

Business Insurance

Reporting weekly for corporate risk, employee benefit and financial executives / \$1.75 a copy; \$70 a year

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Judge OKs permanent injunction against med mal purchasing group

NEW ALBANY, Ind.—A federal judge has issued a permanent injunction against Medical Liability Purchasing Group Inc. of Indiana and its president after finding they violated the federal Risk Retention Act and federal mail and wire fraud statutes.

In a June 22 order, U.S. District Judge S. Hugh Dillin enjoined MLPG and its president, Ted Allen Combs, and ordered the defendants to supply the Indiana Insurance Department with a list

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Punitive damages

No relief now, but high court opens door for future review

By STACY ADLER

WASHINGTON—Corporate America lost a battle last week when the U.S. Supreme Court refused to rule that excessive punitive damages are unconstitutional under the 8th Amendment's excessive fines clause, but the business community is poised to win the war.

All nine justices of the high court indicated that they are concerned with the current system of unrestrained punitive damages and want to consider the issue under the 14th Amendment's due process clause.

The 14th Amendment was not properly raised in the recent case, but three cases now awaiting certiorari from the Supreme Court raise the issue of whether the due process clause prohibits excessive punitive damages.

In addition, the high court's 7-to-2 decision last week focused nationwide attention on the punitive damages issue,

The 8th Amendment's primary focus 'was the potential of governmental abuse of the "prosecutorial" power, not concern with... civil damages.'

— Harry A. Blackmun



which has increased pressure on state and federal legislators to limit these awards, experts say.

"It is a very encouraging opinion," said Martin Connor, president of the American Tort Reform Assn. in Washington, D.C. "The court is opening the door wide open for further

examination of this issue."

Attorney Victor Levit agreed: "All nine justices indicated that punitive damages that are way out of line with actual damages are a denial of due process."

"Corporations lost the battle, but they will win the war," predicted Mr. Levit of Barger & Wolen in San Francisco.

"The fact that there is another avenue under the due process clause means the war is not over," said Quentin Riegal, deputy general counsel of the National Assn. of Manufacturers in Washington, D.C.

"The issue is far from dead," said Craig Berrington, general counsel at the American Insurance Assn. in Washington, D.C.

In its June 26 opinion, the Supreme Court said the 8th Amendment's prohibition against excessive fines "does not apply to awards of punitive damages in cases between pri-

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Photo: Wide World Photos

The Greek tanker World Prodigy spilled 420,000 gallons of fuel oil when it ran aground off the coast of Rhode Island.

P&I clubs cover 3 U.S. oil spills

By MICHAEL BRADFORD
STACY SHAPIRO,
and CAROLYN ALDRED

The owners of three of four ships involved in a recent rash of oil spills in U.S. waters each have at least \$400 million in commercial pollution liability and cleanup insurance, but underwriters expect relatively small claims due to limited cleanup costs and damages.

Underwriters also expect the hull losses to be small, but damage estimates on the ships were not available last week.

And, because the cargo losses are so small, underwriters have not even tracked the cargo insurance to see if they are involved.

The three spills, which occurred during a 12-hour period on

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Section 89 relief near as bill clears Senate

By JERRY GEISEL

WASHINGTON—Senate passage last month of Section 89 reform legislation greatly increases the chances that Congress will overhaul the controversial law this year.

However, the reform effort still has many hurdles to clear before it wins final congressional approval, Washington observers say.

As it debated its Section 89 reform package last month, the Senate added several amendments that will further ease employers' efforts to comply with the welfare benefit plan non-discrimination tests and reduce penalties for some violations of the law.

For instance, the Senate-passed proposal gives small employers more time to comply with Section 89 and gives all employers additional time to comply with Section 89 reporting requirements.

Benefits experts last week hailed Senate passage of Section 89 reform as a signal that Congress is serious about answering employers' complaints about the controversial law.

"I've never seen such a desire on the part of Congress to do something positive for the business community in the benefits area," said James Klein, deputy executive director of the Assn. of Private

Pension & Welfare Plans in Washington, D.C.

"The Section 89 reform train will not be stopped. Congress knows it has to do something," said Henry Saveth, a principal with A. Foster Higgins & Co. Inc. in New York.

"There is a congressional recognition that something has to be done," said Emmett Seaborn, a consultant with TPF&C, the benefits consulting division of Towers, Perrin, Forster & Crosby Inc. in New York.

Because of the opposition of Rep. Dan Rostenkowski, D-Ill., to Section 89 repeal, hardly anyone believes that repeal—rather than overhaul—of Section 89 is likely. Rep. Rostenkowski is chairman of the House Ways and Means Committee, which controls the fate of Section 89 legislation in the House.

"Rep. Rostenkowski is a powerful man and few members will want to cross him," said Dallas Salisbury, executive director of the Employee Benefit Research Institute in Washington, D.C.

While benefit experts are encouraged by the latest round of changes, they agree that Section 89 reform remains on a very long road.

"I believe we have a long way to go before the issues are resolved," said Stuart Brahs, vp-federal affairs in the Washington, D.C., of-

fice of The Principal Financial Group, a diversified financial services organization.

Indeed, a basic issue—assuming the House of Representatives completes action on its version of Section 89 reform proposed by Rep. Rostenkowski—will be how differences in Section 89 reform measures passed by the House and Senate will be resolved.

While the Senate has included its Section 89 reforms in a child care bill, Rep. Rostenkowski is working to include his Section 89 reforms in a budget reconciliation bill.

For Section 89 reforms to be enacted, one of these scenarios would have to occur:

- The House would have to pass a child care bill. If that occurs, a conference committee that would meet to work out differences in the two child care bills could also reconcile Section 89 changes.

- Budget reconciliation legislation would have to be passed by both the House and the Senate. And, under this scenario, Section 89 reforms would have to be included in budget reconciliation legislation passed by at least one of the chambers.

It is widely believed that if Section 89 reforms are included in a House-passed budget reconciliation bill, the Senate Finance Com-

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TPAs win ruling that federal law pre-empts Florida regulations

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Update

Judge halts purchasing group

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of health care providers solicited by MLPG and an accounting of premiums and other funds collected.

Judge Dillin's order labeled MLPG as "merely a front" for direct-mail malpractice insurance solicitations by Guam-based Casualty Assurance Risk Insurance Brokerage Co. (BI, June 26).

Mr. Combs was loaned the start-up money for MLPG by his uncle, a CARIB officer, and CARIB employees answered phone calls and mail for the purchasing group, drafted MLPG's solicitation material and wrote letters in Mr. Combs' name, affixing a rubber stamp signature of Mr. Combs, the judge found.

MLPG's computer-generated solicitations—sent to roughly 400,000 health care providers nationwide—were "false and deceptive" because, among other reasons, MLPG was never registered as a purchasing group in Indiana, and CARIB is not a U.S.-domiciled insurer as the solicitations claimed, the judge found.

MLPG—which continued to solicit business in 10 states after being ordered to cease and desist—violated the Risk Retention Act because it did not buy insurance on a group basis but instead funneled risks to CARIB, which issued individual policies, the judge found.

James L. Petersen, an Indianapolis lawyer representing MLPG and Mr. Combs, said the order will be appealed.

Meanwhile, the U.S. Attorney for the Southern District of Indiana has asked the FBI to investigate MLPG's operations after receiving a copy of Judge Dillin's order, according to Larry Mackey, assistant U.S. attorney and chief of the criminal division.

House kills S&L bill amendment

WASHINGTON—The U.S. House has rejected an amendment to the savings and loan bailout bill that would have removed Federal Deposit Insurance Corp. coverage for bank investment contracts, retroactive to April 6.

The amendment would have placed a moratorium on federal insurance for pension and profit-sharing funds invested in bank investment contracts, which is known as pass-through coverage (BI, May 22). It was introduced as a result of efforts by the American Council of Life Insurance.

Opposition from the FDIC, the House Committee on Education and Labor and the Department of Labor killed the amendment.

The House instead adopted an amendment similar to one already approved by the Senate that calls for a six-month study of the issue.

Some observers believe removing FDIC coverage from BICs could have a negative impact on banks, which are emerging as a major force in the \$150 billion guaranteed investment contract market.

Nevada auto insurance rollback

CARSON CITY, Nev.—Nevada Gov. Bob Miller is expected to sign a bill requiring insurers to cut automobile liability insurance "charges" to 15% below July 1988 levels for one year.

The bill, S.B. 220, would make the rollbacks effective with renewals or new policies beginning Oct. 1. The measure, passed by the Legislature last week, was modeled after California's Proposition 103.

Direct written premiums for auto liability insurance in the state totaled \$281.3 million in 1987—\$52.9 million for commercial coverage and \$228.4 million for private passenger coverage.

The legislation allows insurers to charge rates above the rollback levels only if they are "substantially threatened with insolvency," the same relief standard originally contained in Proposition 103. But in May, the California Supreme Court struck down the insolvency standard as unconstitutional (BI, May 8).

Meanwhile, the California Department of Insurance is reviewing 3,922 applications from 443 property/casualty insurers seeking rate relief for numerous lines of insurance regulated by Proposition 103.

The applications represent most of the 724 property/casualty insurers licensed in California. Of the 281 companies that did not file, many write lines not regulated by Proposition 103 or are inactive, said Milo Pearson, manager of the rate regulation division.

Public hearings and decisions on the requests will begin "shortly," said Insurance Commissioner Roxani Gillespie.

PSA parent to pay damages

LOS ANGELES—USAir Group last week agreed to assume liability for damages in the four remaining cases brought by survivors of the 43 passengers and crew members killed when a Pacific Southwest Airlines jet crashed Dec. 7, 1987.

The agreement was reached June 26, the day before closing arguments were scheduled in a trial in Los Angeles Superior Court to determine liability.

The plaintiffs last week had not yet accepted USAir's proposed settlement, the details of which were not disclosed.

In total, 44 claims were filed against USAir and subsidiary PSA; Ogden Allied Services Corp., the outside security firm contracted by the airlines. Settlements in 39 cases are estimated to total \$20 million to \$30 million. The owner of the property where the crash occurred is pursuing his claim.

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Errors and omissions

• Agricultural Insurance Co. of Sioux Falls, S.D., will underwrite a new weather insurance policy marketed by Worldwide Weather Inc. of Great Neck, N.Y. Great American Insurance Co. of Cincinnati was incorrectly identified as the underwriter of the program in a June 19 Business Insurance story. And, the policy does contain some exclusions, including: fraudulent or dishonest acts committed alone or in collusion with others and weather changes caused by nuclear reaction, radiation, radioactive contamination, etc.

Mentor liquidators may move suit to Bermuda

By DOUGLAS McLEOD

NEW ORLEANS—Liquidators of Mentor Insurance Ltd. probably will move their massive fraud litigation against the insurer's parent, officers and others to a Bermuda court after an appellate court upheld a ruling throwing out their racketeering complaint filed in U.S. federal court.

A three-judge panel of the 5th U.S. Circuit Court of Appeals last month affirmed a lower court order dismissing the lawsuit on the grounds that a U.S. court is an inconvenient forum for the litigation.

The appeals court also concluded that the liquidators cannot block the suit's removal from a U.S. court simply by arguing that they would lose the opportunity to recover treble damages under the federal Racketeer Influenced and Corrupt Organizations law.

Mentor's liquidators have not been deprived of a legal remedy, the appellate judges ruled, noting that the liquidators may still bring fraud and other claims in a Bermuda court against Ocean Drilling & Exploration Co., Mentor's ultimate parent, and other defendants.

"We are disappointed at the outcome, but we are now in a position to bring an action in Bermuda against the same defendants," said Mentor liquidator Charles W. Kempe Jr., a partner with Arthur Young Charles Kempe & Co. in Bermuda.

Mr. Kempe and co-liquidator Michael J. Arnold of Arthur Young in London could ask for a review of

the appellate panel's ruling by the entire 5th Circuit court, or could petition for review by the U.S. Supreme Court.

While the liquidators are considering all of their options, though, further appeal of the dismissal "does not rank as one of the leading ones," Mr. Kempe said.

"By any standard, it's a significant result," observed Ronald A. Jacks, a partner with the Chicago law firm of Mayer, Brown & Platt, which represents ODECO.

In addition to removing the threat of \$1.5 billion in trebled damages under RICO, the ruling "reaffirms the correctness of the trial court's analysis of the public and private interest factors that are involved in deciding a motion to transfer" the case, Mr. Jacks said.

"It's not unexpected, and we are very pleased, and we are confident of our position," said Stephen Lawrence, a director with Pinnacle Reinsurance Co. Ltd., a defendant in the case that the liquidators accused of writing reinsurance contracts designed to conceal Mentor's true financial condition.

Sources familiar with the liquidation say the appellate ruling may add to the dissatisfaction among Mentor creditors with the performance of the insurer's liquidators. Several creditors—including ODECO itself—have criticized Mr. Kempe and Mr. Arnold for a lack of progress in recovering assets and for mounting legal fees and liquidation costs.

The liquidators survived a vote by creditors on a "lack of confidence" resolution at a general creditors' meeting.

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Georgia court says CGL policy covers cleanup

By STACY ADLER

ATLANTA—The pollution exclusion clause in comprehensive general liability policies does not bar coverage for a hazardous waste site cleanup, a state supreme court has ruled after examining the drafting history of the CGL form.

The Georgia Supreme Court on June 22 ruled 4-2 that the pollution exclusion clause, which bars coverage for all pollution incidents that are not "sudden and accidental," is ambiguous and, therefore, does not bar coverage for cleanups.

The Georgia court is the highest state court in the nation to rule on the pollution exclusion clause by looking at the drafting history of the CGL form, and as such, the court's decision could influence other courts, according to attorneys.

The decision stemmed from a dispute between Henry H. Clausen and Aetna Casualty & Surety Co. Mr. Clausen sought coverage for the cleanup of a 52-acre hazardous waste site in Jacksonville, Fla.

Mr. Clausen leased the right to use his property to the city of Jacksonville. Without Mr. Clausen's knowledge, the city used the property for disposal of all types of toxic chemicals and industrial

waste.

Under strict liability imposed by the Comprehensive Environmental Response, Compensation & Liability Act—better known as the Superfund act—Mr. Clausen must share in the cost of cleaning the site with the city of Jacksonville. Some 12 other corporations that also used the site to dispose of their wastes are contributing to the cleanup.

Some estimates put the cleanup cost at more than \$6 million. In a list ranking the 115 worst hazardous waste sites in the nation, the Jacksonville site ranked 26th, only two spots behind the infamous Love Canal site in Niagara Falls, N.Y.

Mr. Clausen sued Aetna for coverage of his portion of the massive cleanup. Aetna wrote general liability coverage for Mr. Clausen from 1967 through the early 1980s. Attorneys for Mr. Clausen and Aetna will not disclose the limits of the Aetna coverage.

In his suit, Mr. Clausen argued that the word "sudden" in the pollution exclusion clause means "unexpected," while Aetna argued that it means "abrupt."

The Georgia Supreme Court agreed with Mr. Clausen, ruling that the word "sudden" in the pol-

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New counts emerge in Howden trial

By STACY SHAPIRO

LONDON—Two of the three former Alexander Howden Group Ltd. executives currently on trial in a London criminal court are facing new charges.

Charges regarding the theft of funds from additional sources were brought against former Howden Director Jack Carpenter and former Lloyd's underwriter Ian R. Posgate late last month by Crown prosecutors. However, no new charges were brought against former Howden Chairman Kenneth V. Grob, who also is on trial.

The prosecutors allege that a group of former Howden executives participated in a "secret empire" that defrauded Howden and Lloyd's syndicates of millions of dollars between 1979 and 1982.

Specifically, prosecutors charge that money was diverted to phony offshore reinsurers and trusts controlled by the Howden executives. Some of the money was used to purchase shares in a Swiss bank, prosecutors add.

The former Howden officials implicated in the scheme are Messrs. Grob and Carpenter, former Howden Deputy Chairman

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Inside

✓ The Racketeer Influenced and Corrupt Organizations law needs reform, says this week's editorial. **PAGE 8**

✓ An insurance agents group will continue to fight the licensing of state-chartered banks to sell insurance in California despite a recent courtroom setback. **PAGE 10**

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Vol.23, No.27—Business Insurance (ISSN 0007-6864) is published weekly at 740 N. Rush St., Chicago, Ill. 60611-2590. Second-class postage is paid at Chicago, Ill., and at additional mailing offices. Postmaster: Send address changes to Business Insurance, Circulation Department, 965 E. Jefferson Ave., Detroit, Mich. 48207; 800-992-9970 or 313-446-1611. Copyright 1989 by Crain Communications Inc.

Outhwaite in court

By CAROLYN ALDRED

Fights asbestos facility claims

LONDON—Lloyd's of London underwriter Richard Outhwaite is asking a London High Court to rule that settlements by the now-defunct Asbestos Claims Facility are not recoverable under a runoff reinsurance policy Mr. Outhwaite wrote for a fellow Lloyd's underwriter.

Mr. Outhwaite filed his case after a Lloyd's syndicate filed suit, alleging that Mr. Outhwaite continues to refuse to pay claims against a runoff reinsurance policy he wrote, even though an arbitration panel last year ruled the policy is valid.

The arbitration panel ruled in November 1988 that syndicate 317/661, managed by R.H.M. Outhwaite (Underwriting Agencies) Ltd., could not void an unlimited runoff reinsurance contract with syndicate 179/884, managed by Anton Managing Agency Ltd., a subsidiary of Merrett Holdings P.L.C.

However, since the arbitration ruling, Mr. Outhwaite has paid only half of the claims

that syndicate 179/884 has presented to him, said underwriter Richard Lark in a lawsuit filed in London's High Court.

Mr. Lark is seeking a summary judgment that the Outhwaite syndicate is liable for all claims filed against the runoff reinsurance policy, said Mark Humphries, an assistant lawyer with the London law firm Linklaters & Paines and counsel to Mr. Lark.

But, an Outhwaite spokesman says that an arbitration panel ruling earlier this year in a dispute between Mr. Outhwaite and another syndicate over a runoff reinsurance policy raises the question of whether settlements made through the Asbestos Claims Facility are recoverable under the runoff policy.

As a result, Mr. Outhwaite has filed a counterclaim seeking a summary judgment that underlying claims paid through the Asbestos Claims Facility are not recoverable

under the runoff contract.

If the court rules on behalf of Mr. Outhwaite, the decision could have "a considerable impact" on other runoff reinsurance policies disputed by Mr. Outhwaite, said a lawyer representing another ceding syndicate.

Mr. Outhwaite and syndicate 179/884 plan to resolve their dispute through the High Court litigation despite recent initiatives by the Council of Lloyd's to encourage negotiated settlements between Mr. Outhwaite and many of the syndicates that purchased runoff reinsurance from the Outhwaite syndicate to cap liabilities from past underwriting years (*BI*, June 19).

Mr. Outhwaite wrote dozens of runoff reinsurance policies in the early 1980s for insurance companies and other Lloyd's syndicates providing excess-of-loss reinsurance, often

on an unlimited basis, for past underwriting years.

Mr. Outhwaite currently is disputing at least 10 runoff reinsurance contracts for which syndicate 317/661 has reserved a total of \$192.8 million. And, just last week he lost another arbitration (see update, page 22).

Mr. Outhwaite is asking syndicate members to pay 64.8 million pounds (\$100.1 million at current exchange rates) this year, the largest cash call in the history of Lloyd's (*BI*, June 5).

Several other disputes stemming from the Outhwaite runoff policies have been settled. But, so far, all settlements have been reached out of court or through arbitration on a confidential basis. Any court judgment interpreting the wording of the runoff policies, even if reached without a full trial, likely will affect subsequent settlements, one attorney noted.

However, each runoff policy is constructed and worded differently, lawyers note.

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Robins, Aetna court victories set precedents

By STACY ADLER

RICHMOND, Va.—A federal court's approval of A.H. Robins Co. Inc.'s novel reorganization plan could forever change the way manufacturers handle mass product liability claims, legal experts say.

The Robins' reorganization plan, which was approved June 16 by the 4th U.S. Circuit Court of Appeals, marks the first time a product liability insurer has been allowed to "piggyback" on its policyholder's bankruptcy filing to shield itself from liability, attorneys say.

And, the Robins' plan marks one of the first times a company in reorganization has set up a fixed-asset trust rather than an open-ended trust to pay all product liability claims brought against it, attorneys point out.

The Robins' reorganization plan calls for the creation of a trust fund valued at as much as \$2.6 billion to pay claims filed by women injured by the Dalkon Shield intrauterine device that Robins manufactured during the 1960s and early 1970s.

"This case will set a precedent for years to come," said Michael Sheppard, director of the Dalkon Shield Trust Fund.

"A lot of major corporations are looking closely at this case," he said.

"This is a very important decision," agreed John G. Harkins, an attorney for Aetna Casualty & Surety Co., Robins' product liability insurer.

Last month's approval of the reorganization plan paves the way for Robins to emerge from bankruptcy and fully fund the Dalkon Shield Trust Fund. Mounting product liability claims linked to use of the IUD forced Robins to file for protection under Chapter 11 of the U.S. Bankruptcy Act in 1985 (*BI*, Aug. 26, 1985).

The company took the Dalkon Shield off the market in mid-1974 but did not issue a product recall until September 1980.

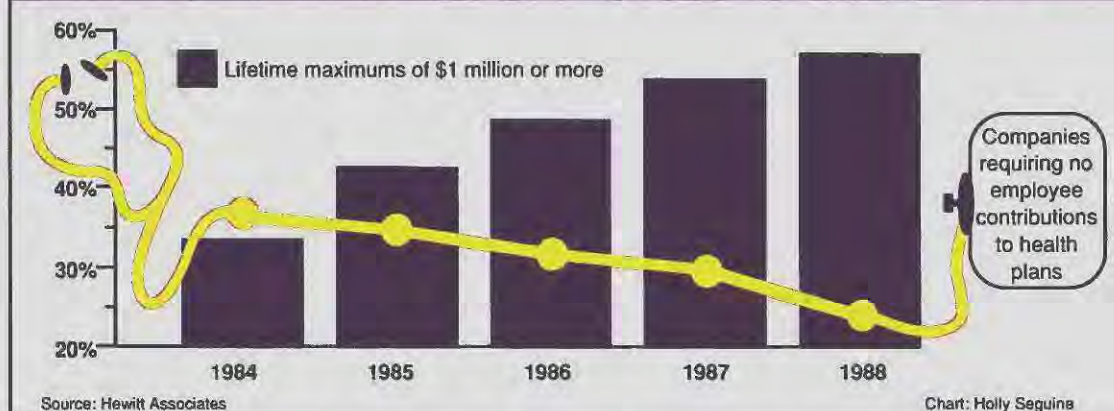
The bulk of the Dalkon Shield Trust Fund will come from American Home Products Corp., which agreed to acquire Robins last year (*BI*, March 21, 1988; Feb. 8, 1988). As part of the acquisition agreement, American Home has until Dec. 31 to withdraw its offer.

Barring an appeal, the acquisition could be completed by the end of this year, said John R. Stafford, chairman, president and chief executive officer of New York-based American Home Products.

According to the reorganization plan, the trust fund will have on deposit \$2.31 billion on the effective date of the reorganization

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More firms seek cost sharing while hiking plan limits



Hewitt study details benefit plan changes

By DONNA DIBLASE

As the battle against health care cost inflation rages on, employers are arming themselves with increased employee cost-sharing requirements and other types of health care cost containment programs, a new study shows.

However, employers also are shielding their employees from catastrophic health care costs by increasing lifetime maximum coverage and capping the annual out-of-pocket costs that employees must pay, the study reports.

In addition, more employers also are adding ancillary benefit plans—such as dental, vision and hearing plans—to their core health care benefit packages, the study reports.

And, flexible benefits plans and 401(k) salary reduction plans are enjoying continued popularity among major employers, the study shows.

These are among the employee benefit trends highlighted in "Salaried Employee Benefits Pro-

vided by Major U.S. Employers in 1984-88," a study of more than 200 employers conducted by Hewitt Associates of Lincolnshire, Ill.

Hewitt's study includes information on the benefit plans of 227 major U.S. employers during the years 1984 to 1988. Each year's data includes the same constant sample of 227 employers, the study report says.

While other benefit studies provide five or more years of comparable data, few studies survey precisely the same group of companies year after year.

In addition, while other studies examine health care plans, the Hewitt survey also includes information on defined benefit and defined contribution pension plans, group life insurance plans, long-term disability programs, and dental, vision and hearing care plans.

The study results include data on benefit plans offered by 72% of the Fortune 100 industrial companies and 53% of the Fortune 250 industrial companies

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TPAs win suit against Florida regs

By DONNA DIBLASE

TALLAHASSEE, Fla.—A national trade group representing third-party claims administrators is praising a federal magistrate's summary judgment that federal law pre-empts a Florida statute regulating administrators of self-insured employee benefit plans.

U.S. Magistrate William C. Sherrill Jr. of the U.S. District Court in Tallahassee ruled last month that the federal Employee Retirement Income Security Act of 1974 pre-empts a Florida law that regulates TPAs and sponsors of self-insured benefit plans.

The Santa Ana, Calif.-based Self-Insurance Institute of

America challenged the 1983 Florida law, which requires TPAs, among other things, to file financial, biographical and organization information; pay annual filing fees; and make annual security deposits to the Florida Insurance Department (*BI*, Jan. 25, 1988; June 30, 1986).

In addition, plan sponsors under the law must file plan documents and reports with the state Insurance Department and must agree to financial examinations by the department unless the sponsor can prove that ERISA exempts it from state regulation.

"We are now positioning ourselves to approach other states on the issue of ERISA pre-emption"

of regulations governing self-funded benefit plans and TPAs, said James Kinder, executive vp of the SIIA.

"The way that this case was decided should help us to prevail in proceedings in other states," he said. The SIIA has not yet filed complaints in the 21 other states that have TPA regulations.

While Magistrate Sherrill's June 2 summary judgment in the Florida case removes that state's authority over TPAs of self-funded benefit plans, officials of some TPAs say they believe that some TPA regulations or licensing requirements are not bad for the TPA industry.

And, the decision probably will not dramatically affect Florida

TPAs' daily operations, TPA officials say.

Meanwhile, the Florida Insurance Department is planning to appeal the decision, said R. Terry Butler, a senior attorney with the department.

The Florida statute, which went into effect Oct. 1, 1983, gave the Florida Insurance Department regulatory authority over both TPAs and sponsors of ERISA-regulated self-funded health and welfare plans.

The statute, which remains in effect pending appeals, specifically requires administrators of self-funded ERISA plans to:

- Obtain a certificate of authority from the department, plus

file extensive organizational information with the department.

- File an annual statement of financial condition, transactions and affairs, plus pay an annual filing fee of \$60.

- Deposit with the department a \$50,000 security deposit in its first full year of operation. In subsequent years, TPAs are required to deposit an amount equal to at least 10% of the amount of funds handled or managed annually by the TPA, up to \$500,000. TPAs can file a fidelity bond to meet the requirement.

- Draw up and comply with written agreements with self-funded employer clients. The

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Howden trial

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Ronald Comery and former Director Allan Page. And, prosecutors allege that Mr. Posgate, who was chairman of Howden's Lloyd's underwriting agency, profited from the "secret empire" (BI, May 3).

Mr. Comery died in 1987, and Mr. Page was declared too ill to stand trial.

On June 21, prosecutors filed a new charge against Mr. Carpenter, saying he conspired with Messrs. Grob, Comery and Page "to steal sums of money" that belonged to Howden affiliates and Lloyd's members.

In addition, Messrs. Carpenter and Posgate face a new charge of conspiring with Messrs. Grob, Comery and Page to steal "sums of money" belonging to Mr. Posgate's syndicates and to Alexander Howden Insurance Brokers Ltd., "namely premiums payable in respect of quota-share (reinsurance)

of the said syndicates, for the purpose of providing funds for the purchase of the Banque du Rhone et de la Tamise S.A."

Mr. Carpenter was charged at the beginning of the trial with conspiring with Messrs. Grob, Comery and Page to defraud Howden, its affiliates and Lloyd's members by dishonestly transferring sums of money belonging to Howden and the Lloyd's syndicates to offshore companies controlled by the four men. In addition, Messrs. Carpenter and Posgate were charged with conspiring with Messrs. Grob and Comery to defraud the members of Mr. Posgate's syndicates 126-129 and syndicate 700/701.

No new charges were filed against Mr. Grob, though he still faces 16 counts of theft, four counts of receipt of stolen goods, four counts of false accounting and three counts of issuing false statements.

Defense attorneys are expected to begin their cases this week after

nine weeks of prosecution testimony. The trial is expected to last until early August.

Among the witnesses testifying for the prosecution was Tony Shearer, a former accountant of Deloitte, Haskins & Sells who is credited with uncovering the How-

den scandal.

Mr. Shearer also testified that he had traced Howden and Lloyd's syndicate money to secret offshore companies. The money was then used to buy, among other things, art work belonging to Mr. Posgate

Tony Shearer, a former accountant of Deloitte, Haskins & Sells who is credited with uncovering the Howden scandal, testified that he had traced Howden and Lloyd's syndicate money to secret offshore companies.

and the Banque du Rhone, he said.

Another witness, Andrew Phillip Richards, an attorney with the law firm of Freshfields, testified that A&A concluded that SIR alone owed it 33 million pounds (\$51 million) and that a total of 51 million pounds (\$74.2 million) was

missing from Howden underwriting companies.

