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Update

EPA proposes rule to shield lenders from Superfund liability

WASHINGTON—A proposed U.S. Environmental Protection Agency regulation would eliminate lenders' liability for cleaning up contaminated property in which they have a secured interest but limited control.

Recent court rulings have raised questions about secured lenders' exemption from liability under the Comprehensive Environmental Response, Compensation and Liability Act of 1980, also know as Superfund (*BI*, Jan. 21; Sept. 3, 1990).

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National health care gets boost

GAO projects big savings from Canadian-style plan

By JERRY GEISEL

WASHINGTON—The administrative savings generated by a Canadian-style national health insurance program would more than offset the cost of providing comprehensive, first-dollar coverage to all Americans, the General Accounting Office says.

Expanding medical coverage to the nation's more than 32 million uninsured through a Canadian-style plan would cost $18.2 billion, while eliminating deductibles and copayments would cost another $45.7 billion, the agency says.

But that $63.9 billion in new annual costs would be offset by the $66.9 billion savings in administrative costs under a Canadian-style program, the GAO contends.

Of those anticipated savings, the greatest chunk—$33.9 billion—would be in reduced insurance administration overhead. A national single-payer system also would cut annual hospital administrative expenses by $18.2 billion and physicians' administrative expenses by $14.8 billion.

And in congressional testimony last week, GAO officials said that the United States could cut health care spending $100 billion to $200 billion a year by adopting the key elements of the Canadian system. Those elements include effective limitations on provider payments and controls on expensive medical technology.

"The key lesson of the Canadian experience is that it is possible to

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GRAPHIC BY CYNTHIA WATSON

Medicare fee plan puts payers on the defensive

Democrats' proposal includes cost control

By JERRY GEISEL

WASHINGTON—Legislation introduced by Senate Democrats last week to widen access to the health care system also would create a new federal board that would attempt to hold down health care costs.

The measure also would give certain small employers tax breaks to encourage them to offer their employees health insurance.

And, in a provision that surprised many benefit experts, the secretary of health and human services would be given authority to set the size of the penalty—in the form of a new payroll tax—on employers that fail to offer a health care plan that meets the standards outlined in the legislation.

Benefit experts had thought the size of the payroll tax penalty would be specified in the bill, S. 1227.

But much of the bill, "HealthAmerica: Affordable Health Care for All Americans Act," is similar to earlier versions that had been widely distributed (*BI*, June 3). Those provisions include:

- Requiring employers, as part

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By ADRIENNE C. LOCKE

WASHINGTON—Group health insurers say they will move cautiously to shield themselves from anticipated cost shifting by physicians trying to recoup revenues reduced by a proposed Medicare physician fee schedule.

However, many employers with indemnity health care plans will avoid the new round of cost shifting by turning to managed care plans, which are insulated from such cost shifts, health care experts predict.

Employers, benefit consultants, and health insurers expect cost shifting to be significant as a result of Medicare's newly proposed physician fee schedule, though they disagree on how soon the cost shifting will be seen.

The Medicare physician schedule, which is expected to be finalized this fall and implemented next January, is similar to the schedule of rates for specific hospital care procedures that Medicare established under its diagnostic related group system in 1983.

Under the new physician fee schedule, physicians would be paid a predetermined amount for more than 4,000 services provided to Medicare recipients.

The reimbursement system will be based on a "resource-based relative value scale" developed by Harvard University medical economist William C. Hsiao and internist Peter Braun (see story, page 45). Dr. Hsiao has assisted the Health Care Financing Administration in drafting the reimbursement schedule.

HCFA Administrator Gail R. Wilensky said the new fee schedule "in part succeeds in correcting historical price distortion, especially for specialized procedures which have been traditionally overvalued, and primary care, which has been undervalued."

In addition, the new fee schedule will "help address the longstanding imbalances between Medicare payment to urban and rural physicians," said Health and Human Services Secretary Dr. Louis W. Sullivan.

Under the schedule, fees for specialty physicians would decrease by 3% to 35% over a five-year phase-in period.

However, fees for general practitioners would increase 14% and fees for family practitioners would increase 15% over the same period.

Health care experts anticipate that physicians will try to make up

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Many members lose confidence in Lloyd's

Lloyd's of London Chairman David Coleridge says fear of huge losses is nothing new.

By STACY SHAPIRO

LONDON—Many members of Lloyd's of London are losing confidence in the institution as losses continue to mount and members' lawsuits against underwriting agencies multiply.

Over the past few weeks, it has become clear that Lloyd's will report a marketwide loss when it announces its global results for 1988 on June 26 (*BI*, May 27; May 6). Overall losses are also expected in 1989 and 1990.

Meanwhile, Lloyd's Chairman David Coleridge is trying to downplay the problems.

Observers that have been spelling doom and gloom for Lloyd's are merely repeating what was said in 1967, at the time of the last marketwide loss, Mr. Coleridge said. That loss was followed by 23 profitable years, he added.

The most recent losses stem from a slew of natural and man-made catastrophes over the last few years, including three windstorms in Europe, Hurricane Hugo, the Piper Alpha North Sea oil platform explosion and the explosion at a Phillips Petroleum Co. plant in Pasadena, Texas. In addition, syndicates are increasing reserves for past underwriting years to cover pollution and asbestos losses in the United States.

Members' agents last week said that at least 200 syndicates are expected to make cash calls on Lloyd's members this year as a result of these losses. Many of the cash calls will be from the nearly 90 syndicate accounts that continue to be left open; while at least 20 syndicates will make cash calls on the 1989 and 1990 years of account that are not yet closed under Lloyd's three-year accounting system, members' agents say.

On top of the gloomy results, six groups of members are suing or threatening to sue members' agen-

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Update

EPA may limit lender liability

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Under the proposed rule, released last week, secured lenders could require borrowers to maintain their property in an environmentally sound manner and advise borrowers on how to clean up contaminated property used for collateral without incurring Superfund liability.

Lenders also would not be considered an owner or operator of a Superfund site, and therefore would be exempt from Superfund liability, when they have foreclosed on and sold contaminated property.

Lenders also would be exempt from liability even if they regularly monitored or inspected a borrower's property used as collateral, monitored a borrower's business condition and financial health, or provided financial, administrative and other advice to borrowers.

Only when the lender directs or becomes so involved in a borrower's environmental operations that the lender is acting in the same manner as a property manager or director would it be considered "participating in management" and thus be liable for cleanup costs, the agency said.

The "rule allows lending institutions to protect their financial interest on properties they hold as collateral, while it assures that those responsible for contamination are held accountable," said EPA Administrator William K. Reilly.

The proposal also would exempt federal government entities from cleanup liability for contaminated property acquired involuntarily.

The EPA is accepting comments on the rule through July 5, after which the proposed regulation could be modified.

Lilly offers Prozac defense

INDIANAPOLIS—Eli Lilly & Co. is offering to defend and indemnify doctors for certain personal injury claims arising from patients' use of the anti-depressant drug Prozac.

Indianapolis-based Lilly is notifying doctors that it will hire lawyers to defend them and cover the cost of judgments in cases where doctors have properly prescribed Prozac, though the company said it will not cover what it considers acts of negligence or malpractice. Doctors will be required to notify Lilly promptly of claims or suits and cooperate with the company's defense. Lilly also is informing doctors they should notify their malpractice insurers of these claims and that Lilly will "work closely" with the insurers "at their request."

The offer, believed to be unprecedented for a pharmaceutical company, is intended to counter an anti-Prozac media campaign by the Church of Scientology, which has denounced the use of psychiatric drugs. The offer was prompted by many lawsuits charging that Prozac has provoked suicidal and homicidal thoughts in patients using the drug (*BI*, July 30, 1990).

Lilly will pay for the defense and indemnity program without any contribution from its product liability insurers, a spokeswoman said. Lilly has not estimated the program's cost, she said.

Insurers' results improve

NEW YORK—U.S. property/casualty insurers' combined ratio fell to 107.4% in the first quarter of 1991 from 108.7% for the same period in 1990, according to data from the Insurance Services Office Inc. and the National Assn. of Independent Insurers.

By contrast, the combined ratio of 30 major insurers surveyed by *Business Insurance* rose to 110.6% in the first quarter from 110.1% in the first quarter of 1990 (*BI*, May 27).

The ISO and NAII data, which is based on reports of insurers that account for 96% of the country's property/casualty business, also shows that underwriting losses declined by 15.2% to $4.4 billion from $5.2 billion in the first quarter of 1990.

Net premiums written increased 2.5% to $56.4 billion from $55 billion for the comparable period a year ago, the survey found. Net investment income rose 6.8% to $8.4 billion from $7.9 billion. And policyholder surplus increased 10.6% to $148 billion from $133.8 billion.

Net industry income increased 53% to $3.8 billion from $2.5 billion. The first quarter's net income reflects $4.1 billion of operating income and $1 billion of realized capital gains less $1.3 billion of income taxes.

Unlicensed insurer liquidated

HARRISBURG, Pa.—A Pennsylvania state judge has ordered the liquidation of Keystone Small Business Assn., an unlicensed Pittsburgh-based firm that provided health insurance to about 1,500 small employers in Western Pennsylvania.

The Pennsylvania Insurance Department does not yet know the size of the insolvency, a spokeswoman said.

However, before consenting to the liquidation, Keystone—which was hit with an Insurance Department suspension order April 16—transferred about 1,300 policies to another unlicensed Pittsburgh entity, Great Lakes Small Business Assn.

The department also hit Great Lakes with a suspension order on May 3, but Great Lakes has since transferred much of its business to National Life Insurance Co. of Montpelier, Vt., which is licensed in Pennsylvania, an Insurance Department spokeswoman said.

In addition, the Pennsylvania department last week issued a suspension order barring new underwriting by World Life & Health Insurance Co. of Pennsylvania. Regulators are seeking to liquidate World Life & Health, charging it is insolvent by $10.9 million (*BI*, April 29; April 8).

Ruling on Executive Life GICs

LOS ANGELES—A state judge said 401(k) plan participants and their beneficiaries whose assets were invested in guaranteed investment contracts written by Executive Life Insurance Co. can individually seek hardship benefits from the insurer, even though GIC participants are not scheduled to receive any payments from the collapsed insurer.

Los Angeles Superior Court Judge Kurt J. Lewin, who is presiding over the Executive Life conservation hearing, said last week that no one would be excluded from seeking hardship benefits. But the judge limited the applications to individuals rather than to classes.

GIC participants are not receiving payments under an earlier modification of Executive Life's conservation order. The insurer is paying

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DES makers appeal privacy ruling in N.Y.

By MICHAEL SCHACHNER

NEW YORK—The former makers of the anti-miscarriage drug DES will seek to appeal a New York court ruling denying them access to the family medical records of plaintiffs who allege that their mothers' use of the drug has caused them health problems.

The defendants are not entitled to secure during discovery the medical records of a plaintiff's mother beyond her pregnancy or of distant family members, the Appellate Division's First Department unanimously ruled on May 28.

Lawyers for the pharmaceutical companies that manufactured diethylstilbestrol from the 1940s until it was banned by the Food and Drug Administration in 1971 say the ruling is unreasonable because it deprives them of chance to show that the women's injuries may have been caused by genetic or hereditary disorders and not exposure to DES.

The FDA banned DES after the drug was linked to vaginal cancer in the daughters of women who had ingested it.

But, plaintiffs' attorneys say the ruling is important because it clearly establishes an individual's right to privacy.

Lawyers for both sides were reticent to speculate whether the ruling will impact cases—other than pharmaceutical cases—in which courts are asked to balance an individual's right to privacy against a defendant's need for the plaintiff's medical history to forge a defense.

Courts will have to determine how relevant the information a defendant is seeking is to the case at hand before permitting a person's doctor/patient privilege to be broken, some attorneys said.

Defense lawyers say they will likely seek leave to appeal the decision to the New York State Court of Appeals in Albany, the state's highest court.

The pharmaceutical companies have until June 27 to initiate their appeal.

However, defense attorneys said the fact that the intermediate appeals court unanimously overturned the trial court's ruling limits their chances of a successful appeal.

The 5-0 ruling affects approximately 800 plaintiffs suing several

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Conference will feature address by U.K. minister

John Redwood, the corporate affairs minister for the United Kingdom, will deliver the opening address at the World Insurance Congress in London on July 1.

Mr. Redwood will comment on the importance of the insurance business in the United Kingdom, the government's support for an open market and the attractiveness of the United Kingdom as a base of operations for insurance companies.

Mr. Redwood will deliver his remarks immediately after the Lord Mayor of London, Sir Alexander Graham, welcomes delegates.

David Coleridge, the chairman of Lloyd's of London, will deliver the keynote address.

The World Insurance Congress is co-sponsored by *Business Insurance* and Lloyd's of London Press, an independent subsidiary of Lloyd's of London.

The three-day conference is being held at the Queen Elizabeth II Conference Centre in Westminster.

WIC
World Insurance Congress

A 49-person faculty of insurance and risk management experts from around the world will address delegates, both in general sessions in the morning and in smaller, breakout sessions in the afternoon (*BI*, Dec. 31, 1990).

General session topics include the insurance distribution system, coping with catastrophes and global restructuring of insurance markets.

Among topics to be discussed in afternoon sessions are professional liability, global insurance programs, financial reinsurance, banking and insurance, toxic torts and product liability, and insurance regulation worldwide.

The congress also includes an exhibition of products and services.

The registration fee is 650 pounds, plus 97.5 pounds value-added tax ($1,270 at current exchange rates, though the fee must be paid in British pounds).

A discount to 585 pounds, plus 87.75 pounds VAT ($1,143 at current exchange rates), is available for each additional registrant from the same company.

The conference registration fee for an accompanying guest program is 275 pounds, plus 41.25 pounds VAT ($537 at current exchange rates).

To register for the congress, contact either *Business Insurance*, 220 E. 42nd St., New York, N.Y. 10017; phone 212-210-0299, fax 212-210-0704; or Lloyd's of London Press, 1 Singer St., London EC2A 4LQ, England, phone 071-250-1500; fax 071-253-9907. ■

Deadline near for RMIS directory

Business Insurance will publish its annual directory of risk management information systems vendors in the July 29 issue, which will include a report on trends in risk management automation systems and analysis.

There is no charge to be listed in the directory, but companies wishing to be included must fill out and return a questionnaire provided by *Business Insurance*.

If your company produces and supplies software to corporate risk management personnel and you have not yet received a questionnaire, please request a questionnaire by contacting Karen Armaganian, Editorial Assistant, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611-2590; 312-280-3195.

The deadline for returning completed questionnaires is June 24.

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✔ Pension plan rules need to be simplified to encourage more small firms to offer programs to their workers, Secretary of Labor Lynn Martin says at the meeting of the Assn. of Private Pension & Welfare Plans. **PAGE 12**

✔ Workers compensation claims and lawsuits increasingly are being filed because of fears of sickness in the future, a legal expert says at the National Council of Self-Insurers meeting. **PAGE 18**

✔ The Federal Aviation Administration is increasingly concerned about runway safety at airports, a speaker says at the recent Aviation Insurance Assn. conference. **PAGE 32**

✔ Aneco Reinsurance Underwriting Ltd. is fighting a liquidation petition filed by Mutual Indemnity Ltd. **PAGE 37**

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U.S. reinsurers' results paint misleading picture

By JUDY GREENWALD

Don't be fooled by U.S. reinsurers' first-quarter results, warn reinsurance executives and other observers: Despite an apparently improved combined ratio, market conditions are not better.

Many attribute the improved results to the more widespread use of financial reinsurance, which caps reinsurers' ultimate liability, rather than to any underlying improvement in underwriting results.

They also note that year-to-year comparisons are favorable because 1990's first quarter still reflected losses from some of 1989's catastrophes, including Hurricane Hugo and the Phillips Petroleum Co. plant explosion in Pasadena, Texas (*BI*, June 4, 1990).

Observers say also that increased retentions by primary insurers, as well as a greater emphasis on excess-of-loss rather than proportional business, has at least to some extent "decoupled" reinsurer results from the deteriorating results of primary insurers.

This is not to say, however, that reinsurers are enthusiastic about first-quarter results.

"We're just sort of bumping along on the bottom of the cycle and nothing much is happening," said Michael G. Fitt, chairman, president and chief executive officer of Employers Reinsurance Corp. of Overland Park, Kan.

Sixty-two property/casualty reinsurers surveyed by the Washington, D.C.-based Reinsurance Assn. of America reported an average combined ratio of 105.8% for 1991's first quarter, an improvement from the 107% reported by a comparable group for the same period of 1990.

The first-quarter combined ratio for the 20 largest U.S. reinsurers improved to 105% from the 107.1% reported by the same reinsurers a year ago.

Meanwhile, the U.S. reinsurance industry's net written premium

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State-of-the-art defense upheld in asbestos suit

By MICHAEL SCHACHNER and STACY ADLER

SAN FRANCISCO—A California Supreme Court ruling that allows asbestos producers to use a "state-of-the-art" defense in suits alleging strict liability for failure to warn is expected to influence other types of strict liability cases.

The ruling also will bring California into the mainstream in this area of law, say product liability experts.

In a 6-1 ruling, the California Supreme Court last month found that when a plaintiff sues an asbestos producer for strict liability for failing to warn of the dangers inherent in exposure to asbestos, evidence that the dangers of the material were neither known or knowable at the time the product was marketed is relevant and admissible at trial (*BI*, June 3).

Attorneys for asbestos producers say the May 30 decision is extremely important for all manufacturers because it establishes a line of defense against allegations of failure to warn. Failure to warn is the most common theory used in bodily injury suits against manufacturers.

In addition, defense attorneys point out that the ruling brings the California Supreme Court in line with most other courts across the country that have ruled on the issue of strict liability for failure to warn.

"Manufacturers generally favor the state-of-the-art defense. We have found it to be very helpful when allowed," said Jan Amundson, general counsel for the National Assn. of Manufacturers in Washington, D.C.

"Most courts allow the state-of-the-art defense. To hold otherwise would hold that manufacturers have an absolute duty to warn even of dangers they are not aware of," said Victor Schwartz, a product liability attorney with Crowell & Moring in Washington, D.C.

Several attorneys that represent insurers in asbestos cases, however, add a note of caution. While the ruling establishes a defense for asbestos producers in strict liability cases for failure to warn, manufacturers still may have trouble proving that they did not know or could not have known about the dangers, they say.

The ruling, the first of its kind by California's highest court in asbestos litigation, resolves a split among state appellate courts.

The ruling stems from a 1984 lawsuit brought by Carl Anderson, who worked from 1941 to 1976 in Navy shipyards in Boston and Long Beach, Calif.

Mr. Anderson alleges that he contracted asbestosis

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Industry's input sought on regulatory reforms

By COLLEEN JOHNSON

SEA ISLAND, Ga.—Reform of the insurance regulatory system appears inevitable, industry executives say.

To make sure that reforms do not threaten the industry, brokers and others must offer input before changes are made, executives said at the National Assn. of Insurance Brokers' 57th annual meeting last month.

"We can either be part of change or be changed," said Caleb L. Fowler, executive vp of Philadelphia-based CIGNA Corp. and president of its domestic property/casualty division, during a panel discussion on regulation.

CIGNA, said Mr. Fowler, supports the American Insurance Assn.'s call for repeal of the antitrust exemptions contained in the McCarran-Ferguson Act, with some 'safe harbor" exceptions for "essential business activities" (*BI*, May 20).

McCarran-Ferguson actually hurts the industry in that it is an "extremely effective" target for critics of insurers and obscures other issues facing the industry, he maintained.

"We are immediately put on the defensive," and insurers must take time to explain that they are not colluding, Mr. Fowler said.

"Regulation, be it at the state or federal level, should support open competition" and allow the industry to return to appropriate levels of profitability, he said.

Mr. Fowler suggested that the industry offer "constructive suggestions" for change. For example, some form of federal oversight would be appropriate, and a dual system of state and federal regulation should be considered, he said.

Marsh & McLennan Inc. President David Holbrook outlined a two-tier regulatory proposal the broker has made, based on a similar idea offered about 15 years ago by a former U.S. senator.

Under the two-tier system, states

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Cedant picks forum for dispute, court rules

By DOUGLAS McLEOD

PHILADELPHIA—Reinsurers waive their right to challenge a ceding company's choice of a forum for litigation under the forum selection clause commonly found in reinsurance contracts, a federal appeals court has ruled.

The 3rd U.S. Circuit Court of Appeals last month found that the forum selection clause gives the ceding insurer the right to choose which court will hear a dispute and bars reinsurers from removing the dispute to another court.

The decision affirms a federal judge's ruling that a Pennsylvania state court should hear a lawsuit filed by the rehabilitator of Mutual Fire, Marine & Inland Insurance Co. against Chesapeake Insurance Co. Ltd., a Bermuda-based reinsurer of Mutual Fire.

Chesapeake had removed the case to the U.S. District Court in Philadelphia from Pennsylvania Commonwealth Court, where Mutual Fire's rehabilitation is being overseen.

Chesapeake will probably not seek a rehearing before the 3rd Circuit, but has not decided whether to ask the U.S. Supreme Court to review the ruling, according to David M. Zensky, a lawyer with Anderson, Kill, Olick & Oshinsky in New York, representing the reinsurer.

"It's what we thought the law was," said Alex Bratic, special deputy rehabilitator of Mutual Fire. "The matter belongs in front of Commonwealth Court."

The 3rd Circuit decision follows rulings by federal judges in several other cases interpreting the forum selection clause as a waiver of reinsurers' rights to seek removal of ceding insurer lawsuits to federal courts.

Peter Bickford, a lawyer with Bickford, Hahn & Haley in New York, noted that the ruling is one element in a growing body of case law surrounding standard reinsurance contract language that has been "put under a legal microscope" in recent years as reinsur-

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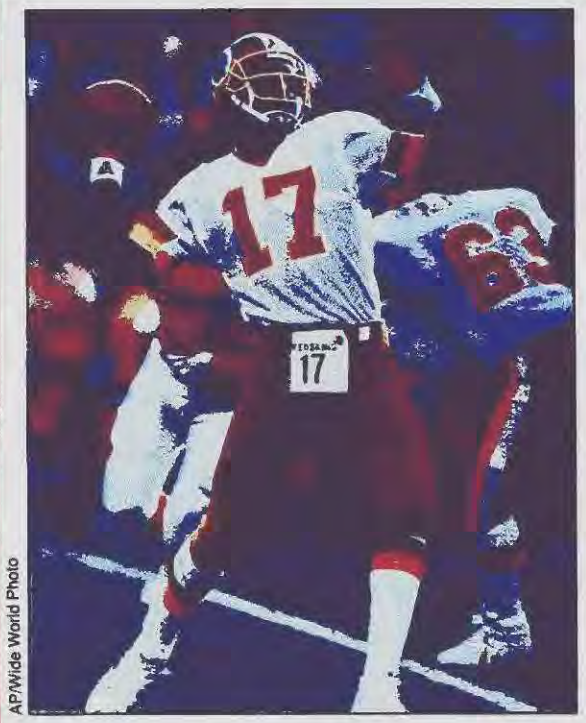

AP/Wide World Photo

Doug Williams will receive $513 a week for life for an injury that ended his pro football career.

Redskins to appeal award

Quarterback gets comp benefits for life following off-season injury

By SARA J. HARTY

WASHINGTON—The Washington Redskins of the National Football League will appeal a $513 weekly workers compensation award for life to former quarterback Doug Williams, says the team's workers comp insurer.

The team will appeal the May 20 decision on the grounds that, among other things, the "second career concept" should apply in workers comp cases involving professional athletes, said William S. Hopkins, an attorney for Hartford, Conn.-based Hartford Accident & Indemnity Co., a unit of the Hartford Group Inc.

Under the second career concept, professional athletes suffering career-ending injuries would be "paid disability benefits for the remainder of their anticipated athletic careers," said Mr. Hopkins, who is with McChesney, Duncan & Dale in Washington, D.C.

Professional athletes "are compensated very highly because they do generally have short careers," Mr. Hopkins explained.

Mr. Williams, who was named most valuable player in the 1988 Super Bowl, injured his back in July 1989 while training on a treadmill in his home during the off-season. He underwent surgery the next month to correct a herniated disc.

While Mr. Williams was able to resume playing with the Redskins later in the 1989 season, he aggravated the injury during a game that November. He played briefly in another two games but was unable to play after that.

Statistics introduced at the hearing suggested that Mr. Williams, who is currently 35, would have had an additional 1.64 years of anticipated playing time had he not been injured in 1989, Mr. Hopkins said.

"Our position is that compensation should be limited to 1.64 years and then he would go on to his second career—which he has," Mr. Hopkins said.

Mr. Williams currently is the athletic director and a football coach at Point Coupee High School in New Roads, La.

However, the District of Columbia's workers compensation statute "is a wage-loss statute," said attorney Gerald Herz, the attorney representing Mr. Williams. "It is not a wage-earning capacity statute."

The hearing board "rejected the second career concept," said Mr. Herz, a partner with the Washington, D.C., firm of Friedlander, Misler, Friedlander, Sloan & Herz.

And, "the act does not differentiate between athletes and other types of employees," Mr. Herz said.

The team also argued that it should not have to pay Mr. Williams the workers comp benefits, which under the decision amount to $26,676 annually, because his injuries did not arise out of the

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ABI seeks to buy McDonough Caperton

By JOANNE WOJCIK

SAN FRANCISCO—American Business Insurance Inc. of San Francisco is seeking to buy a controlling interest in McDonough Caperton Insurance Group of Charleston, W.Va., a combination that likely will produce one of the 20 largest insurance brokerages in the world.

Terms of the transaction were not announced. The acquisition is expected to be completed in late July.

The merged companies would have placed No. 17 in *Business Insurance's* ranking of the world's largest brokerages based on 1989 revenues (*BI*, June 18, 1990). In addition, the merged companies would have ranked as the 10th-largest U.S. brokerage. ABI ranked as the 12th-largest U.S. broker based on 1989 revenues, while McDonough Caperton held 15th place.

ABI reported 1990 revenues of $68 million, a 19.3% increase from $57 million in 1989, while McDonough Caperton produced $37.2 million in revenues in fiscal 1990, up 6.9% from $34.8 million in fiscal 1989.

The acquisition is part of ABI's long-term strategy to expand into the mid-Atlantic region and to diversify into other areas of the insurance business, according to ABI President and Chief Executive Officer Bernard H. Mizel.

For example, McDonough Caperton, which generates about a third of its business from claims administration services, will enable ABI to enhance its employee benefits and workers compensation business, according to Mr. Mizel.

'We talked to many firms and this was clearly the best choice,' says Mr. Becker.

ABI also has become increasingly involved in annuities, surety bonds and financial services in addition to providing commercial retail and surplus lines brokerage services, according to Mr. Mizel.

McDonough Caperton, which is one of the largest brokers in the mid-Atlantic states, "will become the headquarters for ABI's entire mid-Atlantic region," said Mr. Mizel.

"Together with our existing regional affiliates, ABI-Northeast and ABI-Southeast, this acquisition provides ABI the ability to market insurance products throughout the Eastern seaboard," he added.

By consolidating their operations, both brokers also will be able to better weather the competitive marketplace which has slowed commission growth for many small brokerages, according to Mr. Mizel.

"The sluggish economy, competitive pricing by insurers and the low interest rates affecting interest income have made it difficult for brokers" to make a profit in recent years, he said.

"But out of adversity grows opportunity," he said. "We have been able to acquire some very strong firms over the last seven years."

ABI has completed more than 10 acquisitions since 1985, according to Joseph Annotti, ABI's vp-marketing and communications.

The takeover bid was welcomed by W. Marsten Becker, president and chief executive officer of McDonough Caperton, who said the company had decided earlier this year to merge with a larger firm.

"We talked to many firms and this was clearly the best choice for the company, its employees and clients," he said.

"We are extremely pleased about the added growth, service and economic opportunities which will result from this merger for our clients, employees and insurance carriers," Mr. Becker said.

"Both MCIG and ABI will enjoy increased marketing capabilities and gain access to a wide variety of new products, markets and technical expertise," he added.

McDonough Caperton's investment banker, Russell R. Miller, chairman of Russell Miller Inc. in San Francisco, noted that "this is one of those unique transactions that gives enormous new impetus to both firms because of their coming together. Each one is enhanced by the strengths and geographic dispersion of the other."

While there will be some redundancy in the regions where both firms have offices, the overlap will be minimal, according to ABI's Mr. Annotti.

The acquisition will enable ABI, which had a presence in both the Northeast and Southeast, "to fill a gap that had existed between Delaware and North Carolina," he said.

McDonough-Caperton has offices in West Virginia, Florida, Georgia, Kentucky, Ohio, Pennsylvania, Texas, Virginia and Bermuda, while ABI has operations in California, Florida, Illinois, Kansas, Minnesota, Nevada, New Jersey, New Mexico, Ohio, Kentucky, Pennsylvania, Texas and Washington.

Like other ABI subsidiaries, McDonough Caperton will continue to operate under its own name and maintain its home office in Charleston, according to Mr. Annotti. No layoffs or major corporate changes are planned.

The portion of McDonough Caperton stock held by its founder, W. Gaston Caperton III, had been held in a blind trust since his election as governor of West Virginia in 1988 (*BI*, March 13, 1989; May 16, 1988).

Other shareholders include Mr. Becker and Chubb Corp. of Warren, N.J., which purchased a minority stake in the company last year.

It is not known whether Chubb will continue to hold its share of the company, but "it will be worked out in the most harmonious way possible," Mr. Miller said.

Because Chubb holds a seat on McDonough Caperton's board of directors, it was informed of the company's decision to sell early on, according to Mr. Miller.

Chubb officials would not comment on the deal.

McDonough Caperton two years ago was the target of a $12 million lawsuit brought by Dee Caperton, Mr. Caperton's ex-wife, who alleged that she was deceived into selling her share of the brokerage at an unfair price to her husband to avoid conflict of interest charges while she served in the West Virginia House of Representatives (*BI*, Sept. 4, 1989).

Mrs. Caperton's suit was withdrawn on Oct. 24, 1989 (*BI*, Nov. 6, 1989). ■

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NAIB panel

Continued from page 3

would regulate the sale of personal and commercial insurance for "mom and pop" businesses, while the federal government would charter insurers to write large commercial risks, Mr. Holbrook explained. On the federal level, insurers would be regulated only for solvency—rates and forms would be exempt—and there would be no federal guaranty fund for large commercial policyholders, he said.

"We don't think Corporate America needs a safety net of solvency funds," Mr. Holbrook said, noting that no guaranty fund exists for companies that are self-insured, participate in risk retention groups or obtain coverage from a non-U.S. insurer.

Companies writing insurance for large commercial risks could choose either federal or state oversight, explained Philip Petronis, an M&M managing director responsible for risk management services, in an interview following the meeting.

An insurer that writes a combination of personal, small commercial and large commercial lines would have to do so through separately capitalized companies in order to have the large commercial business regulated by federal authorities, Mr. Petronis said.

Noting that the definition of a large commercial risk is open for discussion, Mr. Petronis said that under the M&M plan a company with at least 25 employees and having an aggregate annual premium of at least $25,000 would be considered a large commercial policyholder.

Risk purchasing groups also would qualify for federal regulation if they meet the standards for individual policyholders and each member has an annual premium of at least $10,000, he added.

M&M—working with CIGNA and Alexander & Alexander Services Inc. and American International Group Inc., both based in New York—has explained the proposal to attorneys and legislators in Washington, Mr. Holbrook said. "What we're trying to do is raise the consciousness of the general public to this concept," he added.

But North Dakota Insurance Commissioner Earl R. Pomeroy predicted the M&M proposal will be opposed by insurers that would not fall under federal regulation. And, policyholders will not want to give up the protection of guaranty funds, he said.

"You stand to embarrass yourselves a bit appearing to be pursuing blatant self-interest in the guise of solvency protection," Mr. Pomeroy said. "I don't think it does anything to enhance solvency regulation. It appears as though you tried to exploit a concern for a self-serving end."

The idea that the proposal is self-serving for large commercial insurers is "absolutely not true," Mr. Holbrook responded. Removing insurers writing coverage for large commercial risks from state guaranty funds would have eliminated some of the largest losses to those funds, he noted.

And, eliminating guaranty fund protection for large commercial insurers would not remove protection for consumers of large businesses, since those companies generally have large self-insured retentions and purchase excess coverage through offshore insurers that are not covered by the funds, Mr. Holbrook said.

Mr. Pomeroy, a former NAIC president, also took issue with a General Accounting Office report that said the National Assn. of Insurance Commissioners can't establish a uniform insurance solvency regulatory system because it has no enforcement power (*BI*, May 27).

Charging that the GAO had "marching orders" from the House Oversight and Investigations Subcommittee, chaired by Rep. John D. Dingell, D-Mich., Mr. Pomeroy said the report had "all the objectivity of a rookie law clerk under assignment from a senior partner."

For instance, the GAO did not include regulators' informal actions when considering how states had dealt with troubled insurers, Mr. Pomeroy said.

However, John B. Chesson, counsel to the subcommittee, defended the GAO report, calling it a "thorough, professional and independent inquiry."

Mr. Pomeroy predicted that some form of federal regulation will be imposed before regulatory improvements at the state level can be fully assessed. For example, 43 state legislatures in 1991 have been or are considering model laws that could lead to certification by the NAIC, he said (*BI*, Dec. 3, 1990).

Also, the NAIC has doubled its staff since 1987, increased its computer capabilities and developed a system for early identification of insurers with solvency problems, said Mr. Pomeroy.

"The quickest, cheapest, most effective way to respond" to regulatory problems is through the existing regulatory system, Mr. Pomeroy said, adding that the NAIC has supported federal statutes against insurance fraud and looked for federal authorization that would allow the NAIC to regulate alien insurers.

The best solution to regulatory problems would be to "strengthen what we've got, and then see what the new role would be for the federal government," Mr. Pomeroy suggested.

Mr. Chesson responded that the GAO report found the NAIC solvency standards are "astoundingly vague."

Federal standards are needed so that the uniform standards aren't the "least common denominator" of what 50 regulators with varying resources can agree on, he said, though he said it isn't yet certain what legislation will be proposed as a result of Rep. Dingell's investigations.

Some of the regulatory problems the subcommittee has uncovered include poor capitalization requirements, poor reporting requirements and infrequent financial examinations focusing on the wrong things, Mr. Chesson said. Also, investigation has shown that insurer insolvencies generally have stemmed more from management problems than from technical problems, he said.

Considering the federal government's budget problems, any proposed new system of insurer regulation would be funded by the insurance industry, Mr. Chesson remarked.

"Our intent is certainly not to do harm," Mr. Chesson said. "Our intent is to better the system."

The next step probably will be "some kind of idea paper" to be released this summer, Mr. Chesson said. A bill probably won't be unveiled until late in the year, he said.

It would have been a mistake "had we rushed into this, where we were shooting from the hip just to get something on the books," Mr. Chesson said.

Richard E. Stewart, chairman of insurance consultant Stewart Economics Inc. in Chapel Hill, N.C., and a former New York insurance superintendent, proposed building on the current system of state regulation with a national guaranty fund and liquidation process.

The state regulatory system could remain intact or strengthened, with continued responsibility for the detection and removal of insolvent companies, Mr. Stewart said. Federal authorities could pressure state regulators to detect and remove these companies early, he said.

Keeping in mind that insurer insolvency can be a national problem, guaranty funds and liquidations should be administered on a national basis, Mr. Stewart said. This would ensure uniform outcomes across the country and reduce interstate conflicts, he said.

Mr. Stewart also noted that insurer failures are a natural outcome of a competitive industry.

A federal regulatory system that pre-empted state regulation of rates

Continued on next page

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Continued from previous page
would meet strong opposition from states, as would any reduction in premium taxes collected by states, Mr. Pomeroy predicted.

