

Business Insurance

Reporting Weekly on Corporate Risk, Employee Benefit and Managed Health Care News / \$4

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CIGNA, S&P see eye-to-eye on BBB claims-paying rating

PHILADELPHIA—CIGNA Corp. has accepted a claims-paying ability rating for its U.S. property/casualty insurance business from Standard & Poor's Rating Services for the first time in three years, even though the new BBB rating is slightly lower than the BBB+ rating CIGNA asked S&P to withdraw in August 1993.

CIGNA accepted the rating for its active and inactive operations because of S&P's positive outlook for CIGNA, which "shows an understanding of the improvements

See Updates on next page

Judge strikes Louisiana RRG law

By JERRY GEISEL

BATON ROUGE, La.—Risk retention groups' ability to operate nationwide is safe, after a federal judge last week dismissed a Louisiana law that set numerous standards for groups licensed in other states seeking to do business in Louisiana.

The judge ruled that the federal Risk Retention Act pre-empts a 1995 Louisiana law that requires risk retention groups licensed in other states to maintain at least \$5 million in capital and surplus, post a \$100,000 bond or cash deposit and pay a \$1,000 fee before they can operate in Louisiana.

In addition, Louisiana's risk retention group application procedures, which require group officers and directors to submit a set of fingerprints and biographical affidavits also are pre-empted by the Risk Retention Act.

The Risk Retention Act "expressly pre-empted regulation of risk retention groups by any state other than the one which chartered the group," said U.S. District Court Judge John Parker in Baton Rouge, La.

Judge Parker's ruling is a victory for the nation's risk retention group industry. RRG advocates said that if Louisiana's law and licensing procedures had been al-

lowed to stand, it could have been a first step in the unraveling of the Risk Retention Act.

They warned that if Louisiana had prevailed, other states would have adopted similar licensing procedures and requirements.

"States would have had an opening to ignore the intended effect of the Risk Retention Act's pre-emption of state law and practice," said Philip Olsson, Washington counsel for the National Risk Retention Assn., the industry's trade group that challenged the Louisiana law, and a principal with Olsson, Frank & Weed P.C.

Had that occurred, it would

have gutted the basic regulatory structure for RRGs that Congress established when it enacted the Risk Retention Act, supporters say.

"Judge Parker's ruling is an important vindication of the regulatory framework established by the Risk Retention Act. Specifically, a risk retention group can operate nationwide after meeting the licensing requirements of its domiciliary state," said Jon Harkavy, chairman of the NRRA's government affairs committee and vp and general counsel in the Washington office of USA Risk Group, a captive and risk retention group manager.

If Louisiana had prevailed, the Risk Retention Act "functionally would have been gutted by making it as difficult to form and operate a risk retention group as a commercial insurance company," Mr. Harkavy added.

Louisiana Department of Insurance officials said they are now reviewing Judge Parker's decision.

In papers earlier filed in court on its behalf, the state Insurance Department said it was not trying to regulate non-domiciliary RRGs, but "rather satisfy itself that they are financially suitable to conduct business and provide

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Dueling bids for Tempest Re

ACE, IPC in battle to acquire Bermuda catastrophe reinsurer

By GAVIN SOUTER

HAMILTON, Bermuda—A late \$943 million bid for Tempest Reinsurance Co. Ltd. by rival catastrophe reinsurer IPC Holdings Ltd. could trump an earlier bid by ACE Ltd. in a battle that is

being noted as much for the personalities involved as for the money on the table.

In dollar terms, the IPC offer beats the approximately \$810 million offered to Tempest shareholders by ACE and it comes just two weeks prior to

the proposed closing date for the ACE offer, which was made in February.

ACE said last week that it would not immediately sweeten its offer in light of the new bid.

IPC, whose largest shareholder is American International Group Inc., would become the third-largest catastrophe reinsurer in Bermuda if its bid is accepted. Regardless of the outcome, the new bid could signal the beginning of consolidation in the Bermuda market, analysts say.

An IPC deal would be a setback for the diversification plans of ACE Chairman Brian Duperreault, who has led ACE's expansion into several new lines of business since he took over at the excess liability insurer in October 1994 (*BI*, Oct. 24, 1994).

A successful IPC bid would also be seen as a victory for Mr. Duperreault's former boss: AIG Chairman Maurice Greenberg. AIG is IPC's largest shareholder, with a 24% stake, and the reinsurer's chairman, Joseph C.H. Johnson, is also chairman of AIG's Bermuda subsidiary.

In fact, traces of AIG are found on all sides of the deal. AIG owns 5% of

See Tempest Re page 22

Amoco victory overturned

Insurer bad faith award based on faulty jury instructions: Judge

By JOANNE WOJCIK

LOS ANGELES—Amoco Chemical Co.'s \$386 million punitive damage windfall in a bad faith case became a \$4 million shortfall last week when a California appellate court overturned the verdict and ordered the company to pick up its insurers' costs.

The December 1993 jury verdict in *Amoco Chemical Co. vs. Lloyd's of London et al.* was considered the largest punitive damage award ever in an insurance bad faith case (*BI*, Dec. 13, 1993).

However, the trial court later reduced the punitive damage amount to \$71 million in response to insurers' post-trial motions.

Now, not only does Amoco lose \$106 million—including compensatory damages, legal fees and interest—but it also must pay insurers' cost of obtaining a bond for 1.5 times the amount of the award while the case was on appeal.

The unpublished decision by the 2nd District California Court of Appeal in Los Angeles turned on one issue: an error in the definition of the word "accident" used by the trial court in its jury instructions.

Insurer attorneys argued that "accident" should be construed as a sudden, unexpected event, citing California case law dating back 100 years. But Amoco maintained that California law does not require that an accident be sudden.

On appeal, the 2nd District Court sided with the insurers and remanded the case for a new trial.

"It is far more probable than not that a different jury instruction would have resulted in a substantially different calculation of damages," Justice Miriam Vogel wrote in the 20-page decision issued June 4. "It follows that the entire judgment must be reversed and the matter remanded for a new trial of all issues."

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Bermuda triangle

Tempest Re is the object of a bidding war between ACE Ltd. and IPC, whose largest shareholder is AIG

Maurice Greenberg



IPC's bid
approximately
\$943 million

Source: Tempest Reinsurance Co. Ltd.

Tempest Re

\$177.6 million in 1995
premium volume

\$692.3 million in
capital and surplus



Brian Duperreault

ACE's bid
approximately
\$810 million

GRAPHIC BY TONY BUCCINI

Health reform haggling continues

By JERRY GEISEL

WASHINGTON—Senate and House Republicans are inching closer to reaching agreement on legislation that would curb pre-existing medical condition provisions in health care plans.

Congressional Republicans met last week to try to resolve several major differences in the two bills passed earlier by the House and Senate.

Negotiators made some—but not complete—progress in ironing out those differences. If and when all differences are resolved, a conference

committee would formally approve the measure and it would be sent back to the House and Senate for final approval.

The key stumbling block, though, is medical savings accounts. The House bill includes a provision that would allow employers to make annual tax-deductible contributions to MSAs of \$4,000 for family coverage and \$2,000 for individual coverage. Employees could then withdraw those funds from MSAs tax-free to pay for uncovered health care-related expenses. The Senate bill lacks an MSA provision.

Numerous compromises were being discussed last week by Republicans. Under one compromise, tax law would be changed so employers could offer MSAs for five years. Afterwards, it would be up to Congress to decide whether to reauthorize the tax-favored status of MSAs.

Other compromises being discussed include limiting MSAs—at least initially—to very small employers, perhaps those with fewer than 50 employees.

The Clinton administration has denounced MSAs, but lobbyists pre-

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Bad faith suit
may turn on
ruling ...Page 3

Updates

CIGNA accepts S&P rating

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we've made and are able to make," a CIGNA spokesman said.

S&P cited CIGNA's improved U.S. property/casualty insurance operating results for 1996 and business profile. "More importantly," S&P said, it "believes these improvements are sustainable."

That outlook largely is based on CIGNA's reorganization earlier this year, said Philip Tsang, director of S&P's insurance rating services. The insurer isolated 80% of its environmental and asbestos liabilities in a separately capitalized runoff facility in February. A group of rival insurers and policyholders is still challenging the restructuring, despite its approval by state regulators.

For the first quarter of 1996, operating earnings for CIGNA's active and inactive operations increased to \$13 million from a \$37 million loss in the same period last year. First-quarter results this year include higher-than-average catastrophe losses, S&P noted.

The combined ratios for CIGNA's active operations for first-quarter 1996 improved to 115.2% for its domestic operations, 95% for its international operations and 104.9% overall, the CIGNA spokesman said. For first-quarter 1995, the restated combined ratios were 118.8% for the domestic operations, 97.5% for the international operations and 108.7% overall. The restatement reflects CIGNA's restructuring.

S&P in 1993 attributed its downgrade of CIGNA's claims-paying ability to BBB+ from A to poor underwriting results over several prior years (BI, Aug. 23, 1993). S&P also questioned CIGNA's commitment to its property/casualty units, even though CIGNA had contributed \$150 million to surplus that year.

ELIC payout improves

LOS ANGELES—Policyholders of defunct Executive Life Insurance Co. are now expected to receive an average of 92.5 cents on the dollar on their policies, and a final payout may come as early as next spring.

The settlements are larger than the 86 cents on the dollar that regulators originally promised to policyholders not made whole by state guaranty funds, said California Insurance Commissioner Chuck Quackenbush.

ELIC, which had invested 60% of its assets in junk bonds, became insolvent when the junk bond market collapsed in 1991.

California is close to liquidating the last of ELIC's assets.

Cats widen underwriting loss

NEW YORK—Insurers suffered an underwriting loss of \$4.9 billion during the first quarter of 1996, according to estimates by the Insurance Services Office Inc. and the National Assn. of Independent Insurers.

That underwriting loss compared with an underwriting loss of \$3 billion during the same period a year earlier, and reflected higher than normal catastrophe losses. The underwriting loss was largely offset, however, by nearly \$4.7 billion in realized capital gains by insurers during the first quarter, more than six times the \$763 million in capital gains registered during the same period a year earlier.

The capital gains helped drive the industry's consolidated aftertax income for the first quarter to \$7.2 billion, up 35.8% from the \$5.3 billion reported for the same period a year earlier. Consolidated policyholders surplus grew to \$237.2 billion during the first quarter, up 16.8% from \$203 billion during the same three months of 1995. But the industry's combined ratio deteriorated by nearly 3 percentage points to 106.7% during this year's first quarter from 103.8% during the same period a year earlier.

Sean Mooney, senior vp and economist of the Insurance Information Institute, warned that the industry cannot rely on capital gains forever to make up underwriting losses.

"The industry cannot sustain its profitability by capital transactions. Eventually the stock of underpriced assets runs out, as it did before in 1994, when the industry had a realized capital gain of only \$1.7 billion. Sustained profitability has to come from the fundamentals of pricing, selecting risks and controlling expenditures," he said.

Safety probe of L.A. subway

LOS ANGELES—The California Occupational Safety and Health Administration is investigating allegations of safety hazards in a section of subway tunnel being dug beneath Hollywood.

"We are investigating every aspect of the allegations raised by the complaints," a Cal-OSHA spokesman said. Among the alleged hazards being investigated are oil, fuel and sludge floating on water on the tunnel floor and electrical cables under fuel-tainted water in other areas.

However, officials of the Los Angeles Metropolitan Transportation Authority maintain that the hazards were removed months ago.

The safety probe was started in response to a list of allegations and photographs sent to Cal-OSHA last month by Hollywood Damage Control & Recovery Inc., an organization of business and property owners that is suing the MTA over damage allegedly caused by subway construction (BI, April 3, 1995).

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Errors & omissions

- A May 27 story listed an incorrect telephone number for those wanting more information on the Western Pension & Benefits Conference Seattle Chapter Spring Seminar. Conference information is available from Beverly R. Maggs at 206-624-7940.

- The June 3 directory of alternative risk financing facilities incorrectly listed MEDMARC Insurance Co. Inc. as MEDMARK. Also, the policy form for Intergovernmental Risk Management Agency was incorrectly listed as claims-made and occurrence. The policy form should have been stated as occurrence.

NAIC mulls deregulation

Industry lends strong support at commissioners' hearing

By MEG FLETCHER

NEW YORK—State insurance regulators are moving forward with plans to determine how best to deregulate commercial insurance, after industry representatives voiced strong support for the concept at a public hearing last week.

Comments from buyers, brokers and insurers at the National Assn. of Insurance Commissioners' summer meeting in New York last week supported the notion that sophisticated commercial purchasers have sufficient information, expertise and bargaining

power when purchasing property/casualty insurance that they do not require the same level of regulatory protection as small commercial and personal lines consumers.

NAIC

"The time for customizing regulations to fit distinctive differences in consumer needs is at hand," said Richard C. Heydinger, director of risk management services at Hallmark Cards Inc. in

Kansas City, Mo.

Knowledgeable insurance consumers with full-time risk management staff need only to be assured of "full disclosure by suppliers and supplier solvency," not rate and form limitations, he said.

Mr. Heydinger testified during a two-hour hearing at the NAIC meeting.

"Reforms—such as the exemption of industrial insureds from rate and form regulations, removal of barriers to the surplus lines market, and adoption of a single tax allocation and collection scheme in multistate transaction—See NAIC on page 21

EPA touts cleanup reforms

By MARK HOFMANN

WASHINGTON—Although the Clinton administration is taking a step toward easing Superfund's imposition of retroactive liability, it remains far from willing to grant reform advocates' wishes that the controversial mechanism be abolished.

The Environmental Protection Agency is instituting four reforms "to fundamentally improve the Superfund program by limiting the costly role of lawyers and increasing community participation," EPA Administrator Carol M. Browner said last week.

Of the reforms, the most significant is "guidance" for EPA regional offices concerning the liability of businesses and municipalities responsible for only a small amount of waste at Superfund sites. Under the guidance, EPA officials are not to pursue so-called "de micromis" contributors that accounted for up to 110 gallons or 200 pounds of materials containing hazardous substances at a Superfund site.

Those figures are double the amount of waste permitted before a party faces retroactive liability under the EPA's previous policy. Parties responsible for 0.2% of a site's total volume also will be exempt from retroactive liability if the party sent only municipal solid waste to the site.

The EPA also will shield such small parties from third-party Superfund lawsuits, said Ms. Browner.

In addition, the EPA will increase the amount of money available—See Superfund on page 21

BI conference to focus on workers comp issues

By ROBERTO CENICEROS

Confronting workplace violence, cost-containment performance

THE FOURTH ANNUAL
Business Insurance
WORKERS COMPENSATION
CONFERENCE

measurement and accessing capital markets to finance fortuitous risks are among scheduled topics at the Fourth Annual Business Insurance Workers Compensation

Conference.