In addition, prosecutors last week called as an expert witness Lloyd's underwriter Stephen Merrett, chairman of Merrett Holdings P.L.C. and a Lloyd's Council member, who explained terminology and practices used at Lloyd's during his two days of testimony.

Mr. Merrett noted that between 1979 and 1982—before the Lloyd's Act of 1982 went into effect—there were no regulations regarding reinsurance programs for Lloyd's syndicates, though letters from the Committee of Lloyd's and the Lloyd's chairman spelled out market rules.

Quota-share reinsurance is used commonly at Lloyd's to cede syndicate business, Mr. Merrett testified. However, when asked to look at Mr. Posgate's syndicates' quota-share reinsurance contracts with SIR between 1978 to 1980, Mr. Merrett said that "these are very large portions (of Mr. Posgate's syndicates) to be quota-shared."

One of the policies, which placed 51% of Mr. Posgate's incidental non-marine syndicate's quota-share reinsurance with SIR, represented "a very large proportion indeed of an account to be quota-shared, and I would assume there were special circumstances," said Mr. Merrett. He added that if SIR was, as Mr. Posgate has alleged, a new reinsurer, the large amounts of reinsurance placed with SIR "is quite extraordinary."

"It is quite an extraordinary amount of business for a profitable syndicate to be unselectively reinsuring," Mr. Merrett stated.

However, he added that "Mr. Posgate was widely regarded as being an extremely shrewd underwriter whose business was considered to be extremely profitable."

BI appoints new staffers in editorial

Jeanne M. Bartels, 28, has joined the Chicago bureau of *Business Insurance* as the graphics editor, announced Associate Publisher and Editor Kathryn J. McIntyre.

In addition, Adrienne C. Locke, 25, has joined BI's Washington, D.C., bureau as an associate editor, Ms. McIntyre added.

Before joining BI, Ms. Bartels was an assistant graphics editor at Advertising Age, a sister publication of BI. Both are owned by Chicago-based Crain Communications Inc.

Ms. Bartels received her bachelor of fine arts degree in advertising design and illustration from Northern Arizona University in Flagstaff, Ariz., in 1982.

Before joining BI, Ms. Locke was an assistant editor at Czeschin's Mutual Fund Outlook & Recommendations, a Baltimore-based financial newsletter. She also has researched financial books and reports.

Ms. Locke received her bachelor of arts degree in literature from Southampton Center of Long Island University in Southampton, N.Y., in 1985.

Ms. Bartels can be reached at 312-649-5412, while Ms. Locke can be reached at 202-662-7244.



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*American Psychiatric Association **"Health Benefits Survey: 1988," A. Foster Higgins & Co. Inc.
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FAA opens Chicago-area daycare facility

By MICHAEL SCHACHNER

A group of federal employees in the Chicago metropolitan area has persuaded the Federal Aviation Administration to rent an office site to set up a child care facility for nearby workers.

The daycare center at the O'Hare Lake Office Plaza, which occupies 5,000 square feet and can accommodate 80 children, opened May 22.

Because the government rents the site, which is near O'Hare International Airport, the independent contractor that manages the center is able to charge federal employees below-market rates for care, according to an FAA spokeswoman.

The FAA leases the premises from Hiffman Shafer Anderson

Inc. and allocates the site at no cost to the center's administrator, Parkside Childrens Services—part of the Lutheran General Hospital Assn.

Fees for the facility, which cares for children between the ages of 6 months and 6 years, are \$93 per week for children under 1 year; \$89 for children age 1 year to 18 months; and \$78 for children up to preschool age, said the spokeswoman.

In addition to caring primarily for children of about 500 FAA employees, the facility also is available to the children of employees of 24 other nearby government agency offices.

Benefit beat

The spokeswoman said the FAA employees formed an action group to pressure the government into leasing the building and to solicit bids from child care contractors. She said the group chose Parkside from among 19 bidders.

Securing the rent subsidization was vital because "it is impossible for a provider to come in and lease a space like this, charge the rates they're charging and make a profit," the group's spokeswoman added.

The O'Hare Lake site is the sixth such center nationwide and the second in the Chicago area to open in privately owned buildings with federal tenants.

Genentech day care

Genentech Inc. has opened one of the largest employer-sponsored preschool child care facilities in the nation about a mile from its South San Francisco, Calif., headquarters.

The pharmaceutical manufacturer's 13-classroom, 19,500-square-foot facility, which can accommodate up to 258 children, currently cares for about 100 children between the ages of 6 weeks and 6 years, said Linda Fitzpatrick, Genentech's human resources director.

The facility was deemed necessary because Genentech's 1,800 employees—who average 34 years of age—are currently having children at a rate of three per week, she explained.

Genentech's program is designed to provide more than just custodial care, Ms. Fitzpatrick pointed out. The center employs counselors with either bachelor's degrees or master's degrees in early childhood education that are qualified to offer "learning components that produce self-esteeming kids," she said.

"So far the kids love it."

The current counselor-to-child ratio is 1-to-3 for children under the age of 1; 1-to-6 for children between the ages of 1 and 3; and 1-to-8 for children over the age of 3.

Genentech employees earning more than \$25,000 annually pay \$390 per month for children between 2 and 6 years of age and \$490 for children under 2 years of age.

The company subsidizes child care expenses for employees earning less than \$25,000 per year, lowering employee contributions to \$195 for children ages 2 to 6 and \$295 for children under 2, Ms. Fitzpatrick said.

The average Genentech employee earns about \$40,000 per year, she added.

In contrast, a comparable child care program in the San Francisco Bay area would cost at least 20% more than the amount employees are paying at Genentech, Ms. Fitzpatrick pointed out.

Although the program is only six months old, savings in the form of shortened maternity leaves, lower turnover rates and increased productivity due to improved morale are already noticeable, Ms. Fitzpatrick said.

However, exact figures are not yet available.

The facility costs Genentech approximately \$500,000 to \$750,000 to operate annually, she estimated.

Cost sharing

Limiting employee contributions to health care plans is among the most important benefit issues for unionized workers, according to a recent poll of union representatives.

Meanwhile, executives of large corporations with highly unionized workforces responded that they consider employee cost sharing to be among the most important benefit issues.

The survey, commissioned by the Managed Care Services Group of New York-based Metropolitan Life Insurance Co., was conducted in April and May and consisted of 100 telephone interviews with 50 union leaders and 50 corporate executives of companies with large unionized workforces.

The survey found that 50% of the labor leaders chose limiting employee cost sharing for health benefits as one of their negotiating priorities for 1989.

In addition, 46% said wage increases were among their top concerns, and 44% cited job security as a priority.

Twenty percent of labor respondents said increasing health benefits was of prime concern during contract negotiations.

On the other hand, employee cost sharing was cited by 38% of the corporate management respondents as among their top negotiating priorities.

Job security also was cited as a negotiating priority by 38% of the respondents in management, and wage increases were cited as a negotiating priority by 32% of the management respondents to the survey.

Both groups ranked health care and benefits as the top labor-related issues for the upcoming decade.

Continued on next page

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Continued from previous page

Among the labor leaders, 34% chose health care benefits as their focus, while 22% said retirement and pension benefits were of paramount concern.

Rising health care costs and cost containment were among the top agenda items for the 1990s for 16% of the labor respondents to the survey.

Management, however, said the rising cost of health care is its main problem.

Twenty-two percent chose containing health care costs as among their top issues, while 14% cited overall health care benefits as their biggest concern.

Eighty-eight percent of the labor officials surveyed said health care benefits are now "more important" than they were five years ago, and 76% said they are "much more important."

Meanwhile, 74% of management labeled health care benefits as "more important" than they were five years ago, while 40% thought benefits today are "much more important."

The poll also addressed managed care programs and labor and management's level of satisfaction with health maintenance organizations and preferred provider organizations.

Of those union leaders whose members took part in some form of managed care program, increased health maintenance organization costs and poor quality of HMO physicians, along with inadequate communication and education about PPOs, were the most frequent complaints.

However, when asked to evaluate the overall quality of care administered by managed care programs compared with traditional fee-for-service plans, 46% of the labor leaders and 63% of the corporate executives said it was "about the same."

Twenty-eight percent of each group said managed care programs offered better care, while 13% of the labor officials and only 5% of the management executives preferred traditional indemnity plans.

Regarding methods to control health care benefit costs, 34% of the labor officials said denying coverage for dependents of union members employed elsewhere would be the best way to trim costs.

Four percent of the management officials subscribed to this point of view.

Increasing members' out-of-pocket payments or premium cost sharing was supported by only 18% of labor respondents. But 70% of management responded that they support the move.

Reducing coverage for expensive treatment areas like mental health and substance abuse was supported by 18% of labor and 16% of management respondents, while reducing benefits paid to retirees was considered the best way to cut costs by 2% of labor and 6% of management respondents.

Other key findings included:

- Sixty-two percent of union leaders said long-term care benefits were "important" and 12% of the labor respondents labeled long-term care coverage a "top priority."

However, 84% of management respondents said it was unlikely they would implement an employer-paid LTC plan within the next two years.

- Eighty-four percent of union respondents felt the government should enact legislation requiring employers to offer at least some company-paid health care coverage to all employees. Fifty-two percent of the management respondents agreed.

For a copy of "The Health Poll, Summer 1989," write Stephanie Valeiko, Managed Care Services Group, Metropolitan Life Insurance Co., 276 Post Road W., Westport, Conn. 06880. ■

At issue

Should insolvent HMOs be rehabilitated by state insurance departments?



Karen A. Sutherland
assistant vp-
payroll/benefits
Amerisure
Cos.,
Detroit

I don't see a need for the state to get involved; it would cost taxpayers and members more money than if the HMO went through the normal bankruptcy procedures. And I don't think it would hurt the members because they can fall back on the traditional health plan offered by the employer or join another HMO.



Charles J. Mazza
vp-human
resources
Mead Corp.,
Dayton, Ohio

No. If an HMO goes belly-up, there is either something wrong with the HMO's structure, or it doesn't offer a competitive product or maybe it practiced bad underwriting. But, there shouldn't be any subsidies, real or implied, that give HMOs a competitive advantage. They ought to compete on a level playing field with other health care providers.



Hank D'Ambrosio
director-corporate
benefits/
services
Bell & Howell
Co.,
Skokie, Ill.

No. We need to run HMOs like a business and that has been one of the problems up to now. We should not throw money at the HMOs indiscriminately. They have an obligation to their customers, and we need to find a way to ensure that the people who need coverage aren't left holding the bag.



William Watson
director
-benefits
Illinois Bell
Telephone Co.
Chicago

No. I see no compelling social or financial need to do so. HMOs are not providing a cost-effective alternative to our indemnity plan (which has a PPO option). The state's responsibility should be limited to providing an orderly transfer of membership.

Compiled by Christine Woolsey

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Opinions

RICO must be reformed

THE U.S. SUPREME COURT'S rulings last week on the application of RICO and punitive damages should stir the business community to press for congressional reform of RICO and limits on punitive damages.

The Supreme Court clearly is not going to hand down any decision that would shield legitimate businesses from suits alleging violations of the federal Racketeer Influenced and Corrupt Organizations law and the threat of triple damages and attorneys' fees.

And although there is hope for the court to limit punitive damages in another case under another legal theory, businesses should not pin all of their efforts at punitive damage reform on the Supreme Court. Businesses should continue to press for state statutes limiting non-economic damage awards, since any such federal product liability reform legislation is undeniably doomed to failure.

Regarding RICO reform, the court said: "RICO may be a poorly drafted statute; but rewriting it is a job for Congress, if it is so inclined, and not for this Court."

Clearly the law needs amending. It is so hopelessly vague that it has "produced the widest and most persistent circuit split on an issue of federal law in recent memory," according to the concurring opinion of four justices. Tying up the courts to interpret a badly written law is not efficient use of our judicial system.

And, RICO's provision for the automatic recovery of triple damages and attorneys' fees has created an incentive for plaintiffs to cite RICO in common fraud cases, resulting in abuse of the statute that was aimed at organized crime—not at legitimate businesses that are accused of fraudulent activities.

The solution lies in the RICO Reform Act of 1989, pending in both houses, which, among other things, would restrict recovery to only actual damages in cases brought by non-governmental plaintiffs and non-consumer plaintiffs. The RICO Reform Act is supported by a broad coalition that ranges from the American Civil Liberties Union to the National Assn. of Manufacturers.

The National Assn. of Insurance Commissioners stands along with certain consumer advocacy groups in opposing RICO reform as currently pending in Congress.

The NAIC says RICO reform would deny insurance regulators an effective weapon against insurance fraud.

We certainly want to see regulators deter and punish insurance fraud, but insurance commissioners have yet to do so effectively by bringing suits alleging violations of RICO when insurance companies go bust. Earlier this month, for example, the liquidators of Mentor Insurance Ltd. lost their effort to pursue a RICO count in federal court (see



story, page 2).

Several other cases involving failed insurance companies and alleging violations of RICO are pending, but we disagree with the NAIC that the mere existence of these cases should preclude the proposed RICO reforms. The RICO Reform Act permits plaintiffs in pending civil RICO actions to still recover triple damages at the discretion of the presiding judge. And, even if triple damages aren't awarded in these cases, the plaintiffs can recover the costs of the litigation, if they win their cases.

Insurance commissioners also maintain that they need the threat of triple damages to deter fraud. We disagree. After strict enforcement of licensing laws, the best deterrent to insurance fraud is an insurance market charging reasonable prices so that insurance buyers are not driven by desperation into the clutches of con artists. Furthermore, most insurance fraud is perpetrated by people whose assets would fail to cover actual damages, let alone triple damages if they were awarded.

Certainly we want to see liquidators of bankrupt insurance companies recover as much as possible to pay obligations to policyholders, but not at the expense of permitting them to misuse RICO to induce settlements of cases that may not be won on their merits.

Without evidence that RICO is an effective weapon against insurance fraud and has so far been used properly by insurance regulators, we cannot rally to their cause to include the right of insurance commissioners to bring RICO actions in their role as insurance company liquidators.

It's important to remember that without RICO as a weapon, insurance company liquidators still will be able to press common commercial fraud charges and refer cases for criminal prosecution.

Letters

NCCI does not set rates for Michigan residual market

To the editor: I read with interest the article titled, "NCCI Seeks to Cut Residual Market Losses" (BI, May 22). I felt com-

pelled to write to you to clear up some misconceptions regarding Michigan's residual workers compensation market.

Michigan was cited as one of 12 states where the NCCI is allowed to impose surcharges on the residual market. This is incorrect as the residual market rates for Michigan are developed by the Compensation Advisory Organization of Michigan and filed by it on behalf of the Michigan Workers Compensation Placement Facility. The rates are developed based on a weighting process that uses a 10% weight for residual market experience and a 90% weight for voluntary market experience.

The surcharges provided by Michigan law require that an additional rating plan be provided to cover policyholders who have a demonstrated accident frequency problem, who have a measurably adverse loss ratio over a period of years or who have demonstrated an attitude of non-compliance with safety requirements. Only those employers that meet these statutory tests feel the sting of an imposed surcharge.

Eric D. Nordman
Director, Property & Liability Section
Michigan Department of Licensing
and Regulation
Lansing, Mich.

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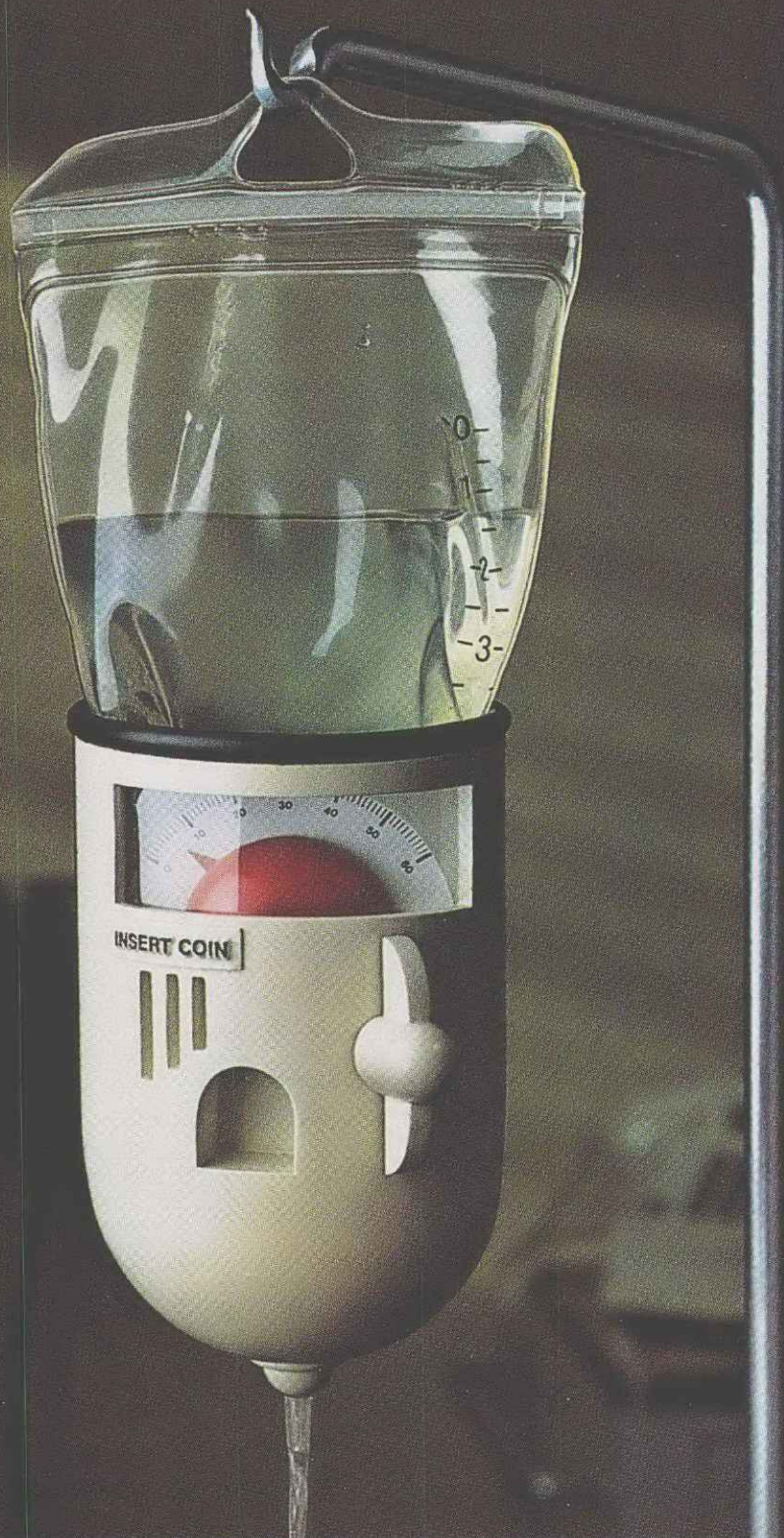
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Striking the right balance between managing costs and maintaining high quality health care. It's one more example of CIGNA's commitment to personalized service to business.



Georgia ruling

Continued from page 2

lution exclusion clause "does not usually describe the duration of an event, but rather its unexpectedness."

In reaching its decision, the court relied, in part, on statements made by the insurance industry in 1970 when the pollution exclusion clause was adopted.

"The interpretation of the policy advanced by Claussen is not contrary to the interpretation Aetna gave the clause when it was adopted," said Presiding Justice Harold G. Clarke, who wrote the majority opinion.

"Documents presented by the Insurance Rating Board to the Insurance Commissioner (of Georgia) when the pollution exclusion was first adopted suggest that the clause was intended to exclude only intentional polluters," said Justice Clarke.

A June 10, 1970, letter from the

Insurance Rating Board, the predecessor to the Insurance Services Office, to the Georgia Insurance Department states: "The impact of the proposals on the vast majority of risks would be no change. It is rather a situation of clarification."

Justices Richard Bell and Willis B. Hunt Jr. dissented from the majority opinion, saying: "While 'sudden' may have a number of meanings and, over the years, may have been used in a number of contexts, in this context it clearly means abrupt and unexpected. Certainly, its use within this context does not encompass the gradual dumping of toxic wastes over a period of several years."

Attorneys say the Georgia Supreme Court decision, since it relies on the drafting history of the pollution exclusion clause, could be very influential to other courts hearing pollution coverage litigation.

Previously, only intermediate state courts in Ohio, New York and

Illinois have ruled similarly after looking at the pollution exclusion clause's drafting history.

The most recent of these cases involved a dispute between Specialty Coatings Co. and Specialty Chemical Co. of Elk Grove, Ill., and United States Fidelity & Guaranty Co. of Baltimore. This case was heard by the Illinois 1st District Court of Appeals on March 7 (BI, March 20).

The Georgia Supreme Court decision could help other policyholders litigating with their insurers, said Mr. Claussen's attorney, Hale Barrett of Hull, Towill, Norman & Barrett in Augusta, Ga.

Policyholder attorney William Hart agreed: "It is almost a certainty" that other courts will be influenced by this decision.

"This is the best presented case thus far to be decided on this issue," said Mr. Hart, who is with Anderson Kill Olick & Oshinsky in New York.

The decision will be especially useful to policyholders litigating in Georgia because this decision creates law in Georgia, Mr. Hart explained.

The dispute between Mr. Claussen and Aetna was originally heard

by the U.S. District Court for the Southern District of Georgia.

The federal court found that Mr. Claussen's claim was barred by the pollution exclusion clause because the environmental damage at the Jacksonville site took place over several years and therefore, was

'This is the best presented case thus far to be decided on this issue,' says Mr. Hart.

not sudden.

Mr. Claussen asked the district court to look at the drafting history documents and reconsider its decision.

After looking at the drafting history documents, the federal court said: "The statements made by the Insurance Rating Board to the Georgia Insurance Department, if not fraudulent, certainly were not straightforward."

However, the judge let his prior decision stand on the theory that

Aetna was now correctly defining the intent of the pollution exclusion clause.

Mr. Claussen appealed the decision to the 11th Circuit Court of Appeals in Atlanta on Dec. 30, 1987. The 11th Circuit certified the case to the Supreme Court of Georgia on Feb. 16, 1989, to rule on the pollution exclusion.

Aetna says it will ask the state Supreme Court to reconsider its decision.

If the Georgia court stands behind its decision, it will send the decision to the 11th Circuit. In cases in which a federal court certifies a question to a state court, the findings are almost always adopted by the federal court.

Aetna attorney James Eichelberger of Neely & Player in Atlanta said the insurer's options at that point would be limited, though the insurer could ask the U.S. Supreme Court to review the case.

"But the Supreme Court has traditionally rejected these appeals, saying they are state matters," explained Mr. Eichelberger.

Claussen vs. Aetna Casualty & Surety Co., et al.; The Supreme Court of Georgia, No. 46749.

Agent group to appeal California bank ruling

By GLENN HUNTLEY

SAN FRANCISCO—A group representing insurance agents and brokers will continue to fight the licensing of state-chartered banks to sell insurance in California despite a recent courtroom setback.

Superior Court Judge James T. Ford ruled last month that state insurance and banking regulators had properly interpreted Proposition 103 as overturning state statutes prohibiting banks from selling insurance.

The decision came in a case brought by a coalition of agent and broker groups led by the Independent Insurance Agents & Brokers of California.

IIABC directors voted last week to appeal the decision. A notice of appeal is expected to be filed soon with the California Court of Appeals, a spokesman said.

"We still believe (combining) banks and insurance is wrong," the IIABC spokesman said.

The coalition, called the California Alliance for the Separation of Banking & Insurance, was formed following the passage of Proposition 103 in November. The voter-approved initiative deleted portions of the state insurance code prohibiting state-chartered banks from selling insurance, but failed to remove parts of the financial code dealing with the same subject.

The agents and brokers alliance contends that the remaining sections of the financial codes prohibit the state from issuing insurance licenses to banks.

According to the lawsuit, state Banking Superintendent Howard Gould erred in January when he issued an opinion stating that Proposition 103 deleted the financial code sections by implication. Insurance Commissioner Roxani Gillespie subsequently relied on the banking regulator's statement in deciding to proceed with licensing of banks to sell insurance.

"The clear intent of the electorate in passing Proposition 103 was to allow banks to engage in the business of selling all types of insurance," Mr. Gould stated in his January opinion.

Proposition 103 is "totally inconsistent" with the insurance provisions of the financial code and thus was intended to supersede the provisions, Mr. Gould wrote.

The agents and brokers alliance contends Mr. Gould and Ms. Gillespie erred by failing to follow public notice and hearing procedures in determining how Proposition 103 should be applied. The group asked the court to find their determinations invalid.

However, Judge Ford found the state regulators had acted within their authority and denied the agents group's request for an in-

junction preventing banks from commencing insurance sales and halting issuance of any further licenses.

The Insurance Department already has approved licenses for First Interstate Bank in Los Angeles and Security Pacific Bank in Los Angeles. Other license applications are pending.

The agents and brokers group also argued that insurance sales by banks would be unfair competition and cause "immediate and irreparable harm" to its members.

"If allowed to enter the insurance business, banking organizations could draw upon vast financial resources to market insurance. Banks have the advantage of point-of-sales contact with their customers at times when the customers are most vulnerable (e.g., when they apply for home, automobile or commercial financing)," the lawsuit states.

The Superior Court decision could set a precedent that grants California judges broad latitude in determining the intent of voters when they approve initiatives such as Proposition 103, the IIABC spokesman said.

Because the case could have wide application to legal challenges to any other initiatives, the alliance stands a good chance to prevail on appeal, he added.

Other members of the alliance include the California Assn. of Life Underwriters and the Professional Insurance Agents Assn. of California & Nevada.

Officials of the other associations have not indicated if they will join the appeal, the IIABC spokesman said. However, if they decline to participate, the IIABC will pursue the case on its own, he said.

One of the challenged financial code provisions, Section 1208, allows commercial banks located in places with populations of fewer than 5,000 to sell insurance if the banks had been licensed prior to Oct. 1, 1949. The section is interpreted to prohibit banks from acting as insurance agents except under its restrictive conditions.

The other provision, Section 772(b), prohibits corporations in which a state-chartered bank has invested from selling or underwriting insurance.

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Texaco captive results linked to Piper Alpha

By ROGER SCOTTON

HAMILTON, Bermuda—The Piper Alpha disaster has taken its toll on Heddington Insurance Ltd., the Bermuda-based insurance subsidiary of Texaco Inc.

Texaco Britain Ltd., a unit of White Plains, N.Y.-based Texaco Inc., had a 23.5% ownership stake in the North Sea platform, which exploded a year ago (*BI*, July 11, 1988).

For the year ended Dec. 31, 1988, the company reported an underwriting loss of \$17.2 million, which includes a provision of \$153.1 million for losses and loss expenses.

The result comes after a \$26 million underwriting profit in 1987.

"The company's loss and expense ratio deteriorated to 111.5% from 74.9% in 1987, which is attributable almost entirely to the Piper Alpha platform disaster," wrote Robert Golden, Heddington's president and chief executive officer, in the company's 1988 annual report.

"The potential total cost has been estimated at \$1.4 billion. The unfortunate nature and magnitude of this disaster highlights the importance the company plays in aiding its ultimate shareholder in managing risk. Heddington and its reinsurers have responded quickly to the adjustment and payment of all claims associated with this disaster. The company has paid the majority of its total obligations, and all remaining potential liabilities have been fully reserved."

Premiums written by Heddington last year increased 18% to \$209.2 million from \$176.6 million, while net premiums earned increased 44% to \$150.2 million. Total underwriting expenses more than doubled to \$167.4 million while investment income gained 16% to reach \$75.5 million.

The insurer's 50% stake in affiliate Heddington Brokers Ltd., a joint venture with Willis Faber P.L.C., brought in another \$5.1 million, which yielded total profits for the year at \$60.8 million—down from the \$93.7 million net income in 1987.

Despite the sharply lower profits, Heddington Insurance paid a dividend of \$34 million—an increase of \$22 million over the 1987 payment—to its immediate parent, Texaco Panama Inc.

The 19-year-old property/casualty insurer, which provides coverage for its parent and affiliates and maintains a non-related book of reinsurance business, increased capital and surplus 4% to \$696.3 million from \$669.4 million.

Total assets were \$1.18 billion in 1988, up 4% from \$1.13 billion in 1987 and the company's reserve for outstanding losses and loss expenses rose 6% to \$478.6 million from \$450.7 million.

Mr. Golden notes in the report that Heddington continued to restructure its insurance and reinsurance portfolio during the year and that "placements that did not provide an adequate rate of return were not renewed and joint venture placements were negotiated."

Pinnacle results

Financial reinsurer Pinnacle Reinsurance Co. Ltd. reported a 1988 underwriting profit of just more than \$11 million, up 4% from its \$10.6 million profit in 1987, and officials plan to open a contact office in London by August.

Bermuda-based Pinnacle's results, released by Chairman Bruce Swann, show that for the year ended Dec. 31, 1988, the subsidiary of Lloyd's of London broker C.E. Heath P.L.C. increased gross premiums by what Mr. Swann describes as a "robust 35%."

Bermuda

Those premiums grew to \$129.5 million from \$95.7 million, while premiums net of reinsurance increased to \$96.9 million, up from \$95 million.