States could continue to regulate rates, with the federal government overseeing solvency, but separating rate and solvency regulation could be dangerous, he pointed out.

"I urge you not to support change for change itself," Mr. Pomeroy said. The industry may be giving support to "a movement for a federal role that may very well not end where you want it to," he said.

"If the insurance industry isn't going to stand tough and provide the direction Congress needs relative to the technical intricacies of this business, who will?" Mr. Pomeroy asked.

The session was coordinated by Alan G. Page, a director and chief information officer for New York-based Johnson & Higgins. ■

Execs blast state solvency regulation

By LAURA MAZZUCA

SEA ISLAND, Ga.—While the insurance industry has staunchly supported state regulation of insurers for years, insurer and brokerage chief executives are—without hesitation—calling on the federal government to play a role in insurance solvency regulation.

The executives, who spoke during a panel discussion at the National Assn. of Insurance Brokers' 57th annual meeting late last month, cited the current state regulatory system's lack of uniformity, slow action and overall inefficiency in heading off solvency problems.

State solvency regulation is "ineffective, inconsistent and, in some instances, punitive," said Dean O'Hare, chairman and chief executive officer of Chubb Corp. in Warren, N.J.

Although the NAIC claims that the state regulatory system works, its definition of "efficient" is an average of 18 insurer insolvencies per year over the past five years, Mr. O'Hare said.

This number is still far too high, "especially for an industry whose basic purpose and product is a promise to pay," he added. "The growing public distrust of our industry is simply hurting all of us."

But while most panelists supported some form of federal solvency regulation to correct inefficiencies in the current state systems, others warned against hasty action that could result in legislation that could hurt the insurance industry, like the insurance tax provisions of the Tax Reform Act of 1986.

"If we don't understand and develop a consensus on these issues, we will get what we deserve," said William H. Bolinder, president and chief executive officer of Zurich-American Insurance Group in Schaumburg, Ill.

While the CEO panelists also tackled perennial insurance industry issues like the market cycles, globalization and environmental problems (see story, page 10), they found themselves returning again and again to insurer solvency and how best to monitor it.

For example, the executives turned their sights on the problems with state guaranty funds.

The current guaranty fund system punishes "responsible" insurers by making them subsidize irresponsible companies, first by having to compete with artificially competitive prices and then by paying assessments after the competitor becomes insolvent, Mr. O'Hare explained.

And although individual policyholders will always need guaranty fund protection on the state level, insolvency funds should not be required for "Corporate America," said Maurice R. Greenberg, chairman and chief executive officer of American International Group Inc. in New York.

Because commercial property/casualty insurance is a form of interstate commerce and cannot effectively be regulated on a state-by-state basis, the "protection" offered by a guaranty fund to a commercial policyholder only increases the overall cost of services and exacerbates the depth and length of market cycles, he said.

"It's inconsistent with everything we believe in" about the free enterprise system, Mr. Greenberg added.

"The fact is there are two distinct buyers in this country: the personal purchaser and the corporate purchaser. There needs to be two-tiered regulation to deal with those two distinct buyers," said Michael K. White, chairman and chief executive officer of Alexander & Alexander Inc. in New York.

Having to meet different state regulations also makes it more difficult for domestic insurers to compete with the growing number of foreign underwriters, which can enter the United States on a non-admitted basis and evade many regulations, Mr. White added.

For most of the panelists, the way to improve solvency regulation is for the federal government to impose some sort of minimum solvency standards. Such a program could be overseen by a federal entity like the Securities and Exchange Commission, Mr. O'Hare said.

He and others supported the proposed "two-tiered" system of regulation, offered by Marsh & McLennan Cos. Inc. and others in the industry, in which personal and small commercial insurers would be regulated for solvency at the state level and large commercial underwriters would be federally regulated for solvency. State guaranty funds would protect only the personal and smaller commercial policyholders (*BI*, April 22).

Such a system would retain the basis of a state regulatory system for the smaller buyer, but would allow for quicker action in the event of an insolvency of a commercial insurer because a central authority "with muscle" could act quickly and decisively when insolvency loomed, Mr. O'Hare said.

But not all panelists agreed on how involved the federal government should be in insurer solvency.

Although he predicted that the federal government would most likely play a role in solvency regulation in the near future, Mr. Bolinder hoped that the role would be limited to the establishment of minimum solvency standards rather than the total dismantling of the state system.

"State regulation may need improvement, but it is not as bad as it's being portrayed," he said.

George W. Brown, president and chief executive officer of Jardine Insurance Brokers Inc. in San Francisco, was concerned that the proposed two-tiered system would neglect the needs of the small corporate buyer, since the division between personal and corporate purchasers would leave a gap in which those policyholders could fall.

And Quill O. Healey, chairman

Continued on page 10

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Opinions

Opening the door

POLICYHOLDERS beware: A recent Illinois Supreme Court ruling could invite insurance companies to collaborate with plaintiffs' counsel against policyholders.

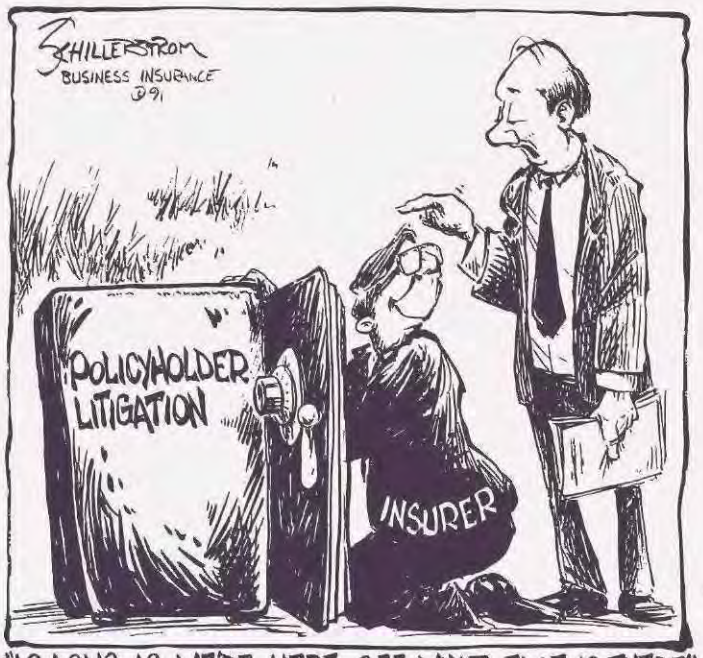
The court ruled that an insurance company disputing coverage for a claim is entitled to access to attorney documents generated in the underlying litigation (*BI,* June 3).

It is difficult to disagree with the court's ruling in this case: The claims had already been settled by the policyholder, which now is seeking coverage from the insurance company. Of course an insurer is entitled to see how and why its policyholder settled a claim for which the policyholder is seeking coverage.

However, unaddressed by the court is the insurance company's right in a coverage dispute to examine documents relating to underlying litigation that still is in progress. Settlements of claims can be structured to maximize insurance coverage or limit it.

If an insurer embroiled in a coverage dispute with a policyholder could obtain all of the details of the underlying claim while it is still in dispute, the insurer could collaborate with opposing counsel to make dure that the settlement is structured to minimize the insurer's liability for the settlement.

To those who still believe that insurance is the business of utmost good faith, this probably sounds ludicrous.



"AS LONG AS WE'RE HERE, SEE WHAT ELSE IS THERE".

But, this scenario is not unbelievable in a world in which insurance companies are increasingly refusing to defend and indemnify policyholders.

It is sad, but true, that some insurance companies believe that the insurance premium buys only peace of mind and that coverage costs a lot more.

Changes at Lloyd's in order

TO HEAR TELL in London, Lloyd's of London is going down the tubes.

Members are deserting the marketplace while others are suing it, threatening the survival of the 300-plus year-old institution. Some in London say that the Lutine bell is about to ring for the last time.

And there's no doubt that Lloyd's faces some serious problems. For example, the market is expected to report its first overall loss since 1967 when it announces its 1988 global results later this month.

However, the London wags are off the mark. We doubt that the death of Lloyd's is imminent.

However, we do believe that the marketplace had better consider some changes if it is to prosper—let alone survive—another 300 years.

The business of insurance has changed too much since the first risks were underwritten in a coffee house in London. The unlimited liability of Lloyd's members, who supply the capital for underwriting insurance at Lloyd's, obviously is no longer viable. It's one thing to bet one's last collar button on the survival of a ship at sea. It's quite another to bet the same on the U.S. legal system.

Lloyd's would be no less an institution if it were to limit members' liability to the amount of money they are willing to invest in underwriting insurance, rather than their entire net worth.

Defenders of unlimited liability contend that limited liability would turn Lloyd's into a second-class British insurance company.

That sells Lloyd's short.

Limiting the liability of Lloyd's members would not damage the institution at all. Indeed, we think that limiting members' liability would attract new investors, which would make the market stronger.

And, the market would still attract innovative underwriters, which is really Lloyd's major asset.

At issue

How often do you review the work of your health plan TPA?

Steven Marom
New York Counsel/Director-Benefits/ Compensation
Kaye, Scholer, Fierman, Hays & Handler,
New York

We review our TPA continually, but on a major basis at least once a year. We receive monthly, quarterly and annual reports that keep us in touch with how the plan is doing. Also, we feel obligated for our own peace of mind to do periodic audits on the performance of the administrator.

Tim Tourville
Personnel Director
Harry Cooper Supply Co.,
Springfield, Mo.

We review our TPA at least annually and sometimes semiannually. We review the claims themselves and claims payment procedures no less than every six months.

Don A. Tucker
Senior Manager-General Services Division
Trinity River Authority of Texas,
Arlington, Texas

Fortunately, our TPA is near our office. It is relatively easy to visit the office and check on any claims. They are experienced but relatively small and their top manager is readily accessible. Claim statements and a record of all provider and member payments are provided monthly. An audit of all claim payments is conducted by an independent auditor annually.

Compiled by Sara Harty

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THE PARTICIPANTS: **MARK A. MARIANI,** *Owner and President of Mariani Packing Company, a leading processor and distributor of dried fruits.* **BOB APPLEBY,** *with Woodruff Sawyer & Co., Mariani's broker.* **STEVE LA SHIER,** *Senior VP Safety Management, Argonaut Insurance Company.* **JOE SILVA,** *Executive Safety Management Consultant, Argonaut Insurance Company.*

MODERATOR We've been talking about how a substance abuse program has benefitted Mariani Packing Company in terms of dollars saved and increased productivity. On the flip side, is there a dollar figure you can put on what it costs to run your substance abuse program?

MM: I'd say our safety program, as a whole, easily costs us over $100,000.

JS: $100,000 seems high.

MM: It depends on how you want to define costs. That $100,000 includes loss of productivity while we administer the program. It's like our stretching program that gets people off the line for a few minutes to give them a chance to stretch their muscles and take a break. Just that 6½ minutes of stretching costs the company $65,000 in lost production time. And we take at least the same amount of time to talk about company policies during the toolbox meetings and so forth. So in real costs to the company from lost time, I would say the figure could easily be in excess of $100,000.

MODERATOR Can you turn that around and estimate what you've gained in productivity by people not having accidents, or taking time off, or filing claims?

MM: Well, just take our worker's comp. One year is a 100% return on our investment.

MODERATOR That's an impressive return.

MM: Obviously every year is going to be less and less. But the big issue is the focus on your safety program. To make sure everyone's thinking about it, and believing in it, and wondering what they can do about it. You walk out into our facility and every department has a white board that says how many days they have gone without an accident. It's just focus and realization and awareness. And, as Joe said earlier, the substance abuse program is one component, but a very important component. I honestly believe you're not going to have a successful program unless you have a strong statement by the company on it.

MODERATOR What would you tell another company about getting started?

MM: Well, if your only concern is for the bottom line you're going at it the wrong way. The bottom line improvement will come as soon as you're able to communicate to the employee base that you care. If they don't think you care, they'll give you every reason in the world why it's not going to work. And I think it's the apathy in the workplace that's going to get you. You have to get the community members caring about what they're doing and caring for each other first.

MODERATOR So it's the culture that has to be changed.

MM: Right. We had a difficult time at first because Joe here was really excited about the programs and wanted to get them implemented as soon as possible, and rightfully so. We felt we needed more lead-in time. We felt that we just didn't want to throw a bunch of programs on our people, a bunch of posters on the wall. We wanted to go into it slowly, because if you don't, people become suspicious of it.

MODERATOR You mean gradually educate them?

MM: With a well laid out program. Say over a three to six month period. That questionnaire we handed out, I'm convinced we wouldn't have had that kind of response if we just handed it out one day without warning. Everybody would wonder if it was a salary review, or an appraisal. If you don't communicate with them, they're not going to understand what you're trying to do. You have to get them thinking in the same terms you are.

MODERATOR But isn't that changing a corporate culture?

We're 225 people who spend nearly half of our lives together, and we'd better work as a community for the safety and well-being of all of us.

MM: And who's responsible for the culture? The CEO. If you leave this whole issue to your safety committee and think you don't have any impact on it, it's a waste of time. The CEO has to have the vision, the belief and the commitment to it. Because if you don't have the CEO and the senior management believing it, it's not going to happen.

MODERATOR How does your community of employees know that you care, that you're involved? Do you spend time out on the floor?

MM: You have to. If there's an accident out there, I want to be one of the first on the scene. We have little calendars within the company, and if someone's worked, say, 112 days without an accident and it beats the record, you'll see my name and "Great job!" written on it. They also hear through our newsletters. And questionnaires—a questionnaires a powerful tool.

SL: I think it's admirable the way you've gone about getting a mandate from your employees, especially with the equipment operators. Something you might consider is post-accident testing for accidents requiring off-site medical treatment. I'm not talking the hangnail-type claim, but the Monday morning injury, the weekend strained back that shows up on your insurance bill. These tend to disappear when any off-site medical treatment also requires a substance abuse screening test. Post-accident testing probably isn't going to come out in an employee questionnaire because they're not going to be thinking about that, except for the guy that may be abusing on the weekends who's filed a few claims.

Substance abuse is just one part of a company's safety program.

MM: That's an interesting idea.

MODERATOR But what would the impact be on your community?

MM: I'm not sure. We just want to make sure we don't come across as police.

SL: The other thing is, anything you do has to start from the top. If any of your senior staff teach driving or how to handle equipment, they're going to have to come under your safety policy. If they ever get on a forklift, even in an emergency situation, they had better be included in your routine and periodic tests.

MM: It isn't coincidental that our policy is worded 'any operators of equipment and vehicles,' and that all my management people drive company vehicles.

MODERATOR Have you had any threats or protected legal challenges from prospective applicants in the last eighteen months stemming from your policy?

MM: Not that I know of.

SL: See, that's the other bit of misinformation that hits the papers. That you'll have trouble hiring, or you'll be sued. Yet none of your applicants cried 'foul.' That's the kind of message we've been trying to get to customers. That a lot of what they read about substance abuse programs is not really the truth.

MM: You know what still tickles me, where did that 30% that failed our test go? Who would they go to work for?

SL: Let 'em work for someone else. Let some other company pay the cost. It's interesting that you based your discussion on productivity, which is really the way you should look at all of this. Because that's really where your major loss is: productivity. But hasn't your safety program paid for that productivity loss in direct savings in insurance dollars?

JS: It will. It's just a matter of time.

MM: Do you want me to quantify productivity? This last month, we had the biggest month ever in the history of the company. We did 32% more business with no new people, no new equipment, no new manager, no new techniques, no new racking, no new anything. And without any overtime or any accidents.

SL: Obviously, whatever your costs are for testing those applicants, it pays Mariani in the long run in increased productivity and better employees.

MM: No question.

SL: Substance abuse in the workplace is something you don't want to go into hastily. But I think what you talked about this whole session is what's going to be a buzzword of the 1990s: Total quality management. With no separation between productivity and safety. They're intertwined parts of the management scheme. If corporations are going to remain productive and profitable and ahead of the competition, they're going to have to have total corporate quality management. Look what it did for you, a 32% increase in productivity. You're getting a better product, a better employee, a better community, a better culture. That's outstanding. And that's what more companies are going to have to take a stand on and realize.

MODERATOR Would you be willing to spend some time with another company that comes to you and says "I've heard about your program and the benefits you've derived from it. How can we get started?"

MM: Absolutely. If they were really serious about it, I'd be glad to. I love to talk about success stories. I'm convinced it works, because we've done it here.

We'd like to hear what you have to say about substance abuse in the workplace, and about our discussions on topics that concern your business. Send your comments to Mike Crall, President, Argonaut Insurance Company, 250 Middlefield Road, Menlo Park, CA 94025.

Argonaut

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State regulation

Continued from page 7

and chief executive officer of Sedgwick James Inc. in New York, expressed dismay that the panelists found such fault with the state regulatory system, which brokers and others in the industry have supported in the past.

"Everybody used to be absolutely petrified to let the feds get into anything, and now we're all jumping with both feet into some type of federal legislation. At least our business does change," Mr. Healey noted.

While federal intervention may be inevitable, it is imperative that the industry work closely with legislators to create a bill that will be able to win approval and still remain favorable to the insurance industry, he added.

The session was moderated by Norman Rosenthal, principal with Morgan Stanley Group Inc. in New York. ■

Many topics discussed by execs

By LAURA MAZZUCA

SEA ISLAND, Ga.—Although federal solvency regulation dominated the agenda, speakers at the annual National Assn. of Insurance Brokers meeting also found time to discuss more perennial issues like environmental legislation, workers compensation, market cycles and foreign competition.

Environmental liability was a major concern among executives attending the NAIB meeting, held on Sea Island last month.

While the Superfund act was approved to clean up the environment, it has instead created a "legal morass," with almost 60% of funds being spent on determining legal liability, said Maurice R. Greenberg, chairman and chief executive officer of American International Group Inc. in New York.

And while Superfund has set limits on future dumping of hazardous waste, it hasn't worked well in mandating a cleanup of existing waste, said Caleb L. Fowler, executive vp of Philadelphia-based CIGNA Corp. and president of the domestic property and casualty division, who spoke at a separate session.

But the Bush administration now agrees that Superfund is "a horrible waste of money," and is looking for alternatives, Mr. Greenberg added.

One possibility is an environmental trust fund. Proposed by AIG, such a fund would be subsidized by a 2% charge added to all commercial insurance premiums, to be used for cleanup of pre-Superfund waste on a no-fault basis while requiring those responsible for waste dumped after Superfund to pay for those cleanups (*BI*, March 6, 1989). There seems to be insurance industry support for the proposal, and federal authorities are now considering it, Mr. Greenberg said.

Workers compensation, the largest single product line in the commercial property/casualty industry, is another problem area, Mr. Fowler said. Specific problems include: increasing assessments to support state-assigned risk pools, which have led some insurers to pull out of markets; increased litigation in a system that was designed to be no-fault; and rising medical costs.

One possible solution could be to apply managed care techniques to the workers comp system, and to permit insurers to raise rates so that they adequately reflect exposures and experience while allowing a reasonable profit, Mr. Fowler said.

These problems are exacerbated by a continuing soft insurance marketplace. Panel moderator Norman Rosenthal, principal with Morgan Stanley Group Inc. in New York, painted a glum picture of an industry low in the underwriting cycle, which he said is unlikely to improve at least until 1993.

Even then, an upturn is likely to be "mild," he said. Alternative markets, foreign insurers and the "increasing dichotomy of have- and have-not companies" will drain off the demand for traditional insurance. U.S. insurers will thus will see their current 70% market share gradually dwindle, he said.

But while Mr. Rosenthal and others saw limitations, other panelists saw opportunities.

Jardine Insurance Brokers Inc., for one, is taking advantage of the downturn to beef up internal functions, said George W. Brown, president and chief executive officer of the San Francisco-based brokerage.

The brokerage is tightening its belt by focusing on strengths and eliminating weaknesses, having divested $25 million in business because it could have led to substantial losses, he said.

Over the past six months, the brokerage has also dedicated itself to improved employee training in a "team building concept," Mr. Brown said.

Executives on the panel were also looking toward global expansion as an opportunity to turn a liability into a gain.

While foreign companies are jostling to get a slice of the U.S. insurance market, only six U.S. underwriters currently are writing a substantial amount of global business, pointed out Quill O. Healey, chairman and chief executive officer of Sedgwick James Inc. in New York.

Political stability and size—the U.S. share of the world market is 38%—draw foreign insurers to the United States, remarked William H. Bolinder, president and chief executive officer of Zurich-American Insurance Group in Schaumburg, Ill.

But at the same time, the corporate clients of U.S. insurers and brokers are increasingly expanding into foreign markets and need coverage abroad. This gives U.S. insurers and brokers an opportunity to get a foot up on foreign competition, Mr. Healey said.

Noting that AIG operates in about 130 countries, Mr. Greenberg said he believes that many critics are overly concerned about foreign competition and should focus instead on opening the world to trade.

"If they (foreign insurers) want to come in and lose money, that's their business," he said.

In spite of the regulation woes and dire market predictions, Mr. Greenberg and other panelists were optimistic that the future of the industry is not as dim as some may believe.

"Just as night follows day, there will be an upturn," Mr. Greenberg predicted.

And Dean O'Hare, chairman and chief executive officer of Chubb Corp. in Warren, N.J., stressed the importance of "operating in the market you're in right now" by sticking to a basic strategy and hoping that the soft market conditions of today will improve before 1993. ●

Associate Editor Colleen Johnson in Chicago contributed to this report.

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Bush pension proposal praised

Labor Secretary calls it solution for small business

By JERRY GEISEL

WASHINGTON—Pension plan rules need to be simplified to encourage more small firms to offer programs to their workers, says Secretary of Labor Lynn Martin.

"The most realistic and effective way to expand coverage is to make it easier and less costly for small businesses to set up a retirement plan to which employees can make tax-free contributions," Ms. Martin said here last month during the annual meeting of the Assn. of Private Pension & Welfare Plans.

Ms. Martin said a recent Bush administration proposal would eliminate many of the time-consuming and costly administrative hoops employers must jump through to prove that their pension plans do not discriminate in favor of highly-paid employees.

Under the administration proposal, known as POWER—short for Pension Opportunities for Workers' Expanded Retirement—employers with fewer than 100 workers that offer a new, simplified retirement plan would be exempt from complex Internal Revenue Services non-discrimination rules.

Those small employers would have to contribute at least 2% of pay on behalf of all employees.

In addition, employees could make up to $4,200 in annual pretax contributions, while employers could match up to 50% of employees' contributions.

'All too often those who "cash out" their pensions spend the money,' says Labor Secretary Martin.

Such a program would extend pension coverage to millions of workers, according to Ms. Martin.

"We estimate that this simplified pension savings plan will be available to about 98% of American businesses and could mean retirement benefits for about 26 million workers who now have no coverage," she said.

She also defended the program against criticism that it is inadequate.

"Frankly, I find it hard to believe that substantially reducing the complexity and cost of government regulation of simplified pension plans and making those plans available to firms employing millions of people won't lead to retirement benefits for more American workers," she said.

In addition, the administration proposal would expand pension coverage in other ways, according to Ms. Martin.

For example, state and local governments and other tax-exempt organizations, like trade associations, would be allowed to offer their workers 401(k) salary deferral plans.

"This proposed change would give 3.1 million workers who today have no pension coverage the opportunity to participate in the very popular 401(k) plan," Ms. Martin said.

The proposal also would require multiemployer pension plans, which now have about 8 million participants, to offer five-year vesting schedules, like many single-employer plans now offer. Workers in multiemployer plans now generally do not vest until completing 10 years of service.

Reducing vesting requirements to five years would immediately benefit more than 1 million workers who have worked at least five years but less than 10 years, Ms. Martin said.

Through several provisions, though, the POWER proposal would discourage employees from taking pre-retirement pension benefits as a lump sum.

For example, the proposal would eliminate a favorable method of taxation—known as five- and 10-year forward averaging—on lump-sum distributions taken in cash.

In addition, the proposal would require employers to offer terminating employees the opportunity to roll over lump-sum distributions directly into an Individual Retirement Account or to a new employer's pension plan—if the new employer allows such transfers.

Curbing pre-retirement lump-sum distributions will help assure that workers will have savings at retirement, Ms. Martin said.

"All too often those who 'cash out' their pensions spend the money rather than save it for retirement. Ultimately, this will create added pressure on Social Security and other government programs, such as Medicare, Medicaid and welfare. Last year, for example, workers received an estimated $12 billion in pension cash-outs before retirement. Most was spent, not saved," Ms. Martin said.

Such massive cash-outs endanger the retirement security of workers, she said. ■

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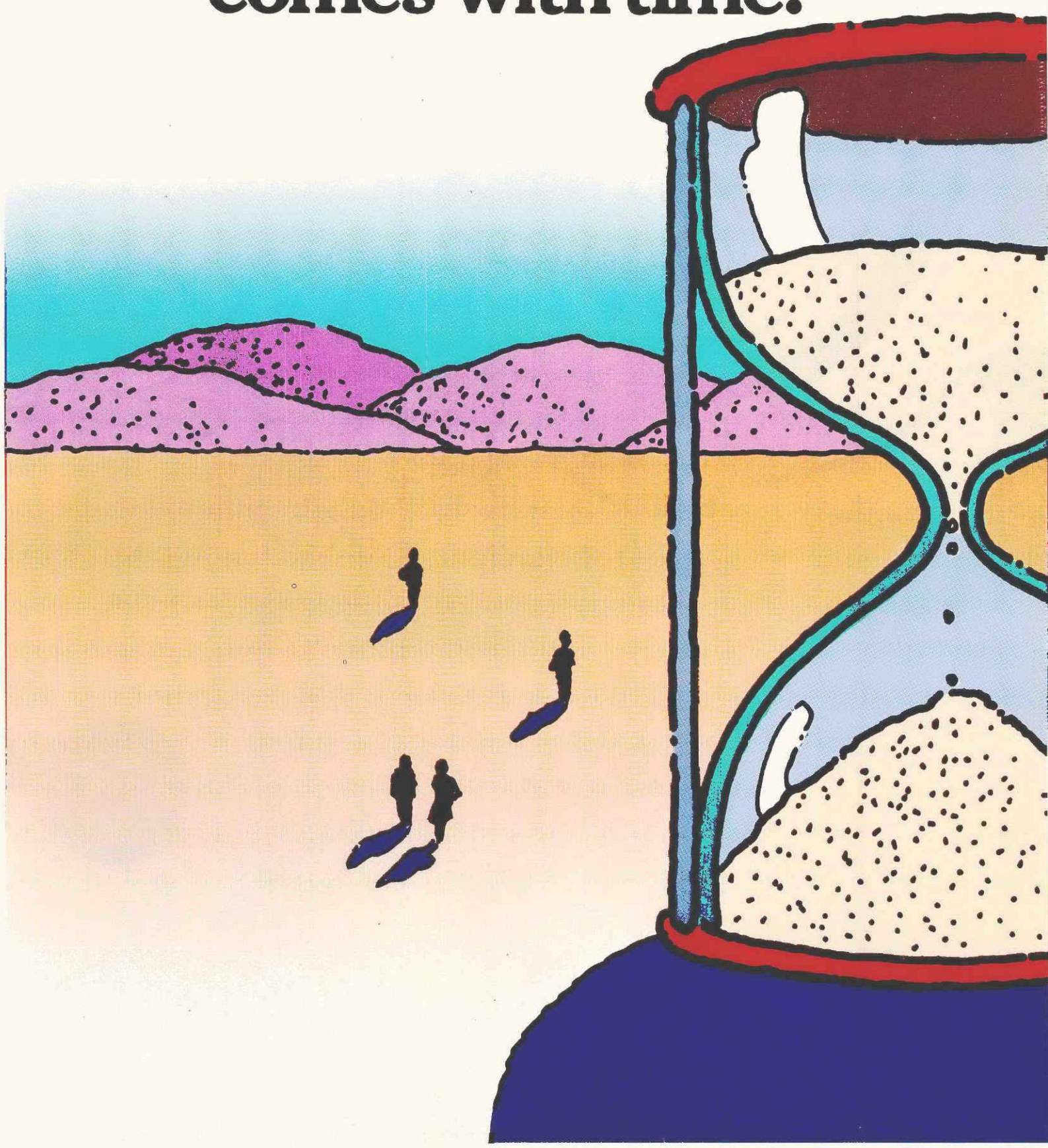


Annuity choice holds fiduciary concerns

By ADRIENNE C. LOCKE

WASHINGTON—Concerns over the ability of Executive Life Insurance Co. to meet its obligations raises questions about the scope of an employer's fiduciary responsibility under the Employee Retirement Income Security Act, a Bush administration official says.

Indications that price rather than the insurer's financial wherewithal was the deciding factor for employers that purchased annuities for participants of terminated overfunded defined benefit pension plans and guaranteed investment contracts for 401(k) plan participants from Executive Life has prompted the Pension and Welfare Benefits Administration to consider outlining a standard for these purchases, said Ann L. Combs, deputy assistant secretary at the PWBA.

The unit of Los Angeles-based First Executive Corp. was placed into conservatorship on April 11, while Executive Life Insurance Co. of New York went into rehabilitation later that month (*BI*, April 22; April 15).

Looking for the cheapest annuity 'doesn't meet fiduciary standards,' says Ms. Varnhagen.

Ms. Combs said the Labor Department believes that purchases of annuities and GICs by employers are fiduciary decisions that must be made prudently and with the best interests of the plan participant in mind.

"I think the language is quite clear" in ERISA, she said.

Even under newly proposed 404(c) regulations, which would make it easier for employers to avoid fiduciary liabilities for investment decisions made by employees in defined contribution plans (*BI*, Dec. 24, 1990), the employer's choice of a GIC as an investment option "is still a fiduciary responsibility," Ms. Combs pointed out.

However, the Labor Department has not clarified how employers can meet their fiduciary responsibility when purchasing those types of annuities and GICs.

As a result, the PWBA will draft rules to address this issue, she said, noting the agency expects to issue advance notices of a proposed rule by mid-July, she said.

"There has to be some minimum level of protection afforded to participants" in defined benefit pension plans when an employer terminates a plan, leaving participants without protection from the Pension Benefit Guaranty Corp., as well as to 401(k) plan participants who direct their investments to GICs, Ms. Comb said.

Michele L. Varnhagen, counsel for the Senate Labor and Human Resources Committee, agreed.

It is "abundantly clear" that there were numerous signals about the state of Executive Life, she said. While state insurance regulators should have acted sooner, "it doesn't absolve pension plan managers from their fiduciary responsibilities," she said.

Ms. Varnhagen said that initial research into the reasons employers bought annuities from Executive Life indicates the insurer was selected because it provided the lowest bids.

Ms. Varnhagen said this "created an inherent conflict of interest" because selecting the lowest-priced annuity would leave more funds for the employer.

But, "looking for the cheapest (price) they can get doesn't meet fiduciary standards," she said.

Ms. Varnhagen also noted that most of the Executive Life annuities were purchased by companies that had just taken over other companies and then terminated the acquired companies' overfunded pension plans.

She recommended all employers that terminate overfunded pension plans should be subject to higher fiduciary standard under pension law.

Ms. Combs said one way to ensure that employers more prudently purchase annuities as well GICs would be for the Labor Department to require that employers purchase annuities and GICs from insurers that meet minimum criteria, thus creating a "floor" of fiduciary responsibility for employers.

If the insurer that issued the annuities or GICs did not meet the requirements, the employer still would be liable for any losses to the beneficiaries, she said.

Ms. Varnhagen said that another solution would be to require employers to use independent fiduciaries to arrange the purchases.

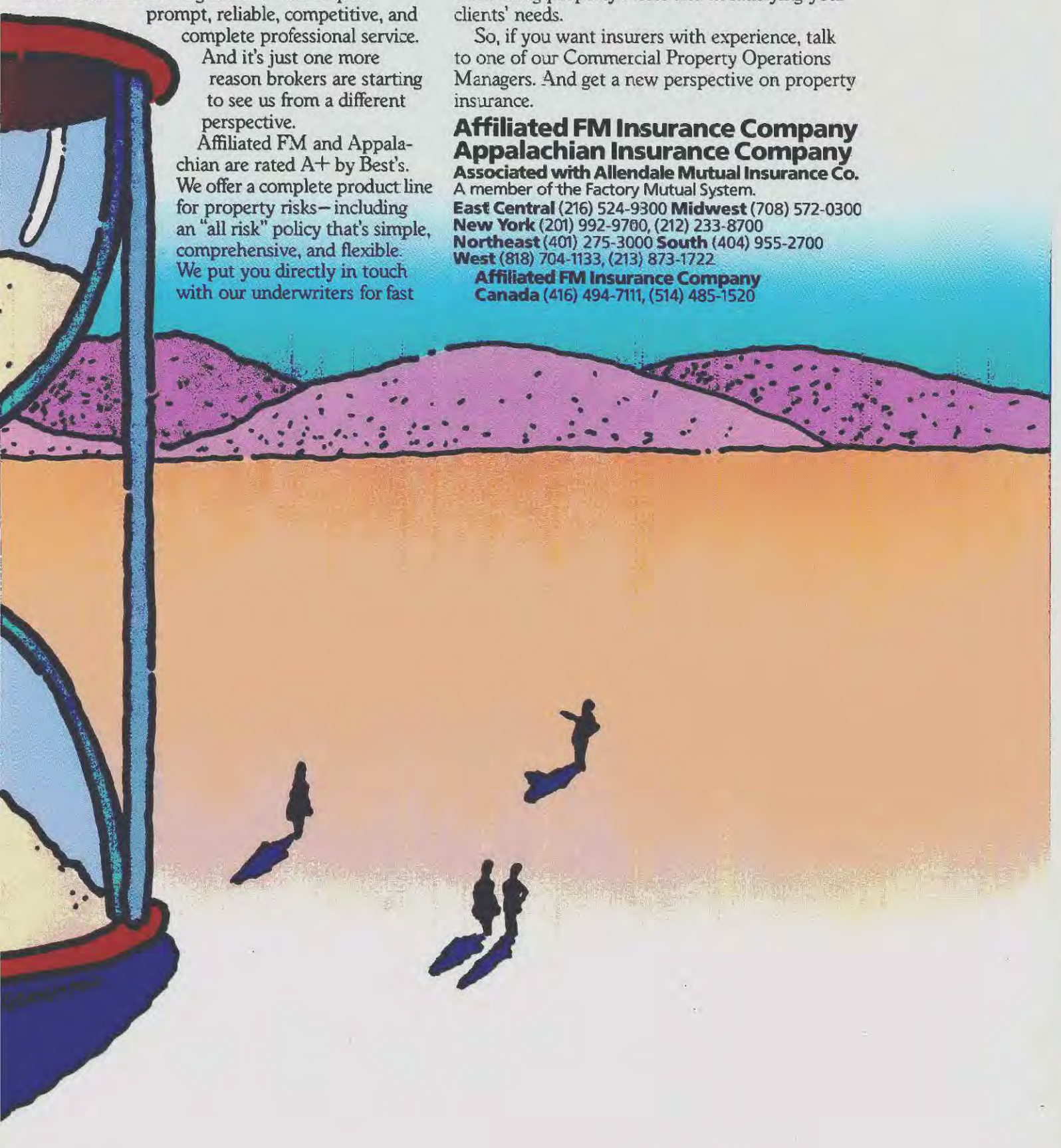
However, Ms. Combs said the PWBA also would have to consider the market implications of any such regulations.

For example, "we don't want to create any monopolies or drive up the cost of annuities," she said.

Ms. Varnhagen said the Senate Labor and Human Resources Committee currently does not have any short-term legislative solutions for those retirees who are facing reduced pension payments because of Executive Life's conservatorship.

