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Update

Democratic proposal would strip insurers of antitrust exemption

WASHINGTON—House subcommittee staff members are circulating draft amendments to strip insurers' current limited exemption from federal antitrust law.

The Democratic staff of the House Monopolies and Commercial Law Subcommittee is examining modifications to the McCarran-Ferguson Act that would make price fixing or the development and publication of recommended rates subject to antitrust law.

Continued on next page

OSHA cracks down

Rules limit toxic exposures

By DEBORAH SHALOWITZ

WASHINGTON—Compliance with a far-reaching Labor Department proposal to reduce workers' exposure to about 400 widely used hazardous substances in one fell swoop will cost employers almost $930 million annually, the government says.

The proposed regulation, announced last week by the Occupational Safety and Health Administration at a press conference in Washington, will apply to about 500,000 facilities using the regulated substances, according to the agency.

About 100,000 of these facilities will incur some costs to comply with the proposed rule, according to OSHA. The total annual cost of compliance, according to OSHA: $927.83 million, including capital outlays and operating expenses.

About 3.7 million workers currently are exposed to higher levels of hazardous substances than will be allowed under the proposed rule, OSHA estimates. Workers' exposure to 205 of the approximately 400 substances has never been regulated before.

The breadth of the proposed rule, which Assistant Secretary of Labor John A. Pendergrass called "the most significant workplace exposure action taken by OSHA in its 17-year history," is a major departure from OSHA's traditional procedure of evaluating the safety of substances individually.

Using that approach, the agency has produced comprehensive health standards for only 24 substances in 17 years after a wholesale adoption in 1971 of exposure limits governing approximately 500 substances.

"The substance-by-substance approach cannot keep up with the number of chemicals in the market," Mr. Pendergrass said.

OSHA estimates that the new standard, which could take effect as soon as early next year, could reduce work-related illnesses by 50,000 cases each year. Furthermore, the new standard could reduce lost workdays due to exposure-related illnesses by 500,000 annually and save up to 500 lives per year.

OSHA has not estimated the savings employers will realize in workers compensation costs as a result of the reduced exposures.

OSHA's recommended new exposure levels did not meet with unanimous approval. The AFL-CIO released a statement shortly after the OSHA announcement claiming that the proposed regulation "does not go far enough."

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Photo: Ken Heinen

Assistant Secretary of Labor John Pendergrass unveils OSHA's sweeping proposal to reduce workers' exposure to about 400 widely used hazardous substances.

House vote unlikely after panel OKs product liability bill

By DEBORAH SHALOWITZ

WASHINGTON—The federal product liability reform bill expected to be approved by a House committee this week probably will not make it to the House floor this year, observers say.

"I don't think the legislation will see the light of day on the House floor," said Tom O'Day, associate vp in the Washington office of the Alliance of American Insurers.

There is only a "remote" chance of the legislation proceeding to the House floor this year, agreed Liberty Mahshigian, co-counsel for The Product Liability Alliance in Washington.

Rep. Thomas Tauke, R-Iowa, told an insurance industry gathering last week that after the House Energy and Commerce Committee finishes its markup of the product liability bill, "we won't hear anything more about it" this year.

Even during markup of the bill, committee members seemed to assume the legislation would not get much further.

"Obviously (the bill) is not going anywhere," said Rep. Ralph M. Hall, D-Texas. "We're just getting on record for the November elections."

And Rep. Henry Waxman, D-Calif., said he plans to work on a broad amendment to exclude all drugs from product liability legislation when the proposal is considered in the next session of Congress.

The watered-down bill that the Energy and Commerce Committee

Continued on page 38

Long-term care legislation may rise from ashes in '89

By JERRY GEISEL

WASHINGTON—Legislation that would establish a new, massive federal long-term health care program will be back on the congressional front-burner next year despite the House of Representatives' decisive rejection of a home health care proposal last week.

Amid charges of by-passing normal congressional review procedures, the House voted 243-169 to decline to consider a $30 billion home health care bill proposed by Rep. Claude Pepper, D-Fla., the congressional champion of the elderly.

The measure would have socked employers with $3 billion in new Social Security payroll taxes annually over the next five years to finance home health care benefits for the elderly and the chronically disabled. Employees would have picked up the remaining $15 billion tab on the program costs.

The cost of the program would have been funded at least initially by subjecting all wages to the Medicare portion of Social Security payroll tax. The Medicare tax—paid equally be employers and employees—currently is 1.45% of the first $45,000 of wages.

The death of the legislation, which had developed a strong head of steam, had as much to do with the manner in which it came to the House floor as with objections to the measure's provisions.

The bill bypassed the House Energy and Commerce Committee and the Ways and Means Committee, which normally would have had jurisdiction over the legislation, after Rep. Pepper worked out a deal with House Speaker Rep. Jim Wright, D-Texas.

Under this arrangement, Rep. Pepper was promised a floor vote on his cherished legislation without committee scrutiny.

In addition, under a rule approved by the House Rules Committee, which Rep. Pepper chairs, the bill was to be considered with limited debate. No amendments could be added to it.

In exchange for the promised floor vote, Rep. Pepper agreed not to offer any long-term health care amendments to legislation recently approved by the House and Senate that expands the Medicare program to cover acute care catastrophic health care expenses (see update, page 2).

Congressional heavyweight Daniel Rostenkowski, D-Ill., chairman of the House Ways and Means Committee, was outraged by this arrangement and used his considerable influence to help kill the bill.

"The committee of jurisdiction has been effectively discharged without the normal requirements and procedures for such action having been followed. I cannot remember a more serious violation of the House rules," Rep. Rostenkowski said in a widely circulated letter to his House colleagues.

"This is a gag rule," said Rep. John Dingell, D-Mich., another congressional powerhouse, referring to the limited debate rule.

"This rule denies the House the opportunity to have

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HMO enrollment topped 30 million in January
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Update

Antitrust changes under review

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Insurers say that if the proposal is enacted, then joint activities, such as the setting of rates by industry organizations like the Insurance Services Office Inc. and the formation of industrywide pools, could be subject to antitrust challenges.

"There would be a tremendous amount of uncertainty. There would be a reluctance to get involved in joint ventures if you faced the prospect of treble damages," said Steve Broadie, senior tax counsel for the Alliance of American Insurers in Washington.

Under the amendments, sharing data on expenses, profits or "contingencies" would be brought under the purview of antitrust laws. Other activities subject to antitrust law would include tying the sale of insurance to any other service or product.

Insurers could continue to share "loss costs," which are not defined in the proposal.

The amendments also would give the Federal Trade Commission full authority to investigate the insurance industry.

Industry lobbyists say more amendments are expected to be unveiled soon.

Travelers puts units on block

HARTFORD, Conn.—Travelers Corp. plans to sell its reinsurance, excess and surplus lines and surety businesses, which accounted for a total of $397.1 million in premiums last year, according to a spokesman.

The sale will include all of Constitution State Management Co., which writes both reinsurance and surplus lines business, and the bulk of the business handled by Plaza Corp., which also writes surplus lines business, the spokesman said. However, Travelers will retain an annuities business operated by Plaza.

Surety business is handled by a Travelers department, he noted.

There already have been several inquiries from potential buyers, said the spokesman, who said: "We're talking to them."

Travelers decided to sell the businesses as a result of its ongoing evaluation of its operations and their strategic importance to Travelers, said Wheeler H. Hess Jr., senior vp-property/casualty, in a statement.

The reinsurance business generated $307.1 million in premiums last year, while the surety business generated $50 million and the surplus lines business $40 million in premiums, the spokesman said.

The business to be sold represented 7.6% of Travelers' reported $5.26 billion in net written premiums in 1987.

Last month, Travelers sold a Plaza subsidiary, C&F Surplus, to Greenwich, Conn.-based W.R. Berkeley for an undisclosed sum, the spokesman also noted. C&F is a surplus lines underwriting manager.

Travelers also plans to sell its Toronto-based Canadian insurance operations, which have assets of more than $682.1 million.

Senate passes Medicare bill

WASHINGTON—Legislation to expand the federal Medicare program is headed to President Reagan for signature.

Last week, the Senate approved landmark legislation 86-11 giving the elderly more protection from catastrophic acute care health expenses. The House overwhelmingly approved the measure earlier this month (*BI*, June 6).

The legislation will expand both Part A of Medicare, which covers hospital expenses, and Part B, which covers physician services, to limit retirees' total out-of-pocket expenses for covered services to about $2,000 a year. The legislation also requires employers that eliminate portions of their retiree health care plans that duplicate new benefits of the expanded Medicare program to pass those savings on to retirees in two phases (*BI*, May 30).

In 1989, employers will have to pass on for one year the cost savings they achieve when they eliminate hospital benefits that duplicate Medicare Part A, which will be expanded that year.

In 1990, employers that reduce benefits that duplicate Medicare Part B will have to pass those savings on to retirees for one year.

The total savings—through the elimination of duplicative benefits—that an employer with a representative retiree health care plan will have to pass on to each retiree will be about $100 to $120 over the next two years, experts say.

The Medicare legislation will be financed through sharp increases in the monthly Part B premium and a new income-related supplemental premium paid by retirees.

N.Y. to drop public entity MAP

NEW YORK—The state of New York will phase out its liability insurance market assistance program for municipalities during the next year because the coverage now is more available.

Under the voluntary Municipal Market Assistance Program, enacted in 1985, approximately 25 insurers wrote liability insurance for towns, villages and school districts that could not obtain coverage on their own. MMAP, which assisted more than 300 municipalities at the height of the program, now serves 150 municipalities.

The MMAP will not accept new business after Sept. 1 and will not renew coverages after July 1, 1989.

A New York Insurance Department spokesman said the program did not include a time limit when it was instituted because "it was to be in effect until the market repaired itself and the participants

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Errors & omissions

- CIGNA Corp.'s aftertax operating earnings declined 55% during the first quarter. CIGNA's earnings were incorrectly reported in a chart in the June 6 issue due to the inadvertent omission of parentheses. The aggregates and averages in the chart are correct.

Former clients charge B.R.I. with extortion, racketeering

By DOUGLAS McLEOD

NEW YORK—B.R.I. Coverage Corp., one of the largest privately held U.S. insurance brokers, is fighting civil racketeering and extortion charges brought by a group of former clients.

In a complaint filed in U.S. District Court in Manhattan, New York-based Potamkin Cadillac Corp. and 19 other Potamkin auto dealerships accuse B.R.I. and two B.R.I. executives of defrauding the Potamkin group of millions of dollars over a six-year period.

Among other things, the complaint charges that New York-based B.R.I.:

- Secretly collected commissions on insurance placements for which it had already received fees.
- Fraudulently misrepresented Potamkin's loss experience during the first two years of a three-year retrospectively rated policy covering Potamkin's auto leasing customers. As a result, Potamkin drastically undercharged its leasing customers for the coverage and suffered out-of-pocket losses of about $6 million.
- Violated New York insurance law by depositing Potamkin premiums in B.R.I. operating accounts rather than in an escrow account.
- Threatened Potamkin that it would go to the state attorney general with allegations about "illegal acts" by Potamkin if Potamkin complained about B.R.I.'s alleged misconduct to the state Insurance Department.

Potamkin also accuses B.R.I. of bad faith for filing a lawsuit against the auto dealership in New York State Supreme Court.

B.R.I.'s own suit—filed last July but dismissed last month—charged that Potamkin underreported the number of leased autos covered by the retro program, failed to pay premiums when due and failed to pay service fees and other amounts advanced by B.R.I. The suit sought compensatory damages of more than $1.3 million.

However, in court papers seeking to dismiss B.R.I.'s lawsuit, Potamkin charged that B.R.I. knew of its plans to file a federal racketeering suit and filed its complaint in state court as a " 'first strike' intended to impede the prosecution of the claims against B.R.I."

State Supreme Court Judge Irma Vidal Santaella dismissed B.R.I.'s lawsuit on May 18, said James B. Zane, a partner with the New York firm of Zane & Rudofsky, which represents Potamkin.

Meanwhile, B.R.I. has denied the allegations in Potamkin's federal complaint and has filed several counterclaims leveling essentially the same charges outlined in the state court action.

B.R.I. President Donald T. Ferrarini, a defendant in the federal lawsuit, said the dispute "is purely a matter of accounting." B.R.I. has suggested that the two sides settle the dispute by hiring independent auditors to resolve the accounting problems, he said.

Potamkin, one of the largest auto dealership groups in the nation, has since shifted its brokerage account to Johnson & Higgins, according to Mr. Zane, who declined to comment further on any of the allegations in the federal complaint.

Potamkin's lawsuit, filed Aug. 3, 1987, names B.R.I.; Mr. Ferrarini; Harold K. Ross, a B.R.I. senior vp; and H.K. Ross Corp., another brokerage based in New York and controlled by Mr. Ross.

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Charges against defendant in Howden scandal dropped

By STACY SHAPIRO

LONDON—Criminal charges have been dropped against one of the five defendants in the prosecution stemming from the alleged theft of underwriting funds from Alexander Howden Group P.L.C. and Lloyd's of London syndicates formerly managed by Howden.

At the beginning of a four-week pretrial hearing last week in the Guildhall Magistrates Court, the only two charges against former Howden Finance Director Allan Page were dismissed.

Mr. Page's lawyer, Derek Inman, said that Mr. Page is too ill to attend the proceedings and has "a short life expectation." Mr. Page has cancer.

Mr. Page was one of five former Howden executives arrested in July 1987 and charged with fraud in the so-called Howden affair, which came to light in 1982 after Alexander & Alexander Services Inc. acquired Howden (*BI*, Aug. 2, 1982).

A&A in civil litigation filed in 1982 accused five Howden executives of misappropriating $56 million of Howden and Lloyd's underwriting funds for their own benefit.

One of those executives, Ronald Comery, died in a car crash before the four other executives and a former Lloyd's underwriter were arrested (*BI*, July 20, 1987).

The proceedings before Magistrate Anne Mallinson will decide if prosecutor Timothy Langdale has a strong enough case to go to trial against the remaining defendants: former Howden Chairman Kenneth V. Grob, flamboyant Lloyd's underwriter Ian R. Posgate, former Lloyd's underwriter Colin Hart and former Howden Director Jack H. Carpenter.

A 22-page detailed list of criminal charges revealed last week that:

- Mr. Grob, who was extradited from France, faces 55 charges including that on various occasions between 1980 and 1982 he stole more than 2.2 million pounds ($3.6 million at year-end 1982 exchange rates) and $2.6 million from Lloyd's syndicates 126 to 129, underwritten by Mr. Posgate.

Under extradition rules between France and England, Mr. Grob cannot be charged with conspiracy, so he has been charged with acts of "false accounting" by dishonestly falsifying records. The charges say he "omitted" in Howden group accounts money paid to secret holding companies belonging to Howden executives.

- Mr. Posgate faces three charges that between Oct. 1, 1979, and Sept. 1, 1982, he conspired with Mr. Grob, Mr. Comery, Mr. Page and Mr. Carpenter to "steal sums of money" belonging to Mr. Posgate's syndicates 126-129 and 701.

Mr. Posgate also allegedly conspired to defraud his members through dishonest reinsurance transactions to help the Howden executives secretly acquire the Banque du Rhone et de la Tamise S.A. for the benefit of himself and the other Howden executives.

- Mr. Carpenter, who faces six charges of dishonesty, and Mr. Hart, who faces four charges, between January 1974 and May 1977 conspired with Mr. Grob, Mr. Comery, and Mr. Page to steal "sums of money" belonging to the members of syndicates 502/64 and 868/35, which were managed by Howden. ■

Inside

- More than half of the public believes it is fair for health insurers to cover the cost of some expensive, high-tech medical procedures and not others, a recent survey shows. **PAGE 7**
- Continued congressional foot-dragging on a federal product liability reform bill and the inevitable compromises made to move it along are discouraging. **PAGE 8**
- In Speaking Out, Donald G. Lightfoot of Blue Cross of California explains the many benefits of a simple workplace exercise program for employees. **PAGE 23**
- The worst service disaster in Illinois Bell's history is over, but the company's legal problems are just beginning. **PAGE 35**
- The nation's first law requiring employers to protect VDT operators is not needed, the bill's opponents say. **PAGE 36**
- One automaker moved closer to settling a class-action suit while another was sued last week. **PAGE 37**
- Leonard M. Wilson, senior vp of Lazard Asset Management Inc., says insurance brokerage managements are thinking about future competitive positions. **PAGE 39**

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Panel debates industrywide 'conspiracy'

Photo: Jerry Geisel

From left: Legislator Michael Stinziano, attorney general Charlie Brown, broker R.C. Riley, attorney George Bernstein, regulator Louis Bergeron and economist Scott Harrington.

By JERRY GEISEL

WASHINGTON—Cutthroat competition among insurers and an expanding civil justice system—not an industrywide conspiracy—triggered the liability insurance crunch of the mid-1980s, several experts say.

At a freewheeling discussion in Washington last week sponsored by two insurance trade groups, insurers, academics, regulators and other observers ridiculed the allegations by state attorneys general in antitrust suits that the property/casualty insurance industry organized a conspiracy to manipulate the liability insurance market.

"I don't think it was a conspiracy. Conspiracy implies collusion. The industry is too greedy to collude," said Lyndon L. Olson Jr., president of The National Group Insurance Cos. in Waco, Texas, and former chairman of the Texas State Board of Insurance.

"The bottom line: The industry was irresponsible in their underwriting. They wanted market share. They competed themselves into the ground," Mr. Olson added.

"In 1982-84, general liability suffered deteriorating results. No doubt insurers lost money. Logic dictates prices will go up. Companies can't lose money over the long term," said Scott Harrington, associate professor of economics at the University of Pennsylvania's Wharton School.

"Activistic" judges sought maximum compensation for victims. When that happens, the insurance system breaks down, said George Priest, John M. Olin professor of law and economics at Yale University's School of Law and director of Yale's Center for Studies in Law, Economics and Public Policy.

State attorneys general, who filed antitrust lawsuits in March charging that individual insurers and certain insurance trade groups conspired to limit commercial liability insurance coverage, defended those charges (*BI*, March 28).

Those suits, said West Virginia Attorney General Charlie Brown, are an effort to get "justice" for insurance consumers.

Insurers acted differently when compared with other industries facing economic pressures: They acted to "conspire," ultimately resulting in restricted liability coverage and "inferior" policies offered to the public, said Mr. Brown, one of the attorneys general participating in the antitrust litigation.

"They (insurers) sat together in London (and) New York. . . .They decided what is

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Aerojet requests rehearing of pollution coverage denial

By STACY ADLER

SAN BRUNO, Calif.—Aerojet-General Corp. is asking a California state court to reconsider its recent decision that comprehensive general liability policies do not cover government-mandated pollution cleanup costs.

Disregarding contrary preliminary rulings made weeks earlier in the same court in the Shell Oil Co. litigation, San Mateo County Superior Court Judge John J. Bible ruled May 25 that costs incurred by a policyholder in complying with a government-mandated cleanup are not legal damages and, therefore, are not covered by CGL policies.

On June 3, La Jolla, Calif.-based Aerojet filed a request for reconsideration of the decision, which bars the company from collecting tens of millions of dollars from its 55 commercial liability insurers from 1956 to 1984.

The underlying litigation involves the leaching of trichloroethylene, or TCE, into the groundwater near Sacramento, Calif. TCE, which was used by Aerojet as a solvent to clean rocket parts, leached into the groundwater under its 8,000-acre facility and is suspected of having leached into the American River.

As a result, both the state of California and the United States have sued Aerojet and its subsidiary, Cordova Corp., for the costs of cleaning up the contaminated area. The federal government's suit was filed under the Comprehensive Environmental Response, Compensation & Liability Act, better known as the Superfund Act. California sued for violations of the state's Regional Water Board regulations.

In addition, Aerojet has settled about 60 private third-party lawsuits involving the leaching of TCE, according to Aerojet attorney Moses Lasky of Lasky, Haas, Cohler & Munter in San Francisco. The average settlement was $200 to $1,000, he said.

Aerojet has paid about $50 million to date to clean the groundwater, but the final cleanup bill will be "substantially" higher, he said.

Some estimates put the total cleanup bill at $80 million to $100 million.

From 1956 to 1960, Aerojet had occurrence-based third-party liability coverage with limits of $4 million to $10 million. From 1960 to 1970, policy limits were $10 million to $50 million. In later years, the limits were increased to in excess of $100 million.

While various primary insurers were on the risk during the 28 years, underwriters at Lloyd's of London and other London market insurers led the primary coverage for 14 years from 1956 to 1970. In addition, the London market wrote excess coverage for Aerojet in later years.

Other insurers that wrote significant limits for Aerojet include AIU Insurance Co. of New York and other units of American International Group Inc.; Argonaut Insurance Co. of Menlo Park, Calif.; CNA Insurance Cos. of Chicago; Fidelity & Casualty Co. of New York in Concord, N.H.; Insurance Co. of North America in Philadelphia; Transport Indemnity Co. of Los Angeles; and U.S. Fire Insurance Co. in Morristown, N.J.

In his ruling, Judge Bible said: "Insurers that have insurance policies and certificates that state 'to pay on

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$3 million deficit in health care plan is blamed on TPA

By MICHAEL BRADFORD

NEW ORLEANS—The Orleans Parish School Board's self-insured health care plan is at least $3 million short of funds needed to pay claims because the plan's third-party administrator mishandled claims payments, school board officials allege.

However, the TPA—Parker, Pleas, Brown & Davis Inc. of New Orleans—argues that the board was aware of the firm's claims payment process and that the deficit is the result of the board's own budgeting mistakes.

Both sides last week were awaiting the results of a recently completed audit by the Dallas office of William M. Mercer-Meidinger-Hansen Inc. of the claims the TPA administered.

Orleans Parish School Board officials contend that the deficit resulted because Parker, Pleas did not process a large volume of claims it should have during the 1987 fiscal year and instead held over the claims until the 1988 fiscal year, which ends June 30.

"The third-party claims administrator got very behind on claims in the spring of 1987," said Sam Scarnato, associate superintendent of business and finance for the school board.

"Claims that should have been paid prior to June 30, 1987, remained on the desk and weren't processed" until after the end of the fiscal year, he said.

Because so many claims incurred in 1987 went unpaid, budgeting for the 1988 fiscal year was based on the artificially low claims recorded in 1987, school board officials explain.

The faulty budget projection, combined with the payment of 1987 claims with 1988 funds, has left a budget deficit that could

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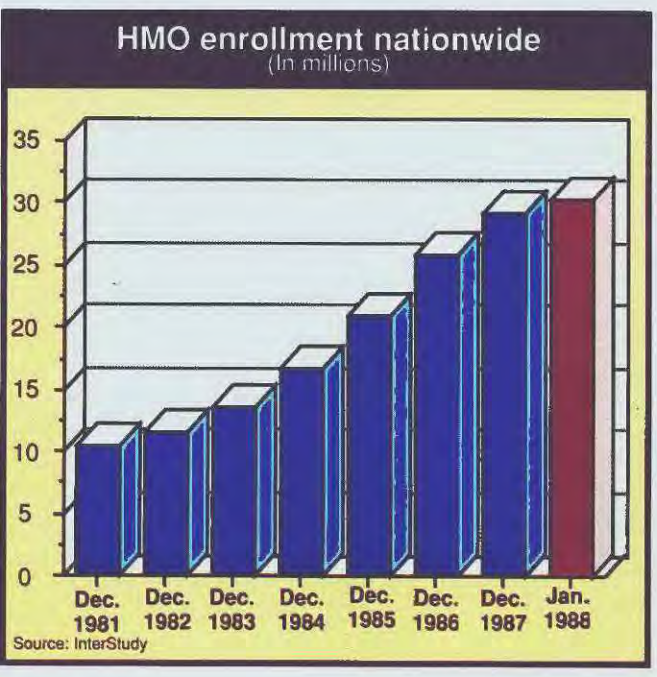
HMO enrollment tops 30 million: InterStudy



By ALISON KITTRELL

Health maintenance organization enrollment nationwide now exceeds 30 million for the first time ever, according to a recent study.

And, although the HMO enrollment growth rate slowed considerably in 1987, significant growth in January 1988 enrollment may indicate that this trend is reversing, says InterStudy, an Excelsior, Minn.-based research organization.

HMO enrollment through January was 30.3 million, which represents a 3.5% gain in just one month from the year-end 1987 HMO enrollment figure of 29.3 million, according to the most recent data InterStudy has collected. Overall, more than 12% of the U.S. population received health care through HMOs in 1987, InterStudy notes.

However, HMO enrollment for all of 1987 increased only 13.6% from 25.8 million at year-end 1986.

By contrast, HMO enrollment grew 22% in 1986, and 26% in 1985 (*BI*, Dec. 7, 1987).

InterStudy believes that several factors contributed to the slower rate of growth in 1987.

First was "the proliferation of preferred provider organizations as an alternative to HMOs," which the research group says siphoned off some of the growth from HMOs.

In addition, "HMO growth is being adversely affected by new marketplace demands being evinced by employers," InterStudy says.

Some of these new demands stem from provisions in the HMO Act of 1973, which introduced standards HMOs must meet to be federally qualified, including defined minimum benefit requirements and mandated community rating. A federally qualified HMO can mandate that an employer offer the plan if the employer has 25 or more employees in the HMO's service area and does not already offer a federally qualified HMO to its employees.

But, InterStudy says: "What was a boon to many HMOs in the mid and late '70s has now become an albatross to many plans confronted with employer demands for group experience rating and a more flexible approach to benefit packages," InterStudy says.

In addition, cost is the employer's major concern in the face of rising premiums, not the promise of cost containment, comprehensive benefits or quality health care, the report suggests.

Growth in HMO enrollment also declined in part because of increased enrollment in alternative managed care products, the study says (see story, page 32).

For example, enrollment in "open-ended" HMOs, which InterStudy defines as "an HMO product that offers enrollees a dual (and sometimes triple) choice regarding the provider(s) from whom they wish to receive care," was 378,671 at year-end 1987, a nearly 50% increase from 251,969 at year-end 1986.

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EC freedom of services nears ratification

Worldwide

BRUSSELS, Belgium—Cross-border placement of insurance among European Community member countries is only a few steps away from becoming law following the adoption of the EC's non-life insurance directive by the European Parliament last month.

The European Council, the EC's final rule-making body, is expected to approve on June 22 the draft directive on non-life insurance freedom of services that will allow insurers in one EC nation to insure large corporate risks based in another EC country (*BI,* May 16; Dec. 28, 1987).

As much as 70% to 80% of the non-life premium volume written in EC member states will be affected by the directive. Currently, only the United Kingdom and the Netherlands allow such freedom of insurance services.

The council's approval will allow the directive, which has been discussed by the EC since 1975, to become European law and will require each EC member country to pass legislation to implement it.

Although the European Council, which is composed of ministers from each EC member nation, approved the directive in February, the European Parliament insisted on formally examining the proposed directive for a second time on the grounds that too much time had passed and too many changes had been introduced since it last examined the proposal in 1978.

The council must again approve the directive following parliamentary approval even though the Parliament, during its meeting last month in Strasbourg, France, rubber-stamped the text agreed to by the council without proposing any further amendments.

The new directive was generally praised by members of the European Parliament. However, some expressed concern about the possibility of insurance companies from non-European Community countries being given freer access to the EC market when EC companies could be barred from providing similar services in those foreign markets.

Some members of the Parliament believe that the principle of reciprocity should be introduced in the directive in order to protect European interests.

—By Denise Claveloux

Filipino fire

MANILA, Philippines—A fire last month at one of Manila's largest department stores will probably cost insurers more than $30 million, making it the largest insured loss in Filipino history.

The Shoemart Department Store in the affluent Manila suburb of Makati caught fire just after closing May 17, killing one person and injuring 11 others. The fire raged out of control for more than two days because there was no sprinkler system and firemen were unable to penetrate the heavy metal sunshades that help keep the four-story building cool.