Some of the company's results were unchanged from 1987. Pinnacle reported investment income of \$4.2 million, general and administrative expenses of \$3.7 million, and net income of \$11.6 million and a dividend of \$10 million.

Writing in Pinnacle's annual report, Mr. Swann makes only a passing reference to the 3-year-old litigation naming Pinnacle brought in federal court in New Orleans by the liquidators of Mentor Insurance Ltd.

A three-judge panel of the 5th U.S. Circuit Court of Appeals last month affirmed a lower court order dismissing the lawsuit on the grounds that a U.S. court is an inconvenient forum for the litigation (see story, page 2). However, the liquidators can file a similar suit in Bermuda courts.

Mr. Swann notes: "The company's expense ratio has again improved in spite of the fact that we consider it prudent to continue to provide against future legal costs."

Pinnacle has set aside \$2 million as "necessary and sufficient" to help the company defend itself against the Mentor action, which sopoght \$700 million from 11 de-

fendants including Mentor parent Ocean Drilling & Exploration Co. of New Orleans. Mr. Swann said that the \$2 million provision, which was included for the first time in the 1986 accounts, is "still intact," though a note to the 1988 report makes clear Pinnacle's view that the possibility of material loss from the suit is "remote."

The report says Pinnacle's proposed new broker contact office in London will help keep the company in the forefront of its principal market and bring it closer to other sources of business in continental Europe.

"We believe the new rep office will help us get a greater showing of business from the London broker market," Mr. Swann said, adding that up to 80% of Pinnacle's business comes from the United

Kingdom's capital.

New Gallagher unit

Arthur J. Gallagher & Co. has formed a new operating subsidiary in Bermuda.

The Rolling Meadows, Ill.-based broker's newly formed unit, Arthur J. Gallagher Intermediaries (Bermuda) Ltd., was established primarily to access the island's markets for excess-of-loss reinsurance.

"It was time to set up a separate specialist broking operation that could access the Bermuda market, including excess insurers, the rent-a-captive reinsurance programs and some of the financial reinsurance companies," said Managing Director David McManus, who oversees other Gallagher operations in Bermuda.

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Hewitt study

Continued from page 3

panies. Also included are 30% of the Fortune 50 commercial banking companies and 42% of the Fortune 50 life insurance companies.

All 227 of the employers surveyed over the five-year period provide medical coverage to their salaried employees, but an increasing percentage of employers are demanding cost sharing by employees under their medical plans, the study reports.

"If you look at the whole five-year period of the study, there is a big swing in the cost-sharing increases. But, the increases in any one year are not that significant," pointed out Perry Brandorff, a consultant in Hewitt's Dallas office.

"The position most employers are in now is that they will make changes in employee cost-sharing that somehow tie into (increases) in inflation. But, there is no real formula" to increasing employees' cost-sharing requirements, he explained.

Individual annual health care plan deductibles increased dramatically among the surveyed employers during the five years of the study.

For example, in 1984, 52% of the employers required individual annual deductibles of \$100 or less,

while 14% required deductibles of \$150; 9% required a \$200 deductible; 1% required deductibles of \$250; another 1% required deductibles of more than \$250; and 7% required deductibles that were based on pay.

Twelve percent reported that deductibles depended on the plan se-

lected by the employee, and 4% said they required deductibles based on other criteria.

However, by 1988, only 29% of the employers required individual annual deductibles of \$100 or less, while 14% required deductibles of \$200; 11% required \$150; 10% required deductibles based on pay; 3% required \$250; and only 1% required deductibles of more than \$250. Twenty-nine percent said individual annual deductibles depended on the plan selected by the employee, and 3% said deductibles were based on other criteria.

Also, the percentage of employers requiring front-end deductibles which require a front-end deductible, only 23% of the employers did not offer plans that included some sort of front-end deductibles in 1988, down from 44% in 1984.

In addition to these changes, the percentage of employers providing 100% reimbursement of hospital room and board charges declined significantly to 29% in 1988 from 53% in 1984.

The percentage of employers providing 100% reimbursement of surgical charges also declined during the study period, with 12% offering full surgical coverage in 1988, compared with 23% in 1984.

The majority of employers—51%—reimbursed employees for only 80% of surgical charges in 1988, compared with 44% of employers in 1984.

The survey also reported an increased use of employee premium contributions among the employers over the five years of the study.

The percentage of plans requiring employee premium contributions for employee-only coverage increased to 47% in 1988, up from 44% in 1984. The percentage of employers requiring employee contributions for dependent coverage increased to 60% from 54% in 1984.

But, along with increasing employee cost sharing to control their health care costs, employers also are taking steps to limit catastrophic health care expenses for their employees, the study shows.

For example, the prevalence of the use of stop-loss features in the coinsurance provisions of benefit plans—which cap the annual out-of-pocket amount that an employee spends on health care services—increased to 91% of the employers in 1988, up from 88% in 1984.

Some 39% of the employers reported a stop-loss cap of \$1,000 per employee or less in 1988, down from 55% of the employers in 1984. Another 15% reported stop-loss amounts exceeding \$1,000, a decrease from 19% in 1984.

The rest of the employers reported stop-loss caps were based on salary or varied according to

the plan selected by the employee.

In addition, employers are increasing the maximum amount a plan will pay over an employee's lifetime.

Fifty-six percent of the plans in 1988 included in the study paid a lifetime maximum of \$1 million or more, up from only 33% of the employers in 1984.

And, the percentage of employers offering lifetime limits of less than \$500,000 decreased significantly, to 10% in 1988 from 31% in 1984.

"Because medical inflation is driving up health care costs, there is a natural trend by employers to build up the lifetime maximum amounts. And, the increase of the limits from \$500,000 to \$1 million is a minor, small cost item for the employer," Mr. Brandorff explained.

Increasing lifetime maximum limits protects employees from catastrophic health care expenses—as opposed to frequent, minor costs—"which is what insurance is supposed to do," he added.

The use of health care cost containment programs, like incentives for employees to obtain second surgical opinions and use outpatient surgical services, increased dramatically among the employers in the five years of the study.

For instance, 63% of the employers in 1988 required employees to obtain a second surgical opinion for certain surgeries or face reduced coverage for surgical expenses, up from only 27% of the employers in 1984.

And, only 29% of the surveyed employers in 1988 provided the same level of surgical coverage whether or not a second opinion was obtained, down from 62% in 1984.

Moreover, 72% of the employers in 1988 said they provided more

dental plans in 1988 required employee premium contributions, up from 54% of those offering dental plans in 1984.

Vision plans were provided by 54% of the employers in 1988, up from 26% of the employers in 1984.

And, hearing benefits were provided by 43% of the employers in 1988, up from 16% of employers in 1984.

The popularity of flexible benefit plans increased among the employers studied. However, data on flex plans was collected only for the years 1985 through 1988.

In 1988, 100 of the 227 employers surveyed, or 44%, offered flex plans, up from 33% in 1987, 24% in 1986 and 20% in 1985.

Most of the employers offering flexible benefit programs designed their plans so that both employer-provided dollars and employee salary reductions were used by employees to "buy" benefits. For example, 48% of those offering flex plans in 1988 used this plan design, while 42% used only employee salary reduction and only 10% used employer-provided dollars only.

In addition to flex plans, 401(k) savings plans also gained popularity among the employers in the study.

For instance, 96% of the surveyed employers in 1988 offered a 401(k) salary reduction option under their defined contribution retirement plans, up from 68% in 1984.

In 1988, 82% of the employers offered a savings plan featuring a company match on employee savings and a 401(k) salary reduction option, up from 56% in 1984. Only 3% of employers offered a matched savings plans that did not include a 401(k) feature in 1988, compared with 18% in 1984.

The remaining 15% did not offer a savings plan with a company

'Because medical inflation is driving up health care costs, there is a natural trend by employers to build up the lifetime maximum amounts. And, the increase of the limits to \$1 million is a minor, small cost item,' Mr. Brandorff explains.

coverage for the cost of a second surgical opinion than they provided for the cost of the initial consultation, up from 44% in 1984.

In addition, 47% of the employers in 1988 provided a higher level of coverage for outpatient preadmission testing, up from 31% in 1984. By comparison, the percentage of employers providing the same coverage for outpatient preadmission testing as for inpatient testing dropped to 47% in 1988 from 60% in 1984.

And, 42% of the employers in 1988 provided increased levels of coverage for outpatient surgery obtained on a voluntary basis by employees, up from 33% in 1984.

An increasing percentage of employers offered coverage for hospice and home health care during the five years studied.

Eighty-five percent of employers provided coverage for hospice care in 1988, up from 52% in 1984. Home health care coverage was provided by 91% of the employers in 1988, up from 79% in 1984.

Meanwhile, more employers also implemented dental, vision and hearing benefit plans during the five years covered by the study.

However, this increase is mainly due to the fact that "we've seen these benefits provided mainly through Section 125 cafeteria plans. Under flex plans, these benefits are purchased by employees with their dollars, so it's a no-cost benefit for the employer," Mr. Brandorff said.

Dental plans were provided by 98% of the employers in 1988, up from 93% of employers in 1984. But, 63% of the employers offering

match.

Seven percent of the employers in 1988 offered unmatched savings plans that included the 401(k) feature in their plans, up from the 4% of employers offering unmatched 401(k) plans in 1984.

Overall, all of the surveyed employers offered some type of defined contribution plan in 1988, compared with 96% in 1984.

Employers offering defined contribution plans gave employees a greater choice of investment vehicles in 1988 compared with 1984, the study shows.

Forty-four percent of the employers offered four or more defined contribution investment options during 1988, compared with 34% of employers surveyed in 1984.

The percentage of employers offering a defined benefit pension plan remained stable during the five-year period, with 97% offering such plans in both 1984 and 1988.

However, employees at some companies vested in their defined benefit plans more quickly in 1988 compared with 1984. In 1989, most employers must offer more generous vesting schedules under a provision in the Tax Reform Act of 1986.

Ten percent of the employers in 1988 said that employees were vested in a defined benefit plan after only five years of service, while only 1% of the employers offered five-year vesting in 1984.

Other types of benefits covered by the survey include:

- Retiree health care benefits. However, the survey only includes

Continued on next page

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Agent/Broker Topics

A monthly editorial section sent exclusively to agents and brokers



Perpetual postponement

By LAURA MAZZUCA

Few prepare continuation plans

The timeworn adage about the shoemaker's children going barefoot applies all too well to insurance agencies.

It seems particularly ironic that insurance agents, who earn a living by finding coverage for clients against unforeseen disasters, are frequently unprepared for their own inevitable death, disability or retirement, and fail to make provisions to pass their businesses on to family or employees.

And, although consultants agree that agency principals are more interested than ever in discussing perpetuation—especially in what one consultant termed “tax-gimmicky” areas like employee stock ownership plans—the fact remains that many agencies, especially small to mid-sized firms, still are “going barefoot.”

However, it's an issue that's gaining more attention, especially since insurers increasingly are requiring agents in their preferred agent programs to develop perpetuation plans (see story, page 12F).

In addition, recent changes in the tax laws—which penalize gifts and trusts—have altered the way agency principals have traditionally handed down their assets.

Perpetuation planning is not a new concept to insurance agents, since the traditional agency of the past had a built-in perpetuation plan: Handing the business down to a son or daughter.

Other forms of agency perpetuation planning include buy-sell agreements,

in which one partner agrees to buy the other out; sale to or merger with another agency or organization; and transfer of ownership to employees, such as through an employee stock ownership plan.

According to a 1987 Future One survey that is conducted biannually by industry trade associations and insurers to determine the state of the independent agency system, the most popular form of agency perpetuation today is a buy-sell agreement, cited by 14% of the respondents.

Following closely behind is family inheritance, cited by 13%; selling to key producers, 6%; transfer to employees such as through an ESOP, 5%; selling out or merging with another agency, 4%; or a combination of methods.

But, even though numerous perpetuation planning options are available, many agency principals find themselves concentrating more on keeping their heads above water in the midst of market changes and pressure from insurers, the public and each other than on planning for the future.

“For the agent, (short-term) survival is first and foremost in his mind, and therefore perpetuation plans take a back seat to that,” said Eric Hall, director of industry affairs for the National Assn. of Professional Insurance Agents in Alexandria, Va.

“This is the area that agents neglect

the most—that is, putting together a workable program that essentially meets all the requirements with regard to moving their skills” to another owner, agreed John Cochrane, assistant vp of finance and planning for Continental Corp. of New York, who has been working with agents since 1983.

This lack of perpetuation planning by insurance agents is corroborated by the 1987 Future One survey. Of the 1,331 agents surveyed, only 38% had formal perpetuation plans; 61% did not; and 1% did not respond.

And, only 34.7% of the 1,166 agents polled in another 1987 survey conducted by the PIA had formal perpetuation plans. Of these, the majority—74%—were larger agencies, or those generating \$10 million or more in annual premium volume.

Larger agencies are more likely to have perpetuation plans because the “structure of a large agency, in and of itself, requires a perpetuation plan,” Mr. Hall explained.

By contrast, the smaller insurance agents “quite frankly have a difficult time facing the eventual fact that he will at some point turn over his life's work to someone else,” said Mr. Hall. “It's a difficult psychological barrier to overcome.”

Others in the industry agree.

“The agency is them (the agent); they identify so closely with the agency per-

sonally that they can't see it in somebody else's hands,” said Continental's Mr. Cochrane.

“The owner has problems looking at his own mortality; it's like a life insurance sale,” commented William “Twig” Branch, president and chief executive officer of Iroquois Insurance Group, an agency cluster headquartered in Olean, N.Y., with \$125 million in annual premium volume.

This attitude is especially prevalent among younger agents who feel they don't need to think about retiring for another 30 years, said Frederick J. England Jr., president of Hastings-Tapley Insurance Agency Inc., a \$76 million premium volume agency in Cambridge, Mass.

But, because it can take five to 10 years to gear up for agency perpetuation, principals should begin planning “30 minutes after they acquire” or start up the agency, Mr. England quipped.

Frequently, the failure to perpetuate is attributable to the bane of all small business owners: lack of time.

“Lack of planning resources” and “lack of time” were the two reasons cited most often by small and mid-sized agencies as likely to prohibit perpetuation planning, according to the PIA survey.

“I'm embarrassed to admit that I don't have a formal perpetuation plan,” said Rick Merrill, president of The Merrill Agency Inc., a \$4.5 million premium volume agency in Austin, Texas.

“It's one of the things you don't want

Continued on next page

Agent/broker topics

Perpetuation

Continued from previous page to think about," because there are so many other things to worry about in running a business, he said.

And, sometimes even larger agencies face the "not-enough-time" dilemma.

For instance, Berwanger Overmyer Associates, a 15-year-old, \$38 million premium volume property/casualty agency in Columbus, Ohio, has been so preoccupied with its small-agency acquisitions that it's still in the process of "developing" its own formal perpetuation plan, noted President Edwin L. Overmyer.

But even those agencies that have perpetuation plans sometimes render them ineffective by failing to take into account elements like financing, transferring of books of

business and establishing a solid sales and management team in the retiree's wake (see story, page 12D).

"There is a huge lack of knowledge about what perpetuation

"The biggest flaw with most independent agents' (perpetuation plans) is that they have an idea of what they want to do, but don't take the most important step" of planning, observed Mr. Cochrane

'The biggest flaw with most independent agents' (perpetuation plans) is that they have an idea of what they want to do, but don't take the most important step' of planning, observes John Cochrane of Continental Corp.

really requires," said Phil Brooks, an attorney specializing in insurance agencies. Mr. Brooks of Moyer & Bergman in Cedar Rapids, Iowa, also is the general legal counsel for the Independent Insurance Agents of America of Iowa.

of Continental.

For instance, a family-owned \$1 million premium volume agency with a single major account not only needs to find a way to finance the senior principal's retirement, but must also have a plan to get the

son or daughter involved in servicing, as well as a contingency plan in case the client is lost, Mr. Brooks said.

To effectively plan a perpetuation, "An agency owner has to be aware of all three sides of perpetuation: financial/economical, book-of-business continuation, and management/operations," explained John H. Jaques, president of John H. Jaques Inc., an agency consultant based in Novato, Calif.

The first step, financial/economical, is the "easiest side" because "numbers are numbers," said Mr. Jaques. An agency's worth is basically determined by the firm's profitability.

However, there are other ways to determine an agency's value, he admitted. While in the past, many agents valued their agencies by multiplying the agency's commissions by a factor of 1.5 to 2, today

most consultants focus on the agency's profits and cash flow rather than a pat formula.

For instance, consultants in CNA Insurance Cos.' perpetuation assistance program use three indicators—projected earnings, actual cash price and the earning stream's present value—to value the agency, said John R. Lusk, vp-property and liability distribution in the marketing department of the Chicago-based insurer.

On the other hand, "we determine agency value purely on the bottom line," remarked Robert H. Hilb, president of Richmond, Va.-based Hilb, Rogal & Hamilton Co., the nation's 12th-largest insurance brokerage.

Although Mr. Hilb said he realizes that the valuation formula of 1.5 times commission has become "a bellwether in the system," it's frequently misleading because even an agency with high commissions can still be unprofitable if expenses and loss ratios are high, he added.

The second step of perpetuation, the transfer of an agent's book of business, is crucial because if it's not planned, clients will leave the agency along with the principal, said Mr. Jaques.

Therefore, at least a year before the principal retires, he should have "zero responsibility" for any accounts, he added. This can be accomplished by gradually easing other producers into servicing the existing accounts.

Also, contingencies should be made for future agency growth rather than simply subsisting on the retiring agent's existing book of business. For this reason, ownership of the agency must be transferred to those who can generate a lot of new business, added Mr. Jaques.

Finally, the agency's management and operations procedures must be taken into consideration, and principals with "leadership and vision" qualities must be chosen to carry on from the retiring principal, he said.

Even after a formal perpetuation plan is in effect, agents must periodically evaluate it to make sure that it's still applicable, perpetuation experts advise.

"It requires not only an effective beginning plan, but constant attention to revising the plan as circumstances and needs of the agency change," noted CNA's Mr. Lusk.

For example, an agency with a big revenue stream based on expertise in a single risk or class could lose everything if a market changes, he said.

Or, a class of business could disappear from the market completely, which could happen when a factory or trade group like a fabric business relocates from New York to North Carolina, he added.

"There are all kinds of things that impact on that entrepreneurial business," he said.

Even the traditional buy-sell agreements used by many small agencies, in which one partner formally agrees to buy the other in the event of death or disability, can go awry.

For example, Berwanger Overmyer ended up buying half of the book of business of an agency that was to be transferred through a buy-sell agreement after Mr. Overmyer determined that the purchasing agent wouldn't be able to retain the selling agent's accounts.

The agency was insufficiently staffed and there was a difference

Continued on next page

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Mr. Jaques

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Perpetuation

Continued from previous page in "personality" between the two agency principals, explained Mr. Overmyer, who was asked to review the agreement because he had a business relationship with the buying agent.

As a result, Berwanger Overmyer, which is actively involved in acquisitions, ended up buying the agency, he said.

Even agents who think they are taking the easy way out—perpetuating the agency by selling it or merging it with another agency—face the problem of finding an outside buyer.

For example, while a small agency—one with revenues of \$500,000 or less—may lure an alphabet broker or larger agency to buy it by having an attractive account or two, generic Main Street agencies may be worth "a dime a dozen" on the market.

In addition, "The value of agencies has diminished in recent years so that the timing is not ideal today to sell an agency," observed Mr. England.

"If you're sitting there with a 60% personal lines book and haven't been paying a lot of attention to the market because you've been making a lot of money, you're in for a serious awakening," he added.

"The appetite to purchase agencies has lessened, especially in states like Massachusetts, where you have such volatile market conditions," Mr. England said.



Mr. England

Larger agencies that are acquiring non-perpetuated agencies are very selective about what they buy, Mr. England explained.

For example, Hastings-Tapley itself has cut back on the number of agency acquisitions it makes, he noted, adding that other larger agencies and brokers also are reporting similar cutbacks.

"If it's a situation where there is no ongoing management, we're not really interested in bailing out old owners who want to retire," said Mr. Hilb of Richmond, Va.-based broker Hilb, Rogal.

"At the moment we have so many prospects that we can pick and choose," he said.

"We're not just looking for a book of business," said Mr. Overmyer.

Instead, Berwanger Overmyer's criteria for agency acquisition is based on key accounts, personnel, insurers and volumes of business that complement their own, he added.

But while many agencies may have a hard time finding a buyer, other industry observers believe a small agent might actually get a better price now, if he has something special to offer a buyer.

"Right now there seem to be enough buyers, so it's not critical," said Robert Martz, assistant vp-agency consulting for Hartford, Conn.-based CIGNA Corp.

But he projects that over the next five years as the marketplace "matures" and as more consolidation takes place, there will be fewer than two potential buyers per agency, compared with about more than 10 today.

Finding a buyer is especially tough for larger agencies, or those with \$5 million or more in revenues.

Unless financing is carefully structured, internal producers might not be able to afford to buy the agency, and the large agency's massive "infrastructure" is expensive to maintain, according to Mr.

England.

For instance, an agency generating between \$12 million and \$15 million in annual premium volume and held by two or three principals with no successors has "an immediate problem, a near-term problem and a long-range problem," said Mr. Brooks.

"Some agents have gotten themselves into a situation where they're so big and closely held that producers can't buy them out—the debt load is staggering," Mr. Brooks added.

For this reason, most consultants agree that internal perpetuation, such as transferring ownership of the company to employees in the form of a stock, is best for larger agencies.

However, recent changes in the tax laws, especially regarding gift trusts and stock recapitalization, have changed the face of internal

agency perpetuation and "raises havoc with any intelligent business planning," Mr. Brooks pointed out.

For example, under current tax laws, gift and estate transfers of up to \$600,000 in net worth are un-

eliminated the use of recapitalization of stock—taking common stock and changing it into preferred stock—since it treats both types of stock the same for tax purposes.

'The appetite to purchase agencies has lessened, especially in states like Massachusetts, where you have such volatile market conditions,' says Frederick J. England Jr., president of Hastings-Tapley Insurance Agency Inc.

taxed, said Mr. Brooks. But once the transaction exceeds this amount, the tax paid by the recipient starts at a 37% rate and could go as high as 55%, he said.

In addition, 1987 amendments to the Tax Reform Act of 1986 have

"A perpetuation plan (that includes stock recapitalization) that doesn't consider the ramifications of this statute is fatally flawed," Mr. Brooks warned.

Because of such complexities, agency principals should consult

with an expert—an attorney, accountant or outside consultant—before finalizing any plans, perpetuation experts advise.

Agents' associations also can help out.

And insurers, with their own interests to protect, frequently offer perpetuation planning programs and financial assistance to agents.

By effectively formulating a perpetuation plan, the agency not only benefits for itself, but also gets an idea of how to best serve its clients, and avoid the "shoemaker's children" syndrome, said CNA's Mr. Lusk.

"Perpetuation is a fact of life for all small businesses, not just insurance," he said.

"If agents can solve their own business problems, it prepares them to solve the business problems of the small clients they deal with," Mr. Lusk said.

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Agent/broker topics

Perpetuation can take many forms

By LAURA MAZZUCA

Well-planned agency perpetuations can take many forms—among them family transfers, internal transfers, mergers and employee stock ownership plans—even though many agencies ultimately choose to sell out to the highest bidder.

"There is no cookie-cutter approach," said John R. Lusk, vp-property and liability distribution, marketing department, for CNA Insurance Cos. in Chicago. "Every situation we see has to be tailored to that particular set of principals in the agency."

Here are some of the perpetuation strategies that an agency can consider:

Family transfer

The time-honored family transfer perpetuation, which epitomizes the independent agency system, has undergone several new twists, especially since the 1986 Tax Reform Act changed the gift tax structure.

The Rosenthal Agency in Metairie, La., illustrates the family transfer. The agency has been a full-time family-run business since 1980, when Leslie Jacobs and her brother, Steven Rosenthal, began working for their father, Stan.

At the time, according to Ms. Jacobs, her father gave his children with several shares of internal agency stock over a period of time, with the understanding that they would purchase the remaining stock with the proceeds of a company-funded life insurance policy upon his death—in other words, a basic buy-sell agreement.

However, this perpetuation plan faced two problems, said Ms. Jacobs, 30. First, the more she and Steven worked to increase the value of the agency, the more life insurance the agency would have to purchase to allow Leslie and Steven to buy out Stan. Rosenthal Agency had \$4 million in billings when the younger Rosenthals started in 1980; now, it produces \$20 million, she added.

In addition, changes to the tax law meant that the difference between the applicable corporate and personal tax rates is now more pronounced—34% vs. 28%, said Steven Rosenthal, 32.

So, the family restructured its perpetuation plan. The agency was appraised and Stan transferred additional shares to Leslie and Steven, taking advantage of the Unified Gift Act (see story, page 12A).

Currently, Stan owns 51% of the agency; Leslie and Steven each own 24.5%.

Rather than depending on the company-funded life insurance policy, which would have been highly taxed, Leslie and Steven now each maintain an individual life insurance policy on their father and each other, which will enable them to buy the 51% of the business upon Stan's death.

Stan, Steven and six other producers sell and service accounts, while Leslie runs the business as de facto president. The arrangement seems to work well, said Steven.

"We had finally reached the point where everybody was comfortable with doing the stock change," said Steven Rosenthal. "We wanted to give ourselves a number of years to make sure our marriages were fine and we were working well together."

Such adjustment is vitally important in a family perpetuation arrangement.

At The Merrill Agency Inc., a \$4.5 million premium volume agency in Austin, Texas, the father and son who run the business had to have some time away from each other to adjust when the son took over.

Richard S. Merrill, who began the business as a "scratch agency" in 1950, decided in 1981 to sell 60% of the agency to a competitor in another town, which took over the management functions that Mr. Merrill found burdensome.

The purchasing agency hired Rick Merrill, Richard's son, to manage the accounts because they thought father and son might clash if they worked at the same office.

In 1984, the agency had the option to buy the other 40% of Merrill's agency, but instead Rick Merrill bought it himself—making him his father's new boss.

"When he was 10 years old, he decided he wanted to go into the business," recalled Richard Merrill, who was 64 at the time his son purchased the share in the agency. But having his own 27-year-old son taking over his

old accounts was hard for the father, and the two clashed on personality and generational issues.

As a result, Mr. Merrill developed a thriving risk management consulting business for municipalities "just to stay away" from the agency. "But little by little he (Rick) kept bringing me back in," said Richard Merrill. He rejoined the agency in 1986.

Today, the senior Mr. Merrill continues his risk management consulting, but is also landing new accounts for the agency while working for commissions only; in fact, he is now developing a national medical malpractice account. He is finally rid of the hassles of management and is free to pursue pure selling, which was always his first love, said Rick Merrill.

"Now it's great, but we went through some turbulent times," said Rick Merrill. "Today we're the best of friends."

Internal transfer

As in family transfer perpetuations, internal stock transfers to another producer are a matter of both farsighted hiring of good producers and careful consideration of financial changes.

At the Brandow, Howard, Kohler & Rosenbloom Inc. agency in Minneapolis, perpetuation planning began when the firm was established 25 years ago, said John B. Van Dyke, president and chief executive officer of the "commercially focused" agency with produced \$40 million in premium volume.

"Perpetuation was dictated by the found-

ing fathers 25 years ago, with the intention that clients be served first," he said.

At the agency's inception, the three original principals drew up a declaration stipulating that beginning at age 60, each must sell back 20% of his own stock every other year and that they must relinquish management and board of directors positions by age 65, said Mr. Van Dyke, who noted a fourth principal joined the agency after it was established.

The "founding fathers" also mandated that company stock would be valued at book, rather than market, value so future young producers would be better able to afford it, said Mr. Van Dyke.

Also, when planning their retirement, the principals dedicated a percentage of profit sharing, pension and 401(k) benefits to fund their retirements rather than relying on the market value of their own agency stock.

In addition, the principals established a deferred compensation program in which they receive a percentage of renewals for the next three years, starting at age 65.

Today, one of the original partners is completely retired; and the other three, who are in their early 60s, are still active in the agency.

To ease the transition process, the agency assigns back-up producers to each account. These younger producers work closely with the senior partner for about five years before the partner's retirement. Newer producers receive servicing compensation for the book of business for an "orderly transition of ac-

counts for retention," said Mr. Van Dyke.

The agency's retention levels are about 95%, including the accounts that were reassigned.

"It's tough when these people reach age 65" for them to let go, he said. "It's traumatic at best in some cases."

Agency clustering

Because of the dwindling number of agency buyers on the market, some consultants recommend that agencies merge or cluster to perpetuate.

For instance, CIGNA Corp. is citing clustering—in which autonomous agencies band together to consolidate operations—as a good alternative to an outright sale of a smaller agency, said Robert Martz, assistant vp-agency consulting at CIGNA Corp. in Philadelphia.

The Iroquois Group, a modified cluster arrangement with more than 200 agencies in New York, Pennsylvania, Virginia, Ohio and Alabama, likes to add "high-quality, highly motivated people" by adding their agencies to the cluster, said William "Twig" Branch, president and chief executive officer, based in Olean, N.Y. Annual premium volume for the group of agencies is about \$125 million.

Iroquois generally sees two types of principals interested in clustering: older principals ready to retire and young principals looking for the expanded markets and programs usually available only to larger agencies, said Mr. Branch.