The conference, to be held Nov. 6-8 at the Ritz Carlton Huntington Hotel in Pasadena, Calif., will feature nearly three-dozen experts in workers comp or related fields.

"We are committed to producing a world-class conference that explores cutting edge practices employers can use to control their workers comp costs," said Conference Chairman Kathryn J. McIntyre, Business Insurance publisher and editorial director. "The speakers who will be attending are among the best in their fields so both seasoned risk managers and novices will gain insights that can be put to practice."

"The professionals who return—See Conference on page 23

Democratic convention elects cover

CHICAGO—The city of Chicago will have a comprehensive insurance program, including \$110 million in general liability insurance, to cover August's Democratic National Convention.

Caroline Cogtella, the city's risk manager, said a St. Paul Cos. Inc. unit will provide the primary liability layer, with limits of \$1 million. The other insurers involved in the general liability program are Chubb & Son Inc., Zurich-American Insurance Group and American International Group Inc. units American International Specialty Lines Insurance Co. and Lexington Insurance Co.

St. Paul also is writing workers compensation, automobile liability and property coverage, each with limits of \$1 million. AIG subsidiary Illinois National Insurance Co. is writing \$1 million in crime coverage and \$5 million in directors and officers liability insurance for the city's bipartisan host committee, Chicago '96.

The program provides coverage for the Democratic National Convention Committee; United Center Joint Venture, which owns the convention site; and Chicago '96.

Community Insurance Center Inc. was the lead broker for the coverage. Other brokers include The Owens Group, Insurance Council Agency and The Spanish Community Insurance Center Inc., or SPANCO.

The city had advertised for proposals from qualified minority-owned and women-owned companies. Both Community Insurance Center and The Owens Group are African-American-owned; Insurance Council Agency is owned by a woman and SPANCO is Hispanic-owned.

—By Mark A. Hofmann

Inside

- A judge's ruling striking down Louisiana's risk retention group restrictions is welcome news, this week's editorial says. **PAGE 8**

- A new benefit program is helping detect cancer early in a Texas company's employees. **PAGE 12**

- Argentina is converting to a U.S.-style workers comp system. **PAGE 17**

- Insurers have agreed to settle claims from a 1989 soccer stadium clash in Sheffield, England, in which 95 people died. **PAGE 19**

- General Motors and Rockwell International are appealing two large punitive damage awards. **PAGE 19**

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Brokers told to stick to sales

By SALLY ROBERTS

COLORADO SPRINGS, Colo.—Insurance brokers need to stick to the basics of selling insurance and leave other risk management services to insurers.

That is the advice of Maurice R. Greenberg, chairman and chief executive officer of American International Group Inc. in New York, who spoke during a session at the National Assn. of Insurance Brokers annual convention held last week in Colorado Springs, Colo.

"If you stay on your side of the fence and we stay on ours, we'll get along great," Mr. Greenberg told brokers, referring to the "hand wrestling" occurring in the industry as to who should provide what services to corporate clients.

When asked what was his side of the fence, Mr. Greenberg quickly pointed out that AIG does "more than just pro-

vide capacity. Yes, we provide risk management consulting," he said. And "if you go back in history, AIG was the first captive manager."

"The insurance company has to provide historic services" like underwriting, claims management, captive management and risk management consulting, he said. In the past, for example, any time brokers have gotten into underwriting, "it has not been a pretty



NATIONAL ASSOCIATION OF INSURANCE BROKERS

picture."

"Brokers need to do what they do best and that is sell business," he said.

During the contentious, and oftentimes combative question and answer portion of the session, Mr. Greenberg also cautioned brokers "to be careful" about supporting the direct market

distribution system.

There is one direct writer "that underwrites most of the workers compensation business in the United States, and it is being supported to expand by the brokerage community," he said, in an obvious reference to Liberty Mutual Insurance Co.

Maybe a mixed distribution system is the way it should be, Mr. Greenberg reasoned. "Let the marketplace decide and the most creative will survive."

Indeed, the marketplace is changing constantly. "Never before in history is so much change happening in our lives," Mr. Greenberg said. He warned brokers, though, that "while change is generally good, it can be mismanaged."

Efficiency and creativity are keys to successfully managing change, according to Mr. Greenberg.

"The most creative, most efficient and most differential (broker) will

See Greenberg on page 21

NAIB pushes for deregulation

By SALLY ROBERTS

COLORADO SPRINGS, Colo.—The National Assn. of Insurance Brokers is throwing its weight behind efforts to deregulate the commercial insurance market for large, sophisticated corporate buyers.

While the NAIB has always supported less regulation for large commercial risks, the broker group is now looking to individual states, not the federal government, for relief in this area.

The broker group's position, which was outlined by Larry R. Sorensen, outgoing chairman of the National

Assn. of Insurance Brokers, during the organization's annual convention in Colorado Springs last week, comes on the heels of several regulatory reform developments occurring at the state level.



NATIONAL ASSOCIATION OF INSURANCE BROKERS

Those efforts—which were undertaken independently by insurance regulators in Massachusetts, New York and Oregon—have all explored insurance law reform, explained Mr. So-

rensen, who also is executive vp-corporate marketing for Aon Risk Services Cos. in Chicago.

In Massachusetts, a special task force that was appointed to examine ways to streamline financial and insurance regulations recommended that insurance products sold to "sophisticated commercial insurance buyers" be exempt from rate and form regulation as well as from guaranty fund protection and assessment (see story, page 2).

New York Superintendent of Insurance Edward J. Muhl last year proposed eliminating or radically

See Deregulate on page 21

Court finds coverage for failed manufacturer

By DAVE LENCKUS

TULSA, Okla.—Cooper Manufacturing Corp., a mom and pop oil rig manufacturer when it first opened for business around 1918, survived steel shortages during world wars and worldwide economic turmoil to grow into a market leader.

After 66 years, though, its fortunes changed suddenly and drastically.

Tulsa, Okla.-based Cooper filed for bankruptcy in 1984 and was unable to emerge as an ongoing concern.

What survives 12 years later is a morass of litigation that ultimately may determine whether Cooper finally faced market



Product liability claims that are blamed for the demise of Cooper Manufacturing in 1984, are to be covered by the oil rig maker's insurers.

troubles it could not conquer or its general liability insurers held it under the bankruptcy waters until the company drowned in product liability claims.

A U.S. Bankruptcy Court ruling on May 29 bolstered claims by Cooper's trustee that insurers acted in bad faith and caused Cooper's demise with their handling of product liability claims, attorneys for the trustee say.

The court ruled not only that Cooper's liability coverage should respond to the claims, but also that the insurers failed to investigate the underlying claims, did not defend Cooper and improperly complicated underlying litigation against Cooper.

See Cooper on page 6

Florida law may skirt ERISA

By MICHAEL BRADFORD

TALLAHASSEE, Fla.—Florida legislators want to provide extended benefits to thousands of employees at small companies under a recently enacted law that extends coverage to workers who lose their jobs.

Whether legislators are able to do so could depend on whether the Florida Health Insurance Coverage Continuation Act runs afoul of the federal Employee Retirement Income Security Act, which pre-empts any state law or regulation relating to employee benefit plans.

Some ERISA experts point out that the Florida law, which was signed last month by Gov. Lawton

Chiles and is effective Jan. 1, 1997, does not conflict with ERISA because it requires insurers—not employers—to provide continuation of coverage as part of group health plans written for companies with fewer than 20 employees.

The federal Consolidated Omnibus Budget Reconciliation Act of 1985 provides continuation of benefits for workers at companies with 20 or more employees. The intent of the Florida law is to give workers at small companies the same option of taking coverage with them when they leave their jobs.

The Florida law is "in the nature of mandated benefits," said John Eggertsen, a partner and

ERISA specialist at the Detroit firm of Honigman Miller Schwartz & Cohn. "Chances are that it would not be pre-empted."

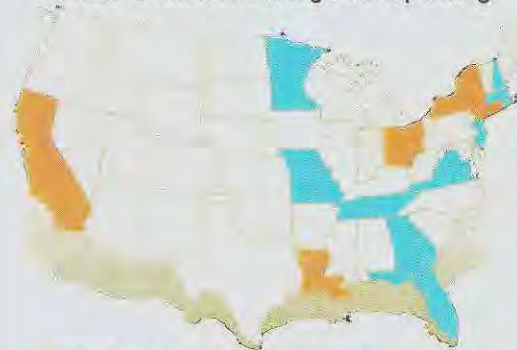
States typically mandate benefits that insurers must provide as part of group health plans because ERISA won't allow states to enact statutes requiring employers to change their plans.

Mr. Eggertsen said language in the Florida law is carefully written to make it clear that, unlike COBRA, the state's regulations apply to health insurers and not employers. And because it applies only to group health plans written by insurers, companies that self-fund plans are not required to offer the continuation benefit.

See Florida on page 14

Special coverage mandates

Fifteen states* have either enacted legislation mandating coverage of autologous bone marrow transplants in treating breast cancer or have similar legislation pending.



ABMT legislation pending

ABMT legislation already enacted

* As of December 1995
Sources: U.S. General Accounting Office, American University Law Review

GRAPHIC BY KIM ROME

More plans cover cancer treatment, GAO study finds

By DEBORAH SHALOWITZ COWANS

Health insurers increasingly are paying for a so-called "experimental" treatment for breast cancer—high-dose chemotherapy followed by autologous bone marrow transplant.

Experts and a recent report by the U.S. General Accounting Office say several factors are responsible for the increased willingness of health insurers to pay for the treatment: clinical evidence of the treatment's success, fear of litigation, adverse publicity for denying coverage and state laws mandating coverage.

The GAO and ABMT experts caution, however, that there is no definitive research based on large, random clinical trials about the effectiveness of the treatment. The treatment involves attacking a patient's breast cancer with doses of chemotherapy that are much higher than those usually used. That treatment also kills the patient's bone marrow, so doctors must inject the patient with her own, previously drawn marrow after the chemotherapy is completed.

"There's been a steady increase" in the number of health insurers paying for the treatment, said Karen Illuzzi Gallinari, a partner with Anderson Kill Olick & Oshinsky P.C. in New York, which represents group health plans and medical centers in coverage disputes.

"It would appear that more coverage is being offered for this" treatment, agreed Kyl Green, executive vp of the Health Insurance Assn. of America in Washington. However, the HIAA does not have data on how many of its members cover the treatment.

"As a general principle, I find increased willingness" on the part of health plans to pay for ABMT, said Dr. See ABMT on next page

Comparing benefit continuation laws

Consolidated Omnibus Budget Reconciliation Act of 1985

- Federal law requires employers to continue benefits
- Benefits continue under insured and self-insured plans
- Applies to firms with 20 or more workers
- Employee pays 102% of group plan rate
- Coverage lasts for 18 months in most cases

Florida Health Insurance Coverage Continuation Act of 1996

- State law requires group health insurers to continue benefits
- Benefits continue under insured plans only
- Applies to firms with fewer than 20 workers
- Employee pays up to 115% of group plan rate
- Coverage lasts for 18 months in most cases

GRAPHIC BY KIM ROME

ABMT

Continued from previous page

Roy Jones, director of the bone marrow transplant unit of the University of Colorado Health Sciences Center in Denver.

"It's extremely likely self-funded employer plans or indemnity insurers will reimburse for this," he said. Among HMOs, "many do, but many do not" pay for the treatment.

The GAO based its conclusions on information collected from 12 health insurers: Aetna Health Plans, Anthem Health Plan of Florida, Blue Cross and Blue Shield of Oregon, CNA Insurance Cos., Harvard Pilgrim Health Care, HealthGuard of Lancaster, HealthPartners, Kaiser Permanente, Mutual of Omaha Insurance Co., Prudential HealthCare Group, United HealthCare Corp. and United HealthCare of Ohio.

ABMT has been performed in the

United States since the early 1980s, Dr. Jones said. "Tens of thousands have received this treatment for breast cancer in the United States."

An estimated 4,000 breast cancer patients received ABMT—which costs between \$80,000 and \$150,000—in 1994, the GAO said.

But, "most of the medical literature and nearly all of the experts we spoke with said that the current data are not yet sufficient to make definitive conclusions about the effectiveness of ABMT and about which groups of breast cancer patients would be most likely to benefit," the GAO report said.

"Although there are wide differences of opinion about the appropriate use of ABMT, nearly all sides of the debate agree that the results of randomized clinical trials are needed to provide definitive data on the treatment's effectiveness," the report said.

The National Cancer Institute cur-

rently is sponsoring three random clinical trials in which breast cancer patients are assigned randomly to a group for either conventional treatment or ABMT, but enrollment is small because breast cancer patients can receive ABMT in so many places without participating in a clinical trial, experts explain.

"This kind of irreversible spread of coverage... has had the unintended consequence of hindering the research process," pointed out Thomas Johnson, a partner in the Omaha, Neb., firm of Baird, Holm, McEachen, Pedersen, Hamann & Strasheim. "I'm not sure we'll ever get reliable data on ABMT and breast cancer."

Instead, ABMT should be done only in certain hospitals so that research results based on a larger number of cases can be obtained, several experts suggested.

However, physicians must tell health insurers ABMT is a treat-

ment—not research—so that insurers will cover the cost, Dr. Jones said.

One expert even called ABMT overrated. "The entire perception that this is a therapy that is going to improve health status or provide a cure is technically wrong," said Jeffrey Lerner, vp for strategic planning at ECRI, a non-profit technology assessment agency in Plymouth Meeting, Pa. "If you look at the evidence, people will live longer with conventional therapies for breast cancer than with ABMT."

Last year ECRI published an analysis of medical literature stating that the overall survival rate for metastatic breast cancer patients was no greater for those receiving ABMT instead of conventional treatments.

The 12 health insurers contacted by the GAO said that although they normally do not pay for experimental treatments, they cover ABMT for breast cancer because "it has become widely used and... the existing re-

search suggests it may be beneficial to certain patients."

But, the "insurers told us a variety of non-clinical factors also strongly influenced their coverage policy, such as the threat of litigation, public relations concerns and government mandates," the report said.

Before changing policies to cover ABMT for breast cancer, half of the insurers contacted by the GAO had been sued for denying coverage for the treatment, the report said.

Health insurers increasingly are paying for ABMT because "they're tired of being sued and there's so much public pressure to pay for this," said Mr. Lerner.

Ten states as of December 1995 had laws requiring insurers to cover ABMT for breast cancer patients. "Some of these laws are mandates requiring that coverage of ABMT for breast cancer be part of any basic package of health insurance," the report explains. "Other laws simply require that the treatment be available as a coverage option, at perhaps a higher premium."

Five other states as of late last year were considering legislation on ABMT coverage for breast cancer patients. **BI**

BI announces staff promotions

CHICAGO—*Business Insurance* is promoting two editorial staffers.

Effective June 15, Roseanne C. White will be managing editor and Regis J. Coccia will be assistant managing editor.