Fire Marshal Ernesto Madriaga said the firemen were unable to contain the fire because the Shoemart building was designed "like an oven. It lacks openings for ventilation."

Gen. Madriaga estimates damage to the store, owned by businessman Henry Sy, will total $33.33 million, including $7.14 million in lost merchandise.

Shoemart's property coverage, placed by in-house brokerage Shoemart Insurance Brokers, is led by The Malayan Group of Insurance Cos., the largest insurance group in the Philippines and Southeast Asia, according to insurance industry sources. Malayan Group was reinsured by at least 10 companies worldwide, the source said.

Shoemart could not be reached for comment.

The loss is the largest fire insurance claim in Filipino history, exceeding the $25 million insured loss of a shopping center in 1984, according to insurance industry sources.

An arson investigation is under way in the Shoemart fire. Investigators say some store employees were still inside the building when the fire broke out in a second-floor stockroom and explosions may have preceded the fire.

—By Kathleen Barnes

Canadian insurers

TORONTO—Banks and other financial institutions may be allowed to compete with Canadian insurers by the mid-1990s, government officials say.

Canada, like the United States, currently prohibits most banks from engaging in many insurance operations.

However, "insurance has been the slowest among financial institutions to meet the needs of the market," said Paul McCrossan, a Conservative member of the Canadian Parliament. "This is because they have been sheltered. They have been very slow to act.

"The insurance industry has probably a six- to eight-year breathing space. If the industry cannot demonstrate that it can develop a worldwide business plan, then that protection" against bank competition "will be taken down," said Mr. McCrossan at a symposium attended by insurers and brokers last month in Toronto.

"Your creativity will be challenged to the utmost as the new financial sector takes clearer shape," said Canadian Finance Minister Thomas Hockin.

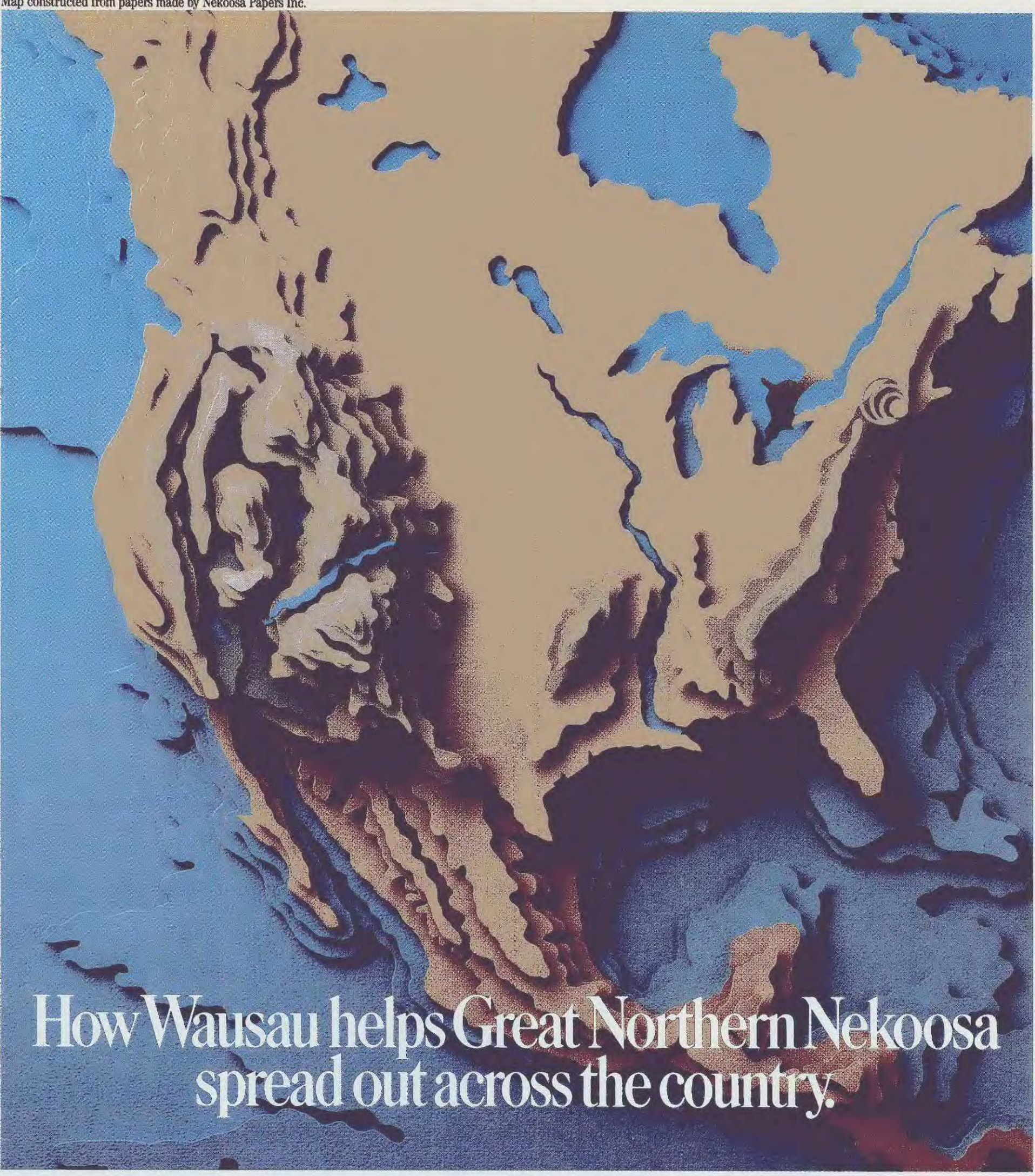
"Government cannot create competitiveness, vitality and originality. But, we can increase incentives for companies which become more competitive and compete more wisely. We can refrain from burdening industry with unnecessary regulations which dampen vitality and choke off originality," Mr. Hockin said.

"We should begin with the premise that within four or five years, the banks and others will be selling insurance products," said Larry Grossman, a former leader of the Ontario Conservative Party and now a senior vp with stockbroker Richardson Greenshields of Canada Ltd. in Toronto.

But, instead of worrying about bank entry into the insurance business, Canadian insurers should increase their own opportunities, said Garth McGirr, president of Price Waterhouse Ltd. in Toronto. He noted that insurers should consider entering new product areas like mutual funds and credit card services.

—By Tony Thompson

Map constructed from papers made by Nekoosa Papers Inc.



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Washington state self-insures benefit plan

By GLENN HUNTLEY

About 90,000 Washington state employees can expect higher deductibles and copayments under a new self-insured benefits plan that starts July 1.

The state decided to self-insure last winter after the only two health care insurers that participated in a competitive bidding process to write the coverage submitted bids far higher than the $233 the state Legislature had authorized to pay per employee per month for health care coverage.

Under legislation approved last fall, state officials were empowered for the first time to seek self-insurance options for employees' health care coverage.

The state's current health insurer, Blue Cross of Washington and Alaska, said it was suffering substantial losses from the medical and dental plan that cost the state $170 monthly per employee.

Blue Cross and Aetna Life & Casualty Insurance Co. offered to provide similar coverage for $283 to $285 per employee per month, a state spokesman said.

After the bidding, the competing insurers offered to lower the costs by increasing deductibles, which the state rejected, said Terry Sebring, legal counsel to Gov. Booth Gardner.

Benefit beat

The self-insured plan should cost about $235 per month per employee, about what the Legislature had budgeted, said Amy Eiden, a budget analyst in the governor's office. The state has budgeted $137.9 million for the first year of the plan.

But even at that rate, the state will pay far more than the $170 per employee it had been charged by Blue Cross.

In addition, annual deductibles under the self-insurance plan will increase from those applied in the Blue Cross plan. Individuals will pay a $100 deductible, up from $75, while families will pay a $300 deductible, up from $225.

As a cost-containment measure, the state has contracted with Sound Health Network, a Seattle-area preferred provider organization, and will provide incentives for employees to use the PPO.

In addition, August International Inc. of Orange, Calif., will provide utilization review services.

The state's self-insured health claims will be administered by Control Data Corp. of Minneapolis, while Washington Dental Service Inc. of Seattle will handle dental claims.

The new plan includes the following provisions:

- Annual out-of-pocket expenses are capped at $500 for individuals and families who use preferred providers and $900 for those who use non-preferred providers.
- Copayments are 10% for preferred providers and 20% for non-preferred providers. However, in areas where preferred providers are unavailable, copayments are 15%.
- Employees and their dependents do not contribute to the self-insured plan, just as under the Blue Cross plan.
- Generic prescription drugs are paid at 90%, while non-generic prescription drugs are covered at 80%.
- Dental care is paid at 90% after an annual deductible of $25 for individuals and $75 for families. The maximum dental benefit is $2,000 per person. Orthodontics is covered at 50%, up to a maximum of $750 per covered individual.

In addition to the new self-insurance plan, the state will continue to offer its employees the option of enrolling in 10 health maintenance organizations around the state.

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Made any benefit changes? Write Glenn Huntley, Business Insurance, 6404 Wilshire Blvd., Los Angeles, Calif. 90048; 213-651-3719.

Comings & goings: buyers

Griffith Labs names Flores risk manager

D. Ted Flores named corporate risk manager for Griffith Laboratories U.S.A. Inc. in Alsip, Ill., a new position. He is responsible for developing and implementing a worldwide insurance and risk management program for the food ingredients producer. He reports to Joseph R. Maslick, vp-treasurer. Previously, Mr. Flores was a senior analyst on Abbott Laboratories' risk management staff in Abbott Park, Ill. He has a bachelor of business administration degree from the University of Iowa in Cedar Rapids. He also holds the Associate in Risk Management and Associate in Claims designations and is working toward the Chartered Property & Casualty Underwriter designation.

* * *

Anthony F. Marino, 38, has been named insurance administrator for Evans Inc. in Chicago. He will handle day-to-day operations of the fur and apparel retailer's insurance department. He replaces **Ellen West**, who left the company, and reports to Sven Thomsen, risk manager. Mr. Marino had been a commercial claims representative for Gallagher-Bassett Services Inc. He has a bachelor's degree from the University of Wisconsin in Stevens Point, and is a deputy member of the Risk & Insurance Management Society.

* * *

Robert L. Powell III, 40, named director of risk management and loss control at Collins & Aikman Corp. in Charlotte, N.C. He oversees property/casualty insurance and loss control and safety programs for the textile manufacturer. He replaces **Donald G. Duncan**, who left the company, and reports to Leon Frederick, president of Collins & Aikman's Science and Service division. Mr. Powell, who most recently served as director of corporate safety, joined Collins & Aikman's safety department in 1973. He has a bachelor of science degree in chemistry and physics from Guilford College in Greensboro, N.C. Mr. Powell is a Certified Safety Professional, vp of Region IX of the American Society of Safety Engineers and past president of the Tar Heel Chapter of the ASSE. In addition, he has received the ASSE's Safety Professional of the Year award.

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To report on staff changes, write Paul Winston, copy editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590, or call 312-649-5442. Please send a photograph, too.

High tech complicates health care choices

By ALISON KITTRELL

More than half of the public—after some deliberation—believes it is fair for health insurers and employers to cover the cost of some expensive, high-tech medical procedures and not others.

However, when first presented with the proposition in a survey, only about one-third of the public thought it was right for health plans to selectively cover medical treatments.

The survey, designed by Louis Harris & Associates, was commissioned by the Loran Commission. That commission was established by the Harvard Community Health Plan, a Massachusetts health maintenance organization, to make recommendations for making decisions about coverage for expensive but potentially life-saving technologies.

In conducting the survey, Louis Harris polled 1,250 people representing a cross-section of the American public, 200 physicians, 200 employers, 100 nurses, 100 federal and state political leaders and 50 labor leaders.

The report says there are few easy answers to the problem of how to finance high-cost medical procedures. "Caught between the explosive growth of powerful, new and expensive medical technologies and the need to contain costs, health insurance plans will face many difficult decisions over the next few years," the report says.

On the one hand, there has been an incredible growth in technology and research, so that lives now can be saved that would have been lost a few decades ago, the study says. But, it adds, the cost of that technology and treatment often is enormously expensive.

At the same time, the spread of acquired immune deficiency syndrome and the general aging of the population has created and will continue to create new pressures on the health care system.

"This might not matter if we were winning the fight to contain health care costs. However, health care expenditures are still rising much faster than increases in the gross national product or gross domestic product. . . .It is clear, therefore, that the need to contain and limit health care expenditures, by government and employers, will be at least as strong in the next decade as it has been in the 1980s," the study says.

The question, the report says, is quite simply: "How does one choose? How should one choose between covering a relatively inexpensive therapy which will improve the quality of life for thousands of people, and a very expensive therapy which will save a few lives?" The survey was designed to get people to think about that question, and the responses show that it did.

For example, at the beginning of the survey, respondents were asked whether it is reasonable that "all health plans cover the cost of some treatments and medical procedures and do not cover some others."

Only 37% of the public believed that this was fair, though substantially higher percentages of the various leadership groups questioned agreed with the statement, including 91% of the employers surveyed.

At the end of the survey, however, the same question was asked. This time, 56% of the general public said they agreed that it was reasonable for health insurance to cover some treatments and not others. The percentage of the leadership groups agreeing with the statement also increased.

The response of the general public on questions of access to health care, and on questions regarding specific choices, reflect the immense complexity of the question.

For example, 91% of the public agreed that "everybody should have the right to get the best possible health care—as good as the treatment a millionaire gets."

But, only 71% said they believe that "health insurance should pay for any treatment which will save lives, even if it costs $1 million to save a life." And, only 66% say that "it's not fair that some people can afford to buy more and better health insurance than others."

The survey also points out that "most Americans also recognize that we do not have, and will not achieve, this ideal of universal access to all necessary health care procedures."

Eighty-five percent said they understand that "whatever system we have, some people will always get more and better health care than others." And, 80% agree that "even if we spent twice as much as we do now on health care, there would still not be enough to provide all the health care services and treatments and procedures that people would like to have."

In addition, 76% of the public said that by the 1990s, the existence of new treatments will force health insurance plans to make difficult choices about what to cover, and 63% said they believe that such choices already are being made by health care plans.

The public's response to how these decisions should be made indicate the wide range of ethical questions involved.

For example, 81% of the public said that it was more important to cover a treatment that would save the lives and completely cure 50 very sick children than it would be to cover a treatment that would save the lives of 1,000 75-year-olds and give each of them three additional years of life.

And, 62% said it would be more important to cover a new treatment that would significantly improve the lives of 100 people with arthritis than it would be to cover a procedure that would give one person five more years of life.

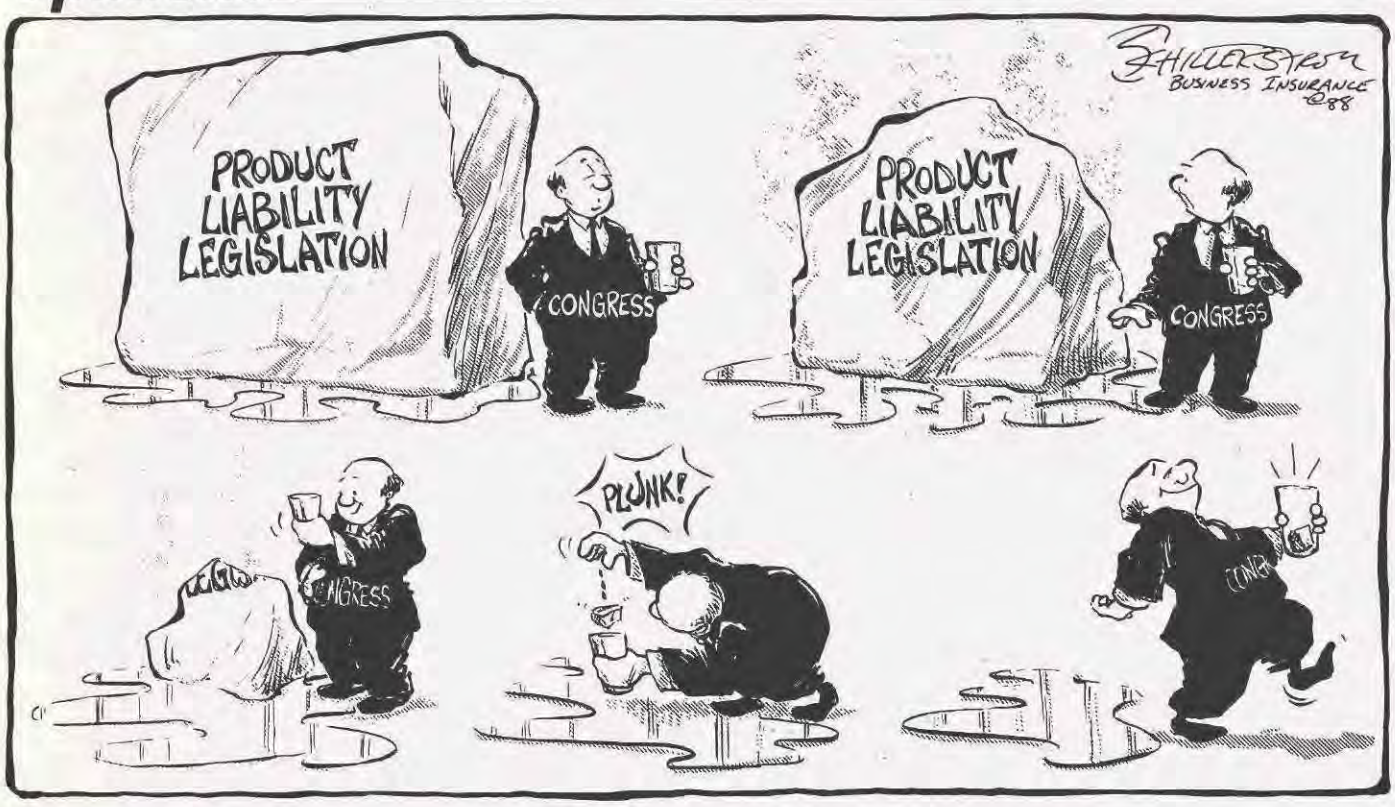
Fifty-eight percent said it was preferable to pay for heart transplants costing $100,000 each that would give patients an average of five extra years of life than to pay for in vitro fertilization costing $20,000 per patient that would help 20% of couples conceive.

And, 54% of the public would opt to cover insulin pumps rather than a new cure for leukemia.

In addition, respondents were asked which of eight criteria would be most important in making a decision about what should be covered. The ranking of the criteria by the general public was:

- That it will help many people.
- That it will help save lives.
- That it will help prevent disease.
- That it will help young and middle-aged people.
- That it will greatly improve the quality of life.
- That it will provide many extra years of life.
- That it will help handicapped people lead normal lives.
- That it is not expensive. ■

Opinions



Watered-down reform

THE CONTINUED CONGRESSIONAL foot-dragging on a federal product liability reform bill and the inevitable compromises made to move it along are discouraging.

For nearly seven years business has lobbied for a federal product liability bill to bring some uniformity and predictability to product liability law in this country. The Senate Commerce Committee has approved federal product liability legislation three times, but the bills have never made it to the Senate floor for a vote.

The House Energy and Commerce Committee was still wrangling last week over provisions of another product liability bill, although it looked like it would pass (see story, page 1). Nonetheless, it is extremely unlikely that the full House will vote on the bill this year.

If this keeps up, members of the European Economic Community soon will have more uniform product liability laws than the United States of America.

But while all this is disappointing, businesses should not despair.

Action by the House committee would give federal product liability legislation some momentum for next year.

At least the next Congress will know that one House committee approved it—and a Democratic-controlled committee at that.

And while the bill is pitifully weak in its reforms —stripped even of a provision eliminating joint and several liability for non-economic damages—it is a starting point that, as unlikely as it seems, could be strengthened next year.

In addition to abolishing joint and several liability for non-economic damages, a meaningful federal product liability reform bill needs several other provisions missing from the bill under consideration: a cap on punitive damages, such as a multiple of two or three times compensatory damages; a provision funneling punitive damage awards into a public trust used to compensate victims of injury who otherwise cannot recover for damages; a statute of repose on consumer goods, such as the presumption that a consumer good is not defective 10 years after it was manufactured; and a provision making it more difficult for U.S. manufacturers to be sued in U.S. courts for accidents occurring outside the United States.

Supporters of a federal product liability reform bill must persevere and out-lobby the trial lawyers, who are the major opponents of the legislation. It will be no small accomplishment, but it can be done.

Letters

Benefit lobbying also needed on the state level

To the editor: Congratulations on your May 16 editorial, "Join the Fight," calling for involvement in government by employee benefit managers and corporate executives.

As Illinois' premier business organization, we regard your comments as music to our ears, with one discordant note: Why involvement only on the federal level?

State government is increasingly active in the benefits arena. The states are often guinea pigs for mandate proposals. For example: Illinois had two laws on the books closely mirroring the federal Consolidated Omnibus Budget Reconciliation Act before COBRA's enactment.

Large or self-insured employers are not immune to the effects of state-level initiatives.

Massachusetts is a prime example of the impact the states can have on self-insured employers. Also, each session the Illinois Legislature addresses parental leave, plant closings and a host of other labor-management issues.

We all have a responsibility to make government responsive. As you aptly put it: "Quit complaining. Get involved."

Lester W. Brann Jr.
President
Illinois State Chamber of Commerce
Chicago

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

Massachusetts law likely to produce deficits

To the editor: I think the euphoria over Massachusetts' new health care statute expressed in your May 30 editorial is premature. The most favorable aspect of the statute appears to be that $1,680 per year is below the actual per employee health care cost of virtually all employers that provide coverage, so no employer of any consequence is currently affected.

Unfortunately, that's also the reason that the program is likely to produce enormous deficits. When that happens and the $1,680 is increased to $2,680, $3,680 or more, then I believe you will join many other benefits experts in concluding that taxing employers because they do not spend enough for health care benefits is a ludicrous approach to solving our problems with respect to delivering and paying for health care.

Charles G. Thacher
President
Williams, Thacher & Rand Inc.
New York

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Antitrust suits

Continued from page 3

best in the industry's interest," said Andrea Ordin, a chief assistant attorney general for the state of California's Division of Public Rights.

These widely differing views of what caused liability insurance premiums to skyrocket and certain lines of coverage to virtually dry up were presented last week at a panel discussion in the National Press Club that was co-sponsored by the American Insurance Assn., a Washington-based trade group representing property/casualty insurers, and the Insurance Information Institute, a New York-based insurance industry information and public relations organization.

The discussion brought together 12 experts representing attorneys general, insurance regulators, academics, consultants, insurance agents, consumer representatives, state legislators and the media.

The panel discussion, moderated by Professor Arthur Miller, Bruce Bromley Professor of Law at Harvard Law School and a legal commentator for ABC-TV and the Public Broadcasting System, was intended to provide a thorough and balanced discussion of public policy issues involved in the attorneys general's antitrust suits.

Those suits, filed in federal courts against leading U.S. and London property/casualty insurers and reinsurers, the Insurance Services Office Inc. and others, detail a chain of events that the attorneys general have charged led to liability coverage restrictions for businesses and public entities.

Among other things, those suits charge that as a result of the defendants' alleged conspiracy, ISO was forced to rewrite its new commercial general liability insurance policy forms to exclude all pollution coverage and to include a retroactive date in its new claims-made CGL form.

The defendants also sought to eliminate occurrence-based CGL forms and to include defense costs within excess liability policy limits, the suits say.

The antitrust suits do not charge insurers with manipulating price, since the McCarran Ferguson Act allows insurers to jointly set rates.

However, the insurers' alleged conspiracy resulted in a scarcity of coverage and a doubling and tripling of premiums when coverage was available, said West Virginia's Mr. Brown.

Profit was the motive for the insurers' actions, he added, pointing out that insurance rates—and later stock prices—went through the ceiling.

Kathryn J. McIntyre, associate publisher and editor of *Business Insurance,* disputed the picture painted by the attorneys general in their suits, including that of insurers meeting behind closed doors to limit CGL coverage.

For example, following the release of the first version of the new CGL claims-made form in May 1982, the proposed form was dissected, reprinted and the subject of numerous news stories and Perspective columns in *Business Insurance,* Ms. McIntyre said. Ultimately, the form was modified.

And, she added, it is the very nature of the insurance industry that its representatives must meet to discuss coverages and policies.

"Insurers are not islands unto themselves," Ms. McIntyre said. "They have to share risks and information," she said.

Ms. McIntyre noted that liability coverage for municipalities did dry up during the market crunch. But that was the result of their loss of sovereign immunity, a development to which she advised attorneys general to pay more attention.

Some of the panel members said the antitrust suits were politically motivated, filed by attorneys general who want to restructure the insurance industry.

'I don't think it was a conspiracy. Conspiracy implies collusion. The industry is too greedy to collude,' says Lyndon L. Olson Jr. 'The industry was irresponsible in their underwriting. They wanted market share.'

"Clearly, the suits have political motivations," said George Bernstein, a Washington attorney who has frequently represented insurers.

The attorneys general want to restrict competition, Mr. Bernstein said, adding that those behind the suits want state or federal officials to have more authority to regulate insurance rates.

New Hampshire Insurance Commissioner Louis Bergeron pointed out that insurance already is one of the most heavily regulated industries, charging that the suits are a "politically motivated scenario" by people running for office.

"I have not seen any concrete proof" that the suits' allegations are "anything other than innuendo," he said.

In fact, the claims-made CGL form is a flop, Mr. Bergeron said. In New Hampshire, for example, the claims-made form is used for just 3% to 5% of all liability risks, he said.

But Mr. Brown suggested that because of inadequate resources, insurance regulators may not be in the best position to judge the behavior of the industry.

"I don't think you can fight with the industry with one actuary," said Mr. Brown, referring to the number of actuaries employed by the New Hampshire department.

But Mr. Olson said the industry is heavily regulated and is not an out-of control "gargantuan octopus." In fact, the Texas State Board of Insurance has a $65 million annual budget and employs about 1,000 people, he said.

Other panelists said the increase in liability insurance costs and the implementation of policy restrictions were the inevitable results of massive underwriting losses in the early 1980s.

Mr. Bernstein, for example, referred to a federal Housing and Urban Development Department study that found that insurers writing coverage for housing authorities paid out $2 42 in claims for every premium dollar they collected between 1982-84.

"What insurer will write insurance under those conditions?" he asked.

The introduction of the new claims-made CGL form, in fact, was an effort by insurers to use a policy form that was better able to help them accurately measure risk than the occurrence form, Mr. Bernstein added.

Regardless of the outcome of the suits, the cost of the litigation and all of the negative publicity is taking its toll, some panelists said.

Mr. Olson, who said only partly in jest that insurers will be defending the antitrust suits for the "next 55 years," worries that insurance company executives eventually will say enough is enough and pull out of the market, agreeing only to provide reinsurance and administrative services.

"This will not assist in regulation," he said.

R.C. Riley, a broker with Peel & Holland Inc. in Benton, Ky., pleaded for all sides to stop arguing

Continued on next page

Continued from previous page

"The only person being hurt is the consumer," he said. If insurers cannot develop standardized forms and collect information, "we will have to deal with 3,500 (different) policies," which would be a great disservice to the consumer, he said.

Mr. Bernstein said the antitrust suits detract attention from the real problem driving insurance costs: the U.S. civil justice system. The public still has not heard or understood the message that there is a link between insurance costs and a liberal tort system, he said.

One industry critic, Jay Angoff, counsel for the National Insurance Consumer Organization in Alexandria, Va., conceded that insurers have good defenses against the antitrust charges under the McCarran-Ferguson Act, which gives insurers limited immunity from federal antitrust laws and leaves primary regulation of the industry with the states.

Mr. Angoff said he hoped that one of the outcomes of the litigation is new pressure on Congress to repeal McCarran-Ferguson.