"It's a decision that (the committee) will have to make: Are they going to protect these people while this is going on?" she said.

"I just don't know if retirees are willing to wait three to four years to resolve this, and I don't know if Congress is going to let them" wait that of long, she said. ■



Better health care access not imminent: Legislator

By JERRY GEISEL

WASHINGTON—The lack of national consensus **APPWP** makes it unlikely that Congress will soon pass comprehensive legislation to improve access to health coverage, a legislator says.

"People are mad, but they don't know what to do. There is a long way to go before a consensus is reached. It will take a while for things to shake out. I would not look for anything in 1991 or 1992," said Rep. Rod Chandler, R-Wash.

Speaking last month at the annual conference of the Assn. of Private Pension & Welfare Plans in Washington, D.C., Rep. Chandler said there are several reasons why a consensus on improving access to health care is so elusive.

One is that physicians are supportive of government moves to improve access but are nonetheless concerned about the increased government health care regulation that would likely accompany such a proposal, Rep. Chandler said.

Another is that the estimated more than 32 million people without health care coverage are not a powerful lobbying group, he said.

While a consensus on improving health care access is not likely anytime soon, debate on the issue is increasing.

"In health care reform, we are beginning to see a national debate. And, the debate is extending beyond the Beltway," Rep. Chandler said, referring to a loop of roads in metropolitan Washington, D.C.

Meanwhile, Rep. Chandler said he is not optimistic about Congress enacting legislation that would allow employers to prefund retiree health care expenses on a tax-favored basis.

Enacting any proposal that loses revenue for the government, like tax breaks for prefunding retiree health care liabilities, is difficult at a time of big federal budget deficits, Rep. Chandler said.

'People are mad, but they don't know what to do' about health care access, says Rep. Chandler.

Under current law, investment income earned on assets held to pay for future retiree health care expenses generally is taxable.

Turning to another area, Rep. Chandler said he plans to introduce later this month revised pension simplification legislation.

The most significant change in the new bill would expand safe harbors that Rep. Chandler proposed last year for employers offering 401(k) plans (*BI*, Aug. 13, 1990). Plans qualifying for the safe harbors would not be subject to the Internal Revenue Service's complex non-discrimination rules that compare contributions of highly-paid employees with those for rank-and-file workers.

Rep. Chandler did not detail how the expanded safe harbors would work. However, last year he proposed two safe harbors. Plans qualifying for either one would not be subject to 401(k) non-discrimination tests. Under the safe harbors, an employer would have to:

- Match 100% of employee elective contributions, up to 3% of employee compensation and 50% of employee contributions between 3% and 5% of employee compensation.
- Automatically make contributions of at least 3% of employee compensation regardless of whether the employees actually contribute to the plan.

Employer contributions also would have to be immediately vested.

Last year, benefit consultants said few 401(k) plans would qualify for the safe harbors then proposed by Rep. Chandler.

Rep. Chandler also said his bill would offer some relief from complex IRS rules affecting employers offering different pension plans to separate lines of business (*BI*, May 21, 1990).

While some employers would like to see non-discrimination tests for 401(k) plans eliminated, Rep. Chandler said repeal of the rules is not politically realistic.

However, he urged employers to step up their lobbying on pension and other employee benefit issues.

"These issues are critically important," he said.

Rep. Chandler acknowledged that lobbying on benefit issues can be difficult because of the technical nature of the subject. Eyes glaze over on Capitol Hill when a lobbyist talks about a safe harbor for 401(k) plans, he said.

Still, employers can influence the debate on benefit issues if they improve their lobbying skills, he said. "You need to shorten your message and make it understandable. Talk to your representatives, but keep your message simple," he said.

That is exactly what employers did in 1989 when they successfully lobbied Congress to repeal Section 89, which set enormously complicated rules for health care and other employer-sponsored welfare plans, and to kill a proposal, known as the Visclosky amendment, that would have required employers to share control of pension assets with workers, Rep. Chandler pointed out.

"In both areas, the message from employers was timely and simple and it was delivered in person," he said.

"From every sector of the business community we had letters and calls. I was amazed," he added. ■

New chairman for APPWP

WASHINGTON—The Assn. of Private Pension & Welfare Plans has a new chairman.

John Troy, vp-managed care and employee benefits operations at The Travelers Life Insurance Co. in Hartford, Conn., was elected to head the group's board of directors during its annual meeting here last month.

Board members also elected Carson E. Beadle, managing director at William M. Mercer Inc. in New York, as vp; Manuel Castells, a partner at Kwasha Lipton in Fort Lee, N.J., as treasurer; and Kevin Flatley, vp-employee benefits at American Express Co. in New York, as secretary.

In addition, two new members were elected to the APPWP board: Charles Kamen, executive director of human resources at US West Inc. in Englewood, Colo.; and Michael J. Willmering, manager-employee benefits at MAPCO Inc., a diversified energy company in Tulsa, Okla.

David G. Marshall, vp of compensation and benefits at RJR Nabisco Holdings Group Inc. in New York, was re-elected president of the APPWP.

The APPWP is a national trade organization for companies and individuals concerned about federal legislation and regulation affecting all aspects of employee benefits. Members include Fortune 500 companies, banks and insurers, as well as law, accounting, actuarial, consulting and investment firms.

For more information call Ellen Goldstein at APPWP, 1212 New York Ave. N.W., Suite 1250, Washington, D.C. 20005; 202-289-6700.

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DES ruling

Continued from page 2

makers of DES under the so-called market share theory of liability for injuries they allegedly suffered as a result of in utero exposure to DES. The U.S. Supreme Court in 1989 refused to review a ruling by New York's highest court that the makers of DES can be held liable for damages based on their percentage of market share at the time the drug was prescribed (*BI,* Nov. 6, 1989; April 10, 1989).

Approximately 300 companies manufactured the drug at some point until it was removed from the market. Among the defendants in the litigation are Abbott Laboratories, Boyle Co. Eli Lilly & Co., Merck & Co. Inc., Rexall Drug Co., Rorer Group Inc., E.R. Squibb & Sons Inc. and Upjohn Co.

The appeals court ruling reverses an August 1990 decision by trial court Judge Ira J. Gammerman, who is coordinating all New York DES cases.

Defendants had argued that the medical information of family members not party to the lawsuits was necessary to show that the plaintiffs' claimed injuries, including cancer and infertility, were not the result of exposure to DES during gestation but instead were the result of hereditary factors.

However, the plaintiffs opposed the discovery request on the grounds that such medical information falls within the scope of the doctor/patient privilege, which is protected under state law.

Some plaintiffs' attorneys also argued that opening a family's medical history to pharmaceutical companies had in the past given defendants a vehicle to drag out cases and harass plaintiffs.

Judge Gammerman ruled that the defendant pharmaceutical companies were entitled to obtain copies of the hospital and medical records of a plaintiff's relative if that relative had previously provided the plaintiff the information.

However, the appellate court, in an opinion written by Judge Sidney H. Asch, disagreed.

"The mere fact that a relative, distant or near in terms of kinship, has commenced a medical malpractice action alleging a birth defect should not subject all her relatives to the 'long arm' reach of the law authorizing medical histories opened to all," Judge Asch wrote.

Judge Asch provided a hypothetical case to support the court's reasoning for not ordering relatives of plaintiffs to open up their medical histories to defendants.

"If a plaintiff relayed information to a doctor that her second cousin had endometriosis and was sterile, such factors might be totally unrelated to the plaintiff's condition It could be the result of diet, environment or the working conditions of the second cousin or it could be a congenital source from a branch of the family which has no connection to the DES family tree member. That second cousin should not be 'presumed' to have waived her confidentiality and be unnecessarily burdened with the necessity of appearing to rebut the presumption of waiver," Judge Asch wrote.

"The requirement of forcing such unsuspecting third parties to retain counsel to fend off demands for private medical documents should not be countenanced without a much stronger predicate for such disclosure," he wrote.

"Clearly, defendant drug companies could abuse such an open-ended discovery device, employing it as a device to harass and embarrass non-parties while delaying plaintiffs' actions," Judge Asch wrote.

The court did not specify under what conditions defendants could obtain such information.

The court, though, said the defendants can access the medical records compiled by a plaintiff's mother during her pregnancy.

Defense attorneys say the court's ruling is unreasonable because it denies them the opportunity to show that plaintiffs' alleged injuries were caused by hereditary factors.

"The whole question in these cases is causation, and the defendant must show that the medical problems may have been family-related and not DES-related," said attorney A. Edward Grashof of Winthrop, Stimson, Putnam & Roberts in New York, which represents Rexall Drug.

"By depriving us of access to family history, we are deprived of our principal defense," he said.

Jay Mayesh of Stroock & Stroock & Levan in New York, which represents Kalamazoo, Mich.-based Upjohn in DES litigation, called the ruling "an unreasonable denial of defense's right to discover."

Mr. Mayesh pointed out that in many DES cases, the only evidence that a plaintiff's mother used DES during pregnancy is the mother's own recollection during testimony of using the drug.

"In a lot of these cases, the only evidence of DES ingestion is the recollection of what the mother was prescribed, and this event took place 25 or 30 years ago. But through a sibling's birth record, we can sometimes find evidence of the administration of DES or drugs that weren't DES at all but got confused by the mother as being DES. This is valuable information we're now denied," Mr. Mayesh said.

But, plaintiffs' attorneys commend the ruling, saying it affirms the true definition of right to privacy and ties the hands of the drug makers.

"This is a tremendous victory for plaintiffs because it keeps the pharmaceutical companies in check," said Leonard L. Finz, an independent New York attorney who represents scores of DES plaintiffs.

"It tells them that they can only focus on relevant issues and that one cannot depose people just because they're blood relatives of someone involved in litigation," Mr. Finz said.

Other plaintiffs' lawyers were more reserved in their assessments, saying the reversal of Judge Gammerman's ruling was the only correct path the court could take.

Paul Rheingold, a partner in the New York firm of Rheingold & McGowan, which represents hundreds of DES plaintiffs, said the ruling confirms what the plaintiffs' bar had always thought: Relatives of plaintiffs have a state-protected right to privacy.

"This isn't a radical ruling," Mr. Rheingold said. "In fact, some plaintiffs' attorneys don't feel the court went far enough. They feel that the mother should also have her medical records kept confidential. We're just happy that defendants aren't being given the right to conduct a fishing expedition."

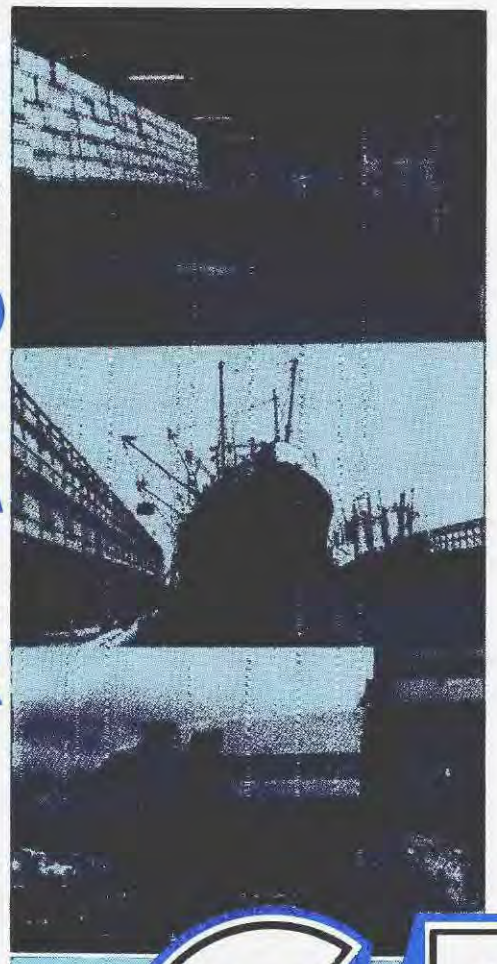
"This was really a simple issue. It's not monumental," agreed William Dinkes of Dinkes & Morelli in New York, which represents DES plaintiffs.

"The court ruled that if information is relevant to your case you can get at it. The relevant issue here is when the mother was pregnant. In that light, the ruling makes perfectly good sense."

The decision also prevents drug companies from strong-arming and intimidating plaintiffs, Mr. Finz said.

"We have been dealing with the pharmaceutical issue for a long time and to say that harassment isn't there is ridiculous. Requesting an entire family's medical records is a form of intimidation," Mr. Finz said.

Mr. Rheingold said that while harassment of plaintiffs is not pervasive, "it's not uncommon, either." ■



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Fear of disease prompts comp claims

By MEG FLETCHER

BOCA RATON, Fla.—Workers compensation claims and lawsuits increasingly are being filed against companies because individuals fear that a company-related event or exposure will make them sick in the future, a legal expert says.

Such "mental distress" workers comp claims and lawsuits are typically filed against asbestos producers, chemical companies, extermination firms, and manufacturers of drugs and medical devices like pacemakers, although "no company is immune from them," said Merton E. Marks, an attorney with Lewis & Roca in Phoenix.

"Fear of future disease" claims often stem from media stories about hazardous products and conditions, like asbestos in buildings, polychlorinated biphenyls (PCBs) in drinking water, the AIDS virus in blood supplies and "even benzene in our Perrier," Mr. Marks told the annual meeting of the National Council of Self-Insurers here last month.

Those reports allege that such toxic agents can cause microscopic changes in human beings that, although undetectable at the time of contact, over many years may result in serious or fatal diseases, he said.

"Anxiety over such consequences has led to litigation by people who have suffered no present personal injuries but who seek recovery for fear of future disease," Mr. Marks said.

Judges historically have been skeptical of these "mental distress" claims because they are "highly subjective, speculative and possibly fraudulent," he said.

As a result, most civil courts require evidence of an initial physical injury before allowing recovery.

However, there is a trend toward awarding funds for medical monitoring if there is sufficient proof of risk, Mr. Marks said.

The situation is different for workers compensation claimants who allege fear of future diseases, he noted.

Claims that are "manifested as a psychological injury or condition" have usually been allowed without any physical injury, Mr. Marks said.

In 1985, for example, a California appeals court upheld compensation for the psychiatric condition of an inspector-repairman who a doctor diagnosed as suffering from asbestosis, he said. The worker was subsequently classified as permanently and totally disabled and became convinced he was dying of the disease. However, other doctors later concluded he had been misdiagnosed and did not have the disease.

Some states like Arizona limit this type of recovery by requiring that the workers comp claimant prove "that the stimulus or stress was extraordinary, unusual or unexpected" before a fear of future disease claim is accepted, Mr. Marks said.

Companies should realize that "in a claim for fear, recovery is allowed if the fear is reasonable, even if the occurrence of the condition is not likely," he said.

To defend itself from such claims, a company may first try to argue that the fear is groundless by showing that the event or exposure could not cause a disease, Mr. Marks said.

Companies have a more difficult task if some causal relationship exists. Then, they will then want to show that the chances of an individual becoming disabled in the future are highly speculative and remote and that the individual's fear is "out of proportion and irrational," he said.

That approach worked for Philadelphia Electric Co., which successfully defended itself against a lawsuit by a nuclear power plant worker who sought damages for fear of contracting cancer from his exposure to radiation, Mr. Marks said.

The worker's wife also sued the utility for emotional distress from an abortion she had performed out of fear that the fetus, conceived eight months after the husband's exposure, would have genetic defects.

Philadelphia Electric defended itself by presenting uncontroverted expert evidence that any risk of genetic damage to the husband was "both hypothetical and infinitesimally small" and that the wife made a medically uninformed decision to abort Mr. Marks pointed out

A difficult aspect of these cases is that although there is little or no risk from an exposure and the plaintiffs' fear is irrational by normal standards, the plaintiffs genuinely believe that they will be disabled by the exposure, according to Mr. Marks.

However, where recovery is sought for the condition itself—as opposed to only fear—the plaintiff must prove that the exposure in question, rather than other possible causes, actually caused the condition, excluding other possible causes.

When defending such a case, employers can use epidemiological and risk assessment experts, Mr. Marks said.

It can be useful to draw comparisons with other statistically established risks, he said. For example, a plaintiff who smokes and who files a "cancerophobia" case arising out of a chemical exposure probably has a greater risk of lung disease from smoking than from exposure to the chemical.

Defense attorneys also should be aware that there is "considerable scientific controversy as to whether the results of short-term, high dose exposure of animals to chemical agents can be accurately extrapolated to long-term, low dose exposure in human beings," Mr. Marks said.

Companies can also contest a worker's ability to bring such a lawsuit or workers compensation claim, he noted. The statute of limitations on such a suit may have run, he said, or a legal doctrine may prohibit a plaintiff who loses a lawsuit seeking damages for fear of a future condition from later bringing a lawsuit over the condition itself.

Fear of future disease claims are expected to increase because health care workers and emergency personnel are increasingly being exposed to the human immunodeficiency virus that leads to AIDS when treating patients.

In addition, some claims may stem from "right to know" laws that require employers to notify workers of toxic hazards without giving them a framework for assessing the risk of their exposure, he added. ■

Firms flee comp system

Decision could benefit, backfire on Texas employers

BOCA RATON, Fla.—Any discussion of the pros and cons of Texas employers opting out of the state's troubled workers compensation system could be drowned out by the stampede of fleeing employers.

"There are now more non-subscribers than there are subscribers" to the Texas system, explained Bennett W. Cervin, an attorney with Thompson & Knight in Dallas.

Mr. Cervin spoke at the National Council of Self-Insurers' annual meeting last month.

However, precise statistics about how many of the state's 320,000 employers have opted out of the system won't be available until mid-June, a spokeswoman for the Texas Workers Compensation Commission said in an interview.

A Texas employer that chooses to become a "non-subscriber" must file a notice with the commission, notify its employees in writing and post a notice at the worksite, she said.

South Carolina and New Jersey are the only other states that do not require employers to subscribe to their individual state workers comp laws.

The Texas system is "in meltdown" due to problems like excessive litigation and pro-claimant court rulings that the Texas Legislature sought to remedy through a 1989 reform law, Mr. Cervin said.

However, that law was declared unconstitutional by a Texas state court judge last month. The decision is being appealed (*BI*, May 20; May 13).

In the interim, workers compensation insurance rates in Texas are still rising, and several insurers have stopped writing coverage in the state to reduce their huge liability for residual market losses, which they pass along to policyholders through so-called residual market loadings.

The impact of residual market loadings is one of the main reasons that Excel Corp.—a subsidiary of Minneapolis-based Cargill Inc. with a total of 3,000 employees at two meat processing plants in the Texas panhandle—decided about a year ago to opt out of the Texas workers comp system, said Brian R. Turnwall, Cargill's casualty insurance manager.

Excel estimates that it was paying about $1 million annually in residual market loadings, he said.

In addition, poor loss statistics prompted the change, he said. For example, an average claim for workers comp medical and indemnity benefits exceeded $20,000. An injured employee typically saw two to four medical providers and consulted attorneys in 95% of all loss-time cases, he said.

With the money it would have spent on workers compensation insurance, Excel obtained an unspecified amount of catastrophic liability coverage written on a manuscript basis and implemented an extensive loss control and medical case management program to reduce the frequency and severity of worksite injuries and illnesses and bring employees back to work as soon as possible, often to "limited duty" jobs.

An injured employee now receives medical benefits and wage benefits—his salary less taxes—without the waiting period that is customarily required under the workers comp law. Excel's policy is to provide all employees—even a worker who has sued the company—with such benefits as long as they continue to use company-designated providers for their health care, he said.

The change has resulted in some "pretty impressive" statistics during the first nine months of fiscal 1990-91, Mr. Turnwall said. For example, the number of lost-time days dropped to 722 from about 7,000 and 13,000 during a similar period in the two previous years.

In addition, incurred losses dropped to $1.4 million from $2.5 million and $3.5 million in the two previous years.

There is no one reason why Excel's loss statistics are improving, Mr. Turnwall explained. Opting out of the workers comp system "is forcing us to do all these things better than we did before," he noted.

The negative aspect of opting out of the workers compensation system is the increased risk employers can face, Mr. Cervin said.

"Historically, a subscribing Texas employer's liability has been considered to be limited to its insurance premiums and, with the exception of the recovery solely of exemplary damages under a claim of gross negligence, the employee's exclusive remedy was the benefit scheme provided by workers compensation," he said.

"A non-subscribing employer, on the other hand, may be sued by its employees with no limitation on the amount that may be recovered from the employer for both compensatory and exemplary damages," Mr. Cervin said.

Other risks a non-subscribing employer faces include:

- The possibility that the company's owners and executives would be held personally liable for an employee's injury or illness.
- Loss of common law defenses like those that state an employee contributed to his accident, assumed the risk of injury or was injured through the negligence of a fellow employee.
- Negative impact on employee morale and difficulty in attracting and retaining qualified employees.
- Difficulty in obtaining other types of insurance, credit and new business because the employer's liability for employee-related injury claims is no longer limited.
- Violation of existing contractual, loan or permit requirements that stipulate that the company must have workers comp coverage.
- The added expense of handling employee claims outside the workers comp system.

If an employer decides that the advantages of opting out of the Texas workers comp system outweigh the risks, it may want to consider providing occupational injury benefits to employees through occupational accident and health insurance or through an occupational injury benefit plan established under the federal Employee Retirement Income Security Act of 1974, Mr. Cervin explained.

As part of an occupational injury benefit plan, Mr. Cervin recommends that employees be asked to voluntarily waive rights to sue an employer, its affiliates, its officers, employees and related others for damages arising from occupational injury or death resulting from such an injury.

Mr. Cervin said he is "very convinced" that such a waiver is enforceable, although it has not been tested before the Texas Supreme Court.

Generally, he advised that employers considering alternatives to the traditional workers comp system "check very carefully before you make the decision."

In addition, he predicted that the current workers comp system in Texas will collapse within two years and that a new system will emerge that requires all employers to participate. ■

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More firms self-insure workers comp risks

By MEG FLETCHER

BOCA RATON, Fla.—The growth in the number of companies that self-insure their workers compensation risks is bringing with it new challenges.

Several speakers at the National Council of Self-Insurers' annual meeting here say those challenges include: maintaining good relationships with regulators; blocking efforts to make self-insurers help fund residual market deficits; and controlling rising workers comp costs through meaningful reforms.

Risk financing alternatives—including self-insurance, excess/surplus lines and various other mechanisms—accounted for $55.6 billion, or 31.6% of a $175.6 billion commercial risk financing market last year, according to a study by broker Johnson & Higgins and The IMR Corp. of Morristown, N.J. (*BI*, Jan. 28).

The study also found that workers compensation is the single most popular line of insurance for companies to self-insure, said David A. North, vp of Johnson & Higgins Resource Group in Chicago, at the NCSI meeting.

Mr. North said the study found that the percentage of companies self-insuring their workers compensation exposure increased to an estimated 27% by year-end 1991 from 19% in 1982 and is expected to continue climbing.

The workers comp self-insurance market had a compounded annual growth rate of 14.9% during that period, compared with 9% in the conventional marketplace, the J&H/IMR study says.

The continuing growth of the self-insurance market, though, may tax the resources of states to handle all the employers that want to self-insure their workers compensation exposure, said Allyn C. Tatum, commissioner of the Arkansas Workers Compensation Commission and president-elect of the International Assn. of Industrial Accident Boards & Commissions.

State administrators of programs for companies that want to self-insure will have to continue their vigilance so that only financially capable employers are granted the privilege of self-insurance, Mr. Tatum said. One employer failure "taints" all self-insurers, he added.

The NCSI is interested in collecting information about the wide range of regulatory approaches different states apply to self-insurers, remarked Douglas Stevenson, executive director of the group and an attorney with of Stevenson, Rusin & Friedman Ltd. of Chicago.

Self-insurers favor reasonable regulation rather than "suffocating" minutiae or practices like requiring utilities to post security when there is little likelihood that they will be unable to pay injured workers' claims, Mr. Stevenson said.

Several speakers expressed concern about suggestions by regulators and insurers that self-insurers help fund deficits in state residual market programs.

Saying that he does not support having self-insurers contribute, Mr. Tatum warned that self-insurers are being "short-sighted" to think they will not have to pay, because the money is not available elsewhere.

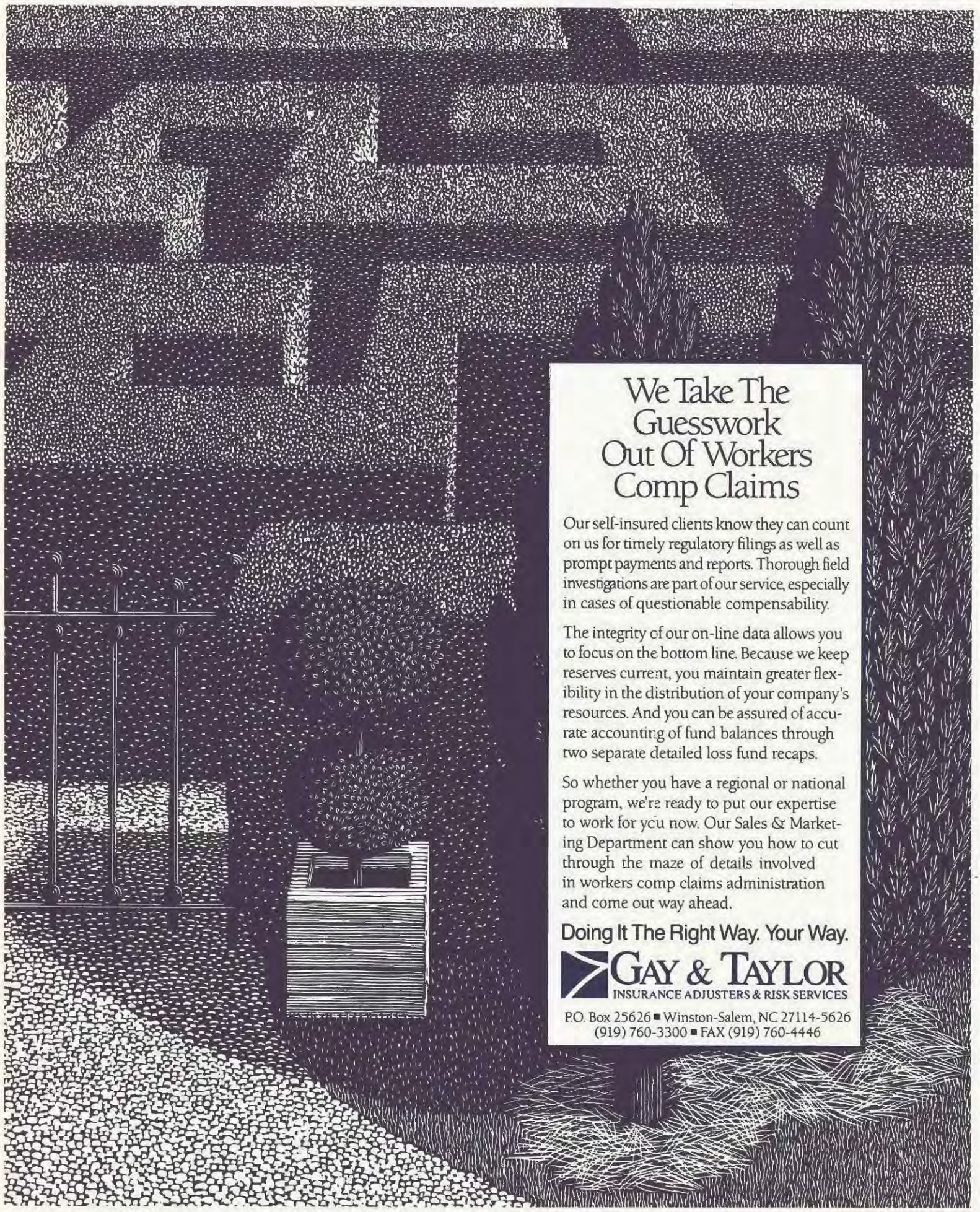
Self-insurers "sympathize" about the poor financial condition of some assigned risk programs, said Alan Strohmaier, director of unemployment and workers compensation issues for General Motors Corp. in Detroit. However, self-insurers won't allow themselves to be used as "deep pockets," he said.

Self-insurers need to be ready to protect themselves with proposals that force all employers to pay their fair share of workers comp costs and provide incentives for safety, pointed out Richard Hoffman, vp-actuarial services and government relations for Midwest Employers Casualty Co. in St. Louis.

In addition, self-insurers should work for system reforms to reduce escalating costs, said GM's Mr. Strohmaier, who co-chairs the Labor-Management Discussion Group on Workers Compensation and is chairman of the National Assn. of Manufacturers' Workers Compensation Committee.

The year-old, labor-management group's current goal is to break down the barriers between the parties and develop consensus about appropriate standards for the administration of workers comp systems, he said.

Mr. Strohmaier said that if the group ever reaches agreement and supports an action plan on the state level, he would urge NCSI members to consider the compromise package as a whole rather than merely the individual proposals it may contain. ■



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Discrimination lawsuits

Americans with Disabilities Act to create new exposures

By MEG FLETCHER

BOCA RATON, Fla.—Employers may face legal problems next year unless they educate themselves now about the federal Americans with Disabilities Act.

The 1990 act becomes effective July 26, 1992, for employers with at least 25 workers, while companies with at least 15 employees will be subject to its requirements two years later, according to G. John Tysse, an attorney with McGuiness & Williams in Washington D.C.

The act is designed to help 43 million Americans who have one or more physical or mental disabilities to become independent and economically self-sufficient by eliminating discrimination against them in employment and several other areas including transportation and accommodations.

It's "a very major" piece of legislation that will affect how employers can screen job applicants and conduct their business, Mr. Tysse told attendees at National Council of Self-Insurers' recent annual meeting in Boca Raton, Fla.

Employers found guilty of violating provisions of the act could be liable to the disabled person for remedies like back pay, promotion, reinstatement and attorneys' fees, Mr. Tysse explained.

The "biggest" lobbying success the businesses community had in connection with the bill was to have drafters remove language that would have made employers subject to punitive damages for violating the act, he said.

However, employers should continue to watch current efforts in Congress to expand damages under Title 7 of the Civil Rights Act—which governs gender-based discrimination in the workplace—because any expansion of damages there would also apply to the ADA, he added.

While the ADA outlines several requirements employers must follow, it leaves unanswered several questions about the meaning of key terms and about how the federal act will mesh with state workers compensation laws, Mr. Tysse said.

The employment-related section of the act, he said, is designed to protect a disabled individual, defined as a person who is considered to have "a physical or mental impairment that substantially limits one or more of the major life activities of such individual."

However, Mr. Tysse said that a disabled individual must be "qualified" for the job and able to "perform the essential functions of the employment position."

The act does not define "essential functions" and leaves it up to the employer to determine what those may be, Mr. Tysse said. For example, the employer might rely on a written job description prepared before advertising or interviewing applicants for a vacancy, he said.

A "critical" part of the act requires employers to make existing facilities and operations readily accessible and usable by disabled individuals, Mr. Tysse said.

However, an employer that is unable to increase workplace accessibility to the disabled worker has several defenses, Mr. Tysse noted. The act states that the employer may claim that modifying the workplace would cause "undue hardship" in the form of "significant difficulty or expense."

For example, an employer that operates a cafeteria inside a major automotive manufacturing plant could argue undue hardship if it could not persuade the automaker to install a wheelchair ramp at the plant's entrance, Mr. Tysse explained.

In addition, an employer could argue undue hardship if complying with the act violated a collective bargaining agreement's seniority provision, which gives older workers priority in choosing easier jobs, according to Mr. Tysse. However, the bargaining agreement must not have been designed to discriminate against disabled workers, he added.

Factors that the Equal Employment Opportunity Commission, which will administer the act, will consider in determining whether an undue hardship exists include: the nature and cost of accommodation; the resources of the facility; the size and financial resources of the corporate entity owning the facility; and the interrelationship of the facility with a corporate entity.

"The burden will be greater on larger employers," Mr. Tysse said.

Employers can also defend their actions if they can show that accommodating a disabled worker would threaten the health of others or the disabled employee, he said.

For example, a food handling employee could be removed without violating the act if the disease he or she suffers from appears on a list prepared by the secretary of Health and Human Services.

Meanwhile, Mr. Tysse said the law does not make any distinction between applicants who are temporarily disabled and those who are permanently disabled. Representatives of the EEOC have indicated that temporary impairment will generally not qualify a person as a protected individual under the act, he said.

However, there is still a question about how long a temporary disability can last before the individual comes under the protection of the act, Mr. Tysse said. For example an employer would probably not have to build a ramp to accommodate an employee with a broken leg unless that leg did not heal properly and the employee was disabled for a significant period, perhaps six months or more, he added.

The act also restricts an employer's ability to require an job applicant or employee to submit to medical examinations and specifies the procedures an employer should follow to keep the results as confidential as possible, according to Mr. Tysse.

Generally, an employer cannot ask a job applicant to undergo a job-related medical examination unless the company has offered the applicant a job and its policy is to require a positive examination result from all applicants, he said.

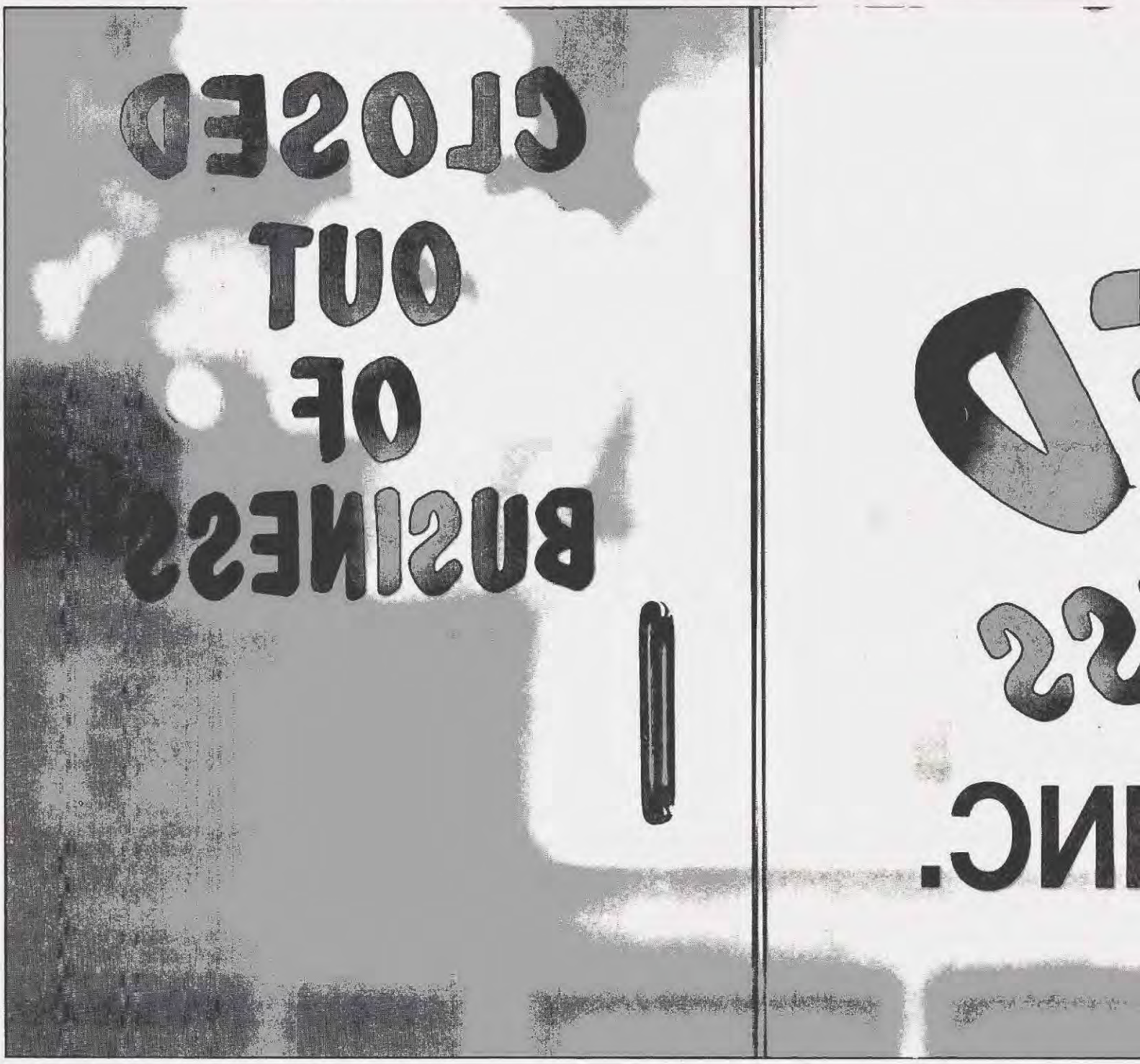
An employer also is restricted in requiring medical examinations during a disabled individual's employment, although some are allowed, including return-to-work physicals, Mr. Tysse said.

