ltd. of Bermuda and Clarendon American Insurance Co. of Delaware, charging that the defendants wrote fraudulent financial reinsurance contracts for Transit during the two years preceding Transit's liquidation in 1985. . . .**Illinois Insurance Director John Washburn** will leave his post Sept. 15 to become the state's deputy governor. . . .The New Jersey Supreme Court on July 14 refused to review an appellate court ruling that reassembled the massive pollution coverage litigation between **Westinghouse Electric Corp.** and more than 140 of its property and liability insurers (*BI*, May 29). . . .Plaintiffs Stephen Juzwin and Mary Juzwin are asking U.S. District Judge H. Lee Sarokin to reconsider his radical March 9 ruling that **multiple punitive damage awards** against a single defendant are unconstitutional (*BI*, March 13). . . .Hearings were held last week in Commonwealth Court of Pennsylvania in Harrisburg on the Pennsylvania Insurance Department's rehabilitation plan for **Mutual Fire, Marine & Inland Insurance Co.** Most aspects of the plan, filed earlier this year, are supported by a policyholders' committee. Mutual Fire entered rehabilitation in 1986 and was officially declared insolvent Feb. 3 (*BI*, March 6).

McCarran reform

Continued from page 2

"If you can go to different insurers and get different prices on auto insurance, where is the problem?" Rep. Douglas asked.

Other congressmen also defended the law.

Rep. Michael DeWine, R-Ohio, said if insurers could not engage in joint activities like collecting and sharing loss information, smaller insurers could be driven out of business.

"We could have less competition" with a McCarran-Ferguson repeal, Rep. DeWine said.

Rep. Romano Mazzoli, D-Ky., also suggested that it may be premature to consider any changes to the McCarran-Ferguson Act. Rather, the first course of action should be to improve the quality of state insurance regulation, Rep. Mazzoli said.

"I'm not satisfied that the insurance departments are doing all that they could," Rep. Mazzoli said, adding that states need to beef up resources to review rate filings.

This congressional skepticism came as the Economic and Commercial Law Subcommittee last week held a hearing on legislation, H.R. 1663, introduced by Judiciary Committee Chairman Jack Brooks, D-Texas, that would strip insurers' current limited exemption from federal antitrust law.

Among other things, the legislation, identical to a bill cleared last year by the subcommittee (*BI*, June 27, 1988), would make subject to antitrust law:

- Insurance price fixing or the development and publication of recommended rates and the sharing of data regarding expenses and profits.
- Tying the sale of insurance to any unrelated insurance product.
- Allocating specific markets or customers among competing insurers.
- Activities that would force competitors out of specific markets.

'The McCarran exemption is very narrow,' says Craig Berrington, general counsel with the American Insurance Assn. in Washington, D.C. 'I'm amazed at the extraordinary confusion about the McCarran-Ferguson Act.'

Rep. Brooks, who also chairs the subcommittee, said in a prepared statement that it has become virtually impossible to defend a law that gives a single industry a measure of immunity from antitrust law.

"In the midst of global competition, immunity for one domestic financial services industry—and not for the others—becomes virtually impossible to defend," Rep. Brooks said.

West Virginia Attorney General Charles Brown said he had no sympathy for insurers' argument that the nature of their business is so different that it deserves special protection from the full force of antitrust law.

"The (insurance) industry continues to say 'We are different.' *Everyone* says they are different," Mr. Brown said.

Mr. Brown argued that scrapping the McCarran-Ferguson Act would lead to more insurer competition.

"Let's have a level playing field. Let's make the largest industry in America compete," Mr. Brown commented.

Michael Strumwasser, special assistant attorney general of California, testified the insurance industry can survive even if it has to abide by the same antitrust rules as other industries.

And, J. Robert Hunter, president of the National Insurance Consumer Organization in Alexandria, Va., said the McCarran-Ferguson Act has resulted in inefficiency and weak competition in the insurance industry.

He also said insurance reform is the No. 1 priority of the consumer movement.

However, insurance industry representatives questioned why the McCarran-Ferguson Act should be repealed or altered.

"There is no compelling reason for making changes," said William Snyder, chairman and chief executive officer of GEICO Corp., a Washington, D.C.-based personal lines insurer.

Mr. Snyder noted, for example, that repeal or overhaul of the McCarran-Ferguson Act would have done nothing to ease the liability insurance crisis of the mid-1980s.