But Michael Stinziano, chairman of the Ohio General Assembly's insurance committee, contended that state regulation is a "damn sight better" than federal regulation, pointing to the recent rash of failure of federally insured and regulated savings and loan association.

Others contend that the attorneys general's argument that the crisis was caused by a conspiracy lacks logic.

Orin Kramer, president of Kramer Associates, a New York-based consulting firm, said the attorneys general, on one hand, have said insurers got in trouble because of competition. Then, the attorneys general argue that the industry colluded. Obviously, they cannot have it both ways, he said.

"We all see reality rather differently," replied California's Ms. Ordin. ■

Health care plan

Continued from page 3

amount to as much as $3.8 million by the end of this month, according to Mr. Scarnato.

The board had budgeted for $12.9 million for health care claims through June 30 but had paid claims totaling $15.96 million as of June 1, according to Mr. Scarnato.

Until this year, the board had accurately budgeted for health care claims, according to Mr. Scarnato. The self-funded health care plan provides benefits for 4,256 employees, dependents and retirees.

However, because funds from the self-funded health care plan and from all of the board's other self-funded benefit plans "funnel into one account," the health care claims are being paid with funds from the entire account, Mr. Scarnato explained. And that account remains in the black, he pointed out.

The board had budgeted for $12.9 million for health care claims through June 30 but had paid claims totaling $15.96 million as of June 1, said Sam Scarnato, associate superintendent of business and finance for the school board.

Parker, Pleas acknowledges that the claims backlog contributed to the fund deficit, but it contends that the board knew about the backlog and did not properly account for rising health care costs when planning its 1988 budget.

Parker, Pleas Chairman Jack Parker said last week that while he had not seen the auditors' final report, he believes it will vindicate the TPA. "I understand that it's favorable, that any shortfall is not our fault."

Mr. Parker blamed the claims backlog on high employee turnover last year, which left the TPA shorthanded, and computer problems. However, those problems have been corrected and claims processing is now current, he added.

Mr. Parker said the computer problems are the first his firm has ever encountered and that last year's claims backlog was "the first time" the firm was ever behind in the eight years the firm has administered the school district's self-funded plan.

Mr. Parker also alleges that the shortfall in funds to pay claims is the result of higher health care costs than the school board had expected.

Peggy Williams, who joined Parker, Pleas as vp of claims last July, agrees that the school board did not properly account for the rising cost of health care in its 1988 budget for the self-funded plan.

Because of the board's improper budgeting, surplus funds that the board should have been able to carry over from its 1987 budget to its 1988 budget to pay the 1987 claims were eaten up by higher than anticipated health care costs, she said.

Ms. Williams also said the Mercer-Meidinger audit likely will convince the board that some changes are needed in the type of health care benefits it offers.

For example, she said, the plan pays 80% of mental health claims with no cap on the amount of benefits paid.

"So many people take advantage of that," Ms. Williams noted. "They know that if they see a psychiatrist, the insurance will pay 80% of it. If they have a problem with their kids, the first thing they do is put them in a center, and the cost is picked up by insurance," she explained.

"I think that has a lot to do with them going over their budget. I think after they see the audit, they will come to the same conclusion. They have to look at their plan document if they want to control costs," she said.

But William Garibaldi, the school board's insurance administrator, says defections in recent years by 60% of the self-funded plan's participants to a health maintenance organization should have offset higher health care costs.

A 12% increase in health care costs "is not a major factor" when the fund is paying claims for far fewer employees, Mr. Garibaldi said.

Mr. Scarnato said the board factored in an 8% increase in health care costs when it drew up its health care claims payments budget for 1988.

"But we were using faulty data because we were budgeting on the past year's claims history and we didn't know about the backlog of claims," he said.

Mr. Garibaldi said he is counting on the audit to reveal why the self-funded plan is incurring such high claims costs even though there are fewer participants than in previous years.

He also pointed out that the board is evaluating bids from TPAs interested in administering the self-funded plan for the next fiscal year. The board's contract with Parker, Pleas expires June 30.

Earlier this year, the board awarded a contract to administer employees' life insurance, dental and vision claims to Group Insurance Administration of Chicago. The $32,000-per-year contract had been held by Parker, Pleas. ■

Outwaite cash calls may extend into '94

By CAROLYN ALDRED

London

LONDON—Members of the troubled Lloyd's of London syndicate managed by R.H.M. Outwaite (Underwriting Agencies) Ltd. probably will have to make cash payments of at least 20 million pounds ($36.2 million) every two years until the mid-1990s to cover massive losses from runoff reinsurance policies underwritten in 1982.

The estimate assumes that the agency loses its battle with cedants to limit payments under the runoff policies.

The 1,614 members of syndicate 317/661 during 1982 already have been asked to pay 20.65 million pounds ($37.4 million) by July 31, and likely will have to pay similar amounts in 1990, 1992 and 1994, according to the annual report published this month by the Outwaite agency.

However, members may be faced with another cash call next year, underwriter Richard Outhwaite says in the report.

The syndicate's losses stem from runoff reinsurance policies underwritten by Mr. Outhwaite in 1981 and 1982, which primarily provided unlimited liability protection above an agreed amount for other syndicates' and insurers' past underwriting years (*BI*, May 23).

Up to 250 members of the syndicate's 1982 underwriting year will meet in London this week to discuss strategy in the face of the syndicate's rapidly deteriorating losses.

The meeting has been arranged by about 50 of the syndicate's members who work in the Lloyd's market and who fear the losses likely will exceed Mr. Outhwaite's current estimates, according to Stuart Beare, a lawyer with the London law firm Richards Butler, which is representing the members.

The Outhwaite annual report shows that the syndicate's reserves to meet outstanding liabilities for the 1982 underwriting year now stand at 263.3 million pounds ($476.6 million), of which 133.8 million ($242.2) is reinsurance recoverable; 44.1 million pounds ($79.8 million) is cash and other liquid assets held by the syndicate; and 85.4 million ($154.6 million) is members' reserves.

The syndicate's reinsurance consists of time-and-distance policies, which provide payments at specific dates.

The syndicate has already made arrangements to collect from one of these policies in 1992 instead of 2006, though the payment will be reduced to $40 million from $75 million, the report says.

Claims and estimated losses on the runoff policies have caused a "devastating loss. Whatever the justification at the time, it has to be admitted that in hindsight it was a mistake," Mr. Outhwaite states in the annual report.

In addition, "the (loss) advices received in February and March of this year were generally much worse than any prediction, however pessimistic, could have forecast," notes Mr. Outhwaite.

For example, one runoff policyholder had told the syndicate that losses totaled $69.9 million in 1984; $81.5 million in 1985; and $87.4 million in 1986.

"Our projections and analysis led us to expect a figure at Dec. 31, 1987, of $96.2 million. The actual figure advised to us was $108.5 million," stated Mr. Outhwaite, adding that at the time the policy was written "the total outstanding losses advised to us were $17.6 million."

This great acceleration of estimated liabilities has led Mr. Outhwaite to question several of the runoff reinsurance contracts ceded to the syndicate.

"Any underwriter faced with the extraordinary difference between figures quoted then and those now would be failing in his duty if questions were not asked. When one remembers that all of these losses arise from past exposures and not from unforeseen future events, our concern is understandable," Mr. Outhwaite notes.

Mr. Outhwaite currently is disputing 185 million pounds ($334.9 million) of claims against the runoff policies on the grounds of inadequate disclosure (*BI*, May 23).

Meanwhile, the Outhwaite agency will be restructured during 1988 to produce a "clear separation of the group's activities and provide a corporate structure better suited to the management of a business which has grown substantially over recent years," according to the annual report.

Ferry litigation

Owners and insurers of automobiles, trucks, cargo and personal possessions lost or damaged when a British ferry capsized in the English Channel last year are suing the ferry's operating company.

In three separate lawsuits filed in London's High Court, 133 claimants are suing P&O European Ferries (Dover) Ltd., formerly Townsend Car Ferries Ltd., for damages sustained when the Herald of Free Enterprise capsized in March 1987 near Zeebruge, Belgium.

Some 171 people were killed in the accident (*BI*, March 16, 1987).

The suits seek 2.25 million pounds ($4.1 million) in damages, according to Anthony Thomas, a partner of the London-based law firm of Clyde & Co., who represents the plaintiffs.

The claimants are suing P&O for breach of contract, duty and negligence in the "loading, handling, custody and care of the plaintiff's cargo," according to the lawsuits.

P&O, which is contesting the claims, refused to comment while the matter is in litigation.

However, a spokesman for P&O's liability insurer, Standard Steamship Protection & Indemnity Assn. (Bermuda) Ltd., which is managed by Charles Taylor & Co. in London, said the claims were currently "under discussion."

Among the companies suing P&O are Norwich Union Fire Insurance Society Ltd., General Accident Fire & Life Assurance Corp. P.L.C., Services Motor Policies of Lloyd's of London, Cornhill Insurance P.L.C., Stahl Chemicals (GB) Ltd., Beecham Group P.L.C., Land Rover Ltd., Ford Motor Co. Ltd. and Courtaulds P.L.C.

Claims filed by survivors of victim are being settled according to a formula established by Standard Steamship Protection and the claimants' lawyers (*BI*, July 13, 1987). ■

Let every man practice the art that he knows best.
—Cicero

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NAEHCA conference

Rising health costs require quick action

The Arizona Biltmore in Phoenix was the site of the annual meeting of the National Assn. of Employers on Health Care Action.

By DONNA DiBLASE

PHOENIX, Ariz.—The time for complaining about the rising cost of health care or giving up on cost containment has definitely run out, asserts one health care expert.

"If I were on your side of the table, I would take very small comfort in being told, 'Think of what would have happened to health care costs if we had done nothing,' " says David L. Rosenbloom, president of Baxter/Health Data Institute, a health care cost management consulting firm in Lexington, Mass.

"We believe that managed care provides the private sector with its most complete and effective response to health care costs," Mr. Rosenbloom said. "And, medical case management of catastrophic illnesses is only one element in what must continue to be a growing armament of tools to fight medical cost inflation."

Mr. Rosenbloom urged employers to quickly and strongly respond to health care cost inflation during his keynote address, "Case Management in Action," delivered at the annual meeting of the National Assn. of Employers on Health Care Action.

The meeting was held June 2-3 at the Arizona Biltmore in Phoenix.

"There is enormous concern and disappointment among employers over not being able to contain health care costs. Many of our chief financial officers are being told health care costs will exceed 50% of profits, and benefit consultants and insurers are reporting 15% to 60% increases in group health insurance premiums," he said.

Employers must take action in four areas to contain costs and remain competitive in the business world, according to Mr. Rosenbloom:

- Obtain essential information on the specific health care cost and utilization problems of their health benefit plans.
- Organize a plan of action.
- Accept managed care as the best cost control and quality control approach.
- Choose the right program to solve their companies' particular benefit problems.

Mr. Rosenbloom noted several current trends in health care cost management.

"Employers are attempting to limit costs by shifting costs to employees through increased copayments; by cutting benefits like coverage of psychiatric care; by limiting their obligations to future retirees; and by implementing flexible benefit plans. However, these by themselves don't reduce expenditures over the long term," Mr. Rosenbloom pointed out.

There also has been a trend of limiting obligations to current employees, either by laying off employees or by relying on temporary help. "However, the federal government is making it harder to do this by enacting benefit mandates," like requiring employers to offer

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continued health care coverage to terminated employees under the federal Consolidated Omnibus Budget Reconciliation Act of 1985, he said.

Some employers are even giving up on benefit cost control, he observed. "And, many of us are ready to throw up our hands and ask the government to regulate the health care industry."

Employers must identify and understand the reasons for the escalation of health care costs so they can react, he said.

The Health Data Institute believes one major reason for the current rise in health care costs is the huge increase in recent years in ambulatory surgery utilization. According to statistics compiled by the American Hospital Assn., the use of outpatient surgery increased 17% from the fourth quarter of 1986 through the first quarter of 1987, Mr. Rosenbloom said.

"We are doing more surgery in the outpatient setting than we ever did in the inpatient setting," he noted.

In addition, "there has been a substantial increase in the price per patient episode. The cost to commercial or private payers of health care, like employers and insurers, is increasing from 12% to 18%. So, it's not so much the utilization of inpatient services that is increasing as it is the price per unit of service," he explained.

However, contrary to popular theory that the increase in the amount of the services delivered is a major contributor to health care inflation, "we at HDI frankly do not see a greater increase in prices because of the intensity of services," Mr. Rosenbloom said.

But, while "medical case management is not aimed at addressing these particular problems, it can help an employer to achieve substantial savings," he said.

"We now define medical case management as a clinical activity in which specialists work with the patient, physician and family to coordinate treatment for a particular catastrophic illness. It is not claim management; it's a clinical process and not an administrative process," he explained.

'Case management must intervene early and stay with a patient throughout treatment and recovery in order to be most effective,' Mr. Rosenbloom says.

Case management should not be a separate, stand-alone program, but rather should be integrated with hospital pre-admission certification programs. This ensures that cases with the potential for requiring intensive, expensive services will be identified as early as possible, he said.

"Case management must intervene early and stay with a patient throughout treatment and recovery in order to be most effective," Mr. Rosenbloom said.

Crucial to the success of case management is reliance on a case manager with specialty skills in the illness or injury he or she is dealing with, he noted. The skills of the case manager are important in developing an alternative treatment plan and in coordinating the special services the patient requires.

The diagnoses with the greatest potential for savings under case management include neonatal cases, physical rehabilitation, acquired immune deficiency syndrome, chronic pain and psychiatric and substance

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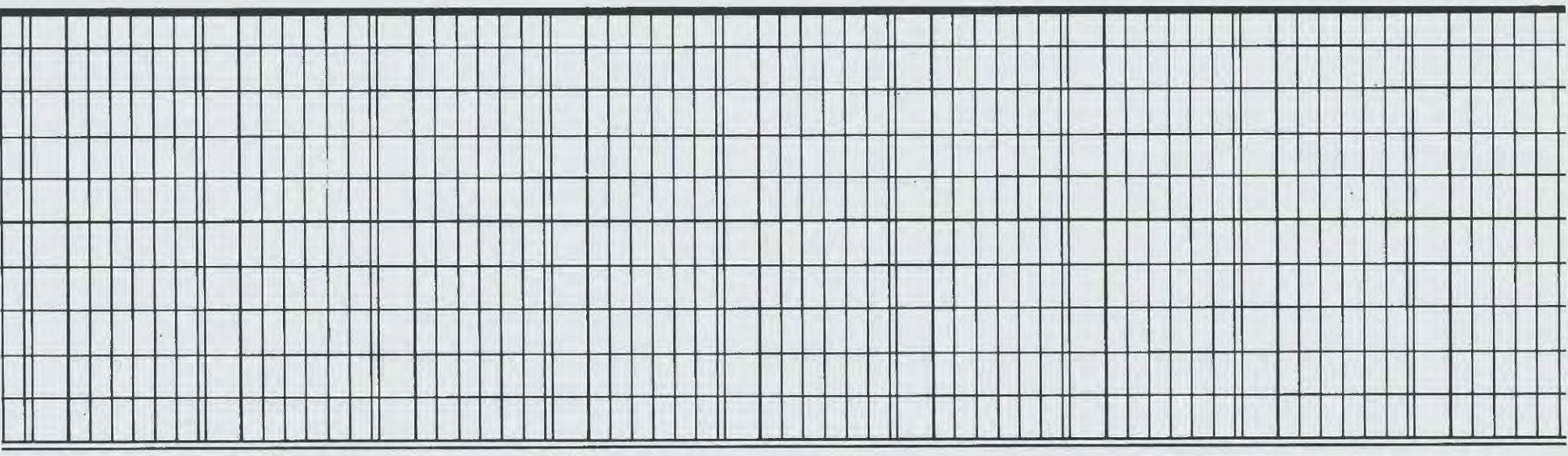

Early alert critical to case management

By DONNA DiBLASE

PHOENIX, Ariz.—Early identification and management of catastrophic illnesses as well as communicating with all employees to help them become efficient health care consumers are two important goals of a case management program, according to two benefit managers.

For example, Minneapolis-based Honeywell Inc. wanted a comprehensive program that not only would "identify potential candidates and see that these cases were entered into the case management program as early as possible" but also would communicate to employees that the program was a benefit and not an intrusion, said Dr. John M. Burns, vp of health management for the electronics giant.

And, Northwestern Bell Telephone Co. decided to "focus on the consumerism issue" when it designed its in-house case management program.

"We decided we had to teach employees to change their health care purchasing behavior," explained Carol Burkhead, insurance staff manager of Northwestern Bell, the Omaha, Neb.-based unit of US West Co. of Denver.

The case management programs of Honeywell and Northwestern Bell were the focus of "Employers' Experience with Case Management," a session at the annual meeting of the National Assn. of Employers on Health Care Action June 2-3 in Phoenix, Ariz.

Honeywell wanted to 'identify potential candidates and see that these cases were entered into the case management program,' and to communicate that the program was a benefit, says Dr. Burns.

"At Honeywell, we had made all of the usual changes in our benefit plans to react to health care cost increases," Dr. Burns explained.

"All health plans should include copayments because requiring employees to share in the cost helps us as employers to be very specific as to the appropriate utilization of health care benefits," he said.

In addition, employees will more carefully consider having certain procedures if they share the cost, Dr. Burns observed.

But, along with employee cost-sharing, the company decided to implement a program that would require employees' participation in their own health care, he said.

"Our problems were that management and employees viewed case management negatively and that the high-cost cases were not being managed effectively," Dr. Burns noted.

So, Honeywell designed a program using the company's own on-site occupational health nurses to identify catastrophic cases, referring them to case management vendors and reporting and auditing the progress of each case. These "health service advisers" act as health care advocates for Honeywell's 78,000 employees and their dependents.

The main candidates for case management at Honeywell are neonatal cases, organ transplants, neurologic conditions, trauma cases, psychiatric cases, cardiovascular conditions, respiratory conditions and malignancies, Dr. Burns said.

Under the program:

- An employee or dependent contacts a health service adviser, who then evaluates the appropriateness of the attending physician's suggested treatment plan.
- The health service adviser then reviews the suggested treatment plan with the patient and his attending physician.

Continued on next page

Health costs

Continued from previous page

abuse, he said.

"In neonatology, the biggest potential for savings is during the hospital phase of the case," when the most appropriate care can be arranged in order to obtain the earliest possible release from the hospital, he said.

In physical rehabilitation cases, moving the patient out of the hospital and into a specialized therapy program generates the most savings.

In AIDS cases, most care now can be delivered in the home with light nursing care and custodial care. This generates substantial savings and also is safer and more comfortable for the patient, he said.

In addition, case managers with clinical expertise in managing AIDS cases may bring new, more appropriate care techniques to the the attending physician's attention.

But, while psychiatric cases are among the highest cost cases in an employer's benefit plan, case management may produce only minimal savings.

"That's because most employers would rather pay for the 30 days of hospital care that they are on the hook for and then walk away from the case as soon as possible," he noted.

Case management can produce savings as well as provide better coordinated treatment in short-term and long-term disability cases, he said.

In addition, case management can be effective in helping an employer manage retiree health care costs—especially since more employers have retirees that are under age 65 and therefore are still receiving primary benefits from the employer's health care plan, he said.

Once retirees reach age 65, Medicare is the primary benefit plan, with the employer's plan covering only costs not covered by Medicare, he explained.

Because of their age and the likelihood that retirees suffer from one or more chronic illnesses, case management can be effective in helping an employer limit liabilities for retirees' health care, Mr. Rosenbloom said.

An employer's primary goals in case management are to save money and to provide help and a positive benefit to employees, he explained.

However, employers must really concentrate on communicating case management as a benefit. "We have seen overwhelming evidence that case management is a very positive benefit to employees. I frankly believe that employers are not admitting to or taking credit for providing this positive assistance to employees," he said. ■

Continued from previous page

The adviser also reviews with the patient his or her health care benefits and any alternative treatments. The adviser then refers the case to one of Honeywell's case management vendors.

- The vendor must develop a treatment plan for the patient within 48 hours of referral by the Honeywell adviser, who reviews the appropriateness of the plan.
- The vendor is then required to report to the adviser the patient's progress and the estimated savings from the alternative treatment plan. The adviser maintains this information in a computer at Honeywell.
- The adviser audits the treatment of the patient, the health care bills incurred and the claims payment.

Honeywell requires its case management vendors to meet strict criteria, such as documenting savings; maintaining confidentiality of cases; coordinating their activities with Honeywell's employee assistance program, utilization review program and third-party claims administrators; and specific timing requirements for screening, assessing and reporting on catastrophic cases.

The vendors also must help Honeywell design communication programs for employees and physicians, Dr. Burns said.

The company measures the performance of its case management vendors based on the achievement of the treatment plan goals, whether the vendor developed alternative plans that were high in quality but lower in cost and whether Honeywell's overall claims experience was positively affected by the vendor's case management activities.

The company also evaluates the vendor's performance based on employees' satisfaction with the case management services, he explained.

Northwestern Bell faced many of the same problems as Honeywell when the company began designing its in-house utilization review and case management program, according to Ms. Burkhead (*BI*, Feb. 15).

"There really were no incentives for our employees to use the health care system wisely. It was part of the 'Ma Bell' culture, where employees were used to having all of their decisions made for them. So, there was a lack of employee knowledge about the problems with the health care system," she explained.

The company began with an education campaign to enlighten employees and their families about the problems of health care inflation and inappropriate use of the health care system.

"We went to safety and health fairs held by the company in the five states in which we operate to tell employees about health care costs. We also developed a union/management committee to discuss solutions to the problem, and we communicated with employees through in-house" newsletters, she said

The utility has 15,000 employees, 10,000 of which are members of the Communication Workers of America union.

The company's first change involved converting the non-union employees' medical plan from a first-dollar coverage plan to a plan requiring a 20% copayment on most procedures. The plan also includes healthy lifestyle incentives, coverage of some preventive services and a mail-in prescription drug program, she said.

"We did this with management employees to convince the union that the 80/20 plan was as good or better than the first-dollar coverage plan," she said.

The company next introduced its "Medical Services Advisory Program," in which four registered nurses provide advice and health care provider referrals.

The company also has contracted with Parkside Health Services Co. of Park Ridge, Ill., to review the program and offer other consulting services.

Under the UR program, union employees, who are covered by a first-dollar medical plan, are required to contact the review nurses or face a $250 per-procedure penalty, Ms. Burkhead said.

Non-union employees who do not contact the program face a reduction in coverage to 50% from the normal 80% to 100% coverage for various procedures.

Employees contact the review nurses through toll-free telephone calls. "We want employees and not physicians to contact the review nurses before a hospital admission because the employee is the person we want to educate," Ms. Burkhead said.

After the initial contact, the attending review nurse obtains the patient's medical history and begins keeping a file. The nurse also provides information to the patient on the tests and procedures suggested by the attending physician, as well as on alternative treatments.

The nurse also advises the patient on the most effective way to use his or her health care benefits.

In addition, the review nurses follow each case closely and provide information on each of their cases to Blue Cross & Blue Shield of Nebraska, which administers claims for the company.

At the end of the patient's treatment, the nurses compute the expenses and savings of the case, Ms. Burkhead said.

The program's objectives include arranging for second surgical opinions; pre-authorizing inpatient surgeries; arranging organ transplants; pre-authorizing home health care or care in skilled nursing facilities or hospices; coordinating mental health treatment; and pre-authorizing inpatient physical rehabilitation. ■

Care costs hot topic in desert

PHOENIX, Ariz.—The hot climate of the desert was the backdrop for discussions on the hottest topic for employers these days: double-digit health care cost inflation.

However, the 110-degree temperature seemed cool compared with the heated discussions on ways to manage the rapidly escalating cost of health care during "Case Management in Action," the annual meeting of the National Assn. of Employers on Health Care Action.

The meeting was held June 2-3 at the Arizona Biltmore, a 39-acre resort whose design was inspired by architect Frank Lloyd Wright.

NAEHCA, which has more than 100 members, has been a consortium for employers on understanding health care issues and managing their benefit plans for more than 10 years.

Along with annual meetings and workshops throughout the year, NAEHCA publishes a variety of managed care directories and books on employer health care management.

NAEHCA will hold its 1989 annual meeting in Minneapolis. For more information, contact NAEHCA at 104 Crandon Blvd., Suite 304, Key Biscayne, Fla. 33149; 305-361-2810.

New techniques reduce costs of psych care

By DONNA DiBLASE

PHOENIX, Ariz.—As the cost of psychiatric and substance abuse care careens out of control, some employers are finding that managed care techniques can help get the costs back on track while retaining quality of care.

For example, Dayton, Ohio-based NCR Corp. decided to use its existing employee assistance program as a referral service for employees needing mental health services beyond what can be provided by the EAP. This way, employees are immediately directed to the most appropriate mental health professional and avoid utilizing unnecessary mental health services.

And, Xerox Corp. of Stamford, Conn., hired a firm that specializes in managed mental health care to help coordinate the most appropriate mental health care for employees in need of those services.

These programs were highlighted during the "Mental Health Case Management Action Programs" discussion at the annual National Assn. of Employers on Health Care Action meeting held in Phoenix June 2-3.

Based on its 1985 claims data, NCR realized its self-insured health plan had covered a total of 351 hospitalizations for mental health care.

The average length of stay for these confinements was 29 days and the company estimated it paid an average of $336 per day for these confinements, according to Douglas M. Bartlett, director of U.S. employee benefits for the computer firm.

To better manage the costs and the quality of the mental health care its employees receive, NCR introduced its "Psychiatric Advisory Service" in January 1987.

"This is a service that provides employee assistance in psychiatric hospitalization and outpatient mental health services," Mr. Bartlett said.

"The employee or dependent can receive short-term, company-paid counseling through our EAP. However, if the condition requires longer treatment, the EAP and a case manager from Prudential determine the most cost-effective treatment program and refer the patient to the appropriate mental health provider," Mr. Bartlett explained.

Newark, N.J.-based Prudential Insurance Co. of America administers claims and provides case management services for NCR.

NCR's Psychiatric Advisory Service includes financial incentives for employees to seek counseling through the EAP.

For example, the company's benefit plan usually covers 50% of the cost of office visits, up to a maximum of $30 per visit and a maximum of 50 visits per year. However, if employees obtain referrals through the EAP, coverage is increased to 80% of the cost of office visits, up to a maximum of $70 per visit for a maximum of 50 visits per year, Mr. Bartlett explained.

For employees that used the EAP referral service in 1987, there were 20 psychiatric hospitalizations at an average cost of $4,707 each, he said. By contrast, there were 346 psychiatric hospitalizations at an average cost of $9,350 each for employees that did not use the referral service the same year.

This indicates there are fewer EAP-directed admissions and the costs are better controlled, Mr. Bartlett said.

Like NCR, Xerox decided it needed to better control the cost and utilization of mental health care services.

"The problem we saw was that under our self-insured plan, mental health care costs continued to consume a larger and larger part of the costs," said Patricia M. Nazemetz, manager of benefits.

"In 1985, 16%, or $11 million, of our health care costs were related to mental health care and in 1986, 20%, or $14 million, went toward mental health care," she said.

"There was excessive and inappropriate utilization of mental health services, as well as inefficient coordination between our EAP and the medical plan. In addition, we had 40% of our employees in HMOs, which leaves some employees with inadequate mental health benefits," she said.

Ms. Nazemetz explained that some health maintenance organizations do not offer comprehensive mental health benefits and request that Xerox allow its employees enrolled in HMOs to receive coverage for these services under the indemnity plan.

The company decided it would establish a managed mental health care program that would manage costs, coordinate appropriate mental health care and better control employees' access to the mental health care system.

Xerox reviewed 10 proposals from managed mental health care companies and selected American PsychManagement Inc. of Arlington, Va. The company provides utilization review and case management services that are performed by psychiatric nurses. The company also has psychiatrists on staff.