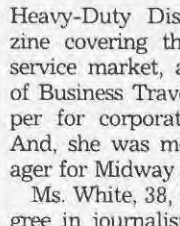
Ms. White succeeds Timothy J. Stanton, who is leaving *BI* to pursue a law career with Gardner Carton & Douglas in Chicago.

Ms. White, who is based in *BI*'s Washington office, will manage editorial staff, help set editorial policy and continue to be the magazine's chief news editor. She has served as assistant managing editor-news since June 1994 and previously was a copy editor.

Before joining *BI* in December 1991, she was editor of *FLASH*, a magazine for creative professionals in advertising and graphic design. She also was editor of



Ms. White



Mr. Coccia

Heavy-Duty Distribution, a magazine covering the truck parts and service market, and Midwest editor of *Business Travel News*, a newspaper for corporate travel managers. And, she was media relations manager for Midway Airlines in Chicago.

Ms. White, 38, holds a master's degree in journalism from Northwestern University's Medill School of Journalism in Evanston, Ill., and a bachelor's degree in political science from Northwestern. She can be reached at 202-662-7216.

Mr. Coccia, based in Chicago, will manage the newsroom's day-to-day operations, including copy editing.

Mr. Coccia, 27, has served as a copy editor and managed *BI*'s Agent/Broker Topics and Insurer Topics demographic sections. He joined *BI* in February 1993.

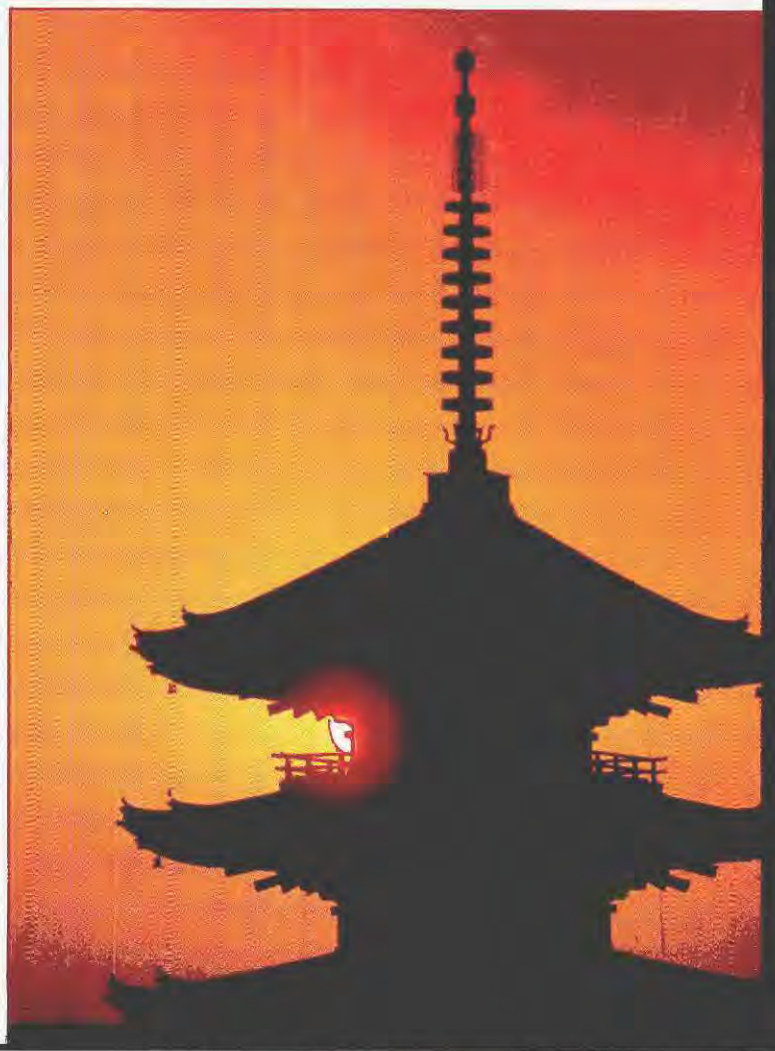
He had been assistant city editor at The Jasper, Ind., Herald. He interned at The South Bend, Ind., Tribune while earning a bachelor's degree in American studies at the University of Notre Dame in Notre Dame, Ind. He can be reached at 312-649-5274. **BI**

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The business insurance experts.



Cooper

Continued from page 3
per.

The court's decision is not final and does not award specific damages, though attorneys estimate that \$81.4 million of limits are at stake. It also stops short of saying the insurers engaged in bad-faith activities—a charge brought by Cooper's trustee in an Oklahoma federal district court.

Attorneys for Cooper's trustee, former Cooper President Jon Barton, who filed the bad-faith case, say the decision is helpful in proving the insurers' actions caused the death of the company. In the separate bad-faith action, Mr. Barton seeks hundreds of millions of dollars of damages for Cooper's estate, including treble damages under Texas' Deceptive Trade Practices Act as well as punitive damages.

"If the coverage had been there, we think Cooper could have come out of bankruptcy," said trustee attorney Mark E. Klein, a partner with Anderson, Kill, Olick & Oshinsky P.C. of New York.

The bankruptcy court's decision should "send a signal to the industry that it can't abandon companies when the coverage they purchased is most needed," said another trustee attorney, J. Denny Moffett, a partner with McKenzie, Moffett, Elias & Books P.C. of Tulsa, Okla.

But, describing the litigation as a uniquely bizarre coverage dispute, the insurers' attorneys say the courts still have to resolve more issues that raise additional coverage questions.

"This case is long from being over with," said Bill Grimm of Barrow Gaddis Griffith & Grimm in Tulsa. Mr. Grimm represents Cooper's excess insurers: Harbor Insurance Co.; Harbor successor Greenwich Insurance Co., a subsidiary of NAC Reinsurance Corp.; and Continental Insurance Co., which has assumed Harbor's obligations to Cooper's trustee.

The case centers on the product liability claims that Cooper customers began filing in 1984 because of defects in the so-called workover drilling rigs that Cooper had begun manufacturing in the late 1970s. Those truck-mounted rigs are used to clean out material from oil pits that could interfere with the oil drilling process, Mr. Klein explained.

In 1984, a Cooper welder found stress cracks in some of the company's steel tubing inventory, which Cooper had obtained from Babcock & Wilcox Co. and USX Corp. unit U.S. Steel Group. Such flawed tubing could render a rig unreliable and dangerous.

During the next year, court papers say, Cooper informed its insurance agent, The Holmes Organization, of:

- Letters it sent customers to warn them of the potential danger the rigs posed.
- Product liability lawsuits claiming property damage that its customers were filing in Texas.
- Its July 1984 filing for protection under Chapter 11 of the U.S. Bankruptcy Code because of its potential liability from the rig-related claims.

The steel suppliers also sued Cooper, alleging that defective welds in the rigs were to blame for some of the claims. Cooper discovered and changed its flawed welding procedures in 1983.

Soon after Cooper sent the warning letters, Holmes President Kent Bogart informed a Cooper official that he thought the company's insurance would not cover the claims.

Cooper's primary insurer was The Home Indemnity Co., which later became The Home Insurance Co. The Home covered Cooper from December 1979 until October 1984, writing \$100,000 of limits annually that would cover third-party property damage. About \$400,000 of that coverage still is available to cover claims against Cooper, Mr. Klein said.

In addition, each of the last two primary policies provided \$500,000 of advertising liability coverage, he said.

Harbor provided excess and umbrella insurance during the same period. Policy limits ranged from \$1 million to \$20 million annually and \$80 million in the aggregate, all of which is still available, according to Mr. Moffett.

Under a December 1987 settlement with Cooper, the steel producers agreed to pay the rig maker \$18 million. Cooper's insurers had

been apprised of the settlement negotiations, court papers say.

Babcock & Wilcox's insurers covered most of the settlement because B&W supplied most of Cooper's tubing, said Arden J. Lea of Tynan & McGehee in New Orleans, who represents the steel suppliers in the litigation. USX either was self-insured, or its contribution fell within a self-insured retention, he said.

Meanwhile, The Home had begun notifying Cooper that it would defend the company in the original product liability litigation filed in Texas only if the insurer could withdraw at any time. In 1989, Cooper began demanding that the insurers either grant or deny coverage.

The Home and Harbor, neither of which had formally denied coverage, also petitioned to intervene in the original Texas product liability case to ask the court to rule on

their duty to indemnify Cooper. The Home argued, among other things, that Cooper did not provide timely notice of the claims.

During that case, Cooper was represented by five attorneys, including Mr. Moffett. At least two pulled out citing a conflict of interest in having to represent both Cooper in the underlying action and The Home in its coverage dispute against Cooper.

The Texas court judge in 1990 ordered the coverage and liability cases severed, but that did not occur before he dismissed the litigation in 1991, attorneys said. A Texas appeals court overturned that decision a year later, ruling the lower court improperly decided coverage issues before resolving liability issues, Mr. Klein said. The case is pending in the lower court.

In his ruling late last month, U.S. Bankruptcy Judge Mickey D. Wilson ruled that the defective steel

primarily caused Cooper's rigs to be unreliable. Cooper's own welding errors were only incidentally at fault, he found.

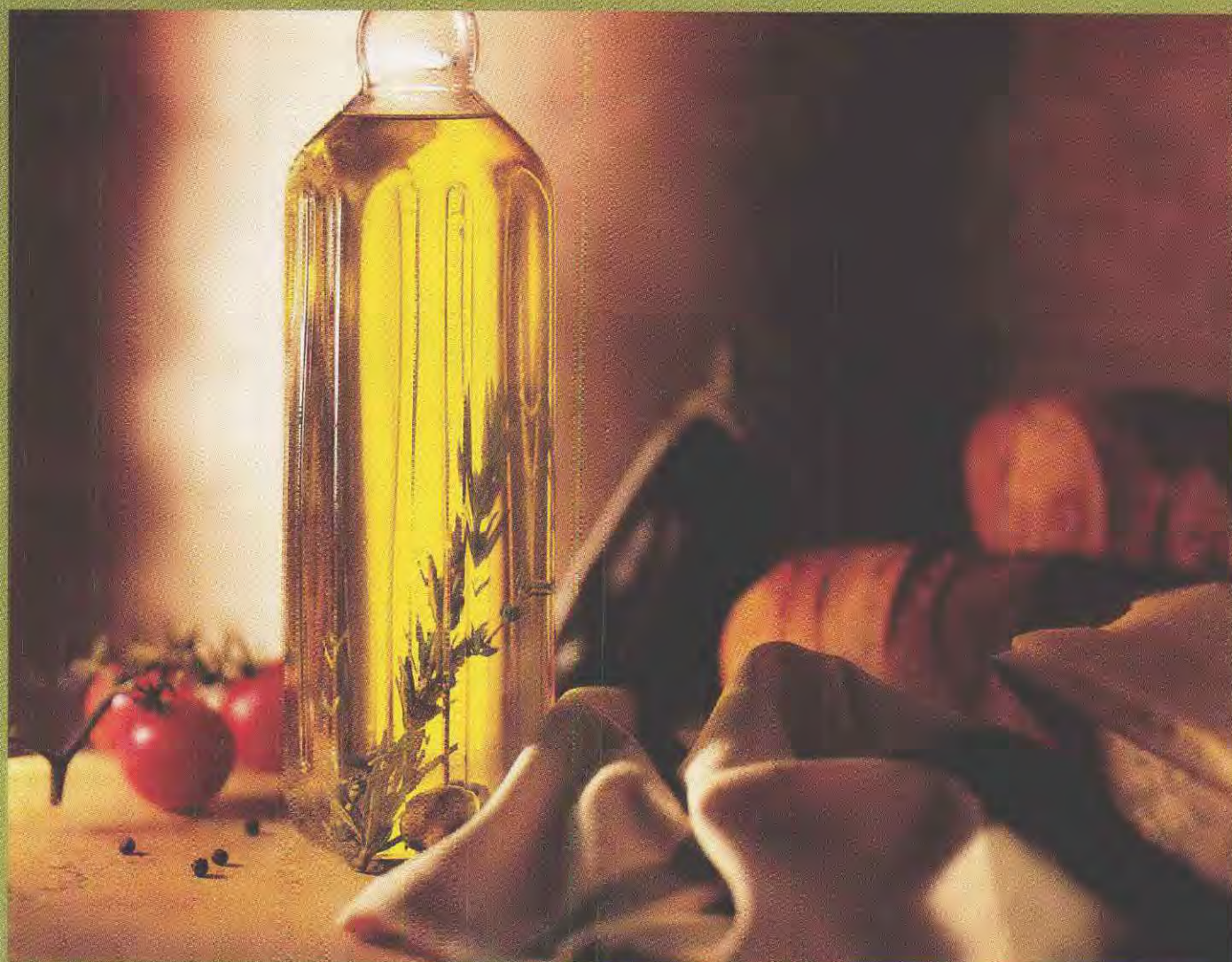
Cooper's insurance covers the rig product liability claims, and Cooper and its trustee did not violate any policy conditions, the judge said. Covered damages include most inspection costs; rig stacking and unstacking costs; rig replacement costs; and customers' loss of gross margin, general and administrative costs and loss of use of collateral property, he said. Other exclusions do not apply to the product liability claims, he ruled without elaborating.

Judge Wilson also ruled that Cooper's warning letters to clients did not constitute a recall, the costs of which would be excluded under Cooper's policies.

He also found that The Home and Harbor never investigated the

Continued on next page

It's terrific on salads,
great on pasta,
and makes one heck
of a fire.



Continued from previous page
rig product liability claims.

While The Home hired an attorney for Cooper in the original Texas case, it did so only days before the case was set to go to trial, and Harbor never agreed to defend Cooper, Judge Wilson said.

He also found that the insurers improperly intervened in the Texas product liability case because Texas case law prohibits trying underlying liability disputes and coverage disputes in the same case. In addition, The Home created a conflict of interest for attorneys representing Cooper in the product liability case by requiring them to also represent the insurer in the coverage dispute portion of the case, Judge Wilson ruled.

Mr. Klein called the findings "extremely helpful" for the trustee's ongoing bad-faith case against the insurers.

"The insurance companies com-

plied with every obligation they had under the policies, under the circumstances presented to them," said attorney Richard Dan Wagner of Wagner, Stuart & Cannon in Tulsa, who represents The Home.

Mr. Grimm, Harbor's attorney, said there are several issues that still could bar coverage once they are resolved.

For example, he said, Cooper sold its insurance policies to Chicago-based Allied Products Inc. in a liquidation sale. Although Judge Wilson earlier ruled, and reiterated in his latest decision, that Cooper owns the policies, the insurers want the judge to review new evidence that they say shows the policies were not among the assets Cooper retained.

Mr. Moffett responded that Allied has submitted an affidavit that it does not own the policies.

Mr. Grimm asserted that other than some claims in Texas court

that the insurers did investigate but were settled, no other lawsuits existed. The other claims were filed in bankruptcy court, and Cooper never asked the insurers to defend those claims, he said. "How many insurance companies cover bankruptcy claims?" he asked.