The cluster itself usually approaches potential acquisitions, keeping an eye out for smaller rural agencies with a good loss ratio and a premium volume of about \$2 million.

Iroquois acquires agencies at a "formula" price: 33.3% of annual commissions payable over a 12-year period. For example, assuming an agency with an average commission rate of 15% and an annual premium volume of \$1 million, Iroquois' payment would be \$50,000 per year, or a total of nearly \$600,000 for the 12-year period.

The cluster expects to recoup this investment in 12 to 15 years. Since it's a family run business, Iroquois is more concerned about steady growth rather than reaping quick financial benefits, said Mr. Branch.

To get qualified personnel to run the acquisition—frequently the owner's son or daughter—Iroquois gives them one-third of the agency's ownership, plus 50% of the agency's profits by contract. They also leave the acquired agency's staff and name intact.

However, in some cases, Iroquois simply buys the agency outright; "about half of them just want to take their money and retire," added Mr. Branch. In these cases, Iroquois dissolves the agency and places the book of business at an existing branch office.

Iroquois also sets up buy-sell arrangements and options on agencies, then provides the agency with markets and backup in the meantime, said Mr. Branch.

"We give the agent the tools to get bigger, and then pay them" by way of a higher buyout price when they purchase the agency, he added. Final payment in such an arrangement is based on the agency's final financial performance, and is paid out incrementally by Iroquois on a monthly basis, he added.

Iroquois itself is perpetuated through many Branch family members. "Twig" is 33, while two siblings who work in the agency are 31 and 30. Two younger brothers in their 20s are expected to join them later.

Paul Branch, 62, while not retired, is "moving into the position of slowing down" by turning over some accounts for servicing to other producers as well as transferring some stock ownership to his children.

ESOPs

While most consultants agree that employee stock ownership plans work best as perpetuation vehicles for large agencies, they agree that more agents are expressing an interest in setting up such a plan because of changes in the tax law.

Under an ESOP, the stock of a retiring principal is sold to all of the corporation's employees collectively over a period of time, explained David A. Bakst, an attorney with Morrison, Mahoney & Miller in Boston. The

Continued on next page

Agencies in debt make poor acquisition targets

By LAURA MAZZUCA

Most independent agencies go on the sales block to perpetuate their business, but those that are in debt or that need other "reclamation" work are poor acquisition targets, say principals of two agencies/brokerages that are heavily active in acquiring other agencies.

The lack of an alternative perpetuation plan is "the major reason why most insurance agencies will be sold," said Robert H. Hilb, president of Hilb, Rogal & Hamilton Co. of Richmond, Va., the nation's 12th-largest brokerage.

Mr. Hilb noted that about 25% of the agencies acquired by Hilb, Rogal & Hamilton have no perpetuation plan.

And, an additional 50% to 60% of the agencies that seek buyers have perpetuation plans but are not disciplined enough to maintain them, he said.

For example, sometimes an acquired agency has a perpetuation plan, but its younger principals tire of financing the retirement plans of the agency's retiree, he said. "It's a very difficult thing for an agency to be disciplined enough that they put the money aside" for perpetuation.

Even some well thought-out perpetuation plans can run into trouble, according to Mr. Hilb.

For example, one agency that Hilb, Rogal & Hamilton acquired this year had a solid perpetuation plan in place, with four equal partners prepared to cede stock upon retirement to their successors.

However, the youngest principal, the "bright star" of the agency, died, "and the whole perpetuation plan went down the tubes," Mr. Hilb said.

Since the agency's three other partners are in their mid- to late-50s and will all retire at about the same time, Hilb, Rogal & Hamilton will help them by transferring one of its own producers to the acquired agency, if necessary.

The soft commercial property/casualty insurance market also has led to the increase in agencies for sale, according to Mr. Hilb.

He noted, for example, that he sees many acquisition prospects with a perpetuation plan that involves borrowing

money in the hard market to fund a retirement plan for an agency owner or principal. But those agencies now are "just avoiding bankruptcy" because their commissions have dwindled during the soft market, making it difficult for them to repay the loans.

Mr. Hilb noted that even good perpetuation plans, such as those based on an employee stock ownership plan, can go awry in the soft market because agencies find it more difficult to contribute to these plans when commissions begin to shrink.

"We're seeing a number of acquisitions coming to us that have these problems," Mr. Hilb said. "They're looking to survive rather than capitalize on their company."

Because some agencies that failed to establish a successful perpetuation plan view the sale of their businesses to an outsider as a "last resort," such transactions are almost destined to be less than satisfactory for the seller, Mr. Hilb said.

Another agent that actively acquires other agencies notes that most purchasers are not interested in "doing reclamation work."

"You're in a position where you can solve a lot of problems for them," noted William "Twig" Branch, president and chief executive officer of Iroquois Insurance Group, a clustered agency based in Olean, N.Y., that is active in acquiring small, rural agencies.

For example, an acquired agency's principals may garner many benefits from an acquisition, such as agency perpetuation, expansion of the agency's expertise, access to more insurers and a funded retirement plan.

"But, you also wind up delivering an amount of bad news" about the agency's financial condition and operations, Mr. Branch explained.

The buyer "could be perceived poorly unless you handle it well," he said.

"We don't want to just bail somebody out from bankruptcy and have him be unhappy with his lot in life," Mr. Hilb agreed.

"Why should we come in and do that and find the guy is as bitter and unhappy as he was when he ran the agency into the ground himself?" he asked.

Network loans help agents perpetuate

An alternative to bank and insurer loans to fund agency perpetuation plans is offered free to members of Assurex International, the agency and broker marketing network organization owned by independent agencies.

Assurex operates the Assurex Development Corp., a "common sense" organization established by Assurex in 1981 specifically to assist member agencies in perpetuation planning and financing, said Robert P. Ashlock, president of Assurex.

The Columbus, Ohio-based agency network consists of 64 agents in the United States, Canada and London, each with average annual commissions of \$6 million, he said.

"The structure of the independent

agency system is both its major strength and its major weakness," said Mr. Ashlock, referring to the fact that an agency principal's very independence makes it difficult to turn the business over to somebody else.

In the late 1970s and early '80s, the large national brokerages were eager to make acquisitions, and some Assurex members that failed to retain earnings to fund principals' retirements were forced to sell out to the alphabet houses, he said.

This absorption of independent agencies by large brokers was damaging both to Assurex and to insurers, which were concerned that the big brokers were getting too large and independent agents were losing their place in the market, he said.

It was apparent that agents needed both consulting and financial assistance to set up perpetuation plans, he said, noting that insurers have traditionally provided such help. However, the resulting relationship between agent and insurer—agents that were tied financially to insurers through perpetuation loans—sometimes compromised the agent's independence, said Mr. Ashlock.

So, at the suggestion of Mr. Ashlock, eight insurers agreed to invest \$1.5 million each to start up ADC.

Today, there are seven participating insurers—Chubb Corp. of Warren, N.J.; Commercial Union Insurance Co. of Boston; Hartford Insurance Group of Hartford, Conn.; AmBase Corp., the new name for The

Home Group Inc. of New York; The St. Paul Cos. Inc. of St. Paul, Minn.; Travelers Corp. of Hartford; and United States Fidelity & Guaranty Co. of Baltimore.

Each insurer sets aside \$2.5 million to be made available for loans, giving ADC an equity base of \$17.5 million. And, ADC maintains a supplemental line of credit of about \$12 million with a local bank, he said.

When a loan is drawn from ADC funds, ADC stock in the amount of the loan is issued to the insurers in exchange for the use of their cash.

The insurers don't earn interest or dividends on ADC loans, but since the money is not drawn down until needed, all they lose is the use of the cash, said Mr. Ashlock.

ADC lends money to agents for three reasons, all for perpetuation:

- Retirement of a principal.
- Acquisition of another agency if it fits the perpetuation objective.
- Purchase of major automation systems.

The agent has about seven years to repay the loan, at an interest rate "well below market," he said. The average loan value is \$1.2 million.

Since ADC was founded, it has made 30 loans totaling more than \$35 million to 25 agencies, he added.

ADC doesn't usually have to "bail out" agencies that haven't made adequate perpetuation plans or are in financial trouble because of Assurex's stringent education programs.

—By Laura Mazzucco

Strategies

Continued from previous page

stock purchase can be financed by a bank loan, which is then paid back by the corporation making a tax-deductible contribution to the ESOP trust fund, with both principal and interest tax-deductible, he said.

However, fewer than 5% of agencies qualify for an ESOP because ESOPs can be expensive to maintain, said John H. Jaques, president of John H. Jaques Inc., agency consultants in Novato, Calif.

Because the tax deduction only applies to employers' contributions to the ESOP that equal 25% or less than the employees' total compensation, smaller agencies may not have a large enough payroll to make an ESOP work, said Mr. Bakst.

In addition, administration—including record keeping and the required annual agency valuation—can be costly as well, said Mr. Bakst.

The initial agency appraisal could run from \$3,500 to \$7,500, with subsequent valuations costing about \$1,500, he said. Administrative and record keeping costs could run another \$1,000 annually, he added.

Because of this, the initial cost of an ESOP can run from \$5,000 to \$25,000, said Phil Brooks, an attorney with Moyer & Bergmar in Cedar Rapids, Iowa.

In addition, businesses with ESOPs are subject to the same federal statutes as pension plans, compliance with which could cost the agency several thousand dollars annually, he added.

However, if the agency is large enough, and the plan is carefully thought out, an ESOP can not only fund a perpetuation, but offer many other perks as well.

For example, Kinney, Pike, Bell & Conner, a \$24 million premium volume agency in Rutland, Vt., started its ESOP 10 years ago to replace a "normal boilerplate buy-sell agreement" and create a mechanism to buy the stock of a retiring principal, said President Edward C. Pike.

Over the years, the agency has realized the value of the ESOP, not only from a perpetuation standpoint, but because it "stimulates employee interest in the firm." It also serves as a "drawing card" for up-and-coming producers "who may be future leaders of this firm," he said.

In addition, the agency's stock value has grown since then to \$3,100 per share from \$1,600 per share, he added.

To set up its ESOP, the agency used the assistance of an outside consultant. Later, when planning acquisitions, the agency took out a loan from a perpetuation program offered by Assurex International, an agency franchise (see story, page 12E), said Mr. Pike.

So far under the ESOP, about six employees—both staff and management—have retired. There are no special provisions for principals under the plan, he added. ■



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Agent/broker topics

Agents, insurers gain by perpetuation

By LAURA MAZZUCA

Although insurers and agents may look at the agency perpetuation from different perspectives, the issue is important to both—for many of the same reasons.

"The term 'agency perpetuation' is more of a company term, because what we're talking about is perpetuating the company's book of business and the relationship they've developed with the agency and the business," said John R. Lusk, vp-property and liability distribution, marketing department for CNA Insurance Cos. in Chicago.

"From the agent's perspective, perpetuation is really estate planning and should be looked at as more than just planning for retirement, but for death and disability," he added.

"The most significant advantage for Continental when our agents perpetuate is that there is a stability there," noted John Cochrane, assistant vp-finance and planning for Continental Corp. in New York.

"Continental puts in a great deal of effort and spends money developing relationships with its Circle (preferred) agents, so it's in our best interest for them to perpetuate."

Because of this mutual interest in perpetuation, many insurers not only require perpetuation plans from their preferred agents, but will also assist them in planning, executing and sometimes even financing these plans.

For example, CIGNA Corp. of Philadelphia began offering agency perpetuation workshops around the country this year at the request of interested agents, said Robert Martz, assistant

vp-agency consulting. CIGNA places a strong emphasis on perpetuation, especially for its COMPAR preferred agents, Mr. Martz said, adding that the insurer expects all COMPAR agents to have a contingency plan for death or disability of agency principals by 1990.

The four-hour perpetuation workshop includes topics such as legal forms of ownership, financial planning, perpetuation planning, internal perpetuation issues, agency clusters, valuation of agencies and where to get profes-

sional assistance. CIGNA places a strong emphasis on perpetuation, especially for its COMPAR preferred agents, Mr. Martz said, adding that the insurer expects all COMPAR agents to have a contingency plan for death or disability of agency principals by 1990.

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'The term 'agency perpetuation' is more of a company term, because what we're talking about is perpetuating the company's book of business and the relationship they've developed with the agency and the business,' says John R. Lusk of CNA Insurance Cos. in Chicago.

sional assistance.

Perpetuation consists of "two fundamental business issues: how to fund it and will there be the right management in place to execute the plan," said CNA's Mr. Lusk.

Because one of the most common perpetuation funding mechanisms is the purchase of life insurance for the agency principal, CNA's life insurance branch can provide perpetuation life insurance products; estate and business planning consultants are also available from CNA, said Mr. Lusk.

For CNA's preferred High Performance pre-

ferred agents, who are required to have a perpetuation plan, an agency loan program enables a principal to borrow either directly from CNA or from an outside source like a bank, with CNA paying the interest if the agency meets commitment goals.

Continental, too, will make loans of \$50,000 to \$500,000 to its agents so they can acquire and perpetuate agencies, even though the insurer "encourages" rather than requires its preferred agents to make formal perpetuation plans, Mr.

Cochrane said. Full payment is expected within five years of the loan.

To better assist its agents in funding a perpetuation plan, Continental is now developing a program in which the insurer would internally guarantee the agency's perpetuation funding mechanism, he added.

However, Continental recommends that its agents setting up a perpetuation plan use either a life insurance or a profit sharing plan as a funding mechanism, said Mr. Cochrane.

CIGNA offers both its COMPAR preferred agents and its regular agents loans to acquire

and perpetuate agencies, with negotiable terms. And, CIGNA will sometimes forgive loans in exchange for premium commitment, said Mr. Martz.

Once perpetuation funding is secured, most insurers will assist in the follow-through.

Coordinating incoming management and sales personnel and keeping the quality of agency performance high after an agency perpetuates is the biggest problem in perpetuation, agreed Mr. Martz of CIGNA.

The continuing quality of management is vital because one way to fund an agency principal's retirement is through a share of the earnings from his or her book of business after he or she retires, said CNA's Mr. Lusk. Poor management can cause accounts to slip away, leaving the retiree with a smaller income than expected because the agency's profits have declined.

To avoid such problems, CNA's assistance program, available since 1978, offers both its regular and preferred agents the services of a consulting group during or after an ownership change, said Mr. Lusk. This group would help the agency adjust to changes in work flow, administration, organization and other areas.

For instance, if the agency underwent an internal buyout, CNA might help it with restructuring, he added.

And Continental, which looks for "a perpetuation plan that provides for the transfer of the sales, management and other skills from senior to junior partners," also stresses the importance of following up with consultation through its Circle Agent Management Program, said Mr. Cochrane.

agent/broker briefs

PIA launching plan to educate consumers

WASHINGTON—The National Assn. of Professional Insurance Agents is using auto insurance reform as the springboard for a new, nationwide community and political action program to educate consumers on insurance issues.

"As community members, agents can go straight to the ultimate opinion leaders—consumers," said PIA President David L. Ream. "Consumer leaders also trust agents as fair, balanced mediators."

The PIA has set aside \$75,000 in national funds and collected \$90,000 from state affiliates for the three-pronged program, which will:

- Develop a community outreach and image-building campaign that agents can use to educate consumers about auto insurance.

The community outreach program, called "Agents and Communities Together," will provide agents with educational materials so they can speak to school groups and civic organizations about insurance issues, particularly why auto insurance prices are rising.

- Build coalitions of state consumer groups and PIA state and regional associations.

The PIA will develop material on how to build and manage coalitions; provide a field adviser to help set up coalitions in states; and provide telephone hot lines for states with coalition questions.

- Write an auto insurance "white paper" in conjunction with the Consumer Insurance Interest Group describing auto insurance reform proposals.

Banking regulations

WASHINGTON—The Federal Reserve Board, in order to fully protect consumers, must not override the congressional intent of the Bank Holding Company Act, a spokesman from the Alliance for the Separation of Banking and Insurance told the board recently.

A judicial opinion that closes every loophole allowing banks in the insurance business and that requires the board to judge every bank holding company by the standards of the act is the only way to protect consumers, said A. William Bailey, who is also senior vp of the Independent Insurance Agents of America, based in Washington, D.C.

Mr. Bailey urged the board to rescind the current regulation, which allows state banks owned by bank holding companies to acquire so-called operation subsidiaries—non-bank entities—without prior approval by the board.

He explained that because banks are in a position to approve credit, prohibiting bank entry into the insurance business protects the consumer's ability to choose insurance free from credit concerns.

Unfair practices

OLYMPIA, Wash.—The Washington Insurance Department has passed two regulations governing unfair practices by insurers and agents.

The first, Regulation WAC 284-30-660, states that it is an unfair or deceptive practice for any insurance company, broker or agent to use quotations or evaluations from rating or advisory services in a manner likely to deceive a potential customer.

For example, if an insurer represents in its advertising that it received an "A" rating from an advisory service, the representation must also explain that there could be higher ratings, such as "AAA."

Regulation WAC 284-12-110 states that it is unfair for an insurance agent initiating a sales presentation away from his office to fail to inform the prospective client that he is acting as an insurance agent.

The regulations apply to all lines of insurance in the state.

Repeated violations of these or other codes could result in the revocation of an agent's license.

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Agent/Broker Topics

Texas suit calls State Farm hiring unfair

By LINDA J. COLLINS

HOUSTON—Seven Texas women are charging four State Farm Mutual Auto Insurance Co. units with denying recruitment and hiring opportunities to women, blacks and Hispanics.

All seven, who applied for sales agent trainee positions between 1980 and 1988, allege in a class-action suit that, despite their qualifications and experience, they were turned down because of their sex, race or national origin.

Five of the seven are now sales agents with other insurers.

The suit, filed June 22 in U.S. District Court for the Southern District of Texas in Houston, seeks a declaratory judgment that State Farm's hiring practices are unlawful and in violation of the federal Civil Rights Act. The plaintiffs also request a permanent injunction barring the Bloomington, Ill.-based insurer from engaging in those practices.

In addition, the suit seeks:

- Assignment of the plaintiffs and any other eligible plaintiffs under the class action to the jobs they originally sought at a pay scale comparable to what they would be earning had they been hired when they applied for the positions.

- Back pay with interest.

- Actual, compensatory and punitive damages, plus court and attorneys fees.

- A court order stipulating that State Farm must "institute and carry out policies, practices and affirmative action programs which provide equal employment opportunities for

women, Hispanics and blacks and which eradicate the effects of its past and present employment practices."

Plaintiffs' attorney Guy Saperstein, a partner of Farnsworth, Saperstein & Seligman in Oakland, Calif., said that his firm initiated the class action because "class actions change companies. Each individual who suffered the same kind of discrimination deserves to be compensated, not just the seven women who filed the suit.

"A class action vehicle is the only way to do it," Mr. Saperstein added.

However, a State Farm spokesman stressed: "State Farm has never had a policy to discriminate on the basis of age, sex or race. The fact is, there are more females in the job market now of a level necessary to set them-

selves up as an independent contractor and with the motivational aptitude necessary to succeed as a State Farm agent."

There are currently 1,173 State Farm sales agents in Texas, of which 367 are women and/or minorities, the spokesman noted.

Some 41.9% of the agents State Farm has appointed since 1979 have been women or minorities. In the last five years, that percentage has grown to 58.8%, the spokesman added.

However, State Farm paid a total of \$1.2 million in March 1988 to settle a similar class-action suit filed in California by three named defendants alleging sex discrimination against women. The insurer also agreed that it will hire women for at

least 50% of its job openings in California for 10 years.

"That injunctive decree is in full operation and State Farm is complying," said Mr. Saperstein, whose firm also represented plaintiffs in that action.

"In the last two to three years, more than half of the agents we have appointed in California have been women," a State Farm spokesman agreed.

Following the California settlement, the plaintiffs' attorneys launched an advertising campaign in May 1988 in various insurance trade magazines and newspapers to notify other women who might have been discriminated against in California that they could seek retribution

through the class action.

There are "about 1,000 potential (class action) claimants remaining" in that litigation, a State Farm spokesman estimates.

While Farnsworth, Saperstein & Seligman and the Houston law firm of Susman Godfrey held a press conference the day the suit was filed in Houston, generating "very heavy" local press coverage, Mr. Saperstein said that his firm does not intend to launch another advertising campaign in Texas to alert potential plaintiffs.

And he also has no plans to pursue similar actions in other states. "I don't plan to spend the rest of my career pursuing actions against State Farm," Mr. Saperstein explained.

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Growth plan can stave off stagnation

By LAURA MAZZUCA

CHICAGO—No matter how successful an agency is, it eventually will reach a growth plateau that it must overcome to survive and thrive, an agency consultant says.

An agent that is content with the "status quo" will move backward, warns Tim Cunningham, a consultant and agency appraiser for Hales & Associates Inc., an Oak Brook, Ill.-based agency consulting firm.

To avoid becoming stagnant, agency principals must take an "evolutionary" view and do everything within their power to grow, Mr. Cunningham advised Chicago-area members of the Society of Chartered Property & Casualty Underwriters during a recent meeting.

"Failure to manage change will result in decline," he stressed.

Although a universal solution to the doldrums of agency revenue growth lies in strategic planning, the agency principal cannot take a "boilerplate approach" to the problem, Mr. Cunningham said. Instead, the agent must be realistic and objective about his or her agency's unique strengths and weaknesses.

A major roadblock to clearing the "agency plateau" hurdle is the stagnant attitude of many agency principals, said Mr. Cunningham. "Principals get into a comfort zone, both financially and psychologically."

Financially, the principal might become complacent and reluctant to spend money to surpass that plateau.

"Frankly, we have some fat cats in the business," he added.

And, psychologically, the agency principal might deny that he or she is no longer capable of handling every detail of agency operations the

Continued on next page

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Business Insurance
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Observations from NAIB

Brokerage becomes big business: Page

By LAURA MAZZUCA

SEA ISLAND, Ga.—Even though the past 17 years have brought five tumultuous soft and hard market cycles, the passage of time has helped establish insurance brokerage as big business and emphasized the importance of cooperation within the industry, says a top brokerage executive.

"We in the underwriting community have come to terms with each other," said Richard M. Page, chairman and chief executive officer of Fred S. James & Co. Inc. of New York, in a keynote address to the National Assn. of Insurance Brokers at its 55th annual meeting last month in Sea Island, Ga. (BI, June 12).

Brokers and insurers "seem to have recognized once and for all that mutual profit depends on mutually profitable relationships which can only be achieved together."

Mr. Page traced the growth of the brokerage industry since *Business Insurance* first published annual broker results in 1972.

The first results, which reported on 1971 revenues, showed Marsh & McLennan Cos. Inc. had \$151 million in revenues; Johnson & Higgins, between \$75 million and \$100 million; and Alexander & Alexander Services Inc., \$58 million. Total revenue for the industry stood at \$385 million, added Mr. Page (BI, July 31, 1972).

Over the years, the price and availability of insurance swung wildly, with "the two soft markets of the '80s, and the hard market of the mid-'80s being the severest the industry ever saw," he observed. "And contrary to the home truth of the mid-'50s, they (cycles) were not harmless, and people were hurt."

During this time, insolvencies increased, capacity ebbed and flowed, and "worst of all, the industry lost the confidence of the American consumer," he said.

The formerly close relationships between insurer and broker began to deteriorate, too, as insurers offered their stock to the public and brokers began emphasizing their clients' increasingly diverse needs over the simple peddling of insurer products, said Mr. Page.

However, in spite of these growing pains, the brokerage industry showed significant gains during this period. Mr. Page pointed to BI's 1988 broker report on 1987 results, in which M&M reported \$2 billion in revenues, A&A \$1.2 billion, and J&H, \$690 million, with the 20 largest brokers generating more than \$6 billion in revenues and more than 70,000 employees (BI, June 20, 1988).

"For my purpose, the point is made: Brokers are big business and a significant part of the financial services industry," he said.

And, according to Mr. Page, the insurance industry has its work cut out for it in the 1990s in light of the industry's image problem.

Brokerages are both "socially and corporately" answerable to their constituency—clients, staff, underwriters and shareholders—concerning issues of professional image, the moral issues underlying these relationships, the industry's proper role in the political process, and how to attract young people to careers in insurance.

McFadden urges leadership

By LAURA MAZZUCA

SEA ISLAND, Ga.—Good service to policyholders, improved communications and cooperation within the insurance industry are the best remedies for the industry's poor image problem, says the outgoing president of the National Assn. of Insurance Brokers.

And, brokers should be on the cutting edge of providing that medicine, he said.

"We must develop a message which applies a common-sense perspective to the debate and explains the industry's operations in terms that the average person can understand," said Martin J. McFadden Jr., managing director of Marsh & McLennan Inc. in Chicago, at the 55th annual meeting of the National Assn. of Insurance Brokers last month in Sea Island, Ga.

"In the days when we enjoyed greater credibility, we (brokers) were seen as a sentinel of public safety," he said. "We protected the public against injury and financial disaster. As we responded to tort liability problems, prices escalated and cycles turned hard and fast. In turn, we became the culprits responsible for an unstable marketplace."

Today's hostile public attitude toward the insurance industry was mainly driven by the availability and affordability crises of the mid-1980s, as well as deep cycles, insurer insolvencies, lack of standard regulation, the tort system and high health care costs, said Mr. McFadden.

"People are fed up with roller-coaster rates in commercial business," he said.

Commenting on the passage of Proposition 103 in California, Mr. McFadden continued: "On the personal lines side, I'd be willing to guess that many of us, if we were paying \$4,000 for auto insurance, would readily vote for a 20% rate cut. It's human nature to want to pay less."

Providing better service to policyholders is an important way for brokers to address the image problem, he said.

"Let's face it; we aren't selling the ultimate dream machine," he said. "When you're not fulfilling fantasy, you had better provide service. . . . We must recruit and train bright young people to do this, and we must give them the authority to act."

During his term in office, Mr. McFadden noted that the NAIB has been active in fostering communication with the public by increasing liaisons with other industry associations such as the National Assn. of Insurance Commissioners, stepping up involvement in government affairs and expanding the NAIB's public relations program.

The NAIB has been active in lobbying on a variety of issues, such as support of the McCarran-Ferguson Act, product liability reform and amendment of the Risk Retention Act Amendments of 1986 to include minimum financial solvency standards for insurers of risk purchasing groups, said Mr. McFadden.

At a September NAIC conference, the NAIB led a fight against a proposal by state regulators to make brokers guarantors of business placed with insurers in which brokers have a financial interest. The NAIC, however, approved such a model law (BI, Sept. 26, 1988).

In addition, the NAIB sponsored a study of insurer insolvency that led to publication last fall of "Managing Insurer Insolvency," which enhanced the NAIB's reputation as an information source, said Mr. McFadden.

He said the study concluded that the changed nature of liability insurance and the potential for high losses in areas such as asbestos and product liability show that the industry's regulatory approach to insolvency must change.

"Delaying action in the hope that a company can recover in the hard market phase of the cycle will not work," said Mr. McFadden. The "NAIB has pledged to support regulators who act promptly to take an insolvent underwriter out of the marketplace."

NAIBPAC, the association's public action committee, also had a successful year, and he urged members to contribute to the fund.

NAIBPAC made contributions to many political candidates in the last general election, and about 65 were voted into their respective offices nationwide, he said.

"Like it or not, as long as the rules of politics permit PAC contributions, we can't sit at the table unless we ante up," he said.

However, he added that McCarran-Ferguson and tort reform will be perceived in the near future as "red herring issues," piling in importance compared with market stability and insurer insolvency.

"How we deal with pricing and servicing issues ultimately will have a greater impact on the future of our industry than the repeal of McCarran-Ferguson. Think about it," he said.

In addition, he predicts that the federal government eventually will oversee insurers and their financial stability. This, in turn, will change the guaranty fund system for large commercial risks—the broker's bread and butter.

"Guaranty fund costs are moving in an upward spiral, and insurers want them capped," said Mr. McFadden. "Future regulators will be sympathetic only to protecting small commercial buyers and personal lines consumers. One task we will face is helping policymakers determine where to draw the line."

However, these changes present brokers with an opportunity for increased public policy involvement, he said.

"Today's pain can be tomorrow's gain if we address real problems rather than attempting to mollify the buying public with a slick public relations campaign," said Mr. McFadden. "I'm convinced that the winners for the future will be those companies and brokerage firms that improve their operating efficiency and provide good service to their customers."

Agency growth

Continued from previous page

way he or she did when the business was new, Mr. Cunningham said.

"As firms grow, we must realize that we don't have the skills and talents we had before," not because the principal is unskilled, but because the agency has grown beyond the principal's management capabilities, he said.

Another roadblock to getting over the plateau is that the agency may be buffeted by the changes in the insurance marketplace. For instance, the current soft property/casualty insurance market can put agencies "under tremendous pressure from a financial standpoint," Mr. Cunningham said.

The type of plateau an agency may hit and the steps it must take to get beyond it are based on the size of its workforce and its revenues, according to Mr. Cunningham, who offered the following examples:

- The principals of agencies with revenues of \$150,000 to \$250,000 and three to six employees often are caught up in the details of managing the agency, rather than producing business. In addition, the staff usually is too small or inexperienced for the principal to delegate his or her duties effectively.

To avoid this, he suggested the principal add more producers, which would free up the principal to sell, or merge the agency with another firm.