Under the program, which became effective Jan. 1, employees either can access APM through the Xerox EAP or they can have their own mental health provider contact APM.

The vendor then authorizes an inpatient admission and works with the patient's mental health provider to coordinate the inpatient or outpatient treatment, Ms. Nazemetz said.

The company also changed its mental health coverage when the managed care plan was implemented.

Previously, mental health benefits were covered both by a separate EAP plan and the indemnity plan. Under the EAP, the first two diagnostic outpatient visits were covered at 100%, with the next eight visits covered at 80%. After that, the plan covered only a closing session at 80%.

Continued on page 25

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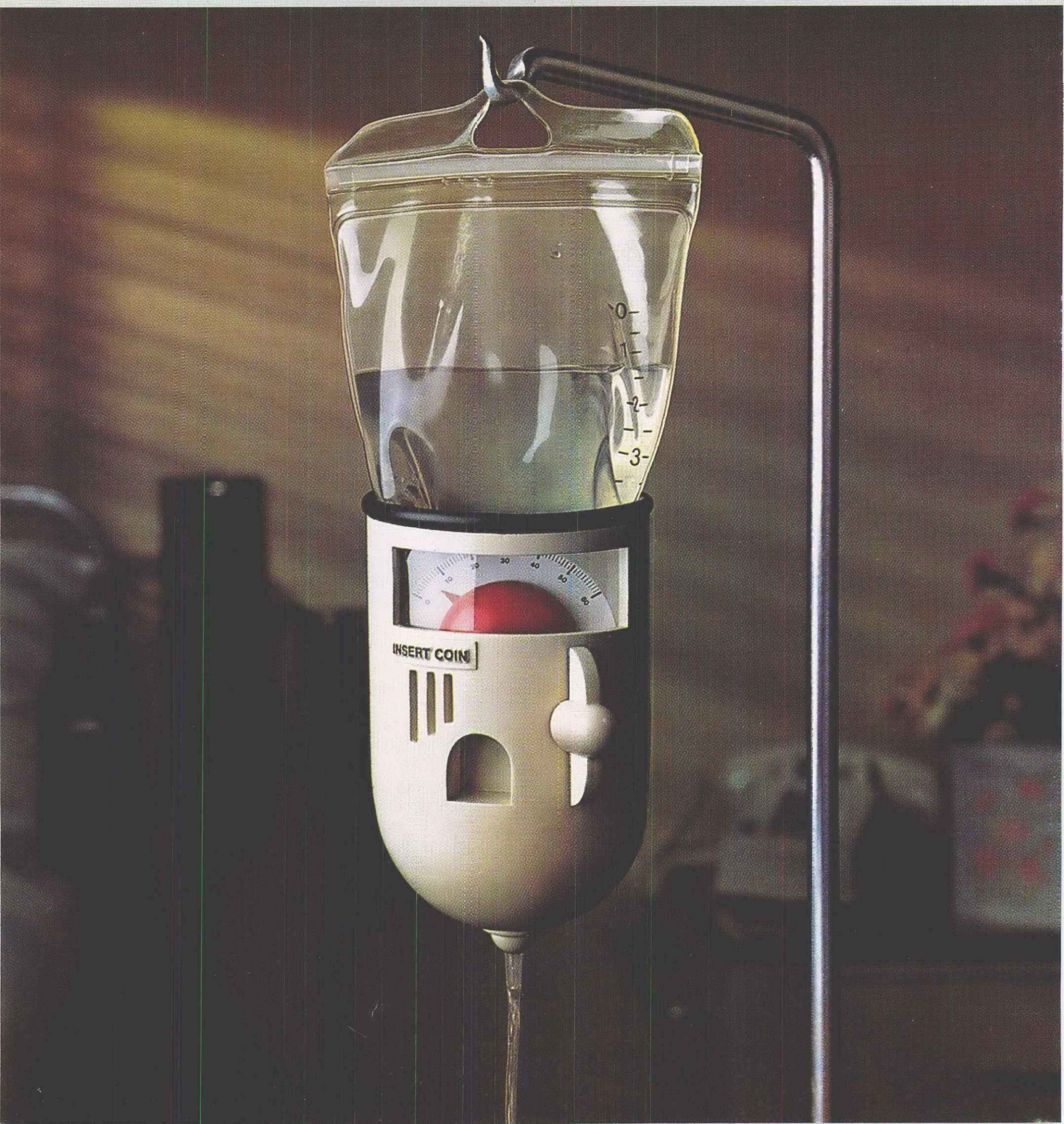

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ASK A RISK MANAGER

Right-to-know plan stresses judgment

Q **The Occupational Safety and Health Administration's Hazard Communication Standard requires all non-manufacturing employers to have a compliance program in effect. As a company with many locations spread throughout the country, how have you structured a "right-to-know" program?**

A Over the past several months we have spent a great deal of time and effort in addressing the compliance aspect of this standard as it relates to our major type of operation: fast-food restaurants.

It is our position that most chemical products found in our restaurant are not considered hazardous. However, we are communicating the standard to our employees in simple, non-technical language that stresses the importance of being aware of chemicals found at home and in the workplace.

We certainly did not want to alarm a mostly youthful workforce by overemphasizing the dangers of handling chemicals that consist mainly of cleaning products. Instead, we are concentrating on the importance of using good judgment and safe operating practices when handling chemicals.

A complicating issue we face is the fact that our industry has a high employee turnover rate. It was, therefore, necessary for us to design a uniform program that is relatively easy for a manager to review with all current employees and new hires immediately upon employment. The end result is intended to offer a program balanced somewhere between "overkill" and "underdeveloped" in its methodology.

There are three fundamental steps for program compliance:

- Proper container labeling.
- Availability of material safety data sheets.
- Employee education and training.

Initially, it is important for one person to assume a leadership role in the creation and implementation of the overall program. The risk manager—or safety manager, depending on individual responsibilities—should be fully aware of activities involving other departments with the project. I can think of nothing worse than facing the compliance deadline with a program that is fragmented and incomplete because someone assumed another person had taken charge or receiving a citation following an initial OSHA inspection because the information was never distributed!

Since we also have manufacturing and distribution facilities servicing our restaurant division, we became involved in the first two steps approximately two years ago. The manufacturing division had a 1986 compliance deadline, so we decided to prepare for a total corporate program at that time. It was determined that our distribution division would assume responsibility for assuring proper container labeling by dealing directly with our outside vendors. This process was simplified because the restaurants use a common source for each product.

The purchasing department was responsible for obtaining MSDS from each vendor and forwarding them to my department. It became my task to coordinate the design of the overall program with our training department.

We have elected to distribute a complete hazard communication package, including MSDS, to each location and think that approach is the most effective means of adhering to the standard. I might add that a few of our restaurants were spot checked earlier this year by state compliance officials to determine what we were doing in this regard. I know of some multilocation operators that are maintaining MSDS in one central location rather than at individual sites. This could lead to disputes over compliance somewhere down the road. We prefer to have the total program in place at each restaurant facility to avoid undue confusion.

Employee training has been addressed in oral and written forms. Prior to the creation of the standard, we used various posters as part of our safety program. They are now incorporated into one poster, which lists the rules for basic first-aid treatment, safe handling of chemicals and general safety. At one time, we gave serious consideration to preparing a videotape as a manager's instructional tool.

However, the most popular training concept and the one we finally adopted was the design of a guide for chemical hazard instructors with a brief questionnaire to be completed by each employee following his or her instruction. The questionnaire is retained in the employee's files as evidence of the completion of our "right-to-know" training program. I feel some type of training verification is necessary. This appeared to be the most logical choice for us.

In summary, each location has received the following information:

- Poster revised to include chemical safety.
- Manager's chemical hazard instructor's guide.
- MSDS.
- Chemical hazard questionnaire.

The material is now considered part of the risk management section in a procedures manual that is distributed to our restaurants.

Have we done too much? Too little? Our objective all along has been to inform our employees of chemical hazards using a positive approach.

Hopefully, we are prepared for individual inspections similar to what we experienced with the inception of OSHA's Recordkeeping Requirements Standard in the early 1970s.

I believe an employer should not expect to encounter problems with OSHA, providing an honest attempt is made to comply with the hazard communications standard. Time and the outcome of the first inspection will tell if we have done our job well.

Would you like advice from an experienced colleague on a risk management, benefits management or actuarial problem? Four features in the Perspective section of Business Insurance can give you some answers.

Ask A Risk Manager, Ask A Benefit Manager, Ask A Benefit Actuary and Ask A Casualty Actuary answer written questions from readers on risk and benefits management issues and actuarial problems.

Ms. Werner

This month's column on risk management issues is written by Susan M. Werner, director of risk management at Hardee's Food Systems Inc. in Rocky Mount, N.C. Joseph W. Duva, director of employee benefits at Allied-Signal Inc. in Morristown, N.J., answers benefits management questions. William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions on benefits issues. And, Richard E. Sherman, a principal with Coopers & Lybrand in San Francisco, answers actuarial questions in the casualty field.

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

Ms. Werner's next column will appear in the August issue.

Address your questions to ASK, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. Please give us your name, title and employer; however, Business Insurance will consider unsigned letters.

Prevention programs reduce costs

Continued from previous page

When employers make the commitment to this prevention program, Athletes in Industry consultants work with the firm's personnel to:

- Introduce the program to supervisors and employees.
- Explain to them how flexibility stretching works to prevent injuries both on and off the job.
- Train team leaders.
- Implement the flexibility stretching program.
- Follow-up throughout the year with performance measurement and support.

All employees then do the stretching exercises, with management support, for eight to 10 minutes at the beginning of each work day. The success of this prevention program is in its simplicity, packaging and tracked effectiveness. Every level of employee can and does participate in the stretching.

Typically, employers initiate a pilot program to a number of their employees, with expansion to other members of the workforce after a few months. The cost depends on the number of participants, but generally the one-time price would be around 2% of the monthly employee health care premium.

Saving one back injury, which on the average costs more than $6,000, could pay for this prevention program for 200 employees.

With significant percentages of workers compensation and group health claims occurring due to the sprains and strains of the torso, it stands to reason that the cost/benefit ratio with this stretching program could be at least 4-to-1, or better. The results will vary depending upon a corporation's industry and past injury claims history.

Corporations that have implemented this stretch program report they would do it all over again without considering any financial gains because of the improved employee awareness and attitude. Furthermore, they report that unlike other corporate fitness and exercise classes where relatively few participate, virtually all the employees offered the stretch program do the routine daily and they have fun doing it.

The trend toward more proven prevention programs that address today's major issues will become a way of corporate life. The economic impact of AIDS and substance abuse, for example, is too great to ignore.

A recent survey of chief executive officers across the country found that 67% plan to institute or expand health promotion programs during the next two years.

The double-barreled rate hikes from both workers compensation and health care insurance have forced many corporate decision-makers to revisit prevention programs that work both on and off the job. No longer is there justification for "fluff" wellness programs that accomplish little for so few of their employees.

Prevention is back.

Donald G. Lightfoot is director of sales for Blue Cross of California in Woodland Hills.

Hospitals, treatments on the examining table

By DONNA DiBLASE

PHOENIX, Ariz.—Just as the health care industry has undergone tremendous change in the last decade, so have the techniques for measuring and assuring the quality of care the industry delivers, according to some health care experts.

"There is definitely a movement in the health care industry to police itself," said Dr. Clifford R. Guy, president and medical director of the Winston-Salem Health Care Plan Inc. in North Carolina.

The management of quality and utilization of health care services has evolved since the early 1900s from a hospital quality assurance program to the development in the late 1970s and early 1980s of programs to manage the care delivered to recipients of Medicare benefits, noted Dr. Dennis S. O'Leary, president of the Chicago-based Joint Commission on Accreditation of Healthcare Organizations.

The evolution of health care quality assurance and measurement techniques was discussed at the annual meeting of the National Assn. of Employers on Health Care Action in Phoenix June 2-3.

Perhaps the oldest quality assurance organization is the JCAHO, which has existed in several forms for about 70 years, according to Dr. O'Leary,

Continued on next page

New techniques

Continued from page 18

Under the indemnity plan, the 11th and subsequent outpatient visits were covered at 50%, and inpatient care was covered at 80%, with no out-of-pocket maximum.

Under the new mental health benefits plan, the first two outpatient visits also are covered at 100%, with the next four visits covered at 80%, with no out-of-pocket maximum. However, if employees have their care certified by APM, they receive 80% coverage for all subsequent visits.

Inpatient care still is covered at 80%.

If employees do not contact APM before receiving either inpatient or outpatient mental health care, coverage is reduced to 50% for the first 10 outpatient visits or 50% for the first 10 days of inpatient care, Ms. Nazemetz explained.

Under the managed mental health program, Xerox also expanded the list of the types of mental health care providers employees may use and still receive coverage. In addition to clinical psychologists with a doctorate degree, licensed psychiatrists and hospitals accredited by the Joint Commission for Accreditation of Hospitals, employees who have their care certified by APM now may use licensed social workers and psychiatric nurses.

Xerox expanded the types of mental health care providers employees may use and still be covered.

Since the program is only six months old, savings figures are not yet available, Ms. Nazemetz said. However, the program has been well received by Xerox employees. Acceptance of the program is due in part to the communication effort by the company.

Xerox began communicating the program in December 1987 through literature in the annual personal explanation of benefits distributed through the first part of this year.

In addition, a letter was included in every claim payment made to employees already receiving mental health services.

Employees also received a letter explaining the program from Prudential, which administers claims for Xerox.

"People really took the program seriously. APM had received 1,400 calls by Feb. 1," Ms. Nazemetz noted.

There also have been surprisingly few complaints from employees so far, she said. ■

Hospital reviews

Continued from previous page

who added that the JCAHO just recently changed its name from the Joint Commission on Accreditation of Hospitals.

"The Joint Commission started out of a professional interest in the public sector," he said.

The Chicago-based American College of Surgeons in 1917 developed an organization to review the performance of and set minimum standards for the quality of care delivered in hospitals, he explained.

Over the next 30 years, more than 3,000 hospitals nationwide volunteered to undergo this external review.

Then, in 1951, the American Medical Assn., the American Hospital Assn., the American College of Surgeons and the American College of Physicians created the JCAH, he said.

"By the late 1960s, there was a JCAH accreditation program for long-term care and outpatient surgery centers. By the 1980s, there were programs for mental health centers, hospices, home health care agencies and managed health care organizations," Dr. O'Leary continued.

"The job of the JCAHO is to assure that health care organizations maintain their optimum achievable performance," he said, explaining that each organization is evaluated on an individual basis.

During the 1980s, there have been three major methods of quality review, he said. Specifically:

- Case-based review. This type of review evaluates the quality of the care delivered to an individual patient.

"This form of review took hold when the Professional Standards Review Organization program was created by the federal Medicare system. Since Medicare paid for care on the basis of the individual case, it made sense to review care on an individual case basis," Dr. O'Leary explained.

The PSRO program involved physicians reviewing the care delivered by other physicians to Medicare recipients. The PSROs became known as Peer Review Organizations in 1980, he said.

- Structure and function review. In this type of review, a JCAHO survey team visits a hospital to evaluate the hospital's compliance with JCAHO standards.

"However, this type of review leaves unanswered the questions of whether the hospital did all the things it says it can when the patient was admitted to the hospital and also what was the outcome of the patient's hospitalization. This type of review is organization-focused," Dr. O'Leary pointed out.

- Statistical profiling. This type of review evaluates the quality of care delivered in a hospital based on the hospital's mortality rates.

The problem with this type of review is that "you can't sit down, look at numbers and read quality. You need to look at the differences among patients," such as the severity of a patient's condition when he or she entered the hospital. "Mortality rates are random numbers," he explained.

The JCAHO currently is developing a new method for measuring and assuring quality. Hospitals are being asked to compile statistics and other information on trends and occurrences that fall outside of established norms in three areas: high-volume services delivered at the hospital; risky procedures; and problem procedures or problem areas of the hospital.

"It data as such does not give you the answer, we are examining whether you can use data to build a means to measure quality. The numbers are not an end product; they are a means to look into problems, then look beyond the numbers to see specific problems and develop a means to deal with the problem," he said.

Based on the information from the hospitals, the JCAHO is developing "clinical indicators" for specialty areas of medicine. "Clinical indicators deal with rates of occurrence. So, a sentinel event, or a bad occurrence, will mandate a hospital to look into ways to avoid the same occurrence," he explained.

Clinical indicators will be developed for 49 medical specialties. So far, they have been developed for the areas of anesthesia, obstetrics and hospital care.

In 1988, the JCAHO plans to work on the areas of cardiovascular medicine, cancer, trauma, long-term care and mental health care, he said.

The JCAHO also plans to develop indicators to assess the performance of the management of health care organizations, he noted.

In addition, "as far as the issue of appropriateness of care is concerned, we know that there are wide variations in the care delivered. Some of this is driven by the professional liability problem. This is part of your problem as well because this problem is costing you a pretty penny," Dr. O'Leary explained.

For example, he said, the health care industry is very hesitant to develop clinical efficacy standards because "the minute you develop standards and a physician has to go outside the standards to deliver appropriate care, the standards will be held against you in a court of law. A lot of physicians are very nervous about the idea of cookbook medicine."

Indeed, "medicine is a very personal thing. The patient is ultimately at the center of the big picture of medicine," noted Dr. Guy of the Winston-Salem Health Care Plan.

"First, you must distinguish between quality assessment—which is the measurement of compliance with standards—and quality assurance—which is the incorporation of standards into practice," he said.

"The standards must be interpreted on a local basis because the delivery of health care is a local phenomenon. Then, through quality assurance, there must be a means to give the health care provider the ability to modify clinical behavior," he said.

"And, there must be physician involvement in the establishment of standards, in the monitoring of compliance and in professional feedback and dialogue," Dr. Guy emphasized.

A health care organization's quality assurance program should include monitoring of provider credentialing; education and feedback; risk management; surveys of patients and health care purchasers, like employers, on the quality of care delivered; and research and development, among other things, according to Dr. David J. Ottensmeyer, executive vp and chief medical officer of Nashville, Tenn.-based Equicor.

Equicor is a managed care company formed through a joint venture of New York-based Equitable Life Assurance Society of the United States and Nashville-based Hospital Corp. of America.

For example, "our quality assurance program is designed to systematically monitor and evaluate the quality and appropriateness of patient care, pursue opportunities to improve patient care and to identify and resolve problems in patterns of care," Dr. Ottensmeyer said. ■

EBC

Employee Benefits Communication Conference

On August 1 & 2 you can join an influential group of employee benefit executives meeting to explore issues critical to their professional responsibilities. The annual Business Insurance Conference provides you with valuable insight into communicating benefits to employees.

Agenda

Keynote Address ***Monday, August 1***
Benefits Communicators — The New Dimension
Wesley Poriotis, Chairman and Chief Executive Officer of Wesley, Brown & Bartle, a management consulting and executive search firm in the benefits and communications field, sets the tone for the 1988 EBC Conference with a look at the benefits communicator as business person, creative artist, benefits practitioner, or all three. Who are they, where are they coming from and what does the future hold?

Employee Assistance Programs
If you don't use it, you loose it. To achieve high participation and maximum value for your company's EAP investment, you've got to do more than just communicate. You've got to market the product to your employees. Hear the strategy applied by one company.

Long Term Care
Problems & Solutions. This session presents a case study from one of the first corporations to introduce long term care as an employee benefit. See this company's success story.

EBC Awards Luncheon
Recognizing outstanding communications programs, Alfred Malecki, Publisher, Business Insurance, presents the 16th Annual EBC Awards. Also shown will be the first place a-v winner.

Concurrent Sessions
These three workshops all on state-of-the-art interactive communication programs are presented as concurrents, giving you the opportunity to attend all sessions. These case studies will be presented by both company and consultant firm. Time will be provided after Monday's sessions for additional demonstrations and informal questions/answers.

#1 Flexible Benefits
Abbott Lab's Flex Benefits System, developed by Alexander & Alexander Consulting Group, gives employees a unique tool for making complex benefit decisions. This direct access, interactive system allows employees to model 'what if' scenarios for health care, flexible spending accounts and their 401(k) plan.

#2 Pension/Profit-Sharing & Retirement Planning
Projecting financial scenarios for employee retirement — Allstate's "Search For Security" program, developed by their consultant, Mercer-Meidinger-Hansen, offers new visions. And because it's educational and fun to use, information is better retained.

#3 Benefits Communication & Management
Becton Dickinson is using technology, developed by their consultant, The Wyatt Company, to communicate and administer it's long term savings plan. Employees can sign-up, check account balances, calculate loans and more, in a private, secure, user friendly environment.

401(k) Under Tax Reform ***Tuesday, August 2***
Communicating 401(k) plans and changes to employees within this new tax reform environment can be complicated, even for a seasoned communicator. Here's what has worked — and what hasn't — for one company.

You Be The Judge
A-V Excellence. Presented annually, this energetic session presents audio-visual programs submitted to the EBC Competition. You be the judge — see what other industry professionals are doing in this medium.

Luncheon
Jerry Geisel, BI's Washington Editor, gives you a *View From The Capitol.*

Wellness Programs
Michael Scofield, PhD, leads this panel on effectively communicating the health promotion message to employees. Panelists representing large, medium and small size companies discuss the communication channels needed for a very different benefit area — promoting good health and positive lifestyles. They'll look at what works and what has backfired for their own companies.

Adjournment
Until next year ...

Speakers

Craig Bryars
Consultant
THE WYATT COMPANY
WORKSHOP #3:
Interactive Communication

Catherine A. Corse
Asst. VP/Mgr.,Employee Benefits
BARNETT BANKS INC.
Employee Assistance Programs

Pattie Duca
Mgr, Employee Benefit Planning
BECTON DICKINSON & COMPANY
WORKSHOP #3:
Interactive Communication

Jerry Geisel
Washington Editor
BUSINESS INSURANCE
LUNCHEON SPEAKER:
From the Capitol

Beth Learman
Vice President
BENEFACTS, INC.
ALEXANDER & ALEXANDER CONSULTING GROUP
WORKSHOP #1:
Interactive Communication

Alfred Malecki
Publisher
BUSINESS INSURANCE
LUNCHEON SPEAKER:
EBC AWARDS

Karen Manning
VP, Employee Benefits
AMERICAN EXPRESS TRAVEL RELATED SVCS, CO.,INC
Long Term Care

Daniel McCarthy
Asst. VP, Comp & Benefits Planning
ALLSTATE INSURANCE COMPANY
WORKSHOP #2:
Interactive Communication

Kathryn J. McIntyre, A.R.M.
Editor
BUSINESS INSURANCE
OPENING REMARKS

Laurel Nicholson
Principal
MERCER-MEIDINGER-HANSEN
WORKSHOP #2:
Interactive Communication

Wesley Poriotis
Chairman & CEO
WESLEY, BROWN & BARTLE
KEYNOTE SPEAKER

Robert Schumacher
Director, Corporate Benefits
ABBOTT LABORATORIES
WORKSHOP #1:
Interative Communication

Michael Scofield
Mgr, Employee Health Promotion
A T & T
Wellness Programs

Russel Wert
Director of Benefit Services
AETNA LIFE & CASUALTY
401(k) Under Tax Reform

Herb Zeltner
President
HERBERT ZELTNER CONSULTING INC.
You Be The Judge

Business Insurance

Registration

The BI Conference opens Sunday, July 31, with registration check-in and a cocktail reception from 5-7pm. Sessions begin Monday, August 1 at 8:30am. The conference adjourns Tuesday, August 2 at 3:30pm.

The cost is **$650.** A 10% discount is offered to additional registrants from the same company. The fee includes sessions, workbook, educational materials, and scheduled functions.

Payment required with registration. All registrations will be confirmed.

Cancellations must be received in writing. A refund will be made on cancellations received before July 1.
A **$100** service charge will apply to cancellations received after July 1. No refund will be made on cancellations received less than 5 business days prior to the conference. If your plans change, you may substitute another person from your company without penalty.

To register, complete the form and send it with your payment to:

Business Insurance,
Communication Services Dept.,
220 E. 42nd St., New York City, NY 10017

For information call: Barbara Dalton, Registrar, (212)210-0780

Hotel Accommodations
We have set aside a limited block of rooms at a special rate of **$145 single/$165 double,** at the Grand Hyatt Hotel in New York City. These rates are available to Conference Registrants only, and will be honored until July 15.

You must mention the *Business Insurance Benefits Conference* when making your reservations. Hotel cards will be included with your Conference Registration Confirmation. Or call the Grand Hyatt Hotel at (212)850-5900; or toll free at (800)228-9000.

Awards Luncheon
A luncheon ticket is included with your Conference registration. A limited number of additional seats are available for the EBC Awards Presentation Luncheon. Additional tickets are **$60** each, available on a first come-first serve-basis; **reservations required.** Contact Registrar.

Please register me for the 1988 BI Conference

Employee Benefits Communication:
August 1 and 2
The Grand Hyatt Hotel, New York City

Name _____

Title _____

Organization _____

Address _____

City _____ State _____ Zip _____

Phone _____

Additional Registrants from my organization:

Name _____

Title _____

Name _____

Title _____

☐ Conference (incl. Awards Luncheon)

☐ EBC Awards Luncheon ONLY

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Account # _____

Expiration Date _____

Signature _____

Comings & goings: industry

Dean O'Hare named chairman of Chubb

Dean R. O'Hare was named chairman and chief executive officer of Warren, N.J.-based Chubb Corp. He succeeds Henry U. Harder, who retired.

Mr. O'Hare, 45, was also named chairman and president of two of Chubb's subsidiaries, Federal Insurance Co. and Vigilant Insurance Co.

Mr. O'Hare joined Chubb in 1963, was named a director in 1984 and most recently was president. Mr. O'Hare continues as chairman of Chubb Life Insurance Co. of America and Bellemead Development Corp.

In addition, **Richard D. Smith**, formerly an executive vp of Chubb, succeeds Mr. O'Hare as president.

In other insurer changes:

Edward K. Trowbridge named chairman and chief executive officer of Atlantic Mutual Cos. effective July 1. He is succeeded as president and chief operating officer by **Kenneth J. Gorman,** who most recently was comptroller and executive vp-economic controls. Mr. Trowbridge succeeds **John J. Mackowski**, who retired as chairman and chief executive officer.

Samuel D. Ross Jr. named president and chief executive officer of Pennsylvania Blue Shield in Camp Hill, Pa. Most recently, he was executive vp.

Also at Pennsylvania Blue Shield, **Dr. R. Robert Tyson** appointed chairman, replacing **Dr. Harry V. Armitage**, who retired.

Stephen R. Smith named president of Harleysville Group Inc. in Harleysville, Pa. Most recently, Mr. Smith was president and chief operating officer of Harleysville Mutual Insurance Co., a member of the Harleysville Group.

Also, at Harleysville Mutual Insurance Co. in Harleysville, Pa., **Walter R. Bateman** named senior vp-field operations. Previously, he was a regional vp for General Accident Insurance Co.

Jack Powers promoted to resident vp of New Jersey operations for Warwick Insurance Co. in Morris Plains, N.J. Previously, Mr. Powers was vp of marketing.

Ruud H. Bosman named senior vp of Allendale Insurance in Johnston, R.I. Mr. Bosman previously was regional manager of the New York region.

Clifford Wess appointed vp of Selective Insurance Group Inc. in Branchville, N.J., and two of its subsidiaries, Selective Insurance Co. of America and Selective Way Insurance Co. Mr. Wess previously was chief actuary.

Geoffrey W. Shisler named vp-underwriting of commercial operations for Ranger Insurance Co. in Houston. Mr. Shisler previously was manager of casualty underwriting.