Mr. Moffett responded that a claim amounts to a lawsuit and that Judge Wilson prohibited further litigation against Cooper except in the bankruptcy case.

The insurer attorneys also question whether Cooper—even if it had not faced the rig claims—could have survived the steep downturn in Oklahoma's oil industry during the early 1980s. Mr. Grimm said

Cooper's trustee has acknowledged that the downturn led to the sale or bankruptcy of nearly all leading workover rig producers.

Cooper also was in debt, Mr. Grimm said. He added that the rig claimants did not force Cooper into

bankruptcy because most of them either had found no defects or had only minimal damage to their rigs.

"This is the same Cooper that survived depressions and world wars, when you couldn't get steel. We just disagree with them," Mr. Moffett said.

Meanwhile, the bad-faith case in Oklahoma federal district court awaits a jury trial, which is unscheduled. U.S. District Judge Michael Burrage in April refused to grant the insurers a summary judgment that the Cooper trustee is time barred from filing the case. But that issue still is open.

Judge Burrage also refused to dismiss the bad-faith case based on the defendants' argument that Bankruptcy Judge Wilson had ruled coverage issues remained to be resolved. The trustee's charges are based on the insurers' entire claims-handling conduct, not solely any denial of coverage, he noted. **B**

Louisiana

Continued from page 1
liability coverage."

In his ruling, though, Judge Parker said the federal law clearly provided that after a RRG had been approved by insurance regulators in one state it could operate nationwide.

"Once a risk retention group is approved by a particular state, that state's minimum capitalization requirements and other insurance regulation measures are binding on the risk retention group on a national basis because of the presumption that if a risk retention group has sufficient financial strength to support risks assumed in one state, it has sufficient strength to underwrite risks nationwide," Judge Parker wrote.

"In order to give effect to this scheme... the Act expressly preempted regulation of risk retention groups by any state other than the one which chartered the group," he added.

Louisiana's capital and surplus requirements for RRGs licensed in other states conflicts with the Risk Retention Act, which exempts RRGs from traditional insurance rules regulating capitalization and bond posting requirements, Judge Parker said.

In addition, the "burden" of Louisiana's application process, which includes filing fingerprints of RRG officers, is broader than allowed by the Risk Retention Act, he said. Non-domiciliary states are entitled to a copy of a group's plan of operation and an annual financial statement, he noted.

Insurance regulators in non-chartering states also have the right to go to court to seek an injunction to shut down groups in hazardous financial condition.

After an RRG has been approved by regulators in one state it can operate nationwide, Judge Parker says.

"While the insurance commissioner cannot discriminate against or regulate risk retention groups chartered in another state, he is entitled to act to protect the citizens of his state where the financial condition of a particular risk retention group requires it," Judge Parker said.

The Risk Retention Act was passed in 1981 to allow businesses to band together to cover their product liability exposures through RRGs, a special type of multiple-owner captives. Policyholder-owners of RRGs, though, only can cover their own risks and not write coverage for the general public.

In 1986, though, the Act was considerably broadened so that RRGs could write coverage for all commercial liability risks—except workers compensation—of member owners.

Sixty-eight RRGs now operate, with 33 licensed in Vermont, whose liberal captive law makes it an attractive domicile for RRGs. In 1995, RRGs generated about \$640 million in premiums, according to The Risk Retention Reporter, a Pasadena, Calif., newsletter that tracks the industry.

National Risk Retention Assn. et al. vs. James Brown, Commissioner of Insurance of the State of Louisiana, U.S. District Court, Middle District of Louisiana, No. 95-1926-A.

At Allendale Insurance, we believe that most property loss can be prevented. But that means asking some very tough questions, and looking for risk in some unlikely places. For example, take vegetable oil in plastic bottles. Conventional wisdom has been that warehousing this very high flashpoint liquid presented no more of a hazard than storing ordinary combustibles. Yet tests conducted through our ownership of Factory Mutual Research revealed that even sprinkler systems arranged for high hazard commodities could not control fires of this type. Further tests revealed that this was no ordinary combustible. Once heated by the fire in their cardboard packaging, the plastic bottles leaked and the preheated vegetable oil burned with the intensity of a flammable liquid. And once the fire spread from the cardboard to the



liquid, the fire was uncontrollable.

This led to the development of a strategy aimed at replacing conventional in-rack sprinklers with the quick response model, and spacing

them closer together. As a result the fire is suppressed in its earliest stages when it's limited to the cardboard. This solution is easy to implement and uses the sprinkler piping and water supplies normally in place in grocery warehouses. Plus, it

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ing at commodities and the hazards they pose. In fact, for over a century and a half, we've never stopped asking the kind of difficult questions that lead to the cost-effective solutions our clients need to minimize risk. Even if that means looking in places as surprising as, yes, a salad.



Opinions

Eliminating RRG obstacles

WE ARE RELIEVED that common sense has prevailed in a dispute over regulation of risk retention groups.

As we report on page one, a federal district court judge last week essentially threw out a 1995 Louisiana law that required RRGs licensed in other states to meet hefty capital and surplus requirements, among other hurdles, before the groups could operate in Louisiana (*BI*, Dec. 18, 1995).

Risk retention groups and their supporters correctly argued that the federal law plainly pre-empts state licensing requirements.

Without such pre-emption, these special multi-owner captive insurers would have a hard time getting off the ground, let alone meeting the needs of their members.

Thankfully, U.S. District Judge John Parker agreed: "The Act pre-empted regulation of risk retention groups by any state other than the one which chartered the group."

We have said since the Louisiana law was enacted that this was the only conclusion to be reached. We now hope that the judge's ruling makes that clear for other states that may have been contemplating similar restrictions on risk retention groups.

Ensuring that risk retention groups operate free from multistate regulation is critical if they are to be viable risk financing options.

Congress clearly saw the need for such an alternative when the Risk Retention Act was enacted in 1981 and amended in 1986. Federal lawmakers were justifiably concerned about the availability and affordability of many forms of liability coverage during the last hard market in the 1980s. They wanted to provide buyers with a lasting option to the frequent—and sometimes violent—swings in the commercial market's pricing.

To make risk retention groups a viable alternative, Congress broadly—though not completely—pre-empted state licensing requirements. Simply put, a risk retention group could operate nationwide after



meeting the licensing requirements of any one state.

This is not to say that other states are powerless to protect policyholders. The Risk Retention Act permits a state regulator, for example, to go to a federal court and obtain an order to shut down groups in hazardous financial condition.

But preventing a risk retention group from becoming insolvent and preventing them from operating in a state are two very different aims. The Louisiana law was a blatant attempt to keep risk retention groups out of the state and eliminate a potential source of competition for traditional insurers and brokers.

We are glad Judge Parker blocked Louisiana's efforts and hope the ruling will prevent other states from trying the same.

This will preserve risk retention groups as an option for years to come, especially if the market turns again.

Letters

Bring more weapons to bear on claims fraud

To the editor: When all is said and done, there is nothing really new in the insurance industry's approach to combating dishonest health insurance claims.

Investigation of health insurance fraud, no matter how sophisticated, is expensive and hit or miss. Instead, the industry needs to refine standard operating procedures and revamp basic philosophy at the onset of a claim for benefits allegedly due to injury or illness.

Within current budgetary allocations, a better return on the case expense dollar is possible if all case data analysis is directed by a forensic analysis of the claim.

The initial assessment of medical claims is currently performed under conditions that essentially guarantee that any claim, no matter its veracity, will be paid. Basic assumptions about

the nature of a claimed injury direct all other case decisions, including investigation. Adjusters, managers and their attorneys first perceive and then react.

Forensic analysis of the medical case first sees all data as potentially relevant, identifies which data is objectively admissible, then investigates all cause and effect relationships. Forensic analysis is a cost-efficient expenditure early in the

life of a claim and represents the greatest opportunity to maximize later resource allocation.

If the goal is to ensure payment of legitimate claims, the industry should engage in a self-examination of how current resources can be better utilized.

Marc Steven Kreiter
Director of Forensic Analysis
Forecast Systems L.L.C.
Chicago

Names can't have it both ways

To the editor: Having just read the letter to the editor from Roy W. Bidwell of the New Mexico Names Group in your May 20 issue, "Opinion Ignores Lloyd's Sins," plus many other similar gripes in a number of other publications, I must voice my total disgust.

For years the Bidwells of this country have been collecting healthy profits from their participation in Lloyd's operations.

They knew, as in fact did everyone, that when one invests in a Lloyd's syndicate one has unlimited liability if losses are incurred. The pitfalls were explained to these investors in some detail prior to their becoming names, and considering the amount of investment required before becoming a name at Lloyd's, these people were not unsophisticated novices.

I never heard any cries of fraud and deceit when they were pulling in the profits.

Now that they are faced with a loss, they appear to be coming up with every reason as to why they should not honor their contracts.

If you are going to invest your money, Mr. Bidwell, do what smart people do: investigate the opportunity. Check beforehand on whether it violates your state security regulations and, most of all, stop whining and appealing to every regulator in the land when it goes sour on you.

Pay your debts and walk away a wiser man knowing that all investments are not necessarily going to let you retire early in Rio.

Tim Morton
Orange, Calif.

Business Insurance

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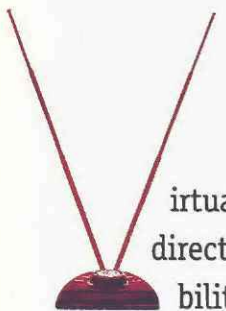
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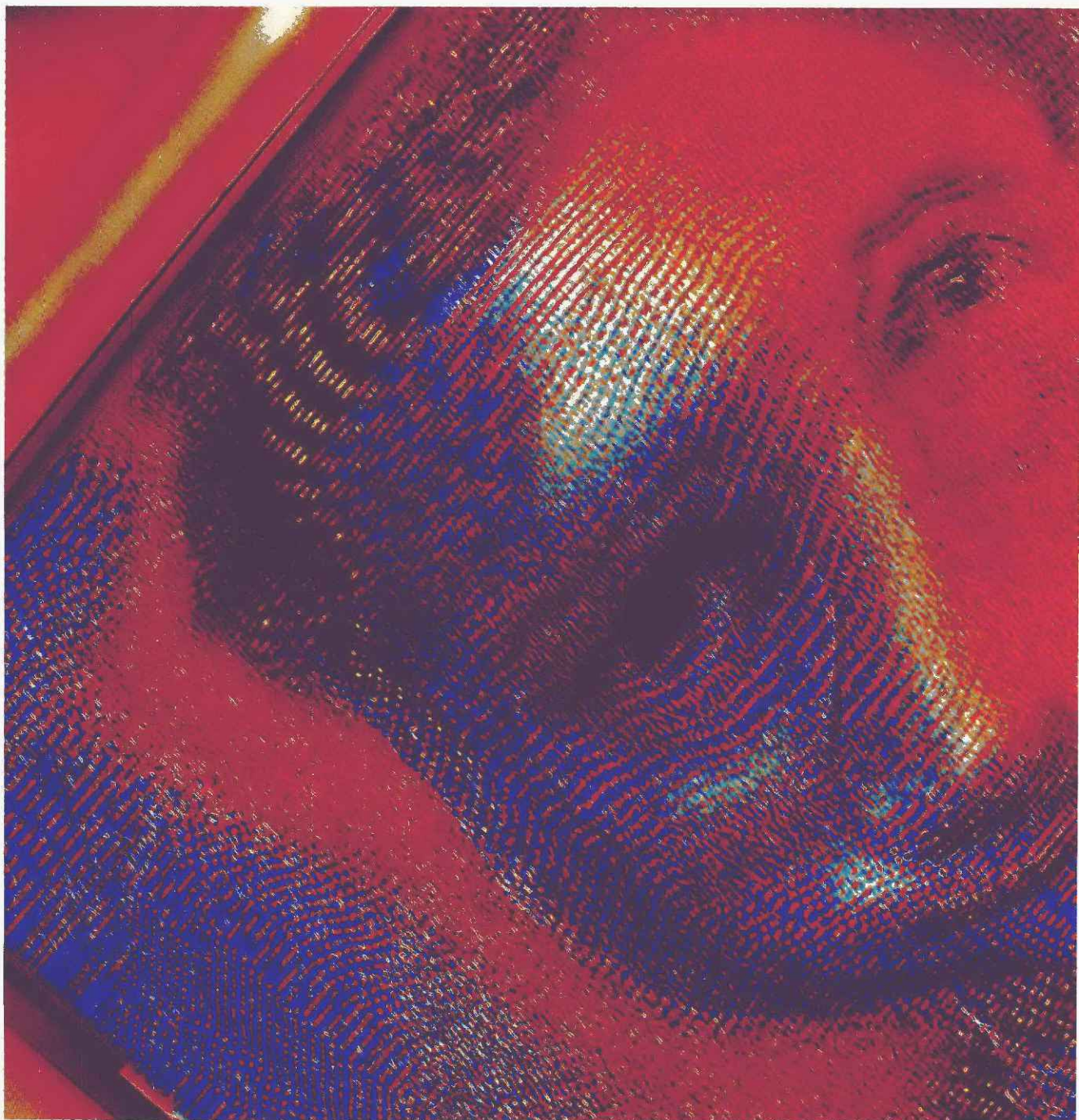
Like the commercial banking profession a decade ago, the reinsurance brokerage industry is changing dramatically. Today's top reinsurance brokers work smarter, faster and are more responsive to clients' changing needs. In addition to directing reinsurance programs, most have created highly specialized consulting units to help clients deal with issues from financial and tax planning to complex risk-based capital requirements.