And, he said it was incorrect to charge that the McCarran-Ferguson Act permits insurers to fix prices.

"The McCarran exemption is very narrow," said Craig Berrington, general counsel with the American Insurance Assn. in Washington, D.C. "I'm amazed at the extraordinary confusion about the McCarran-Ferguson Act."

The subcommittee plans to hold an additional hearing in fall, Rep. Brooks said. ■

Antitrust

Continued from page 1

the form.

Further, the suits allege that the defendants conspired to eliminate occurrence-based general liability insurance and to include defense costs within policy limits.

While attorneys involved in the case acknowledged that the memorandum was sent out last week, none would release it to *Business Insurance*. However, they did confirm its contents.

The memorandum, which is not a public document, was sent July 27 to the coordinating counsels for the defendants, the attorneys general and private plaintiffs.

Issuing a proposed memorandum is a relatively unusual legal procedure in which a judge indicates his thinking on several issues and then allows the parties further debate.

Of the defendants who could be reached by press time, General Reinsurance Corp.'s Edmond F. Rondepierre, senior vp and general counsel, said: "We have received a copy of a draft order and we are studying it. We are preparing for the oral argument and look forward to seeing the matter resolved at that time."

ISO declined to comment, as did Prudential Reinsurance Co. and Kemper Corp., whose U.K. reinsurance subsidiary is named in the suits.

The litigation, which erupted in March 1988 when eight states filed complaints, grew to 18 suits when 10 more states joined the action in June 1988 (*BI*, June 20, 1988; March 28, 1988). Louisiana joined the litigation in April.

Among other plaintiff states are California, New York, West Virginia, Connecticut and Massachusetts.

A separate suit filed under state antitrust law also is pending in Texas.

The federal litigation is estimated to have cost the insurance industry defendants $30 million in defense costs, with 35 law firms involved.

Among the plaintiffs that could be reached for comment, Washington Assistant Attorney General James M. Beaulaurier said the memorandum "is extremely helpful to have in advance of the hearing."

The attorneys general expected to hit legal stumbling blocks in this case because they are "journeying into unchartered water," he noted.

"We expect it to be a difficult fight, but to prevail in the end," said Mr. Beaulaurier.

New York Assistant Attorney General George Sampson agreed. "We think we will prevail in the end."

In discussing the McCarran-Ferguson issue in the 58-page memorandum, Judge Schwarzer writes that the defendants' involvement in designing an insurance policy form is the business of insurance and therefore protected from antitrust challenges under the 1945 federal law. He notes that the give and take involved in the design of an insurance policy form is part of the protected activity.

Judge Schwarzer also concludes that the development of insurance forms is regulated by the states.

Discussing the plaintiffs' contention that the insurance industry defendants engaged in a boycott because they refused to deal except using a certain form, Judge Schwarzer disagrees. He takes up the defense argument that a boycott is an absolute refusal to deal on any terms.

If Judge Schwarzer issues a final opinion along the lines of the memorandum, his rulings can be appealed by the attorneys general.

Other U.S. defendants in the litigation include: Hartford Fire Insurance Co.; Allstate Insurance Co.; Aetna Casualty & Surety Co.; CIGNA Corp.; The Reinsurance Assn. of America; Constitution Reinsurance Corp.; Mercantile & General Reinsurance Co. of America; North American Reinsurance Corp.; Winterthur Swiss Insurance Co.; and reinsurance broker Thomas A. Greene & Co. Inc.

Among London market defendants are Merrett Underwriting Agencies Ltd. and its former underwriter Robin A.G. Jackson; Murray Lawrence & Partners; former Lloyd's of London Chairman Peter N. Miller; and broker Ballantyne, McKean & Sullivan Ltd. ■

Record award

Continued from page 3

for the village of Palatine.

Mr. Leonard said Palatine plans to vigorously fight to get the award reduced.

"It is likely the case will be appealed," agreed IRMA attorney Stuart Diamond of Baker & McKenzie in Chicago. "There is a reasonable chance the case will be reversed."

IRMA pays the first $250,000 of each liability claim. The next $250,000 is reinsured with a unit of Crum & Forster Inc. of Morristown, N.J. The remaining $9.5 million is reinsured with syndicates at Lloyd's of London.

"This is the largest award IRMA has ever paid," said Sal Bianchi, the pool's administrator.

Previously, the largest award IRMA paid was $450,000 in 1984, he said.