Joel V. Kamer appointed senior vp and group insurance actuary of group benefit services for John Hancock Mutual Life Insurance Co. of Boston. Most recently, Mr. Kamer was vp and group insurance actuary.

Donald M. Lowry appointed vp at CNA Insurance Cos. in Chicago.

John T. Unipan named president and chief executive officer of Continental American Life Insurance Co. of Newark, Del. Most recently, Mr. Unipan was executive vp at Provident Mutual Life Insurance Co. in Philadelphia, Continental's parent company.

Industrial Indemnity Co., a Crum & Forster unit, announced the following promotions to vp: **Stephen J. Albers** in Seattle, who also serves as president of Industrial Indemnity Co. of the Northwest, a subsidiary of Industrial Indemnity; **Robert J. Giarraputo** in Fresno, Calif.; **Gary R. Purdom** in Anchorage, Alaska; **Ronald G. Hashimoto** in Honolulu; **Roger P. Newman** in Phoenix, Ariz.; **Donald L. Blackwell** in Walnut Creek, Calif.; and **Stephen A. Gold** in Orange, Calif.

American General Life & Accident Insurance Co. in Nashville, Tenn., promoted **Rex H. Roberts** to senior vp and **James Crowell** to vp-field compensation and registers.

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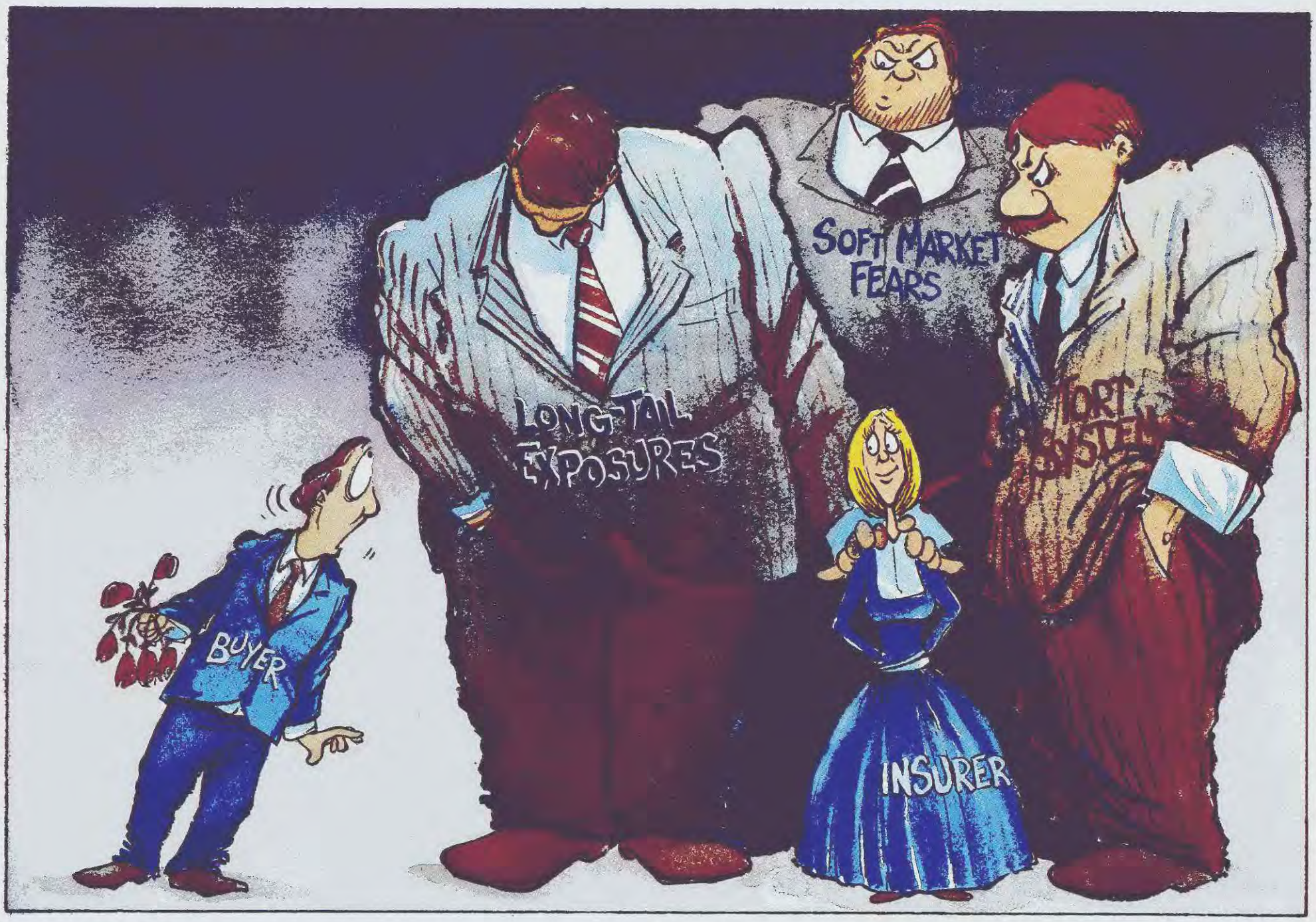
InsurerTopics

A special editorial section
sent exclusively
to insurers and reinsurers



No urge to merge?

Outsiders wary of insurance company acquisitions

By MARK A. HOFMANN

Insurers, whose stocks generally are underpriced, should be among the belles of the merger ball, but corporate suitors still are acting bashfully.

Potential buyers are hesitant to approach insurers because, among other reasons, they fear property/casualty insurers' long-tail exposures, the unpredictability of the U.S. tort system and the possibility of another soft property/casualty insurance market.

In addition, some suitors may be uncomfortable with the strict regulation of the insurance industry.

However, a combination of factors may cause buyers to make more advances within a few years, with foreign companies most likely emerging as the boldest suitors.

Among other reasons, insurers' depressed stock values, foreign buyers' eagerness to pick up bargains using cheap U.S. dollars and the financial burden that the new tax code will place on some insurers could fuel insurance industry merger mania by the early 1990s.

"I expect to see more acquisition activity, mostly because the stocks are so cheap," said Gloria L. Vogel, associate director with Bear, Stearns & Co. in New York.

"I think potential buyers are sitting back to see if their targets won't get even cheaper in a bear market," she added.

"The property/casualty insurance companies are quite depressed in valuation," said Gerard Mizrahi, managing director of Charles Street Securities, a New York-based financial consulting firm specializing in insurance industry acquisitions and divestitures. The firm publishes The Charles Street Insurance Review, a quarterly compendium of insurance company merger activity.

Mr. Mizrahi pointed out that investor skittishness born of the Oct. 19 stock market crash continues to linger. And, some stock analysts still are pessimistic about the market, he added.

However, property/casualty insurers have been able to build up their reserves in recent years, he pointed out. If the property/casualty insurance market does not turn overly soft, property/casualty companies should be good buys, Mr. Mizrahi concludes.

Yet, despite general agreement among stock analysts that property/casualty companies are priced right, buyers are not jumping into the market.

One reason is property/casualty insurers' long-tail exposures.

"Long-tail exposures are a negative, particularly for foreigners, who tend to be very wary of U.S. casualty risks because they don't understand our tort system," explained Ms. Vogel of Bear, Stearns.

Udayan D. Ghose, vp and senior insurance analyst at Shearson Lehman Hutton Inc. in New York, agreed. "They think that our tort system has gone crazy."

Europeans "are clearly put off by the tort liability folly," said Myron M. Picoult, senior vp and senior insurance analyst for Oppenheimer & Co. in New York.

"Long-tail lines of business concern foreign investors, primarily because you just don't know the rate adequacy of that business that was written in the early

Continued on next page

Insurer acquisitions

Continued from previous page

1980s, said Hank Tilman, vp with Donaldson, Lufkin & Jenrette in New York.

The lingering fear of an unstable property/casualty insurance marketplace is another factor causing investors to shy from the stocks. Memories of the last soft market are still fresh, some analysts say.

"The merger market seems to be assuming that this down cycle will be as bad as the last one. I don't think it will because conditions are different," said Bear, Stearns' Ms. Vogel. She cited the Tax Reform Act of 1986, which forces insurers to pay some federal income tax no matter how high their underwriting losses, and lower interest rates as reasons why insurers will not slash prices to dangerously cut-rate levels.

But, many investors still fear the possibility of another bloodletting, observed Gil Marmol, principal with McKinsey & Co.'s Dallas office.

"If you believe the industry is heading for a downturn, people are still somewhat uncomfortable with the idea of buying a company whose earnings are expected to plummet," he said.

The recent increase in insurer competition is a major source of fear among potential insurer investors, according to Joanne Morrissey, president and chief executive officer of Morristown, N.J.-based Firemark Consultants Inc., an investment banker specializing in the insurance industry.

"Rate hikes are increasingly rare," she said. Although some specialty insurers have managed to hold the line on prices, most insurance companies appear to be slipping in their commitment to avoid price slashing, she said.

In addition, the downturn in insurers' results has made potential buyers cautious, analysts said.

Property/casualty insurers' direct written premiums increased by 20% in 1986, about 9% in 1987 and only about 5% so far this year, according to Ms. Morrissey. At the same time, slowly rising interest rates, while increasing insurers' interest income slightly, have had a significant negative impact on the value of insurers' bond portfolios, she said.

And, what has been a short-term positive factor for insurers—the absence of major insured catastrophes over the past two years—will not last forever, Ms. Morrissey pointed out. When disasters such as major hurricanes and earthquakes begin to strike, they will have a devastating effect on underwriting results, she predicted.

Another factor keeping buyers away from insurers is the lingering effect of Black Monday on insurers' surplus. The stock market decline cost U.S. insurers about 12% of their surplus, Ms. Morrissey estimated.

Potential foreign suitors also are staying away insurers because they are awaiting a further drop in the value of the dollar, added Ms. Vogel of Bear, Stearns.

Many foreign suitors have put off entering the U.S. market because they are still somewhat unsure of the stability of the dollar, Mr. Picoult agreed.

But, analysts are divided concerning the effect of risk management alternatives—like risk retention groups and captive insurers—on the merger climate.

Oppenheimer's Mr. Picoult said that "more and more commercial business is going to the captives." That means that commercial property/casualty insurance companies' opportunities to grow in an expanding marketplace are getting slimmer, he said.

But Bear, Stearns' Ms. Vogel believes that the non-traditional markets' impact on the property/casualty business and on the attractiveness of property/casualty insurers to would-be acquirers will be minimal.

"I don't think most business going to the risk retention groups is business most traditional insurers ever wanted," she said.

Within the next few years, several factors besides the undervaluation of insurers' stocks probably will prompt buyers to move more aggressively on insurers, analysts say.

"If you believe the industry is heading for a downturn, people are still somewhat uncomfortable with the idea of buying a company whose earnings are expected to plummet,' says McKinsey's Gil Marmol.

For example, the industry's reserves-to-surplus ratio is high by historical standards, Ms. Morrissey pointed out.

"Many buyers have been wary about property/casualty companies screaming about reserves," she said. The high level of insurer reserves should be of comfort to potential acquirers, she added.

Potential buyers also see that insurers are taking greater care in purchasing reinsurance in light of past problems collecting reinsurance, Ms. Morrissey said.

Primary insurers are staying away from the cheaper and marginal reinsurers and are placing a greater emphasis on obtaining reinsurance from a quality market, she explained.

In addition, the new tax law will help dampen price competition and encourage a more stable marketplace, Ms. Morrissey predicted.

One group of potential buyers that might be comfortable enough with the insurance industry's relatively stringent regulatory oversight to make a bid for insurance companies are the managements of highly regulated industries, said Ms. Morrissey.

Executives of non-regulated industries quickly grow impatient with the insurance industry's rules and regulators, she said.

But the managements of companies in some already highly regulated industries, such as power utilities and oil companies, may be willing to work with regulators to enter the insurance business, she predicted.

But perhaps the most logical buyers of domestic insurers are foreign concerns, several analysts say.

Foreign insurers already "basically have saturated their own markets," so they are looking to expand in other geographic regions, Ms. Vogel explained.

Ms. Morrissey predicted that "foreign buyers will continue to exploit the economic confusion in this pre-election period." They have money and they need to spend it, she said.

Ms. Morrissey foresees British, West German, Swiss, Dutch and possibly Japanese concerns using their strong currencies to buy up insurers priced in bargain-basement U.S. dollars.

Foreign penetration of the U.S. market is logical because potential foreign buyers, particularly Europeans, have both the cash and management savvy, Oppenheimer's Mr. Picoult said.

If Europeans begin to make major purchases of U.S. insurers, Mr. Picoult thinks they might bring a welcome change in management. "More often than not, they're more disciplined underwriters" than their American counterparts, he said. "I think in many instances, foreign managers would be more diligent in running companies."

However, while there are many overseas companies that would like to establish a major presence in the U.S. market, there are a relatively small number of acquisition candidates attractive to foreign investors, according to Mr. Tilman of Donaldson, Lufkin.

There also is "a lack of catalysts" promoting mergers involving insurers, he said, pointing out that well-known corporate merger makers, such as T. Boone Pickins, have not chased insurers with the enthusiasm with which they have sought other acquisitions.

Part of the reason for this reluctance is that acquiring an insurance company through a leveraged buyout is very difficult, Mr. Tilman said. Since regulators limit the amount of debt that buyers of insurance companies can incur when acquiring an insurer, the buyer has to have more equity on hand to capture his prize, he explained.

At the same time, a buyer will find it difficult because of state insurance regulation to raid an insurer's assets for cash to service debt, according to Mr. Tilman. There also can be severe delays in wrapping up a deal, he said, pointing to the attempt by B.A.T. Industries P.L.C. to purchase Farmers Insurance Group, which has been pending for several months.

Still, Mr. Tilman does not see buyers shying away from insurer acquisitions for long. "I think more and more people will get comfortable with the insurance industry," he said.

Currently, Mr. Mizrahi of Charles Street Securities sees "no particular pattern" to insurance company mergers. Most recent merger activity—regardless of the industry segment: property/casualty, life and health, brokerage and service—seems to involve what Mr. Mizrahi called "small deals."

He also cautioned against reading too much significance into actions such as insurers spinning off small subsidiaries, such a regional personal-lines automobile companies. "There's always a certain amount of intra-industry restructuring," he said.

But, Firemark's Ms. Morrissey predicted that such intra-industry restructuring may be one of the major trends of the next few years. Small insurers—those with market values of between $20 million and $40 million—will find themselves unable to compete, she said. "To protect themselves, they will merge," she said.

Bear, Stearns' Ms. Vogel also pointed to the possibility of smaller companies coalescing to survive. If the McCarran-Ferguson Act, which grants insurers limited exemption from antitrust law to allow them to cooperate in developing rates, is abolished, some companies will lack the resources to compete.

"If you do away with rating bureaus, some smaller companies won't have any (rating information) base," she said, adding that those companies would have to merge or die.

Ms. Vogel also said that the Tax Reform Act of 1986 also may spur merger activity because many companies may not have the financial wherewithal to weather the law's impact on their bottom lines and "don't have the sophistication" to accurately predict that impact.

"Companies will have to earn more to get to the same bottom line. Cash flow will be hurt. That might encourage some companies to look for help" in the form of new owners, she said.

Financially strong regional property/casualty insurers with solid personal lines business are attractive to European investors because of those potential buyers' fears of insurers' long-tail claim exposures, said Mr. Ghose of Shearson Lehman.

Mr. Tilman agreed that non-U.S. companies tend to look for property/casualty insurers that have commercial business with short-tail exposures, emphasize property coverages or concentrate on personal lines.

B.A.T.'s hard-fought attempt to acquire Farmers illustrates this strategy, Mr. Tilman observed.

"B.A.T. carefully selected a personal lines company with continued potential to grow," he said.

Would-be buyers looking for a way to penetrate a particular or market niche also might find mid-sized property/casualty insurers with marketing problems attractive, Mr. Tilman said.

"The most vulnerable companies are those that are not market-responsive and middle-sized," he said, pointing out that there is a similar trend in the banking industry.

Like small banks, small regional or niche insurers—those with market values of less than $100 million—may not be likely takeover targets because they know their markets inside and out and because they engender feelings of customer loyalty, he explained.

Insurers with market values exceeding $400 million—like giant, multistate banking operations—would be difficult for a would-be acquirer to swallow because of their sheer size.

That leaves both property/casualty and life insurers with market values of $100 million to $400 million as prime takeover targets, particularly by foreign investors, Mr. Tilman explained. ■

Multiline companies shedding life units

By MARK A. HOFMANN

Large, multiline insurance companies increasingly are divesting life, accident and health insurance subsidiaries to focus on their property/casualty business.

In the past year, both Continental Corp. and CIGNA Corp. have sold life insurance operations and are hoping to divest others. In addition, a life insurance subsidiary of Travelers Corp. is currently on the block.

Observers say that the insurers' decision to sell the units is at least partially based on changes in the life insurance industry, especially the new wave of interest rate-sensitive products that has made that marketplace more competitive.

"I think a lot of property/casualty companies have come to the conclusion that in the life industry, they're caught on the horns of a dilemma," explained Udayan D. Ghose, vp and senior insurance analyst for Shearson Lehman Hutton Inc. in New York.

Traditional whole life products are very profitable for insurers, but there is very little growth in this segment of the market, he said. However, interest-sensitive products, such as variable life insurance, are growing at an attractive rate but have "virtually no margin spread" because that segment of the industry is so competitive.

To be competitive in this market, life insurers have been offering first-year returns of at least 9%, and some have offered more than 10%, he said. To generate that kind of return, insurers have bought junk bonds to increase their investment returns, Mr. Ghose said.

"In the past, some property/casualty companies had viewed their life insurance lines as stable and quite profitable businesses," said Gil Marmol, a principal with McKinsey & Co., Inc., in Dallas. Property/casualty insurers viewed their life insurance units as means by which to offset some of the losses registered in property/casualty lines, he said.

But, the life insurance industry's shrinking profit margins made some property/casualty insurers rethink the wisdom of remaining in a highly competitive field in which they were not major players, Mr. Marmol said.

Rather than sink large amounts of money into their life insurance units in hope of making them more competitive with the giants of the industry, some of the property/casualty companies decided "to take the money and walk," Mr. Marmol said. "If life business had remained stable and profitable, they might have increased investment," he added.

Myron M. Picoult, senior vp and senior insurance analyst for Oppenheimer & Co. in New York, said that some property/casualty insurance-driven companies thought that they would be able to use their independent agency forces to sell life insurance as well as property/casualty products.

"They thought there would be synergy, but that turned out to be a frivolous hope," he said.

In addition to that miscalculation, the property/casualty industry discovered that the life insurance industry was skating on extremely thin profit margins, Mr. Picoult pointed out. The pricing required to compete in the life insurance arena was simply inadequate, particularly as new interest-sensitive products such as variable life and universal life policies came to dominate the marketplace.

A major reason for property/casualty insurance companies to sell their life insurance units is the feeling that their operations simply are not large enough to compete in the marketplace, said Hank Tilman, vp with New York-based Donaldson Lufkin & Jenrette Inc.

"There's a feeling among companies that 'I have to get to a certain size. I must be a certain size to compete,' " Mr. Tilman said.

Faced with the choice of committing more resources to the life insurance operations or divesting them, many property/casualty insurers have chosen to sell the life insurance units, he said.

For example, New York-based Continental put four life insurance units on the market in September 1987.

The four companies—Commercial Life Insurance Co. of Piscataway, N.J.; Loyalty Life Insurance Co., also of Piscataway; William Penn Co. of New Hyde Park, N.Y.; and Toronto-based National Life Insurance Co. of Canada—generated operating income of about $6.3 million during the first quarter of 1987.

Continued on page 28D

Does It Really Matter Which Reinsurer You Get?

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Life insurers

Continued from page 28B

In March 1988, Quebec-based Industrial Alliance Life Insurance Co. offered $130 million in Canadian dollars (about $104 million U.S. at appropriate exchange rates) to acquire National Life Insurance. The deal is pending regulatory approval.

The other three Continental life insurance units remain on the market.

Linda Tegnestam, Continental's assistant vp-investor relations, said the decision to sell the companies was one of "critical mass."

The interest-sensitive products that now dominate the life insurance industry require massive investment in automation to be profitable, she explained. Justifying the expense of automation requires that a certain amount of business be generated.

Continental decided that its strategy would be to market selectively, in both product lines and regions, Ms. Tegnestam said. The life insurance operations no longer fit that strategy, she said.

'In the future, a small to medium-sized player (is) not going to compete successfully against the big players,' says Gerald L. Maatman, executive vp of Kemper Corp. and president of Kemper Group's national property/casualty companies.

In addition, InterContinental Life Insurance Co. of Elizabeth, N.J., a unit of Financial Industries Corp., announced in March its intent to buy CIGNA's Individual Insurance Products Division for about $140 million. IIP, which CIGNA put on the block last August, consists of INA Life Insurance Co., Investors Life Insurance Co. of North America and INA Security Corp.

CIGNA also put its Horace Mann Insurance Cos., based in Springfield, Ill., on the market at the same time. However, Horace Mann —which writes life, automobile and homeowners coverage to educators and education association members—has not yet been sold.

Also, Hartford, Conn.-based Travelers announced in October that it was considering the sale of Keystone Provident Life Insurance Co., a wholly owned subsidiary. According to a Travelers spokesman, the life insurance unit has assets of roughly $4.5 billion and annual revenues around $1.5 billion.

Keystone Provident remains for sale.

Not all property/casualty insurers, however, are following such a strategy.

For example, Long Grove, Ill.-based Kemper Corp. over the past decade has bolstered—rather than discarded—its life insurance operations.

In 1977, life insurance accounted for only 8.2% of the corporation's total sales, with property/casualty business bringing in more than three-quarters of the company's revenues. But, by 1982, life accounted for 27% of total sales and rose again to 35.5% in 1987.

Gerald L. Maatman, executive vp of Kemper Corp. and president of Kemper Group's national property/casualty companies, said that while Kemper has enhanced its life operations, it has divested itself of its accident and health insurance business and two small personal lines auto insurance companies during the past two years.

Kemper sold its accident and health business in two parts in the summer of 1987 for a total of about $25 million, Mr. Maatman said. It sold its group and association accident and health insurance business to Des Moines, Iowa-headquartered Central Life Assurance Co., while New York-based National Benefit Life Insurance Co., a subsidiary of Primerica Corp., bought Kemper's disability insurance operations.

Mr. Maatman said Kemper sold the units because, in part, "it was our feeling we didn't have sufficient expertise" to compete in the accident and health marketplace.

Mr. Maatman

In addition, Kemper perceived the trend in the accident and health insurance business to be one of vertical integration, he said, meaning that competitive players in the market must offer all types of accident and health insurance products, including health maintenance organizations.

In 1986—the last full year of its accident and health insurance operations—Kemper Group wrote $155.6 million in such coverage. That amounted to 4% of the organization's total sales of $4.5 billion, meaning that Kemper was clearly not a major force in the accident and health business, Mr. Maatman said.

"In the future, a small to medium-sized player such as ourself was not going to compete very successfully against the big players," Mr. Maatman said. He said that the choice was to either invest heavily in upgrading the accident and health operations, or selling them.

Kemper also sold two regional personal automobile insurance companies during the past two years:

- Menlo Park, Calif.-based Sequoia Insurance Co. was sold to QBE Insurance Group Ltd. of Sydney, Australia, for $19 million in the fall of 1986. Sequoia's 1985 revenues had totaled less than $45 million.
- Pasadena, Calif.-headquartered National Automobile & Casualty Insurance Co. was sold for $9.5 million last month to New York-based Prospect Group. National Auto had revenues of about $26 million last year.

Once again, the choice had been to invest or divest, Mr. Maatman said. "We were getting only mediocre results. It would have been very difficult to achieve above-average results with these companies," he said.

William M. McCormick, chairman, president and chief executive officer of Fireman's Fund Insurance Co. in Novato, Calif., noted that his company did not retain its life insurance division when it became independent of its parent, American Express Corp., in October 1985 (see story, page 28I). In addition, Fireman's Fund has also divested itself of its accident and health business.

Just a few weeks ago, the insurer announced an agreement to sell Southern Guaranty Insurance Co. of Alabama to Swiss-based Winterthur Insurance Group. Montgomery, Ala.-based Southern Guaranty sells both commercial and personal lines property/casualty coverages, Mr. McCormick said.

Southern Guaranty was sold because the company did not fit into Fireman's Fund's long-range strategy, a spokesman said, adding that Fireman's Fund already had branch offices throughout the Southeast. ■

Insurer monopolies unlikely: Experts

By MARK A. HOFMANN

It's unlikely that seven—or even 17—sisters will emerge to dominate the commercial property/casualty insurance marketplace in the foreseeable future, industry observers say.

And, when established insurance companies do merge, new companies generally pop up to take their place, diluting concentration in the industry.

"There's really not much evidence that the industry is becoming more concentrated," said Sean F. Mooney, senior vp and economist for the Insurance Information Institute in New York.

"I don't think you'll ever get down to seven companies that will dominate the market. I could see the big getting bigger and the small getting smaller, but I don't think you'll ever see it getting down to a handful," remarked Gloria L. Vogel, associate director of Bear, Stearns & Co. in New York.

Udayan D. Ghose, vp and senior insurance analyst for Shearson Lehman Hutton Inc. in New York, agreed.

The barriers to entry in the insurance industry are not terribly high, Mr. Ghose said, adding that the major necessities are capital and expertise.

Hank Tilman, vp with Donaldson, Lufkin & Jenrette Inc. in New York, pointed out that insurer executives often resign to form their own insurance companies, thus providing the expertise required for new players in the property/casualty marketplace.

In addition, if a company wants to increase its share of the market, it can always try to buy market share through rate cutting, Mr. Ghose said.

He questioned, though, whether any company would want to follow this strategy given the industry's experience during the soft market of the early 1980s.

And, "the advantages of size, beyond a certain critical mass, are not obvious," he added.

A third factor working against concentration in the property/casualty insurance marketplace is that economy of scale is not always possible, Mr. Ghose said.

Gil Marmol, a principal in management consultant McKinsey & Co.'s Dallas office, said that big is just not necessarily better in the commercial property/casualty insurance business.

Commercial property/casualty underwriting relies heavily on individualized information that does not respond to economies of scale, he said.

Mr. Ghose pointed out a possible exception in the property/casualty area. Personal lines automobile insurance, which has become increasingly dominated by direct-writing insurance companies, lends itself to economies of scale, he said, noting that commercial property/casualty business, in which each risk must be examined separately, cannot be dealt with on a mass basis.

Direct writers have been able to effect economies of scale in certain personal lines and, thus, gain market share at the expense of traditional agency companies, agreed Myron M. Picoult, senior vp and senior insurance analyst with Oppenheimer & Co. in New York.

And, some direct writers have "made some inroads into plain-vanilla commercial" business, like smaller, "Main Street" property/casualty accounts, he said.

Donaldson Lufkin's Mr. Tilman said that while there has been some concentration among insurers in certain commercial property/casualty lines like medical malpractice insurance, such concentration is the exception rather than the rule.

Ms. Borowski

"I tend to think consolidation, if it occurs, will take a long time," Mr. Tilman pointed out.

Mr. Marmol of McKinsey & Co. said that automation concerns would slow any drift toward concentration in the marketplace through mergers and acquisitions.

Systems conversion—making certain that a company's electronic data processing system is compatible with the others'—is "time-consuming, costly and complex," Mr. Marmol said.

'I could see the big getting bigger and the small getting smaller,' says Gloria L. Vogel.

However, making sure automation systems mesh following a merger is critical because if the newly merged companies cannot mutually communicate, relations with the field are sure to suffer, he said.

Patricia A. Borowski, vp-government and industry affairs for the National Assn. of Professional Insurance Agents in Alexandria, Va., also rejects the idea that the industry could become dominated by a handful of companies.