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A NETWORK OF PROBLEM SOLVERS

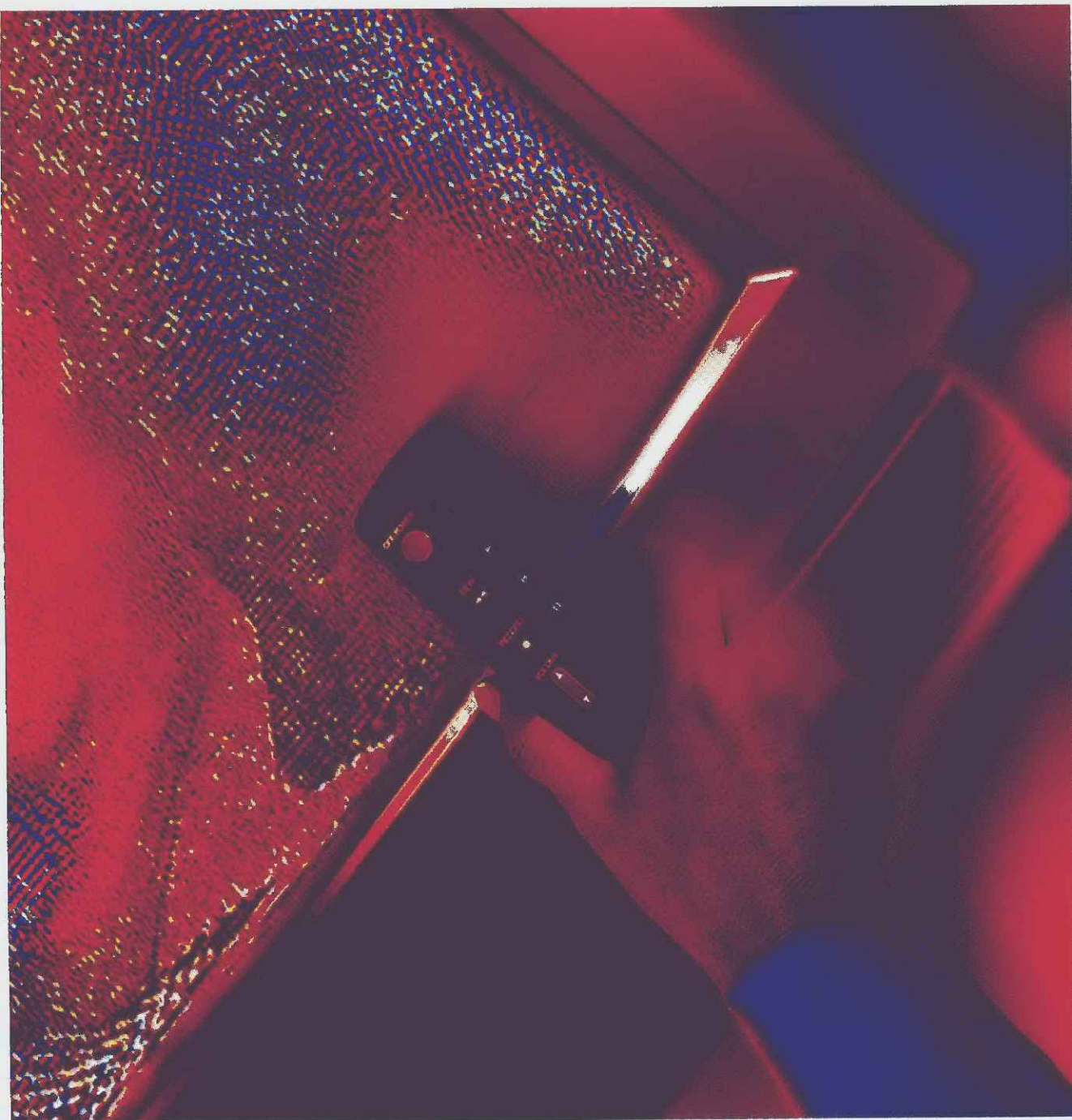
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Cancer program helps with early diagnosis

By ROBERT KAZEL

HOUSTON—A new benefit program that links doctors at a leading Texas cancer center with employees of Houston-based Randalls Food Markets Inc. is designed to do more than save lives. It's intended to give Randalls a statistical picture of how common cancer is among its workers—numbers that are often elusive and underestimated.

dren and elderly dependents whose usual daycare has fallen through.

Last month, the president of All Metro Health Care Inc. turned his workers' expertise into a benefit: All Metro workers in New York now can get elder care and child care provided by their own co-workers.

The Lynbrook-based agency, which does most of its business in home health care, will provide up to 30 hours of in-home care for

Benefit Beat

Randalls, a major Texas supermarket chain, announced in May that 24,000 employees and dependents could obtain free expert advice at the University of Texas M.D. Anderson Cancer Center in Houston. The benefit is intended to be used by employees whose primary care physicians suspect they may have cancer, and who want a second opinion by a cancer specialist, said David S. Stone, assistant vp for managed care at M.D. Anderson. In the past, the disease has not been diagnosed definitely as cancer until late in its course, often after surgery, he said.

"That is proven not to be an effective way to treat cases of cancer as soon as possible," Mr. Stone said.

Those who use the program can travel expense-free to the medical center and obtain housing, if necessary, on the M.D. Anderson campus. Through examinations, laboratory tests and follow-up clinic visits, doctors will gather information for a treatment program, with dual goals of pinpointing the employee's problem and easing the company's financial burden by avoiding erroneous treatment approaches.

"This is going to provide for earlier treatment of a very expensive disease," Mr. Stone said. "We hope it will get the employee treated correctly the first time and returned to work as quickly as possible."

The program at M.D. Anderson, which does not include cancer treatment, is separate from the company's health plan and does not charge a copayment, he said. Instead, Randalls has agreed to pay the cancer center a fixed fee per consultation, a fee that could range "from a couple of hundred to a couple of thousand dollars," depending on the complexity of the case, Mr. Stone said.

The cancer center considers Randalls' program to be a pilot project and is trying to market programs of this type to other corporations. Such a program may be valuable to a company in trying to assess the incidence of cancer among its employees and establish statistical baselines for comparison, since conventional ways of diagnosing patients often miss cases of cancer that could be caught and counted earlier.

"The typical employer looking at claims data is almost always going to underestimate the amount of cancer in the employee population by just relying on data," Mr. Stone said.

Backup in-home care

LYNBROOK, N.Y.—More than 70 companies rely on Glenn Edwards' company to supply backup, temporary home caregivers to chil-

workers' dependents in non-acute situations, such as when a babysitter is ill. Dependents may include grandchildren and grandparents as well as children and parents.

The new benefit applies to 800 workers in New York, and Mr. Edwards said he plans to extend the program to 3,500 other All Metro workers in Maryland, New Jersey, Virginia, and Washington, D.C. The benefit also may be expanded to 55 to 60 hours per employee next year, he said.

Although it may seem curious to pay a homemaker to spend the day at a caregiver's home so that the latter can work, Mr. Edwards said it makes economic sense for All Metro to keep its workers content.

"Every time we recruit a homemaker worker, it costs us about \$1,000," he said. "You can spend it in retaining or you can spend it in recruiting—you have a choice."

Life-cycle benefits

NEW YORK—Employees of The Segal Co., an actuarial and benefits consulting firm, can now choose from a small array of "life cycle benefits"—a smorgasbord of perquisites that Segal had helped to introduce previously at other companies.

The New York-based company in April introduced the benefits for all of its 700 employees, said Susan Copeland, vp and life cycle practice leader.

Segal contributes a \$10,000 maximum lifetime allowance for each full-time employee. These employees may withdraw up to \$500 annually for health club memberships, exercise equipment, child or elder care, adoption expenses, or financial planning. They also may take out up to \$1,000 a year to buy a primary residence. These are purposes not covered under other Segal benefit programs.

Part-time employees at Segal get \$375 per year for miscellaneous expenses and up to \$750 per year for a home purchase.

The funds are an after-tax benefit, as opposed to standard flexible benefits programs which are typically disbursed on a pre-tax basis, Ms. Copeland said.

Life cycle benefits, sometimes called lifestyle benefits, are designed to supplement an employee's traditional benefits without placing an undue financial strain on the employer in any one year. They also help companies to retain staff because employees know the benefits will be available as long as they stay with the company and don't need to be used by a certain deadline, Ms. Copeland said.

So far few companies have adopted life cycle benefits, she said. Segal first set up such a program

The

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Not all attorneys see it that way.

"There's little question that it will be pre-empted by ERISA," argued Nancy G. Ross, a partner and ERISA specialist in the Chicago law firm McDermott, Will & Emery. "I would certainly counsel my clients to challenge it."

Ms. Ross said her reading of the Florida law does not leave a clear understanding that it is aimed exclusively at insurers and not at all plans sponsored by companies with fewer than 20 employees.

She said language stating the purpose and intent of the law could be more widely interpreted to cover all plans that don't offer COBRA benefits. That language says the law's intent is to "ensure continued access to affordable health insurance coverage for employees of small employers and their dependents and other qualified beneficiaries not currently protected by the Consolidated Omnibus Budget Reconciliation Act of 1985."

"It's definitely going to come up in the legal sense before long," predicted John Erb, a principal with A. Foster Higgins & Co. Inc. in Miami. "I think most self-insured employers are questioning it."

Other states have passed laws calling for insurers to provide continued benefits as part of plans offered by small companies. For example, several states have passed laws requiring insurers to extend the benefit period for divorced and widowed spouses beyond the time required by COBRA.

But the Florida statute may be the closest to mirroring most aspects of the federal law.

"I don't know of anything that so closely mirrors COBRA," said Ms. Ross.

States that previously have passed such laws have been very careful with their statutes' wording, according to Henry Saveth, a Foster Higgins principal in New York. "Because of the ERISA problem, they try to focus as narrowly as possible on the insurers."

Dubbed a "mini-COBRA," the Florida act amends the state's Employee Health Care Access Act. It calls for continuation of coverage for up to 18 months for workers who leave their jobs unless they are terminated for "gross misconduct." The employee's spouse and dependents also are eligible for continued coverage. Employees can be required to pay up to 115% of the group rate for the extended coverage.

Workers with disabilities are eligible for a total of 29 months of coverage, which after 18 months can be priced at up to 150% of the group rate.

The act places the entire administrative burden for continuing benefits on the insurer. It does allow insurers to contract with a third party to perform the administrative requirements. The insurer also has the option of contracting with the employer to handle the administrative duties for a fee.

A Senate staff analysis of the legislation referred to an estimate by the Rand Corp. that indicated approximately 82,000 Florida workers and dependents would experience a qualifying event that would leave them eligible for continuation of coverage under the new law.

Florida businesses and insurers say they didn't particularly want the law, but they are not terribly displeased with its final structure. Businesses generally are happy that they won't incur any direct expenses related to continuing coverage.

However, insurers indicate that

group health rates may eventually have to rise as a result of "adverse selection" that will occur because less healthy employees are the most likely to opt for continuing coverage.

"It's going to affect rates" because continuation plans naturally lead to adverse selection, said Ralph Scott, assistant general counsel at the Health Insurance Assn. of America in Washington.

Mr. Scott said that while the requirements are "another administrative piece we have to deal with," he doesn't believe insurers "generally are unhappy with it. We've never liked mandates in the insurance industry, but the structure is fairly good."

Blue Cross & Blue Shield of Florida is pleased with the legislation, said a spokeswoman in the insurer's Jacksonville office. "We were part of the creation of that bill, and we were delighted that it passed," she said. "We felt strongly that people should remain covered."

Both Mr. Scott and the Blue Cross & Blue Shield spokeswoman said they don't believe an ERISA conflict exists and pointed out that such an issue was not part of the drafting of the legislation.

The Senate analysis bears out Mr. Scott's prediction of rising group health care rates. The analysis indicates that those costs will have to rise about 3% to pay for additional costs related to adverse selection.

"The law may say that the cost is initially borne by the insurers," said Mr. Saveth of Foster Higgins, "but they are going to pass it along."

Small businesses are happy, though, to be escaping the administrative cost and burden of the law.

"It's invisible to the small business owner," said Bill Herrle, Tallahassee, Fla.-based state director of the National Federation of Independent Business. "We weren't pushing it, but we wanted to make sure the Legislature did it right. We're pleased that if you have to do a COBRA draw-down, this is the way to do it."

Mr. Herrle said employers are pleased that they hold no legal burden to notify employees of the continuation of benefits and have no duty to collect premiums or keep track of employees after they leave the job.

The NFIB has been unable to identify any administrative expense that small businesses would incur under the law, Mr. Herrle said.

"This will be an interesting thing to watch," he remarked. "If this works, there's no reason not to bring a plan to other states or Washington itself. We can say, 'Hey, look at this, it doesn't have to be a burden to the employer.'" **BI**

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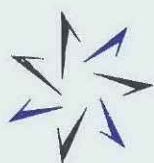
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Ariane 5 lost on first flight

By SARAH GODDARD

KOUROU, French Guiana—The loss of the European Space Agency's new Ariane 501 rocket and its cargo of four satellites, which were destroyed last week shortly after launch, was uninsured and likely will not immediately affect insurance rates.

Underwriters will become more aware of heightened risks and the loss could drive up insurance rates for future launches. The satellite insurance market had been watching development of the Ariane 5 rocket because its cargo capacity is greater than other launch vehicles and therefore could place added demands on the insurance market's capacity (BI, March 11).

The ESA opted to self-insure the prototype rocket and satellites, partly due to the high cost of coverage.

The \$60 million rocket veered off course 30 seconds into its initial flight from the ESA's launch facility in Kourou, French Guiana. Half a minute later, as the vehicle continued to stray from its planned path, ESA officials destroyed the rocket and its payload of four scientific satellites, valued at a total of \$500 million.

An ESA spokesman in Paris said the agency exploded the rocket to ensure the safety of people on the ground. By that time, Ariane 501 was above the Atlantic Ocean, but officials were concerned the rocket could veer over land and explode.

As a prototype, the launch vehicle was not insured. The four satellites on board, part of a scientific investigation into the earth's magnetosphere and its interaction with solar winds, belonged to the ESA

and also carried no coverage.

"It is very difficult for insurance underwriters to assess the value of scientific satellites," the spokesman said. As a result, "quotes we have received have been beyond our budget."

Simon Clapham, underwriter for the Marham Space Consortium in London, said the explosion will make space insurers more cautious, but he didn't think it would affect rates in general. "It will make us more aware of the high-risk nature of our business," he said.

However, there are placements in the space insurance market for commercial launches on Ariane 5 and rates for these

could well be affected, Mr. Clapham said.

This year the market has already had two major claims. In February, the Chinese Space Agency's Longmarch 3B launch vehicle blew up seconds into its first voyage, destroying a \$218 million Intelsat 708 satellite on board. The satellite was insured, though the claim falls into the 1995 account (BI, March 11).

In March, Telesat Canada's Anik-E1, which though still functioning, was severely disabled while in orbit. Scientists are still investigating the cause of the orbiter's malfunction.

"So far, we have made more money than we have lost," said Mr. Clapham.

The Ariane 5 program, which has a budget of \$7 billion, is on hold until the ESA determines why the rocket veered off course. Nozzles that direct the rocket's thrust apparently changed position, though the cause is not known. The ESA expects to issue a preliminary report by mid-July.

In the meantime, a second Ariane 5 launch scheduled for this fall is unlikely to happen before the end of the year.

Meanwhile, launches using the ESA's existing rocket, the Ariane 4, will not be affected by the recent loss. The ESA is confident that the next scheduled Ariane 4 launch, carrying telecommunications satellite Intelsat 709 for Telesat Canada, will proceed at the end of the month.

Intelsat 709 had been provisionally booked onto Ariane 5's second flight, until the Longmarch rocket's failure in February.

After that explosion, Telesat Canada moved the launch to Ariane 4. **BI**



This Ariane 5 rocket was destroyed shortly after takeoff as it veered off course. The uninsured loss is not expected to greatly affect insurance rates in the space market.