However, the act allows employers generally to order an individual to submit to tests for drug abuse—excluding alcohol—which are allowed by other federal laws, he said.

While the act appears to protect former drug users, employers may prohibit the illegal use of drugs in the workplace, require that employees not be under the influence of drugs, and hold alcoholics and illegal drug users to the same standards of job behavior and performance as other employees, Mr. Tysse said.

The employer generally is restricted to disclosing information contained in an employee's medical record to essential persons, like first-aid and safety personnel.

The EEOC is expected to present final regulations by July 26 and its technical assistance guidelines by Jan. 26, 1992, he said. ■



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Attorney warns of OSHA's new vigilance

By MEG FLETCHER

BOCA RATON, Fla.—The Occupational Safety and Health Administration's new, vigorous approach to finding and remedying workplace hazards may make employers warier of dealing with the agency, an attorney advises.

OSHA is "a reborn agency" and the energy its enforcement officials stored up during the agency's first 17 years of relative inactivity is now being released with official approval, said Stephen C. Yohay, an attorney in the Washington, D.C., office of Jones, Day, Reavis & Pogue.

For example, OSHA recently implemented a seven-fold increase in penalties for some types of violations and continues its "megafine" policy, which proposes large fines on employers, he said at the annual meeting of the National Council of Self-Insurers in Boca Raton, Fla., last month.

In addition, OSHA has shortened the time it takes to adopt workplace standards by taking a "generic" approach that includes regulating groups of chemicals instead of each one individually (*BI*, Nov. 5, 1990).

Several recent explosions and fires at petrochemical plants have added impetus to OSHA's mission and sparked the concern of several members of Congress, Mr. Yohay said.

Most recently, an explosion and fire at a chemical plant in Sterlington, La., killed eight employees and injured about 120 people, including workers and town residents (*BI*, May 6).

Such calamities prompted OSHA to develop programs to improve safety in the petrochemical industry. For example, the agency is expected to release in November a new standard on process safety management of highly hazardous chemicals and to investigate the use of contract work in the industry.

"One would think, with a Republican administration, that the brakes would come on" to rein in OSHA's enforcement efforts, Mr. Yohay said. However, the number of serious accidents—and the resulting congressional concern—has prevented that from happening.

When a serious accident occurs, OSHA responds by performing an extensive investigation, sometimes with expert investigators drawn from around the nation and others brought in for on-the-job training.

In one such case, Mr. Yohay said, he saw at least a dozen OSHA inspectors descend on the site with a trailer housing secretarial help and a fax machine.

In addition, OSHA inspectors have become "very aggressive" recently in requesting internal documents in such cases.

It may be impossible to keep investigators from obtaining them, Mr. Yohay said.

OSHA investigators will be particularly interested in detailed, written programs that spell out the company's procedures for handling safety and health-related issues.

For example, an employer must have in writing information about its "lockout/tagout" program to prevent a machine from accidentally starting up when it is being serviced (*BI*, April 8; Nov. 13, 1989).

Employers should keep detailed, written programs and logs related to health and safety issues and follow them, he urged.

In addition, an employer's self-evaluation audit can be "one of the most incriminating documents," because it provides investigators with "virtually a road map" to the company's problems and proposed remedies, which usually are not immediately implemented, Mr. Yohay said.

OSHA's more aggressive approach to enforcement results in its recommendation of larger and more serious penalties—as well as more sophisticated remedies to abate hazards—than in the past.

A key factor is whether OSHA charges the employer with any "willful" violations, he said.

A proposed willful violation may provide plaintiffs' attorneys with the beginning of a way around the exclusive remedy doctrine that limits most injured workers' recoveries to benefits spelled out by a state's workers compensation law, he said.

Employers need to realize that an OSHA file can be "a gold mine" for plaintiffs' counsel, although they may need to file a Freedom of Information Act request to obtain it, Mr. Yohay said.

An employer, in order to protect its interest, may want to consider contesting an OSHA citation before the federal agency's review commission. The proceedings, including depositions of OSHA compliance officers, can be used to discover a lot about the other side's position, he said.

Many employers do not realize that an uncontested citation becomes a final order of OSHA, which defines the hazard that the employer is expected to abate.

If the company fails to act, OSHA has the authority to seek a contempt citation from a federal court of appeals, Mr. Yohay said.

Thus far, employers have little to fear from federal authorities imposing criminal liability for injuries and diseases caused by workplace accidents, primarily because congressional attempts to pass such bills have so far been unsuccessful, he said.

However, local prosecutors in several states are becoming more active in pursuing criminal charges against employers, he said. ■

NCSI re-elects top officers

BOCA RATON, Fla.—Kenneth L. Gipson, director of statutory benefits, safety and health at Weyerhaeuser Co. in Tacoma, Wash., was re-elected president of the National Council of Self-Insurers during the group's 1991 annual meeting.

In addition, Gregory A. Saxum, director-workers compensation at Eastman Kodak Co. in Rochester, N.Y., was re-elected vp; Lawrence J. Holt, manager-benefit administration at AT&T Network Systems in Newark, N.J., was re-elected treasurer; and Thomas D. Nyhan, executive secretary of the Illinois Self-Insurers Assn. in Chicago, was re-elected secretary.

Each officer was re-elected for a one-year term.

Members of the NCSI include state associations of self-insurers, individual companies that self-insure and members of professions interested in self-insurance.

About 150 registrants and 35 guests attended the group's annual meeting May 12-15 at the Boca Raton Resort & Club in Boca Raton, Fla.

Next year's meeting is scheduled for May 27-30 in Portland, Ore.

For additional information, contact NCSI Executive Director Douglas F. Stevenson, an attorney with Stevenson, Rusin & Friedman Ltd., 10 S. Riverside Plaza, Suite 1530, Chicago, 60606; 312-454-5110.

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ASK A BENEFITS ACTUARY

Pension simplification proposals' impact varies

Q **What are the pension simplification proposals?**

A This question comes from the benefits manager of a large industrial corporation. The benefits manager has read about many pension simplification proposals and is interested in determining their potential impact on the qualified retirement plans sponsored by his company.

Some of the pension simplification proposals will have little or no impact on large employers. One such proposal, S. 318, has been introduced by Sen. Robert W. Packwood, R-Ore. This bill would permit small employers with fewer than 100 employees with no other qualified retirement plan to establish Private Retirement Incentives Matched by Employers—or PRIME—accounts.

Under the bill, employees would be permitted to make a salary reduction contribution of up to $3,000 per year. Employers would be required to match dollar for dollar the first 3% of compensation contributed by employees, up to $3,000. It is intended that PRIME accounts would operate much like an Individual Retirement Account and would not require complicated record keeping or form filing on the part of the employer.

A second proposal comes from the Department of Labor and is known as the Pension Opportunities for Workers' Expanded Retirement—or POWER—plan. Some provisions of this proposal may have an impact on large employers. This proposal has not yet been introduced in Congress and is intended only as an outline for congressional deliberations. Some key elements of the POWER proposal include the following:

- Employers with fewer than 100 employees could sponsor new simplified pension plans. No discrimination testing would be required for the small employer with no other retirement plan if the employer made a contribution of 2% of pay for all employees. Employees could make a pretax contribution up to $4,200 per year to the plan. Employers could match up to 50% of that contribution.
- The proposal would simplify, in an unspecified manner, the rules for aggregating family members for applying "pension limitations" and 401(k) rules. The family aggregation rules require that family members of certain highly compensated employees (5% owners or those among the 10 highest-paid employees in the current year) and the highly compensated employee be treated as a single employee for a variety of employee benefit plan purposes, including coverage and non-discrimination testing of qualified retirement plans. This requirement greatly complicates the data gathering for plan testing, as well as the actual testing.
- Tax reporting for distributions would also be simplified in an unspecified manner.
- Tax-exempt institutions and state and local governments could establish 401(k) plans.
- Multiemployer plans would be subject to the same vesting rules as single-employer plans: either

Continued on next page

Lenders beware environmental risks

By David M. Rosenberg

IN RECENT YEARS, environmental liability has been a constant source of new risks for the American business community. Unprepared for the wave of federal and state laws in the early 1980s and the resulting litigation, lenders, insurers, property owners and others are stunned by the high cost of environmental cleanups. Worse, they often have to accept responsibility for contamination to which they contributed little or nothing.

Currently, Congress is reviewing legislation to limit this liability for certain businesses. But the proposed law may cause more problems than it solves because it would limit the liability only for secured creditors.

Rep. John J. LaFalce, D-N.Y., recently introduced legislation to protect lenders from Superfund liability when they foreclose on contaminated property. The bill, H.R. 4494, would protect mortgage lenders, charitable institutions and public-sector lenders, like the Small Business Administration, as well as commercial lenders. It also expands protection to corporate fiduciaries holding title to property to administer an estate or trust.

Similarly, Sen. Jake Garn, R-Utah, is sponsoring a bill that would reduce, or in some cases eliminate, the Superfund liability of lenders, the Federal Deposit Insurance Corp. and the government's Resolution Trust Corp., the agency disposing of the real property of failed savings and loan associations. He wants to avoid spending funds for resolving the thrift crisis and protect depositors on environmental cleanup instead.

It is certainly true that the Comprehensive Environmental Response, Compensation and Liability Act of 1980, better known as the Superfund law, has in recent years found the deep pockets of the banking community. Most recently, the 11th U.S. Circuit Court of Appeals in Atlanta ruled that a lender that has "the capacity to influence the corporation's treatment of hazardous waste" could be held liable for cleanup costs under Superfund (*BI*, Sept. 3, 1990; June 4, 1990).

The decision in *U.S. vs. Fleet Factors Corp.* broadens previous judicial decisions that have ruled that a lender must participate in the management of the corporation's affairs to be liable for cleanup costs under Superfund.

The suit stems from an action brought by the Environmental Protection Agency in 1987 against Fleet and the Swainsboro Print Works. Swainsboro filed for bankruptcy and court protection in 1979. The company's property was used to secure a loan from Fleet and instead of foreclosing on the property, Fleet arranged to auction the company's inventory and equipment in an attempt to recoup its security interest.

The litigation is the result of asbestos being released from the facility during bankruptcy proceedings and could cost Fleet more than $900,000 for cleanup costs.

While the decision in this case certainly expands the liability of the secured creditor in comparison to prior court holdings, the expansion of liability is not shocking. In fact, the decision represents a continued pattern of expanding liability for those parties with deep pockets demonstrating the ability to pay. The court's choices in finding a party responsible for the costs of cleanup were a secured lender with minimal involvement with the release of contaminants, a bankrupt borrower or the taxpayer.

In examining the decision, considering these alternatives, it is completely logical. And the decision is consistent with the pattern of widely divergent judicial interpretations in the area of environmental liability.

The significance of *Fleet Factors* to secured lenders is that the decision offers little guidance on how much control a lender may exercise over a borrower's business without risking environmental liability under the Superfund law. As a result, a lender must take defensive measures to protect itself from potential environmental hazards and liability. There are precautionary steps that can be taken at various points throughout the loan process, including:

- Performing an environmental risk assessment. The environmental risk assessment serves as a snapshot of the property at a particular point in time. At the minimum, the survey should include a site survey or inspection of the facility of the borrower, a survey of the surrounding land used to identify all site sources of contamination, regulatory review of current and past activities and an assessment of the environmental setting. This should include an assessment of geological, hydrogeological, topographical, historical and meteorological trends, as well as surface water conditions—both on-site and in surrounding areas.
- Adopting borrower disclosure requirements. The lender should specifically ascertain what use the borrower will make of the property and whether hazardous materials will be used in the course of the borrower's business.
- Obtaining environmental warranties. The loan commitment should include warranties regarding the environmental condition of the property and the borrower's compliance with federal and state environmental laws. These documents should be drafted by experienced counsel.
- Obtaining adequate insurance to cover the cost of a potential cleanup. In some circumstances a lender may be added as an additional named policyholder on the borrower's pollution liability policy. This will afford the lender insurance. At the minimum, a lender should obtain a copy of all insurance policies held by the borrower for review by counsel.
- Modifying the loan documents. The loan documents should contain certain warranties regarding the environmental condition of the property. The commitment also should include an indemnification provision regarding a breach of those representations.
- Undertaking ongoing monitoring activities through the duration of the loan. As stated, little guidance is offered with respect to how much control a lender may exercise over a borrower's business activities during the course of the loan. In this manner, a lender can take action if business matters are proceeding in an environmentally unsound manner.

It is most likely that other appellate courts will gravitate to the decision in *Fleet Factors*. The more pro-active stance taken, the better prepared the lender will be to recognize and minimize its potential exposure. ■

David M. Rosenberg is executive vp of Environmental Compliance Services Inc., an Exton, Pa.-based consulting firm.

ASK A RISK MANAGER

A good disaster plan is flexible, multi-faceted

Q **I have been asked to formulate a crisis management plan for our company. Where do I begin?**

A It is apparent that your company's management has become aware of its responsibility to provide a safe environment for employees and to ensure the company's survival in the event of a crisis. In recent years some executives have been held personally accountable for deaths or injuries to employees because of a lack of preparedness during a disaster. Nor is it uncommon for a once-healthy, successful company to go out of business because it didn't have a crisis management plan in place to ensure its ability to operate during and following an emergency.

A crisis management plan is as unique as the organization it is designed to serve. Therefore, I'll outline the basic components of a plan since you will ultimately use one that meets your organization's specific needs.

Whenever a disaster strikes, many critical decisions must be made on the spot, since the full dimensions of the catastrophe are not immediately known. The first objective of any crisis management plan is to ensure the survival of individuals and the business itself. Any decisions made during this critical time will affect the ability of the business to survive in the immediate future, as well as for many years to come.

Before you begin designing the crisis management plan, you must receive the full, unconditional support of executive management. The crisis management plan will succeed only when the people at the top are aware of its importance and communicate that awareness by example. This makes it easier to get support from other levels of management and employees.

Every team needs a leader and every crisis management plan must be headed by someone in charge of the overall operation. Further, the plan should specify the full extent of the leader's authority. This individual will work with other key personnel representing critical areas of the company, like finance, data processing, marketing, operations, human resources and production.

The plan must be multifaceted and flexible, because day-to-day operations of the business are subject to change. Keep in mind that emergencies present themselves in a variety of forms. Perils like fire, tornado, earthquake or disturbances from employee strikes pose a direct threat to the physical assets of an organization and can create an income loss for vendors and other outside entities that conduct business with the company. Also, your organization will lose revenue in the event of destruction of a key supplier's or customer's premises. Not only do we need products or services to sell but we must have materials and customers to turn our efforts into income.

By expanding the crisis management team to include personnel from key areas of the company, we keep the broad scope of emergency situations in focus and can design a plan to include all categories of disasters.

Regardless of the category, disasters do share common phases. Solomon Garb and Evelyn Eng, authors of the "Disaster Handbook" (Springer Publishing Inc., New York City), identify these phases as threat, warning, impact, inventory, rescue, remedy and recovery. The crisis management team's objective is to have an appropriate action plan in place to deal with each of these seven disaster phases.

In addition to working with persons within the organizational structure, the individual in charge of the plan must also have a network of outside support services available. These include representatives of utility companies and fire and rescue services, as well as other property owners who may have a temporary facility for use as a crisis command center or alternate site where day-to-day operations can continue over an indefinite period. Each of these entities should be aware of the organization's crisis management plan, be familiar with responsibilities of the various team members and be capable of responding to the organization's needs during the seven disaster phases.

The plan itself must be communicated to all employees in simple, straightforward language.

In addition to the crisis management team members already mentioned, it is a good idea to recruit other individuals to help carry out the plan. For example, designate certain workers to serve as "captains" responsible for making certain the facility is properly evacuated, communicating to other employees messages from the command center and providing damage assessments to the center. Captains should be trained in cardiopulmonary resuscitation and first aid.

Captains should be easily recognizable by others. It's a good idea to provide arm bands, vests or other means of identifying those in charge. I also recommend having quarterly meetings of team members to review the plan, make any necessary revisions and execute practice drills so that all are familiar with their respective responsibilities. Don't make the mistake of thinking that once the crisis management plan has been drafted it will operate on automatic pilot. Practice, practice, practice is a

Continued on next page

Pension simplification plans

Continued from previous page

five-year cliff vesting or a seven-year graded schedule.

- The proposal would eliminate five- and 10-year averaging for lump sums.
- The proposal would encourage the preservation of retirement savings by making it easier for employees to qualify for tax-free rollovers, as well as by making sure employees have the option of having their lump sum distribution transferred directly to an Individual Retirement Account.

While these pension simplification proposals may not have a major impact on a large industrial organization, other proposals might. Rep. Rod Chandler, R-Wash., has indicated in recent speeches that he will introduce pension simplification legislation in the House. While Rep. Chandler has not revealed the details of his proposal, he has indicated that it will be similar to the pension simplification legislation he introduced last year (*BI*, Aug. 20, 1990; Aug. 13, 1990). That bill included the following provisions:

- Determinations of highly compensated employees would be simplified. An employee would be a highly compensated employee if he or she were a 5% owner during the current or preceding year, or if he or she during the year earned more than $50,000 indexed from 1986 ($60,535 for 1991).
- Excess deferrals and excess aggregate contributions distributed from 401(k) plans for failure to meet the non-discrimination tests would go to employees who deferred the highest dollar amounts, rather than the highest percentage of compensation.
- Any taxable distributions other than minimum distributions could be rolled over to an IRA or another qualified plan.
- Five-year averaging would be repealed.
- Minimum distribution requirements for individuals over age 70½ would generally return to the pre-1986 tax reform rules. Under those rules, individuals who continue in employment would not have to begin receiving benefits unless they are 5% owners.
- An accrued benefit under a defined benefit plan for an individual working past age 70 would have to be actuarially increased.
- For employee benefit plan purposes, compensation would generally be W-2 earnings. Alternatively, base pay could be used if it did not discriminate in favor of highly compensated employees.
- Family aggregation rules would be simplified.
- The minimum participation requirement—or 50 employee/40% test—would be changed to a 25 employee/40% test and would apply only to defined benefit plans.
- Two design-based safe harbors would be available for 401(k) non-discrimination testing. One safe harbor would permit plans to pass the 401(k) non-discrimination test if they include a match that is not less than 100% of the employee's deferrals up to 3% of compensation, with at least 50% matching on the next 2% of compensation deferred. Alternatively, the plan could pass if employers made non-elective contributions of 3% of compensation for all non-highly compensated employees.

While pension simplification is a laudable end, plan sponsors should carefully monitor "pension simplification proposals" as they progress through Congress. Recent history has taught us that legislation that is originally intended to simplify the tax code in general, and employee benefits plan requirements specifically, may not do so. The Tax Reform Act of 1986 sought to create a "simpler, fairer and more efficient tax system" (from the Report of the Senate Finance Committee to Accompany H.R. 3838, Tax Reform Act of 1986). But that piece of legislation gave the employee benefits community both Section 89 and new non-discrimination rules for qualified retirement plans, two of the most complex issues ever to face the employee benefits community. In that light, pension simplification proposals merit close attention. ■

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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 benefits management issues and actuarial problems.

This month's column on actuarial issues in the benefits field is written by William J. Miner, an actuary with The Wyatt Co. in Chicago. Richard E. Sherman, a principal with Coopers & Lybrand in San Francisco, answers actuarial questions in the casualty field. Susan M. Werner, director of risk management at Hardee's Food Systems Inc. in Rocky Mount, N.C., answers risk management questions. Dennis J. Nirtaut, manager of employee benefits at Continental Bank Corp. in Chicago, answers questions on employee benefit plans. Mr. Miner's and Mr. Sherman's columns appear alternately on the first Monday of each month. Ms. Werner's and Mr. Nirtaut's columns appear alternately on the second Monday of each month. Mr. Miner's next column will appear in August.

Mr. Miner

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.

Choosing among HMOs

Look beyond hype to evaluate a plan's health

By LARRY KUGELMAN

TOO MANY HEALTH maintenance organizations are getting away from the basics of managed care by introducing ancillary products they cannot support and by diluting their resources through unwise acquisitions. The challenge of the 1990s is for employers, brokers and consumers to recognize that sound HMOs that concentrate on the basics of quality managed care provide the basis for the most cost-effective health plan coverages.

When choosing an HMO, one way to navigate through the shoals of confusion is to focus on the fundamentals, to look beyond the marketing hype and examine how the organization is run. For example, two vital components for any HMO are managerial control systems to accurately track cost and utilization information and a sound organizational basis for operations. Yet not all HMOs have these systems. In a case reported in the Harvard Business Review (March/April 1989), one HMO had neither a chief financial officer nor a controller at a time when it was entering into fixed-price contracts to deliver its services. The HMO subsequently suffered heavy losses. Operating in this manner is not only fiscally irresponsible, it borders on the naive.

Fortunately, some help for the beleaguered purchaser of medical services is at hand. Evaluation criteria that can serve as a guide for public and private companies, brokers and consumers has been developed recently by A. Foster Higgins & Co. Inc., an employee benefits consulting firm.

Last year the California Public Employees Retirement System, which oversees benefits for 327,000 state workers, commissioned Foster Higgins to evaluate the 19 HMOs currently contracting with Cal PERS and four applicant HMOs (*BI*, Dec. 24, 1990). To do so, Foster Higgins devised objective screening criteria intended to be more rigorous than those used by state licensing agencies. The result was a 100-point rating system based on the categories of financial stability, service area/access, data reporting, providers, quality assurance, utilization management and member services/administration.

These measures should be the fundamentals of any successful HMO operation, or, for that matter, any health care delivery model. Financial stability, for instance, is critical. Please note, however, that financial stability does not emanate from a sponsoring organization's capital infusions, but rather from realistic contracts with providers, efficient administration and other factors. When assessing an HMO's financial stability, it is prudent to consider such aspects as tangible net equity, liability insurance, litigation history, auditing of member groups, profit and loss history, premium per member per month experience and the percentage of expenditures for administration or advertising compared with that actually spent on health care.

'One HMO had neither a chief financial officer nor a controller at a time when it was entering into fixed-price contracts to deliver its services. The HMO subsequently suffered heavy losses. Operating in this manner is not only fiscally irresponsible, it borders on the naive.'

If an HMO cannot demonstrate financial stability, employers, brokers and the other purchasers are best served not to do business with it. Financial instability can imperil quality of care as unpaid providers either refuse care or leave the network. In addition, if an HMO fails, members experience a major disruption of service that can be not only inconvenient but life-threatening.

Service area/access and member services are important in determining member satisfaction. Members want hospitals and physicians near their homes, services offered at convenient times, access to specialists when needed and thorough and timely responses to grievances.

Among the most basic—and most critical—components of managed care are utilization review and quality assurance. The Cal PERS study pointed out that "successful, stable HMOs invariably have good utilization management programs. HMOs without such a program eventually face financial problems."

A good utilization management program requires significant investments in systems that can easily track costs as well as the types and frequency of services provided. Continual data review ensures that all treatment is necessary and appropriate, contributing significantly to cost control. Although health care costs continue to rise, HMOs with programs like these have held their average increases to under 10% per year over the last four years, compared with increases of 20% and more in fee-for-service plans.

Quality assurance has become an issue of national concern, both for employers and employees. Cost containment has been the most important focus for employers in the past 10 years, but along with that there has been increased awareness of its effect on quality of care. The fact that some large organizations like Cal PERS have commissioned studies (at their own expense) to evaluate HMOs against several criteria, including quality assurance, suggests that employers are feeling a greater sense of responsibility to offer employees the best quality of care.

Currently, RAND Corp. and the University of California at Los Angeles are conducting a study, and they expect to release quality assurance benchmarks for various medical procedures that employers, brokers and consumers can use to evaluate quality of care.

Tending to these fundamentals generally assures an HMO not only of financial stability but of member acceptance as well. A staff model program like that of the Kaiser Permanente Medical Care Program pays close attention to managing costs by providing its own facilities and employing its own physicians and staff. The independent practice association model under which Health Plan of America operates controls costs through capitated payments to contracted providers and extensive utilization control and case management programs.

Beyond their usefulness in evaluating existing HMO plans, the criteria developed by Foster Higgins and others can be extremely helpful in analyzing new models of care.

One such model is the point-of-service HMO in which HMO members can receive services outside the HMO. When they need care, HMO members can elect not to see their personally selected primary care physician in the HMO and go outside of the network. Of course, there is a financial penalty in terms of reduced benefits for doing so.

This model raises some key questions about maintaining true managed care. If members can go to outside providers, how can quality of care or utilization of services be controlled? What happens if a fee-for-service physician's second opinion differs from an HMO doctor's opinion? What happens if there is an adverse outcome on a procedure performed by a non-HMO doctor and the patient then returns to his or her HMO physician?

Buyers of medical services also should be aware that some HMOs have not changed with the industry. Consequently, they are effectively offering indemnity plan options within the HMO nomenclature. Here again, the way to identify such HMOs is to focus on fundamentals. Do they have the basic economic underpinnings of the business, like capitation, case management, utilization review and quality assurance? How extensive is their management information system? What criteria do they use in their quality assurance program? What qualifications do their utilization review teams have to conduct sophisticated case reviews?

When making HMO selections in the 1990s, employers, brokers and consumers should focus on the fundamentals as expressed in the Foster Higgins study and that of other research groups. The HMOs that adhere to these fundamentals are the ones that provide cost-effective, quality services. ■

Larry Kugelman is president of Health Plan of America, an Orange, Calif.-based health maintenance organization.

Crisis management plan

Continued from previous page

key to its successful implementation.

The process of designing a crisis management plan can appear overwhelming. Tackle the project step by step to ensure that all critical areas are addressed. Remember, you can't accomplish the task alone because of the many complex issues that result from emergency situations.

Risk management should serve as the focal point in the continuous effort to protect the organization's most important assets: people, facilities and cash. A crisis management plan provides a vehicle to accomplish this objective. ■

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Ms. Werner

Ms. Werner's and Mr. Nirtaut's columns appears on the second Monday of alternate months. Mr. Miner's and Mr. Sherman's columns appear alternately on the first Monday of each month.

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Lloyd's

Continued from page 1

cies and managing agencies over the massive losses they have been asked to pay. Altogether, as many as 7,000 of Lloyd's 28,770 members are suing or threatening to sue, attorneys say.

As a result of this loss of confidence, many members may resign at the end of this year. That could reduce capacity next year to between 10 billion and 10.5 billion pounds ($17 billion to $17.9 billion) from the record 11.1 billion pounds ($18.9 billion) this year, Lloyd's sources predict.

More than 2,100 members resigned last year, with Lloyd's total membership declining by 8.1% to 28,770 this year from 31,329 in 1990 after new members were taken into account.

Mr. Coleridge said he is also confident that Lloyd's members will continue to support the market, whose results will improve as rates harden in the next few years.

"We will make money again," probably between 1992 and 1995, said Mr. Coleridge during a luncheon speech last week.

Mr. Coleridge said he feels sorry for the widows farmers and other members hurt by market losses, noting that he receives many letters from members.

But he cautioned Lloyd's members to remember that they are in the risk business. Members from now on should be "seriously rich," with up to a million pounds ($1.7 million) of readily available securities and assets to invest at Lloyd's, said Mr. Coleridge.

As a member, the chairman admitted that he, too, will lose money this year. "I hate it as much as everyone else," he said. However, he noted that, like many other members, he has made "huge" amounts of money at Lloyd's over the years.

At meetings recently, Mr. Coleridge has urged members and managing agents, marine underwriters and brokers to improve syndicate results or shut down non-profitable syndicates, *Business Insurance* has learned.

Last month, Mr. Coleridge also wrote to members, explaining that "I know that many of you are very concerned about the present situation and the losses you may be facing."

In the letters, Mr. Coleridge told members that the Council of Lloyd's is "keenly aware of the financial hardship which many of you are facing." He said that he was "vigorously" pursuing all avenues to ensure that members can successfully recover from current losses.

Sounding an optimistic note, he told members that he believed that "we are now at a point in the trading cycle when we will soon be able to put all our available capacity to profitable use."

Mr. Coleridge also told members that he has also spoken to Britain's highest-ranking finance official, Chancellor of the Exchequer Norman Lamonts, about changing the tax treatment of Lloyd's syndicate reserves, which could reduce some of the losses.

Meanwhile, Lloyd's is also exploring different avenues to improve members' positions:

- A hardship committee, chaired by Mary Archer, a member of the Lloyd's Council, is examining severe cases. To date, 170 members have applied for examination, of which 26 cases are being considered. The applications include two members who are being sued by Lloyd's for failing to pay debts. These writs, however, have not been served and may not be served if the hardship committee settles their cases, said a Lloyd's spokesman.
- Lloyd's last year boosted its Central Fund—which is used to pay losses that members cannot or will not pay—to 1 billion pounds ($1.7 billion).
- A runoff insurance company, known as CentreWrite Ltd., chaired by former underwriter Robin A.G. Jackson, will offer syndicates and members a chance to reinsure their outstanding losses.

The premiums charged by CentreWrite, however, will be competitive and therefore expensive, Lloyd's Chief Executive Alan Lord said.

The company will probably examine eight or nine syndicate accounts this year, he said.

- Lloyd's last week issued bylaws to establish a "review committee" to examine syndicate losses that exceed 100% of a syndicate's capacity.
- Lloyd's has recruited a task force headed by Sedgwick Group P.L.C. Chairman David Rowland to discuss major changes in the market that may be needed, including whether members should continue to bear unlimited liability for losses.

This task force has been meeting every five or six weeks this year in Windsor to discuss the progress of its subgroups, which meet more regularly, said Mr. Rowland. The task force's recommendations are expected to be announced at the end of this year, but in light of members' concerns, it may make some recommendations sooner, he said.

Lloyd's expects those recommendations to be made public.

"I have told the task force that it should think about establishing a healthy structure for the future of the market and think about the regulatory and tax consequences afterwards," said Mr. Rowland. "I am working on the basis that Lloyd's is an extremely valuable institution. There is a lot of goodwill. And if the task force can get it right, there will be a lot of people (regulators, etc.) who will support them."

Not all members are satisfied with Lloyd's efforts, however.

"You have syndicates out there with improper reinsurance in place," said Tom Benyon, an advocate of dissenting members and chairman of the Warrilow Members Assn., which is suing members' agencies and managing agency C.J.W. (Underwriting Agencies) Ltd. for negligence in connection with syndicate losses.

At the moment, about 30% of Lloyd's membership is paying for 70% of the losses, with 20 syndicates causing "huge havoc in the marketplace," said Mr. Benyon.

Most of the losses have been caused by inadequate reinsurance in place, he said. Lloyd's should therefore examine syndicate reinsurance programs to make sure that members are adequately protected, he said.

"I have spoken to hundreds of members," added David Tiplady, a lawyer for Elborn Mitchell, a law firm representing some of the members' groups protesting the cash calls. "The average member is not particularly wealthy. He's a businessman or farmer or widow who has been left some money. . . .By far the typical name is facing ruin."

At this stage, Lloyd's future "looks terribly bleak," said Mr. Tiplady. The actions that Lloyd's has implemented may not do any good because they have no clout, he added. "The losses are so much that I wonder where they will get the money from," he said.

He admits, though, that Lloyd's has so far not bankrupted anyone.

Meanwhile, Mr. Benyon, who says he gets "hundreds of phone calls from ruined people" who are members, says he has no wish to hurt Lloyd's. However, "there is a great confidence loss at Lloyd's. People are losing confidence in the market. It's not the downturn that is causing this loss of confidence, but the fact that 30% of members are having to pay 70% of the market's losses."

In a letter to the Financial Times last week, Mr. Benyon specifically criticized Lloyd's attempt to set up a review committee to look at substantial syndicate losses.

The procedure "is presumably intended to save time and costs and assist names. I have long since suspected Greeks bearing gifts and, when Lloyd's Council appear to bear them, even more so. This review committee will, I forecast, have the opposite effect from that advertised so far. Either Lloyd's knows this, in which case it is an exercise in cynicism, or they have not thought it through,"

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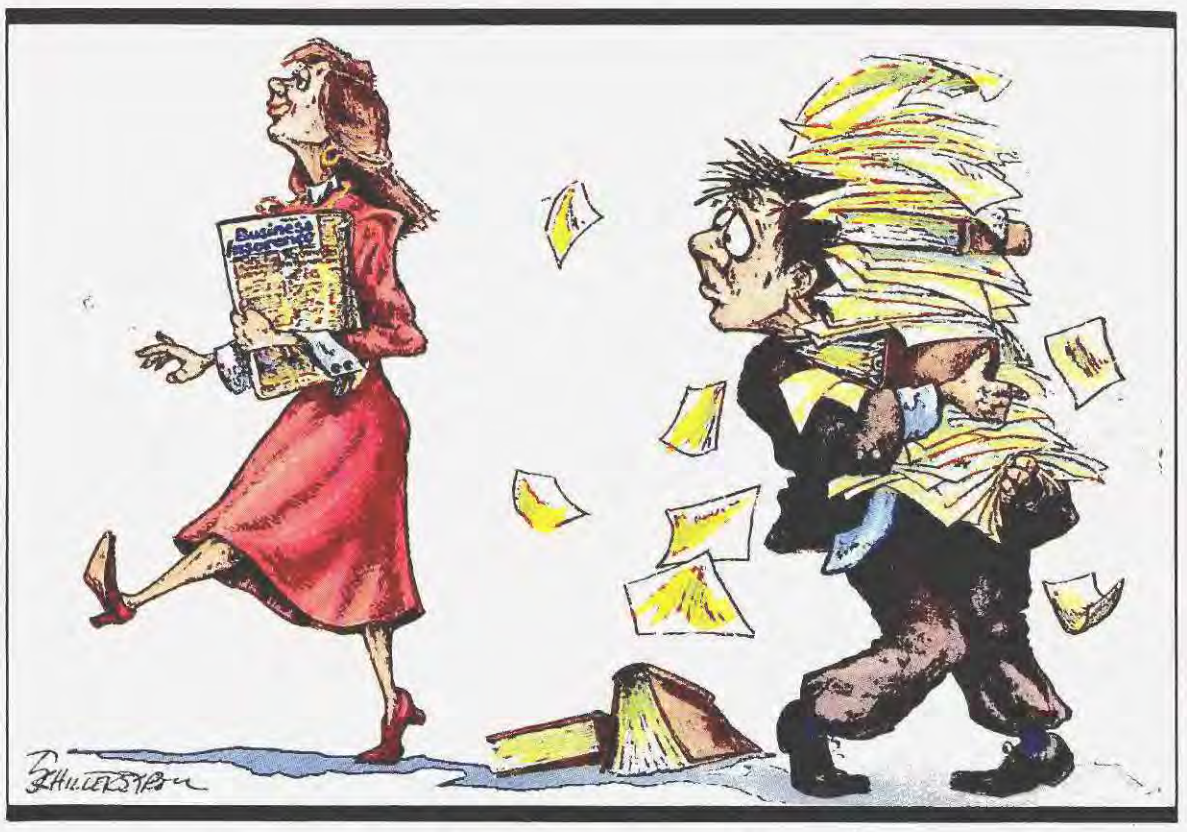
For lost souls...