Mr. Hunter

There is a difference between concentration and what Ms. Borowski called "weeding out" in the marketplace, she explained. "There hasn't been a concentration in the marketplace. By and large, we still think there's enough variety in the marketplace.

"If the concentration were to be accelerated or extreme, certainly we'd be concerned," she said.

"We want a sufficient number of carriers to ensure and assure that in tough times, there will be a sufficient number of players in the marketplace.

"We want a sufficient number of players to give us openings, to provide innovation at all times and to see that we have ways to meet varying market appetites," Ms. Borowski said.

But J. Robert Hunter, president of the Alexandria, Va.-based National Insurance Consumer Organization, says that despite what he perceives as a trend toward concentration in the industry, there are still too many companies in the marketplace.

Continued on page 28H

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Insurer monopolies

Continued from page 28E

"The industry is inefficient. Some players will have to go," said Mr. Hunter, who called the vast majority of property/casualty insurers inefficient.

In addition to a drastic cut in the number of insurers, Mr. Hunter thinks competition could be furthered by allowing banks to enter the insurance marketplace (see related story).

By buying existing insurers or launching their own insurance operations, banks would dilute concentration and further competition, he said.

Joanne Morrissey, president and chief executive officer of Morristown, N.J.-based Firemark Consultants, Inc., agreed with Mr. Hunter, up to a point.

"I think we'll end up with a few big players and a lot of medium-sized ones," she said, adding that she expects the number of property/casualty insurers to decrease by 20% by 1992.

For instance, if British-based B.A.T. Industries Inc. is successful in its attempt to acquire control of Los Angeles-based Farmers Insurance Group, "the floodgates will open to consolidation," Ms. Morrissey said.

And, she made it clear that she does not necessarily consider a marketplace with fewer but stronger players a bad development.

Many insurers are not efficient players in the marketplace, she said, again agreeing with Mr. Hunter. Their inefficiency will cost them, whether by forcing them out of business or by encouraging them to merge with other insurers.

Governmental action could also encourage concentration in the property/casualty industry, said the III's Mr. Mooney.

While holding that there is no drift toward concentration in the property/casualty insurance industry, Mr. Mooney warned that concentration could increase if the McCarran-Ferguson Act is repealed or significantly amended. That law, passed in 1945, grants insurers a limited exemption from federal antitrust laws, among other things.

Without the exemptions provided by McCarran-Ferguson, notably the right for industry organizations to calculate rates for their members, smaller companies would be hard-pressed to compete with their larger counterparts, Mr. Mooney pointed out. Abolition of McCarran-Ferguson, which some have advocated in the name of greater competition, might therefore dampen competition.

"If McCarran-Ferguson were repealed and the industry were federally regulated, I think you'd see a move toward a more oligopolistic structure," Mr. Mooney said. ■

Banks may set sights on brokers, not insurers

By MARK A. HOFMANN

Financial institutions likely will be among the suitors for insurers if federal barriers restricting the entry of banks into the insurance business come tumbling down.

However, insurance company analysts don't expect banks to stampede to buy insurance underwriting operations if they are given the green light by Congress.

If banks enter the insurance business, they are more likely to buy brokers than underwriters, predicts Gloria L. Vogel, associate director of Bear, Stearns & Co. in New York.

Banks will be looking for distribution systems and brokerages are "a more logical way to distribute their products," she said, adding that banks have no particular desire to underwrite insurance.

If the legal barriers separating banking and insurance were rescinded, banks would be more likely to acquire insurers than insurers would be to acquire banks, said Udayan D. Ghose, vp and senior insurance analyst at Shearson Lehman Hutton Inc. in New York.

Mr. Ghose stressed, though, that banks probably would be very selective about the types of operations they sought to acquire.

Banks seeking to add insurance operations would be interested in personal lines property/casualty insurers because their products would fit well with banks' traditional products, he said, adding that banks also would seek to acquire brokerages if permitted.

In addition to providing banks with a new distribution system for their products, brokerages would be "basically a way for them to get involved in total capital management functions," Mr. Ghose said. For example, banks would consider brokers' risk management services a particularly attractive avenue, he explained.

But banks would shy away from assuming commercial lines underwriting responsibilities, he added. "I really don't think major commercial banks want to pick up major pollution liabilities that would linger for years."

Joanne Morrissey, president and chief executive officer of Firemark Consultants Inc. in Morristown, N.J., agreed, noting that large banks might seek to acquire large brokerages if they were allowed to because banks would view brokerages as new sources of fee income.

Continued on next page

Six criteria used to rate acquisitions

Would-be insurance company owners generally look for at least six things before making an acquisition, said Joanne Morrissey, president and chief executive officer of Firemark Consultants Inc., a Morristown, N.J.-based insurance research and investment banking firm.

The six factors are:

- The target company's balance sheet position and earnings potential. Suitors look beyond the most recent year's results to get an indication of the insurer's likely long-term performance, she said.
- The target company's future expectations, both in terms of finances and management outlook. The acquiring company has to ask, "Will this be a good fit?," Ms. Morrissey said.
- Recent prices paid for comparable companies relative to book value, earnings and actuarial appraisal information.
- Recent financial analysts' reports if the target company is publicly traded. Ms. Morrissey said the potential acquirers look beyond buy/sell recommendations to get indications of what sort of image the target company has among financial analysts.
- The number of available acquisition alternatives on the market. "The more companies there are, the less valuable they are," she said.
- The number of bidders for the target company. The more bidders, the higher the likely sale price, Ms. Morrissey pointed out. ■

Breakup hard for Fireman's Fund CEO

By MARK A. HOFMANN

NOVATO, Calif.—The top executive at Fireman's Fund Insurance Cos. says his experience in taking the insurer public reminds him most of a man Mark Twain wrote of: "I feel like the guy who was tarred and feathered and ridden out of town on a rail. When somebody asked him how he felt about it, he said, 'If it hadn't been for the honor of the occasion, I'd just as soon have walked.' "

William M. McCormick, president, chairman and chief executive officer of Fireman's Fund, presided over the largest initial public stock offering to date in October 1985 when American Express Co. spun off Fireman's Fund (*BI*, Oct. 28, 1985). The financial services conglomerate had owned the California-domiciled insurer since 1968. But, as the soft market of the early 1980s grew increasingly flabby, Fireman's Fund no longer fit into American Express' strategic plan, Mr. McCormick said.

American Express found the property/casualty insurance business to be both complex and cyclical, he explained. After months of consideration, American Express put Fireman's Fund on the market, but it kept its life operations.

'Everybody feels like they're in the Fireman's Fund canoe. We've developed an "It's up to us" mentality,' says Fireman's Fund Chairman and President William McCormick.

The new, independent Fireman's Fund's stock hit the New York Stock Exchange on Oct. 23, 1985, in an offering valued at $906.4 million. Individual shares were valued at $25.75.

Mr. McCormick, who had been with American Express for about a decade—but with its Fireman's Fund division for less than two years when the insurer was sold—said that taking the insurer public was among his most difficult tasks. For one thing, he did not think that American Express should divest itself of Fireman's Fund.

"I thought Fireman's Fund could be fixed and turned around in five years," he said. In addition, American Express was a good owner, Mr. McCormick added.

When he learned that he would be going with Fireman's Fund, "I tried not to take it personally," he said.


Mr. McCormick

But he soon found that independence had its pluses, many of which were psychological, he said.

For example, because Fireman's Fund was no longer part of American Express—even though American Express continued to hold a large minority share of the insurer's stock initially—Mr. McCormick was able to rally employees around the idea of going it alone.

"Everybody feels like they're in the Fireman's Fund canoe. We've developed an 'It's up to us' mentality," he said.

Bolstering that perception was the creation of a Fireman's Fund employee stock ownership plan. Six percent of the initial stock offering was set aside for the ESOP, which demonstrated that "our staff will have a stake in the new Fireman's Fund," Mr. McCormick said. That employee stake in Fire-

Continued on next page

Insurer suitors

Continued from previous page

But, there is no reason to believe that a financial tidal wave of banks would sweep up insurance companies if federally mandated separation of the two industries ended tomorrow, she said.

The recent antitrust suit brought by several state attorneys general against leading domestic insurers, the Insurance Services Office Inc. and Lloyd's of London underwriters has cast some question in the eyes of banks about entering the insurance business, Ms. Morrissey said (*BI*, March 28).

In addition, challenges in Congress to the McCarran-Ferguson Act, which grants insurers limited immunity from federal antitrust laws, also has made would-be suitors nervous, she said.

"Until the antitrust suit is settled and McCarran-Ferguson is decided, I don't think we'll see too much activity by banks" even if the prohibitions against banks are eased, she said.

'I really don't think banks want to pick up major pollution liabilities,' says Udayan D. Ghose.

Hank Tilman, vp with Donaldson, Lufkin & Jenrette Inc. in New York, said that banks may not be as interested in acquiring insurance concerns as they once were.

Banks are interested in geographic expansion, he explained. The recision of federal barriers to interstate banking has made many bankers direct their energies toward making acquisitions in the banking industry rather than expanding into insurance, he said.

If banks might find insurers attractive partners, insurers do not seem very anxious to return the favor, Shearson's Mr. Ghose remarked. Just as banks are hesitant to acquire insurers' massive long-tail liabilities, insurers have no desire to saddle themselves with the possibility of defaulted loans by acquiring banks, he said.

Ms. Vogel pointed out that although a few insurance companies have acquired limited service or "non-bank" banks, there has been no insurer rush into banking. She sees no sign that this will change anytime soon.

J. Robert Hunter, president of the National Insurance Consumer Organization in Alexandria, Va., and a vocal critic of the insurance industry, hopes that banks enter the insurance industry soon. "I think bank entry would mean less concentration" of the insurance industry's power, he said. ■

State approval may curtail mergers

By MARK A. HOFMANN

Hostile takeovers are rare in the insurance industry largely because of state regulatory intervention, some industry analysts say.

Regulators in each state in which an insurance company's affiliates are domiciled must approve a pending acquisition. And, regulators are often reluctant to approve an insurer takeover without the insurer's blessing, some observers suggest.

"I think one of the unfortunate things is that there are many managements who will try to hide behind the regulators," remarked Myron M. Picoult, senior vp and senior insurance analyst for Oppenheimer & Co. in New York.

Joanne Morrissey, president and chief executive officer of Firemark Consultants Inc., a Morristown, N.J.-based insurance research firm and investment banker, agreed that insurers often attempt to persuade regulators to drag their feet on hostile takeovers.

Some of the defensive strategies undertaken by Farmers Insurance Group in its effort to preclude a hostile takeover by B.A.T. Industries P.L.C. of Great Britain have nothing to do with the merits of the B.A.T. takeover bid but, rather, played on emotions, Ms. Morrissey said.

Ms. Morrissey cited attempts to play up B.A.T.'s tobacco connection as an example of a play on emotion designed to thwart the takeover.

However, Gil Marmol, a principal with management consultant McKinsey & Co.'s Dallas office, discounted concerns that regulators go out of their way to block hostile takeovers.

"If we haven't seen too much hostile takeover activity, it's a function of the fact that we haven't seen much activity, period," he said.

And, insurance regulators also do not see themselves as being overly protective of insurers' interests.

Each state has its own rules regarding insurer mergers and acquisitions, but most regulations stem from various pieces of the National Assn. of Insurance Commissioners' model legislation, like the model Insurance Holding Company Act.

At the center of any attempt to acquire an insurer in any state is the so-called Form A submission. Form A is a statement regarding the acquisition of any domestic insurer. The NAIC's holding company model act provides a multiple-page form that outlines the information regulators should seek when judging a possible merger.

The information sought ranges from the address of the would-be acquirer to detailed financial statements. And, the amount of data required often results in delays in approving merger applications, pointed out Lorraine Johnson, staff counsel for the California Department of Insurance.

But, she added, the delays are necessary to protect the interests of policyholders, she said. "The bottom line is how the change will affect policyholders," said Ms. Johnson.

Continued on next page

Fireman's Fund

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man's Fund is "very powerful medicine" for enhancing employee performance, he said.

Yet another benefit of independence was being able to set policies for an insurance business without having to contend with outside, non-insurance corporate restraints. Independence also allowed Fireman's Fund to re-establish control over its financial destiny, said Mr. McCormick.

By operating on its own, the insurer has "made a lot more money from our investments," he said. Mr. McCormick estimated that Fireman's Fund was able to make $300 million more from its investments during the past two years than it would have had it remained part of American Express.

As part of its strategy to control its destiny, Fireman's Fund has periodically repurchased its own stock, Mr. McCormick said. After Fireman's Fund's initial stock offering, American Express retained control of slightly more than 40% of its outstanding shares.

In December 1986, August 1987 and March of this year, Fireman's Fund repurchased blocks of its own stock from both American Express and on the market as a whole. By this spring, American Express' interest in Fireman's Fund had dropped to about 20% of outstanding shares.

Mr. McCormick made clear that despite pride in his accomplishment, taking Fireman's Fund public was no picnic. He took over the reins at Fireman's Fund when the insurer was mired in financial trouble. To correct that, he needed not only to put the insurer's monetary house in order but to change the thrust of its corporate culture.

"Those were three years that I didn't see many movies," Mr. McCormick said. "It's satisfying, but it's not really fun."

With the insurance market softening again, Mr. McCormick does not see the situation getting any easier. He drew a military analogy to explain his ideas of how insurers should respond:

"My heroes for the insurance business are Marshal Foch and Marshal Kutuzov," he said. Both Ferdinand Foch, commander of the French army in World War I, and Mikhail Kutuzov, commander of a Russian force during Napoleon's 1812 assault on Moscow, practiced forms of strategic retreat. Both commanders drew their enemies farther and farther into the interior, stretching supply and intelligence lines to the breaking point before pouncing. Mr. McCormick sees great wisdom in this defensive strategy for American insurers caught in a softening market.

"The name of the game is to survive and hang on. This is not a Patton-type industry," he said. ■

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Ms. Johnson declined to comment on the current struggle for control of Farmers Insurance Group between the insurer's management and British-based B.A.T. The matter is still before the California regulators.

California regulators have several criteria by which they judge potential insurance company acquirers, Ms. Johnson said.

Among the questions that corporate suitors must answer is whether the merger will result in a restraint of trade, she said, adding that this question generally applies to very specialized lines of insurance like title and mortgage coverages.

Another key concern is whether the acquiring company will be able to pay claims as they are filed. The department also looks at the experience, expertise and integrity of the would-be buyer, she said.

In California, the Insurance Department has 60 days in which to act on a merger application. However, in many cases, this limit is waived by the parties involved because of the amount of information that must be gathered and reviewed, Ms. Johnson said.

Ms. Johnson stressed that the California in-

Among the questions that corporate suitors must answer is whether the merger will result in a restraint of trade, says Lorraine Johnson.

surance code makes no references to foreign purchase of domestic insurers except in one case. The statutes specifically prohibit any governmental body other than the state of California from exercising "ownership, operation or control" of a California-licensed insurer.

Rather than nationality, "financial review is where it's at," Ms. Johnson said. Any submission receives close scrutiny from both the Insurance Department's legal and financial analysts, she said.

California does not require public hearings on mergers: All review is internal.

Iowa requires a public hearing within 30 days of the submission of merger papers and a decision on the merger within 30 days of the hearing. But, even though Iowa, unlike California, requires a hearing, the Iowa Insurance Department focuses on the same areas of inquiry as California, said Iowa Insurance Commissioner William D. Hager.

"Iowa law sets out specific criteria regarding acquisitions and mergers," he said, "but the basic grassroots considerations are:"

- Does the company doing the buying have the money, and if so, in what form?
- What is the reputation and integrity of the companies involved?
- What are the plans for the company?

Mr. Hager

Kevin Howe, an attorney with the Iowa Insurance Department, said the final question requires many answers.

For example, Iowa regulators want to know if would-be owners are planning to shut the operation down, Mr. Howe said. In addition, even if the company remains intact, the department wants to know whether it will be moved elsewhere, thus costing Iowa residents their jobs. ■

Report gives actuaries AIDS model

ITASCA, Ill.—A report by the Society of Actuaries provides life and health insurance actuaries with models for calculating losses and reserve requirements stemming from AIDS.

The report, "The Impact of AIDS on Life and Health Insurance Companies: A Guide for Practicing Actuaries," stresses that a potential for significant loss exists.

By the end of last year, the report points out, about 50,000 cases of acquired immune deficiency syndrome had been diagnosed in the United States. About 28,000 of those people diagnosed as having AIDS have died.

By the end of 1986, U.S. life and health insurance companies had paid out more than $290 million in AIDS-related claims, according to the report. However, that figure may be low, the report says, citing a joint study by the American Council of Life Insurance and Health Insurance Assn. of America, which noted that AIDS is often not reported as a cause of death for either legal or personal reasons.

"Although the current level of claims does not represent a threat

The report notes that individual life and health insurers' AIDS claims experience varies widely.

to industry solvency, the burden of claims is not falling equally on all companies and the burden can be expected to increase as infection spreads and more infected people develop AIDS," the report says.

"Because of the very long-term nature of this epidemic, there is time for insurance company management to plan how to control exposure and how to finance the claims that will begin to emerge," adds the report.

The report, which is broken into 10 chapters, points out that individual life and health insurers' AIDS claims experience varies widely.

Some companies' AIDS claims have amounted to less than one-half of one percent of all their ordinary life claims. But others have experienced an AIDS claim rate of more than 4% of all ordinary life claims. The report stresses that an individual company's exposure is significantly affected by the population and geographic area it serves.

Much of the report consists of actuarial models to help actuaries project costs attributable to AIDS. The models describe the possible impact on individual ordinary life claims as well as group medical, disability and life insurance plans.

The book also focuses on the impact of AIDS on Canadian insurers, which have a lower incidence of AIDS claims than U.S. insurers.

Another chapter outlines management strategies for dealing with AIDS-related claims. This section includes discussions of strengthening reserves and the possibility of creating an AIDS mortality reserve.

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"The Impact of AIDS on Life and Health Insurance Companies: A Guide for Practicing Actuaries" report costs $50 for Society of Actuaries members and $75 for nonmembers. For a copy, contact the Society of Actuaries, Research Department, 500 Park Blvd., Itasca, Ill. 60143.

Insurers filling management positions

STAMFORD, Conn.—Insurance industry management hiring is returning to normal following an industrywide hiring slowdown that began in mid-1987, an executive search firm reports.

"In the past three to four months, industry hiring has picked up significantly and is now about 80% back to normal," said Michael Blount, senior vp of Halbrecht Associates Inc. in Stamford, Conn.

To illustrate the impact of the recent hiring freeze of middle- and senior-level managers, Mr. Blount said: "Ordinarily, the industry would have hired about 1,500 managers by mid-1987. Instead, about 1,500 were laid off."

The recent hiring surge has been concentrated primarily in insurers' financial and budgeting departments, according to Mr. Blount.

Last year, insurers concentrated on recruiting people in areas such as new product development or financial services marketing, for instance, he said.

"But now it's back to such basics as administration, sales support, customer service, data processing, financial controls and automation," Mr. Blount explained.

IT briefs

Texas property

DALLAS—Texas' depressed economy is leading to frequent downgradings of the construction, hazard and protection features of property inspected by the Fire Prevention & Engineering Bureau of Texas, the FPEB says.

Because of the economy, building owners are leasing to tenants that would have been rejected in better economic times because of the hazards they pose, reported FPEB Manager R.A. "Dick" Constock at the bureau's 69th annual meeting in Dallas.

Coupled with the fact that many policyholders have less funds to maintain and test fire protection equipment, the bureau is making numerous recommendations to property owners and is frequently downgrading its assessments of properties, he said.

Mr. Constock also reported that insurers last year filed an increased number of requests with the bureau for new property surveys and surveys of multiple location accounts.

Also at the meeting, Charles N. Myers, manager-agency operations department for Travelers Corp., was elected chairman for the 1988-89 term.

Smoke-free insurers

HARRISBURG, Pa.—Two Pennsylvania insurers were recently recognized for creating smoke-free workplaces.

Camp Hill-based Blue Shield of Pennsylvania and The Penn Mutual Life Insurance Co. of Philadelphia were recently awarded the Smoke-Free 2000 Business Award from the Pennsylvania Interagency Council on Tobacco and Health.

The state program was established in 1980 to promote public awareness of the health risks of tobacco, to support legislation that would reduce tobacco use and to exchange information on education resources.

Penn Mutual celebrates its one-year anniversary as a smoke-free company this month.

Blue Shield of Pennsylvania has been smoke-free since Jan. 1.

Vehicle theft losses

ROCKVILLE, Md.—Losses from motor vehicle thefts totaled $52 billion between 1973 and 1985—measured in 1985 dollars—before vehicle recoveries and reimbursements from insurance companies, a recent survey says.

The Bureau of Justice Statistics' National Crime Survey reports the net loss to owners during the 13-year period was almost $29 billion after vehicle recoveries and $16.1 billion after insurance payments.

Half of the incidents involved a loss of $2,455 or more before recoveries and insurance payments, the report said. And, about 10% of the incidents involved losses of $10,000 or more.

The other half half of the incidents involved a net loss of $242 or more after insurance reimbursements and recoveries, according to the report.

An automobile was stolen in 76% of thefts, and the rest involved trucks, vans and motorcycles, the report said.

The number of completed motor vehicle thefts per 1,000 households fell 21% from 1973 to 1985. In 1985 there were 10.5 thefts per 1,000 households, compared with 13.3 thefts per 1,000 households in 1973. ■

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Agents/brokers

John B. Sullivan named president of Corroon & Black of Illinois Inc. He succeeds **Gary R. Griffith**, who became president and chief executive officer of Corroon & Black's San Francisco office.

Garry Nelson named president of the professional liability division of Cal-Surance Group in Anaheim, Calif. He remains chief operating officer of the division and president of Lancer Claims Services Inc., also in Anaheim.

Donald F. Mackay joined Richard N. Goldman & Co. in San Francisco as vp and manager of loss control engineering. Previously, Mr. Mackay was vp and assistant manager of engineering of Alexander & Alexander of California Inc. in San Francisco.

Dianne S. Knapp and **Nicholas H. Garrow** promoted to vps at Rollins Burdick Hunter Co. of Oregon Inc. in Portland. Ms. Knapp is a special accounts supervisor-workers compensation; Mr. Garrow is an account executive-commercial production.

Timothy J. Mahoney named executive vp of Marsh & McLennan Inc. in New York. Previously, Mr. Mahoney was a managing director of Northeast brokerage operations.

Erv Remmele named vp at Marsh & McLennan Inc. in Portland, Ore., serving as regional boiler and machinery specialist for commercial clients.

Larry E. Davis promoted to managing director of Marsh & McLennan Inc. in Norfolk, Va. He previously was a senior vp.

John P. Kovach appointed vp and national accounts coordinator in the claims management services division of Fred S. James & Co. Inc. in Chicago. Previously, he was account executive and assistant vp.

Robert G. Moody promoted to vp for Bayly, Martin & Fay of Oklahoma Inc. in Tulsa.

Ed Gottlieb promoted to president from executive vp of Jardine Emett & Chandler Inc.'s Orange County, Calif., office.

Reinsurance

Robert F. McDonnell appointed vp and casualty facultative underwriter of Skandia America Group in New York. He previously was assistant vp.

Stan Gorecki promoted to vp-workers compensation claims at American Re-Insurance Co. in New York. Previously, Mr. Gorecki was assistant vp-work comp claims.

Raymond L. Osterhout joined North American Reinsurance Corp. in New York as senior vp. Most recently, he was president of American Independent Reinsurance Co.

HMOs/PPOs

P. Robert Larson named chief operating officer for Physicians Health Plan of Minnesota, a Minnetonka-based health maintenance organization and subsidiary of United HealthCare Corp. Most recently, Mr. Larson was senior vp of United HealthCare Corp. and president of subsidiary operations.

United HealthCare also announced the following appointments: **Thomas F. Heaney** named president of subsidiary operations; **Jack L. Reid** named president of United's subsidiary Life of Mid-America Insurance Co.; and **John K. Middleton** named president of United's pharmacy subsidiary.

Excess/surplus

Lori Ortiz joined J.J. Negley Associates of Cedar Grove, N.J., as vp. Previously, Ms. Ortiz was a vp with Johnson & Higgins in New York.

William Yurek named executive vp of AVRECO Inc. in Chicago, an independent wholesale surplus lines broker.

Previously, he was vp-professional liability.

Della Garrison, **C. Samuel McDonald** and **Harold P. Straus** appointed vps of Markel Service Inc. in Richmond, Va. Previously, Ms. Garrison served as associate vp, Mr. McDonald was director of operations for governmental programs and Mr. Straus was an account executive in equine insurance.

James M. Lenihan appointed vp of Specialty Lines Underwriters, a Milwaukee-based surplus lines broker. Mr. Lenihan will be in the Lisle, Ill., office.

Other suppliers

Crawford & Co. has promoted: **James R. Austin** to senior vp-regional manager for the Southwestern region in Dallas; **Dennis A. Smith** to senior vp-regional manager for the Midwestern region in Schaumburg, Ill.; **George L. Box** to senior vp-regional manager for the mid-Atlantic region in McLean, Va.; and **James A. McGee** to vp-regional manager for the Northeast region in Mahwah, N.J. Also, **Donald N. Hull** promoted to senior vp-general manager for Crawford & Co. Insurance Adjusters Ltd. in Toronto. ■

New Aon unit to manage Paumanock

By ROGER SCOTTON

HAMILTON, Bermuda—Grumman Corp. is moving the management of its Bermuda-based reinsurer from Frank B. Hall (Bermuda) Ltd. to a new underwriting manager formed in Bermuda by Aon Corp.

Paumanock Insurance Co. Ltd., the third-largest Bermuda-based treaty reinsurer, will be managed by Anchor Underwriting Managers Ltd., the new Aon unit, beginning at the end of June.

The move follows the departure of Hall (Bermuda) President Robin Spencer-Arscott to Aon's Bermuda operation, Rollins Burdick Hunter (Bermuda) Ltd., as chairman and chief executive officer. He holds the same titles at the newly formed Anchor.

Paumanock, a 14-year Hall client, was Hall's largest underwriting client. The 15 Hall employees who worked on the account will be interviewed for positions with Anchor. Former Hall underwriter John Williams already has joined Anchor.

Paumanock wrote $38.8 million in gross premiums in 1987, mostly London market excess and property catastrophe reinsurance.

Anchor also will underwrite reinsurance for Virginia Surety Co., an Aon property/casualty insurer.

In addition, RBH is merging the captive management operations of RBH (Bermuda) and Adams & Porter International Ltd. EBH acquired Houston-based Adams & Porter International Inc. in October. Adams & Porter had managed about six active captives writing premiums of about $100 million, including subsidiaries of McDermott International Inc. in New Orleans and Enron Corp. of Houston.

The four Adams & Porter staff members in Bermuda are joining RBH.

RBH now manages 42 captives in Bermuda. After employees are hired to serve Paumanock, the Aon units in Bermuda will employ about 35 people.

Hall which manages about 70 captives in Bermuda, will continue as Grumman's U.S. retail broker.

Bermuda briefs

Insurer opens

Bermuda-based Prospect Insurance Ltd., the newly formed joint venture between Britain's Midland Bank P.L.C. and Lloyd's of London broker C.E. Heath P.L.C., opened for business last month with initial capital of $10 million (*BI,* April 18).

Prospect, in which Midland owns a controlling 59% stake, specializes in underwriting financial reinsurance products for international commercial insurance buyers.

Prospect Chairman Jeffrey Cooper, who heads Midland's financial institutions division, said the new company is part of an increasing trend toward the use of structured funding techniques and financial products in the long-term management of insurance costs.

Prospect initially will target Midland's and Heath's client bases in Britain and continental Europe, where it will be promoted as a vehicle offering balance sheet protection in addition to existing insurance, he said.