Despite the size of the claim, "based on our best judgment at this time there will be no assessments" for IRMA members as a result of the award against Palatine, Mr. Bianchi said.

Mr. McDermott, who is now 22 years old, was left paralyzed from the neck down after he accidentally rode his bicycle into a 6-foot-deep ditch in 1984.

Mr. McDermott sued Palatine, which owned an easement in the ditch; the Metropolitan Sanitary District of Greater Chicago, which owned the land on which the ditch was situated; and the Salt Creek Rural Park District, which maintained a park nearby.

During the trial, Mr. Demos showed that Palatine officials knew that the ditch was hazardous for nearly two years prior to Mr. McDermott's accident.

"The jury was angry at Palatine because they had notice from the Metropolitan Sanitary District two years before the accident about this specific hazard and the village totally ignored it," Mr. Demos said.

As a result, the jury awarded Mr. McDermott $16 million in compensatory damages.

Under Illinois law, punitive damages cannot be assessed against a municipality.

The jury found that Palatine was 67% responsible for the accident and that the sanitary district was 33% responsible.

That translates into a $10.72 million verdict against Palatine and a $5.28 million verdict against the sanitary district.

'The jury was angry at Palatine because they had notice from the Metropolitan Sanitary District two years before the accident about this specific hazard and the village totally ignored it,' says the plaintiff's attorney, James Demos.

However, before the jury returned its verdict, the defendants reached a settlement that effectively reallocated the verdict, Mr. Demos explained.

As a result of that agreement, Palatine's liability increases to $13.85 million, the sanitary district's liability drops to $500,000 and the park district now must pay $1.65 million of the award.

The Metropolitan Sanitary District of Greater Chicago, now known as the Metropolitan Water Reclamation District, has no insurance to cover its share of the award, according to attorneys.

The Salt Creek Park District offered the full limits of insurance when it agreed to the settlement, according to park district attorney Gerald Maatman Jr., a partner with Baker & McKenzie in Chicago.

At the time of the accident, the park district had $500,000 in primary liability insurance written by Transit Casualty Co., which was ordered liquidated in 1985.

The district also purchased $500,000 in liability coverage excess of $500,000 from Safety Mutual Casualty Corp. of St. Louis. In addition, it purchased an umbrella policy with $950,000 in limits from Safety Mutual.

The park district's share of the award in part will be financed by $150,000 collected from the Illinois Insurance Guaranty Fund on behalf of Transit, the maximum amount collectible under law.

In addition, a U.S. District Court judge in Chicago ruled in November 1988 that Safety Mutual must drop down and pay $1.5 million to the park district excess of the $150,000 from the guaranty fund.

The judge ruled that since the excess liability policy did not explicitly state that it does not drop down, it is ambiguous and therefore must drop down, Mr. Maatman explained.

However, because Safety Mutual must assume $350,000 of Transit's liability, the judge reduced the limits of the umbrella policy to $650,000, Mr. Maatman said. ■

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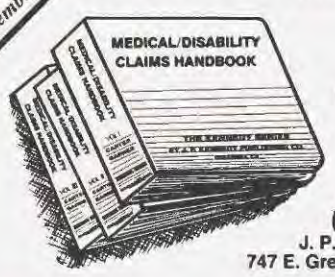

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Brokers see productivity gains despite tepid revenue growth

By LEONARD M. WILSON

Special to Business Insurance

IN THE DEPTHS of the last soft market, a contact at a leading publicly owned insurance broker volunteered that his company was being managed as if competitive pricing could be a permanent condition. He was responding to the difficulty in forecasting a turn in premium rates and the pressure on profit margins as the inevitable result of declining prices. Fortunately, not long after this conversation, prices began to harden and the need for austerity diminished.

Mr. Wilson

This vignette reaffirms the role of tight cost control in managing an insurance brokerage during a soft market. Currently year-over-year revenue growth for the typical public broker is running at roughly 2%-3%. Maintenance of profitability, therefore, depends mostly on successful cost restraint—effectively the ability to improve organizational productivity.

Although the present competitive insurance market has entered its third year, few observers are willing to forecast a turn and some are suggesting that the soft market might last into 1991. Thus, insurance brokers could conceivably face two more years of trying conditions. If so, productivity gains —the obverse of cost restraint—will remain the critical variable in bolstering the bottom line.

In thinking about brokers' cost controls, we began to ponder how productivity had behaved in recent years. Revenue per employee is a common measure of productivity because it is simple to calculate and allows for comparison among brokers.