However, Mr. Cunningham warned against merging with agencies with

similar management problems. Instead, the principal should merge with a larger, well-organized firm, which would allow the agent to devote himself to selling.

- Agencies with revenues ranging between \$250,000 and \$450,000 typically don't have the plateau problems of smaller and larger agencies.

- Agencies with revenues of between \$450,000 and \$600,000 and six to eight employees may be suffering because principals still are taking the hands-on approach and cannot delegate responsibilities.

In addition, these agencies may have "grown by osmosis," acquiring more producers and, as a result, may be moving from being generalists to specialists, he added.

Solutions include automation—to ease the workload of administration and management—and perpetuation planning, he advised.

- Agencies with revenues of between \$1 million and \$1.5 million and between 16 and 25 employees may encounter problems produced by a heavy client load.

The agency president, even if he is devoted to sales, is stretched; the organization may be specialized and complex; and most of the principals may be "stale," he explained.

Solutions include a complete reorganization of the producers' duties; having the principals concentrate on the agency's operational support or "back-office administration" to en-

sure efficiency; refining the agency's compensation structure; improving systems and quality control through more streamlined office procedures; and preparing for perpetuation by making the agency more attractive to a potential buyer.

- Because agencies with revenues of \$2 million to \$2.5 million and between 30 and 35 employees have grown in complexity and their leadership often is "old and tired," they may suffer from "inertia and stagnation," according to Mr. Cunningham.

The solution is to focus on the next tier of management. The emphasis should be on the sales manager to oversee his department and on internal marketing, which will help take the load off outside producers.

- Many agencies with revenues of \$3 million and more and 35 or more employees have massive perpetuation problems.

The principals of these agencies often are nearing the end of their careers and haven't made provisions for a middle management employee to take over, and the agency often is too big to attract a buyer, Mr. Cunningham said.

From a practical standpoint, "you've got one choice—sell" the agency, he said.

Before a sale, the chief executive officer and chief operational officer functions should be separated because "producers generally make the worst managers," he said.

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Business Insurance

Datebook

JULY 13-15. Utilization Management: Responding to New Challenges conference in Philadelphia, sponsored by the Group Health Assn. of America Inc.; \$450 for GHAA members; \$510 for non-members. Also Sept. 7-9 in San Diego. GHAA Inc., 1129 20th St. N.W., Suite 600, Washington, D.C. 20036; 202-778-3228.

JULY 14. Watershed 103—A Conference on Proposition 103 in San Francisco, co-sponsored by Sullivan, Roche & Johnson and Hemming Morse; \$445. Patty Prince, Sullivan, Roche & Johnson, 415-296-0333.

JULY 17-19. Claims Management: Fine-Tuning Your System conference in Minneapolis, sponsored by the Group Health Assn. of America Inc.; \$495 for GHAA members; \$595 for non-members. Registrar, GHAA, 1129 20th St. N.W., Suite 600, Washington, D.C. 20036; 202-778-3228.

JULY 17-19. Understanding Property/Casualty Statutory Financial Statements conference in San Francisco, sponsored by Executive Enterprises Inc.; \$990. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

JULY 17-21. Sampling and Evaluating Airborne Asbestos Dust course in Los Angeles, sponsored by the University of Southern California Institute of Safety and Systems Management; \$775. University of Southern California, Institute of Safety and Systems Management, Office of Extension and In-Service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 213-743-6383.

JULY 18-19. Crisis Communications Management seminar in Portland, Maine, sponsored by E.I. du Pont de Nemours & Co.; \$1,045. Du Pont, Attn. CAK, 1300 First State Blvd., Suite A, Wilmington, Del. 19804; 302-999-6977; 800-248-7020.

JULY 20. Illinois Insurance Exchange Brokers Assn. Seminar in Pittsburgh; no charge. Terry Ryan, Illinois Insurance Exchange, 175 W. Jackson Blvd., Chicago, Ill. 60604; 312-939-2400.

JULY 20-21. Defending a Personal Injury Case seminar in New York City, sponsored by the Practising Law Institute; \$250. PLI, Department 8A-105, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700, ext. 271.

JULY 20-22. 90th Annual Independent Insurance Agents of Missouri Convention in Kansas City, Mo.; \$80 for agents/company representatives; \$40 for spouses. Independent Insurance Agents of Missouri, P.O. Box 1785, Jefferson City, Mo. 65102; 314-893-4301.

JULY 21-23. Second Annual National Conference of Insurance Legislators in Boston;

\$150. COIL, P.O. Box 217, Brookfield, Wis. 53008.

JULY 24-26. Making Sense of Environmental Regulations course in Kansas City, Mo., sponsored by The University of Kansas Division of Continuing Education; \$595; 20% discount for three or more attendees from the same organization. Also Sept. 6-8 in Kansas City, Mo., and Nov. 13-15 in Tampa, Fla. University of Kansas, 6600 College Blvd., Suite 315, Overland Park, Kan. 66211-1522; 913-491-0221.

JULY 24-26. Corporate Retirement Benefits Conference in Boston, sponsored by the International Foundation of Employee Benefit Plans; \$615 for IFEBP members; \$690 for non-members. IFEBP, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

JULY 26-28. Intermediate Employee Benefits Management course in Brookfield, Wis., sponsored by the International Foundation of Employee Benefit Plans; \$1,000 for IFEBP members; \$1,125 for non-members. Registration Department, IFEBP, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

AUG. 28-29. First Annual Corporate Benefits Management Conference: Take Control of Your Benefits—A Strategic Plan conference in Lake Tahoe, Nev., sponsored by the Corporate Benefits Institute of the International Foundation of Employee Benefit Plans; before July 14: \$410 for IFEBP members, \$460 for non-members; after July 14: \$455 for IFEBP members; \$505 for non-members. Registrations, International Foundation of Employee Benefit Plans, 18700 Bluemound Road, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

SEPT. 5-8. Reinsurance Contract Wording seminar in Tarrytown, N.Y., sponsored by Robert W. Strain Seminars Inc.; \$1,445. Robert W. Strain Seminars Inc., P.O. Box 1000, Wingdale, N.Y. 12594; 914-832-9384.

SEPT. 18-22. Fundamentals of Employee Benefits Management course in Brookfield, Wis., sponsored by the International Foundation of Employee Benefit Plans; \$1,000 for the five-day Fundamentals Course, \$600 for the three-day Intermediate Course. Also Oct. 2-6. Registration Department, IFEBP, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

SEPT. 19-20. Reinsurance Claim Management course in Chicago, sponsored by The College of Insurance; \$595 for College sponsors; \$695 for non-sponsors. Professional Programs, The College of Insurance, 101 Murray St., New York, N.Y. 10007-2132; 212-962-4111.

SEPT. 25-27. Reinsurance Accounting & Auditing course in Chicago, sponsored by The College of Insurance; \$795 for College sponsors; \$895 for non-sponsors. Also Nov. 1-3 in San

Francisco. Professional Programs, The College of Insurance, 101 Murray St., New York, N.Y. 10007-2132; 212-962-4111.

OCT. 3-5. National Risk Retention Assn.'s Second Annual Conference in Washington, D.C.; \$350 for NRRA members; \$450 for non-members. Nick Garnett, National Risk Retention Assn., 3299 K St. N.W., Seventh Floor, Washington, D.C. 20007; 202-955-7510.

OCT. 14-22. American Assn. of Managing General Agents Foreign Seminar in Vancouver, British Columbia, and Banff, Alberta; seminar fee: \$175 for AAMGA members, \$125 for spouses and guests; tour fee (includes accommodations, air fare from Vancouver to Calgary, guided tours): \$969 double occupancy, \$1,319 single occupancy. American Assn. of Managing General Agents, 9140 Ward Parkway, Kansas City, Mo. 64114.

OCT. 15-18. 1989 Risk Management Forum in Monte Carlo, co-sponsored by the European Risk Management Assn. and the Risk & Insurance Management Society Inc.; 4,900 French francs (\$745 at current exchange rate) for risk managers; 2,500 French francs (\$380) for academicians and students; 6,900 French francs (\$1,049) for all others. Payment must be in French francs. Sally Greene, RMS/Monte Carlo Conference, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

OCT. 24-25. Reinsurance Systems course in Chicago, sponsored by The College of Insurance; \$595 for College sponsors; \$695 for non-sponsors. Professional Programs, The College of Insurance, 101 Murray St., New York, N.Y. 10007-2132; 212-962-4111.

NOV. 5-9. National Assn. of Independent Insurers' 44th Annual Meeting in Seattle; \$250 for NAII members; \$350 for subscribers and non-members; \$100 for spouses and guests. National Assn. of Independent Insurers, 333 N. Michigan Ave., Suite 1600, Chicago, Ill. 60601; 312-297-7800.

NOV. 14-16. Ninth Annual Construction Insurance Conference in San Antonio, Texas, sponsored by the International Risk Management Institute Inc.; \$548. IRMI, 12222 Merit Drive, Suite 1680, Dallas, Texas 75251; 800-527-2580; 214-960-7693.

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Hewitt study

Continued from previous page
retiree health care benefit data for the years 1986-1988.

Ninety-nine percent of the employers surveyed said they offered health care coverage to retirees under the age of 65 in both 1986 and 1988. Of these employers, 85% in 1988 offered retirees under age 65 coverage through the active employees' plan, down from 86% in 1986, while 13% of the employers in 1988 offered coverage through a special retiree plan, up from 12% in 1986.

The other 1% of employers in both years offered another arrangement.

Ninety-seven percent of surveyed employers in both 1986 and 1988 offered retirees over age 65 health care coverage. Of these employers, 41% in 1988 offered coverage through the active employees' plan with a Medicare carve-out feature, down from 43% in 1986. Another 34% of employers in both 1986 and 1988 offered a Medicare supplement plan, while the remainder of the employers use some other type of plan design for retirees over 65.

• **Group life insurance benefits.** The percentage of employers that paid the full cost of group life insurance programs decreased to 9% in 1988 from 13% in 1984. Eleven percent of employers in 1988 required employees to pay the full cost of group life insurance, down from

12% in 1984, while 80% of employers in 1988 shared the cost with employees, up from 75% in 1984.

Employee contributions are now more likely based on an employee's age, the survey shows. Only 27% of plans in 1988 required a flat contribution rate for employees of all ages, down from 43% in 1984.

Also, employees could opt for much higher optional levels of group life coverage in 1988 than in 1984. For instance, 33% of the plans in 1988 offered an optional group life benefit of five times salary or more, compared with 16% in 1984.

In addition, 50% of employers in 1988 offered employees the option of dependent group life coverage, compared with 39% in 1984. However, only 5% of employers in both years made any contribution toward dependent coverage.

• **Long-term disability benefits.** Many employers offered higher maximum monthly LTD benefits in 1988 compared with 1984. For instance, 18% of plans surveyed in 1988 offered a maximum monthly benefit of \$10,000 or more, compared with only 8% of plans in 1984.

• **Copies of the survey, "Salaried Employee Benefits Provided by Major U.S. Employers in 1984-88," are available for \$45 by contacting Cathy Schmidt at Hewitt Associates, 100 Half Day Road, Lincolnshire, Ill. 60015; 312-295-5000.**

NOTICE

Korean Reinsurance Company

Korean Reinsurance Company of Seoul, Korea wishes to give notice that it has come to its attention that Nippon Kei-Ei Consultant of Tokyo has purported to grant a binding authority dated 3rd March 1989 to McDonald Management LBS Forum and McDonald Financial Management (U.K.) Limited LBS Forum both of London on behalf of Korean Reinsurance Company.

Korean Reinsurance Company has given no authority of any description to:—

- Nippon Kei-Ei Consultant
- McDonald Management LBS Forum
- McDonald Financial Management (U.K.) Limited LBS Forum

Anyone who is offered or shown an alleged authority to the above companies in the name of Korean Reinsurance Company should immediately notify us.

Please direct all inquiries about this notice to The Manager, (Mr. K. H. Kim), Overseas Underwriting Dept. Korean Reinsurance Company, CPO Box 1438, Seoul, Korea.

Telephone (02) 739-6141
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Mentor ruling

Continued from page 2

meeting last September (BI, Sept. 19, 1988). However, a similar resolution is expected to be introduced at the next creditors' meeting in September, one source said.

In addition, a dissident group of Mentor creditors is seeking to call a special creditors' meeting to appoint an additional liquidator for Mentor (BI, May 1).

Mr. Kempe and Mr. Arnold filed their RICO complaint in U.S. District Court for the Eastern District of Louisiana in New Orleans in March 1986, seeking to force ODECO and several ODECO and Mentor officers to cover the estimated \$500 million insolvency (BI, March 24, 1986).

In addition to ODECO, the defendants were Mentor's immediate parent, Mentor Holding Corp.; Bermuda-based Pinnacle; and current and former ODECO and Mentor Holding officers William L. Colson, Clovis H. Steib, Ronald W. Herman, Odie F. Vaughan, James L. Kilpatrick, Hugh J. Kelley, Herman S. Kelley and J. Douglas Higley.

The suit alleged that seven of the defendants devised a scheme to defraud Mentor, its policyholders and its creditors by arranging excess-of-loss reinsurance contracts with Pinnacle that concealed Mentor's financial problems.

Mentor took credit on its balance sheet for two Pinnacle contracts without disclosing side agreements providing that Pinnacle would not pay any reinsurance claims for 10 years, at which time it would make lump-sum payments in predetermined amounts, the suit charged.

As a result of the contracts, Mentor reported net income of \$8.3 million in 1982 instead of a \$2.5 million loss, and a net loss of \$59,000 in 1983 instead of a \$7.7 million loss, the liquidators alleged.

The defendants denied the allega-

tions and filed a forum non conveniens motion to dismiss the lawsuit, charging the liquidators with forum shopping in an attempt to recover treble damages under RICO.

In April 1988, U.S. District Judge Marcel Livaudais Jr. granted the motion dismissing the liquidator's complaint (BI, April 25, 1988).

Noting the liquidators' argument that a trial in Bermuda would hamper discovery against U.S.-based defendants, Judge Livaudais granted a six-month stay of his ruling to allow discovery in the United States.

Those discovery proceedings have been concluded, lawyers involved in the case say.

Mentor's liquidators appealed the dismissal to the 5th Circuit, and the three-judge panel on June 23 affirmed the lower court order.

The liquidators argued that RICO actions—like actions brought under federal antitrust law—should be immune from forum non conveniens motions, since granting such motions "would frustrate Congress' intent to give RICO plaintiffs a right of access to a federal forum to seek redress," the appellate court ruling notes.

However, the critical issue in the case, the panel observed, was whether the liquidators would be deprived of all legal remedies if the case were moved to Bermuda.

"To ask this question is to answer it," the panel concluded. "The district court specifically found that even without the RICO count, Bermuda permits litigation in its courts of the fraud, negligent misrepresentation, breach of fiduciary duty and piercing the corporate veil counts of the liquidators' complaint."

Quoting from another federal case cited in the appeal, the panel concluded that "although potential damage award may be smaller, there is no danger they will be deprived of any remedy or treated unfairly."

"Although the RICO cause of action is not available in Bermuda, a forum is inadequate only where it would afford a plaintiff no remedy at all," the panel ruled.

The appeals court also affirmed Judge Livaudais' finding that trial in Bermuda is favored in light of both the private interests of the parties involved and the public interest.

Most of the parties and potential witnesses are located in Bermuda, Judge Livaudais had noted.

In addition, Bermuda—as an international insurance center with "a strong interest in regulating its industry so as to retain credibility abroad"—has a greater stake in the litigation than Louisiana, which has no such broad interest in the case, the appellate court found. ■

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California health care mandate advances

SACRAMENTO, Calif.—The California Assembly has narrowly approved an amended version of a bill that would require employers in the state with five or more employees to provide health care insurance to full-time and many part-time employees.

A.B. 350, which was introduced earlier this year by Assembly Speaker Willie L. Brown Jr., D-San Francisco, now is awaiting assignment to a Senate committee (BI, Feb. 6).

The amended version of the bill would require employers to pay 75% of the premium for health insurance provided to employees working a minimum of 86.67 hours a month, or 21 hours a week. Employers would be able to deduct the remaining 25% of the premium from employees' paychecks.

Around the states

Previously, the bill would have required employers to pay the full premium for health insurance.

However, the bill still would prohibit employers from requiring employees to pay annual deductibles or copayments for services such as hospital inpatient services for medical or psychiatric care; physician and surgeon services provided in the hospital; laboratory services; or ambulatory surgical services. Employers could require a copayment on other services, provided the copayment does not exceed 25% of charges.

The bill also was amended to require employers to offer health insurance to employees who have

worked for them three consecutive months or more. Previously, the bill would have required that coverage be extended to employees who worked for the employer for four consecutive weeks.

And, since A.B. 350 would apply to self-insured plans, California is seeking an exemption from the federal Employee Retirement Income Security Act of 1974, which pre-empts state regulation of self-insured benefit plans.

"We went to Washington to discuss the ERISA exemption, and the authorities said they wouldn't consider the matter until they make one more try at passing a federal mandated health insurance bill. If

their federal bill fails, then our bill will take effect in January 1993 and we would receive the ERISA exemption," said a spokeswoman for Assemblyman Brown.

In addition to these changes, the amended version of A.B. 350 would enable small employers to purchase health insurance plans on a pooled basis.

Assemblyman Brown estimates that the minimum health insurance mandated in the bill would cost employers between \$75 and \$85 per employee per month.

"We're optimistic that this bill will pass the Senate. Our votes in the Assembly have not been totally partisan," the spokeswoman said, noting that the major opposition to A.B. 350 is from the small business community in California.

—By Donna DiBlase

New commissioner

BOSTON—Timothy Gailey is expected to be sworn in soon as commissioner of the Massachusetts Division of Insurance.

Gov. Michael Dukakis appointed Mr. Gailey to succeed Roger Singer, who resigned June 30 after nearly two years in office.

Since 1985, Mr. Gailey has been employed as assistant secretary in the state's Executive Office of Consumer Affairs and Business Regulation, where he was responsible for insurance issues.

Mr. Gailey, 43, also was employed previously as a trial attorney with Hale & Dorr in Boston. He is a graduate of Harvard College and Harvard Law School.

In announcing the appointment, Gov. Dukakis said, "I am very pleased that Tim Gailey will be our new commissioner. He has played a leading role in developing insurance policies in this administration, ranging from automobile insurance reform to medical malpractice insurance and life insurance AIDS testing."

Mr. Singer resigned to become senior vp and general counsel for Commercial Union Insurance Co. in Boston.

In commenting about Mr. Singer, Gov. Dukakis said, "In the last two years he has been responsible for greatly improved efficiency at the division as well as promulgating new regulations involving long term care, unisex rating and AIDS testing, and implementation of last year's auto insurance reform legislation—which resulted in an overall rate decrease of 8%."

Mr. Singer moved into the commissioner's chair from the post of first deputy commissioner in July 1987, after the resignation of Peter Hiam.

Mr. Hiam resigned in a dispute with Gov. Dukakis over AIDS testing of life insurance applicants (BI, Aug. 3, 1987).

—By Meg Fletcher

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RISK MANAGEMENT

July 24

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The second of three risk management feature issues this summer will be devoted to information systems. From new ways of interpreting data to identifying problem areas — BI editors will examine the tools and trends that risk managers, financial and administrative executives rely on to control their operations.

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ASK A CASUALTY ACTUARY

Prop. 103 may foster availability problems

Q What, in your opinion, will be the impact of Proposition 103 on the marketplace for insurance in California?

A Because so much of the final form of the new style of insurance regulation has yet to emerge, it is impossible to know at this point what impact Proposition 103 will have on the California insurance marketplace. All that seems likely at this point is that the degree of change will probably be substantial.

Almost overnight, the rate regulatory environment in California has changed from one of the most laissez faire in the nation to one of the most heavily regulated—in theory at least.

The degree of change that may be expected is not unlike what would have occurred if George McGovern had just succeeded Barry Goldwater as president of the United States.

Those insurance companies that take a wait-and-see attitude about the nature and extent of the changes in California, rather than actively improving their preparedness to deal with the new environment, will find themselves at a serious disadvantage relative to their competitors.

It is possible to reasonably speculate on the nature and extent of some of the changes by considering what has occurred over time in other states that have a regulatory system similar to that which has just been mandated in California. If that picture is accurate, we may expect developments like the following:

- A rapidly growing assigned risk plan for automobile risks. Many of these new assigned risks will come from areas where rates will be reduced because of restrictions on territorial rating.
- Growing availability problems among classes of risks or lines of business and/or in growing geographic areas where insurance companies believe that there is little or no real opportunity to make a reasonable profit by writing the business.
- Insurance rates that are higher than they would otherwise be during a soft market and somewhat lower than they would otherwise be during a hard market. Significant availability problems would tend to become widespread during a hard market.
- If rate regulation is based primarily on return on equity, as opposed to return on earned premium, smaller, less well-capitalized insurance companies will be at a pricing disadvantage in competing against larger, well-capitalized companies.
- By applying rate adequacy standards on a line-by-line basis, the practice of account underwriting, which involves writing an unprofitable line of coverage in conjunction with being able to write coverage for a profitable line, will become much less common.

For example, if unprofitable liability business had previously been underwritten by an insurer as an accommodation to writing profitable property business, downward pressures on property insurance rates under Proposition 103—without allowing for increases in liability insurance rates—will tend to cause insurers to restrict the underwriting of liability coverage.

The extent to which this phenomena will occur will of course depend on the manner in which the California Insurance Department implements and interprets the various provisions of Proposition 103. The degree of uncertainty that may result from this is unusually high because:

- The change in the regulatory environment has been so sudden and so dramatic.

- The enormous volume of filings that must be reviewed and responded to within a very short time frame while using a large number of state employees, many of whom have only recently been hired (or who have yet to be hired), may require the adoption of practices or procedures that may differ substantially from those that the department would otherwise follow under a less Herculean timetable.

- There is a wide range of possible approaches that could be deemed acceptable for measuring and regulating rate of return and for allocating surplus by line and state.

- There are a number of ambiguities that are created by the fact that Proposition 103 was obviously designed to address characteristics of personal automobile coverage, and yet it is being applied to numerous commercial lines of insurance as well.

One of the primary sources of confusion relates to what is subject to regulation. Is it the manual rates, or the rates that are actually charged (after schedule and experience debits and credits are applied)? Since these typically differ to a large degree, and to significantly different degrees over various parts of the underwriting cycle, it is important to clearly define which rates will be the subject of regulation.

If the former is selected, it is easy to track but fairly irrelevant to what businesses finally pay for

To the extent that insurers are not allowed to adequately reflect large differences in average loss costs by territory, there could be disruption in the auto insurance market.

coverage. If the latter is selected, it is often very difficult, if not impossible, to accurately and meaningfully track changes in what has actually been charged. This is true because of the discretion allowed in the use of schedule credits or debits and because of the frequent changes in the details of coverage that occur between successive policies for commercial risk (like deductibles, limits, coverage restrictions and endorsements, exposure units and changes in retrospective rating features, to name only a few).

If you resort only to tracking changes in the actual premium charged for those commercial risks that do not have key changes in coverage features, then often you are looking at only a minor proportion of the business. Additionally, commercial business tends to move around with some degree of frequency, and it is not uncommon for a good percentage of the current book of business to consist of newly written risks. This further complicates any meaningful efforts to track changes in the actual level of premiums that are charged to commercial risks.

- There are a variety of ways that one can conclude that certain rating variables are used in a descending order of importance, as is called for by Proposition 103. To the extent that insurance companies are not allowed to adequately reflect the large differences that exist in average loss costs by territory, there could be a significant amount of turbulence and disruption in the normal marketplaces for automobile insurance. The fact remains that the rating variables that are permissible for use (driving record, miles driven annually and years of driving experience) can only reflect to a modest degree the types of major differences on loss costs that exist by geographic area.

California Insurance Commissioner Roxani Gillespie will be under a great deal of political pressure to reduce rates and limit rate hikes. This will be a difficult task in an environment where the

forces of competition (during the current soft market) have already pushed prices down to low or negative rates of return in many situations. It would have been much easier for the commissioner, from a political standpoint, to be given her current mandate in the midst of a hard market. Because competitive pressures are so strong during a soft market, it is not likely that rate of return regulation will result in lower rates during this phase of the underwriting cycle.

There is another factor at work that will tend to result in higher insurance rates as a result of Proposition 103. Insurance companies that now recognize they will have to justify every future rate increase before a less-than-friendly audience will be very slow to reduce current market rates as a result of the competitive pressures of the soft market. Such further decreases would normally occur during this part of the cycle. Additionally, as insurers have to calculate rates of return on their various segments of business, it will probably draw more clearly into focus the relative lack of profitability of many segments of their book where they are responding strongly to competitive pressures. Thus, it is more likely that less well-managed companies will now begin focusing on their need for higher rates on business that they heretofore would have pursued for the sake of the premium dollars.

It is insurance companies' misfortune that rate regulation is being implemented from the starting point of the relatively low rate levels that currently prevail during this phase of the soft market. Because of this, insurance companies will be seeking many potentially available avenues for cutting costs. Some of these avenues, like major efforts to reduce insurance claims fraud, may produce long-term benefits for both insurance buyers and providers. Other insurer responses to their misfortune, like stricter underwriting standards, will probably result in availability problems that can hardly be said to benefit insurance buyers.

It may be expected that there will be a number of new insurance companies and alternative vehicles established to meet areas affected by these availability problems. Additionally, many other companies may be formed to target market niches of opportunity created by all the change in the marketplace that will occur.

Whatever occurs between now and November will only be a precursor to the ensuing implementation of full prior approval regulation. The installation of California's first elected insurance commissioner may well bring further significant changes.

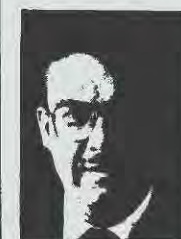
Would you like advice from an experienced colleague on a risk management, benefit management or actuarial problem? Four features in the Perspective section of Business Insurance can give you some answers.

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

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

Mr. Sherman's and Mr. Miner's columns appear alternately on the first Monday of each month. Ms. Werner's and Mr. Duva's columns appear alternately on the second Monday of each month. Mr. Sherman's next column will appear in September.

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



Mr. Sherman

Building overseas

International projects demand risk management

By Douglas N. Smith

AS A RULE, WHAT GOES up must come down. Yet the gravity of building overseas is often overlooked until a loss occurs or a company is forced to move or modernize its existing quarters.

Because construction involves serious contractual risks, U.S. multinationals that undertake work in foreign countries must contend with the complexities of differing legal and banking systems, as well as varying commercial customs. While insuring an international construction project can be a confusing process, it does lend itself to the following risk management principles:

- Establish contractual risk management procedures for controlling and managing all foreign construction risks.
- Identify the types and phases of risk for each project.
- Indoctrinate key personnel in the procedures, and specify their roles in carrying out the program.
- Establish control and review procedures to evaluate and monitor program performance.

Let's look at the important role these principles will play in insuring a foreign construction project.

A typical construction project begins with the concept phase, the preconstruction period during which variables affecting the planning, scope and management of the project are weighed against its cost. The concept phase allows a company to study the relative risks associated with various project alternatives and furnish an optimum plan for adequate insurance protection.

Since a project's design defines its form and substance, engineering-related issues must be competently interpreted before the insurer can establish proper insurance limits and premiums. You'll probably want to determine:

- Whether the project duplicates, in size and design, another corporate operating facility, or whether it incorporates new factors.
- Whether the design includes an acceptable hazard level for new processes or equipment or whether measures should be incorporated to reduce or protect against any known hazards.
- Whether the plan incorporates new processes or machinery that will require special temperature conditions.
- Whether the new site is subject to environmental controls that may not have regulated the former site. Hazardous waste and old foundations are usually the owner's responsibility.
- Whether the design contemplates highly protected risk-type fire protection equipment.
- Whether the project includes an on-site program to ensure that the installation of protection features keeps pace with the progress of construction.

Business risks associated with the project—such as economic,

technological, completion, debt service and force majeure—also should be reviewed during the concept phase.

When the project progresses into the construction phase, the risk exposures shift from planning to supervision. Potential project delays and possible overruns, often the result of bad planning or poor coordination, must be monitored during the construction phase since delays can cause devastating financial consequences.

You'll want to analyze what percentage of market share will be permanently lost if rebuilding is completed on July 15 instead of Feb. 6. Also, does your corporate management realize that this peril is uninsurable, as is consequential loss coverage for design and construction activities.

To be sure, reasonable goals must be set for controlling and managing foreign construction risks. Cost management, job safety, differing national construction laws and alternative supplier sources can pose myriad problems for U.S.

When the project progresses into the construction phase, the risk exposures shift from planning to supervision. Potential project delays and possible overruns, often the result of bad planning or poor coordination, must be monitored during the construction phase since delays can cause financial losses.

multinationals that need to rebuild or relocate overseas.

Some companies control foreign construction risks by putting the entire project on a turnkey basis. With a turnkey contract, the site, design and finished building are bought as a complete package. Although this solution passes direct responsibility to the contractor, it forces the owner to abandon all flexibility and control.

Other companies negotiate a "wrap-up" program—that is, an all-inclusive owner-controlled insurance program that furnishes coverages such as builders risk, general liability, workers compensation and umbrella liability for all contractors and subcontractors involved in the project. Nevertheless, "wrap-up" insurance does not fit every foreign risk.