David Potter, Midland's global corporate banking director, said that Prospect is targeting large international companies that have been taking more and more risk on their balance sheets.

John Boardman has been named president of Prospect, which has signed an underwriting management contract with Bermuda-based Heath Risk Services Ltd.

Heath Risk Services also manages Heath's financial reinsurance subsidiary, Pinnacle Reinsurance Co. Ltd.

OIL posts loss

Oil Insurance Ltd., the Bermuda-based property and liability mutual that insures 49 oil and gas companies, has reported an underwriting loss of $23.8 million for the year ended Dec. 31, 1987.

Net premiums written and earned were $66.1 million, a 77% decrease from net premiums earned of $293.7 million in 1986 (*BI,* May 11 1987).

Underwriting income of $313.3 million was recorded for 1986, the year in which OIL assigned to a syndicate of banks its right to receive certain future premiums in return for a payment of $128 million. The payment appeared in OIL's financials as premiums written and earned in 1986.

OIL recorded a net loss of $19.3 million for 1987 against a profit of $319.6 million the year before.

Although the net loss is in stark contrast to 1986 results, Charles Bailey, OIL president and chief executive officer, called it "in line with the historic pattern of recording an occasional loss year."

"Under the premium development procedure this will continue to be the case," says his report. "Large loss years will be followed by premium increases as reflected in 1986 and good loss years will be followed by premium reductions as reflected in 1987. Year-on-year comparisons will almost always result in a distorted view of OIL's performance and the longer-term trend is the only way to measure OIL's results."

OIL's losses last year were $90 million, a figure Mr. Bailey described as being "about the average for the last five years, exclusive of 1986 in which negative losses were recorded."

Investment income was $7.1 million against $8.7 million previously.

His report predicts: "Premium volume in 1988 is expected to be in line with that of 1987 and, unless loss experience is better than average, we do not expect substantial net income. Another loss year would be no great surprise."

OIL wrote the first $150 million of liability coverage for Ashland Oil Co., which faces extensive losses from a 1-million-gallon diesel oil spill outside Pittsburgh in January (*BI,* Jan. 11).

In addition, OIL wrote the insurance coverage for a Shell Oil Co.

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refinery in Norco, La., where an explosion and fire killed at least three workers and caused extensive damage (*BI*, May 9).

But Mr. Bailey says OIL's balance sheet is now "stronger than at any time in its history." Statutory capital and surplus rose $28 million to reach $929.5 million, while total assets advanced $85 million to $1.1 billion.

OIL's per-occurrence coverage of up to $150 million, with an additional 50% for annual aggregate, was increased last year with the offer of an additional optional $150 million layer.

Exel stock buyback

Cayman Island-based Exel Ltd. is offering to buy back shares held by 32 non-sponsor shareholders.

The shareholders previously had to buy stock in Exel as a condition of purchasing insurance from X.L. Insurance Ltd., the Barbados-domiciled excess liability underwriting subsidiary of Exel.

The May 25 offer is to close on June 28, said Chairman and Chief Executive Officer Ian Heap.

The redemption scheme will be a Dutch auction in which Exel will pay not less than $180 a share and not more than $230 for each unit of stock, Mr. Heap said. The 32 stockholders own 260,000 shares in the company, which has a total of 102 shareholders, he noted.

"The offer is tax strategized in that those who tender their shares will relieve themselves of liability for Related-Person Insurance Income," he said. "But we also took the view that it would be only fair to allow companies who were involuntary investors in Exel to divest themselves of their holdings if they so wished."

If all eligible shareholders tender their stock and Exel buys it at the ceiling price of $230, the redemption would cost about $60 million.

"But it's improbable that anything like this will happen," he added. "My own view is that many of the involuntary investors will feel that they made a good investment in Exel and will not want to sell back their shares."

The offer is the second of its kind by the excess insurer. Its first stock redemption, a fixed-price offering, was staged last July. Just under 400,000 shares at $190 each were purchased—an exercise that cost Exel about $75 million.

Exel Ltd., which maintains a contact office in Bermuda, has $700 million in shareholders equity and assets in excess of $1.2 billion.

Heddington Insurance

Heddington Insurance Ltd., the Bermuda-based property and casualty unit of Texaco Inc., reported 1987 underwriting income of just more than $26 million, down $1.3 million from 1986.

Gross premiums fell 38% to $176.6 million last year, leaving net premiums earned at $103.8 million compared to $207.9 million in 1986. Loss provisions fell to $72.5 million, down from $159.9 million, while investment income rose $3 million to top $65 million. Net income increased $1 million to reach $93.7 million for the year.

Heddington's lower premium volume followed the decision "to discontinue its participation on a major portion of U.S. business," said Robert Golden, Heddington's president and chief executive officer.

In the company's 1987 annual report, he said: "Heddington's combined loss and expense ratio improved significantly from 86.8% in 1986 to 74.9% in 1987 due to this restructuring of our worldwide portfolio. However, the company continues to monitor U.S. source risks for gainful opportunities."

Mr. Golden said that Heddington, which insures its parent and affiliates and underwrites unrelated property and casualty reinsurance, increased stockholders' equity 14% to $669.4 million, while total assets grew to $1.1 billion. Heddington's total reserve for outstanding losses increased $15.6 million to $450.7 million.

Heddington declared a dividend of $12 million last year, the same as in 1986. It also advanced $175 million to Texaco, a loan that is repayable over the next five years.

Cambridge Re

Liquidators of failed Cambridge Reinsurance Ltd. have been unable to find any creditors willing to argue against their novel liquidation plan in a proposed court hearing in Bermuda.

Joint liquidators David Lines and Gerry Weiss want to use actuarial methods to determine the reinsurer's future contingent liabilities. The two were appointed by Bermuda's Supreme Court in May 1985, after Cambridge, a subsidiary of Halifax, Nova Scotia-based National Sea Products, put itself into liquidation.

They say this approach, which makes unprecedented use of the island's century-old Bankruptcy Act and the 1981 Bermuda Companies Act, could shorten the duration of the liquidation by about 15 years.

To demonstrate that their plan for handling the $63.3 million insolvency was fair, the liquidators hoped to stage an adversarial court hearing in which creditors would either argue against the overall concept or the actuarial methodology of the liquidation.

Mr. Lines, a Bermuda-based partner of Coopers & Lybrand, said the plan would not be allowed to founder simply because nobody is prepared to disagree with it.

In a final effort to flush out a dissenting party, the liquidators last week wrote to Cambridge's 2,000-3,000 creditors indicating that if no respondent applies to the island's Supreme Court by Sept. 7, the liquidators will apply for court approval to proceed without the hearing.

Aug. 7 is the scheduled deadline by which the liquidators must be informed of a respondent's decision to oppose the plan.

If a respondent does not come forward, however, it is unlikely that a cash dividend will be paid by year-end as had been hoped, said a liquidator spokesman.

Cambridge Re as of July 31, 1987, owed unsecured creditors about $80 million and had assets of $16.3 million as of July 31, 1987.

Reiss sale closed

Swiss Reinsurance Co. has completed its acquisition of a controlling stake in the Bermuda-based captive management group founded by Fred Reiss.

The sale of a 70% holding in the consulting and management business was completed May 24, said Arthur Deters, chief executive officer of International Risk Management Group Ltd., the new holding company (*BI*, March 14).

A 30% shareholding remains in the hands of existing management.

International Risk Management will be run as an independent unit within the Zurich-based reinsurance organization, Mr. Deters said.

Mr. Reiss remains chairman of the new holding company, Mr. Deters said. However, the group will no longer be known as the Reiss Organization, a descriptive label rather than a legal entity.

Mr. Deters said all group operating companies will adopt the name of International Risk Management except Fort Lee, N.J.-based American Risk Management Inc. and European Risk Management Ltd., based in Weybridge, England. "Basically, everything outside the United Kingdom and the United States will carry the name of the Bermuda holding company," he said. ■

HMO enrollment growth

Continued from page 3

And, enrollment in "Prudential Plus," an open-ended HMO-like product introduced by Prudential Health Care Plans Inc. in 1987, totaled 381,271 at year-end 1987.

However, the significant increase in HMO enrollment between December 1987 and January 1988 indicates that enrollment may be picking up again, according to InterStudy.

"This improved enrollment (in January) may be a reflection of employers' rejection of substantially higher indemnity insurance premiums for 1988 and the impact of employer-offered open enrollment periods at the end of the year," the report states.

The research group reports that there were 62 new HMOs formed in 1987, of which 59 were independent-practice association HMOs. Fifty-four of the HMOs were not federally qualified, and 49 were for-profit entities.

Meanwhile, 30 HMOs shut down during 1987, and 26 merged, were acquired or consolidated with other plans.

At year-end 1987, there were 650 HMOs in the nation, counting each separately incorporated HMO as one even if it is affiliated with an umbrella organization.

The strongest growth during 1987 was in California, where two new HMOs were developed and enrollment increased by 621,965. California accounts for one-fourth of the nation's HMO enrollment.

Other strong gains were seen in New York, where there were seven new HMOs and 257,551 new enrollees; and Illinois, where enrollment grew by 211,176 during 1987.

HMO enrollment dropped in two states during 1987: South Carolina, where enrollment was down 18,567, or 10.7% to 155,603; and Utah, where the decrease was 13,956, or 5.8%, to 224,117.

Other highlights of the InterStudy report include:

- Seventy-five percent of all HMO enrollees are in plans with 500,000 or more members, and 50% are in plans with 100,000 or more members.

However, InterStudy notes: "While the majority of enrollees are concentrated in large plans, the majority of plans continue to be relatively small." For example, 60% of all HMOs have 25,000 or fewer members.

- HMOs that were 10 years old or older accounted for almost 50% of total HMO enrollment in 1987, down slightly from 51.1% of total enrollment in 1986.

HMOs that were 2 years old or less accounted for 15% of total enrollment in 1987 but represented 53% of the total number of plans nationwide. In 1986, HMOs that were 2 years old or less accounted for 15.7% of total plan enrollment and represented 56.8% of all HMO plans.

- IPA-type plans accounted for 41% of total HMO enrollment at year-end 1987 and had an annual growth rate of 20.9%.

"The IPA-model HMO is clearly the most popular type of plan in existence, with 63%. . .of all plans organized as IPA-model HMOs in the last quarter of 1987," InterStudy says.

However, staff plans—plans that deliver health care through a group of physicians controlled by the HMO—grew 24.1% for 1987.

"The strong growth can be explained by a shift to the staff model in some Maxicare and CIGNA plans," InterStudy noted.

- Eighty percent of all HMO enrollees are in federally qualified plans. There currently are 342 federally qualified plans and 308 non-qualified plans.

In general, InterStudy says: "The HMO industry is entering a new era." The research group predicts this era "will be one of more efficient and effective management of a soundly established competitive health care marketplace."

"Market growth will be secondary to developing or refining strategies that can produce managed care: care that can undergo analysis for appropriateness in the rendition, effectiveness of outcome and reasonableness of price.

"In this new era, the individual consumer's influence will lessen while employer/payer power will be made manifest," InterStudy concludes.

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The HMO report appeared in the spring 1988 issue of The InterStudy Edge, with the January data appearing in a special supplement of The Edge, which is published quarterly by InterStudy. The annual subscription rate is $160, the single-copy rate is $45, and the cost of the January supplement is $35. Contact InterStudy, P.O. Box 458, Excelsior, Minn. 55331.

Open-ended HMOs gaining momentum

The growth in health maintenance organization enrollment is slowing somewhat from the boom years of 1985 and 1986, partly because more people are enrolling in non-traditional HMO plans, a study reveals.

HMO enrollment grew only 13.6% during 1987, much less than the 22% growth rate in 1986 and the 26% in 1985 (see story, page 3). And, according to InterStudy, an Excelsior, Minn.-based research firm, "A partial reason for slower HMO growth is due to enrollment increases in alternative managed care products."

Enrollment data on two non-traditional HMO products—"open-ended" HMOs and the "Prudential Plus" HMO—support InterStudy's statement.

InterStudy defines an open-ended HMO as one in which members have two or sometimes three choices of providers from whom they receive services.

Prudential Plus is an HMO product virtually identical to an open-ended HMO that was introduced by Prudential Health Care Plans Inc. in 1987.

Interstudy does not include enrollment in these types of plans in its overall HMO statistics.

An open-ended HMO is one in which members have two or sometimes three choices of providers from whom they receive services.

"By choosing the traditional HMO option, the enrollee has fewer financial outlays and a narrower choice of providers. By choosing the open-ended option, the consumer has a wider choice of providers but is responsible for a co-payment (typically 20% of the provider's charges) and sometimes deductibles for leaving the HMO provider network," Interstudy explains.

"In some cases, where state law permits, the HMO insures the out-of-network benefits. But, more often, costs for services provided outside the HMO are covered by a separate agreement with an insurance company," Interstudy adds.

At the end of 1987, 23 HMOs in 11 states offered an open-ended product and enrollment in such HMO arrangements grew almost 50% during 1987, including an increase of 10% during the last quarter. A total of 378,671 people were enrolled in these HMOs by the end of 1987.

In addition, year-end 1987 enrollment totaled 381,271 in Prudential Plus.

And the growth in open-ended HMOs continued into 1988, according to InterStudy. By Jan. 31, 1988, there were 40 HMOs offering open-ended products in 20 states, and enrollment has climbed to 450,340—an increase of nearly 19% over the previous month.

And, Prudential Plus had 463,802 members in January 1988.

"InterStudy expects the dramatic growth of HMO hybrids to continue this year as HMOs respond to market demands for more flexibility and for the desire of employers to deal with fewer carriers for their health care plans," the research firm says.

The open-ended HMO product allows employers to offer more flexibility to their employees without complicating their administration of the health care plan.

"Member lock-in is viewed by many as the most significant barrier to HMO enrollment. The open-ended product removes this barrier while allowing the HMO to encourage enrollees to utilize plan personnel before going to outside providers," InterStudy explains.

"With the open-ended plan, HMOs can improve their appeal to employers by offering a product that can compete more effectively with traditional indemnity insurers."

The problem for such HMOs, though, is to control enrollees' inappropriate utilization of providers outside the HMO network.

"Consumer choice of the HMO network, rather than the indemnity option, depends on a number of factors, including the enrollee's previous experience with an HMO, prior contact with and dependence upon a particular physician, and the cost differential between use of the HMO and the indemnity plan," InterStudy says.

—By Alison Kittrell

Exposure limits

Continued from page 1

Diane Factor, an industrial hygenist at the labor federation's Washington, D.C., headquarters, cited silica and petroleum distillates as substances for which OSHA's proposed standards fall short.

She said that in both cases OSHA followed exposure recommendations made by the American Conference of Governmental Industrial Hygienists rather than the considerably more stringent recommendations made by the National Institute of Occupational Safety and Health.

Ms. Factor also questioned whether the new exposure limits might stress quantity at the expense of quality. While OSHA's proposals would affect a large number of substances, many of them "were not of primary concern" as potential workplace hazards, she said.

Eric Frumin, health and safety director for the New York-based Amalgamated Clothing and Textile Workers Union, has reservations about the enforcement that would accompany the proposed standards.

"The Reagan administration drastically cut back enforcement of OSHA toxic substance standards in 1981, and OSHA has never recovered. Workers have literally been murdered by chemical exposures since then. Thus, OSHA's plan to cut exposure limits will be of little real benefit to workers, especially since OSHA will not require employers to measure exposure on a regular basis," he said.

The Washington, D.C.-based Chemical Manufacturers Assn., on the other hand, supports the new regulations, said Randy Schumacher, director of health and safety for the trade association. "We support OSHA's update. We think it's long overdue. We think it's an excellent effort in the agency's attempt to stay current in advances in toxicology and epidemiology on those specific substances," he said.

Mr. Schumacher noted that the proposed regulations will not place a significant new burden on many of the CMA's 170 member companies because they follow ACGIH recommendations as they are published, and in some cases adopt even stricter standards. However, the CMA has not estimated how much the OSHA proposals would cost members.

Howard Greene, associate legislative director for the Risk & Insurance Management Society Inc. in New York, said that RIMS had not had a chance to examine the proposals yet.

Safety consultants were pleased that that the OSHA proposals were based on ACGIH recommendations.

"My feeling is that current permissible exposure limits are based on information that's somewhat dated," said Ronald Pearson, toxicologist and industrial hygenist with Delta Environmental Consultants Inc. in St. Paul, Minn.

Harry Shirley, assistant vp—casualty loss control for Alexander & Alexander Services of New York Inc., said that if OSHA standards are to stay up to date, adoption of the ACGIH standards is a step in the right direction. He pointed out that ACGIH publishes new threshhold standards annually, which allows the incorporation of current toxicological data.

"It's an extremely smart move—it is ridiculous to use values that are 20 years old," said Niru Dave, a casualty loss control consultant with A&A of New York. The current OSHA standards are "extremely outdated," he said, noting that some reflect data published in 1968.

"From a health standpoint, I definitely advocate adoption of the ACGIH standards," Mr. Pearson said.

'We support OSHA's update. . . .We think it's an excellent effort in the agency's attempt to stay current in advances in toxicology and epidemiology,' says Randy Schumacher of the Chemical Manufacturers Assn.

However, he added that economic questions must also be answered before standards are adopted. He said that imposition of too-stringent standards for some substances could force some small businesses to close their doors.

William G. Lauffer, vp, corporate risk control services division of Fred S. James & Co. Inc.'s Short Hills, N.J. office, also stressed the importance of examining the proposals closely.

"The decision will require more study and analysis as to its impact on both employers and employees. The degree of change and how the workplace will be affected need to be evaluated. Costs of implementing these proposed standards are an important factor that also has to be considered," he said.

The proposed rule will:

- Lower the eight-hour-average permissible exposure limits for about 100 substances listed on what are called "Z" tables established by OSHA.
- Set eight-hour-average permissible exposure limits for 205 hazardous substances currently not regulated by OSHA.
- Set new short-term, 15-minute exposure limits for 70 substances.
- Set skin exposure limits for substances where appropriate.
- Raise the permissible exposure limit for flourine.

Some of the commonly used substances subject to lower exposure limits include chloroform, carbon monoxide, hydrogen cyanide, ammonia and trichlorethylene.

Industries that will be most affected by the proposal include smelters, foundries and steel manufacturers, according to Deputy Assistant Secretary of Labor Frank White.

Mr. Pendergrass noted that many companies already limit worker exposure to many hazardous substances to the levels permitted under the proposed rule.

The proposed standard "coincides with what good industrial hygiene practice is," Mr. Pendergrass said. Although "it would be nice if we could say that everyone's already there," that is not the case, he added.

In an analysis of how much the proposed rule could cost different industries, OSHA estimated that the lumber and wood products industry would be most heavily hit, perhaps facing an annual compliance cost of $196.07 million, with smaller lumber plants shouldering $175.55 million of the burden.

The industries next hardest hit would be printing and publishing, facing an annual compliance cost of $75.69 million, followed by rubber and plastics, which face an annual cost of $75.48 million.

Other industries that could face annual costs for compliance in excess of $40 million include chemical production, metal production, machinery production and transportation equipment.

Under the proposal, employers would have to comply with the new exposure limits within six months of the standard's effective date,

Continued on next page

Exposure limits

Continued from previous page

which will be announced when OSHA publishes the final rule in November.

During the first four years the new standard is in effect, employers could use any engineering mechanism to comply with the rule, including ventilation systems, isolating workers from the substances, enclosing the source of the emissions, modifying the production process to decrease the amount of the hazardous substance produced, modifying equipment or substituting non-hazardous chemicals in place of the hazardous substances.

Employers also can require workers to wear personal protective equipment, although OSHA does not prefer this approach to compliance.

After the initial four years of the standard, employers will be required to comply with as-yet unspecified mandates on how to achieve permissible exposure levels in their facilities.

Some of the more common illnesses workers can experience due to overexposure to hazardous substances include cancer; mucous membrane irritation; systemic toxicity; metabolism problems; liver, kidney, respiratory, cardiovascular and nervous system diseases; narcosis; and development of allergies.

Current permissible exposure levels for substances on OSHA's "Z" list have been in effect since 1971, when OSHA adopted wholesale workplace exposure limits developed by the ACGIH. The ACGIH exposure limits were based on 1968 data.

The Occupational Safety and Health Act of 1970 gave the agency the authority to adopt health and safety standards without conducting a formal rulemaking procedure during its first two years of existence.

OSHA's proposed standard is also based primarily on recommendations from the ACGIH, with supplementary consideration given to recommendations from NIOSH.

The proposal will be available for public comment before the agency drafts a final standard, which may order new permissible exposure levels based on comments.

Written comments on the proposed standard must be postmarked by July 8. Comments should be sent to the OSHA Docket Office, Docket H-020, Room N-3670, U.S. Department of Labor, Washington, D.C. 20210.

A public hearing on the proposal is scheduled to begin July 20 in Washington, D.C. The hearing will be in the auditorium of the Labor Department building, Third Street and Constitution Avenue N.W. The hearing will begin at 9:30 a.m.

Notices of intention to appear, testimony and documentary evidence to be submitted at the hearing should be sent to Tom Hall, OSHA Division of Consumer Affairs, Docket H-020, Room N-3647, U.S. Department of Labor, Washington, D.C. 20210.

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Associate Editor Mark A. Hofmann in Chicago also contributed to this story.

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(i) If by 7 August 1988 no creditor or Insurance Debtor of Cambridge Reinsurance Limited shall have informed the joint liquidators in writing of their intention to apply to the Court to be made a party to the Summons dated 16 June 1987, issued by the joint liquidator for directions to enable them to estimate on an actuarial basis the value of the contingent liabil ties and other liabilities uncertain value to its creditors, for the purpose of opposing the making of an Order for the said directions or

(ii) If by 7 September 1988 no creditor or Insurance Debtor who shall has so informed the joint liquidators shall have applied to the Supreme Court of Bermuda to be so joined for such purpose then the joint liquidators shall be at liberty to apply ex parte for the relief sought in the said summons.

Accordingly any creditor or Insurance Debtor who wishes to apply to joined as a respondent to the Summons for the purpose of opposing the making of an Order for the said directions must notify the joint liquidators in writing of their intention no later than 7 August 1988 to the following address:

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Thereafter any such person who has notified the joint liquidators may apply to the Court by no later than 7 September 1988 to be joined as respondent to the proceedings.

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If no creditor or Insurance Debtor notifies the joint liquidators in writing by 7 August 1988 of their wish to act as a respondent in opposition to the said Summons, or having notified, no creditor or Insurance Debtor applies to be joined as a respondent by 7 September 1988 then the Court directed that the joint liquidators shall be at liberty to apply ex parte for the relief sought without further notice to creditors or Insurance Debtors.

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Illinois Bell sued over service disruptions

By MEG FLETCHER

CHICAGO—The worst service disaster in Illinois Bell Telephone Co.'s history ended last week when the last telephone lines damaged by a May 8 fire were reactivated, but the company's legal and regulatory problems are just beginning.

Disgruntled local businesses have begun filing lawsuits against Illinois Bell, while regulators with the Illinois Commerce Commission are launching a special investigation into the service outage.

And, the ICC is expected to rule this week on demands by Illinois Attorney General Neil Hartigan, who wants the ICC to hold a formal inquiry on the service outage; order Illinois Bell to create a special fund to compensate people for losses due to the telephone outage; and order Illinois Bell to submit a disaster plan for ICC approval.

The requests for damages challenge the utility's traditional immunity from customer's claims for damages due to lack of service, attorneys say.

And, while Illinois Bell was insured for its own property losses from the fire, it is uninsured for customer claims, company spokesmen said (*BI*, May 16).

Regardless of the outcome of the legal actions, the massive disruption increased telephone-dependant executives' awareness of the potential for losses from an extended service disruption, for which most businesses apparently are uninsured.

The Mother's Day fire at an Illinois Bell switching station in the west Chicago suburb of Hinsdale, one of five major switching points for the Chicago metropolitan area, and the water used to fight the blaze destroyed some of the fiber optic equipment that handled an average of 3.5 million calls daily, according to an Illinois Bell spokeswoman.

The fire interrupted service for nearly a week in parts of a five-county area. In addition, 35,000 Hinsdale-area customers on 42,000 lines were without any local service from six days to two weeks. Half of these customers did not have reliable local phone service for 19 days, while it took 28 days to restore full service to the remainder. And, long-distance service returned sporadically until the new equipment was installed, the Bell spokeswoman said.

"I don't think anybody thought this was a possibility," said Wayne Hilty, operations business manager for Prime Computer Inc. in Oak Brook Terrace.

Prime Computer's Mr. Hilty was most concerned about business customers' frustration at being unable to reach Prime to make their service requests known. "I don't think we can put a dollar amount on goodwill."

For businesses like insurance brokerages, "it is pretty difficult to prove losses," added George Morency, chairman of Morency, Weible & Sapa, a Hinsdale-based agency serving commercial clients. His business fared better than most by sending secretaries outside to make calls from seven producers' cellular car phones before it purchased two portable phones for the office.

Among companies filing lawsuits against Illinois Bell are Lee & Eddie's Catering Inc. of Wood Dale, which claims that lack of reliable phone service has cost it at least $100,000. Incoming telephone calls dropped to 30 from 300 to 400 daily, said President Robert Veles, and "receipts of $13,000 to $14,000 per day dropped to $3,000."

In addition, a Naperville travel agency filed a lawsuit in Du Page County Circuit Court after losing an estimated $25,000 per day—or a total of $250,000—in revenues, said attorney Vincent L. DiTommaso of DiTommaso & Berman P.C. in Oak Brook.

At least one other suit was filed in Cook County by attorney Karla Wright on behalf of accounting firm H.A. Gorden & Co. P.C.; James D. Fiala Paving Co.; and Orvin Wilkin, a commodities trader.

The lawsuits filed by both Ms. Wright and Mr. DiTommaso, which the attorneys are asking the courts to certify as class actions, allege that Illinois Bell violated the Public Utilities Act and/or common law statutes by committing negligent and willful actions, including the failure to provide adequate fire detection and suppression systems.

The lawsuits point out that critics have said that the fire alarm at the unmanned Hinsdale switching station sounded at a supervised Illinois Bell office in downstate Springfield, rather than at the local fire station. That delayed notification of firefighters for 30 minutes to one hour, depending upon how alarm signals are interpreted, the critics charge.

In addition, the sensitive equipment was not protected by an automatic Halon suppression system, critics complain.

Illinois Bell's procedures, which are now under review, involved alerting Bell personnel in the Hinsdale area who were to contact the local fire station and enter the building at the same time firefighters did, according to James Eibel, vp of operations.

Both Ms. Wright's and Mr. DiTommaso's lawsuits seek unspecified compensatory damages above $15,000, while Ms. Wright's lawsuit also seeks unspecified punitive damages.

Illinois Bell contends it has immunity for such damages as a result of a provision in a tariff it has filed with the Illinois Commerce Commission.

"The liability of the company for damages arising out of mistakes, omissions, interruptions, delays, errors or defects in transmission occurring in the course of furnishing service or other facilities, and not caused by the negligence of the customer, shall in no event exceed an amount equivalent to the proportionate charge to the customer for the period of service during which such mistake, omission, interruption, delay, error or defect in transmission occurs. No other liability shall in any case attach to the company," the tariff says.

Utilities like Illinois Bell are typically granted near-total immunity because they are required to provide telephone service to all customers, an Illinois Bell spokeswoman said.

The ICC allows that tariff provision in an effort to keep telephone service reasonably priced, an ICC spokesman said.

Illinois Bell says it has no insurance coverage for customer's claims of lost business, even though American Information Technologies Corp., its parent company, purchases excess liability insurance in the London market.

Insurance industry observers point out that telephone companies can purchase coverage for loss-of-service claims, but they were unsure whether it would be automatically included in a typical general liability policy or would have to be added through a policy endorsement.