Airport's insurers cancel cover

DUSSELDORF, Germany—Property insurers are canceling the Dusseldorf airport's coverage, citing alleged negligence as the cause of a recent fire that killed 17 people and caused more than \$225 million in insured property losses.

A spokesman for a consortium of insurers led by Dusseldorf-based Provinzial Versicherungs A.G. cited the Rhein-Ruhr Airport's "serious fault" and "joint responsibility" for the fire as reasons for the cancellation.

Matthias Tuempel, managing director of Dusseldorf Flughafen A.G., which runs the airport, called the insurers' reasons "unfounded."

"The whole action is based on suspicion. We were pre-judged and sentenced. After 48 years with our insurer, it's an action I don't accept," Mr. Tuempel said.

Under German law, insurance companies can cancel a policy under so-called warranty stipulations. These are conditions and/or exclusions in a policy that require certain action on the part of the policyholder.

In this case, a recent investigation into the April 11 fire alleged that the airport

was negligent in supervising welding on an access road that passes over the terminal. Sparks from the welding are suspected of igniting the insulation on a nearby power line and causing the fire (BI, April 15).

The insurers also allege the airport was negligent in complying with safety regulations. For example, investigators found loudspeakers used to warn passengers disconnected and fire extinguishers missing from one airport lounge.

However, Mr. Tuempel said that insurers inspected the airport only 10 days before the accident and its fire safety measures were deemed "optimal." Airport managers said that they were told that, prior to the fire, insurers even were considering a 50% cut in the airport's property premium, though insurers deny that.

Insurers said their decision to cancel coverage was not because of any reluctance to settle claims from the fire, though a dispute could arise should the airport be proved at fault. Insured property claims from the fire total 350 million DM (\$225.8 million).

A separate consortium of insurers,

called Luftpool, that writes the airport's liability coverage, has not canceled its coverage, which would pay claims of passengers killed and injured in the blaze. Estimates of liability claims were unavailable as of last week.

The property consortium of insurers includes Dusseldorf-based Provinzial Versicherungs A.G.; Cologne-based Nordstern Versicherungs A.G.; Hannover-based Landschaftliche Brandkasse Hannover; and Stuttgart-based Wuertembergische Versicherungs A.G.

The Dusseldorf airport has since found other insurers to write its property coverage following the cancellation.

A new consortium under the lead of Dusseldorf-based Victoria Versicherungs A.G. will insure the airport's property risk at a "higher premium," according to acting broker Gradmann & Holler, a subsidiary of Marsh & McLennan Cos. Inc.

Victoria leads a 12 insurer consortium, including Cologne-based Gothaer Versicherungs A.G. and Hamburg-based Albingia A.G., which each have 20% of the risk.

—By Don Lewis Kirk



Argentine employers and insurers are focusing on workplace safety since employers are required to purchase workers comp insurance by July 1.

Workers comp conversion in Argentina

By ROBERTO CENICEROS

BUENOS AIRES, Argentina—The implementation of a U.S.-style workers compensation system is under way in Argentina with employers required to purchase insurance by July 1.

Argentina's risk managers expect that their legislature's adoption late last year of an exclusive remedy system will lead to the maturing and growth of their profession as they rush to negotiate insurance or learn about self-insuring.

They say companies are already looking to implement measures now common in the United States, such as return-to-work, loss prevention and safety programs.

"It will be a system that is very strange and very new to us, working with the idea of prevention before a claim is filed," said Jorge D. Luzzi, risk manager for Pirelli Group in Buenos Aires and president of the Asociacion de Administradores de Riesgos de la Republica Argentina. "I suppose that is not so different from the American system. For here, it is totally a revolution, because it is the first case in Latin America and we are not used to having this kind of legislation."

Argentina's former system was mired in litigation with workers suing in civil courts. A form of liability insurance was optional for employers.

"The lawyers were making a lot of money," said Carlos Barros de Moura, a risk management consultant and founder of Barros de Moura & Associates in neighboring Sao Paulo, Brazil.

Now workers compensation insurers expect Argentina will generate between \$1.5 billion and \$1.8 billion in annual revenues, as the number of covered employees swells to more than 4 million from 1.5 million workers.

Boston-based Liberty Mutual Insurance Co. sees it as an opportunity to boost earnings by exporting technology and expertise gleaned in the U.S. workers comp market. Liberty is among three non-local insurers—including Mapfre Group of Spain and W.R. Berkley Corp. Group of Greenwich, Conn.—that have moved into Argentina to provide coverage as labor risk insurers, known as "aseguradoras de riesgos de trabajos," or ARTs.

The implications are expected to spill beyond Argentina's borders, said James McCarty, president of Liberty International's Latin American operations in Boston.

"Argentina is an interesting market overall, because it is the third-largest market in Latin America for all lines (of insurance)," he said. "For workers comp it is very interesting because... this is probably going to be a model for other countries that are opening up their insurance markets and privatizing social security."

Workers compensation in many emerging markets is part of the national social security system, as are pensions. But those social security systems have been collapsing in one country after another, leading to the privatization of pension and workers comp systems, Mr. McCarty explained.

Last week, Brazil's lower house approved a proposal to privatize insurance for work-related accidents as part of a pension system reform plan.

See Argentina on next page

INTERNATIONAL

Argentina

Continued from previous page

Meanwhile, Argentina's risk managers are scrambling to comply with the changes.

Companies with fewer than 200 employees will be subject to a fixed-rating plan with no experience modifications. Rates for companies with 200-500 employees will vary from the fixed rates by a factor of 15%, according to the company's loss experience. Employers with more than 500 employees will be completely experience rated.

Initially, rates are expected to be about 5% of payroll, but could be as low as 1% for a good risk, Mr. Luzzi said.

But Mr. Barros de Moura said that with such a new system, it remains to be seen what future public reaction will be if rates eventually increase to 20% or 25% to cover losses.

To minimize losses and receive the most favorable rates, large policyholders will now want to implement safety and loss prevention programs, Mr. Luzzi said.

However, there is more than just financial incentive. Argentina's new law requires that insured companies implement a safety-improvement program certified by an insurer, Liberty Mutual's Mr. McCarty explained.

In that way, Argentina's law

may be even more advanced than those in the United States, Mr. McCarty suggested.

"In effect, the government has made the insurance industry the regulators of compliance with their safety regulations," he said. "So it is almost as if you privatized the inspection part of OSHA."

Argentina's risk managers are studying whether to purchase insurance or self-insure, Mr. Luzzi said. But final implementation of regulations for self-insurers has been slower to come than for companies that buy coverage because of fighting between employer associations and insurers, he added.

The insurance industry wants to limit self-insurance, Mr. Luzzi said. The battle to influence the Argentine Congress and the public is being waged through public relations campaigns.

"The fighting is in the press, it is on TV," Mr. Luzzi said.

Mr. McCarty expects self-insured companies will be regulated similarly to insurers and required to separate from their balance sheets a minimum of \$1 million to be placed in a regulated trust fund. They will also be accountable for full loss reserving.

In the past, many Argentine companies claimed to be self-insured, Mr. Luzzi said. But that usually meant they neither had insurance nor did they adhere to practices for mitigating or fund-

To minimize losses and receive the most favorable rates, large Argentine policyholders will now want to implement safety and loss prevention programs, says Jorge Luzzi.

ing claims. There was an absence of regulation.

Now self-insurers are likely to face stiff scrutiny by Argentina's regulators in the Superintendencia de Seguros de la Nacion and the Superintendencia de Aseguradoras de Riesgos de Trabajo, Mr. Luzzi said. Engineers for the superintendents are expected to inspect workplace safety programs, while other technicians monitor employers' contracts with medical providers for the treatment of injured workers.

That is all likely to lead to an expansion of risk management activity, Mr. Luzzi said.

Risk managers "have so much work now," he said. "Much more than before. If my company decides to go with self-insurance we will need to have people in the administration of that program. We will need to contract with a hospital. We will need to work on safety very hard to prepare our company for inspections from the government. And we will need to manage our accident (rate) per

day, per month, etc."

For insurers, the greatest boon is expected to come from servicing large, local companies rather than multinationals.

"That is where the players are expected to make money. The multinationals are usually part of a worldwide insurance program insured through captives," said Anthony Motola, president of AFM Associates Ltd./Water Street Group Inc., a New York-based risk management consulting company that specializes in Latin American concerns.

Multinationals have a significant presence in Argentina and Liberty Mutual expects many of them to become clients, Mr. McCarty said. But most of Liberty ART's marketing efforts are being directed at 4,700 local companies.

Along with an indemnity product, Liberty ART will offer clients expertise in accident prevention, immediate response to injuries and medical treatment rehabilitation based on protocols developed in the United States.

To boost local workforce expertise in those practices, Liberty has trained 40 Argentines in the United States and has assigned several U.S. workers to tours six months to two years in Argentina.

This will "make sure that the technology transfer takes place," Mr. McCarty said. **BI**

AGF finalizes share issue

PARIS—The French government announced late last month that institutional investors would be offered shares in Assurances Generales de France at 136 French francs (\$26.22) a share.

Earlier in May, the government sold 18.7 million AGF shares to private investors at 123 francs (\$24.68) each and it offered 42.8 million shares to institutional investors. Another 5.8 million shares have been offered to banks organizing the institutional investor offering.

The French Finance Ministry estimates the share issue will raise between 8.5 billion francs and 9.2 billion francs (\$1.64 billion to \$1.77 billion).

The French government gave the go-ahead to AGF's privatization in May (BI, May 13).

—By Sarah Goddard

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OF REASSURANCEAFVILINGS-AKTIESELSKABET (THE "COMPANY")
CASE NO. 96-B-42629 (JLG)

NOTICE IS HEREBY GIVEN that on June 3, 1996, a Preliminary Injunction Order was issued (the "Order") which (a) enjoins and restrains the commencement or continuation of any judicial action, arbitration proceeding, administrative or regulatory action or proceeding against the Company or any of its property in the United States; (b) enjoins and restrains the enforcement of any judicial proceeding, arbitration award, administrative or regulatory proceeding to create, perfect or enforce any lien or other claim against the Company or any of its property in the United States; and (c) requires all persons to turn over and account to the Petitioner for all funds resulting from the drawdown of letters of credit in excess of what is expressly authorized by the terms of the contracts and any related trust or other agreements pursuant to which such letters of credit have been posted, in their possession, custody or control after written demand for turnover and accounting is made by the Petitioner against such entity, subject to a turnover motion and further order of this Court. The Order shall remain in effect pending a hearing scheduled to be held in Room 610 of the Alexander Hamilton U.S. Custom House, One Bowling Green, New York, New York on December 4, 1996 at 10:00 a.m. Any party in interest who has not received a copy of the Order should contact counsel for the Petitioner/Supervisor in writing at the following address:

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INTERNATIONAL

\$1.9 million settlement in '89 soccer tragedy

By SARAH GODDARD

LONDON—Insurers have reached a settlement with 14 police officers caught in the middle of the 1989 Hillsborough Stadium disaster in which 95 people died and 170 were injured in a crush of soccer fans.

Around £1.2 million (\$1.9 million) in compensation will be shared between the South Yorkshire police officers, who have all suffered from post-traumatic stress disorder because of the disaster, though the amount each officer receives will be decided by individual circumstances.

Of the 14, five quit the force as a result of Hillsborough-induced PTSD, and two left because of injuries not associated with the stadium incident but compounded by PTSD. Since leaving the force, none of the seven has found regu-

lar work. The other seven have remained on the police force.

The disaster occurred when thousands of fans tried to enter the oversold stadium as the game was ready to begin (*BI*, Dec. 4, 1989; Aug. 14, 1989; April 24, 1989).

Last year, insurers of the South Yorkshire Police Force; the Sheffield Wednesday Football Club, which owns the stadium; and Sheffield Wednesday's consulting engineers, Eastwood & Partners. However, the settlement was only reached last week, the first day of a High Court hearing to assess quantum.

The police force was insured by now defunct Municipal Mutual Insurance, whose runoff is being managed by Zurich Municipal. Coverage for Sheffield Wednesday was provided by the Sun Alliance & London Insurance P.L.C.,

and Eastwood & Partners is believed to have been insured at Lloyd's of London.

In addition to PTSD, some of the victims have suffered other mental illnesses, including severe depression.

Compensation levels in English and Welsh courts are prescribed by the "Guidelines for the assessment of general damages in personal injury cases" published by the Judicial Studies Board. According to the guidelines, damages for mental health claims stemming from such incidents range from £500 (\$774) to a maximum of £45,000 (\$69,682), and are classified into minor, moderate, moderate/severe and severe categories. None of the compensated police officers fall into the highest category.

The so-called Ogden Tables (*BI*, March 18) have also been used in

calculating the settlement levels, assessing future loss of earnings as a result of the disaster.

Claims from another 23 South Yorkshire police officers for psychiatric problems have been turned down by the High Court and liability has not been accepted by the insurers. The Court of Appeal in London will hear an appeal from the officers next month, though lawyer Peter Metcalf, a partner in Leeds-based law firm Hammond Suddards and who is acting on behalf of the insurers, noted they would not be

resisting the suit unless they thought they had a good case.

The difference between the two suits, said Mr. Metcalf, is that the 14 compensated officers had been in pens 3 and 4 in the stadium, where the lethal crush took place. Legal precedents stretching back to 1954—including a House of Lords decision—have supported the awarding of compensation to emergency professionals when they have been injured in the course of rescue work. These precedents strictly define the circumstances in which compensation is payable. "Those in the thick of the disaster qualified as rescuers," explained Mr. Metcalf. **B1**

Amoco

Continued from page 1

In addition to the \$386 million punitive damage award, a Los Angeles Superior Court jury had awarded \$34.1 million in compensatory damages, plus \$1.6 million in attorneys' fees and \$3.5 million in prejudgment interest to Amoco after a two-month trial during which two Amoco units—Amoco Chemical Co. and Amoco Reinforced Plastics Co.—alleged that Lloyd's of London and its other insurers delayed claims payment for six years. The trial court also reduced those damages to a total of \$35 million.

"They've (Amoco) gone from a situation of being up some \$400 million to being down \$3 or \$4 million," said Vito C. Peraino, a partner with Hancock, Rothert & Bunshoft in Los Angeles who represented the insurers on appeal.

The \$3 million to \$4 million figure is an estimate of the premium insurers paid for a bond equal to 1.5 times the award amount, as was required by the court.

"We're disappointed by the decision and we expect to prevail on rehearing," said a spokesman for Amoco. Attorneys for Amoco could not be reached for comment.

"This is the kind of opinion which restores sanity... because I think that this was the result of a jury that was out of control," Deborah A. Pitts, also a partner with Hancock, Rothert, said of the initial award. "A lot of plaintiffs, in reading about this highly publicized verdict a couple of years ago, thought that they could hit the jackpot. I think it encouraged bad-faith claims in California."

But, because the appeals court's decision is not certified for publication, "it will not be of precedential effect in other cases," she said.