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Mr. Benyon charged.

Colin Hook, chairman of the Feltrim Names Assn., set up last month to protest massive losses by syndicates managed by Feltrim Underwriting Agencies Ltd., also is concerned about the independence of the review committee. However, the Lloyd's members that have joined the group intend to ask Lloyd's to review the Feltrim losses, estimated in a worse-case scenario to be around 350 million pounds ($595 million), according to Mr. Hook.

"We will be concerned that the inquiry is independent and not staffed by market practitioners," he said. "Also, we will have consultations with the inquiry on terms of reference for the investigation. It would be imprudent if the inquiry didn't address members' concerns."

Meanwhile, late last month, representatives of six groups of members facing huge losses and their legal advisers attended a closed meeting to discuss their common experiences. Mr. Benyon, who chaired the meeting, would not comment on what was discussed, though others described the meeting as an informal gathering that could help the groups pool information that will assist in their litigation.

The six groups represented at the meeting are made up of members of:

- Defunct syndicates managed by Oakeley Vaughan Underwriting Ltd.

At the moment, 24 members are suing Lloyd's of London to recover more than 5 million pounds ($8.5 million) of losses they incurred between 1981 and 1983 (*BI*, May 6).

The Oakeley Vaughan members filed suit under the Lloyd's Act of 1871 and the Lloyd's Act of 1911, which allowed members to sue the Corporation of Lloyd's. The 1982 Lloyd's Act, which currently is in effect, does not allow members to sue Lloyd's, though the Oakeley Vaughan members are trying to pierce this immunity.

- The open 1982 underwriting year of syndicate 317/661 managed by R.H.M. Outhwaite (Underwriting Agencies) Ltd.

Outhwaite last month made a cash call on its still-open 1982 underwriting year of 17.5 million pounds ($29.8 million). The total loss on the 1982 underwriting year of the Outhwaite syndicate now totals 200.7 million pounds ($341.2 million), or 486% of the syndicate's original capacity.

The losses stem from 31 runoff reinsurance policies placed with the Outhwaite syndicate during or prior to 1982, many of which were placed by other Lloyd's syndicates. U.S.-related asbestos and pollution losses payable on the runoff policies—and hence on the open 1982 Outhwaite syndicate account—are continuing to rise.

Last year, about 800 Outhwaite members sued the managing agency and about 80 members' agencies, claiming unspecified damages. The trial is expected to be heard in the High Court in London in October (*BI*, April 1).

- Former syndicate 553 managed by C.J.W. (Underwriting Agencies) Ltd.

The syndicate's 1984, 1985 and 1987 underwriting years have been left open. Members so far expect losses to reach about 270% of the premium income that they underwrote. In 1984 alone, that would come to a total of 86.2 million pounds ($146.5 million), though sources believe the losses are closer to 100 million pounds ($170 million).

In 1989, more than 570 Lloyd's members sought unspecified damages in lawsuits against C.J.W., 39 members' agents and two accounting firms (*BI*, March 27, 1989). The litigation is expected to go to trial next April, said a spokesman for the members' law firm Elborne Mitchell.

- Syndicates 90 and 334 managed by Pulbrook Underwriting Management Ltd.

Last year 310 members of syndicate 90 sued Pulbrook and seven members' agencies over huge losses stemming from U.S. liability business (*BI*, April 9, 1990). The writ was served in April this year, says David Tiplady, a lawyer with D.J. Freeman & Co. which represents the Pulbrook Names Assn.

In March this year, members of syndicate 334 filed a writ in London's High Court against 10 members' agencies and Pulbrook for unspecified damages for breach of duty of care; negligent or wrongful disclosure and/or misrepresentation; and/or for negligent advice, according to the writ. About 210 names so far are represented on this writ, with about 75% of them participating in the syndicate 90 litigation, said Mr. Tiplady. This writ must be served by July 28.

Syndicate 90's members have been asked to pay 17 million pounds ($28.9 million), while syndicate 334's members have been asked to pay 29.4 million pounds ($50 million) (*BI*, May 28, 1990).

- The open 1985 underwriting year of syndicate 105/106/109 managed by John Poland (Managing Agency) Ltd.

Before the Poland Names Assn. was formed, several members filed suits independently, but these will be consolidated into one action, said Mr. Tiplady, who is representing the Poland Names Assn. The members expect to meet in July to discuss legal action against members' agents and Poland. As many as 250 to 300 are expected to take part in the litigation, said Mr. Tiplady.

The Poland members will be required by July 1 to pay a $50.4 million ($85.7 million) cash call, according to a January 1991 summary report on the open 1985 underwriting year.

- The 1987 to 1989 underwriting years of three syndicates formerly managed by Feltrim.

Last November, Lloyd's set up Additional Underwriting Agencies (No. 7) Ltd. to manage the runoff of Feltrim syndicates 540, 542 and 847 (*BI*, Nov. 19, 1990).

The Feltrim syndicates, which primarily wrote catastrophe excess-of-loss reinsurance, face a worst-case estimate of 350 million pounds ($595 million) in losses, said Mr. Hook, chairman of the Feltrim Names Assn. To date, members have been asked to pay between 80 million and 100 million pounds ($136 million and $170 million), he said.

Early last month, about 1,400 Feltrim members—including about 100 represented by proxy—met to discuss what action to take. Before any litigation is considered, however, the members want to know: the extent and nature of the syndicates' reinsurance program between 1987 and 1990; the position of Feltrim's auditors Arthur Andersen & Co.; and the role played by 59 members' agents, confirmed Mr. Hook.

The members also want to know more about the Corporation of Lloyd's role when syndicate 540 came under the management of Feltrim. The syndicates were managed by WMD Underwriting Agency Ltd., which was linked with the notorious PCW Underwriting Agencies Ltd.

When Lloyd's negotiated a settlement between loss-riddled PCW names and members' agents and brokers, syndicate 540's liabilities and 24 million pounds ($40.8 million) in reserves were transferred to the reinsurance facility established to run off the PCW syndicate accounts, confirmed Mr. Hook (*BI*, April 13, 1987). The loss of the reserves may have seriously impaired the syndicate, the members say.

Altogether, about 50% of the names belonging to each of the syndicates represented at the meeting have joined the litigation, said Mr. Tiplady, though 70% of the Pulbrook syndicate members are plaintiffs in the litigation.

The outcome of all of the cases could depend on what happens in the Outhwaite trial next October, Mr. Tiplady added. The trial is expected to last 10 to 25 weeks.

"When we have the result of that case, probably next Easter, the picture will be clearer. It depends on who wins," said Mr. Tiplady. ■

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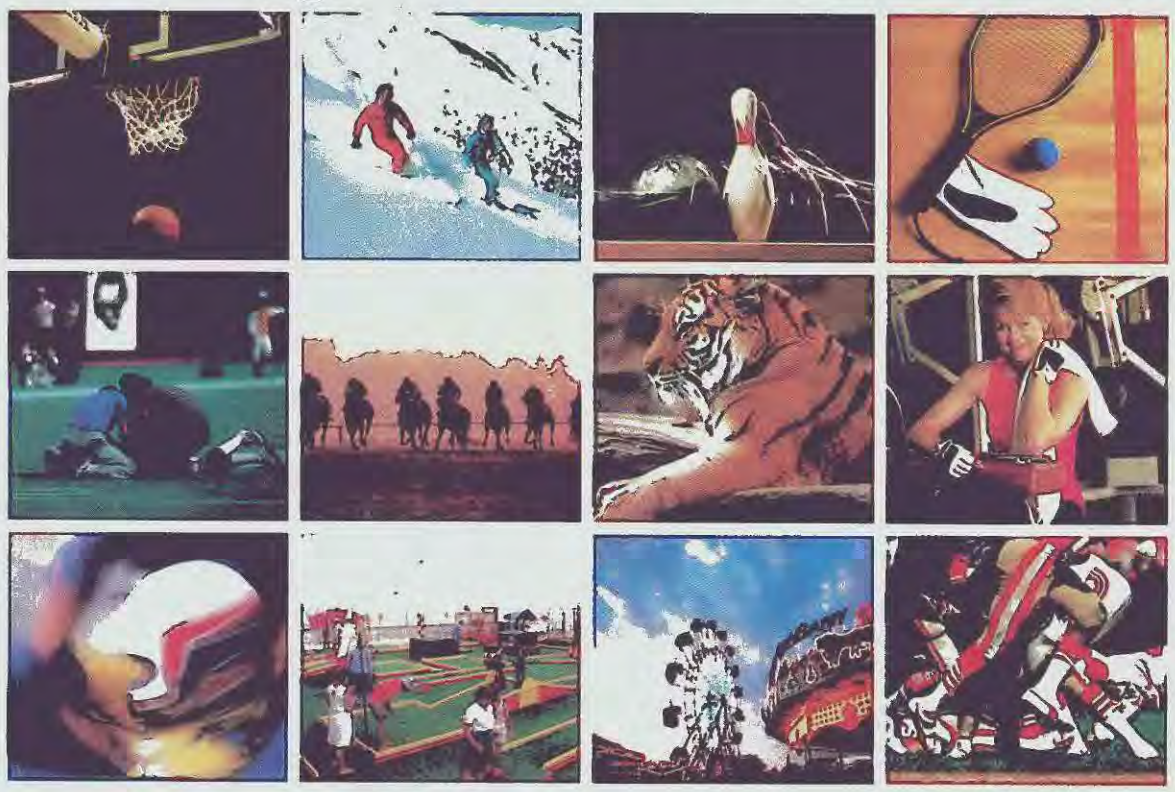

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Runway accidents spur FAA action

Task force looks at safety issues

AIA CONFERENCE

By STACY SHAPIRO

SAVANNAH, Ga.—The Federal Aviation Administration is increasingly concerned about runway safety at airports following two jetliner crashes that occurred on airport runways within the past six months.

"Although the conditions and circumstances between these two occurrences were entirely different, it again raises the level of concern for the safety of operation on our nation's airports," said William R. Hendricks, director of the FAA's Office of Accident Investigation.

"Runway incursions and the possibility of a major runway collision have been a matter of ongoing concern to the FAA for some time," Mr. Hendricks told members of the Aviation Insurance Assn. at their annual conference, held last month in Savannah, Ga.

"A number of different programs have been initiated over the past few years to improve safety in this area and we have seen a significant decline in these occurrences.

"However, last year the number of runway incursions increased by 21%, and so far this year it appears that these occurrences are still on the rise. With two runway collision accidents occurring within a two-month period, our level of awareness for these occurrences has been piqued again," Mr. Hendricks said.

The FAA has set up a special task force to examine runway collisions, and "a lot of resources are being brought to bear" at the FAA and in the airline industry to improve runway safety, he told AIA members.

The FAA has about 50,000 staff members to assist in accident investigations, according to Mr. Hendricks, who is responsible for direct oversight and policy guidance for the agency's aircraft investigation programs; coordination of all safety recommendations; and appropriate industrywide safety initiatives.

He also is agency liaison with the government, industry and military officials concerning aviation safety issues and testifies before Congressional committees on the full range of accident investigation issues.

During his talk to AIA conference members, Mr. Hendricks detailed the major aviation crashes that have occurred since last December, including two major runway collisions.

On Dec. 3, a Northwest Airlines Boeing 727 collided with a Northwest DC-9 at Detroit's airport, killing eight people aboard the DC-9 (*BI*, Dec. 10, 1990).

Aviation underwriters have estimated liability losses at $43.5 million and the hull loss at $5.5 million, according to a March aviation report by London-based broker Bain Clarkson Reinsurance Brokers Ltd.

"As you may remember, this accident rekindled a lot of the old problems and concerns pertaining to the possibility of a runway accident at one of our nation's busy airports," Mr. Hendricks told AIA members.

According to Mr. Hendricks, there was low visibility due to ground fog at 1:45 p.m. when Northwest DC-9 Flight 1482 was cleared to taxi from its gate to Runway 3 Center and Northwest Boeing 727 Flight 299 was cleared to taxi behind the DC-9 the same way.

However, Flight 1482 "erroneously" turned onto the wrong taxiway so that Flight 299 ended up arriving at the runway first.

The Detroit airport "is a confusing complex even in the best of circumstances," Mr. Hendricks observed.

Because of the wrong turn, Flight 1482 ended up facing the wrong direction on Runway 3 Center and was hugging a side of the runway when Flight 299 was cleared for takeoff.

The two aircraft collided right side to right side rather than head-on, which would have resulted in even more fatalities, Mr. Hendricks said.

The impact and resulting fire claimed eight lives on the DC-9 and destroyed the aircraft, while the Boeing 727 was extensively damaged. No one aboard the Boeing 727 was killed.

Preliminary analysis after autopsy proceedings indicated that four victims died of traumatic injuries when the wing of the 727 passed through the DC-9 cabin, while two died from extensive burns, Mr. Hendricks said.

A passenger and a flight attendant also died of smoke inhalation—though one also suffered a head injury—in the tail of the DC-9 when a broken emergency release handle on an emergency exit door made it impossible to open the door and the deploy a slide, Mr. Hendricks said.

The FAA investigation has not determined whether the handle was broken before the disaster or by either the flight attendant or the passenger, he said.

If the flight attendant broke the handle, then the FAA "has to look at the training that the flight attendant received," Mr. Hendricks said.

If the passenger broke the handle, then the FAA will have to consider whether the door handle on aircraft have to be redesigned, he said.

If the handle was broken before the accident, then the FAA will have to examine aircraft maintenance, he said.

After the accident, the FAA ordered the "immediate inspection" of the emergency release handles on these types of aircraft, Mr. Hendricks noted.

"Other issues brought out in this investigation included airport complexity; signs and lighting; and air traffic control procedures during low visibility operations," he said. "These procedures are receiving intensive review and attention right now."

Another runway disaster occurred two months later on Feb. 3: A USAir Group Inc. Boeing 737 collided with a SkyWest Inc. Metroliner at Los Angeles International airport, killing 34 people (*BI*, Feb. 11).

The U.S. government has accepted 85% to 95% of the responsibility for the collision, which occurred when an air traffic controller cleared the USAir jetliner to land shortly after she had

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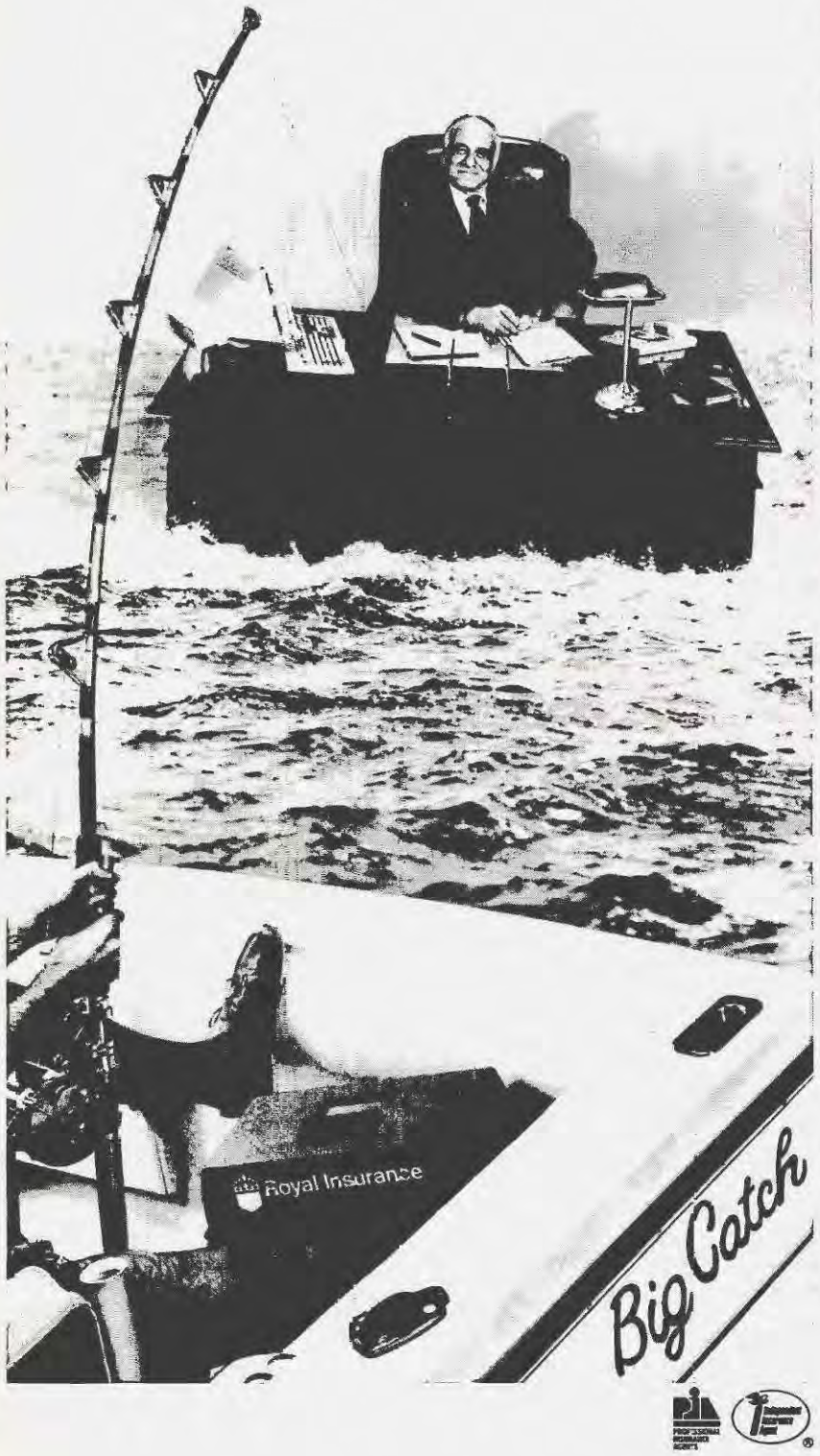

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plane to hold on the same runway for takeoff (*BI*, May 13).

Following the USAir runway collision, "once again we had a level of concern raised as to the safety operation at our busy airports," Mr. Hendricks said.

The accident occurred only as the result of human error, he admitted.

After the USAir collision, the FAA ordered that air traffic controllers abandon the "position and hold" practice during nighttime hours and periods of poor visibility. Under this practice, aircraft hold their position on the runway —instead of a taxiway—until they receive clearance for takeoff.

However, Mr. Hendricks feels that the practice should be discontinued altogether.

"Although we do have now a number of programs in place to make airports and runways safer, the possibility of a major runway collision remains a matter of great concern to the FAA," Mr. Hendricks said.

He also provided details about some of the other major aviation accidents that have occurred this year. These include:

• The March 3 crash of a United Airlines Boeing 737-291 during its landing approach at Colorado Springs Municipal Airport. Flight 585 from Peoria, Ill., crashed four miles south of the runway, killing all 25 people aboard: two cockpit crew members, three flight attendants and 20 passengers.

The aircraft hit the ground almost vertically. "Almost all of the aircraft parts and all of the passengers and crew were compressed and contained within the impact crater," Mr. Hendricks noted.

Mr. Hendricks termed the crash a mystery, because weather at the time of the accident was clear, with visibility of 100 miles and winds at 20 knots gusting up to 28 knots. Until 12 seconds before the crash "everything in the cockpit appeared to be normal," Mr. Hendricks said.

"For some apparently unknown reasons, at this time the plane appeared to roll into a nearly vertical dive into the ground. There are no clear-cut causal areas apparent at this time," he said.

However, the National Transportation Safety Board is continuing to look into possible flight control problems and weather phenomena like wind shear.

The United hull was insured for $14.2 million and the liability reserve is estimated to be around $30 million, says the aviation report by Bain Clarkson Reinsurance Brokers.

• The March 12 crash of an Air Transport International DC-8 cargo plane on takeoff at John F. Kennedy International Airport, which killed three crew members.

The crew apparently miscalculated the required takeoff speed for the gross weight of the aircraft, said Mr. Hendricks, noting the weight had changed shortly before takeoff.

• The April 4 midair collision of a Piper PA-60-601 Aerostar and a Bell 412 helicopter approximately 7 miles north of Philadelphia International Airport. The crash killed Sen. John H. Heinz, R-Pa., the two pilots and two children in a schoolyard where the debris fell. Other children in the schoolyard also were injured.

The accident occurred while the helicopter was attempting to check whether the Aerostar's landing gear was in proper position.

The Aerostar pilot had advised the Philadelphia International control tower that a cockpit warning indicator showed the landing gear was in an unsafe position.

However, the pilot of the Bell helicopter, which was flying nearby, advised the control tower that he had the Aerostar in sight and the landing gear appeared to be down.

The control tower cleared the Aerostar for a "fly-by" to visually check the landing gear. After the fly-by, the tower advised the Aerostar that the landing gear appeared to be down.

As the Aerostar turned to make a second approach to land at Philadelphia International, the Bell helicopter offered to take another look at the landing gear, and the Aerostar accepted the offer.

After the Bell helicopter passed the Aerostar on its right and indicated the landing gear was down, the Aerostar radioed the tower and advised that it was turning left to return to the airport.

"That was the last transmission from either aircraft" before collision, Mr. Hendricks said.

"This actually is a dumb accident because only one of three things could possibly happen here," he said.

"Either there was a faulty light indication in the cockpit, a bad microswitch or the gear was not down and locked. In any event, the pilot would do the same procedure, and that is land on the main landing gears and keep the nose up as long as possible and ease it down on the nose. And, in this case it probably wouldn't have even nicked the prop," Mr. Hendricks said, referring to the propeller.

"So, there was no need for any further examination once (the tower) did advise that the gear appeared to be down. There was nothing to be gained from the helicopter taking a closer look. There was no way to verify that the gear was locked or not locked," he said. "It was a useless accident."

• The April 5 crash of an Atlantic Southeast Airlines Embraer 120 Brasila N270AS en route from Atlanta, Ga., in a wooded area two miles from Glynco Jetport in Brunswick, Ga.

The 23 fatalities—including former Texas Sen. John Tower, his daughter and astronaut Sonny Carter—were the most ever in the crash of a commuter airliner of this size, Mr. Hendricks said.

Propeller malfunction is the most likely cause of the accident, which still is under investigation, he said.

Despite the number of recent accidents the number of aviation disasters per 1 million departures has declined considerably since the 1960s, according to Mr. Hendricks. In the last seven to eight years, there has been a flat rate of 1.4 major hull losses per 1 million departures annually, he said.

"Most observers would agree that this accident rate has resulted in a comfort level acceptable to the traveling public," he said. "The public, the media and Congress have accepted this level as being safe."

However, this rate, coupled with the projected huge increase in transport operations over the next decade, will mean a "continually increasing number of accidents," so by the year 2000 there will be about one major accident every two weeks, according to Mr. Hendricks.

This rate of aviation accidents would erode the public's confidence in flying, he believes.

Therefore, the FAA, the insurance industry and the airline industry must find ways of improving airline safety even more, he said.

One area to improve is "human performance," given that many of the accidents this year involved some error in human judgment.

On a brighter note, though, more passengers now survive a major air crash than ever before, Mr. Hendricks said.

"I believe that this is due in large measure to the quality of the safety regulations and technical initiatives that have been incorporated into our system over the past decade which not only makes flying safer but also makes airplanes more survivable," he said. ■

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Tort costs hurt aircraft manufacturers

By STACY SHAPIRO

SAVANNAH, G .—Product liability costs that skyr keted in the mid-198 Os continue to p at a major dent in light aircraft mar ufacturing in the United States.

The high cost c general aviation product liability itigation and insurance has mean that "the manufacture of pisto -engine general aviation aircraft i this country has come to a virtua halt," said Phil Boyer, president of the Frederick, Md -based Aircraf Owners & Pilots Assn.

Piston-engine ge eral aviation aircraft generally are small planes that seat four to 10 peo le.

In addition, "th prices of general aviation aircraft, parts and accessories have shot u in the past decade," he told a din er audience at the annual Aviation Ir urance Assn. conference held here May 4-7.

"You know, too, that many manufacturers and suppliers have simply closed down their general aviation operations. The reason in most cases is product liability costs, which have risen to match the unbridled awards of courts and juries," Mr. Boyer said.

In 1979, a total of 17,048 new light aircraft were built. But the product liability crisis hindered manufacturers so that in 1987 only 1,085 light aircraft were manufactured, Mr. Boyer said.

Though the market has somewhat recovered, production rose to only 1,144 last year—less than 7% of the 1979 output, he said.

During this period, Mr. Boyer says, two of the general aviation manufacturers slashed their output by between 88% and 98% while their product liability costs rose to $200 million in 1985 from $24 million in 1977.

Today, about $24,000 to $30,000 of each $200,000 plane built in the United States goes toward product liability costs, Mr. Boyer said.

This is twice the figure for European aviation manufacturers, he added.

Many accusations have been made for the reasons behind the product liability crisis, said Mr. Boyer.

Some people have accused "greedy plaintiffs' attorneys" for the significant increase in awards or "profit-hungry insurance companies" for increased prices or "uncaring manufacturers (for) producing faulty products," he commented.

Yet none of the accusations matter to consumers, Mr. Boyer said.

"If a problem is perceived and this causes manufacturers to cease production, or deters new entrants from the marketplace, or forces insurance companies to charge premiums too high for a manufacturer to pass on because no customer will be found for the product at that price—then the perception becomes the reality. Result: the desired aviation product is priced out of the market or is simply not available at all," he said.

One general aviation manufacturer hit by steep increases in product liability costs is Vero Beach, Fla.-based Piper Aircraft Corp.

At the peak of economic health Piper only produced 1,000 airplanes a year, most of which cost less than $200,000 each. However, since the product liability insurance crisis in the mid-1980s, Piper has grown smaller, according to Jan K. VonFlatern, a Palm City, Fla., attorney who was general counsel for Piper before leaving the firm earlier this year.

Piper, which is 53 years old, has built more than 125,000 aircraft, of which 90,000 are still flying, and 60,000 of those are in the United States, said Ms. VonFlatern. Because so many planes—at an average age of 24 years—are still flying, Piper has one of the longest product liability tails in the general aviation business, she said.

In 1986, Piper's product liability insurance costs soared to $26 million in premium with a $15 million retention, nearly seven times what Piper was charged in 1976: $4.1 million in premium with a retention of $1.75 million, Ms. VonFlatern stated in a paper accompanying her speech. "Ironically, this increase from $6 million to $41 million in costs occurred during a period when the fatal accident rates for general aviation decreased by 40%," she said.

When M. Stuart Miller purchased Piper Aircraft in 1987, he decided that Piper should totally self-insure its product liability risks because insurance costs were so high, Ms. VonFlatern said. Today, she said, Piper's product liability program remains totally self-insured with no excess product liability insurance above the retention.

Piper's product liability costs have dropped since it became self-insured. Costs for 1987-1988 were less than $9 million; for 1988-1989 they were around $10 million; and for 1990-1991 they currently are around $7 million, said Ms. VonFlatern. This "spectacular reduction" is attributable "to a combination of the elimination of the premiums and the company's refusal to settle anyway."

Ms. VonFlatern partially blames the lack of common goals between the aviation insurance industry and general aviation manufacturers for the lack of consistent affordable product liability insurance.

For example, headline-grabbing astronomical awards force "terrified boards of directors to buy as much insurance as possible at whatever cost," she said.

Also, says Ms. VonFlatern, "it is an apparently unalterable fact of life that having insurance in itself enhances the likelihood of a manufacturer's being sued in the first place. Insurance attracts lawsuits not only because it provides the deeper pockets, but also because the aviation plaintiffs' bar rightly discerns a strong propensity to settle among aviation liability insurers."

However, if light aircraft manufacturers fail it won't be because of product liability costs, added Ms. VonFlatern. It will be because "the perception" of high product liability costs has made it "impossible" to find domestic finance companies interested in investing in Piper and has made foreign investors "very, very shy" about doing so, she said.

"I think that the message that is going out to the world about what the American tort system is, what product liability is, what the real risk is, has got to change," said Ms. VonFlatern.

"That particular failure of communication may cost us the general aviation business entirely."

Meanwhile, action is being taken to reduce the problem of general

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aviation product liability litigation. This could reduce manufacturers' product liability costs, allowing them to manufacture more light aircraft.

The Aircraft Owners & Pilots Assn., along with several other aviation associations, is supporting federal legislation that would control liability arising out of general aviation accidents, said AOPA President Mr. Boyer.

These groups are supporting legislation introduced by Sen. Nancy Kassebaum, R-Kan., that aims to "regulate interstate commerce by providing for uniform standards of liability for harm arising out of general aviation accidents," he said.

"In our opinion, this is a fair and moderate tort reform bill, which would go far to leveling the playing field for American aviation manufacturers and suppliers," said Mr. Boyer. The only voice to oppose the bill so far is the Assn. of Trial Lawyers of America, which represents plaintiffs' attorneys, he said.

"We would like to think this opposition springs entirely from deep concern for the victims of accidents," said Mr. Boyer.

The bill does not seek to restrict attorneys' fees or the contingency fee system or limit non-economic and punitive damages, Mr. Boyer explained.

However, the bill does "seek to reduce unnecessary expenditures related to general aviation accident liability claims, while providing quicker and more effective compensation for individuals harmed in general aviation accidents," he said.

"Achievement of these aims should result in the corollary benefit of lower prices and greater availability of general aviation products, and enable your companies to lower insurance premiums while expanding your business to cover a growing and more active general aviation fleet," Mr. Boyer said.

In addition, Diane Swenson, vp of legal and legislative affairs at the American Tort Reform Assn. in Washington, urged AIA members to fight for tort reform at the state level.

She said that every U.S. consumer pays $1,200 per year in a "tort tax," meaning product liability costs added to the prices of products. ■

Aviation conference draws record crowd

SAVANNAH, Ga.—This year's annual Aviation Insurance Assn. conference drew its largest crowd ever with more than 360 attendees, making it the largest aviation insurance conference in the world, according to AIA President Lloyd B. Ericsson.

Both U.S. and about 40 foreign-based aviation underwriters, brokers, agents and lawyers attended the AIA conference, held May 4-7 at the Hyatt Regency Hotel on the banks of the Savannah River in Savannah, Ga.

The AIA originally started as a social club among U.S. aviation underwriting agents and insurers and was known as the Assn. of Independent Aviation Insurers until the late 1970s.

AIA members first held an informal conference in 1975 in Memphis, Tenn., and continue to this day to begin each conference with a golf tournament. However, over the past seven years the meeting also has become an educational venue, packed with information about general aviation issues, airline topics and legal affairs pertaining to the aviation insurance industry.

The AIA knows how to mix business with pleasure, however, and provides interesting tours and a taste of the local cuisine wherever the meeting is held. This year, for example, the association hired the paddleboat "First Lady" for a scenic ride down the Savannah River to an old fort for an outside barbecue and banjo entertainment.

And, the International Aviation Womens Assn., which was formed in 1989 and now has between 30 and 40 members, met for breakfast to discuss the progress of its organization. IAWA members include senior executives in aviation and aviation-related industries and the group is recruiting new members both in the United States and overseas.

The conference has been traditionally geared toward the general aviation market for light aircraft, helicopters and aviation manufacturers. However, airline topics are discussed, and next year the AIA plans to make a concerted effort to introduce more topics pertaining to airlines.

Next year's meeting will be held in Scottsdale, Ariz., on May 3-5. For more information, contact Bob Cannon, Forbes Westar Aviation, 3001 112th Ave. N.E., P.O. Box 245, Bellevue, Wash. 98009; 206-822-8176. ■

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Greater risk for helicopters adds to rates

By STACY SHAPIRO

SAVANNAH, Ga.—Helicopters are greater risks than fixed-wing aircraft and therefore more expensive to insure, according to a senior aviation underwriter.

Although better equipped to survive engine failures, helicopters have a higher accident rate than fixed-wing aircraft and are used for more dangerous purposes says William H. Gossell, senior vp and marketing director for Aviation Office of America Inc. in Dallas.

That's why when a helicopter owner calls his underwriter for a quote, the underwriter will say "oh no, here we go" and look at various factors before insuring the risk, said Mr. Gossell.

He spoke at a continuing education course at the annual Aviation Insurance Assn. conference last month.

AIA CONFERENCE

Aviation underwriters have several factors to consider when giving a quote for helicopter coverage.

Accident rates are one consideration. Helicopters are "the best place to have an engine failure" because they can land almost anywhere, unlike airplanes, which need a smooth landing strip, said Mr. Gossell.

But accident rates are generally higher for helicopters than for fixed-wing aircraft, he added. In 1990, the accident rate per 100,000 flying hours was 7.7 for helicopters, compared with 3.5 for commercial aircraft and 0.16 for corporate aircraft. While the rate for helicopters has fallen from 30.46 in 1970, underwriters still perceive helicopters as dangerous, he said.

Another consideration for underwriters is what the helicopter will be used for.

Helicopters are used for many purposes, most of them close to the ground, which allows little time for corrective action or emergency landing if they are in danger, he noted.

These purposes include: charters, sightseeing, fish and crab spotting, firefighting, police work, power line and pipeline control.

"Wild" is how he describes some uses for helicopters.

For example, helicopters are used to plant poles for electricity and telephone lines. One company in the past planned to place explosives at the bottom of each pole, Mr. Gossell recalled. Set to detonate as the helicopter was hovering overhead to place a pole on the ground, the explosives would have blown up a hole for the pole just before it was inserted into the ground. The company was persuaded not to go ahead with its plans.

"Frost control" is another task for helicopters. A helicopter hovers while a worker hangs out of it trying to knock ice off power lines, he said.

He also saw a helicopter bring in Santa Claus one Christmas. "If he lifts his hand to wave—wow!" said Mr. Gossell, noting that Santa's hand might come off in the rotor blade.

Another factor underwriters consider when insuring helicopters is the human factor. Pilot error is sometimes more likely in helicopters than in fixed-wing aircraft, he said.

Some helicopter pilots are trained in airplanes first and think they "know it all" before they fly helicopters, said Mr. Gossell. But "it's not a fixed-wing aircraft," he said. "It's a helicopter and it does different things." A helicopter pilot must always be in charge of his aircraft and "work at it all the time," while airplane pilots can sometimes cruise at higher altitudes and relax, he said.

Mr. Gossell learned this from personal experience during his first helicopter flight in the U.S. Marine Corps. Having already flown airplanes, "you think you're hot and the instructors can't tell you anything," he said.

Putting Mr. Gossell into a large field, his instructor bet him a bottle of whiskey that he couldn't keep the helicopter in the field. Needless to say, the instructor won the bet. Mr. Gossell reckoned the bottle was just one of many that the instructor won from know-it-all airplane pilots.

"I am a firm believer that if you get a military-trained (helicopter) pilot, you are one step up. . . .I always give credit for military-trained pilots, even if he's from the Army," the Marine loyalist said to a round of laughter.

Another factor for aviation underwriters to consider is helicopter maintenance.