Another approach adopted by many multinationals operating overseas is construction management. As an option used for smaller projects, construction managers are hired to supplement in-house expertise while contractual risk management procedures are used to transfer hazards.

Contractual risk management begins with a review of all contracts, including: owner, general contractor, design and design/build contracts; subcontracts; equipment rental lease agreements; and real property purchase/lease agreements. Each contract component must be identified, analyzed and handled appropriately.

For example, the hold harmless

agreement review should identify the agreement's scope—i.e. is it broad or limited? To whom does it extend? What are the assumed responsibilities? Is the hold harmless agreement insurable under the contractual liability coverage of the contractor's general liability program? If not, the policyholder should try to negotiate the necessary modifications.

Likewise, the subrogation waiver review is important because many coverages—such as general liability, workers compensation, builder's risk, property coverage and professional liability are affected.

It is critical to both identify subrogation waivers to comply with coverages and also to require similar waivers of other contract parties. For example, a subcontractor's insurer will indemnify equipment damage at a project site and then attempt to subrogate against your policy for the loss. Such an action could be precluded by inserting a subrogation waiver in

your contract with the subcontractor.

Finally, an insurance requirement review is vital to determine whether contract parties are in compliance or whether the requirements can be "flowed down" to other parties such as contractors.

An effective contractual risk management program also should specify procedures for certificate control and compliance. For example, all contracts should stipulate insurance and certificate requirements as well as compliance so that your company can legally pursue breach-of-contract suits in cases of non-compliance.

With few exceptions, contracts must be written in the language of the land. The same rule holds true for performance bonds, which cannot exist without a contract.

On the whole, U.S. multinationals buy performance bonds to:

- Ensure that the contract is performed—i.e. that the plant is built or the goods are supplied.
 - Provide cash reimbursement for advance moneys paid or released to the contractor prior to the project's completion. Most foreign countries require a project owner to make an advance payment ranging from 10% to 30% of the contract price, and post a separate advance payment bond.
- Generally, the face value of a performance bond should be the amount it would cost to replace the contract, plus any additional moneys that may be required to offset inflation, exchange

rate fluctuations, loss of down payments and incentive costs and geographical restrictions that may influence raw material supplies. When appropriate, the main contractor should insist that sub-subcontractors are bonded to subcontractors, especially when a contract is sensitive to their supplies.

Another international bonding quirk—principally common in Latin America—is the requirement of an additional bond to guarantee the payment of wages, social security benefits and certain taxes. Moreover, some foreign contracts provide for a bond in lieu of retainage and many require maintenance bonds for a period of one to five years. Premiums for bonds usually are negotiable, although in many Latin American countries bond premiums are established and approved by the Federal Insurance Commissioner.

The control and management of foreign construction risks also should include a review of political risks perils, such as:

- Confiscation of tangible assets and bank accounts.
- Damage to tangible assets in the project country resulting from war, revolution or insurrection.
- The inability to convert local currency into U.S. dollars.
- Losses arising from the project owner's failure to honor the dispute-resolving procedures set forth in the construction contract.
- Failure of the project owner to pay an arbitration award.
- Arbitrary or unfair drawing of letters of credit given as bid, performance and advance payment guarantees.

The third step in the risk management process is to assess your corporation's ability to staff a construction team. The key to success lies in picking a balanced, interdisciplinary, business-oriented team that balances centralized control with management commitment to the project. Hierarchical tiers, however, should be kept to a minimum.

Training the team is the requisite next step, since critical decisions must be made on a timely basis. Obviously, the project supervisor should have some construction experience, but it is also imperative for team members to understand the project goals and, more specifically, what is required of them.

The last step, monitoring and evaluating program performance, is essential to the success of the entire construction project. Since initial cost and time estimates are likely to change as work progresses, project overviews should be made on a periodic basis.



Mr. Smith

Douglas N. Smith is vp and manager of the International Department of Johnson & Higgins in New York. His column appears the first Monday of every month.

Section 89

Continued from page 1
 mittee would attach the Section 89 reforms that now are part of the already Senate-passed child care bill onto its version of the budget reconciliation legislation.

Once the Senate completes action, the differences between the two budget bills, like Section 89 reforms, would have to be resolved by a conference committee.

But some benefit observers worry that, even if either scenario goes according to plan, Section 89 reform could be sidetracked.

For example, while Congress may pass a child care bill, the measure could be vetoed. Indeed, President Bush last month indicated that he was unhappy with the Senate-passed child care bill.

If there was a presidential veto and the veto was not overridden, that would be the end of the child care legislation—and possibly Section 89 reform.

Section 89 reform faces a similar potential problem if it is attached to budget reconciliation legislation.

Administration sources have sent out word that a budget reconciliation bill that is too heavily weighted in favor of tax increases over cuts in federal spending also runs the risk of a presidential veto.

And, even if a budget reconciliation bill is passed and signed into

law, that could occur very late in the year and leave employers little time to digest the Section 89 changes before they become effective.

It's also possible, some observers believe, that if the child care or budget reconciliation bills bog down, a move could be made to attach Section 89 reform legislation to a measure that would raise the federal debt ceiling.

At the same time, regardless of the legislative vehicle on which Section 89 reform hitches a ride, there are substantive differences that will have to be worked out between the House and Senate changes in Section 89.

"There are some rather substantial differences. Compromise will not be easy," said Gerald Uslander, a principal in the Louisville, Ky., office of William M. Mercer Meidinger Hansen Inc.

At the same time, while the Section 89 reforms in the Senate-passed bill are much more favorable to employers than those in the Rostenkowski bill, there is no guarantee that the Senate provisions ultimately will be accepted.

"Employers shouldn't assume they can just relax and that the Senate provisions will become law without vigorous lobbying on their part," said Frank McArdle, a consultant in the Washington, D.C., office of Hewitt Associates.

"Employers will have to communicate to their representatives why they prefer the Senate bill," Mr. McArdle added.

Before giving final approval to its Section 89 reform package on June 23, the Senate added several amendments to it that will further ease Section 89 compliance efforts and penalties.

Under those amendments:

- Employers with fewer than 20 employees would not have to comply with Section 89 until Jan. 1,

that requires, among other things, employers to document in writing the benefits available under a plan—would be delayed until Jan. 1, 1991, or three months after the Treasury Department issues Section 89(k) rules, whichever is sooner.

The Bentsen bill originally proposed delaying Section 89(k) compliance from Oct. 1 to Jan. 1, 1990.

- The penalty for flunking Section 89(k) would be altered.

Originally under the Bentsen bill, employers would pay a 34% excise tax on the amount of health care claims paid for Section 89 violations. For example, if a health care plan that violated Section 89(k) paid out \$1 million in claims, the employer would have to pay \$340,000 in excise tax.

But, under a revision to the Bentsen bill that was added on the Senate floor, the excise tax would be assessed according to the length of the violation.

For violations that are corrected within six months, the excise tax would be 10%, while the tax would increase to 20% for violations that are corrected between seven and 12 months. A 34% excise tax would be imposed on Section 89(k) violations that are not corrected within one year.

In addition, another amendment makes it easier for flexible benefit plans that offer employees credits

that can be taken as cash to pass the non-discrimination tests (see story, page 17).

In addition, the Senate left intact an earlier amendment proposed by Sen. John Heinz, R-Pa., that would require employers—when running the non-discrimination tests—to include employees who work at least 30 hours a week.

Sen. Bentsen's original proposal called for employers to include employees working at least 25 hours when running the test, while the current Section 89 statute mandates that employees working at least 17.5 hours a week must be included for Section 89 testing purposes.

While these amendments were added to Sen. Bentsen's original proposal, no changes were made by the full Senate to the basic framework of the Bentsen bill, which includes an easier to pass non-discrimination test and exempts group term life insurance plans from Section 89.

Benefit experts are encouraged by the latest round of amendments—all of them favorable to employers—tacked onto the Section 89 legislation.

"Each step along the way, improvements—compared with earlier versions of the legislation—have been made," said the APPWP's Mr. Klein.

"The latest changes are very good news for employers," added Mark Ugoretz, executive director of the Washington, D.C.-based ERISA Industry Committee. ■



1991. The Senate bill, introduced by Finance Committee Chairman Lloyd Bentsen, D-Texas, had earlier proposed that the effective date of Section 89 be delayed from Oct. 1 to Jan. 1, 1990, regardless of the size of a company.

While Section 89 was scheduled to take effect Jan. 1, the Treasury Department earlier this year issued a notice that delayed compliance to Oct. 1.

- The effective date of Section 89(k)—the portion of Section 89

Experts prefer Senate proposal

By JERRY GEISEL

WASHINGTON—The Section 89 reforms passed by the Senate last month are much more favorable to employers than the Section 89 overhaul package proposed by House Ways and Means Committee Chairman Daniel Rostenkowski, D-Ill.

"It is a difference of night and day," commented Allen Steinberg, a consultant with Hewitt Associates of Lincolnshire, Ill.

The Senate bill proposes a later effective date for Section 89, a much easier and more logical non-discrimination test and more sensible rules for flexible benefit arrangements.

"From an employer perspective, the Senate bill has many of the positive elements of the Rostenkowski bill as well as many additional attractions," said Eric Grossman, a consultant in the Stamford, Conn., office of The Wyatt Co.

Both measures share in common a simplified and more fair approach to health care plan non-discrimination testing. For example, unlike the current Section 89 statute, a health care option that is available to all employees, like a health maintenance organization, cannot fail a non-discrimination test just because too many highly compensated employees enroll in the plan.

While both the Senate and House proposals have the same intent—simplifying Section 89—the differences in the two measures are striking.

The differences start with the measures' proposed effective dates.

The Rostenkowski bill, H.R. 1864, does not delay compliance with Section 89 beyond the current effective date of Oct. 1.

Meanwhile, under the Senate bill, S. 5, the effective date of Section 89(a)—the portion of the law that includes the non-discrimination tests—would be delayed until Jan. 1, 1990, for most employers.

In addition, Section 89(k)—the portion of the law that lays down rules on how welfare plans must be documented and communicated to employees—would be delayed until three months after the Treasury Department issues regulations, or Jan. 1, 1991, whichever is earlier.

Small employers—those with 20 or

fewer employers—would not have to comply with any aspect of Section 89 until Jan. 1, 1991.

Ultimately, observers say, Rep. Rostenkowski and the House will accept most of the Senate's delayed Section 89 effective dates.

"The longer it takes Congress to resolve Section 89, the greater the likelihood there will be a delayed effective date, at least until Jan. 1, 1990," said Frank McArdle, a consultant in the Washington, D.C., office of Hewitt Associates.

But few believe that Rep. Rostenkowski will be willing to accept a Section 89 effective date much beyond Jan. 1, 1990.

The House and Senate bills also take completely different approaches

limits employee contributions for individual coverage to less than 40% of the total cost, it could require employees to pay more than 40% of the total premium for family coverage (BI, June 12).

Observers say the House approach to measuring "affordability" is flawed.

If employers raised employee premium contributions to keep up with medical inflation, eventually their health care plans would flunk the eligibility test and highly compensated employees would be taxed on their health care benefits.

But if employers do not raise employee contributions to match medical care inflation, employers would have to absorb a greater percentage

'From an employer perspective, the Senate bill has many of the positive elements of the Rostenkowski bill as well as many additional attractions,' explains Eric Grossman, a consultant with The Wyatt Co. in Stamford, Conn.

on a test used to determine if a sufficient percentage of employees are eligible for "affordable" health care coverage. If a plan fails this "eligibility" test, highly compensated employees would be taxed on the full cost of their health care coverage.

The Rostenkowski bill says that a health care plan, consisting primarily of "core" medical coverage, must be offered to 90% of non-highly compensated employees to pass the eligibility test.

In addition, employee contributions could not exceed \$520 a year for individual coverage and \$1,300 a year for family coverage. These maximum contribution limits would be indexed to the annual increase in the average national wage.

Under the Senate bill, core health care coverage would have to be available to 90% of all employees—not just non-highly compensated employees.

In addition, the Senate bill states that employee premium contributions could not exceed 40% of the total premium. And, if an employer

of health care costs.

The Senate bill avoids this problem. Employers could continue to charge employees the same percentage of the premium and still pass the eligibility test.

Possible compromises that could emerge on the eligibility test include:

- Continuing to measure affordability in terms of the percentage of the total premium, but lowering the maximum percentage of the premium that could be paid by employees to 30% or 35%.

- Measuring affordability in terms of a dollar threshold, but link increases in the threshold to the annual rise in the medical care component of the Consumer Price Index rather than annual wage increases.

The House and Senate Section 89 reforms also include a second test known as the benefits test.

Under this test, a plan that is only available to a limited class of employees would be considered non-discriminatory if the cost of coverage is no greater than 133% of the cost of coverage for a core health plan avail-

able to at least 90% of non-highly compensated employees under the Rostenkowski bill or 90% of all employees under the Senate bill.

But the two bills differ significantly in the way they treat employees' pretax contributions toward health care premiums—under certain conditions—in running the 133% benefits test, with the Senate bill more favorable to employers.

For example, under the Rostenkowski bill, employees' pretax contributions toward premiums are treated as employer contributions for highly compensated employees but as employee contributions for non-highly compensated employees.

This increases the chances that a plan will fail the 133% test and that highly compensated employees will be taxed on a portion of their health care benefits.

Under the Senate bill, though, pretax contributions for both highly and non-highly compensated employees are treated as employer contributions as long as those contributions are equally matched by the employer.

And there are significant differences in the way the two bills treat flexible benefit plans.

For example, the Rostenkowski bill counts unused flexible benefits credits that can be taken as cash as employee contributions to a health care plan. As a result, many flexible benefit plans could fail the 90% eligibility test because employee contributions, including cashable credits, would more easily exceed the \$520 and \$1,300 ceilings on employee contributions imposed by the Rostenkowski bill.

By contrast, under the Senate bill, cashable credits would not be counted as employee contributions to a health care plan, so long as the employee certifies that he or she has health coverage from another source.

As originally proposed by Sen. Lloyd Bentsen, D-Texas, cashable credits would have been counted as employee contributions if employees did not reject all employer-provided health care coverage. This requirement was dropped on the Senate floor under an amendment proposed by Sen. Rudy Boschwitz, R-Minn., and Majority Leader George Mitchell, D-Maine. ■

Bill would hike tax credits for child care

WASHINGTON—The Section 89 reform proposal passed by the Senate is attached to child care legislation that would, among other things, expand the existing tax credit for dependent care and create a new tax break for the purchase of either group or individual health insurance coverage by low-income workers with children.

Under current law, taxpayers now can take tax credits of between 20% and 30%—depending on their income—for dependent care expenses of up to \$2,400 annually for one child and \$4,800 for two or more children.

To qualify for the tax credit, the dependent children must be under age 13.

Under the child care bill, the tax credit in 1990 would be raised to 34% for taxpayers earning less than \$8,000 and would be set at 32% for taxpayers earning between \$10,000 and \$12,000.

In addition, starting in 1991, taxpayers who earn less than \$28,000 and who do not owe taxes could receive 90% of the tax credit in cash.

The new tax credit for health insurance premiums would be available to taxpayers earning less than \$18,000 a year with children under age 19. The credit would apply to up to \$1,000 in health insurance premium costs; the credit would not be available for coinsurance and deductible payments. The credit also would not be available for premium contributions that were made through salary reduction arrangements.

The credit would be phased in over four years, starting in 1991. The maximum credit would be 35% in 1991 and would rise until it reached 50% in 1994.

Also, starting in 1991, eligible taxpayers who do not have taxable income could receive 90% of the tax credit in cash.

—By Jerry Geisel

Robins plan

Continued from page 3
plan.

In addition, Aetna Casualty & Surety, which wrote product liability insurance for Robins from March 1968 to February 1978, will make contributions valued at \$425 million to pay claimants.

Under terms of a class-action settlement that also was upheld last month by the federal appellate court, Aetna will contribute \$75 million to the trust fund and provide a \$250 million insurance policy should claims from victims exceed the fund. This will boost the fund to \$2.6 billion, the Robins spokesman calculated (BI, June 19).

In addition, Aetna also will provide a \$100 million insurance policy to cover claims from victims who are not eligible to receive compensation from the trust fund.

"This plan is good for the women" injured by the Dalkon Shield, says claimants' attorney Joseph S. Freidberg of Minneapolis.

"A lot more money will go to these women than prior to the Chapter 11," said Mr. Freidberg.

"There is more than enough money" in the trust to adequately compensate the Dalkon Shield claimants, he said.

However, a small minority of claimants disagrees with Mr. Freidberg's assessment of the plan and may ask the U.S. Supreme Court to review the case, said Alan B. Morrison an attorney with Public Citizens Litigation Group, an organization headed by consumer advocate Ralph Nader.

"There is not enough money in the trust to pay all the claimants," said Mr. Morrison, who represents claimants opposed to the reorganization plan.

If these claimants seek review by the Supreme Court, it will further delay funding of the trust, said Mr. Sheppard, the trust's

director.

"Women have been waiting 10 years and 15 years for their money," he said. "We must now wait and see if these people will further prolong this case by appealing to the U.S. Supreme Court."

Mr. Freidberg characterized appeals of the reorganization plan as "frivolous" and "self-serving."

Aetna's contributions to the trust fund are the result of the settlement of a massive class-action lawsuit filed against the insurer by a group of women injured by the Dalkon Shield. The suit, filed in 1986, alleged that Aetna conspired with Robins to hide the dangers of the intrauterine device (BI, April 21, 1986).

'There is more than enough money' in the trust to adequately compensate the Dalkon Shield claimants, says Joseph S. Freidberg.

The suit also alleged that Aetna was a joint tort-feasor with Robins because from "the time (Aetna) agreed to insure Robins and continuing up to the present, (Aetna) became an active participant in all stages of development, testing, promotion and marketing of the product as well as being inexorably involved in the palliation of the public and the medical profession."

The suit sought unspecified actual and punitive damages as well as treble damages under the Federal Racketeer Influenced and Corrupt Organizations law.

In exchange for Aetna's agreement to contribute to the Dalkon Shield Trust Fund and

provide additional insurance, the settlement stipulates that all Dalkon Shield lawsuits must be filed against the trust and not against Aetna, thus freeing Aetna from all liability.

"When the parties have funded the trust, Robins, Aetna and any successor corporation are relieved of any further liability, and this is proper since Dalkon Shield claimants will be paid by the trust the full value of their claims," said the ruling by the 4th Circuit.

The appellate court noted that the settlement of the class-action lawsuit was directly tied to the viability of the reorganization plan. The court noted that if the women were successful in pressing their claims against Aetna, Aetna, in turn, would be entitled to seek contribution from Robins. This contribution claim would delay the bankruptcy proceedings, the court explained.

"The plan of reorganization and the settlement are interdependent. Failure of approval of either... would derail hopelessly the carefully negotiated and crafted plan and the settlement and leave the Dalkon Shield claimants to the vagaries, expenses and delay of further extended litigation," the appellate court said.

Furthermore, American Home Products' contributions to the fund are contingent on the settlement of all Dalkon Shield claims against any party.

American Home Products feared that if the class-action suit against Aetna were successful, Aetna would acquire a right to seek contribution against the successor company to Robins.

"The settlement of the Aetna suit became the linchpin of the reorganization plan," said claimants' attorney Mr. Freidberg.

Aetna attorney Mr. Harkins of Pepper, Hamilton & Scheetz in Philadelphia agreed: "American Home made it clear it wanted all controversies resolved."

However, critics say the Aetna settlement, in effect, allowed the insurer to piggyback on Robins' Chapter 11 filing and shield itself from liability.

Mr. Harkins denies this: "We weren't piggybacking; we were complementing."

"Aetna and Robins had separate interests, but they were complementary," he said.

Some attorneys say the federal appellate court's approval of Aetna's settlement opens the door for similar arrangements in the future.

"Now when you have bankruptcy, this decision will provide an opportunity for claimants to bring in non-bankrupt parties," said Mr. Freidberg.

These non-bankrupt, but related, parties "should be willing to pay a premium to be shielded from liability," he said.

However, Mr. Harkins noted that the Aetna settlement resulted from "a very unique situation that is not readily applicable to other mass tort cases."

Mr. Freidberg, who filed the class-action lawsuit against Aetna, pointed out that "Aetna and Robins had a close interlocking relationship... more so than you would normally find between an insured and an insurer."

In approving the class-action settlement, the appellate court also had to approve certification of the Dalkon Shield victims as a class, a move that could have profound impact on class-action litigation, according to attorneys.

Because the issue of whether Aetna was guilty as a joint tort-feasor with Robins was at the heart of the women's claims in the lawsuit, the U.S. District Court said there was sufficient commonality among the claimants for certification as a class action.

The 4th Circuit agreed: "It was accordingly very much in the interests of both

Continued on next page

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Outhwaite suit

Continued from page 3

The litigation pending in London's High Court centers on an aggregate excess-of-loss runoff reinsurance policy that Mr. Outhwaite wrote for syndicate 179/884 in 1981.

The policy was written to "reinsure the liability of (syndicate 179/884) arising from all business in respect of the (syndicate's) underwriting years of account 1959-1968," the lawsuit filed by Mr. Lark states.

For a premium of 250,000 pounds (\$405,000 at year-end 1982 exchange rates) Mr. Outhwaite agreed to reinsure syndicate 179/884 "howsoever and wheresoever arising of all sums falling due for payment after Jan. 1, 1981, excess of an aggregate net payment (termed an excess) of 1.25 million pounds" (\$1.9 million at current exchange rates), court papers say.

The policy contract says that "no further particulars shall be required by the reinsurer, but the books of the reinsured so far as they may concern policies and/or contracts falling within the scope of this reinsurance shall be open to the inspection of an authorized representative of the reinsurer at any reasonable time during the continuance of this reinsurance," Mr. Lark's lawsuit notes.

In April 1987, syndicate 179/884 sought an arbitration ruling that the runoff policy was valid after Mr. Outhwaite disputed the policy.

In the Nov. 15, 1988, arbitration award for syndicate 179/884, umpire Simon Tuckey declared "that the contract remained in full force and effect" and awarded the syndicate 2

million pounds (\$3.6 million at year-end 1988 exchange rates), which was the value of the claims for which syndicate 179/884 sought coverage from the Outhwaite syndicate at the time, according to the lawsuit.

The umpire further declared that Mr. Outhwaite was liable to indemnify syndicate 179/884 "for all further liabilities" arising from its 1959-68 underwriting years, the suit says.

A High Court judge on Feb. 17 dismissed Mr. Outhwaite's application to appeal the arbitration award.

Since then, syndicate 179/884 has submitted to the Outhwaite syndicate additional claims totaling 542,603 pounds (\$838,322 at current exchange rates), the lawsuit says.

Mr. Outhwaite paid 271,301 pounds (\$419,160) to the syndicate on April 25 but "wrongfully, and in breach of contract, the defendant has refused to pay the balance of 271,302," the lawsuit claims.

Although the arbitration upheld the validity of the contract in general, "not all claims are recoverable under the policy," explained Stephen Bailey, a partner with the London law firm Elborne Mitchell, which represents Mr. Outhwaite.

Mr. Bailey explained that Mr. Outhwaite's defense for not paying all claims submitted by syndicate 179/884 is "linked" to a subsequent arbitration ruling by Lord Wilberforce in a dispute between syndicate 317/661 and syndicate 347/570, managed by M.H. Cockell & Partners.

Lord Wilberforce ruled that the Outhwaite syndicate need not reimburse the Cockell syndicate for "gaps and surcharges"—or the share of the

costs the Cockell syndicate incurred in setting up the Asbestos Claims Facility and the claims the syndicate paid for facility members on behalf of insurers that were not facility members.

In an earlier arbitration decision, Lord Wilberforce declared the Cockell contract was valid, though he did not determine the exact amount of claims that the Outhwaite syndicate must pay under the policy (*BI*, Oct. 24, 1988).

Claims filed by Outhwaite syndicates' cedants that fall under gaps and surcharges represent a very small proportion of the total claims filed under most runoff policies, ceding underwriters say.

However, Mr. Outhwaite contends that the judgment could pertain to all claims against the runoff policies relating to underlying claims settled through the facility, not just "gaps and surcharges." Mr. Outhwaite wrote in this year's annual report that "in stating his reasons, Lord Wilberforce held that we should not be liable for sums paid, for example, under the terms of the Asbestos Claims Facility agreement where no legal liability under any original insurance policy could be proved."

Mr. Outhwaite further states: "In our view a substantial number of claims have been paid by ceding syndicates to which the Wilberforce judgment apply."

Outhwaite has paid about 50% of the claims filed by Mr. Lark but the "other 50% has been withheld because of the implications of the Wilberforce judgment," an Outhwaite spokesman confirmed. ■

Outhwaite claims also under dispute

LONDON—While Lloyd's of London underwriter Richard Outhwaite disputes claims filed under runoff reinsurance policies he wrote for other insurers and syndicates, a retrocessionaire of one of Mr. Outhwaite's syndicates now is questioning claims Mr. Outhwaite has filed.

Meanwhile, Mr. Outhwaite has filed suit against the broker that placed the reinsurance coverage for his syndicate.

London-based reinsurance company Mercantile & General Reinsurance Co. P.L.C. is questioning claims against a quota-share reinsurance policy it wrote covering the 1982 underwriting year of incidental non-marine syndicate 661, managed by R.H.H. Outhwaite (Underwriting Agencies) Ltd.

The business covered by the non-marine quota-share reinsurance policy includes the runoff reinsurance policies written by the Outhwaite syndicate, explained an Outhwaite spokesman.

However, "there is no dispute on the policy at present. Mercantile & General is asking questions," the spokesman said.

M&G "has raised and asked questions about the balance of payments which allegedly is owed under the policy (written by M&G), and the matter is now the subject of correspondence," said Tim Hardy, a partner with the London law firm Barlow Lyde & Gilbert, which represents M&G.

Many of the questions raised by M&G relate to the runoff policies written by Mr. Outhwaite, Mr. Hardy confirmed.

He said the policy is a non-marine quota-share reinsurance policy written 100% by M&G, but he would not provide further details on policy limits.

The Outhwaite spokesman refused to disclose details of the policy.

Syndicate 661 and sister syndicate 317, managed by Outhwaite, have not closed their 1982 underwriting year, and outstanding liabilities and incurred-but-not-reported losses from that year currently total 304 million pounds (\$469.7 million).

The syndicates' liabilities stem mainly from dozens of runoff reinsurance policies Mr. Outhwaite wrote to cover ceding insurers' past liabilities.

Outhwaite has made a cash call this year of 64.8 million pounds (\$100.1 million) on the 1982 members of the syndicate, and the members face future cash calls of 76 million pounds (\$117.4 million) (*BI*, June 5).

As a protective measure, Outhwaite has filed a lawsuit against the London reinsurance broker that placed the policy, an Outhwaite spokesman confirmed.

Outhwaite filed the lawsuit against Golding Stewart Wrightson Ltd., a subsidiary of Willis Faber P.L.C., on May 25, but the suit has not yet been served, the spokesman said. Under English law, plaintiffs have up to 12 months to serve a lawsuit on a defendant.

The lawsuit seeks unspecified "damages in respect of losses caused to the plaintiff as a result of breach of contract and/or breach of duty and/or negligence by (Golding Stewart Wrightson) in respect of their placement, on behalf of syndicate 661 at Lloyd's, of a written non-marine quota-share contract for the year 1982 with the Mercantile & General Reinsurance Company P.L.C."

"We are aware litigation has been filed but we have not received a lawsuit," said a Willis Faber spokesman.

—By Carolyn Aldred

Robins reorganization

Continued from previous page

Aetna and Dalkon Shield claimants as well as the public interest that this issue common to every Dalkon Shield case be resolved through a class certification rather than through an innumerable procession of thousands of individual cases."

The 4th Circuit appears to be relaxing the rules for class certification, attorneys say.

"The court adopted a flexible approach," said Mr. Harkins.

"The court's ruling will hold the door open" for more class certifications, said Mr. Freidberg.

"This case might start a trend as far as flexibility of class-actions," agreed Mr. Sheppard, director of the

Dalkon Shield Trust Fund.

The Dalkon Shield Trust Fund is unique in that it caps the amount of money to be used to pay claims.

For instance, Manville Corp.'s Personal Injury Trust, established during the Manville bankruptcy to pay asbestos claims, is open-ended with the ultimate value of the trust tied to the company's profits (*BI*, Feb. 13).

However, Mr. Sheppard points out: "Unlike Manville... there is a finite number of claimants."

"There was no reason to leave the trust open-ended," agreed Mr. Harkins, who noted that the plan is set up to pay 100 cents on the dollar. Many other reorganization plans pay only a fraction of the dollar.

Currently, the Dalkon Shield Trust is using \$100 million that was advanced by the trustees to pay certain smaller claims. To date, the fund has paid \$52 million to 78,000 women. The trust still must pay 118,029 claims, Mr. Sheppard said.

The trust fund will not receive the payments from American Home Products until all court appeals related to the reorganization plan are exhausted, he explained.

While it is not clear what the trustees will do if there is not enough money in the trust to pay all the claimants, any money remaining after all claims are paid will be distributed to claimants as a form of punitive damages, he said. ■

Florida TPA statute

Continued from 3

agreements must: contain statutory requirements, such as stating that the TPA has a fiduciary liability under the plan; stipulate that the TPA must maintain adequate books and records for five years after the end of the contract with the employer; and stipulate that the TPA's compensation cannot be contingent on the plan's claims experience.