We have computed 1988 revenues per employee for the leading public brokers. Our figures are based upon total revenues as reported for the year and the end of the year level of employees. We have also included pretax margins for 1988. There is a distinct and logical correlation between per capita productivity and profitability:

- Marsh & McLennan Cos. Inc.: $99,700 revenue per employee, 22.7% pretax margin.
- Corroon & Black Corp.: $90,400 revenue per employee, 16.1% pretax margin.
- Arthur J. Gallagher & Co.: $88,300 revenue per employee, 15.4% pretax margin.
- Alexander & Alexander Services Inc.: $75,300 revenue per employee, 10.4% pretax margin.
- Frank B. Hall & Co. Inc.: $73,200 revenue per employee, pretax margin is not meaningful.

The variation in absolute levels of productivity can be explained in large measure by differences in mix of business. Comparisons are influenced by average office volume, account size, lines of business, wholesale vs. retail, the proportion of international revenues, activities other than insurance brokerage and, in some instances, acquisitions.

We also calculated revenues per employee in 1984 for each of the brokers, with the aim of examining productivity gains from 1984-88, a period characterized first by rising and then falling commercial insurance prices. Based on our analysis, revenues per employee advanced a whopping 45%-50% during this period, or an average of better than 10% annually.

However, these results as a measure of advancing productivity are deceptive because revenues per employee are distorted by rate increases or reductions and changing insurable values.

Consider a year of commissions expanding 15% in response to rising premium rates and general inflation at 5%. Conceivably, revenues per employee might rise 20%, a rather dramatic increase. But per capita productivity, measured by policy count or any other internal unit of physical activity, has not changed.

Since the analyst cannot gain access to each broker's units of production, it is necessary to estimate the impact of rate changes and general inflation on revenues per employee, and then adjust the nominal figures accordingly. These manipulations create a worthwhile, but perhaps not definitive measure of progress on the productivity front.

Based on our estimates of insurance price changes over the 1984-1988 periods, we estimate that the deflated or real revenues per employee, in contrast to actual data, rose about 20% for each of the public brokers. Marsh & McLennan moderately outstripped the group with an estimated 24% rise.

Thus, over the period 1984-88, annual progress in productivity seemingly amounted to 4% to 5%, impressive enough compared with most industries and the U.S. economy as a whole.

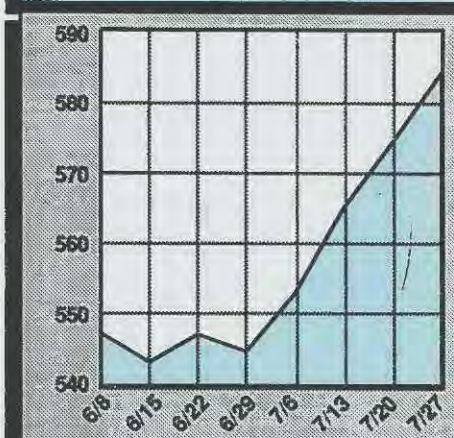
The four-year period includes two fat years during which head count was restrained. Doubtless, outlays for more sophisticated information systems helped fuel the improvements in per capita productivity. Few businesses are so well situated to benefit from judicious attention to data processing as insurance brokerage.

We believe that continued productivity gains have distinctly positive implications for the insurance brokers in a period of tepid revenue growth. At the same time, we are cautious about extrapolating an apparent annual productivity rise of 4% to 5% into future years.

A more plausible long-term target for productivity might be 2% to 3% annually. This range, sustained for a number of years, would have a significant effect on both profitability and the level of client service. In the current period of narrow revenue growth, productivity advances of this magnitude would make the difference between steady operating profits and a decline. In an environment of moderate progress for insurance brokers, perhaps revenue growth of 10% annually and a 2% increase in internal efficiency would permit about a 15% rise in operating profits.

Moderate growth could be one possible scenario once the soft market runs out of steam, instead of a steep climb in prices as in 1985. Consequently, the need for continuing attention to productivity may not diminish as a priority in a tighter market. Our capsule analysis suggests that brokerage managements have become well-attuned to the issue of productivity. ■

BI Insurance Index



Insurance industry stocks continued their ascent last week, as the *Business Insurance Index* rose 9.8 points to 584.1 on July 27, from 574.3 on July 20. Advancing issues were led by Sierra Health Services, up 14.3%; Arthur J. Gallagher & Co., up 9.8%; and AVEMCO Corp., up 9.5%. Decliners followed United HealthCare Corp., down 5.6%; USLIFE Corp., down 3.2%; and Poe & Associates Inc., down 2.9%. The most active issue during the period was Sears, Roebuck & Co., 3.5 million shares traded. The *BI Index* gained 1.7% for the period; the Dow Jones 30 Industrials were up 2.3%; the New York Stock Exchange Composite grew 2.2%; and the Standard & Poor's 500 gained 1.3%.