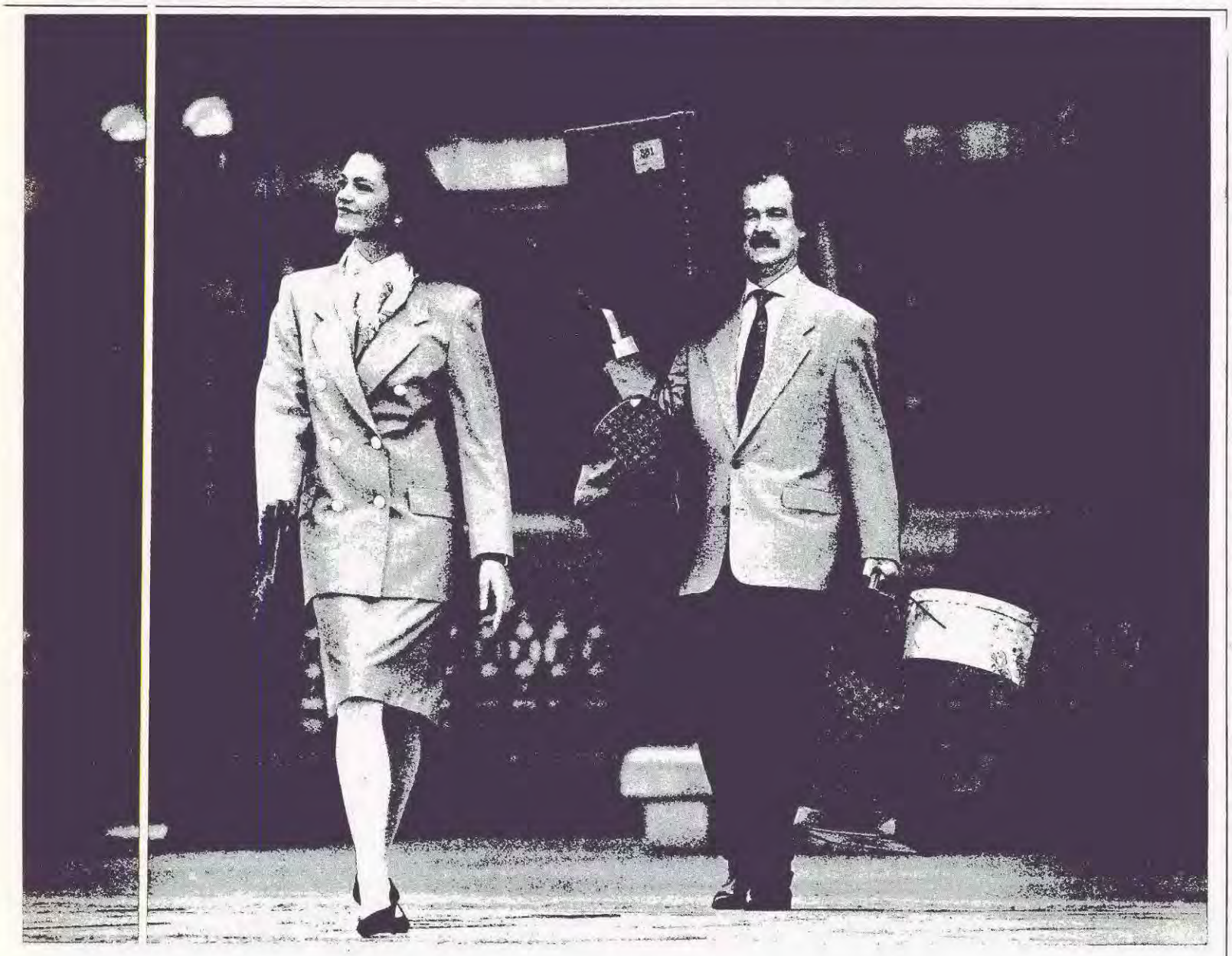
Two factors make maintenance a problem, he said: mechanical complexity and a shortage of qualified mechanics.

To help alleviate one problem, discussions are under way with the Federal Aviation Administration to allow military mechanics who are coming off duty to get their private licenses more quickly.

After reviewing all the underwriting factors, an underwriter will probably conclude that a helicopter has more accidents than fixed-wing aircraft, is more dangerous and is "a maintenance hog," Mr. Gossell said.

"Therefore, as an underwriter you must determine that you would charge more for insuring helicopters than for fixed-wing aircraft," said Mr. Gossell.

Helicopter insurance is competitively priced, but rates are still higher than fixed-wing aircraft rates, he added. ■



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Redskins appeal

Continued from page 3

course of his employment.

However, Rodney P. Ruffin, hearings and appeals examiner for the district's Department of Employment Services, noted in his decision that the Redskins sent several notices to Mr. Williams prior to a May mini-camp that did "specifically advise treadmill running."

And, team memorandums to Mr. Williams in April 1989, as well as in several previous pre-seasons, specified that conditioning should continue between the May camp and summer practice.

Mr. Ruffin also pointed out in the decision that the team's conditioning coach and trainer arranged for Mr. Williams to purchase "the treadmill from the manufacturer in exchange for promotional considerations."

The decision stated that "there is a sufficient nexus between the workouts and the employment to sustain a finding that the injury arose out of and in the course of" Mr. Williams' employment.

If the team's appeal is unsuccessful, the Redskins will have to pay the tax-free benefits for the rest of Mr. Williams' life, unless he again earns an annual salary of $1.1 million—his salary at the time he was injured.

The decision also ordered the Redskins to pay Mr. Williams' "reasonably related medical expenses" now and in the future.

Mr. Herz said he could not give a total dollar amount for Mr. Williams' medical expenses but that the workers comp coverage had already paid for his surgery and orthopedic expenses. ■

INTERNATIONAL

Liquidation of Aneco Re sought

Reinsurer fighting petition by Mutual Indemnity

By ROGER SCOTTON

HAMILTON, Bermuda—Aneco Reinsurance Underwriting Ltd., formerly Bermuda's largest reinsurer of captive insurance risks, is fighting a petition to liquidate the company filed last week by Mutual Indemnity Ltd.

Mutual Indemnity, one of three operating companies in the Insurance Profit Centre rent-a-captive program, filed the petition in Bermuda's Supreme Court under the 1978 Insurance Act's Section 33, which deals with insolvencies and winding up proceedings.

Robert A. Mulderig, chairman and chief executive officer of Mutual Risk Management Ltd., the Bermuda-based parent of the IPC companies, said the petition reflected certain concerns about Aneco's financial health, but he declined to elaborate.

"All I can tell you is that this matter arises out of a series of old reinsurance transactions in which we owed them (Aneco) and they owed us (Mutual Indemnity) amounts and the issue of set-off came up," he said. "We believe that a liquidation would be the best way to handle the set-off and resolve this matter."

Aneco, however, is arguing that Mutual Indemnity is not a creditor, but a debtor of the defunct reinsurer.

According to Mutual Risk Management's Form S-1 registration statement filed with the Securities and Exchange Commission in connection with its proposed public offering of shares (*BI*, May 13), the IPC companies are a net debtor of Aneco, the company charges.

Aneco specifically points to notes to Mutual Risk Management's Dec. 31, 1990, financial statements, which says: "In the case of one reinsurer, the company (Mutual Risk Management) determined not to establish a provision in the consolidated financial statements at Dec. 31, 1990, for potential uncollectible amounts of reinsurance, estimated not to exceed $1 million, because the company has a payable to the reinsurer of a larger amount and expects to offset this against the reinsurance recoverable.

'We believe that a liquidation would be the best way to. . . resolve this matter,' Mr. Mulderig says.

"However, in the event that the company's payable in the future becomes less than the reinsurance recoverable, it might then have to establish a provision for the uncollectible portion of the net amount receivable."

Although the Mutual Risk Management note does not identify the reinsurer involved, Aneco contends that it can only be Aneco. And, the reinsurer says that if the note is true, then the Mutual Indemnity petition must be inaccurate. Both documents, Aneco argues, cannot be correct.

According to Aneco, the winding-up petition claims that Mutual Indemnity "is both an ordinary and contingent creditor" of Aneco. The petition also alleges that under one book of excess covers known as the "MIRMA book," Mutual Indemnity's "best estimate" of Aneco's overall liability to Mutual Indemnity could exceed $5 million, Aneco notes.

In a letter to Mr. Mulderig dated June 5, Aneco Chairman Mark Hardy contends that if these allegations are true, then the SEC filing must be amended and the Mutual Risk Management prospectus withdrawn until such time as full disclosure can be made to prospective investors.

Meanwhile, newly installed Aneco President Peter Wilson is preparing to fight the petition in court (*BI*, April 15).

Although the matter could not have emerged at a worse time for a company in the throes of a public offering, Mutual Risk Management's Mr. Mulderig says: "The whole thing is unfortunate, but this situation will not materially affect Mutual Indemnity."

Mr. Mulderig was reached in New York where he is helping to prepare a promotional show for institutional investors on Mutual Risk Management's offering.

"We're not able to release a final prospectus yet, but we're certainly not expecting to make any major changes in our proposed prospectus," he said. ■

British Rail sues over coverage for flood losses

By CAROLYN ALDRED

LONDON—The liability insurers for the British Railways Board, the operator of Britain's state railway network, are disputing coverage for tens of millions of pounds in claims stemming from the collapse of a sea wall in North Wales that the railway was responsible for maintaining.

British Rail's insurers claim they were not informed of the railway's responsibility to maintain the sea wall and that the insurers could not have anticipated such a loss.

British Rail faces a deluge of claims from the town of Towyn in North Wales, which was flooded by Irish Sea waters in 1990 after waves broke through the sea walls.

GRAPHIC BY JOHN SMITHER

Residents of the town and local authorities claim that British Rail is responsible for maintaining the sea walls, which run alongside its coastal railway line.

The breach led to the flooding of 3,000 homes. Insurers estimate the claims will total tens of millions of pounds and could reach 100 million pounds ($169.7 million).

British Rail had at least 50 million pounds of coverage ($84.9 million) placed throughout the London market excess of a 7.5 million pound retention ($12.7 million).

British Rail's first layer of liability coverage above the retention at the time of the incident was led by Royal Insurance P.L.C. Additional excess insurance layers were led by Lloyd's of London syndicate 683, underwritten by Michael Payne.

The insurers, though, are disputing coverage on the grounds of "material non-disclosure."

British Rail "did not advise the insurers that they had a legal obligation to maintain sea defenses. It wasn't the type of catastrophe that immediately springs to a railway insurer's mind and would have affected some of the insurers' decision to participate in the excess layers" if they had been aware of it, a spokesman for the insurers said.

However, the insurers have indicated to the railway that they "are prepared to negotiate on the claim, and they have agreed to go along with that," the spokesman noted.

"The exercise now is to try and ascertain the likely potential claim. The worst position is that it could exceed 100 million pounds," the spokesman said.

Meanwhile, British Rail has filed a lawsuit against its former broker, Sedgwick Group P.L.C., in case the negotiations with insurers break down and it is denied coverage.

British Rail refused to comment on the lawsuit, noting the suit has not yet been served on Sedgwick.

A Sedgwick spokeswoman said it could not comment because the writ had not been served and no detailed allegations had been made.

Under new court procedures in Britain, British Rail will have until June 18 to serve the lawsuit on the brokerage. The suit was filed in London's High Court on March 18. Previous court procedures would have allowed up to a year after the suit was filed to serve notice.

Sedgwick acted as insurance broker to British Rail from 1978 through 1989 and was responsible for manag-

Continued on page 40

Rebuilding Kuwait

Projects delayed by politics

By MARIA KIELMAS

KUWAIT CITY, Kuwait—There is plenty of insurance capacity for construction-related risks in Kuwait but few buyers because political infighting in the emirate is delaying the awarding of contracts to firms, according to sources.

Kuwait's four insurers and one reinsurer began writing business for Kuwaiti clients earlier this month, according to Fathi Haman, general manager of Kuwait Reinsurance Co.

Reinsurance arrangements between Kuwait Re and the four insurers were renewed May 1, Mr. Haman said. The ceding companies "now have reinsurance cover and are in the market writing business for Kuwaiti clients," he said.

The reinsurer's employees have been called back to work and the majority have returned, said Mr. Haman, who planned to return to Kuwait and his desk by late last week.

Under a Kuwaiti rule that predates the Aug. 2 Iraqi invasion, almost all coverage for companies registered in Kuwait—but not necessarily foreign companies operating there—have to be written through Kuwait's four insurers: Al Ahleia Insurance Co., Gulf Insurance Co., Kuwait Insurance Co. and the Warba

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AP/Wide World Photo

About half of the cost of rebuilding Kuwait will go toward rebuilding the emirate's oil industry.

Trilateral trade pact a boon for Mexico: Economist

North America's '1992'

By ROGER SCOTTON

HAMILTON, Bermuda—The planned free trade agreement among the United States, Canada and Mexico will create the same environment expected for the European Community in 1992, an insurance economist predicts.

As a result of the agreement, which is expected to be signed Oct. 12, 1992, major investment funds will soon begin to flow into Mexico, according to Edward Guay, senior vp and chief economist for CIGNA Investment Inc. in Philadelphia.

During the past four years, the prospect of "Europe 1992" has created massive business investment and positioning in Europe, Mr. Guay said here last month at the Second International Conference on the Global Insurance Market. The meeting was co-sponsored by the New York Chapter of the Society of Chartered Property & Casualty Underwriters and the Bermuda Insurance Institute.

"Every major industrial group or financial group has attempted to reposition itself based on the concept of a single market in Europe," Mr. Guay said. "This has led to one of the greatest capital spending booms that Europe has experienced in the post-war period and, in fact, has taken investment spending in Europe to the highest level relative to normal that has been experienced in the post-war period," he said.

During the next two years, as the world refocuses on prospects for " 'North America 1992,' we believe that the positioning investment that has already begun among Canadian, U.S. and Mexican investors will also include Japanese and European investment in North America," Mr. Guay said.

"That means major investment in Mexico. It means major investment in the Southwestern United States, in the transportation infrastructure that connects Canada, the United States and Mexico," he said.

"We expect a significant acceleration in North American economic activity coming out of this agreement. For the United States, the free trade agreement means that instead of 2.5% growth, the real growth during the next couple of years is likely to be on the order of 3%. For Mexico, though, it means the difference between 3% or 4% real growth and 6% to 9% growth."

Rate of growth shows changes in gross national product, expressed as a percentage; adjusted for inflation, it is called the real growth rate.

Strategic changes are already under way in Mexico. Rather than retaining its internal, self-sufficient economic and political strategy, the nation is focusing on how to use outside world markets to stimulate domestic growth, said Mr. Guay. Foreign investment, once punished, is now encouraged, he added.

Mr. Guay said he had no doubt

Continued on next page

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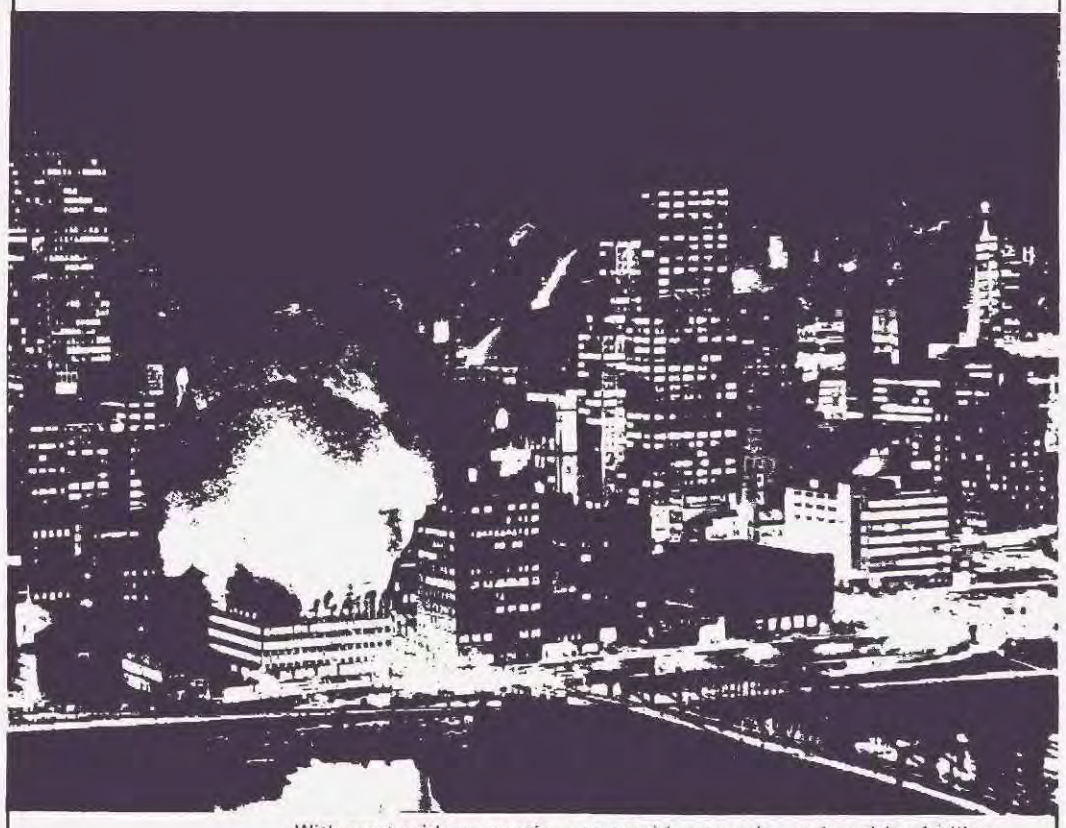

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Mexico

Continued from previous page

that Mexico's future ability to attract capital would be "one of the more dynamic aspects of the world economy during the coming decade."

The economist added that the '90s could see Mexico also concluding free trade negotiations with Chile, noting that such talks have already begun. And, Australia and New Zealand, as well as Argentina, Brazil, Uruguay and Paraguay, have all expressed interest in joining the North American free trade pact, he said.

"We believe that the world is moving to two, possibly three, trading areas over the course of this decade," Mr. Guay said. "We don't believe that a yen trading bloc will be a separate defined area. We believe that there will be a Pacific Basin trading area that will include not only the North American and South American trading areas, but also Australia, New Zealand, the (Asian) tigers and Japan as we move through this decade."

However, a U.S. insurance industry official held out little hope of rapid change in Mexico as a result of the free trade agreement with the United States and Canada.

"It is difficult to see the free trade negotiations producing much rapid change in Mexico," said Gordon J. Cloney, president of the Washington, D.C.-based International Insurance Council. The council is an industry-supported group committed to reducing international trade barriers confronting U.S. insurers abroad.

"The Mexican companies are under a certain amount of pressure from the changes that are already in place and until they get that act sorted out and the major players feel more comfortable, I don't think we're going to see a rapid opening to, say, 100% foreign ownership of Mexican companies. We, as an institution, would like to see it, but I don't think that's going to happen quickly. It's a matter of negotiation."

Nevertheless, Mr. Cloney noted that while Mexico's reinsurance market is still restricted, recent changes allow 49% of reinsurance companies to be held by foreign interests.

"There has been a freeing of tariffs and, with regard to policy forms, there is a 30-day file-and-use practice now in place," he said.

Other recent trends in Mexico include "liberalization in earthquake covers" and greater capitalization requirements for Mexican insurers, he said.

"There has also been a movement to adopt a modified version of a European solvency margin standard that is now in place and this practice is going to produce some kind of a shakeout in the market," Mr. Cloney said.

As for the size of the Mexican property/casualty insurance market, Mr. Cloney said it has the "feasible potential" to increase 15 fold to $30 billion over the next five years. ■

European marketplace faces crisis: Insurer

By ROGER SCOTTON

HAMILTON, Bermuda—The low premium rates and stiff competition that now characterize the European liability insurance market are living on borrowed time.

Europe could soon face a capacity crisis similar to the mid-1980s U.S. crisis that led to the formation of policyholder-owned facilities like X.L. Insurance Co. Ltd. of Bermuda, said Patrick Tolan, managing director of X.L. Europe Ltd., the excess liability insurer's new unit in Dublin, Ireland.

"I'm convinced that all the underlying factors that brought about (the U.S. crisis) are present in the European market today," Mr. Tolan said at the Second International Conference on the Global Insurance Market held last month in Bermuda.

"It's only a matter of time before some major catastrophe causes a flight of capacity and severe hardening of rates," he said.

A consensus is emerging that the longer the current soft market continues, the more severe the turnaround in Europe will be, Mr. Tolan said.

Pressure on rates is growing from new environmental laws that are potentially tougher than U.S. measures. As an example, he cites the Environmental Protection Act that took effect in Germany this year. "It is of major concern to insurers because strict liability now applies irrespective of fault."

And for the whole European Community, the single-market laws have introduced the principle of "polluter pays," said Mr. Tolan. "The draft directive on civil liability for damages caused by waste, set to become law before 1993, will move E.C. law away from a regime of fault liability toward a strict liability criterion similar" to the U.S. Superfund law.

"Commentators believe that pollution costs could be almost limitless," added Mr. Tolan.

Cleaning up inactive E.C. waste sites could cost more than $1 trillion, or more than a quarter of the gross E.C. national product, Mr. Tolan said.

Another development affecting European claims, he said, is a growing demand to equalize personal injury awards throughout the community.

"Obviously, the trend will be to standardize the awards at the highest current prevailing levels," he said. Germany and Ireland currently are at the high end of a wide range of average awards within the European Community, while Greece, Denmark and Spain are at the low end (*BI*, Feb. 11).

The demand for standardization is making risk managers buy higher limits, said Mr. Tolan. "They see the levels of insurance purchased by their U.S. subsidiaries and can no longer reconcile that with the lower levels of cover in Europe."

Yet he pointed out that despite these and other factors that could be expected to force rates up at some point, premiums for now remain under downward pressure. U.S. pricing trends are partly responsible for that, but there is also a "high degree of competition," he said.

Contributing to the competition, he said, are conventional non-life insurers like Allianz A.G. Holdings, Assicurazioni Generali S.p.A., Sun Alliance & London Insurance P.L.C., Commercial Union P.L.C., Colonia Versicherung A.G., and Winterthur Swiss Insurance Co.

Each of these companies provides coverage in the excess layers using excess-of-loss reinsurance purchased from major reinsurers like Munich Reinsurance Co. or Swiss Reinsurance Co.

"Some of these companies are even becoming net-line underwriters in the excess layers," he said.

Another factor influencing the market is the increasing power and expertise of risk managers in Europe, said Mr. Tolan. When forming captives and buying higher excess limits, they "shop around more than ever before."

Premium taxes are another reason why risk managers are now more inclined to do some shopping around, comparing not only different insurers but also the tax regimes of different jurisdictions.

Under the single market directive, "an underwriting account must be maintained and supplied upon request to any member state if the annual premiums earned in that state (without deduction of reinsurance) amount to more than 2.5 million ECUs ($3 million)," he said.

Premium taxes now vary widely within the community. Britain, Spain and Denmark do not tax premiums, and the rates range from 7% in Germany and the Netherlands, to 9% in France and Portugal, to 21% in Italy. "With such wide variations, there is obviously scope for risk managers to shop around to see where they should purchase their next excess limits," Mr. Tolan said.

Brokers, too, have had a hand in spurring competition in Europe.

"The brokers, particularly in Europe, where their penetration with the large industrial corporations is significantly lower than in the United States, are competing strongly to bring attractive programs at low cost to their industrial clients," he said.

"Eventually," predicts Mr. Tolan, "the bubble will burst." After an "exit of capacity," the "field will be left to professional players who know the risks that they are taking on and the cost of carrying these risks.

"These will be the specialist industrial catastrophe underwriters with dedicated capital and underwriting staff with an intimate knowledge of their industrial sectors and their attendant risks," Mr. Tolan said. ■

INTERNATIONAL

Insurers face Taiwan cleanup

By ROGER SCOTTON

HAMILTON, Bermuda—Taiwan has budgeted $10 billion for improving its environment and is introducing the concept of strict legal liability as a way to get the private sector, including insurers, to help fund a massive cleanup project, says a brokerage executive.

That cleanup will form part of a $300 billion, six-year infrastructure development plan aimed at addressing "years of neglect" in what is perhaps the most polluted country in Asia, said Leonard Battifarano, vp in charge of global business development with Alexander & Alexander International Inc. in New York.

Business opportunities for insurers and other companies, both foreign and domestic, appear "significant" in Taiwan, he said at the Second International Conference on Global Insurance the Market, held last month in Bermuda. "And, American firms with an interest stand to be the first in line, since Taiwan has announced it will buy American philosophy for this plan."

In a wide-ranging review of current developments in the Asia-Pacific region, Mr. Battifarano said Taiwan's environmental engineering experts are attempting to estimate potential damages done to drinking water, croplands and domestic fish farms "as a means of engaging insurer liability under broadly worded public liability policies."

He said Taiwan is now revising its insurance regulations for the first time in 60 years and expects to release the final versions of the new laws by August.

"It would appear, after analyzing the new government regulations, that the concept of strict liability will be introduced into the legal system," he said.

"And if local courts can be persuaded to enforce such an alien concept, domestic insurers will face huge liabilities: literally, the creation overnight of an environmental Superfund on the back of Taiwan's insurance industry."

While Mr. Battifarano acknowledged that there was still some doubt about whether Taiwan's courts can be persuaded to fully embrace the concept of strict liability, he said that one thing remains clear: Environmental issues, including pollution liability, will become a permanent item on the agenda of Taiwanese insurers.

Many of the new laws address the need for both life and non-life insurers to be better managed. Capital requirements will be raised, license and renewal procedures toughened and audits performed more frequently, said Mr. Battifarano.

Insurers in Taiwan have not been particularly innovative, and one result is that only 40% of the country's physical assets are insured, he said.

"What is also of particular interest are laws that appear to encourage an expansion of the local industry. Many of the larger holding groups are expressing interest in setting up either in-house insurance companies or captive brokers, primarily for tax-related benefits once the new laws take effect," Mr. Battifarano commented.

Taiwan is not setting out to attract many U.S. insurers. According to Mr. Battifarano, U.S. insurers write barely 1% of the $2 billion in annual premiums written by foreign firms.

"However, considering that the industry loss ratios have exceeded 100% since 1988 and are expected to reach 115% by the end of this year, that may not be so bad," Mr. Battifarano said.

As Taiwan's importance in the region is rising, that of Hong Kong is on the wane. Although still a key financial center, Hong Kong is no longer the region's most dynamic and open marketplace.

Since June 1989, when the Chinese government beat down the prodemocracy movement in Tiananmen Square, people, capital and corporations in the British colony have been lining up for safe havens within Asia and in North America, said Mr. Battifarano.

The prospect of continued outflow worries insurers in Hong Kong. According to a recent survey of the industry, it will "lead to reduced capacity and premium volumes and an increase in claims, political risk exposures and, ultimately, to an insurance industry which reflects Hong Kong's changing fortune as an economic second to emerging financial centers" in the region.

Singapore, predicts Mr. Battifarano, will be the prime beneficiary of Hong Kong's loss. He said the country continues to work hard to become an attractive domicile for captive insurers, while being used as a regional headquarters by leading international reinsurers, including Munich Reinsurance Co. and Swiss Reinsurance Co.

"Singapore's insurance industry appears to be gaining at Hong Kong's expense, since both American International Group Inc. and Chubb Corp. have transferred significant operations to Singapore from Hong Kong," he said. "This is compounded by the relocation of several non-insurance headquarters."

"Significant" amounts of capital are finding their way into Singapore's banking and insurance businesses, he added. Contributing to that trend are Singapore's modern infrastructure and its proximity to the region's fastest-growing economies.

"But Singapore has also become aware of the perils this profit can bring. The (insurance commissioner) recently amended local laws to better protect against both insurer and intermediary insolvencies," said Mr. Battifarano.

Among the ways the industry is now being policed are more stringent licensing laws, higher minimum capitalization, more frequent and more thorough audits, rigidly enforced 60-day premium warranties, and formal broker and company associations.

"Singapore is especially vulnerable to industry problems due to the relatively low premium volume of $25 million placed by more than 60 intermediaries in more than 140 insurance companies," he said.

"However, the belief is that Singapore has this situation well in hand and in fact looks forward to supplanting Hong Kong as Asia's service industry capital. While many of the region's business leaders see a strong interrelationship between China's isolation, Hong Kong reverting to Chinese control in 1997 and Singapore's dominance, it remains to be seen whether such a fundamental shift in the region's financial center will actually take place after 1997."

In South Korea, by comparison, despite the best efforts of U.S. trade negotiators over the past five years, foreign participation is still limited. Neither U.S. insurers nor brokers licensed as local agents have had any real impact on the local market, said Mr. Battifarano, who wondered whether "America's insurance industry is truly interested in competing globally, based on the Korean model."

One product of U.S. trade talks was the dissolution of the domestic fire-pooling arrangement, "a cartel. . .which historically shared all the best Korean property risks," he said.

New licenses have since been granted to Johnson & Higgins as a local agency company and to Bain Clarkson Ltd. of London, Assurances Generales de France and Winterthur Swiss Insurance Co. as local liaison offices, he added.

In theory at least, foreign companies should also welcome the legal end to compulsory reinsurance cessions to the Korean Reinsurance Co., said Mr. Battifarano, "although in practice, domestic companies continue with these cessions to the detriment of newly licensed foreign firms and international reinsurers."

Despite such problems, Asia maintains an "unmitigated optimism" about its future, said Mr. Battifarano. Most Asians, he said, believe regional investment opportunities far exceed those in Europe or North America.

"Freer market practices will continue to thrive, whether Hong Kong or Singapore is at the center of those activities and, despite some obvious problems, the region's insurance industry has cause for optimism," he observed.

Asia, he said, will continue to increase its share of the world's premiums, due to both pure economic expansion and concerns about the environment and consumer-focused liability issues.

"It is my view that the current problems besetting Asia—the environment, insurer insolvencies and soft markets—are more a reflection of unparalleled economic growth, rather than fundamental financial weakness," said Mr. Battifarano. "I see these issues being successfully dealt with and believe we will see an Asia which will continue its march toward even greater prosperity." ■

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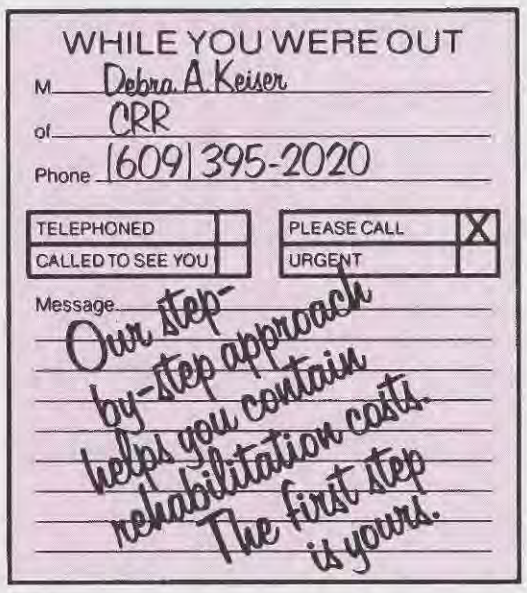

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Reluctantly, reinsurers face the 'end of an era'

By ROGER SCOTTON

HAMILTON, Bermuda—International reinsurance markets are coming to the end of an era of overabundant and inexpensive capacity, a reinsurance executive says.

But this change is more than just another cyclical adjustment, according to Dewey P. Clark, senior vp of Prudential Reinsurance Co. of Newark, N.J.

"I think it may well signal the total transformation of the way capacity is delivered and priced," he said last month at the Second International Conference on the Global Insurance Market in Bermuda.

For many companies, the "reinsurance game" has lost its appeal. By offering their capacity too easily and too cheaply, they directly endangered their solvency and the solvency of their cedants, Mr. Clark said. As these unsophisticated players withdrew, capacity was diminished for the reinsurance market as a whole.

In addition, reinsurance from Second and Third World markets has been steadily disappearing since the mid-1980s, and U.S. reinsurers are becoming less active internationally, he said.

However, he said, recent developments at Lloyd's of London represent by far the most dramatic forces for change.

Catastrophe losses since December 1987 have exceeded $25 billion. And those heavy losses, combined with the collapse of the London excess-of-loss market, have severely reduced available capacity, leaving reinsurers facing far higher prices for retrocessional coverages and a shortage of catastrophe protection, he explained.

"Supply and demand were suddenly forcing reality upon us," Mr. Clark said. With London supplying capacity to the world—much of it dependent on the availability of retrocessional protection, which is now in very limited supply—Mr. Clark described the evolving situation at Lloyd's as a "dramatic and significant development."

"Some think that this is a temporary occurrence," he said. "I see it as a fundamental change in the way we do business, which is directly and significantly impacting capacity levels worldwide.

"Reinsurance, like banking, develops its capacity directly from its capital and surplus, plus whatever retrocessional arrangements it can make. If retrocessional possibilities are decreasing, capacity must also be expected to decrease," he said.

In the European market, Mr. Clark predicted that eventual harmonization of financial reporting regulations will help to maintain pressure on insurance and reinsurance capacity. He said the regulations will "give more transparency to true balance sheet values across Europe."

"They will be accompanied by and contribute to competitive tendencies, toward stronger solvency margins, demands for higher dividends from shareholders. . .and the adoption, by the better-managed companies, of (return on equity) concepts as the standard of measurement," Mr. Clark said.

Combined, these changes will limit or shrink insurance and reinsurance capacity, he said.

"Catastrophe capacity is strained now and there are signs that the strain will continue. I believe that, as the ripples spread, the impact will be felt well beyond the catastrophe markets. These evolving pressures on capacity will bring supply and demand closer to equilibrium. . .all of us—reinsurers and buyers alike—can look forward to a healthier environment," Mr. Clark said.

As part of the trend toward "more knowledgeable capacity" in the international markets, security will generally improve, he said.

Also, terms for both excess-of-loss and proportional reinsurance, at least in contracts with catastrophe exposures, are expected to become more favorable as the strain in aggregate capacities in catastrophe-prone areas intensifies, Mr. Clark said.

These developments alone, however, will not solve all the problems facing reinsurers, he warned.

For example, primary insurers are increasingly retaining more of their own business, he pointed out. "The larger the insurer, the more they tend to keep. Therefore, reinsurers are finding capacity demands reducing at the same time as the supply of capacity—which seemed unlimited just two years ago—begins to show its true finite nature," he said.

Mr. Clark said the challenge now facing international reinsurers is "to be more attentive to strengthening our financials, delivering value-added to our customers and keeping expenses under control.

"The challenge for buyers is to be even more vigilant" in selecting reinsurers," he said. "Shaken by the eroding financial conditions of many (reinsurers) during the last decade, buyers have every right to demand impeccable security from their current and future reinsurers." ■

Kuwait

Continued from page 37

Insurance Co.

However, it is unclear whether the law will be enforced or changed, some Kuwaiti officials say.

In addition, soon after the informal cease-fire was called by coalition forces, London brokers and underwriters assembled facilities to underwrite construction risks.

And, it was expected that many U.S. contractors would be able to tap their existing construction all-risk insurance packages to cover Kuwaiti projects (*BI*, March 18).

The most recent official figures from the Kuwaiti government estimate that rebuilding the country will cost $40 billion, about half of that for rebuilding the nation's oil industry.

In addition, the insurance sector could benefit from the recent cabinet reshuffling, Mr. Haman said. The new minister of commerce and industry is Abdullah Hassan Al Jaralla, the former chairman of Warba Insurance Co.

Kuwait Re has resumed reinsuring projects that were under way before the Iraqi invasion. But, with government decision-making nearly at a standstill, only a few small reconstruction projects have been awarded, insurers and brokers say.

Political tension is growing between the government and the ruling Al Sabah family on the one side, and pro-democracy activists and Islamic radicals on the other.

Tensions are fueled further over allegations by Islamic radicals, who comprise the Kuwaiti resistance movement, that resident non-Kuwaitis collaborated with Iraqi invasion forces.

Both insurers and bankers agree that until the political situation is resolved, decisions on rebuilding the emirate, including awarding construction contracts, will be delayed.