The coverage case arose from suits filed between 1985 and 1989 by six municipal sewer and irrigation districts that had bought reinforced plastic pipe made by a former Amoco division in Riverside, Calif. The municipalities—in Alaska, California, Hawaii and North Dakota—all claimed the pipe, with the trademark name Techite, was defective.

Between 1987 and 1992, Amoco spent more than \$45 million to defend and settle the lawsuits without any contribution from its insurers.

When Amoco notified its general liability insurance companies of its claim, the insurers issued reservation of rights letters and said they needed more information to complete their investigations, court papers say.

"Defendants did not investigate

GM, Rockwell to appeal awards

DETROIT—Two giant corporations hit with huge punitive damage awards by juries in Alabama and Kentucky are vowing to appeal.

A Lowndes County, Ala., jury last week ordered General Motors Corp. to pay Alex Hardy \$50 million in compensatory damages and \$100 million in punitive damages for injuries he suffered when he lost control of his Chevrolet Blazer. The jury agreed with Mr. Hardy's attorney that GM had failed to change the design of certain car door latches that allegedly opened unexpectedly, and in this case allegedly contributed to Mr. Hardy's injuries.

Thomas A. Gottschalk, GM's general counsel, denounced the verdict as "the crowning example of a state tort system gone berserk."

Ironically, GM would not have been shielded from the punitive damage award by the product liability reform bill vetoed by President Clinton earlier this year because the punitive award amounted to two times the compensatory damages, which happened to be the maximum allowed under the failed measure.

In another punitives case, Seal Beach, Calif.-based Rockwell International Corp. announced it would appeal a \$210 million punitive damage award levied upon it by a Russellville, Ky., jury on May 31. The jury also hit Rockwell with an \$8 million compensatory award in a civil suit brought by landowners who claimed that their property was fouled by polychlorinated biphenyls, or PCBs, released before 1974 by a plant Rockwell used to own.

William J. Calise, Rockwell's senior vp and general counsel, said Kentucky's 1988 punitive damages law requires proof of malice before punitives can be awarded, and charged that no such proof was offered.

—By Mark A. Hofmann

Amoco's claim, did not participate in the defense of any of the underlying cases and, according to their own admissions, did not even bother to affirm or deny coverage despite having notice of Amoco's claim for six years and an unequivocal demand for payment for over 2½ years," Amoco attorney Ronald M. Oster asserted in his brief for the 1993 trial.

At trial, insurers argued that Amoco's CGL policy did not include a defense obligation; that Amoco had knowingly sold the defective pipe, which would have voided the coverage; that each lawsuit constituted a separate occurrence with a separate \$5 million retention; and that the property damage caused by Amoco's pipe was expected and intended.

While acknowledging the insurers' slow response to the Amoco claim, the appellate court found for the insurers based on its interpretation of the word "accident" in the policies.

"The policies do not define 'accident.' For that reason, Amoco was able to convince the trial court the word was ambiguous and that, therefore, a dictionary definition ought to be used. The premise was wrong," the appeals court said.

"Noticeably absent from this instruction is any suggestion that an event, to qualify as an accident, must be 'sudden' or that it otherwise has a temporal nature," the court pointed out. "Since the word 'accident' has been defined by cases dating back to the last century, the simplistic dictio-

nary definition adopted by the trial court was wrong."

"If a term used in an insurance policy 'has been judicially construed, it is not ambiguous and the judicial construction of the term should be read into the policy unless the parties express a contrary intent,'" the court said, citing a 1989 California appellate court ruling in *Bartlome vs. State Farm Fire & Casualty Co.*

Amoco was insured by a consortium of insurers that included 50 Lloyd's of London syndicates plus 40 other European insurance companies. Lloyd's syndicate 619, managed by Janson Green Ltd., led the risk. The occurrence-based CGL policies had aggregate limits of more than \$75 million and a per occurrence self-insured retention of \$5 million.

While Amoco's coverage suit listed all of its general liability insurers dating back to 1973—the first year the company made and sold Techite pipe—it only sought coverage on the risk from the date of the first pipe break in 1976 onward.

In its 1993 verdict, the jury decided the first- and second-layer insurers in the 1975-1976 policy years, which wrote \$50 million in coverage above a \$5 million self-insured retention, would pay the compensatory and punitive awards.

Amoco Chemical Co. vs. Lloyd's of London, 2nd District California Court of Appeal; Superior Court. No. BC030755, June 4, 1996.

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Greenberg

Continued from page 3

win," he said. And while differentiating oneself from competitors is essential, brokers need to look at how efficiently they are differentiating.

For instance, "if a segment of the business believes the only way to be more profitable is to raise commissions, that's inefficient," he said. It is the low cost providers that win.

Mr. Greenberg touched on other issues raised during the question and answer period.

Among them, Mr. Greenberg predicted continued consolidation among insurers within the industry.

"Our business has a long fuse, if we're on the wrong track, it will catch up to us," he said. "Either you have discipline and focus or you'll be a household name not around anymore," he said.

"I don't make these rules," he continued. "They are the rules of nature."

Of the international issues raised, Mr. Greenberg said it was "too soon to tell" the effect the offshore Bermuda market has had on the marketplace. He, however, was candid

on the emerging market in China.

"It will be a long time before China opens its markets to foreign markets," he contends.

"U.S. and China relations are so rocky," he said. "We don't have a foreign policy that is consistent. We're threatening them with sanctions and that's not the way to build relations."

In addition, Mr. Greenberg said those insurers and brokers that think donating money to charitable organizations in China is the way to obtain an insurance license are "naïve."

"That's not the way it works," he said. "I've been going over (to China) since 1975 trying to get a license. We're in two cities and it's taken a long time to get there."

As to alternative sources of capital, Mr. Greenberg described the trend of underwriters combining traditional insurance with financial products as "lots of smoke, but not much fire."

The capital markets will not accept the risk at prices that the insurance market is willing to, he said. "My concern is how to get the price up to what the capital markets want." **BI**

Deregulate

Continued from page 3

reforming about 70% of the state's insurance code in an effort to cut regulatory red tape (*BI*, Nov. 20, 1995).

The proposals are awaiting Gov. Pataki's approval.

During a separate interview, Mr. Sorensen said that federal initiatives had once seemed to be the solution to relieving the regulatory burden.

"We've developed a different course because the prospects of federal activity became limited, and we've been encouraged by the interests and activity within certain state insurance departments and the National Assn. of Insurance Commissioners," Mr. Sorensen said.

"The NAIB has been at the forefront of this reform movement with our focus being the promise of efficiency and consequential cost reductions for our clients," Mr. Sorensen said during his address.

He added, however, that the NAIB does value the state regulatory sector's contribution in such areas as insurance company solvency oversight.

"We believe our efforts to streamline the process for commercial insureds will allow regulators to focus their limited resources on key issues," Mr. Sorensen said.

Over the past year, the NAIB has written "critical issues papers" that outline what it perceives as regulatory restrictions on brokers, as well as regulatory complexities that impede large commercial buyers' ability to obtain appropriate and low-cost insurance.

In the global marketplace, insurance regulation places too great a burden on sophisticated buyers operating in more than one state or county, the NAIB papers contend.

"We propose a regulatory 'free trade zone' for large, sophisticated commercial insurance buyers that permits them to access any insurance market with their broker," the NAIB said in one of the issues papers.

In addition to insurance deregulation, Mr. Sorensen outlined other issues the NAIB is advocating.

For instance, the NAIB has

"taken a leadership role" at the National Assn. of Insurance Commissioners in developing an approach to electronic licensing.

The NAIC currently is considering a partnership between industry and regulators to develop the technology and interface needed for a single electronic application that could be filed simultaneously in all states.

"This could cut by more than half the soft costs of licensing compliance, which is estimated at about \$20 million annually" for the NAIB's six largest member brokers alone, according to Mr. Sorensen.

Electronic licensing also would further reduce the frictional costs borne by clients, he said.

Other issues of importance to the NAIB include:

- A role in developing a quality and cost-effective continuing education program with The College of Insurance.

- Providing testimony opposing state securities regulators that have sued Lloyd's of London on behalf of U.S. members who claim their recruitment to Lloyd's constituted a violation of securities laws.

The litigation threatens to freeze the Lloyd's U.S. trust fund, which in turn could have a "serious impact" on claims payments to policyholders, according to Mr. Sorensen.

- Beginning work on a plan for a brokerage industry in China. The NAIB is distributing its "model brokerage law" to Chinese government officials and hopes to achieve a position that gives customers consistent brokerage services as they expand globally, Mr. Sorensen said.

- Remedying the "unfair" tax treatment of foreign subsidiaries of U.S. brokers.

The Omnibus Budget Reconciliation Act of 1993 left unrepatriated active earnings of U.S.-owned foreign insurance brokers subject to current taxation while exempting similar earnings of securities brokers, banks and insurance companies.

The NAIB has won support for legislation to correct the "unfair tax," Mr. Sorensen said.

The association now is waiting for a tax bill to be enacted.

Graham S. Anderson, a director for Acordia/Pettit-Morrey Co., will succeed Mr. Sorensen as chairman of the NAIB. **BI**

NAIC

Continued from page 2

tions—will make transactions more efficient for large purchasers and will facilitate market competition," said Patricia C. Vaughan, associate general counsel of the Risk & Insurance Management Society Inc.

Those themes were echoed by several insurance industry representatives, who said they were pleased that state regulators are interested in deregulation—or "reregulation," as some called it.

Regulators see the process as beneficial because encouraging large businesses to purchase coverage from insurers in the United States, rather than Bermuda or other foreign markets, could improve domestic employment and boost tax revenue (*BI*, April 1).

The most concrete deregulation proposal was presented to state regulators at the meeting by the National Assn. of Insurance Brokers. The plan is similar to an NAIB proposal unsuccessfully presented to Congress a few years ago when it was seeking streamlined federal regulation of insurance for large commercial risks (see related story, page 3).

The proposal hinges on requiring insurers that want to write such risks to first create a separately organized and licensed entity with additional capital and surplus requirements to deal solely with "large commercial insureds." They are defined in the proposal as organizations having a net worth of \$15 million or various combinations of gross assets and revenues. That definition is drawn from a proposal currently before the New York Legislature to deregulate some commercial lines business.

However, some risk managers and smaller insurers questioned the need for establishing separately licensed insurers.

There is greater general support, though, for excluding large policyholders from the limited guaranty fund coverage now available.

The NAIB proposal also suggests insurers approved to write coverage for large policyholders be allowed to operate in all states where a policyholder does business, possibly through a reciprocal licensing agreement that states could agree upon later.

"Let's create a commercial insurance zone in this country, where sophisticated and financially sound buyers and sellers can operate in a free-market environment, using their commercial leverage to negotiate the best terms, conditions and prices for each risk management transaction," said Ralph O. Hanley, executive vp of Marsh & McLennan Inc. in New York.

Some insurers support the deregulation concept, too.

"Globalization of the U.S. economy is severely hampered by costly and inefficient state insurance regulatory requirements imposed on property/casualty insurance companies and the businesses they insure," said Robert E. Vagley, president of the American Insurance Assn. in Washington. "Excessive

regulation wastes government resources and diverts attention away from more important regulatory problems," he said.

Comments from some of the industry representatives raised several questions, including how best to define a large policyholder, and whether state-mandated coverages like workers compensation coverage should be included.

In addition, regulators will have to wrestle with the impact of such a deregulation proposal on surplus lines brokers and insurers, as well as smaller admitted markets.

Members of the National Assn. of Independent Insurers think the NAIB's proposal would tilt the regulatory playing field in favor of the largest commercial insurers, said Donald Cleasby, senior counsel for the Des Plaines, Ill.-based NAII. It would shift guaranty fund assessments and residual market burdens on to small and medium-sized writers, the NAII contends.

"We believe that any deregulation contemplated for company operations should be extended to every insurer who chooses to compete in the commercial marketplace," said Larry E. Kibbee, vp-public affairs for the Alliance of American Insurers in Schaumburg, Ill.

The NAIC subgroups sponsoring the hearing—the Special Committee on Regulatory Re-engineering and the Commercial Lines—Property/Casualty Committee—have proposed taking steps to further study deregulation.

Proposed steps include possibly surveying states about the extent of current deregulation efforts, or at least sharing information that has already been obtained by the regulatory efficiency committee. In addition, that committee decided to ask the NAIC's Executive Committee to assign the issue primarily to the commercial lines committee for study and possible drafting of a model law or white paper.

Regulators also invited other interested parties to submit written comments in the next few weeks.

Representatives of other groups testifying at the hearing included: The Coalition of Alternative Risk Funding Mechanisms, the Insurance Brokers' Insurance Assn. of New York, the Independent Insurance Agents of America and the National Assn. of Professional Surplus Lines Offices Ltd.

In other action at the NAIC meeting last week, regulators:

- Established a Sept. 1 deadline for insurers and states to volunteer funding for two computer-related programs. Without the funds, the programs will be terminated.

Funding is very likely for the Producer Information Network, which would provide regulators and insurers with detailed information about individual agents or brokers seeking a license in any state. Major industry trade associations have endorsed implementing PIN by establishing a unique, non-profit affiliate of the NAIC governed by a nine-member board of regulators and insurers.

Voluntary funding is less certain for a pilot program dubbed SERFF—System of Electronic Rate

and Form Filing—which would standardize some elements of the rate and policy form filings that insurers make with state insurance departments. Industry opposition to the SERFF program has caused the budget-conscious NAIC to back away from its commitment to a broader, \$27 million program.

However, if the funding is not forthcoming for the pilot SERFF program, 27 states say they plan to implement their own electronic rate or form filing systems.

- Announced ongoing discussions with Lloyd's of London over whether to grant its syndicate writing U.S. business a one-year exemption from an actuarial certification requirement for 1995 (*BI*, April 1).

Separately, regulators studying trust fund requirements for non-U.S. insurers received a report that 75% of the 16 states surveyed want the NAIC's International Insurance Department to impose higher trust fund requirements. Most non-U.S. insurers are now required to maintain trust funds at an "appropriate level," in excess of at least \$2.5 million.

- Approved a package of two, pro-consumer health-related model laws on an unusually close 28-18 vote.

The measures are designed to increase the availability of coverage for small employers and individuals by requiring insurers to issue policies regardless of an applicant's health care condition and encouraging community rating. The measures would also help workers keep their health coverage, despite pre-existing conditions, when they change jobs.

Opponents pointed to the negative effects of similar measures enacted in New Jersey and a few other states, which have resulted in adverse selection and higher costs as more people with health problems purchase coverage.

- Delayed final voting on the NAIC's first model investment law for insurers until the September quarterly meeting (*BI*, May 13). That will give drafters time to add language emphasizing that the model's so-called "pigeonhole" approach is not the only valid approach to regulating insurer investments.

It will also give regulators drafting an alternative investment model, which uses a "prudent person" approach, more time to complete their work so both models possibly could be voted on at the fall meeting.