British Issues

July 27 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence pence
Comml Union	419	15.8	29.3	7.0	420—416
Genl Accident	987	9.2	70.7	7.2	989—979
Gdn Royal Exch	221	11.6	15.7	7.1	221—217
Royal	417	12.8	34.0	8.2	418—410
Sun Alliance	299	8.6	17.0	5.7	300-294
Brokers					
Bradstock	200	13.7	10.0	5.0	200—200
CE Heath	465	13.3	34.5	7.4	468—465
Hogg Robinson	139	11.6	9.3	6.7	139—139
Lloyd Thompson	220	16.9	8.0	3.6	220—220
PWS Holdings	46	11.5	3.3	7.2	46—45
Sedgwick Grp	256	18.0	16.7	6.5	256—251
Steel Brri Jones	239	15.9	15.3	6.4	240—239
Willis Faber	230	17.0	15.3	6.7	232—230

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

BI Industry Stock Report

JULY 27, 1989 — 7/21/89 THRU 7/27/89

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander Svcs	NYSE	26 63	0 5	13 3	26 88	22 63	213	1 00	3.8	18.0	2 90	9 18
Corroon & Black Corp	NYSE	36 75	0 7	18 1	36 88	30 75	144	1 24	3 4	15 8	7 62	4 82
Gallagher Arthur J & Co	NYSE	22 50	9 8	34 3	21 75	16 13	19	0 52	2 3	15 8	5 33	4 22
Hall Frank B & Co	NYSE	4 13	-2 8	43 4	4 63	2 50	100	0 00	0 0	-2 0	0 00	N/A
Hilb, Rogal & Hamilton	OTC	18 00	4 3	18 0	18 00	13 75	192	0 20	1 1	15 7	4 60	3 91
Marsh & McLennan Cos Inc	NYSE	68 00	3 0	20 9	67 63	55 13	524	2 50	3 7	16 7	6 48	10 49
Poe & Assoc Inc	OTC	8 50	-2 9	3 0	8 75	8 25	57	0 40	4 7	9 7	1 43	5 94
BROKERS	AVERAGE		1 8	21 6					2 7	12 8		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W R Corp	OTC	33 50	-0 7	13 6	34 25	29 25	113	0 40	1 2	7 0	21 28	1 57
Berkshire Hathaway Inc	NYSE	7475 00	8 3	59 0	7996 00	7500 00	107	0 00	0 0	26 4	2468 63	8 61
ITT (Hartford Group)	NYSE	61 50	2 5	22 7	62 25	49 75	2475	1 48	2 4	10 3	56 33	1 09
Sears, Roebuck & Co (Allstate)	NYSE	46 00	1 9	12 5	48 00	40 13	3532	2 00	4 3	15 7	36 09	1 27
CONGLOMERATES	AVERAGE		3 0	27 0					2 0	14 8		
INSURERS & REINSURERS												
Aetna Life & Cas Co	NYSE	58 50	0 9	23 8	58 88	46 75	1076	2 76	4 7	9 0	58 11	1 01
AmBase Corp	NYSE	14 25	4 5	29 5	14 50	11 00	525	0 20	1 4	5 0	18 66	0 76
American General Corp	NYSE	37 63	1 7	25 9	38 00	29 50	793	1 50	4 0	11 4	28 04	1 34
Amer Heritage Life Invt	NYSE	26 50	1 0	2 9	27 88	25 00	3	1 20	4 5	10 4	22 47	1 18
Amer Indty Fin'l Corp	OTC	11 25	-2 2	7 1	13 00	9 50	5	0 56	5 0	7 2	17 38	0 65
American Int'l Group	NYSE	94 00	7 0	38 7	91 75	66 25	1524	0 48	0 5	13 2	33 55	2 80
Aon Corp	NYSE	35 75	-2 1	27 7	38 00	27 00	205	1 40	3 9	12 4	16 67	2 14
Argonaut Group	OTC	58 00	0 6	32 6	59 25	43 50	48	0 00	0 0	7 6	36 83	1 57