In addition, the law required TPAs to disclose to the Insurance Department ownership interests or affiliations with insurance companies that write coverage for health and welfare plans for which the TPAs provide administrative services.

The Florida statute also gave the Insurance Department the authority to suspend or revoke the license of a TPA administering an employee benefit plan.

The SIIA argued in its complaint, filed against then-Florida Insurance Commissioner Bill Gunter, that "because the Florida statute 'relates to' and purports to regulate directly and indirectly any ERISA 'employee welfare benefit plan' that covers Florida residents, the Florida statute is pre-empted by and in conflict with ERISA."

ERISA's "deemer" clause says that an employee benefit plan shall not be deemed to be an insurance company or engaged in the business of insurance for the purposes of any state law designed to regu-

late insurance or contracts.

The SIIA asked the court to declare that the Florida statute was pre-empted by ERISA and that no administrator or sponsor of a self-insured ERISA health and welfare plan be required to comply with any part of the statute.

The SIIA suit also asked for an injunction prohibiting the Insurance Department from enforcing the statute.

The SIIA contended that four of its members had been fined under the statute for filing financial reports late, according to Mr. Kinder of the SIIA and the magistrate's written decision.

But, the state argued that the state statute regulates insurance and therefore is not subject to ERISA pre-emption because of the federal law's "savings clause."

ERISA's savings clause—which "saves" state law from ERISA pre-emption—says the ERISA pre-emption does not apply to any state law that regulates insurance.

"We have taken the position that a person or company that is administering an ERISA self-funded benefit plan is still subject to regulation by the state. Our position is that those companies are in the business of insuring benefits," Mr. Butler explained.

In his decision, Magistrate Sherrill wrote that "one must conclude that these Florida statutes at least in part 'relate to' ERISA plans. Since they 'relate to' ERISA plans,

the statutes are pre-empted by ERISA unless saved by the ERISA savings clause, which protects state laws that regulate insurance."

However, the judge found that the Florida statute challenged in this case does "not regulate the 'business of insurance'" and, thus, is not protected by the ERISA savings clause.

However, Magistrate Sherrill also noted that the Florida statute is pre-empted by ERISA "only to the extent that such statutes are applied to employer/plan sponsors or contract administrators with respect to their activities, functions and responsibilities performed on behalf of self-funded ERISA employee benefit plans."

While the SIIA considers the decision a victory for administrators and sponsors of self-insured employee benefit plans, some third-party administrators said that some regulation of the TPA industry could benefit both the industry and its clients.

'I don't think these regulations were to the detriment of the TPA business,' says Jessica Harkness.

"I think it's important that there be some standards of performance or standards of financial stability, because there have been a lot of people who have been hurt by TPAs that didn't have the staying power," said Samuel X. Kaplan, chairman of U.S. Administrators Inc., a Los Angeles-based TPA.

"But, the problem is that the licensing is only as good as those who are doing the licensing," he warned.

"I don't think these regulations in Florida were to the detriment of the TPA business. I really don't think that some type of licensing is bad for the TPA industry," pointed out said Jessica Harkness, president of Self-Funding Administrators Inc., a TPA based in Altamonte Springs, Fla.

"I feel the legislation we have right now in Florida is not bad," she said.

In addition, some TPA officials doubt that the decision will greatly affect Florida's TPAs.

"I think all of us in the TPA industry have always felt that the Florida Department of Insurance never had the authority to implement the regulations in the first place," Ms. Harkness said.

"But, at this point, it's really a hide-and-watch situation. We will anxiously await the state's reaction. But, I really don't think the decision's going to change our business dramatically," she said.

Ms. Harkness added that if the

decision is reversed, Self-Funding Administrators is "already in compliance."

The decision mainly "was a good move to try to clarify the authority that the Insurance Department has over ERISA plans," said James Hanahan, president of WHP, First in Employee Benefits Inc., a St. Petersburg, Fla.-based TPA.

Meanwhile, one benefits expert questioned whether ERISA applies to state regulatory control over TPAs.

"It's always been true that ERISA provides pre-emption in as far as a state trying to regulate through the back door," said Frederick D. Hunt Jr., president of the Washington-based Society of Professional Benefit Administrators.

"But, I think it's wishful thinking to think this applies to anything and everything a TPA does," he said.

However, the U.S. Labor Department has not issued a position "one way or the other" on whether ERISA pre-emption extends to state regulatory control of TPAs, noted John Keene, an employee benefits plan specialist with the department.

He noted, though, that the department is preparing advisory opinions on whether some states' laws regulating TPAs are pre-empted by ERISA. Mr. Keene could not identify which states are involved or when those opinions would be issued. ■

Lloyd's reinsures British export cover

By CAROLYN ALDRED
and STACY SHAPIRO

London

LONDON—The British government's Export Credit Guarantee Department, which writes credit insurance for British exporters, is reinsuring with Lloyd's of London for the first time.

The reinsurance, which covers a form of confiscation coverage for aircraft financed under a leasing arrangement, likely will be the first of many risk sharing ventures with the Lloyd's market, says the broker who placed the policy.

The new cover offered by ECGD insures against the risk of an aircraft lessor being unable to repossess an aircraft in the event of payment defaults by the lessee, according to an ECGD statement.

The first aircraft covered by the ECGD facility is an Airbus A310-304 operated by Somali Airlines under a lease arranged by Banque Indosuez in Paris.

The ECGD cover relates to the \$12 million British share of the Airbus, whose manufacturer is a consortium of British, French and West German interests. Meanwhile, French state-owned credit insurer Compagnie Française d'Assurance pour le Commerce Extérieur (COFACE) will be insuring the French portion of the aircraft and Hermes Kreditversicherung A.G. is providing the West German coverage.

The arrangement "marks the first transaction to be reinsured by ECGD in the Lloyd's market. Lloyd's will reinsure ECGD initially for the first three years of the 12-year policy duration," said an ECGD statement.

ECGD Chief Executive Malcolm Stephens said the agency intends to "extend into new sectors of the insurance markets" and added that "by obtaining reinsurance with the Lloyd's market, we have moved into areas of risk sharing that are both challenging and commercially expanding."

Investment Insurance International Ltd., a subsidiary of London broker Hogg Robinson & Gardner Mountain P.L.C., which placed the policy at Lloyd's, is examining the possibility of placing other reinsurance contracts for the ECGD at Lloyd's, said III Director Kit Brownlee.

Meanwhile, a British government-sponsored study into the future of ECGD has recommended a radical restructuring of the ECGD in order to privatize a portion of the agency's operations.

The report, conducted by former ECGD Director Robert Kemp, recommended that the two main ECGD insurance operations—the

Cardiff, Wales-based Insurance Services Group, which handles short-term credit insurance, and the London-based Project Group, which handles medium-term credit risks—should be run as separate businesses, but with a reinsurance link.

The Insurance Services Group should be converted into a wholly government-owned company, which will continue to compete with private insurers, while the Project Group should retain its status as a government department, the report recommends.

According to Mr. Kemp's report, "generally speaking, risks with a horizon of longer than three years cannot be placed in the private sector, and even for shorter risks it is normal for governments to bear most of the political risks."

However, "for risk insurance (mainly in the short-term field) direct government backing is not essential, though it would have to be replaced by capital backing, financial reserves and reinsurance arrangements," it adds.

As a result, the report recommends that ECGD's Insurance Services division be "converted to a government-owned company administered through ECGD, with a view to the eventual introduction of private capital."

Meanwhile, "even for short-term business, it is not recommended that the government should aspire to withdraw its support completely. This would be a very high-risk policy and would be strongly opposed by industry."

Moreover, "it is unlikely that the private sector would adequately supply cover for political risk for small business or provide supporting advice in the way that ECGD does at present," it notes.

New syndicate

Lloyd's of London underwriter John Prestage is leaving non-marine syndicate 212 managed by R.W. Sturge & Co. to set up his own syndicate with another agency.

Mr. Prestage, who was nominated as active underwriter for syndicate 212 in 1986, resigned as underwriter to set up new syndicate 1007, which is to begin underwriting during year-end renewals starting in October.

Non-marine syndicate 1007, with an expected stamp capacity of 10 million pounds (\$15.5 million at current exchange rates), is to be managed by Spreckley Villers Hunt & Co. Ltd., according to the prospectus for the new syndicate. It will write a sim-

ilar portfolio of business as syndicate 212, namely worldwide property business mainly outside the United States and Canada; personal accident insurance; kidnap and ransom insurance; and medical expense coverages.

BPR offer

Four former Lloyd's of London market executives and Bellew Parry & Raven (Holdings) Ltd. are offering 1,500 members of syndicates managed by BPR more than 14 million pounds (\$21.6 million) as "restitution" for money owed to members by the syndicates.

The agency, now part of Oxford Members' Agency Ltd., which is owned by Sturge Holdings P.L.C., wrote to members last December about the proposed settlement after four BPR executives were disciplined by Lloyd's.

John Parry, Arthur Henry Grat-tan-Bellew, Frederick Charles Raven and Edward Nelson were found guilty by Lloyd's on charges related to placing reinsurance of BPR syndicates with offshore companies that BPR executives owned or controlled (*BI*, Dec. 12, 1988; Oct. 5, 1987).

The formal offer is being sent to members this month and "will be conditional on acceptances being received amounting to not less than 90% by value."

'New thinking'

Lloyd's of London must adopt "fundamental new thinking" if it is to survive, contends internationally known philosopher Edward de Bono.

In a letter to *The Financial Times* last month, Mr. de Bono identified several factors that "contribute to the probable decline of Lloyd's."

According to Mr. de Bono, the "Outhwaite affair"—in which syndicate members face hundreds of millions of dollars of losses from disputed runoff reinsurance policies written by Lloyd's underwriter Richard Outhwaite in the early 1980s—"brings into question fundamental concepts" of Lloyd's.

Mr. de Bono argued that "scientific reality tomorrow" may produce other liability losses on the same scale as asbestos losses. For example, it may turn out that "soft drinks in aluminum cans predisposes Alzheimer's disease," he suggested. "There is no way that realistic premiums can ever cope with infinite liability."

Meanwhile, in the United States

—which provides a large part of Lloyd's business—"there is simultaneously a move to cap premiums and to extend losses... which makes for an impossible situation," he said.

However, "the mechanisms at Lloyd's continue to be inadequate, and seem designed to protect the institution of Lloyd's... at the expense of the members," he contends.

In addition, "there is the death-wish of Lloyd's; it seems to prefer to die of nostalgia rather than adapt to present-day circumstances," he claimed.

"A special creative commission on changing concepts must be set up immediately... The Outhwaite affair must be settled equitably, and at the same time fundamental new thinking must take place," Mr. de Bono said.

Insurer taxes

The Assn. of British Insurers is "taking every opportunity to impress on" the British government the need to tax British property/casualty insurers on an "equitable basis" with their European counterparts, said outgoing ABI Chairman Peter Dugdale.

"It is important that the industry's competitive position in the European Community should not be weakened by increasing the overall tax burden on (property/casualty) insurance, which is markedly different in incidence from that in other member states, where insurers can build up reserves on a deferred tax basis," said Mr. Dugdale in the ABI's annual report.

"This, in turn, puts them in a better position to cover the large industrial and commercial risks which will be opened up to international competition before 1992," he noted.

Property/casualty premium volume written by British-based companies increased 8.7% to 13.2 billion pounds (\$24.9 billion at appropriate exchange rates) in 1988, while revenues from marine, aviation and transport insurance increased 6.8% to 1.5 billion pounds (\$2.8 billion).

However, British insurers' property/casualty premium volume from U.S. business dropped 1.3% to 1.9 billion pounds (\$3.5 billion) in 1988, while revenues from European Community nations other than Britain fell 3.8% to 963 million pounds (\$1.8 billion).

According to the ABI, "The U.K. economy benefits enormously from London's pre-eminent position as a world insurance market; invisible earnings attributable to insurance continue to run at about 5 billion pounds (\$7.3 billion at current exchange rates) a year."

However, "if this is to be maintained, then the London insurance market itself must adapt to the challenges posed by the developing insurance centers in other parts of the world, not least within the European Community. We must have the systems, and on a wider front the infrastructure, to support the service and expertise which the world has come to expect of the U.K., and of London in particular," said Mr. Dugdale in the annual report.

Joe Palmer, group chief executive and a director of Legal & General Group P.L.C., succeeded Mr. Dugdale as chairman of the ABI on July 1.

NZI takeover

General Accident Fire & Life Assurance Corp. P.L.C. is bidding to acquire the remaining 49% stake in NZI Corp. Ltd., a New Zealand insurance and banking company, for

\$302 million New Zealand (\$176.7 million).

The offer, which would give General Accident full control of NZI, coincided with the announcement June 16 of a \$320.5 million N.Z. (\$187.5 million) loss by NZI for the fiscal year ended March 31.

NZI was hit badly by the world stock market crash of 1987, which "affected New Zealand and Australia to a greater degree than other countries... (and) particularly affected NZI Bank which had just obtained its banking license," according to a statement by NZI Chairman T.N. Johnston.

The bank has been forced to write off bad debts and make provisions against possible losses totalling \$336.5 million N.Z. (\$196.9 million), added Mr. Johnston, who recommended that shareholders accept the offer.

General Accident, based in Perth, Scotland, claims that "the requirement to maintain NZI's status as a fully independent listed company... has inhibited General Accident from taking the necessary steps to restore the situation."

Acceptance of the offer "will allow General Accident to exercise effectively the full rights and enjoy the full benefits of ownership. It will also identify NZI more firmly with General Accident in the perceptions of clients and depositors and underpin the long-term prospects of the business to an extent not possible in the context of a significant minority shareholder presence," said a General Accident statement.

Comings & goings

K. Taketazu has been appointed deputy managing director and financial director of The Yasuda Fire & Marine Insurance Co. of Europe Ltd. Also, K. Adachi has been appointed general manager and director at Yasuda Fire & Marine, while D. Gasking and C.I. Thornton have been appointed assistant general managers.

David Cooper has been appointed a general manager at Guardian Royal Exchange P.L.C. to head its strategic planning division. Mr. Cooper previously was deputy general manager in the investment and finance division. ■

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Punitive damages

Continued from page 1
vate parties."

The court said "The 8th Amendment was adopted with the particular intent of placing limits on the powers of the new government" and does not apply to civil litigation.

The 8th Amendment states: "Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted."

Justice Harry A. Blackmun, writing for the seven justice majority, said, "Simply put, the primary focus of the 8th Amendment was the potential of governmental abuse of the 'prosecutorial' power, not concern with the extent or purpose of civil damages."

The court traced the history of the 8th Amendment's excessive fines clause to 13th Century amendments, which were a type of fine paid to the English Crown, and to the Magna Carta, which limited the use of amendments.

The court found that neither the English Bill of Rights, the forerunner to the American Bill of Rights, nor the Magna Carta provides compelling reason to apply the 8th Amendment to punitive damages.

However, the court clearly indicated that the 14th Amendment's guarantee of due process could be applied to punitive damages.

"We have never addressed the precise question: 'Whether due process acts as a check on undue jury discretion to award punitive damages in absence of any express statutory limit,'" said the court. "That inquiry must await another day."

The case that attracted 20 amicus curiae briefs stemmed from a dispute between the owners of Kelco Disposal Inc., a small Burlington, Vt.-based waste disposal firm, and Browning-Ferris Industries Inc. of Houston, the nation's No. 2 trash hauler. Kelco sued Browning-Ferris for attempting to drive the small competitor out of business. A federal jury in Vermont awarded Kelco \$51,146 in compensatory damages and \$6 million in punitive damages. The award was sustained on appeal (BJ, Dec. 12, 1988).

The court said the attorneys for Browning-Ferris failed to raise the due process argument early enough in the proceedings.

"While the decision is disappointing for Browning-Ferris, it is in fact somewhat encouraging to the business community as a whole," said Andrew Frey, an attorney with

Mayer, Brown & Platt in Washington who represented Browning-Ferris.

"The most important aspect of the decision is that it is not over," said Jim Morris, chairman of the Defense Research Institute, an association representing defense attorneys.

"The most viable constitutional argument to excessive punitive damage awards has been due process and that is still alive," said Mr. Morris, who is with Browder, Russell, Morris & Butcher in Richmond, Va.

"I am encouraged by the commentary in the opinion that there may be other grounds under which the court will review punitive damages," said Franklin Nutter, president of the Alliance of American Insurers in Schaumburg, Ill.

Jon Harkavy, director of government relations for the Risk & Insurance Management Society Inc. in New York, said: "While RIMS is disappointed the court declined to apply the 8th Amendment prohibition against excessive fines to punitive damages, we are nevertheless pleased by what we read as an almost open invitation by the court to revisit the issue under the 14th Amendment due process clause."

"One constitutional avenue has been closed, but the remaining one remains open," agreed Mr. Riegall of the National Assn. of Manufacturers. "I believe the court will act quickly to take another case raising the question under the due process clause."

"Since there are three such cases pending there could be a decision next term," said Steve Bokot, general counsel for the U.S. Chamber of Commerce in Washington, D.C. "I would not look for a decision before this time next year," he said.

In a concurring opinion, Justices William J. Brennan Jr. and Thurgood Marshall highlighted problems with the current system of awarding punitive damages: "Without statutory (or at least common law) standards for the determination of how large an award of punitive damages is appropriate in a given case, juries are left largely to themselves in making this important, and potentially devastating, decision."

"Punitive damages are imposed by juries guided by little more than an admonition to do what they think is best," the two justices said.

They went on to indicate their support for review of the constitutionality of excessive punitive damages under the due process clause.

"Several of our decisions indicate that even where a statute sets a range of possible civil damages that may be

awarded to a private litigant, the due process clause forbids damages awards that are 'grossly excessive' or 'so severe and oppressive as to be wholly disproportionate to the offense and obviously unreasonable.'"

ATRA's Mr. Connor observed: "There is a high probability the court will find there are due process problems with our current system of awarding punitive damages."

Mr. Riegall of the National Assn. of Manufacturers agreed. "It is very likely we will have some restriction on punitive damages from the court under the due process clause."

In their dissent, Justices Sandra Day O'Connor and John Paul Stevens III said: "The threat of such enormous awards has a detrimental effect on the research and development of new products."

And, they noted: "Awards of punitive damages are skyrocketing. As

'The most important aspect of the decision is that it is not over,' says Jim Morris.

recently as a decade ago, the largest award of punitive damages affirmed by an appellate court in a products liability case was \$250,000. Since then, awards more than 30 times as high have been sustained on appeal."

The justices dissented, in part, because they believe the 8th Amendment excessive fines clause does provide sufficient leeway for the court to review the constitutionality of excessive punitive damage awards.

"If a corporation is protected by the due process clause from overbearing and oppressive monetary sanctions, it is also protected from such penalties by the excessive fines clause," they said.

However, the two justices concurred that the 14th Amendment argument had not been properly raised to allow the court to consider it.

"Businesses will continue to be exposed to punitive damages until the Supreme Court considers punitive damages vis-a-vis the due process clause," said Thomas M. Chrisham, president of the Defense Research Institute and an attorney with Hinshaw, Culbertson, Molemann, Hoban & Fuller in Chicago.

"Manufacturers have been laboring under the burden of unrestrained pu-

nitive damage for 20 years," said Mr. Riegall.

"The unpredictability of punitive damages and the possibility of extraordinary punitive damage awards discourages industry from new developments," said Dennis Connolly, senior vp of Johnson & Higgins in New York.

Mr. Nutter of the Alliance said punitive damage awards often increase claim costs and make it difficult for insurers to price risks. Even the threat of punitive damages increases the settlement cost of most claims, he said.

This was also the finding of the recent study by the Insurance Services Office (BI, Jan. 16, 1988).

But, consumer activists and trial lawyers say that not placing any more restrictions on punitive damages is essential to the jury system.

Awarding punitive damages "benefits the public because punitive damages have been used to force companies to clean up their act," said Allan Morrison, an attorney with Public Citizens Litigation Group, a Ralph Nader consumer organization.

Bill Wagner, president of the Assn. of Trial Lawyers of America, agreed: "Punitive damages serve an important function in our civil liability system."

Juries currently are given sufficient guidance on awarding punitive damages, said Mr. Wagner, an attorney with Wagner, Cunningham, Vaughan & McLaughlin in Tampa, Fla. They are told punitive damages can only be awarded in cases of outrageous misconduct and they are told to sufficiently punish to hurt but not to kill, he said.

"Juries do not need additional guidance because after a jury reaches its decision the trial judge has an opportunity to review the award," said Mr. Wagner. In addition, punitive damages are subject to appellate court review, he said.

Trial lawyers and consumer activists are pitted against businesses in battles over state and federal legislation to limit punitive damages.

Many legal experts say the Supreme Court's decision not to limit punitive damages will put additional pressure on state legislators to enact such laws.

"This decision will put further momentum behind state bills to limit punitive damages," said attorney Mr. Schwartz.

ATRA's Mr. Connor agreed: "I would predict that states are going to take a hard look at giving juries guidance in awarding punitive dam-

ages."

"I hope this decision would add a certain urgency to state legislative efforts," added AIA's Mr. Berrington.

Any actions by state lawmakers probably will not come this year because most state legislatures are currently not in session.

Some 27 states have passed legislation limiting the use of punitive damages since 1984, according to attorney Alfred W. Cortese Jr. of Kirkland & Ellis in Washington, D.C.

Most states now permit punitive damages only when compensatory damages are awarded.

Some 19 states have raised the burden of proof a plaintiff must show for punitive damages to be awarded from a preponderance of evidence to clear and convincing evidence.

Eight states have set caps on punitive damages and five states require punitive damages to be awarded in a separate trial from compensatory damages.

In addition, two states do not permit punitive damages—New Hampshire and Michigan—and two states permit them only under statutes: Louisiana and Massachusetts. And, Nebraska only permits damages to be trebled.

While it is clear that the Supreme Court's decision will put added pressure on state legislators, it is not clear what effect the decision will have on Congress.

A federal product liability reform bill recently introduced in Congress does not cap non-economic damages, like punitive damages, unless the product was approved by the federal Food & Drug Administration, in which case such awards are barred (BJ, June 26).

"The decision can add momentum to the federal product liability bill," said attorney Mr. Schwartz. However, he said, it would be "politically impossible" for the federal product liability bill to be amended to further limit punitive damages.

ATRA's Mr. Connor said the Supreme Court's ruling will not have any impact on the federal product liability bill.

And, Mr. Berrington of the AIA said: "Any decision which appears to allow the unbridled and undisciplined use of punitive damage awards makes the product liability issue and the tort reform issue more important."

Browning-Ferris Industries of Vermont Inc., et al. vs. Kelco Disposal Inc. et al.; United States Supreme Court, No. 88-556.

U.S. Supreme Court leaves RICO intact

By STACY ADLER

WASHINGTON—The U.S. Supreme Court last week provided no reprieve to corporations seeking relief from the Racketeer Influenced and Corrupt Organizations law.

In essence, the court said Congress intentionally made RICO broad and that it was not the court's place to rewrite it.

Meanwhile, the high court's June 26 decision is being viewed as a victory for insurance commissioners who say RICO is their most powerful tool in prosecuting insurance fraud.

However, critics maintain that the 1970 law, which provides for the payment of treble damages and attorneys fees, was intended to prosecute organized crime—not legitimate businesses that are accused of fraudulent activities. They also contend that suits alleging RICO violations are being filed too often, as a scare tactic to force defendants into settlements.

"The argument for reading an organized crime limitation into RICO's pattern concept, whatever the merits and demerits of such a limitation as an initial legislative matter, finds no support in the act's text, and is at odds with the tenor of its legislative history," said Justice William Brennan, who wrote the unanimous opinion.

"Congress' decision not to explicitly limit RICO's broad terms strongly implies that Congress had in mind no such narrow and fixed idea of what constitutes a pattern," he said. "Indeed, the legislative history shows that Congress knew what it was doing when it adopted comradious language capable of extending beyond organized crime."

"RICO may be poorly drafted, but rewriting it is a job for Congress, if it is so inclined, and not for this Court," said Justice Brennan in the decision.

RICO is so confusing that it has "produced the widest and most persistent circuit split on any issue of federal law

in recent memory," according to the concurring opinion of four justices.

The decision stemmed from a lawsuit filed by the customers of Northwestern Bell Telephone Co. of Omaha, Neb., alleging that between 1980 and 1986 the company tried to influence the Minnesota Public Utilities Commission to approve rates in excess of a fair and reasonable amount.

The suit alleged that the phone company made cash payments to members of MPUC, negotiated with them regarding future employment and paid for parties, meals, tickets to sporting events and the like. The plaintiffs sued for RICO violations as well violations of Minnesota bribery laws. However, the lower appellate courts held that the telephone customers did not prove RICO violations.

The Supreme Court therefore was asked to analyze what type of activity is required to meet RICO's standards. In doing so, the high court also analyzed the scope of the law.

Because the decision provides no relief for businesses seeking RICO reform, their only remaining avenue is legislative action.

"The silver lining in the decision is that it underscores the importance of congressional action," said Philip A. Lacovara, chairman of the Coalition for RICO Reform in Washington, D.C.

"The flaw in the statute—its overbreadth—was created by Congress and must be fixed by Congress," Mr. Lacovara said. "This is a problem the courts can't deal with."

Attorney Victor Schwartz of Crowell & Moring in Washington, D.C., agreed, saying congressional action is "absolutely necessary" if RICO is to be simplified.

RICO reform legislation is currently pending before the full Senate Judiciary Committee and the House Subcommittee on the Judiciary.

The RICO Reform Act of 1989, pending before both cham-

bers of Congress, would, among other things, restrict recovery to only actual damages in cases brought by non-governmental plaintiffs and non-consumer plaintiffs.

Action is expected on both bills in the fall.

However, state insurance commissioners generally oppose the pending RICO reform because they say it would deny them access to treble damages under the law, which is their most powerful tool in curbing insurance fraud.

"RICO is the best tool we have in prosecuting insurance fraud," said North Carolina Insurance Commissioner Jim Long.

"If we lose the ability to bring treble damage suits, people can perpetrate insurance fraud and simply pay actual damages as a cost of doing business," he said.

Illinois Insurance Director John Washburn agreed: "RICO is an important tool to make sure we can regulate this business."

Mr. Washburn says the RICO reform legislation pending in Congress would make it impossible for insurance commissioners to use RICO.

Under provisions of the RICO reform bill, "We would not be able to bring a RICO claim against a regulated entity without spending years in litigation," Mr. Washburn said. "It would be so discouraging that no one would bring RICO suits."

The RICO reform could prolong the litigation because it permits a defendant to present an affirmative defense that it had relied upon a regulatory action.

Mr. Long says he hopes that the RICO reform legislation now pending in Congress will exempt insurance commissioners from the reform provisions.

H.J. Inc. et al. vs. Northwestern Bell Telephone Co. et al.; Supreme Court of the United States, No. 87-1252.

U.S. oil spills

Continued from page 1

June 23 and 24, totaled almost 1 million gallons and fouled waters in the Delaware River; Narragansett Bay, R.I.; and Galveston Bay off the Texas coast.

The 794-foot Uruguayan government-owned tanker Presidente Rivera spilled 306,000 gallons of No. 6 oil on June 24 in the Delaware River near Philadelphia.

Original estimates had put the spill at about 800,000 gallons, but the U.S. Coast Guard revised the estimate last week.

Although the oil was relatively easy to scoop up soon after the spill because it floated in large clumps, cleanup efforts last week were hampered by increasingly warmer weather, which began thinning the oil and causing it to spread out.

Environmental concerns, particularly for an island bird haven toward which the spill was moving last week, prompted the state of Delaware last week to sue the Presidente Rivera's captain and the government of Uruguay.

The previous day in Narragansett Bay, the World Prodigy, a 531-foot Greek tanker owned by Ballard Shipping Co., spilled 420,000 gallons when it ran aground off the coast of Rhode Island.

The tanker was carrying No. 2 oil, which is lighter but more toxic than the oil spilled in the Delaware River.

However, the oil was either cleaned up or evaporated quickly, minimizing damage, according to the U.S. Coast Guard.

That same day off the coast of Texas, a barge owned by Coastal Towing Inc. in Houston collided with a Panamanian tanker and spilled its load of 250,000 gallons

of heavy crude oil. Fault in that accident had not been determined by late last week.

The Narragansett Bay and Texas spills were largely cleaned up by the end of last week.

Underwriters say the recent spills have attracted a lot of attention because of the publicity generated since the Exxon Corp. tanker Valdez ran aground in March, spilling more than 10 million gallons of crude oil in Alaska's ecologically rich Prince William Sound (BI, April 3).

The Exxon spill is expected to cost insurers at least \$400 million in pollution cleanup and third-party liability claims (BI, June 26).

Exxon says it has received 1,300 claims from fishermen and others and is named as a defendant in 31 lawsuits, most of which seek class-action status (BI, May 1).

But, underwriters believe that the three recent spills will be far less costly.

The three oil spills are pretty much bread-and-butter types of losses, summed up one Lloyd's of London underwriter, meaning that the size of the claims are expected to be similar to many marine-related claims that hit the market on a regular basis.

The owners of three of the four ships involved have \$400 million of pollution liability and cleanup insurance with protection & indemnity clubs.