Moreover, credit insurers say, the Kuwaiti banking system is not geared to provide clients with irrevocable letters of credit. Credit insurers will not provide policies to contractors and firms exporting essential goods for the reconstruction process unless the buyers are backed by LOCs issued by Kuwaiti banks and the buyer is a government agency.

But, the Kuwaiti banking system is still not ready to handle such requests in any great amount, insurers say. Indeed, it cannot handle any such requests if the Kuwaiti client is a private sector company, they say.

London broker Lloyd Thompson Ltd. set up a $20 million line slip to cover credit insurance. "Our initial idea was to put together credit guarantees for Kuwait and Saudi Arabia and have some capacity available on the lines that each risk would be vetted and evaluated by the leading underwriters," said Director Mark Drummond Brady.

"The stuff we were looking for was construction projects, sales of essential supplies, etc.," he explained.

"Capacity has been allocated, and now we are waiting until the inquiries start coming through," said Miles Wright, managing director and underwriter at Polwring Underwriting Agency Ltd., which manages Lloyd's of London non-marine syndicate 1098.

"But the problem is that the Kuwaiti government doesn't have a corporate financing plan. We have all been slightly astounded at the lack of preparation," he said.

Another Lloyd's underwriter said he had decline a few requests for credit insurance for unsecured exports to Kuwait to a private company or individual buyer.

"With no security, the credit risk is entirely on the buyer, and we would never write that business. We only write cover where the buyer is a government-owned company," said the underwriter.

Until the Kuwaiti financial sector is sorted out, potential Western contractors say they are restricting themselves to tendering offers for small projects and are asking for cash payments up front.

For example, Over Arup & Partners, a large London engineering firm, has been talking with the Kuwaiti government about a damage assessment survey that would cost about $200,000, said Nigel Thomson, a company director. With such a small contract, the company could ask for cash up front so credit insurance would not be needed.

The situation could be eased later this month, though, when Kuwaiti companies will be allowed to apply to the central bank for a release of funds, which could be used to pay for goods up front.

The central bank will allow Kuwaiti companies to withdraw 4,000 Kuwaiti dinars ($1,160) monthly, Mr. Haman said. "They want to see the impact of withdrawals," he said.

The hope is that the bank will remove all restrictions on withdrawals by June 24, he said. ■

Railway suit

Continued from page 37

ing and placing coverage for the railway's property and liability risks, according to the lawsuit.

British Rail seeks unspecified damages for losses from Sedgwick's failure to "give adequate advice to (British Rail) regarding (British Rail's) duty as insureds of the utmost good faith and disclosure of material facts" and for failing to "carefully or sufficiently or at all identify and evaluate (British Rail's) exposure to third-party liability risks."

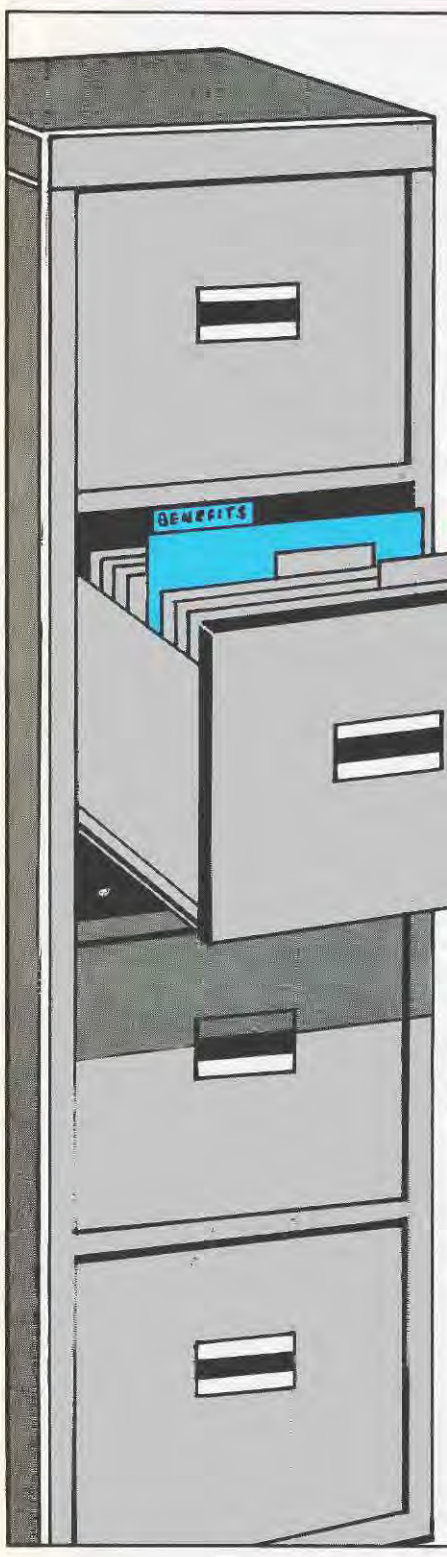
Specifically, the railway claims that Sedgwick failed to take the necessary steps to "identify the risk of (British Rail) becoming liable in substantial amounts to third parties by reason of flooding and by reason of (British Rail's) responsibility to maintain sea defense works and walls protecting the lands and properties of (British Rail) and such third parties, in particular in the area of Towyn in Wales."

The same insurers disputing the Towyn claims have faced a series of large claims in recent years following a string of fatal train crashes.

For example, millions of pounds of claims arose from:

- A 1989 collision outside Purley in South London, which killed five people and injured several more.
- A 1989 wreck near Glasgow, Scotland, which killed two people.
- A 1988 train collision near Clapham Junction in London, which killed 35 people and injured 500 (*BI*, Dec. 19, 1988).

A commuter train crash in London earlier this year is covered by different insurers (*BI*, Jan. 14). ■



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*Source: An Audience Profile of the Business Insurance "Buyer" Reader, 1990

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WIC

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July 1-3, 1991

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Afternoon breakout sessions will focus on more specialized subjects: Professional Liability, Financial Reinsurance, Global Insurance Programs, Banking & Insurance, Claims Handling Following a Disaster, The LMX Market, Toxic Torts & Product Liability, Insurance Regulation Worldwide, The Green Movement and EC Directives.

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Alexander Howden Reinsurance Brokers
A. P. Benson, Head of Group Risk Management
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Fred Bottcher, Vice Chairman, Reaal Group
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IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS COUNTY DEPARTMENT, CHANCERY DIVISION

IN THE MATER OF THE LIQUIDATION OF INDUSTRIAL FIRE & CASUALTY INSURANCE COMPANY — **NO. 91CH 02081**

PLEASE TAKE NOTICE, that on March 6, 1991, an Agreed Order of Liquidation With A Finding of Insolvency was entered against Industrial Fire and Casualty Insurance Company ("Industrial") by the Honorable Lester D. Foreman, Judge of the Circuit Court of Cook County, Illinois. James W. Schacht, Acting Director of Insurance of the State of Illinois is the statutory and court affirmed Liquidator of Industrial.

TAKE FURTHER NOTICE that pursuant to the Order of said court, all rights and liabilities of Industrial and its creditors, policyholders and all other persons interested in its assets are fixed as of March 6, 1991 unless otherwise provided by such other Order of the Court.

TAKE FURTHER NOTICE that any and all persons, partnerships, corporations, associations, estates, trusts and governmental units having or claiming to have any accounts, debts, claims or demands against Industrial or claiming any right, title or interest in or to any funds on property of Industrial in the possession of the Liquidator are required to file a Proof of Claim with the Liquidator on or before 4:30 p.m. Chicago Time, March 6, 1992.

TAKE FURTHER NOTICE that the form of and required content of all proofs of claims are described in the **Illinois Revised Statutes**, 1989, Ch. 73, Par. 821. Proofs of claim together with supporting documents, if any, are to be filed with and may be secured from the Liquidator of Industrial Fire & Casualty Insurance Company, in Liquidation, 446 East Ontario Street, Suite 700, Chicago, Illinois, 60611. Filing shall occur upon the receipt of Proof of Claim by the Liquidator. The Liquidator reserves the right to require such additional information with respect to any claims as he may deem necessary. The Liquidator further reserves all rights to any and all defenses of Industrial concerning such claims. All Proofs of Claim must be duly sworn to before an Officer authorized to take oaths.

THE LAST DATE FOR THE FILING OF PROOFS OF CLAIM WITH LIQUIDATOR AT HIS ABOVE-MENTIONED OFFICES is March 6, 1992, at 4:30 p.m. Chicago Time. No person having or claiming to have any claims against Industrial Fire & Casualty Insurance Company SHALL PARTICIPATE IN ANY DISTRIBUTION OF THE ASSETS OF THE COMPANY UNLESS SUCH CLAIMS ARE FILED WITH THE LIQUIDATOR ON OR BEFORE March 6, 1992, at 4:30 p.m.

James W. Schacht, Liquidator; Office of the Special Deputy, 446 E. Ontario, Suite 700, Chicago, Illinois 60611 (312) 915-4700

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Secretaries, Treasurers, contollers and other Financial Personnel 4,349

Risk/Employee Benefits:
Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations 10,606

Sub-total 24,591

Associations 488
Government, unions and Educational Institutions 1,275

Commercial Consumers
Sub-total 26,354

Insurance Agents and Brokers 9,651
Insurance Companies 8,074
Accountants, Actuaries, Attorneys & Consultants 3,438
Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers 1,294
Others Allied to the Field 1,365

TOTAL 50,176

★ Source Business/Occupational breakdown of qualified circulation, November 26, 1990 issue, as submitted to BPA for December 1990 BPA Publisher's Statement.

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Largest U.S. reinsurers' first-quarter 1991 results

Ranked by net reinsurance premiums written. All amounts in thousands of dollars.

Reinsurers	Net reinsurance premiums written 1991	Net reinsurance premiums written 1990	Policyholders surplus (reinsurers only)	Net income 1991	Losses & loss adjustment expenses	Loss ratio	Underwriting expenses	Expense ratio	Combined ratio 1991	Combined ratio 1990
1. General Re	$512,588	$480,676	$3,119,950	$131,484	$364,674	71.7%	$143,606	28.0%	99.7%	99.0%
2. Employers Re	247,303	274,291	1,479,996	94,386	199,738	77.5	64,154	25.9	103.5	102.9
3. American Re	246,274	207,897	688,095	34,536	175,896	76.6	58,794	23.9	100.4	102.0
4. North American/Swiss Re	210,939	180,450	602,071	6,109	149,202	72.2	76,530	36.3	108.5	110.2
5. Prudential Re	144,875	100,783	531,946	6,931	118,829	80.6	55,238	38.1	118.7	117.1
6. Munich Re	136,498	135,831	636,622	16,228	97,415	74.5	45,849	33.6	108.1	113.7
7. Berkshire Hathaway	127,873	51,098	N/A	N/A	64,845	130.5	6,640	13.4	143.9	112.5
8. Kemper Re	99,331	71,835	356,817	10,152	66,800	82.2	24,452	24.6	106.8	120.9
9. Skandia America Group	95,497	80,399	335,341	2,590	77,396	79.7	31,419	32.9	112.6	112.3
10. St. Paul Cos.	92,780	84,214	N/A	N/A	105,268	98.5	32,871	35.4	133.9	157.2
11. Transamerica Re	88,330	79,934	201,178	7,591	71,017	76.9	25,342	28.7	105.6	107.1
12. F&G Re (USF&G)	84,684	255,293	N/A	N/A	54,811	63.6	26,826	31.7	95.2	99.2
13. Transatlantic Re	80,515	75,510	225,462	10,701	67,559	80.3	20,630	25.6	105.9	107.3
14. National Re	66,993	58,321	224,573	11,686	51,064	72.8	20,181	30.1	102.9	103.1
15. CIGNA Re	59,416	59,204	190,487	7,277	39,580	73.9	16,790	28.3	102.2	109.8
16. Constitution Re	58,335	107,927	219,480	8,923	42,153	71.1	20,020	34.3	105.4	105.7
17. NAC Re	52,712	51,222	204,851	6,693	38,660	73.6	18,384	34.9	108.5	110.5
18. Winterthur Re	47,341	20,792	168,990	2,997	33,183	74.9	15,178	32.1	107.0	109.8
19. Underwriters Re	44,306	35,853	166,408	8,386	27,102	67.0	17,285	39.0	106.0	106.0
20. Scor US/Scor Re	42,093	42,883	216,142	7,946	27,987	66.5	15,534	36.9	103.4	103.2
Totals for Top 20	**2,538,683**	**2,454,413**	**9,568,409**	**374,616**	**1,873,179**	**76.0**	**735,723**	**29.0**	**105.0**	**107.1**
Total for all companies	**2,701,047**	**2,523,898**	**12,617,287**	**432,668**	**2,002,441**	**75.4**	**818,538**	**30.3**	**105.8**	**107.0**

Source: Reinsurance Assn. of America and Business Insurance

Reinsurance

Continued from page 3

volume increased 7% to $2.7 billion from $2.5 billion. The Top 20 reinsurers' premium volume increased a more modest 3.4% to $2.54 billion from $2.45 billion.

Despite the improved combined ratio and higher premium volume, rates are not getting any harder and a market turn is not imminent, say observers.

There has not been much change in the market, said Bard E. Bunaes, chairman and chief executive officer of Constitution Reinsurance Corp. in New York. "Competition is continuing to intensify and the worse it gets, hopefully, the sooner it will turn."

"It is becoming an industry of profitless prosperity," he said.

"The market's not showing any signs of improvement," agreed James R. Fisher, senior vp and comptroller of American Re-Insurance Co. in Princeton, N.J.

While reinsurers are doing relatively well, the market is not hardening, and there are no signs it will harden soon, Mr. Fisher said.

Pointing to the higher premium volume, Mr. Fisher said there are a large number of large quota-share transactions taking place that are boosting reinsurers' volume. As such, "it's not really a return of what I'll call a more traditional business flow," said Mr. Fisher.

"I don't believe the results that we're looking at are telling the whole story," said a reinsurance executive who asked not to be identified.

"There seems be a tremendous amount of non-traditional insurance being written by many companies, including the giants," he said. "Probably the biggest part of it" he said, is financial reinsurance.

Jerome Karter, president of Scor Reinsurance Co. in New York, a unit of SCOR U.S. Corp., commented that while first-quarter results have improved, "I don't think it signals any distinct improvement in the market conditions." No reinsurer who understands what is going on "sees any light at the end of the tunnel yet."

Mr. Karter commented that because of increases in retentions and the switch to more excess-of-loss business from proportional reinsurance, "reinsurers are, of course, much more decoupled from the risks of the primary insurers."

The stock market has held up and that could help mask reinsurers' underlying results, commented Paul Ingrey, president of F&G Re, the Morristown, N.J.-based reinsurance unit of USF&G Corp. Bottom-line operations are not suffering as much they might be if the stock market was falling, he said.

Meanwhile, in terms of rate increases, "nothing good is happening outside of marine and aviation and property catastrophe and retrocession catastrophe," he said.

Steven Bensinger, president and chief operating officer of Skandia America Reinsurance Corp. in New York, said the only significant firming so far is in the property catastrophe market, while the industry continues to write at a premium-to-surplus ratio of less than 1-to-1, which will not cause the market to turn. "I don't think it's a particularly optimistic scene at the moment," he said.

"My strong sense is that companies continue to live off their reserves for '85 and '86," said Mark Mosca, vp and manager of the treaty department at NAC Re Corp. in Greenwich, Conn.

But most firms' reserve redundancies have been cut significantly, Mr. Mosca said. "I don't know how much more there is to move" if that is what companies are doing, he said.

Michael Smith, an analyst with Shearson Lehman Bros. in New York, pointed out that results varied significantly according to reinsurer size.

The 10 largest reinsurers, according to the RAA survey, posted an average 104.8% combined ratio. That compares with a 105.4% average for the next five and a 108.8% average for the bottom 47.

"This is a business that continues to move toward quality. Bigger is better, and better is better," he said.

While most agree that the first-quarter results do not indicate the true status of the market, opinions vary as to the course of the market for the rest of the year.

"My prediction is this year is going to be worse than last year," said Constitution Re's Mr. Bunaes.

Despite the first-quarter results, "I just can't see how they can be any better," he said, adding that 1992 is "really a toss-up."

"There's still too much capacity in the industry," Mr. Bunaes said.

Employer Re's Mr. Fitt was more positive. "I don't think we're going to see any dramatic improvement, but I'm reasonably optimistic that the year will be acceptable," he said.

"It's not going to be a great year, but I don't think it will be a disaster," Mr. Fitt added. "The first quarter doesn't give you much of an indication of how the year's going to go," he said, explaining that reinsurers must go into the second and third quarters "before you get much of a feel of what's happening."

Shearson's Mr. Smith said the reinsurance industry's combined ratio has been relatively stable over the past several years, "and I expect it to remain that way."

Assuming there are no major catastrophes, "My guess is there'll be some deterioration, but not pronounced deterioration" in reinsurer results, said Craig Eisenacher, senior vp and comptroller for Prudential Reinsurance Corp. in Newark, N.J.

Observers are reluctant to pinpoint a specific time for market change, though they add it is not imminent.

Skandia's Mr. Bensinger said he is hoping the market will turn next year, "but I wouldn't want to place a wager on it."

Current results do not paint a picture of any kind of impending change, said NAC Re's Mr. Mosca.

"It's still going to be a long time," he said. "I think it's hard to imagine a scenario, barring major catastrophes, that will call for a change in the marketplace in the next 1½ to two years," said Mr. Mosca.

"We're thinking 1992, and I don't think we're expecting a pronounced turnaround, " commented Mr. Eisenacher. Instead of happening all at once, the market turn will occur at first in specific lines, he said.

F&G Re's Mr. Ingrey refused to speculate on when the market will turn. "It looks like at this point it's impossible to know what's going to turn it," he said.

SCOR Re's Mr. Karter said the office joke is that the only thing constant over the past two years is that the hard market is 18 months away, "so as we move forward, it's inevitably 18 months away." ■

Reinsurance ruling

Continued from page 3

ance litigation has become more common.

"Both cedants and reinsurers need to pay more attention than they have in the past to what these clauses really mean," he observed.

Philadelphia-based Mutual Fire was ordered into rehabilitation in December 1986, though it was not officially declared insolvent until February 1989. A final rehabilitation plan was approved in January 1990.

Mutual Fire has an estimated surplus deficit of $450 million, making it the fourth-largest property/casualty insurer insolvency in U.S. history.

The Pennsylvania Insurance Department, acting as Mutual Fire's rehabilitator, filed suit in Commonwealth Court against Chesapeake, charging the reinsurer owed more than $4 million for paid losses under reinsurance treaties in force between 1981 and 1985. Chesapeake owed a total of $19.8 million, including paid claims, case reserves and incurred-but-not reported losses as of year-end 1989, according to Mr. Bratic.

Chesapeake—a unit of Chesapeake Financial Corp., which is controlled by financier Victor Posner—removed the suit to federal court in Philadelphia in October 1989.

Two months later, though, the Pennsylvania department filed a motion to have the suit returned to the state court, arguing among other things that the state court has jurisdiction over the Mutual Fire rehabilitation and that Chesapeake waived its right to remove the case under the forum selection clause in the reinsurance contracts.

A federal judge in Philadelphia granted the regulators' motion, finding that Chesapeake had waived its right of removal under the treaties and remanding the case to Commonwealth Court in a September 1990 order.

The order was stayed pending Chesapeake's appeal, and the 3rd Circuit affirmed the lower court's decision in a May 20 ruling.

The appeals court found the forum selection clause provides that Chesapeake will, at Mutual Fire's request, "submit to the jurisdiction of any court of competent jurisdiction within the United States and will comply with all requirements necessary to give such court jurisdiction." "We agree with the district court that by consenting to 'submit' to 'any court' of competent jurisdiction 'at the request of (Mutual Fire),' and to comply with all requirements necessary to give 'such court' jurisdiction, Chesapeake agreed to go to, and stay in, the forum chosen by Mutual Fire," said the appeals court.

In ruling separately that the forum selection clause is enforceable, the appeals court also observed that such a clause is unenforceable only when it is shown to be "unreasonable."

Enforcement would be unreasonable only if the forum the ceding company selects is so inconvenient as to effectively deprive the reinsurer of its day in court or if the clause was obtained by the ceding company through "fraud, undue influence or overweening bargaining power."

None of these was the case in the agreements between Mutual Fire and Chesapeake, the appeals court found.

"In general, the insurance industry has obviously long found it a convenient and expeditious provision to include in its contracts," the court observed.

"It is a particularly fair provision in a reinsurance treaty, as it allows the ceding company, rather than the many and far-flung (reinsurers), to select the forum when the (reinsurers) have refused to pay." ■

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closing:	June 11	
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Business Insurance
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Garamendi unveils health reform plan

By LOUISE KERTESZ

LOS ANGELES—California Insurance Commissioner John Garamendi's new proposal to require health insurers to write affordable coverage for small groups could backfire, benefit consultants warn.

The commissioner's proposal, viewed as a first step toward achieving universal health coverage in the state, could prompt many health insurers to pull out of the small group marketplace, consultants say.

Mr. Garamendi launched his health insurance reform agenda last week by announcing his support for legislation that would require insurers to issue and renew policies and implement community-based rating for small groups.

"Employers of small numbers of workers have found the insurance marketplace to be particularly volatile and, worse yet, particularly abusive," Mr. Garamendi said in an address to the Pacific Regional Chapter of the American Assn. of Preferred Provider Organizations in Los Angeles.

Various bills already introduced in the state Legislature address many of the items in his six-point plan to improve health care access for workers at small firms, but Mr. Garamendi does not necessarily support all of the legislation as currently written.

"We will be evaluating the small group reform proposals now before the Legislature largely on the basis of how compatible they are with the larger drive for universal access," he said.

For example, one small group proposal, A.B. 14, sponsored by Assemblyman Burt Margolin, D-Los Angeles, would make experience rating illegal and require health insurers in most cases to renew coverage, two provisions under Mr. Garamendi's plan (*BI*, Jan. 28). But, the Margolin bill also would require employers to offer a "bare-bones" health plan or pay a payroll tax to fund coverage for the working uninsured.

Mr. Garamendi said he was "struck by the possibility" of requiring "bare-bones" plans, but he did not specifically endorse A.B. 14.

Mr. Garamendi said the department is assembling an advisory team of "national and world experts" on universal access.

In the meantime, Mr. Garamendi's proposals for small group health insurance reform reflect "the main themes" of industry proposals, including those advanced by the Health Insurance Assn. of America, said Walter Zelman, his special deputy for health insurance (*BI*, March 11).

Small group health care reforms are "a first step to access to health care for all Californians," Mr. Garamendi emphasized.

However, Mr. Zelman conceded that improving the small group market will not markedly reduce the number of Californians without health care coverage.

An estimated 6 million Californians lack health insurance, and most of them are employed or the dependents of employed individuals, said E. Richard Brown, a professor at the University of California at Los Angeles School of Public Health, who also spoke at the conference.

Mr. Garamendi is calling for laws affecting small groups—which were not precisely defined—that would:

- "Mandate that all insurers offer to renew all" health insurance policies currently in force.
- Require health insurers "within limits of capacity, to issue a policy to any small group that wishes to purchase one."
- Create "a state pooling mechanism to enable small employers to. . . .increase their bargaining power in seeking insurance."

Under the pooling mechanism, "various carriers would bid to cover segments of the pool and employers could buy insurance directly from those carriers through the state pool," Mr. Zelman said.

- Require insurers to use community rating rather than experience rating.
- Limit "the use of pre-existing condition restrictions" and prohibit "the repeated imposition of those restrictions as an individual moves from job to job."
- "Set real limits on premium increases—limits that do not allow insurers to individually penalize a small group of insureds because someone in that group experienced a medical problem."

The legislation would not affect large groups.

"The primary advantage" of Mr. Garamendi's proposed reforms is that small groups "will be able to keep their insurance without an exorbitant increase, and it will increase access to those groups perceived to be higher risk," said Emery B. Dowell, veteran political adviser and consultant, who also spoke at the conference.

But "some of his proposals are pretty severe," observed John Loizeaux, vp at Johnson & Higgins in Los Angeles, which places coverage and performs consulting work for "middle-market" employers—those with 50 to 1,000 employees covered by group health plans.

"There is a problem in the small group market, without a doubt," Mr. Loizeaux said. But Mr. Garamendi's proposals "do need further discussion and research."

Forcing insurers to cover groups and prohibiting them from raising rates based on a group's experience puts insurers in a double bind, Mr. Loizeaux said.

"I could see some insurers getting out of the small group market altogether if they were forced to write it and lose money," he said.

Small employers would view Mr. Garamendi's proposals as "pretty beneficial changes," said Robert Griffin, a benefit consultant at Seabury & Smith, a division of Marsh & McLennan Inc. in Glendale, Calif.

But, the proposals would have to be implemented "in conjunction with cost containment" to keep insurers interested in the small group market, Mr. Griffin said.

"His statements are nice, but until we see their implementation, I can't say whether they are feasible," agreed Lovett Goode, another consultant with Seabury & Smith.

"But, the bottom line is we need reforms," Ms. Goode said. The market for employers with fewer than 50 lives is "a very, very difficult market" to find coverage for, she emphasized.

However, Mr. Garamendi's proposals will not result in a "dramatic increase" in the number of insureds, Mr. Zelman acknowledged.

"The general assumption is that these reforms would ease access and affordability problems for those groups now having major problems, namely groups viewed as higher risk," or about 10% to 15% of small groups, Mr. Zelman said.

Mr. Garamendi also said he supports legislation, S.B. 921, that would, among other things, tighten regulation of multiple employer welfare arrangements.

S.B. 921 would require MEWAs to disclose plan coverage in great detail to employer participants. It also would make anyone involved in establishing or promoting a MEWA responsible for paying unpaid claims.

If the commissioner had his way, though, MEWAs would be outlawed in California, Mr. Zelman said. Though MEWAs may begin by legitimately planning to cover employees, some "quickly end up abusing employees" after their funds run out as a result of big claims, he said. ■

Asbestos ruling

Continued from page 3

from exposure to asbestos products made by a dozen manufacturers. He charges the producers with strict liability for failing to warn of asbestos products' hazardous fibers.

Mr. Anderson originally alleged strict liability for design defects. The trial court jury found in favor of the defendants. However, the judge in that case ordered a new trial on the grounds that he prevented Mr. Anderson's lawyers from also forwarding a failure to warn theory.

The manufacturers appealed the case to California's 2nd District Court of Appeal, claiming that if the case was to proceed on a failure to warn theory, they should be allowed to use a state-of-the-art defense.

The 2nd District in January 1990 ruled that state-of-the-art evidence is irrelevant in a case alleging strict liability because it brings negligence into play by questioning the reasonableness of the defendant.

Originally, negligence was not an element of the strict liability theory developed in the 1960s by the California Supreme Court. Under the doctrine, "a manufacturer is strictly liable in tort when an article he places on the market, knowing that it is to be used without inspection for defects, proves to have a defect that causes injury to a human being."

The theory was designed to ensure that costs of injuries caused by defective products are borne by manufacturers and not by injured persons powerless to protect themselves.

However, in a separate 1988 decision on strict liability, the state's 1st District Court of Appeal ruled that a manufacturer must have actual or constructive knowledge of a product's potential risk or danger before strict liability can be imposed. The 1st District ruled that the state-of-the-art at the time a product was marketed may be relevant to the question of knowability and, for that reason, should be admissible.

In clarifying the contrary appellate rulings, last month's Supreme Court ruling establishes the 1st District's interpretation as correct.

"Exclusion of state-of-the-art evidence, when the basis of liability is a failure to warn, would make a manufacturer the virtual insurer of its product's safe use, a result that is not consonant with established principles underlying strict liability," said Judge Edward Panelli, writing for the majority.

Judge Panelli's ruling relied heavily on a 1988 case, *Brown vs. Superior Court*, in which the court held that pharmaceutical manufacturers cannot be held strictly liable for failure to warn of risks they did not know about. He noted in his opinion that the Brown ruling, while applying only to prescription drugs, was based on "logic and common sense not limited to drugs."

The Brown ruling, he wrote, "clearly implied that knowledge is also a component of strict liability for failure to warn in cases other than prescription drug cases."

"While a manufacturing or design defect can be evaluated without reference to the conduct of the manufacturer, the giving of a warning cannot. The latter necessarily requires the communicating of something to someone. How can one warn of something that is unknowable?" he wrote.

The ruling will be extremely helpful to producers maintaining that those at the forefront of scientific knowledge when asbestos products were sold in the 1940s, 1950s and 1960s did not know asbestos was dangerous, defense attorneys say.

"This can be a major and powerful defense," said John Kazanjian, a product liability attorney specializing in asbestos litigation with Anderson, Kill, Olick & Oshinsky in New York. "This decision is in line with the majority of the courts across the country that have considered this issue."

"This decision is a clear statement that strict liability is not absolute liability. This decision shows that risk distribution cannot triumph over fairness," said Mr. Schwartz.

Mr. Kazanjian said the decision gives asbestos producers their strongest defense in failure to warn cases because scientists didn't make some major discoveries about the hazards of asbestos until the 1960s and 1970s.

Because asbestos-related diseases have a long latency period, a plaintiff suing today may have had contact with the asbestos materials up to 50 years ago, or long before producers knew they were damaging, he said.

One prominent plaintiffs' attorney, though, said the defense will do little for asbestos producers. "It doesn't make any difference. I prefer (they) have this defense because it is a defense they cannot prove and it really incenses juries when they try to prove it," said Fred Baron of Baron & Budd in Dallas.

Insurer attorneys were also cautious. Conceding that the California ruling "reflects a mainstream view," Mitchell Lathrop, who represents insurers in asbestos litigation, said its application will be limited. "As a practical matter, most companies knew about the dangers of asbestos," said Mr. Lathrop who is with Adams, Duque & Hazeltine in San Diego. "The 5th U.S. Circuit of Appeals in 1973 stated that asbestos has been recognized as a cause of disease for well over 50 years. By the mid-1930s the hazards of asbestos were accepted by the medical community."

Another attorney who represents insurers in asbestos-related cases agreed that asbestos manufacturers will be hard-pressed to prove they did not know or could not have known of the dangers. "How can the major asbestos producers claim they did not know of the dangers of asbestos when their own employees were coming down with various lung and asbestos-related diseases in the 1930s and 1940s?" asked Jeff Haney of Bishop, Barry, Howe, Haney & Ryder in San Francisco. "If you look at the history of these cases, I'm not sure how helpful this decision will be to manufacturers."

Nonetheless, he called the ruling a "logical" one because "failure to warn presupposes that the danger could have been known."

Attorneys expect the ruling's impact to extend beyond asbestos cases. Other manufacturers facing failure to warn claims will probably cite this decision. "This ruling does go clear across the board of product liability," said Mr. Lathrop.

"Clearly, any type of manufacturer could use this case," Mr. Haney said.

Steve Snyder of Brobeck, Phleger & Harrison in San Francisco, which represents Fibreboard Corp., one of the 12 named defendants in the Anderson case, said the ruling was significant because it was issued by one of the nation's "most prestigious and persuasive" courts.

"It keeps California within the mainstream of jurisdictions that have ruled on this issue. It makes it very clear that a failure to warn claim is defensible. To hold otherwise would make manufacturers their own insurer. I think this decision is important to all manufacturers," he said.

Only one California justice dissented from the majority ruling: Judge Stanley Mosk, author of the Brown decision. He said the court's ruling was a retreat from "the pure concepts of products liability so pridefully fashioned and nurtured by this court." Judge Mosk also wrote in his opinion that the majority "fails to comprehend that Brown was based on a narrow public policy exception to strict products liability for prescription drugs." He said the majority stretches the Brown ruling beyond recognition when applying it to any product other than prescription drugs.

Judge Mosk also said the majority needed to make a clearer distinction in failure to warn cases between evidence that the defendants had actual knowledge of the dangers and evidence that the defendants should have known of the dangers.

If plaintiffs can establish that defendants had actual knowledge, then state-of-the-art evidence would be irrelevant. However, if plaintiffs are only able to show that defendants should have known of the risks inherent in their products, then contrary data and state-of-the-art evidence should be admissible, Judge Mosk wrote. ■

Medicare fees

Continued from page 1

their lost Medicare revenue or equalize their billings by increasing the fees for non-Medicare patients.

"Physicians that are cut back are going to do something to maintain their income," said Nancy Jones, a principal with A. Foster Higgins & Co. Inc. in New York.

"We will see some cost shifting as a result of the fee schedule," added Sharon Canner, assistant vp-industrial relations at the National Assn. of Manufacturers in Washington, D.C.

"All we have to do is look at DRGs and see what is coming down the road," said Brenda Ballard Pflaum, a consultant with William M. Mercer Inc. in Chicago, referring to hospital cost shifting that health insurers and employers experienced after Medicare implemented the DRG system.

But despite their concerns about higher physician charges, insurers offering indemnity plans and managed care plans as well as self-insured employers will not rush to adopt similar fee schedules, experts say. Instead, insurers and employers will wait to see how Medicare handles any problems with the schedules and rely for the immediate future on other cost-containment measures.

"Obviously, there's going to be glitches when implementing a new reimbursement program," said Joel Miller, director of professional services at the Health Insurance Assn. of America in Washington, D.C. "I think that companies may be waiting to see what kind of lessons are learned" by Medicare before adopting a similar system themselves, he said.

"There will be some companies that will try to tailor RBRVS to some of their products," Mr. Miller said. "If it is appealing enough and if they can use it, they will."

"We are looking at it as an option for us," said Rene Lerer, vp and national medical director at Travelers Life Insurance Co. of Hartford, Conn. But, "although we believe that this is the direction we will eventually go, it will not be an easy transition."

CIGNA Life Insurance Co. of Hartford, Conn., is considering adopting a similar physician fee schedule, said Vp Art Lifson. "But, the question for us is whether this new system is as good or better for our purposes than the current system we use."

Employers with insured indemnity plans and self-insured employers also are not clamoring to begin using a similar physician fee schedule.

"Among all the participants affected by this, I detect an element of caution," said Rick Smith, director of policy at the Washington Business Group on Health in Washington, D.C. Mr. Smith said the group's members are "not neglecting" the threat of cost shifting posed by the new fee schedule, but instead are looking at ways to improve utilization of health care.

A major concern for employers is "balanced billing," which is the practice by physicians of billing employees directly for the portion of the physician's fee that exceeds the amount the employer-sponsored indemnity plan will pay, said Ms. Jones of Foster Higgins. "Employers are becoming concerned about how much they have shifted to employees and whether employees have reached their limits," she said.

Travelers' Mr. Lerer said that for indemnity plans, adopting the fee schedule would mean no employee protection from balanced billing. He said an employer must ask itself whether "its goal to protect the company at all cost or protect the company with consideration of the additional cost to employees."

Regardless of the problems associated with implementing a physician fee schedule similar to the one Medicare has proposed, "it's just a question of time" before private payers adopt such schedules, predicted Dr. Roger Taylor, national leader-health care consulting at The Wyatt Co. in Washington, D.C. "When the federal government installs something like this, it sets a precedent that has an effect on the whole spectrum of the population," he said.

In addition, physician cost shifting resulting from the new fee schedule will "greatly speed up the process of moving from indemnity plans into managed care," through which employers and insurers have already contracted with providers to guarantee set fees, Dr. Taylor said.

The move by employers toward managed care is being "accelerated" by the anticipated physician cost shifting, said Kenneth Sperling, a consultant in the Rowayton, Conn., office of Hewitt Associates.

"The short-term solution is to get into a managed care setting where the fees are set," he said.

If employers "can secure a commitment to contract with providers for a set level of fees, then you have a better chance of protecting yourself from potential cost shifting than you would if you weren't in a managed care setting," Ms. Pflaum said.