AVEMCO Corp	NYSE	26 00	9 5	0 5	26 13	22 63	49	0 40	1 5	14 0	9 20	2 83
Baldwin & Lyons Inc	OTC	19 38	2 0	30 2	19 50	14 50	48	0 20	1 0	6 8	17 57	1 10
Belvedere Corp	AMEX	4 63	-2 5	2 9	6 50	4 50	2	0 04	0 9	7 0	8 43	0 55
Chandler Insurance	OTC	10 38	1 3	49 6	10 88	7 00	236	0 00	0 0	6 0	9 53	1 09
Chubb Corp	NYSE	74 00	5 5	27 6	74 00	57 63	867	2 32	3 1	8 1	53 50	1 38
CIGNA Corp	NYSE	59 25	0 6	25 7	59 88	45 88	828	2 96	5 0	10 4	53 08	1 12
CNA Fin'l Corp	NYSE	78 00	1 0	28 9	79 25	57 63	169	0 00	0 0	12 2	54 52	1 43
Continental Corp	NYSE	36 00	1 8	11 2	36 25	31 50	476	2 60	7 2	24 5	42 10	0 86
Durham Corp	OTC	33 25	1 5	0 8	34 00	30 00	16	0 92	2 8	19 2	26 32	1 26
Fireman's Fund Corp	NYSE	36 88	5 4	26 1	36 00	29 00	1195	0 60	1 6	9 6	32 74	1 13
Fremont Gen Corp	OTC	16 88	0 8	26 2	18 25	12 13	69	0 60	3 6	13 0	17 61	0 96
Frontier Insurance Group	OTC	19 75	-1 3	58 0	20 00	11 13	34	0 00	0 0	10 5	7 53	2 62
General Re Corp	NYSE	72 50	3 9	30 6	71 63	54 38	877	1 36	1 9	13 6	29 04	2 50
Hanover Ins Co	OTC	28 50	1 3	6 5	30 25	25 75	228	0 44	1 5	5 8	31 47	0 91
Harleysville Group Inc	OTC	21 00	1 8	16 7	22 50	17 75	24	0 48	2 3	7 3	18 94	1 11
Hartford Steam Boiler	OTC	49 75	8 2	35 4	48 50	34 75	220	1 60	3 2	13 3	13 04	3 82
Kansas City Life	OTC	35 25	0 0	2 2	36 00	32 75	13	1 04	3 0	12 6	39 22	0 90
Kemper Corp	NYSE	44 50	4 4	85 4	44 25	22 75	717	0 84	1 9	10 4	28 91	1 54
Lawrence Ins. Group	AMEX	7 00	-1 8	11 2	8 50	6 63	1	0 24	3 4	14 9	3 19	2 19
Liberty Corp S C	NYSE	37 50	2 0	4 2	38 00	32 50	5	0 80	2 1	21 3	21 17	1 77
Lincoln Nat'l Corp	NYSE	54 38	1 2	23 6	54 50	42 75	193	2 48	4 6	13 5	39 21	1 39
NAC Re Corp	OTC	28 00	-2 2	32 3	28 75	20 63	213	0 20	0 7	15 1	15 21	1 84
Navigators Group	OTC	26 50	-0 9	32 5	27 25	20 50	4	0 00	0 0	11 3	15 22	1 74
Nobel Ins Ltd	OTC	2 25	0 0	-52 6	5 00	1 50	61	0 42	8 7	-8 7	7 76	0 29
Northwestern Nat'l Life	OTC	37 25	0 0	19 7	39 13	26 88	145	1 20	3 2	13 4	37 50	0 99
Ohio Cas Corp	OTC	46 75	2 7	30 8	46 25	35 50	282	2 08	4 4	7 0	33 30	1 40
Old Rep Int'l Corp	OTC	25 38	-2 4	5 8	28 88	23 38	105	0 74	2 9	12 9	26 50	0 96
Orion Cap Corp	NYSE	22 88	0 0	48 8	23 00	15 38	53	0 84	3 7	7 4	12 93	1 77
Phoenix Re Corp	OTC	9 75	-2 5	2 6	11 00	8 75	19	0 00	0 0	5 4	12 99	0 75
Protective Life Corp	OTC	15 75	2 4	18 9	16 25	12 88	89	0 70	4 4	78 8	14 54	1 08
Re Capital Corp	AMEX	12 63	1 0	38 3	12 75	9 13	17	0 00	0 0	12 6	12 60	1 00