Pollution losses covered by the clubs include:

- Losses and damages resulting from the oil spill.
- The costs of any reasonable measures taken to avoid or minimize pollution and any liability for losses or damages to property resulting from those measures.
- Costs of, or resulting from, liabilities from complying with an

order or direction from any government or authority to prevent or reduce pollution.

The clubs sometimes require minimal deductibles of no more than \$15,000.

The clubs retain the first \$1.2 million of a loss. Then, the International Group of P&I Clubs assumes the next \$10.8 million.

Limits excess of \$12 million to \$400 million are reinsured by Lloyd's of London, the Institute of London Underwriters and world markets.

"The cleanup costs would only involve the London market if the claim exceeded the P&I club's deductible of \$12 million per incident, which none look like doing," said Derek Wills, chairman of Lloyd's Underwriters' Assn.

The Auxiliary Service of the Uruguayan Navy, which operates the Presidente Rivera, has \$400 million of pollution liability insurance from the West of England Shipowners Mutual Insurance Assn. (Luxembourg) Ltd., confirmed Christopher South, claims correspondent for the club in London.

But, Mr. South said he does not expect the accident to result in large claims. "It is not a major spill. It looks nasty" because the fuel had congealed into lumps floating on the surface, he observed.

"But, it isn't toxic. There is little damage to the environment. I don't think it will be a major disaster," Mr. South said.

However, the state of Delaware and the U.S. Environmental Protection Agency are more concerned about the possible adverse effects of the spill on the environment.

Delaware's suit against the ship's captain and the government of Uruguay seeks "recompense for damage to the Delaware environment," according to Michael Foster, state solicitor in the Delaware Department of Justice.

Mr. Foster, who filed the suit on behalf of the state in U.S. District Court in Wilmington, said the action also seeks reimbursement of cleanup costs and payment of statutory fines for violating the Delaware Environmental Code.

Mr. Foster said cleanup costs were mounting last week as 50 boats, 300 National Guard troops and private companies were enlisted to clean up the spill. A final tally on the cleanup will not be known "for some time," he added.

The fines amount to \$10,000 for each day the tanker spilled oil into the water, Mr. Foster said. "It may only be one day or two, but the damage it has caused will last a long time," he noted.

And, a spokeswoman for the U.S. Environmental Protection Agency said officials were particularly concerned about the fragile ecology of Pea Patch Island, which is a haven for several types of birds.

A flock of Canadian Geese were being removed from the island, she noted. But, only three fish had been found dead, she said.

But, the spill, which occurred approximately 21 miles off the Delaware coast, is not expected to reach the island, the Coast Guard said late last week.

The Coast Guard said cleanup efforts in the Delaware River are expected to continue at least into this week, but it could not estimate when the cleanup will be completed or its total cost.

The Presidente Rivera's cargo was being delivered to Jersey Central Power & Light in Morristown, N.J. and to Consolidated Edison Co. of New York.

A spokesman for Jersey Central said last week he was still expecting delivery of the 100,000 barrels, or 4.2 million gallons, of oil. At least 80,000 barrels had been pumped onto a barge destined for the utility and "another 20,000 are still on the ship," he said.

Continued on next page

Update

PSA parent to pay damages

Continued from page 2

At the time of the crash, USAir had \$600 million in liability coverage written by U.S. and French aviation insurers (BI, April 18, 1988; Dec. 14, 1987). The lead underwriter was U.S. Aircraft Insurance Group.

Ogden Allied's contribution to the settlements "is still being resolved," the spokesman said, acknowledging that USAIG also insured Ogden Allied.

Authorities have determined the crash was caused by a disgruntled former USAir employee who boarded the plane with a pistol.

Warner revocation order stayed

BOSTON—A Massachusetts Insurance Division order revoking all licenses of Fireman's Fund Insurance Co. subsidiary Warner Insurance Co. in the state has been stayed until at least July 12 under an agreement between the insurer and the state.

Supreme Court Justice Ruth Abrams will hear arguments on continuing the stay on that date, and the justice has referred the matter to the full state Supreme Court for review in September.

The Insurance Division on June 29 held that Fireman's Fund bought Lisle, Ill.-based Warner from Wausau, Wis.-based Employers of Wausau Insurance Co. last September in an attempt to circumvent its agreement with the division that allowed the insurer to stop writing business in Massachusetts. Fireman's Fund tried to let its licenses expire without notifying the state (BI, March 27; Oct. 17, 1988; Nov. 20, 1987). Fireman's Fund cited the increasing burden of assessments to the state's residual private automobile insurance pool as reason for its withdrawal.

"The settlement agreement under which Fireman's Fund withdrew was intended to prevent the kind of backdoor re-entry into Massachusetts that they attempted in purchasing Warner," said Daniel R. Judson, an attorney for the Insurance Division.

Warner has written 208 commercial insurance policies totaling \$839,798 in premiums in Massachusetts since January, according to Fireman's Fund attorney Richard J. Underwood, who is with the Boston firm of Finnegan, Underwood, Coombs, Ryan & Tierney.

Outhwaite runoff policy valid

LONDON—Lloyd's of London underwriter Richard Outhwaite lost another arbitration ruling Friday in his long-running battle to void runoff reinsurance policies he wrote to cover other insurers' past underwriting liabilities.

Arbitration umpire Robert MacCrimmon Q.C. ruled on June 30 that an unlimited runoff reinsurance policy Mr. Outhwaite wrote for syndicate 33, managed by Roberts & Hiscox Ltd., "is enforceable," said Clive Boxer, a partner in the London law firm Fishburn Boxer, which represented syndicate 33.

Syndicate 317/661, managed by R.H.M. Outhwaite (Underwriting Agencies) Ltd., in 1982 wrote 100% of an unlimited runoff reinsurance policy for underwriter Robert Hiscox's syndicate excess of \$7.5 million to cover losses on underwriting years prior to 1974.

Although the syndicate has yet to file many claims under the policy, paid losses and outstanding liabilities likely to fall under the policy total about \$20 million, Mr. Hiscox said.

Meanwhile, Mr. Outhwaite is asking a London High Court to rule that settlements by the now-defunct Asbestos Claims Facility are not recoverable under a runoff reinsurance policy he wrote for Lloyd's syndicate 179/884, managed by Anton Managing Agency Ltd., a subsidiary of Merrett Holdings P.L.C. underwriter (see story, page 3).

Raymark loses class action bid

PHILADELPHIA—The U.S. Bankruptcy Court in Philadelphia June 27 rejected Raymark Industries Inc.'s motion to lift its bankruptcy stay so that it could pursue its attempt to consolidate all pending asbestos-related claims against it into a mandatory class action in Texas.

If Raymark had been successful in its motion, it could have pursued certification of a mandatory class action in the U.S. District Court for the Eastern District of Texas in Beaumont. That mandatory class action would have precluded plaintiffs from attaching the assets of Raytech Corp., Raymark's former parent company, under successor liability, said plaintiffs' attorney Timothy Eble with Ness, Motley, Loadholt, Richardson & Poole in Barnwell, S.C.

Raytech, which was formed in 1986 to protect Raymark's profitable operations from ongoing asbestos litigation (BI, Sept. 15, 1986), filed for Chapter 11 protection March 10 to shield itself from mounting lawsuits while it appeals an Oregon federal court ruling that it does have successor liability to Raymark.

Meanwhile, Raytech is suing four asbestos plaintiffs in U.S. Bankruptcy Court in Bridgeport, Conn., seeking a declaratory judgment that it is not a successor of Raymark's.

Briefly noted

James B. Lockhart, former vp and treasurer at Alexander & Alexander Services Inc. in New York, was, as expected, named executive director of the Pension Benefit Guaranty Corp., succeeding Kathleen P. Utgoff (BI, May 8). . . . President Bush has nominated Gerard F. Scannell director of corporate safety, fire and environmental affairs at Johnson & Johnson Products Inc. in New Brunswick, N.J., as the new chief of the federal Occupational Safety and Health Administration. . . . The District of Columbia council preliminarily approved a law that would make gun manufacturers, dealers and importers strictly liable for any injuries or fatalities caused during shooting incidents (BI, Feb. 6). . . . The House last week voted to bar the Overseas Private Investment Corp. from writing new political risk insurance policies for U.S. companies investing in China. The proposal would not affect existing OPIC policies. . . . A series of storms that ripped through the South Atlantic states caused about \$60 million in insured property damage, according to the American Insurance Services Group. . . . The New York Court of Appeals has ruled that the pollution exclusion bars coverage to Technicon Electronic Corp. because the company knowingly discharged hazardous wastes (BI, Dec. 5, 1988).

Insurance services guide

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U.S. oil spills

Continued from previous page
The Jersey Central spokesman said the oil was valued at \$16.50 per barrel.
Based on that figure, the value of the spilled oil was approximately \$120,200.
A spokeswoman for Con Edison would say only that the utility did not own the oil it had ordered and therefore had not suffered a loss.
The oil was owned by Interior, a unit of Petrobras, a Brazilian oil company. Officials of Interior could not be reached for comment.
In a Coast Guard hearing in Philadelphia last week, the captain of the Presidente Rivera testified that the tanker dropped anchor too soon, causing the vessel to run aground.
West of England Shipowners' Mr. South could not estimate the insured value of the hull.

However, one Lloyd's underwriter believes that the cost of repairing the Presidente Rivera, which he said has a hole in one side of its hull, will not exceed \$500,000.

Ballard Shipping, the owner of the World Prodigy, also has \$400 million of pollution liability and cleanup insurance for the Narragansett Bay spill. The company is covered by the United Kingdom Steamship Mutual Assurance Co. of London, which is managed by Thomas R. Miller & Son, confirmed a spokeswoman.

The ship's captain, 43-year-old Iakovas Georgidis, surrendered last week to the U.S. attorney in Providence, R.I., and was charged in U.S. District Court in Providence with violating the federal Clean Water Act and the Refuse Act. Each of the counts carries penalties of up to one year in prison and a \$100,000 fine, or double the actual damages.

Mr. Georgidis was released on \$50,000 bond but is confined to the ship. The court has scheduled a hearing on July 18 to determine the probable cause of the grounding.

The 420,000-gallon spill off the Rhode Island coast was the largest of the three spills. But Joe Nicols, a technical manager for The International Tanker Owners Pollution Federation Ltd., which advises member tanker owners on pollution containment, called it a "non-event."

The ITOFF visited the spill site last week and says that the oil spilled is a light heating oil that either evaporated rapidly or dispersed into the sea.

Therefore, damage from the spill will be minimal," Mr. Nicols predicted.

However, some areas of the bay that are used by small shellfish businesses were closed immediately after the spill, said a spokeswoman for Rhode Island Gov. Edward Di Prete.
She said it is expected that some of the 600

to 700 businesses that use the bay will sue the shipowner if they lose revenue.

The spokeswoman could not provide a breakdown of revenues related to shell fishing in the area tainted by the spill, but said the state's shell fishing industry generates annual revenues of around \$24.5 million.

Nearly all of the closed areas were expected to be reopened by Sunday, she said.

The cost of cleaning up the Rhode Island spill will total at least \$1.6 million, according to Steve Morin, chief of emergency response with the Coast Guard.

But, a spokeswoman for Clean Harbours Inc. in Quincy, Mass., the company directing the effort, said the final bill for the cleanup is "the \$1 million question. No one knows until it's all done and we can add up the Ps and Qs."

The spill in the bay was completely cleaned up and shoreline cleanup efforts were nearly finished late last week, according to the governor's spokeswoman.

The World Prodigy's hull, insured for \$10 million in the London and world insurance markets, "will be saved," said a Lloyd's underwriter on the risk.

Divers last week inspected the portion of the hull that remained underwater and an estimate on the damage is expected this week, said Jim Baker, an adjuster with Transport Mutual Services Inc., the U.S. agent for United Kingdom Steamship Mutual, said last week.

The oil aboard the World Prodigy is valued at approximately \$19 per barrel, according to the American Petroleum Institute in Washington, D.C. Based on that figure, the value of the spilled oil is approximately \$190,000.

In Galveston Bay, a barge owned by Coastal Towing Inc. in Houston collided with the Panamanian-registered tanker Rachel B., spilling 252,000 gallons of fuel oil from the barge.

Coastal Towing has at least \$400 million of pollution liability and cleanup insurance with the Steamship Mutual Underwriting Assn. (Bermuda) Ltd., confirmed Chris Adams, claims manager for the P&I club.

Underwriters were not clear about the insurance program for the owner of the Rachel B or who owned the vessel.

However, the Coast Guard says the owner has \$1.2 million of pollution liability and cleanup coverage with The Japan Shipowners Mutual Protection & Indemnity Assn. in Tokyo.

Coastal Towing officials did not return calls seeking information on the accident.

The spill occurred in an industrial area of the bay and posed no environmental hazards, according to Lynn Garner, president of Garner Environmental Co. in Houston, which is in charge of cleaning up the spill. "There are three chemical plants there," he said.

"We've seen a few oiled birds, and that's about it. We haven't had a fish kill," said David Sager, chief of the environmental contaminants branch of the Texas Parks and Wildlife Department.

Mr. Garner estimates the cleanup will cost between \$300,000 and \$400,000.

The spill in the bay was cleaned up last week, and crews were finishing cleaning up the bay's shoreline late last week, according to the Coast Guard.

The values of the vessels involved in the incident were not known.

The barge, known as the Coastal 2514, has been pulled from the water and is being repaired, according to the Coast Guard. Three of the barge's 12 tanks were ruptured, the Coast Guard said.

Minor damage to the Rachel B had been repaired last week, the Coast Guard added.

The oil aboard the barge was valued at between \$16 and \$19 per barrel, according to the API. Based on that figure, the value of the spilled oil is between \$96,000 and \$114,000.

One London underwriter observed that the recent increase in shipping activity combined with the aging tankers could result in an increase in incidents like the three recent spills.

Many of the tankers now in service were built before 1979, and few tankers have been constructed since then, he pointed out. Replacing tankers is expensive, he said, so fleet owners are extending the life of ships by as much as 15 years.

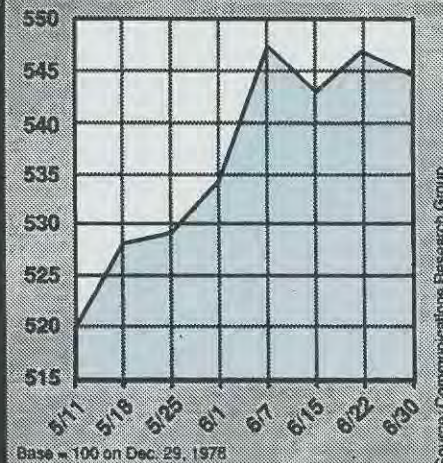
Meanwhile, Congress is considering President Bush's proposed comprehensive liability and compensation system for oil spills by tankers and other sources (BI, May 15).

Under the bill, tanker owners' liability for cleanup damages sought in federal courts would be capped at \$78 million. However, the legislation would allow plaintiffs to sue under state law for economic losses above the liability limits. And the cap would not apply if the proximate cause of an oil spill was due to "willful misconduct."

The legislation would establish a \$500 million oil pollution liability trust fund to cover cleanup costs and damages in excess of the liability limits. The fund would be financed with a fee of 1.3 cents per barrel on domestic and imported oil.

And, an oil industry task force of major oil companies last month proposed spending more than \$250 million over five years on a national oil spill prevention, containment and cleanup program. Under the proposal, participating oil companies would fund five regional oil spill response centers throughout the country as well as a five-year oil-spill containment and recovery research program (BI, June 26).

BI Insurance Index



Insurance industry stocks fell 2.2 points last week, as the *Business Insurance Index* dropped to 545.0 on June 29 from 547.2 on June 22. Advancing issues were led by Safeguard Health Enterprises, up 8.7%; FHP International Corp., up 6.5%; and Argonaut Group, up 5%. Declining issues followed HMO America Inc., down 14.8%; Chandler Insurance Co., down 8.9%; and Fremont General Corp., down 7.5%. The most active issue was Sears, Roebuck & Co. (All-state), 4.6 million shares traded. The *BI Index* dropped 0.4% for the period; the Dow Jones 30 Industrials fell 1.0%; the New York Stock Exchange Composite lost 0.7%; and the Standard & Poor's 500 fell 0.2%.

British Issues

		1 Week	
June 29	Price	P/E	Div. Yield
Companies	pence		pence %
Comm Union	379	13.1	25.3 6.7
Genl Accident	943	8.8	58.7 6.2
Gdn Royal Exch	208	10.7	13.3 6.4
Royal	395	12.3	30.0 7.6
Sun Alliance	1116	8.7	54.7 4.9

		1 Week	
June 29	Price	P/E	Div. Yield
Brokers	pence		pence %
Bredstock	210	11.9	9.0 4.3
CE Health	465	14.6	34.5 7.4
Hogg Robinson	138	12.2	8.7 6.3
Lloyd Thompson	220	16.9	8.0 3.6
PWS Holdings	47	12.7	4.6 9.9
Sedgwick Grp	245	20.2	16.0 6.5
Steel Brl Jones	235	20.1	13.3 5.7
Willis Faber	244	18.1	15.3 6.3

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

BI Industry Stock Report

JUNE 29, 1989

6/23/89 THRU 6/29/89

		Weekly	Year to Date	Annual									Mkt/Bk.			Weekly	Year to Date	Annual									Mkt/Bk.																								
		Price	% change	% change	High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	value			Price	% change	% change	High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	value			Price	% change	% change	High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	value													
BROKERS																																																			
Alexander & Alexander Svcs	NYSE	25.13	-2.0	6.9	26.50	22.63	468	1.00	4.0	17.0	2.90	8.67	Lawrence Ins. Group	AMEX	6.88	-1.7	-12.7	8.50	6.63	3	0.24	3.5	14.6	3.19	2.16	Lincoln Nat'l Corp.	NYSE	51.50	0.7	17.0	52.25	42.75	183	2.48	4.8	12.8	39.21	1.31													
Corroon & Black Corp.	NYSE	33.88	-3.2	8.8	35.75	30.75	72	1.24	3.7	13.2	7.62	4.45	NAC Re Corp.	OTC	38.75	2.0	22.0	39.75	31.00	139	0.30	0.8	13.9	22.81	1.70	Navigator's Group	OTC	26.50	-1.9	32.5	27.25	20.50	8	0.00	0.0	11.3	15.22	1.74													
Gallagher Arthur J. & Co.	NYSE	20.00	-0.6	19.4	20.25	16.13	11	0.52	2.6	14.2	5.33	3.75	Nobel Ins Ltd.	OTC	2.25	-5.5	-52.6	5.00	1.50	14	0.42	8.7	-8.7	7.76	0.29	Northwestern Nat'l Life	OTC	36.25	1.4	16.4	37.25	26.88	246	1.20	3.3	13.1	37.50	0.97													
Hali Frank B. & Co.	NYSE	4.00	3.1	38.9	4.63	2.50	101	0.00	0.0	-1.9	0.00	N/A	Ohio Gas Corp.	OTC	45.75	1.7	28.0	46.00	35.50	105	2.08	4.5	6.6	33.30	1.37																										
Hib, Rogal & Hamilton	OTC	15.00	3.4	-1.6	15.75	13.75	55	0.20	1.3	13.5	4.60	3.26	Old Rep Int'l Corp.	OTC	25.25	2.5	5.2	28.88	23.38	107	0.74	2.9	14.1	26.50	0.95																										
Marsh & McLennan Cos. Inc.	NYSE	64.00	0.4	13.8	65.25	55.13	202	2.50	3.9	15.8	6.48	9.88	Oron Cap Corp.	NYSE	22.25	-1.7	44.7	23.00	15.38	23	0.84	3.8	7.2	12.93	1.72																										
Poe & Assoc. Inc.	OTC	8.75	0.0	6.1	8.75	8.25	1	0.40	4.6	9.5	1.43	6.12	Phoenix Re Corp.	OTC	9.88	0.0	4.0	11.00	8.75	23	0.00	0.0	5.4	12.99	0.76																										
BROKERS	AVERAGE		0.2	13.2					2.9	11.6			Protective Life Corp.	OTC	15.50	1.6	17.0	16.25	12.88	35	0.70	4.5	77.5	14.54	1.07																										
CONGLOMERATES & HOLDING COMPANIES																																																			
Berkley W.R. Corp.	OTC	32.00	3.2	8.5	34.00	29.25	276	0.40	1.3	6.7	21.28	1.50	Re Capital Corp.	AMEX	12.25	1.0	34.2	12.50	9.13	8	0.00	0.0	12.3	12.60	0.97																										
Berkshire Hathaway Inc. DEL	NYSE	6675.00	-0.3	42.0	7000.00	5948.00	91	0.00	0.0	23.6	2468.63	7.68	RLI Corp.	NYSE	7.38	-1.6	-3.3	9.25	7.13	30	0.36	4.9	7.2	10.71	0.69																										
ITT (Hartford Group)	NYSE	57.50	-3.0	14.7	60.75	49.75	1394	1.48	2.6	9.8	56.33	1.02	St Paul Cos. Inc.	OTC	22.88	-0.5	18.9	24.75	19.13	546	0.68	3.0	9.7	23.24	0.98																										
Sears Roebuck & Co. (Allstate)	NYSE	43.63	-3.0	6.7	48.00	40.13	4569	2.00	4.6	16.3	36.09	1.21	SAFECO Corp.	OTC	30.00	-0.8	27.0	32.00	23.13	778	1.20	4.0	7.5	24.88	1.21																										
CONGLOMERATES	AVERAGE		-0.8	18.0					2.1	14.1			SCOR US Corp.	NYSE	8.50	-5.6	-6.9	9.50	7.50	26	0.20	2.4	6.4	10.35	0.82																										
INSURERS/REINSURERS																																																			
Aetna Life & Cas Co.	NYSE	55.00	-1.6	16.4	56.38	46.75	787	2.76	5.0	8.5	58.11	0.95	Seibels Bruce Group Inc.	OTC	13.63	4.8	19.8	13.63	10.25	123	0.80	5.9	11.4	13.42	1.02																										
AmBase Corp.	NYSE	13.50	0.9	22.7	14.50	11.00	313	0.20	1.5	5.1	18.66	0.72	Selective Ins Group Inc.	OTC	24.25	-1.0	5.4	26.00	21.75	54	1.40	5.8	5.3	22.33	1.09																										
American General Corp.	NYSE	35.88	-4.7	20.1	38.00	29.50	847	1.50	4.2	10.8	28.04	1.28	Statesman Group Inc.	OTC	3.31	3.8	5.8	4.00	2.38	85	0.05	1.5	82.8	3.48	0.95																										
Amer Heritage Life Inv't	NYSE	26.13	-0.9	1.5	27.88	25.00	5	1.20	4.6	10.2	22.47	1.16	Tokio Marine & Fire Ins	OTC	70.50	-1.4	-22.8	95.50	66.00	3	0.24	0.3	42.7	0.00	N/A																										
Amer Indly Fin'l Corp.	OTC	12.25	0.0	16.7	13.00	9.50	3	0.56	4.6	7.9	17.38	0.70	Torchmark Corp.	NYSE	39.00	-1.9	27.9	41.25	30.00	170	1.20	3.1	12.3	12.24	3.19																										
American Int'l Group	NYSE	83.25	1.7	22.9	87.38	66.25	1247	0.48	0.6	11.7	33.55	2.48	Transamerica Corp.	NYSE	36.38	0.7	7.4	37.50	32.75	1165	1.88	5.2	8.2	30.70	1.19																										
Aon Corp.	NYSE	35.63	2.2	27.3	35.88	27.00	145	1.40	3.9	12.4	16.67	2.14	Travelers Ccpr.	NYSE	40.50	-0.9	16.5	42.75	34.50	618	2.40	5.9	31.6	44.85	0.90																										
Argonaut Group	OTC	58.00	5.0	32.6	58.00	43.50	109	0.00	0.0	8.0	36.83	1.57	Trenwick Group Inc.	OTC	16.25	-1.5	12.1	17.75	13.75	12	0.24	1.5	9.2	16.91	0.96																										
AVEMCO Corp.	NYSE	22.75	-2.7	-12.1	26.13	22.63	20	0.40	1.8	12.0	9.20	2.47	United Fire & Cas Co.	OTC	32.00	0.0	4.9	32.50	29.00	10	1.20	3.8	5.8	22.56	1.42																										
Baldwin & Lyons Inc.	OTC	18.13	0.0	21.8	18.25	14.50	14	0.20	1.1	6.4	17.57	1.03	United States Fid & Gly	NYSE	31.75	-3.8	11.4	34.00	28.50	693	2.80	8.8	11.8	22.57	1.41																										
Belvedere Corp.	AMEX	5.25	0.0	16.7	6.50	4.50	6	0.04	0.8	8.0	8.43	0.62	UNUM Corp.	NYSE	33.63	1.1	24.6	34.88	26.63	284	0.60	1.8	11.1	30.64	1.10																										
Chandler Insurance	OTC	8.88	-8.9	28.0	10.88	7.00	140	0.00	0.0	5.1	9.53	0.93	USLIFE Corp.	NYSE	44.50	2.3	27.6	45.63	34.13	234	1.40	3.1	10.8	54.27	0.82																										
Chubb Corp.	NYSE	68.88	-3.0	18.8	73.50	57.63	422	2.32	3.4	8.0	53.50	1.29	Washington Nat'l Corp.	NYSE	26.75	-0.9	-0.9	27.63	24.00	16	1.08	4.0	-19.1	32.33	0.83																										
CIGNA Corp.	NYSE	56.63	1.6	20.2	58.00	45.88	523	2.96	5.2	9.9	53.08	1.07	Zenith Nat'l Ins Corp.	NYSE	19.00	-0.7	8.6	19.75	16.75	69	0.84	4.4	8.8	13.61	1.40																										
CNA Fin'l Corp.	NYSE	73.75	-1.7	21.9	79.25	57.63	162	0.00	0.0	11.5	54.52	1.35	INSURERS/REINSURERS	AVERAGE		-0.4	14.2					3.2	12.6																												
Continental Corp.	NYSE	33.63	-0.7	3.9	36.00	31.50	379	2.60	7.7	22.9	42.10	0.80	HEALTH MAINTENANCE ORGANIZATIONS																																						
Durham Corp.	OTC	32.25	0.0	-2.3	33.75	30.00	23	0.92	2.9	18.6	26.32	1.23	FHP International Corp.	OTC	28.75	6.5	137.0	30.25	11.75	706	0.00	0.0	14.7	3.54	8.12	HMO America Inc.	OTC	7.88	-14.8	3.3	4.69	0.44	655	0.00	0.0	-6.9	1.12	7.04													
Fireman's Fund Corp.	NYSE	34.38	3.0	17.5	36.00	29.00	269	0.60	1.7	8.5	32.74	1.05	Pacificare Health Systems	OTC	27.50	2.8	124.5	32.50	12.25	0	0.97	3.5	22.0	6.35	4.33	Pacificare Health Systems	OTC	27.50	2.8	124.5	32.50	12.25	0	0.97	3.5	22.0	6.35	4.33													
Fremont Gen Corp.	OTC	15.50	-7.5	15.8	18.25	12.13	120	0.60	3.9	11.9	17.61	0.88	Safeguard Health Ent.	OTC	7.88	8.7	43.3	8.00	4.75	106	0.00	0.0	13.4	2.99	2.64	Sierra Health Services	AMEX	4.75	-7.4	191.4	5.75	1.50	18	0.00	0.0	-3.9	1.59	2.99													
Frontier Insurance Group	OTC	18.25	2.8	46.0	20.25	12.25	36	0.00	0.0	8.8	7.53	2.42	United HealthCare Corp.	OTC	8.75	-4.2	99.8	9.25	4.13	466	0.00	0.0	-4.0	0.31	28.23	United Medical Corp.	AMEX	5.88	2.3	12.0	6.75	5.13	4	0.00	0.0	1.8	4.11	1.43													
General Re Corp.	NYSE	66.13	-1.3	19.2	68.88	54.38	589	1.36	2.1	12.4	29.04	2.28	U.S. Healthcare	OTC	11.00	-1.2	89.3	13.00	5.25	1138	0.20	1.8	157.1	2.87	3.83	Western Health Plans Inc.	AMEX	0.69	0.0	0.0	1.13	0.44	3	0.00	0.0	-0.3	0.82	0.84													
Hanover Ins Co.	OTC	27.25	-1.8	1.9	30.25	25.75	218	0.44	1.6	5.6	31.47	0.87	HMOs	AVERAGE		-0.8	77.8					0.6	21.5		ALL COMPANIES	AVERAGE		-0.4	21.6				2.8	13.7																	
Hartleysville Group Inc.	OTC	20.13	-2.4	11.8	22.50	17.75	90	0.48	2.4	7.0	18.94	1.06	ALL COMPANIES	AVERAGE		-0.4	21.6					2.8	13.7																												
Hartford Steam Boiler	OTC	42.75	1.2	16.3	44.00	34.75	240	1.60	3.7	11.8	13.04	3.28																																							
Kans City Life Ins.	OTC	35.25	0.0	2.2	36.00	32.75	3	0.00	0.0	12.6	39.22	0.90																																							
Kemper Corp.	NYSE	37.63	2.7	56.8	38.38	22.75	578	0.84	2.2	8.8	28.91	1.30																																							

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