- Awarded the first renewal of accreditation status to South Carolina.

The NAIC has accredited 48 insurance departments, including the District of Columbia. Hawaii and Nevada are outside the fold, as is New York, which had been accredited before its legislature failed to pass needed model laws in 1993.

An accredited department must undergo annual reviews and a full re-accreditation every five years, as South Carolina did. The NAIC recently extended some re-accreditation deadlines so more flexible standards could be developed. **BI**

Superfund

Continued from page 2

able to reimburse companies that pick up so-called orphan shares—the portion of liability for which no financially responsible parties can be found—by more than \$50 million, Ms. Browner announced. Such compensation, which would be funded by special taxes that haven't been collected since the end of last year, would be limited

to 25% of the projected cost of cleaning the site.

The EPA's other reforms are allowing money collected for future cleanup at designated sites to earn interest and to create an ombudsman's office in each region to "help resolve Superfund issues that fall through the cracks," according to the EPA.

However, reform advocates say the steps don't go far enough.

"It's certainly nice to see them try to make the process more

user-friendly, but they're missing the point. The point is the process itself is too wasteful, too convoluted and too bureaucratic to fix with administrative reform. Structural reform through legislation is what is needed," said Julie Rochman, assistant vp in Washington for the Alliance of American Insurers.

Ms. Rochman also noted that without legislation the reforms could be revoked or altered in the future. **BI**

MSAs

Continued from page 1

dict President Clinton will not veto the legislation if MSAs are limited to a specific period of time, such as part of a demonstration project.

House and Senate Republicans—who met in informal sessions—also were trying to resolve a major stumbling block involving mental health care benefits. The Senate bill would require health plans to offer the same coverage for mental disorders as for physical ailments. The House bill lacks a mental health care benefits parity provision.

Earlier last week, Sen. Pete Domenici, R-N.M., who authored the Senate's mental health care benefit amendment, suggested a compromise in which equal coverage would not have to be provided for mental health benefits covering substance

abuse treatment. He did not provide many details, but said that the cost impact on health care plans of his revised proposal would be about half that of his original amendment. According to the Congressional Budget Office, mental health care benefits parity, as originally proposed, would increase costs by about 4% (BI, May 20).

Meanwhile, Senate Majority Leader Robert Dole, R-Kan., said there was informal agreement to drop a provision in the House bill that would allow small employers to band together—free of state regulation—to cover their health care risks through multiple employer welfare arrangements. The Senate bill does not include a comparable provision.

The Clinton administration and various insurance trade groups denounced the provision, warning that

it could lead to a new round of MEWA collapses. The provision is championed, though, by small employer interests that say there are sufficient protections to reduce the likelihood of MEWA failures.

Other differences in the House and Senate bills are relatively minor and should be able to be resolved quickly once an agreement can be reached on MSAs and mental health care benefits.

The core of both bills, though, are identical: curbing pre-existing medical condition exclusions. About 70% of group indemnity plans have such exclusions.

Under both bills, group health care plans still could deny coverage for a new employee's pre-existing condition for 12 months. But that 12-month exclusion would be offset by previous health care coverage the new employee had. **[B]**

Tempest Re

Continued from page 1

Tempest Re; Mr. Duperreault spent more than 20 years at AIG and was a star executive at the company before leaving to join ACE; and Jeffrey W. Greenberg, another ACE director and former AIG executive, is Maurice Greenberg's son.

The late IPC bid could be an attempt by AIG to force an improved offer by ACE and consequently get a better price for its shares of Tempest Re, analysts say.

While the IPC bid makes sound business sense, it also would be seen by some as a personal victory by Mr. Greenberg over former AIG associates.

The value of both offers ultimately will depend on the value of IPC and ACE stock, though IPC appears to be outbidding ACE by more than \$100 million.

IPC would pay a \$100 million cash dividend to Tempest Re shareholders, as well as \$146 million in cash to General Reinsurance Corp. for 75% of its share in Tempest Re and the cancellation of its ties with the company. General Re currently owns 20% of Tempest Re. The balance of the deal would be paid 61% as IPC stock and 39% as cash.

AIG would purchase enough shares in the combined company to ensure that it maintains its 24% stake in IPC.

IPC shares have been traded on the NASDAQ exchange after an initial public offering in March. The shares were trading at \$20.25 last Friday.

ACE's offer is principally based on exchanging shares of ACE stock (BI, Feb. 12). Under that deal, Tempest Re shareholders would receive approximately 13.3 million shares of ACE. ACE stock closed on the New York Stock Exchange at \$44 last Friday, which would value those shares at about \$585 million. ACE stock lost about \$4 per share last week after the IPC offer was announced, down from \$48.13 per share on June 3, the day before the new bid.

In addition to the ACE stock, prior to the acquisition Tempest Re would pay \$172 million to General Re to buy back its shares, and any net assets of Tempest Re over \$500 million would be distributed to Tempest Re stockholders. According to the latest figures available, about \$40 million would be distributed.

ACE will not immediately sweeten its offer to counter the IPC bid, said Mr. Duperreault. "I'm keeping my options open," he said.

The IPC offer currently is being reviewed by the Tempest Re board of directors and, if they favor the IPC deal, ACE will have five days to respond, he noted.

However, Mr. Duperreault said,

the ACE proposal offers more certainty to Tempest Re shareholders and already is superior.

The IPC offer would close after the brunt of the hurricane season and a major storm loss could have an impact on the IPC share price, he explained, whereas the ACE offer is scheduled to close in two weeks, before hurricane season picks up.

"Also, I think that our company is a superior company and the combination of ACE and Tempest is compelling," Mr. Duperreault said.

But if IPC wins the battle for Tempest Re, it would significantly increase its size and make it the third-largest property catastrophe reinsurer in Bermuda.

Partner Reinsurance Co. Ltd. is the largest property catastrophe reinsurer in Bermuda, and Mid Ocean Reinsurance Co. Ltd. is the second-largest.

At year-end 1995, IPC had capital and surplus of \$434.3 million and it had written gross premiums of \$104.1 million.

Tempest Re had capital and surplus of \$692.3 million at its fiscal year end, Nov. 30, 1995, and gross premiums of \$177.6 million.

"This acquisition will, in a single step, expand our client relationships and diversify the geographic spread of risk to levels that would otherwise require several years for either company to achieve on its own," said Mr. Johnson of IPC.

The two deals are difficult to compare, said Peter Wade, vp at Lehman Brothers in New York.

"In pure dollar terms, IPC's is a higher bid but there is a hell of a lot more uncertainty," he said.

ACE's stock is quoted on the New York Stock Exchange and is more widely traded than IPC's over-the-counter stock, Mr. Wade noted.

Also, a big hurricane could severely affect all companies in Bermuda, he said. "It would be a bit like holding a retail stock through Christmas—you just don't know how sales are going to go at Macy's."

The bid could be a way for AIG to gain more for its investment in Tempest Re than ACE is currently offering, said Donald Watson, a director of Standard & Poor's Corp. in New York. "AIG thinks that the offer by ACE does not offer an appropriate return for the founders of Tempest," he said.

By either prompting ACE to increase its offer, or by increasing its stake in Tempest Re and enjoying further profits from the company, AIG could secure a better return on its investment, he said.

If the IPC offer is accepted, the combined IPC and Tempest Re company could secure more business as buyers of reinsurance would likely view the larger company as a more secure reinsurer, Mr. Watson said.

Besides the potential returns from

the deal, another factor behind IPC's offer may be the personalities involved.

AIG's Mr. Greenberg has taken retaliatory action in the past against a company run by a former associate.

AIG terminated \$45 million in ceded reinsurance premiums to Prudential Reinsurance Co. after Joe Taranto left AIG affiliate Transatlantic Holdings Inc. to run Pru Re. AIG declined to comment.

While the IPC deal makes good business sense for AIG, it could also contain a personal element, analysts agree.

"It is pure speculation, but it's hard to dismiss the idea given the personalities involved," said Mr. Watson of S&P.

Mr. Greenberg would have made the offer regardless of who he was up against, "but because it is Brian Duperreault he probably has a smile on his face," said Michael Smith, an analyst at Salomon Brothers in New York.

Donald Kramer, chairman of Tempest Re, is the personality who will reap benefits, whichever bid prevails. Mr. Kramer owns 10,000 shares in Tempest Re and has 66,666 vested stock options in the company.

Mr. Kramer had previously sought alternative deals for Tempest Re in an attempt to reap stronger rewards for the investors in Tempest Re. Last year, he was involved in discussions with Lloyd's of London managing agency Methuen Group Ltd. A plan for Tempest Re to invest in Methuen was vetoed by General Re, which did not want to invest in a competitor in the reinsurance market.

ACE, which also had discussions with Methuen, invested in the managing agency.

The IPC offer for Tempest Re could signal consolidation among Bermuda's catastrophe reinsurers.

The original eight cat reinsurers were established in 1992 and 1993 and have enjoyed high premiums and profits since. However, over the past year catastrophe reinsurance rates have weakened and investors' returns have fallen, provoking some speculation that one or two of the reinsurers might be taken over.

"I would not be surprised to see one more linkup," said Mr. Wade of Lehman.

Smaller catastrophe reinsurers in Bermuda might unite to form larger companies that are better equipped to satisfy reinsurance buyers' growing desire for catastrophe reinsurers that have \$500 million or more in capital, Mr. Wade said.

Regardless of the future ownership of the Bermuda reinsurers, "having two quality outfits making offers to by Tempest validates the concept that the Bermuda market is here to stay," said Willis T. King, chairman of Willcox Inc., a reinsurance broker in New York. **[B]**

Updates

Eljer settles with former parent

PROSPECT HEIGHTS, Ill.—Household International Inc. will pay \$27.2 million to settle litigation with Eljer Industries, a former unit.

The suit, filed in Delaware state court, arose out of the 1989 spinoff of Eljer, a plumbing products manufacturer. Eljer claimed the spinoff left it without adequate reserves to cover product liability claims against U.S. Brass Corp., a wholly owned subsidiary. U.S. Brass filed for Chapter 11 bankruptcy protection in 1994 under the weight of suits involving its manufacture of plastic piping.

The settlement also disposed of Household's counterclaims against Eljer.

Without admitting any wrongdoing, Household said it settled the suit to "avoid the significant expenses and uncertainties" of continuing the litigation. A trial was set to begin on May 20 but was adjourned because of the settlement talks. "We felt that it would be best for us to come to a meeting of the minds," said a spokesman for Prospect Heights, Ill.-based Household.

The proceeds of the settlement eventually will be placed in a trust fund to cover the costs of suits pending against U.S. Brass when it emerges from bankruptcy protection, said Eljer General Counsel George Hanthorn. Household's spokesman said none of the settlement is covered by insurance.

Banks expect fraud recoveries

RICHMOND, Va.—Eight banks defrauded of \$350 million by a former Philip Morris Cos. employee who pleaded guilty June 5 to bank fraud and money laundering charges still expect significant recoveries of the funds.

Edward J. Reiners is scheduled to be sentenced Oct. 21 in U.S. District Court in Richmond, Va., on the charges stemming from the fraud scheme he engineered over a two-year period beginning in 1993. Mr. Reiners secured the loans from a syndicate led by Richmond-based Signet Banking Corp. after convincing bank officers that the funds would be used to purchase computer equipment needed for a top-secret Philip Morris project aimed at developing smokeless cigarettes and other cigarette alternatives (BI, March 25).

"We're still optimistic about the recovery situation," a Signet spokeswoman said. Government officials have informed the bank that they have recovered \$200 million to \$220 million of the \$350 million, she said, "and there are some indications there may be additional recoveries beyond that." Signet is insured for losses resulting from fraud, the spokeswoman said.

Briefly noted

In a case pitting **Allstate Insurance Co.** against California insurance regulators, the U.S. Supreme Court ruled that federal judges cannot refuse themselves in civil cases where only monetary damages are sought. California sued Allstate to recover about \$7 million in reinsurance it had written for Mission Insurance Co., which was declared insolvent in 1987. Allstate had sought to have the suit heard in federal court, but a federal judge agreed with state regulators that the matter should be heard in state court because of the state's overriding interest in uniform regulation of insurance insolvencies. Allstate appealed, and a unanimous U.S. Supreme Court agreed there were no grounds for the federal judge's abstention. . . . The trust fund that pays **Medicare hospital benefits** for the elderly faces insolvency by the year 2001, one year earlier than previous estimates, fund trustees said last week. . . . Rep. Marcy Kaptur, D-Ohio, is drafting legislation that would require employers to share control of **defined benefit plan assets** with their employees. A similar proposal was defeated by the House of Representatives in 1989. . . . A hearing on **Aetna Life & Casualty Co.**'s proposed acquisition of Blue Bell, Pa.-based U.S. Healthcare Inc. (BI, April 8) was scheduled last Friday by the Connecticut Insurance Department. Regulatory approval has already been obtained in Delaware and Virginia, while another hearing is scheduled in Georgia this week and approvals in several other states are pending. . . . Nearly \$900 million in bonds **Orange County, Calif.**, issued June 5 as a cornerstone of its bankruptcy recovery plan sold briskly, though at higher-than-market interest rates. Meanwhile, the county announced plans to file up to 10 more lawsuits this week related to the derivative investments that led to its financial woes. . . . Chubb Life Insurance Co. of America, speeding its retreat from group managed health care, said last week it would sell its 85% interest in **Chubbhealth Inc.**, a New York-based HMO, to Hooksett, N.H.-based Healthsource Inc. for \$25 million. The HMO has grown to 45,000 members since Healthsource and Chubb co-founded it in 1993. . . . **Blue Cross & Blue Shield of Michigan** will refund more than \$25 million to as many as 250,000 contract holders. The rebates represent partial compensation for copayments that the Blues' customers paid to hospitals between 1989 and 1994, charges that were calculated without taking into account hospital discounts received by the plan. Cypress, Calif.-based **Yamaha Motor Corp. U.S.A.** will appeal a \$35 million compensatory damages award an Elba, Ala., jury ordered it to pay to a youth injured while riding one of its all-terrain vehicles. Although the award contained no punitive damages, Yamaha said it far outstripped awards made for comparable injuries and "inevitably lends substance to foreign distrust of the American legal system." . . . Washington is the latest state to **sue cigarette makers**, filing suit last week in state court to recover medical costs over the past 40 years for tobacco-related illnesses. In the first lawsuit against cigarette manufacturers filed by a local government, San Francisco's city attorney filed suit in federal court on behalf of the city and county to recover medical costs. . . . A California legislative conference committee is still working on bills to start up the **California Earthquake Authority** and the facility is not dead yet, despite the withdrawal of its tax-exempt status by the Internal Revenue Service, a spokesman for state Senate President Pro Tem Bill Lockyer said. Supporters are hoping to see legislation passed before the end of the session in August.

Cargo Vessel

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30 March
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