RLI Corp	NYSE	8 88	2 9	16 4	9 25	7 13	25	0 36	4 1	8 7	10 71	0 83
Provident Life & Acc Ins Co	OTC	25 00	2 0	29 9	24 88	19 13	430	0 68	2 7	8 5	23 24	1 08
St. Paul Cos. Inc	OTC	58 25	8 9	33 9	55 50	43 00	1121	2 20	3 8	7 9	32 00	1 82
SAFECO Corp	OTC	32 13	3 6	36 0	32 13	23 13	1732	1 20	3 7	7 6	24 88	1 29
SCOR U S Corp	NYSE	9 13	2 8	0 0	9 50	7 50	43	0 20	2 2	6 9	10 35	0 88
Seibels Bruce Group Inc	OTC	11 63	1 1	2 2	13 63	10 25	215	0 80	6 9	9 7	13 42	0 87
Selective Ins Group Inc	OTC	25 75	0 0	12 0	26 00	21 75	62	1 40	5 4	5 6	22 33	1 15
Statesman Group Inc	OTC	3 25	-1 8	3 8	4 00	2 38	48	0 05	1 5	81 3	3 48	0 93
Tokio Marine & Fire Ins	OTC	78 13	7 8	-14 5	95 50	66 00	15	0 23	0 3	47 4	0 00	N/A
Torchmark Corp	NYSE	46 88	7 4	53 7	46 75	30 00	424	1 20	2 6	13 7	12 24	3 83
Transamerica Corp	NYSE	41 00	5 1	21 0	40 25	32 75	706	1 88	4 6	9 2	30 70	1 34
Travelers Corp	NYSE	43 00	0 0	23 7	43 38	34 50	839	2 40	5 6	33 6	44 85	0 96
Trenwick Group Inc	OTC	17 00	0 0	17 2	17 75	13 75	28	0 24	1 4	9 6	16 91	1 01
United Fire & Cas Co	OTC	33 00	1 5	8 2	33 13	29 00	6	1 20	3 6	6 0	22 56	1 46
United States Fid & Gty	NYSE	33 50	1 5	17 5	34 00	28 50	558	2 80	8 4	12 5	22 57	1 48
UNUM Corp	NYSE	35 88	1 4	32 9	36 13	26 63	406	0 60	1 7	11 9	30 64	1 17
USLIFE Corp	NYSE	45 25	-3 2	29 7	47 50	34 13	192	1 40	3 1	10 6	54 27	0 83
Washington Nat'l Corp	NYSE	29 00	4 5	7 4	29 13	24 00	113	1 08	3 7	-20 7	32 33	0 90
Zenith Nat'l Ins Corp	NYSE	19 50	-0 7	11 4	19 88	16 75	107	0 84	4 3	9 1	13 61	1 43
INSURERS & REINSURERS	AVERAGE		1 7	20 5					3 1	13 1		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International Corp	OTC	37 25	2 8	207 1	36 25	11 75	404	0 00	0 0	19 0	3 54	10 52
HMO America Inc	OTC	9 50	-1 3	24 5	10 13	0 88	1064	0 00	0 0	-8 3	1 12	8 48
Pacificare Health Systems	OTC	38 25	1 3	212 2	41 00	12 25	133	0 97	2 5	30 6	6 35	6 02
Safeguard Health Ent	OTC	9 00	-1 4	63 6	9 50	4 75	130	0 00	0 0	15 3	2 99	3 01
Sierra Health Services	AMEX	8 00	14 3	390 8	7 75	1 50	212	0 00	0 0	-6 5	1 59	5 03
United HealthCare Corp	OTC	10 38	-5 6	137 0	11 50	4 13	1106	0 00	0 0	-4 7	0 31	33 48
United Medical Corp	AMEX	6 00	0 0	14 3	6 75	5 13	7	0 00	0 0	1 8	4 11	1 46
U S. Healthcare	OTC	13 88	3 7	138 9	13 88	5 25	1112	0 20	1 4	198 3	2 87	4 84
Western Health Plans Inc	AMEX	0 44	0 0	-36 2	1 13	0 25	34	0 00	0 0	-0 2	0 82	0 54
HMOs & PPOs	AVERAGE		1 5	128 0					0 4	27 2		
ALL COMPANIES	AVERAGE		1 8	33 3					2 7	14 9		

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