However, the ability of insurers and employers to negotiate a managed care fee scheduled that matches the rates to be charged to Medicate "would depend on our ability to change the contracts with our providers and their willingness to sign up," Travelers' Mr. Lerer said.

But, preferred provider organizations that do not depend on the business of one employer could resist any demand that they lower their fees to Medicare levels, Mr. Sperling said.

"Unless you have a significant percentage of a provider network's business, you don't have a lot of leverage" to force the network to accept reduced reimbursement, he said.

Meanwhile, there is some disagreement about how soon the new round of cost shifting will be felt.

Foster Higgins' Ms. Jones expects cost shifting to occur "fairly soon" after the Medicare fee schedule is implemented. Indeed, she expects that some physicians will begin increasing the fees they charge non-Medicare patients before the new schedule is even implemented.

The HIAA's Mr. Miller agreed. "We have some members who say that physicians, in anticipation of the fee schedule, have already begun billing in a cost shift."

CIGNA's Mr. Lifson estimates that physicians will begin cost shifting "within the first year, maybe six months" after the physician fee schedule is implemented.

Those expectations are based on estimates of how soon hospitals began cost shifting after Medicare implemented the DRG system.

"The effect was almost immediate, with some cost shifting in anticipation of the changes," said Wyatt's Dr. Taylor, who expects to see some cost shifting by physicians immediately after Medicare adopts its fee schedule. But, Dr. Taylor said most physicians will need time to gauge the effect of the changes in reimbursement and react accordingly.

Mercer's Ms. Pflaum noted that the fee reductions are phased-in between 1992 and 1996. So, as Medicare "starts to wrench down the fees in these schedules in 1993 and 1994, you will start to see" the effect in the private insurance market, she said.

Ms. Pflaum said it was 18 months to two years before the effects of hospital cost shifting were felt after the DRG system was implemented because the initial DRG reimbursement to hospitals was more generous than in later years. ■

Medicare fees tied to value scale

WASHINGTON—Medicare's proposed physician fee schedule is based on a "resource-based relative value scale" developed by Harvard University medical economist William C. Hsiao and internist Peter Braun (*BI*, Sept. 18, 1989).

Under the RBRVS system, each type of physician service is assigned a numerical value, which is based on the actual work of the physician, the typical expenses incurred by physicians in that specialty and the cost of medical malpractice insurance. The schedule will list numerical values for more than 4,000 physician services, which represent about 85% of the services for which physicians bill Medicare, according to the Health Care Financing Administration, which oversees Medicare.

A physician's fee is determined by multiplying the numerical value of the service by a dollar-based conversion factor that Congress will determine each year.

The physician fee changes would be phased in over a five-year period, beginning in 1992.

For example, orthopedic surgeons would see their Medicare reimbursement fee decrease to 8% below the current prevailing rates, or CPR, in 1992.

But, by 1996, their reimbursement would be 35% less than the 1996 CPR.

Family practitioners, though, would see their Medicare reimbursement increase to 113% of current prevailing rates in 1992.

And, by 1996, their fees would be increased an additional 15% of the 1996 CPR.

During the phase-in period, physicians billing Medicare at CPRs that more than 115% above the fees established in the new fee schedule would see their charges reduced by as much as 15% of the fee listed in the schedule each year until 1996.

Physician charges that are 85% of the fee schedule amount or lower would be increased by 15% of the schedule amount each year until 1996.

All physician charges would be brought in line with the new fee schedule in 1996.

During a 60-day comment period, which will end Aug. 5, HCFA will be smoothing out some rough edges on the fee schedule, a HCFA spokesman said.

For example, the HCFA must differentiate more clearly among types of office visits for purposes of establishing reimbursement fees, he said.

In addition, the HCFA must clarify what collateral services—like pre-operative, post-operative and follow-up visits—are considered part of a single surgical procedure, he said.

However, these problems were not unexpected, he said.

In fact, "those were the same problems that Hsiao himself ran into in designing the schedule," the spokesman said.

The fee schedule is expected to be completed by October.

—By Adrienne C. Locke

GAO report

Continued from page 1

have universal coverage of health care without incurring additional costs, if reform also includes simplification of the payment system and more effective expenditure control," Comptroller General Charles Bowsher told the House Government Operations Committee, which requested the GAO study.

This was the first in a series of reports from the GAO, the investigative arm of Congress, on national health care systems in foreign countries. Rep. John Conyers Jr., D-Mich., the committee chairman, described the report on Canada as a landmark study.

"The most stunning finding in the report is that if the U.S. were to adopt a Canadian-style single-payer program, the savings from reduced administrative waste would be enough to cover the 32 million Americans who lack health insurance and protect the tens of millions of underinsured at no additional cost to society," Rep. Conyers said.

But the report has triggered a wave of controversy from employers, benefit consultants and insurers who doubt a Canadian-style program would reduce administrative costs anywhere near as much as the GAO suggests.

"I have yet to see a government bureaucracy that is more efficient than the private sector," according to Dirk Van Dongen, president of the National Assn. of Wholesaler-Distributors in Washington, D.C.

"While we spend too much on administrative costs, I'm really skeptical of these purported savings," said Sharon Canner, assistant vp at the National Assn. of Manufacturers in Washington, D.C.

"It is hard to believe that we could set up 50 state-run insurance programs and save $34 billion," said Kenneth Sperling, a consultant with Hewitt Associates in Rowayton, Conn.

Others contend that comparing administrative costs in the United States with those in Canada is unfair and misleading. Canada, they point out, has only about one-tenth the population of the United States.

"To project the cost savings for a program in a country with a population of less than 30 million to the United States, which has 10 times the population, doesn't seem quite right. We can't assume Canadian administrative costs would be American administrative costs," said Henry Saveth, a principal with A. Foster Higgins & Co. Inc. in New York.

The Health Insurance Assn. of America acknowledges that administrative costs are higher in a private-payer system than they are with government-run programs. However, the extra administrative costs of a private system also lead to better care, the Washington, D.C.-based trade group maintains.

"When experts agree that 25% to perhaps 40% of medical services provided yield no significant medical benefit, and in some cases are downright harmful, it is clear that we need to focus administrative resources on making sure that the medical care our insureds receive is appropriate and of good quality," said HIAA President Carl Schramm in testimony last week before the Government Operations Committee.

"In something as complex and costly as health care, you have to know what is going on. And that requires significant administrative dollars," said Ellen Goldstein, director of health care at the Assn. of Private Pension & Welfare Plans in Washington, D.C.

The GAO report comes at a time when the issue of health care access is again capturing national attention.

Key Senate Democrats, including Majority Leader George Mitchell, D-Maine, Edward M. Kennedy, D-Mass., Donald Riegle Jr., D-Mich., and John D. Rockefeller IV, D-W.Va., last week introduced their own health care access bill. That proposal would set up a new public plan for the uninsured and require employers to offer comprehensive coverage to employees or be slapped with a new payroll tax (see story, page 1).

While lawmakers here grapple with trying to provide coverage to the 32 million uninsured, Canada has provided universal comprehensive coverage of medical and hospital expenses for 20 years.

In Canada, health care programs are administered by the 10 provinces. Generally, the provincial governments are the single payers of physicians and hospitals. Some employers, though, provide supplemental coverage, such as upgrades so employees have semi-private rooms rather than hospital ward accommodations.

Doctors fees are negotiated annually by provincial officials and medical societies. Provinces also decide how much money they will provide to hospitals, effectively controlling hospital budgets.

Like Americans, though, Canadians have the freedom to select their own doctors and hospitals.

Despite universal coverage, health care costs are much lower in Canada than in the United States, the GAO found. In 1989, for example, U.S. health care costs comprised 11.6% of the gross national product compared with 8.9% in Canada.

Canada's lower per capita annual health care costs—$1,700 compared with $2,300 for the United States—reflect the country's lower spending on insurance administration and physician and hospital reimbursement, the GAO's Mr. Bowsher said.

In estimating that a Canadian-style system could cut insurance administrative costs by $34 billion, the GAO assumes that overhead could be cut to Canadian levels of just over 1% of total expenses. In 1989, the average overhead of public and private insurers in the United States was 6% of total expenditures, according to the agency.

These savings would accrue because a universal access system "administered by a non-profit agency would reduce costs by eliminating the need to determine coverage, eligibility and risk status and by eliminating marketing costs," according to the GAO report.

In addition, if U.S. hospitals reduced their administrative costs to just the level of Ontario—the largest of the 10 provincial plans—about $18 billion could be saved annually. In 1988, U.S. hospitals spent about 15% of total revenues on administration compared with 9% for their Ontario counterparts, the GAO estimated.

This difference in hospital overhead is largely due to the complex reimbursement system that confronts U.S. hospitals.

"The U.S. payment system requires hospitals to maintain a large administrative and financial apparatus to determine coverage, charge patients and insurers and resolve billing disputes," the GAO said.

By contrast, Canadian hospitals have virtually no billing departments and only a minimal accounting structure, the report noted.

Physician administrative costs could be cut by about $15 billion annually through a Canadian-style program, the GAO says.

In Canada, physicians submit claims for all their patients to a single payer in each province and receive prompt payment with minimal physician time spent on billing.

"Unlike U.S. physicians, they are not burdened with determining insurance status, filling out different claim forms, managing collections or compensating the uncollectible accounts," the GAO said.

U.S. physicians, though, have to file multiple forms, resolve disputed claims and wait for delayed payments, factors that drive up administrative costs, the report said.

Several assumptions underlie the GAO estimate of $67 billion in administrative savings from a Canadian-style system. Those assumptions include:

- All aspects of the Canadian program—including limits on hospital budgets and physician fees—would be adopted.

The study also assumes that physicians would be required to reduce their charges to reflect their lower administrative costs.

- The entire Canadian program would be implemented within one year.

The study does not estimate the costs of shifting to a single-payer system from a multipayer program. Consultants say those transition costs would be considerable.

"Costs to be incurred during this transition would come from building the administrative machinery to implement global budgeting, physician fee controls and other policies," the report said.

In a study of the Ontario health care system, the GAO found no evidence of lengthy waiting times for residents to make appointments to see their family physician or general practitioner.

Similarly, the GAO found Canadians do not have to wait for emergency care, a point with which Canadian consultants concur.

"If, for example, you are in a car accident, you will be taken care of right away," said Bob McKay of Hewitt Associates in Toronto.

But for elective, specialized procedures—which the GAO defined as conditions in which treatment is needed, but the patient is in no imminent danger—waiting lists are common, the study found.

In a study of Ontario hospitals, the GAO found that patients have to wait at least 30 days, and up to about a year, for elective eye surgery. For cardiovascular surgery, the wait can be as short as seven days, but waits of up to about half a year were reported.

Waits for cardiac surgery are the results of government policy, the report notes.

In Ontario, for example, the Ministry of Health limits the number of heart surgery wards and gives hospitals funding to perform a specified number of heart operations, according to the GAO.

"Thus a cardiac surgeon who has the capacity to do four to five operations weekly may be limited by the hospital to only three to four operations per week," the report said.

"A waiting list is an inevitable consequence when hospitals have to live within a global budget," said Laurene Graig, a research analyst with The Wyatt Co.'s Research and Information Center in Washington, D.C.

Despite long waits for certain specialized elective procedures, Canadians are not crossing the border in droves to obtain medical care in the United States.

Canadians accounted for less than 1% of total admissions in hospitals in nine border states, the GAO said, citing a 1989 study by the American Medical Assn.

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Copies of "Canadian Health Insurance: Lessons for the United States," are available from the U.S. General Accounting Office, P.O. Box 6015, Gaithersburg, Md. 20877; 202-275-6241. The first five copies are free. Additional copies are $2 each. Checks should be made out to the Superintendent of Documents. Specify report GAO/HRD-91-90.

Update

Ruling on Executive Life GICs

Continued from page 2

100% of death benefits and 70% of retirement annuities (*BI*, April 29). Some employees enrolled in 401(k) plans that bought GICs from Executive Life are suing the plan sponsors to recover losses (*BI*, May 27).

Attorney Alan Wolen, a partner with Barger & Wolen in Los Angeles, told Judge Lewin that hardship payouts to GIC participants probably would not exceed $50 million over the next 12 months. Mr. Wolen represents the Group Annuity Participant Protection Assn., composed of retirement plan fiduciaries.

After Coopers & Lybrand, the Insurance Department's actuary in the conservation, reported the insurer would have a cash flow of $200 million over the next 12 months, Judge Lewin said the GIC hardship payouts would not compromise Executive Life's assets.

Texas workers comp exodus

DALLAS—Employers in Texas are watching the market for workers compensation coverage shrink as two more insurers announced their withdrawal from the state.

Hartford Insurance Group, beginning July 1, will not renew Texas workers comp policies or write new business for Texas employers paying less than $350,000 in annual premiums. The Hartford, Conn.-based insurer will, however, continue to provide coverage for policyholders in the Texas Small Premium Policy Plan, a small-employer pool.

"Significant" operating losses and residual market assessments prompted the withdrawal, said a Hartford spokesman. Hartford's voluntary workers comp premiums volume of $112 million in 1990 represented less than 2% of the market, he said.

Ohio Casualty Corp. of Hamilton, Ohio, plans to stop writing Texas workers comp coverage some time this summer. Losses and a recent court decision declaring a workers comp reform law unconstitutional led to the pullout, a spokesman said (*BI*, May 20; May 13).

Ohio Casualty wrote about $3.2 million in annual workers comp premiums in Texas.

Jury blames TWA for 1986 loss

BROOKLYN, N.Y.—A federal court jury in Brooklyn last week found Trans World Airlines Inc. guilty of willful misconduct for not providing adequate security to prevent a midair bomb explosion aboard a TWA jetliner near Athens in 1986.

As a result of the jury's verdict, which was returned in the second phase of a civil trial, TWA's insurers will have to pay $2.8 million to the survivors of a passenger who was killed in the explosion and $250,000 to an injured passenger. Those awards were made in the trial's first phase.

The Warsaw Convention limits airlines' compensatory liability for accidents on international flights to $75,000 per passenger unless willful misconduct can be proved.

Four passengers were killed and seven more were injured in April 1986 when a bomb exploded on board the TWA Boeing 727 jetliner en route to Athens from Rome (*BI*, April 7, 1986). TWA's insurance coverage at the time was written by U.S., London and French insurers.

A TWA spokesman would not comment on the award.

Storms cause huge damage

RAHWAY, N.J.—Two storm systems caused an estimated $165 million of insured property damage in a wide area of the nation late last month, reports the Property Claim Services division of the American Insurance Services Group.

Wind, hail and flooding, assigned Catastrophe No. 76, caused an estimated $85 million of insured property damage to Texas on May 21. A major hailstorm in the El Paso area caused much of the loss.

Wind, hail, tornadoes and flooding, assigned Catastrophe No. 77, caused an estimated $80 million of insured damage to areas of Colorado, Kansas, Missouri, Oklahoma and Texas May 23-26. Colorado, particularly the area around Denver, sustained $50 million of insured property damage.

Briefly noted

The House Subcommittee on Economic and Commercial Law this week is scheduled to hold a hearing on a bill introduced by Judiciary Committee Chairman Jack Brooks, D-Texas, to overhaul the **McCarran-Ferguson Act**. Insurance trade groups strongly oppose the legislation, H.R. 9. . . .Colorado Gov. Roy Romer last week signed legislation, S.B. 218, that overhauls the state's **workers compensation law** and is expected to stabilize employers' premiums (*BI*, May 13). . . .Texas Gov. Ann Richards has signed a measure **reforming Texas' insurance law** (*BI*, June 3). . . .**Walbrook Insurance Co. Ltd.** has asked a London court to liquidate Bermuda-based Chesapeake Insurance Co. Ltd., to which Walbrook ceded reinsurance, a lawyer who represents Chesapeake in separate U.S. litigation (see story, page 3.) Chesapeake will contest Walbrook's London action, he said, noting that Walbrook unsuccessfully tried to obtain a Bermuda court liquidation order against Chesapeake earlier this year. . . .A California Senate committee has killed a bill supported by the insurance industry that called for a **no-fault auto liability** system. Gov. Pete Wilson, who supported the bill, said he would veto a rival bill sponsored by Assembly Speaker Willie Brown, D-San Francisco, because it would retain the current fault-based liability system and force motorists to subsidize low-income drivers. . . .**Health Net** has rejected two unsolicited takeover bids submitted after controversy over the health maintenance organization's financial worth stalled an earlier management buyout initiative. Both deals would have converted the non-profit HMO to for-profit status. Health Net is California's second-largest HMO with 840,000 members. . . .Federal judges have the authority to order litigants to pay their opposition's **legal fees** as a penalty for abusing the court system through fraud and delays, the U.S. Supreme Court affirmed in a 5-4 ruling last week. . . .An investment group in which American International Group Inc. was a participant has discontinued discussions with the **Equitable Life Assurance Society of the United States** about an investment in Equitable (*BI*, May 6).

Democratic proposal

Continued from page 1

of a "play or pay" approach, to offer employees a health care plan or pay a new tax to help fund coverage for the uninsured.

- Creating a new federal program, known as AmeriCare, which would largely replace Medicaid to provide comprehensive coverage for individuals without employment-based health insurance.

Unlike Medicaid, though, AmeriCare would not restrict eligibility to the poor. Others also could obtain the coverage, though they would have to pay a much greater share of the cost.

- Eliminating state laws that mandate that certain types of services be covered by health care plans sold by commercial insurers.

The legislation was introduced last week at a jammed press conference by its sponsors: Senate Majority Leader George Mitchell, D-Maine, and Sens. Edward M. Kennedy, D-Mass.; Donald Riegle Jr., D-Mich.; and John D. Rockefeller IV, D-W.Va.

Sen. Kennedy, the congressional champion of universal health care, proclaimed the introduction of the bill as a "historic day for the Senate and for the nation."

Indeed, as benefit experts earlier noted, the legislation marks the first time that Senate Democratic leaders have united on a single approach to improving health care access. Previously, Sen. Kennedy had worked pretty much alone—without significant backing from party leaders—in advocating that employers be required to offer health care plans.

Sen. Mitchell pledged that he will work to win passage of the legislation during the current congressional session; hearings by the Senate Labor and Human Resources Committee, chaired by Sen. Kennedy, are set to begin this week. A similar bill is expected to be introduced in the House within a few weeks.

Despite the strong push by Senate Democrats, benefit experts say congressional passage of the legislation is not likely anytime soon.

"The chances of passage are zero" because of a lack of consensus on improving access to health care, said Dallas Salisbury, president of the Employee Benefit Research Institute in Washington, D.C.

But the introduction of the bill will expand the debate on health care access, said Dr. Roger Taylor, national health care leader with The Wyatt Co. in Washington, D.C.

Unlike earlier bills introduced by Sen. Kennedy, which were criticized as paying only lip service to cost containment, the Senate Democrats' proposal does create a mechanism to try to control national health care spending.

A Federal Health Expenditure Board would be created to establish voluntary targets for annual health care spending in specified areas, like hospital care and physician services.

The board also would bring together health care providers, like hospital associations, and purchasers, like employers and insurers, to conduct negotiations on rates for services.

However, the board only would mandate rate levels if a majority of both providers and purchasers reach an agreement. If agreement is not reached, the board would only issue non-binding recommended rates.

Many benefit experts said last week they want to study this complex provision before commenting.

However, the proposal at least pays attention to the importance of cost containment, noted Frank McArdle, a consultant with Hewitt Associates in Washington, D.C.

"For the first time senior members of Congress are taking a step to control costs. That is a step forward," agreed Mark Ugoretz, executive director of the ERISA Industry Committee, a Washington, D.C.-based employer lobbying group.

The measure also would give new tax breaks to certain small employers that offer health plans meeting standards laid down in the measure.

For example, employers with fewer than 60 workers would receive a tax credit equal to 25% of the cost of coverage for each full-time employee earning less than $20,000. The tax credit would not be available to certain highly profitable firms.

Meanwhile, as earlier reported, the measure would require employers to either offer a health care plan or pay a payroll tax, to be set annually by the secretary of health and human services.

Generally, the employer would have to pay 80% of the premium, while deductibles could not exceed $250 for individual coverage and $500 for family coverage. Employee coinsurance could not exceed 20%, with a maximum annual out-of-pocket limit of $3,000.

Employers, though, could offer a health plan with different cost-sharing requirements so long as its "actuarial value" was equal to that of the basic health plan.

Small employers—those with fewer than 25 employees—would have five years to comply. If, at the end of five years, fewer than 75% of workers at small firms do not have health insurance, the employers would either have to offer a health plan or be subject to the payroll tax.

This same requirement would apply to employers with between 25 and 99 employees, except they would have only four years to voluntarily provide coverage.

Newly established employers with fewer than 25 employees would be exempt from offering coverage or paying a tax during their first two years of operations. ■

Criminal charges stem from insurer failure

RALEIGH, N.C.—A former North Carolina Insurance Department official and the former owner of now-defunct Interstate Casualty Insurance Co. face criminal charges stemming from the insurer's collapse.

A state grand jury last month indicted Bobby W. Gray, a former North Carolina department chief examiner, on charges that he took $41,000 in bribes in 1985 and 1986 to influence his actions regarding Interstate, based in Kinston, N.C. Mr. Gray, who became an Interstate Casualty officer after leaving the Insurance Department in 1987, is also charged with five corporate malfeasance counts.

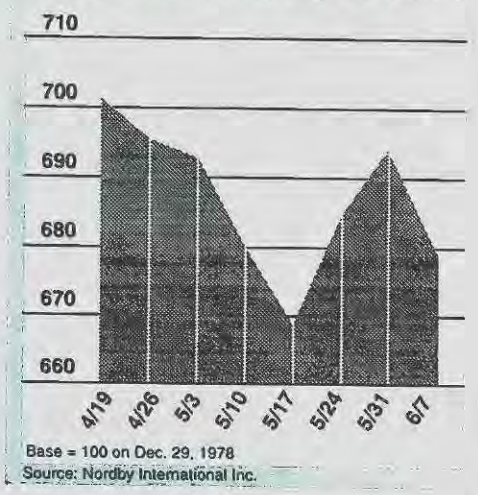
William C. Shackelford, the insurer's owner, is charged with paying the alleged bribes, along with five counts of corporate malfeasance and 15 counts of misuse of funds.

Both men, scheduled to be arraigned this week, face up to 15 years in jail on each malfeasance count and lesser jail terms on the other charges if convicted, said District Attorney Donald Jacobs in Goldsboro.

Separately, a federal grand jury last month indicted Mr. Gray and Mr. Shackelford on 38 counts of mail fraud and 21 counts of making false statements to banks. The federal indictment charges that Mr. Shackelford diverted more than $33 million in premiums owed to Interstate and its reinsurers—Munich American Reinsurance Corp. and the North Carolina Reinsurance Facility—by Interstate Insurors Inc., a managing general agency Mr. Shackelford owned. Mr. Shackelford and Mr. Gray concealed the alleged fraud in false financial statements from 1986 to 1989, the indictment charges. If convicted, they face five to 30 years in jail and up to $1 million in fines on each mail fraud count and two to 30 years in jail and up to $1 million in fines on each count of making false statements to banks.

—By Douglas McLeod

BI Insurance Index



Base = 100 on Dec. 29, 1978
Source: Nordby International Inc.

Insurance industry stocks dropped last week, as the *Business Insurance* Index fell 15.2 points to 678.3 on June 7, from 693.5 on May 31. Advancing issues were led by Statesman Group Inc., up 15.9%; Fremont General Corp., up 12.6%; and American Indemnity Financial Corp., up 8.0%. Decliners followed U.S. Healthcare, down 17.0%; Sierra Health Services, down 16.9%; and HMO America Inc., down 16.8%. Argonaut Group completed a 3-for-1 stock split last week. The most active issue during the period was U.S. Healthcare, 6.8 million shares traded. The *BI* Index lost 2.2% for the week; the Standard & Poor's 500 fell 2.7%; the New York Stock Exchange Composite was down 2.3%; and the Dow Jones 30 Industrials lost 1.7%.

British Issues

June 10 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	515	N/M	30.7	6.0	515	487
Genl Accident	533	N/M	35.7	6.7	541	531
Gdn Royal Exch	195	N/M	15.9	8.1	202	195
Royal	431	N/M	34.7	8.0	440	429
Sun Alliance	364	N/M	18.7	5.1	364	363
Brokers						
Bradstock	148	16.9	6.0	4.0	148	140
CE Heath	468	15.9	34.5	7.4	487	468
Hogg Group	202	12.3	10.7	5.3	202	200
Lloyd Thompson	343	22.8	10.0	2.9	343	340
PWS Holdings	86	10.5	4.7	5.5	87	86
Sedgwick Grp	255	24.5	16.0	6.3	258	255
Steel Brrl Jones	274	14.6	16.3	5.9	274	270
Willis Corroon	293	15.5	17.6	6.0	293	289

Source: Philip Olsen, Insurance Industry Analyst London

BI Industry Stock Report

JUNE 3, 1991 THROUGH JUNE 7, 1991

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander	NYS	23.00	0.00	-0.54	27.63	16.13	217	1.00	4.35	17	9.77	2.35
Gallagher Arthur J. & Co.	NYS	23.00	3.93	-1.08	28.38	19.75	50	0.64	2.78	17	5.88	3.91
Frank B. Hall	NYS	3.50	-6.67	-3.45	4.13	2.00	71	0.00	0.00	-7	-5.24	-0.67
Hilb, Rogal & Hamilton	OTC	17.00	1.49	15.25	17.50	11.25	112	0.36	2.12	25	3.56	4.78
Markel Corp.	OTC	18.25	5.80	55.32	21.00	10.25	72	0.00	0.00	10	3.56	5.13
Marsh & McLennan	NYS	76.13	-2.72	-2.40	87.25	59.75	645	2.60	3.42	18	14.77	5.15
Poe & Associates	OTC	10.50	2.44	64.06	11.00	6.25	7	0.32	3.05	13	2.09	5.02
BROKERS	AVERAGE		0.6	18.2					2.2	13		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W R. Corp.	OTC	29.50	-5.60	-21.33	32.25	19.00	95	0.32	1.08	16	23.89	1.23
Berkshire Hathaway Inc.	NYS	8425.00	-3.71	26.22	8900.00	5675.00	0	0.00	0.00	-27	4612.00	1.83
ITT (Hartford Group)	NYS	61.50	-0.61	28.13	63.00	40.25	1191	1.72	2.80	8	64.01	0.96
Sears (Allstate)	NYS	39.00	-4.01	53.69	40.88	22.00	3120	2.00	5.13	13	37.38	1.04
CONGLOMERATES	AVERAGE		-3.5	21.7					2.3	3		
INSURERS/REINSURERS												
Aetna Life & Casualty	NYS	41.50	0.00	6.41	53.88	29.00	1533	2.76	6.65	8	64.23	0.65
American General	NYS	38.63	-2.22	25.61	49.00	23.50	779	2.00	5.18	8	37.14	1.04
American Heritage	NYS	31.63	2.02	50.60	32.13	19.63	7	1.04	3.29	14	19.25	1.64
American Indemnity/Fin'l	OTC	6.75	8.00	107.69	7.50	2.75	13	0.08	1.19	13	12.93	0.52
American International	NYS	88.00	-2.76	14.47	102.00	57.00	1429	0.48	0.55	13	45.34	1.94
Aon Corp.	NYS	40.25	-1.54	15.83	41.75	26.75	180	1.60	3.98	11	18.50	2.18
Argonaut Group (s)	OTC	30.00	-0.70	40.63	33.29	17.67	39	2.04	6.80	3	48.26	0.62
AVEMCO Corp.	NYS	32.50	1.15	28.71	34.25	21.13	17	0.40	1.23	17	9.55	3.40
Baldwin & Lyons Inc.	OTC	23.50	1.08	25.33	25.25	17.00	1	0.32	1.36	8	24.29	0.97
Belvedere Corp.	ASE	3.13	-0.16	25.00	4.00	1.75	2	0.04	1.28	22	7.65	0.41
Chandler Insurance	OTC	3.75	7.14	-45.45	9.00	2.75	11	0.00	0.00	-3	5.95	0.63
Chubb Corp.	NYS	71.50	0.70	31.80	75.25	34.63	945	1.48	2.07	11	35.19	2.03
CIGNA Corp.	NYS	48.63	-6.49	18.96	56.75	33.25	575	3.04	6.25	11	73.15	0.66
CNA Financial Corp.	NYS	78.63	-2.93	14.57	92.50	49.50	60	0.00	0.00	13	70.23	1.12
Continental Corp.	NYS	28.75	-2.54	15.58	31.25	15.75	1124	2.60	9.04	11	37.83	0.76
Durham Corp.	OTC	32.50	6.11	16.07	33.00	23.00	16	0.92	2.83	16	28.04	1.16
Fund American Corp.	NYS	63.50	-1.17	22.41	65.25	32.50	419	0.68	1.07	14	36.11	1.76
Fremont General Corp.	OTC	23.50	12.55	62.07	23.50	10.13	557	0.88	3.74	7	19.13	1.23
Frontier Insurance Group	NYS	25.00	-1.96	31.58	33.00	15.38	68	0.00	0.00	10	11.20	2.23
General RE Corp.	NYS	92.50	-1.99	-0.54	102.50	69.00	633	1.68	1.82	13	37.50	2.47
Hanover Insurance Co.	OTC	28.25	-4.24	6.60	30.75	21.00	48	0.44	1.56	12	37.44	0.75
Harleysville Group	OTC	29.00	-2.52	26.78	31.50	13.50	6	0.64	2.21	9	22.99	1.26
Hartford Steam Boiler	NYS	61.25	0.20	25.64	63.75	43.50	99	1.80	2.94	16	17.05	3.59
Kansas City Life Ins.	OTC	34.75	0.72	12.55	36.50	30.00	7	1.20	3.45	9	39.22	0.89
Kemper Corp.	NYS	36.38	-4.28	53.16	43.13	17.13	364	0.92	2.53	66	34.20	1.06
Lawrence Insurance Group	ASE	9.00	-1.42	28.57	9.50	6.38	1	0.48	5.33	14	4.71	1.91
Liberty Corp.	NYS	45.00	2.27	9.42	50.25	39.00	17	0.92	2.04	15	23.86	1.89
Lincoln National	NYS	47.00	-3.85	9.30	56.00	30.75	230	2.72	5.79	10	45.16	1.04
NAC Re Corp.	OTC	39.00	-1.89	18.18	42.50	25.50	168	0.20	0.51	14	18.90	2.06
Navigators Group	OTC	32.00	-3.76	46.56	34.00	16.50	20	0.00	0.00	17	13.52	2.37
Nobel Insurance LTD.	OTC	3.88	-0.13	29.17	4.38	2.38	30	0.00	0.00	-	7.76	0.50
NWNL Companies	NYS	25.75	-2.39	52.59	33.00	11.75	317	1.40	5.44	6	42.73	0.60
Ohio Casualty Corp.	OTC	47.38	-0.79	15.55	49.00	26.75	90	2.48	5.23	10	36.38	1.30
Old Republic Int'l	NYS	29.50	-1.67	28.96	31.13	17.38	42	0.72	2.44	7	33.09	0.89
Orion Capital Corp.	NYS	28.88	0.86	65.00	29.13	13.00	14	0.92	3.19	9	20.42	1.41
Phoenix RE Corp. *	OTC	9.50	0.00	22.58	11.25	5.00	183	0.20	2.11	12	13.30	0.71
Protective Life Corp.	OTC	21.25	4.94	42.86	21.50	10.25	181	0.84	3.95	10	16.29	1.30
Provident Life	OTC	21.25	-1.16	21.43	26.25	12.00	306	0.92	4.33	6	25.88	0.82
Re Capital Corp.	ASE	18.00	0.00	39.81	18.63	11.75	27	0.20	1.11	13	15.05	1.20
RLI Insurance Corp.	NYS	14.63	-0.85	0.86	16.38	9.63	34	0.44	3.01	7	14.41	1.01
St. Paul Companies	OTC	63.75	-1.54	1.59	74.25	47.00	549	2.60	4.08	7	52.00	1.23
SAFECO Corp.	OTC	40.63	-1.52	23.57	44.75	25.13	1067	1.48	3.64	10	31.50	1.29
SCOR U.S. Corp.	NYS	14.00	-0.92	13.13	15.25	8.38	10	0.24	1.71	9	11.19	1.25
Seibels Bruce Group	OTC	7.38	-4.84	73.53	10.50	4.25	25	0.36	4.88	-148	7.35	1.00
Selective Ins. Group	OTC	15.50	-3.13	16.98	18.00	12.50	6	1.04	6.71	8	18.91	0.82
Statesman Group Inc.	OTC	3.19	15.93	103.97	3.00	1.25	421	0.00	0.00	-32	2.48	1.29
Tokio Marine & Fire	OTC	47.50	0.00	0.53	56.50	34.50	0	10.44	21.98	-	70.93	0.67
Torchmark Corp.	NYS	53.75	-1.38	9.97	58.50	38.00	318	1.60	2.98	13	16.70	3.22
Transamerica	NYS	32.88	-4.71	0.77	41.00	23.25	275	1.96	5.96	11	36.56	0.90
Traveler's Corp.	NYS	24.50	-1.01	47.37	31.88	11.50	694	1.60	6.53	-13	41.44	0.59
Trenwick Group Inc.	OTC	27.75	5.71	20.00	30.00	16.25	150	0.60	2.16	11	21.71	1.28
United Fire & Casualty	OTC	45.00	-1.10	28.11	58.00	28.75	0	1.32	2.93	8	35.39	1.27
USF&G Corp.	NYS	10.00	-5.93	33.33	29.00	7.00	1347	0.20	2.00	-1	11.96	0.84
UNUM Corp.	NYS	64.38	3.20	38.07	69.00	32.13	311	1.04	1.62	12	37.25	1.73
USLIFE Corp.	NYS	39.38	-0.32	40.63	41.75	23.25	71	1.64	4.17	10	60.34	0.65
Unitrin	OTC	38.25	-1.29	24.39	41.50	24.50	801	0.80	2.09	14	30.70	1.25
Washington National	NYS	14.50	-2.55	33.33	21.75	9.38	20	1.08	7.45	-7	26.86	0.54
USLICO Corp.	NYS	19.88	1.92	25.20	22.25	14.75	31	1.00	5.03	9	29.44	0.68
Zenith National Ins.	NYS	18.13	5.07	33.03	18.50	9.88	166	1.00	5.52	-76	13.14	1.38
INSURERS/REINSURERS	AVERAGE		-0.1	28.6					3.6	5.7		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	21.00	-10.64	37.70	29.75	8.88	699	0.00	0.00	18	5.44	3.86
HMO America Inc.	OTC	13.63	-16.82	109.62	17.13	4.25	688	0.00	0.00	17	0.61	22.34
Pacificare Health Sys.	OTC	31.75	-9.29	95.38	36.50	12.00	289	0.00	0.00	19	6.55	4.85
Safeguard Health Enter.	OTC	5.50	0.00	15.79	7.63	4.00	2	0.00	0.00	19	3.53	1.56
Sierra Health Services	ASE	20.88	-16.93	51.82	29.50	5.50	232	0.00	0.00	36	1.78	11.73
United Healthcare Corp.	OTC	44.00	-10.20	89.25	50.00	13.13	3679	0.06	0.14	29	3.76	11.70
United Medical Corp.	ASE	10.50	-2.33	31.25	11.38	6.63	8	0.20	1.90	13	8.79	1.19
U.S. Healthcare	OTC	31.13	-17.00	5.96	38.00	10.00	6843	0.32	1.03	23	3.38	9.21
HMOs	AVERAGE		-10.4	54.6					0.4	22		
ALL COMPANIES	AVERAGE		-1.2	29.2					3.0	8		

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