Illinois Bell responded to the needs of customers without telephone service by providing trailers with free or coin-operated telephones. In addition, the company also is giving customers double credit toward line charge fees for the days they were without service.

And, as "a gesture of good will," Illinois Bell is discussing how it can help compensate local communities for extra expenses they incurred from the fire, the spokeswoman said. The expenses included extra police patrols and 24-hour staffing of radio-equipped village vehicles, which were scattered around the communities so residents would only have to run a few blocks to summon emergency services.

Illinois Bell plans to absorb any uninsured fire-related costs rather than seek to raise rates to generate those funds, the spokeswoman said.

Illinois Bell's damaged property is insured under polices written for Ameritech. The coverage was written by Arkwright Mutual Insurance Co. of Waltham, Mass., a member of the Factory Mutual System. However, spokesmen for the companies would not provide details of the coverage or estimate damage.

While Illinois Bell has coverage for its property losses, few —if any—of its customers are covered for loss of business because of the phone outage.

Contingent business interruption coverage to protect against telephone service outages is available by using a standard Insurance Services Office endorsement (CP 0417) titled "off premises power direct damage," according to Robert Lindemann, a commercial property underwriting officer with the Long Grove, Ill.-based Kemper Group.

But in order for the endorsement to apply to this loss, it would have to specifically describe lack of phone service and list Illinois Bell's Hinsdale switching station, he said. Protection from damage to overhead lines would require a separate endorsement, he said.

Companies seldom use this type of endorsement because insurance buyers perceive that utility service outages are relatively rare and of short duration, Mr. Lindemann said.

A spokesman for Aetna Casualty & Surety Co. in Hartford, Conn., said the company knew of no contingent business interruption policy that cited telephone service.

"The Hinsdale situation may make the insurance buying public a little more sensitive to this coverage," Mr. Lindemann said.

"Risk managers have to address this, and companies have to think of these concerns," said Richard Denning, president of consultant Risk Sciences Group in Atlanta.

"But any effective crisis management program should be broad in scope" and "should be pre-incident oriented rather than after the fact," said Richard H. Soper, executive vp/chief operating officer of Crisis Management Corp. in Redondo Beach, Calif.

Meanwhile, another telephone company has had mixed experience with claims stemming from two service outages caused by fires.

No lawsuits were filed against New York Telephone Co. following a 1987 fire that disrupted 41,000 lines, 90% of which were residential, for 1½ to three weeks, according to an NYT spokeswoman.

However, "several" lawsuits are still pending from a 1975 fire in which 170,000 lines, serving relatively more NYT business customers, were disrupted for up to three weeks. Many of those lawsuits, though, allege that toxic substance were released by the fire, the spokeswoman said. ■

Aerojet decision

Continued from page 3

behalf of the insured all sums which the insured shall become legally obligated to pay as damages,' or otherwise limit the insurers' obligations to legal claims for 'damages' asserted against the insured, have no obligation with respect to claims for equitable relief against the insured.

"The complaints filed by the state of California and the United States against Aerojet. . .assert only claims for equitable relief," he said.

In its request for reconsideration, Aerojet said: "This court's ruling. . .is not a narrow one confined in its effect to one small case. The issue exists throughout the United States; it is now being litigated in various courts by innumerable insureds and insurers. The legal principle in question is of enormous importance, and the interpretation of the court, if followed, will. . .impact, not only on Aerojet, but. . .numerous policyholders throughout the nation."

Aerojet also said, "the decision can be expected to attract national attention and it is likely to be cited as a major precedent by the insurance industry."

"All over the United States insurers are trying to escape their liability by saying these costs are not legal damages," said Aerojet attorney Mr. Lasky. Policyholders maintain, however, that cleanup costs are insurable and do not represent "equitable monetary relief."

Richard L. Seabolt, an attorney with Hancock, Rothert & Bunshoft in San Francisco, who represents London insurers collectively known as Cheshire & Cos., also said the case is likely to be cited by insurers.

In addition, he pointed out that any appellate court rulings in the Aerojet litigation would affect the Shell litigation.

Mr. Lasky speculated that appeals could reach the California Supreme Court.

He criticized Judge Bible's ruling because it conflicts with preliminary statements made by San Mateo County Superior Court Judge William Lanam in the Shell litigation; because it fails to interpret ambiguity in the insurance policy against the insurers; because it fails to consider the drafting history of the CGL policy; and because it conflicts with many other court rulings.

"A policy must be interpreted if 'semantically possible' to conform to the reasonable expectation of the insured," said Aerojet. The company asserts that Judge Bible's definition of damages is a highly technical one, and not one that would be assumed by most policyholders.

However, attorneys for insurers in the case applaud Judge Bible's ruling, stating the CGL policies were never intended to cover a policyholder's costs of doing business.

"A liability insurance policy is not the equivalent of a bank account for the payment of safety-related and environmental-related ordinary business expenses," say insurers in their brief.

Furthermore, insurers contend that in enacting Superfund, Congress "intended to force industrial companies to internalize the costs of hazardous waste disposal."

Although Judge Bible is hearing the Aerojet case in the same high school theater/courtroom that Judge Lanam uses in the Shell litigation, the two judges took divergent courses.

Judge Bible said, "I have looked at what Judge Lanam said. . .and while I respect his opinion. . .I think we have to also look at each case as it comes before us."

Judge Lanam has indicated in preliminary rulings that government-mandated cleanup costs would be covered by CGL policies (*BI*, May 30).

Specifically, Judge Lanam said: "The mere fact that otherwise covered 'damages,' or damage to property is the subject of a suit or action brought under the provisions of (the Superfund act) does not relieve the insurers of their liability in accordance with their CGL policy."

Judge Lanam noted that this statement was "not in complete or concrete form (but rather) a tentative response to some of the issues that have been raised in connection with CERCLA."

While a ruling from a judge in the same court is not binding, Aerojet says, "a decision of a judge of a superior court is normally followed by other judges of the same court."

Aerojet also criticized Judge Bible's decision because he failed to apply the prominent legal principle of construing ambiguity in insurance policies against the insurers.

"The (policy) language was the creation of the insurance industry itself, became boilerplate, and therefore must be interpreted against the insurers" if there is ambiguity in its meaning, said Aerojet.

Mr. Seabolt, who represents the London market, said there is no ambiguity in the term "damages" and therefore no need for the judge to construe the policy against the insurers.

Aerojet also said Judge Bible's decision is flawed because he failed to consider the drafting history of the CGL policy. Aerojet maintains that the drafters of the policy, the Insurance Services Office Inc., intended for government-mandated cleanups to be covered.

However, Mr. Seabolt, who pointed out that the London market is not a member of ISO, said legally if a judge can interpret policy language by examining the contract, he does not have to look at any other extrinsic evidence.

Furthermore, Mr. Seabolt noted that Aerojet's broker, Marsh & McLennan Inc., had ample opportunity to make any adjustments to the wording of the policy.

Finally, Aerojet says Judge Bible's decision fails to follow numerous other courts that have held that cleanup costs are insurable under the standard CGL contract.

"In the overwhelming majority of the cases, on a ratio of 6 or 7 to 1, the contention (of the insurers that CGL policies do not cover government-mandated cleanup costs) has been rejected by the courts as thoroughly unsound," said Aerojet.

However, the insurers point to two federal circuit courts that have ruled cleanup costs incurred under Superfund are not insurable.

Most recently, the entire 8th U.S. Circuit Court of Appeals said: "The term 'damages' used in the CGL policy refers to legal damages and does not cover cleanup costs." The state of Missouri is asking the U.S. Supreme Court to review that decision (*BI*, June 6; March 17).

In addition, the 4th U.S. Circuit Court of Appeals in July 1987 ruled that CGL policies do not cover the cost of government-mandated hazardous waste cleanups (*BI*, July 27, 1987).

As insurers in the Aerojet case said: "Only small children—not a company composed of the nation's leading chemists and rocket scientists—are entitled to assume that someone else will clean up their mess." ■

B.R.I. litigation

Continued from page 2

The Potamkin plaintiffs include auto dealerships based in New York, New Jersey, Florida, Pennsylvania and Georgia.

Charging B.R.I. with violations of the Racketeer Influenced and Corrupt Organizations Act and broker malpractice, the complaint seeks at least $6 million in compensatory and $10 million in punitive damages.

The defendants could be liable for treble damages if RICO violations are proved.

According to the complaint, Mr. Ross solicited Potamkin's insurance business on B.R.I.'s behalf in 1980, after which the defendants "started to systematically loot and plunder Potamkin, simultaneously creating a 'paper jungle' that Potamkin is still trying to untangle."

The brokerage fraudulently induced Potamkin in 1981 to pay service fees for its insurance placements, representing that the fees would be in lieu of commissions and that this arrangement would result in savings for the dealerships, the lawsuit alleges.

B.R.I.—which refused to put the service fee agreement in writing—then sent Potamkin "inflated" invoices, which Potamkin paid with the understanding that B.R.I. would apply the overpayments to its fees and remit net premiums to insurers, Potamkin charges.

Without Potamkin's knowledge, the suit charges, B.R.I. was also collecting commissions from insurers in addition to the fees Potamkin paid. B.R.I. collected at least $714,670 in such undisclosed commissions from The Home Insurance Co., Chubb Corp. and Zurich-American Insurance Co. between 1981 and 1986, Potamkin claims.

"In essence, Potamkin was paying twice over for B.R.I.'s services," the lawsuit charges.

In 1984, B.R.I also induced Potamkin to enter a three-year retro program underwritten by The Home providing workers compensation, garage liability, comprehensive general liability, business auto coverage and other miscellaneous coverages.

Under the program, Potamkin was able to offer business auto coverage to its leasing customers, who in turn would pay Potamkin a pro-rata share of the program's expenses, the suit says.

Through the first two years of the program, B.R.I. told Potamkin that its loss ratio on the policy was "fabulous" and that retro premiums due at the end of the program would be low. Relying on this, Potamkin continued to charge its customers a reduced rate originally established in consultation with B.R.I., the complaint says.

But, Potamkin's loss ratio was "horrendous," and its premium for the third year of the retro program doubled, the complaint says. Because the low rate fixed for Potamkin's leasing customers did not accurately reflect the true cost of the program, the dealership suffered unrecoverable losses of about $6 million related to the leased vehicles, the lawsuit charges.

Throughout the retro program, B.R.I. was secretly collecting commissions from The Home in addition to service fees paid by Potamkin, the suit charges.

Potamkin discovered the allegedly fraudulent commissions in May 1986 and confronted B.R.I., which then offered to return about $572,000 of the commissions it had taken on commissions related to the premium for the first $100,000 in coverage under the retro program to help offset the increased premiums in the program's third year, the suit says.

However, B.R.I. has not returned similar commissions it took for the premium related to coverage excess of $100,000 under the retro program and on other policies placed for Potamkin, the complaint charges.

Potamkin also charges that B.R.I. has sent numerous fraudulent invoices to Potamkin since 1981, including billings for premiums that included commissions B.R.I. was not entitled to collect, inflated premiums designed to disguise illegal service fees, double billings of previously paid premiums and invoices for non-existent or unnecessary coverage.

To support mail and wire fraud charges associated with its RICO allegations, Potamkin cites several allegedly fraudulent mailings from B.R.I., including:

- A March 17, 1983, cover note from Insurance Co. of North America in which the notation "commission 12.5%" was obliterated by B.R.I. "in an effort to conceal from Potamkin the secret commissions which B.R.I. was receiving on that policy."
- A cover note dated June 14, 1985, issued by The Underwriters Inc. of Parsippany, N.J., and forwarded to Potamkin by B.R.I., in which B.R.I. "intentionally placed an opaque advertising sticker over the words 'commission 7.5%.' "

The lawsuit does not say which insurer was being represented by The Underwriters, a managing general agency.

In a separate case, The Underwriters has been accused in a civil RICO suit of defrauding American Centennial Insurance Co. of millions of dollars by skimming commissions on reinsurance placements. These reinsurance placements are also under criminal investigation by federal authorities in New York (*BI*, June 6).

- Two letters to Potamkin from B.R.I. dated Feb. 11, 1987, and March 2, 1987, in which B.R.I. falsely stated that it received no commissions on The Home retro program.
- A Dec. 5, 1985, letter regarding a Potamkin claim for damage to a building sign, in which B.R.I. said it expected payment of the claim and urged Potamkin to pay other disputed premiums.

However, B.R.I. knew that the insurer, Atlantic International Insurance Co., was denying the claim on the grounds that a policy addendum providing the applicable coverage was never signed, despite the payment of premium.

B.R.I. itself later paid the $67,000 claim, but intended the letter to fraudulently induce Potamkin to pay additional disputed premiums, the lawsuit charges.

In March 1987, Potamkin advised B.R.I. that it would complain to the New York Insurance Department if the brokerage did not provide documents showing how much it had been paid in commissions, the suit says.

B.R.I. then threatened to go to the New York attorney general with allegations about Potamkin, according to the complaint.

B.R.I. later falsely accused Potamkin of illegally understating the number of cars covered under the Home retro program in an effort to extort money from the auto dealer, the suit says.

Potamkin did file a complaint against B.R.I. with the Insurance Department Feb. 23, according to a department spokesman, who said the complaint is being investigated.

Meanwhile, B.R.I. has denied Potamkin's allegations and has leveled several counterclaims against its former client, including that Potamkin:

- Has refused to pay $900,000 in premiums due or advanced by B.R.I. to INA, which wrote most of Potamkin's fire, theft, physical damage, umbrella and workers compensation insurance between March 1, 1981, and March 1, 1984.
- Has failed to pay a $300,000 service fee on the INA program.
- Underreported the number of leased vehicles covered by The Home retro program.
- Agreed to compensate B.R.I. on a fee basis for the Home program. B.R.I. has paid all net premiums owed to The Home but has received neither commissions nor the full amount of fees owed by Potamkin, including fees for such "extraordinary services" as cash-flow management and engineering services.

Potamkin owes a total of $1 million in fees to B.R.I. for services connected with The Home program, the complaint says.

- Owes $67,382 advanced by B.R.I. on Potamkin's claim for the damaged sign, for which Potamkin agreed to reimburse the broker. ■

VDT safety bill drawing criticism

By COLLIN NASH

RIVERHEAD, N.Y.—Medical evidence does not support the need for what could be the nation's first law requiring employers to protect workers who regularly use video display terminals, opponents of the Suffolk County, N.Y., proposal contend.

The proposal, which County Executive Patrick G. Halpin was expected to sign late last week, would require employers in the Long Island county with 20 or more VDTs to implement several safeguards designed to prevent injury to anyone who operates a terminal for 26 or more hours per week (*BI*, May 30).

The VDT law would affect thousands of businesses and 15,000-20,000 VDT operators, a county spokesman said.

"The medical evidence is not conclusive enough to impose such a costly burden on Suffolk County," said Mitchell H. Pally, director of legislative and economic affairs for the Long Island Assn., the regional chamber of commerce for Suffolk and Nassau Counties.

But Terence G. Pearsall, legal aide to John J. Foley, D-Patchogue, who sponsored the VDT bill, cited a recent study that suggested there is a risk of miscarriage among pregnant VDT users.

The study, titled "The Risk of Miscarriage and Birth Defects Among Women Who use Visual Display Terminals During Pregnancy," was conducted by Kaiser Permanente of Oakland, Calif., the country's largest health maintenance organization.

The study says: "VDT use may be associated with miscarriage risk among, at least, administrative support and clerical workers."

While the study concedes that its finding "contrasts with conclusions from previous studies that VDTs are probably safe to use during pregnancy," it asserts that "consistent evidence across studies provides some basis to suspect" that the possibility of such risks "could be real."

"Even if VDTs are deemed electronically safe, ergonomic factors and stress associated with their use might contribute to reproductive risk," the study says.

The regional chamber's Mr. Pally also claims that many businesses will move out of Suffolk County and others will drop their plans to move there because of the cost to employers to comply with the proposal.

But, any additional costs to employers as a result of the VDT law would be offset by increased productivity and better attendance, Mr. Pearsall said.

Opponents of the legislation also argue that it was drafted because of competition among the county's legislators to sponsor another regulation that is the first of its kind in the country or the state.

Suffolk County is known for pioneering efforts in consumer and environmental regulations. For example, it was the first U.S. public entity to require bottle deposits and ban non-biodegradable detergents and plastic food wrapping, and the first in New York state to ban smoking in public areas.

However, supporters of the VDT bill say the recent profusion of legislation is intended to protect the county's delicate ecology.

Among other provisions, the VDT bill would:

- Require employers to pay 80% of the costs for initial and annual eye examinations and the same amount for any lenses and basic frames required as a result of working on the terminals.
- Set ergonomic standards for VDT work station equipment leased, rented or purchased after Jan. 1, 1990. For example, seats and backrests would have to be adjustable.
- Require employers to establish an education and training program for all VDT operators, including providing oral and written information about the potential health hazards of VDTs. At a minimum, the training would have to include a description of the maladies that may be caused by VDT use and an explanation of the protective measures employees can take to reduce or alleviate them.

Employers also would have to provide VDT operators with information concerning proper and safe procedures for using terminals and equipment and explain to employees their rights under the law.

- Require a minimum 15-minute break after every three hours of continuous VDT work. However, the breaks would not entitle employees to refuse to perform other, non-VDT-related tasks assigned by employers. ■

Audi proposes settlement; Suzuki faces class action

By MARK A. HOFMANN

CHICAGO—As one automaker moved closer to settling year-old class-action litigation, another was hit with a massive lawsuit last week.

Troy, Mich.-based Audi of America Inc., is offering rebates of up to $2,000 each to nearly 400,000 owners of Audi 5000s equipped with automatic transmissions to settle a class-action lawsuit charging that the cars accelerate without warning.

However, the owners only can apply the rebate to the purchase of a new Audi within the next three years. The suit involves model years 1978-86.

An Audi spokesman said the company's parent, Volkswagen of America Inc., is self-insured and that the costs of any settlement "will have no effect on the insurance industry."

Meanwhile, a class-action suit against Brea, Calif.-based American Suzuki Motor Corp. and its Japanese parent, Suzuki Motor Co. Ltd., was filed June 3 in Cook County Circuit Court in Chicago, alleging that the automaker's Samurai sport utility vehicles are inherently unsafe.

The suit contends that about 150,000 Suzuki Samurai owners should receive a total refund from the vehicle's manufacturer.

Aron Robinson, of the Chicago law firm Holstein, Mack & DuPree, which represents plaintiffs in both the Audi and the Suzuki suits, emphasized the Audi proposal was worked out by both Audi and plaintiffs' attorneys.

"We think the settlement's fair. We recommend that it be accepted," he said.

Audi's spokesman stressed, however, that the automaker is not admitting any liability for the alleged defect. The spokesman said the settlement offer was based in part on National Highway Traffic Safety Administration data on owner complaints. Although the class action-suit may involve as many as 391,000 Audi 5000 owners, NHTSA has only 1,302 complaints regarding the car, the spokesman said.

No one has determined how many accidents may be related to the alleged sudden acceleration problem, he said.

And, no one has been able to prove that a defect caused the sudden acceleration in the Audis, said Robert Holstein, another attorney with Holstein, Mack & Dupree.

The Audi spokesman also said that the proposed settlement contains an "opt out" provision. Members of the class can refuse the settlement and pursue their cases in court, he said.

"If 15% or more opt out, then we have the option of backing out of the proposed settlement," the spokesman explained.

Audi has no idea how much the settlement will cost.

A Cook County Circuit Court judge is scheduled to hold a hearing July 21 on the proposed Audi settlement.

The Suzuki suit contends that roughly 150,000 people who bought Suzuki Samurais in 1986, 1987 and 1988 should receive a total refund from both the U.S. unit of Suzuki and its parent.

The suit also asks that both companies pay unspecified punitive damages to the plaintiffs.

The suit alleges that the Samurais "are defective in design or production in that they suddenly and unintendedly roll over when the driver swerves the vehicle at 40 mph or more."

Earlier this month, Consumers Union of U.S. Inc., publisher of Consumer Reports magazine, called on Suzuki to buy back all Samurais, contending that the four-wheel drive utility vehicle is prone to roll over when rounding sharp curves (*BI*, June 6).

Suzuki held a satellite news conference a week later to denounce the Consumer Reports tests as inaccurate.

Spokesmen for Suzuki declined to comment on the suit or on insurance coverage that might apply.

Mr. Holstein said he could not estimate the cost of a recall. However, he said the affected vehicles cost between $7,000 and $13,000. As many as 15,000 Samurais are sold every month nationwide, he said.

Mr. Robinson said that arriving at a total cost figure is impossible because a court could rule that the cars are used cars and that the plaintiffs are not entitled to a full refund.

A Suzuki spokesman said that the automaker believes that statistics compiled by the NHTSA demonstrate that the Samurai is a safe vehicle.

The spokesman noted that NHTSA data show 28 accident-related deaths involving Samurais since the vehicle was introduced to the American market in 1985. All of these accidents were attributed to driver error, the spokesman said. ■

Marine Office of America offers new package policy

Marine Office of America, a Continental Corp. unit, has introduced a new property package policy.

MOAC's Property Account Coverage package includes first-party coverage for real and personal property, boiler and machinery, and commercial inland and ocean marine risks.

The policy can be written for companies in the communications, construction, manufacturing, distributing, import/export and service industries. The policy includes coverage for, among other things, theft, debris removal and return shipments. In addition, the policy covers first-party pollution cleanup with a $10,000 maximum limit.

Flood and earthquake coverage is available on an optional basis.

For information contact Richard Maiocco, Vp, Marine Office of America, 180 Maiden Lane, New York, N.Y. 10038; 212-440-3068.

Health promotion

Equicor Inc. is offering a new health promotion package to both clients and non-policyholders.

"Businesses are discovering that helping their employees cultivate healthy habits is a positive way of controlling the costs of providing health care coverage," points out Don Hall, Equicor's health promotions director.

The Equicor HealthChoice program includes:

- The Smoke Stoppers smoking cessation program and the Leaner Weight weight-loss program, both designed by the National Center for Health Promotion.

Products & services

- A monthly newsletter addressing a variety of health-related topics.
- Equicor's "Health Promotion and Medical Guide," a compilation of health care information from the American Medical Assn.
- Exercise programs, like a self-help booklet on walking.
- Health risk appraisal questionnaires.

The program also offers as an option computerized health risk appraisals, which help spot lifestyle-related problems among employees and provide motivation for change. Employers can also order health and fitness brochures on various topics.

The HealthChoice plan is implemented in three stages:

- An awareness phase, which helps employees recognize how lifestyle affects health.
- An assessment phase, during which employees determine their current health status and learn how to improve it.
- The action phase, during which employees participate in the smoking cessation, weight loss and exercise programs.

Equicor is a joint venture of the Equitable Life Assurance Society of the United States, New York, and Nashville, Tenn.-based Hospital Corp. of America.

For more information on the program, contact Laura Sumrall, Equicor Inc., 1801 West End Ave., P.O. Box 1115, Nashville, Tenn. 37202; 615-340-3732.

PRIMA videos

The Public Risk & Insurance Management Assn. is producing risk management videos for education and training through its newly formed PRIMAVISION videotape division.

Two videos, "Assembling a Safety and Loss Control Program" and "Claims Management: Inside vs. Outside," currently are available.

Howard Taylor, a loss control expert and risk manager for the South Florida Water Management District, explains an "effective workable safety and loss control program" to viewers during the one-hour safety and loss control tape.

The 75-minute claims management tape focuses on the advantages and disadvantages of both in-house claims management and claims management through third-party administrators.

The RIMS tape is co-produced by Mary L. DeCampli, risk manager at Metropolitan Washington Airport Authority, Washington, D.C., and Jimmy Glisson, risk manager for the city of Tallahassee, Fla.

Each of the VHS-format tapes costs $45 and includes outlines or other written material about the featured program.

To order, contact Ron Dixon at PRIMA, 1120 G St. N.W., Suite 400, Washington, D.C. 20005; 202-626-4650. ■

Update

N.Y. to drop public entity MAP

Continued from page 2

were able to buy in the voluntary market."

The spokesman pointed out that New York's flex rating system should help solve municipal liability insurance affordability problems. The system, instituted in 1986, prohibits insurers from adjusting rates more than 15% for municipal risks without prior approval from the commissioner. All rate changes must be filed with the department (*BI*, Sept. 22, 1986).

Times Beach group loses case

ST. LOUIS—Northeastern Pharmaceutical & Chemical Co. has no liability to 184 residents of Times Beach, Mo., who alleged they contracted cancer from NEPACCO-produced dioxin that was sprayed in the area, a St. Louis Circuit Court jury ruled last week.

The suit was one of several bodily injury cases pending against the now-defunct NEPACCO.

In addition, the federal government is suing NEPACCO under the Comprehensive Environmental Response, Compensation & Liability Act, better known as Superfund. The entire 8th U.S. Circuit Court of Appeals has ruled that NEPACCO's insurance does not cover government-mandated cleanup costs. NEPACCO is asking the U.S. Supreme Court to review the decision (*BI*, March 7; June 6).

In a related case, Syntex Corp. of Palo Alto, Calif., has reached a $14.5 million settlement with 1,223 residents of Times Beach over their dioxin-related bodily injury claims. The company says it is fully insured for the settlement but will not identify its insurers.

Unpaid leave bill revised

WASHINGTON—Sen. Christopher Dodd, D-Conn., last week introduced revised legislation that would guarantee working parents unpaid leave to take care of a newborn, newly adopted or seriously ill child and would require employers to continue to provide the employee with health care coverage.

A General Accounting Office study released by Sen. Dodd estimates the legislation would cost employers $194 million annually.

The legislation, S. 2488, would guarantee workers up to 10 weeks of unpaid parental leave and up to 13 weeks of unpaid leave for a personal illness. An earlier version of the legislation set longer maximum unpaid leave times.

Workers who take a leave would be guaranteed the same or equivalent position when they return. The unpaid leave benefit would be available to workers employed for at least one year.

Employers with fewer than 20 employees would be exempt from the bill's requirements.

Record pollution penalty levied

WASHINGTON—Texas Eastern Transmission Corp. will pay the government about $400 million in cleanup costs to remove PCBs from dozens of sites in 14 states and a record $15 million civil penalty for violating federal environmental laws, the Justice Department announced last week.

The $15 million penalty is twice as large as any ever before obtained in a federal environmental case, the government said.

The Houston-based company, a subsidiary of Texas Eastern Corp., had agreed to a settlement with the government last November to clean up polychlorinated biphenyls and associated pipeline fluids at as many as 89 gas pipeline compressor stations along the company's 10,000-mile pipeline (*BI*, Nov. 16, 1987).

The company has said it will seek to recover its costs from its insurers and through its natural gas rate receipts.

Oklahoma OKs work comp rate

OKLAHOMA CITY—A workers compensation rate increase in Oklahoma actually will save employers millions of dollars annually, says a state business group.

The Oklahoma State Board of Property & Casualty Rates last month granted an average 23.8% rate increase to insurers writing workers comp coverage in the state.

However, insurers already had increased rates 25.9% on a consent-to-rate basis, so they now must lower their rates. Workers comp insurers were granted a 25.9% increase in November 1985 that was overturned by the state's Supreme Court in July 1986, explained Kathie Stepp, a rate analyst with the rate board (*BI*, Aug. 4, 1986). "However, many companies felt they needed that rate so they used it on a consent-to-rate basis" with the approval of policyholders, she said.

The new rate, which becomes effective July 1, will save employers in the state between $5 million and $7 million annually, estimates the Oklahoma State Chamber of Commerce & Industry.

The recently approved rate hike was less than the 33.9% increase sought by the National Council on Compensation Insurance.

Briefly noted

Monsanto Corp. of St. Louis has agreed to pay $1.2 million to settle litigation with current and former workers at its Nitro, W. Va., plant who alleged they contracted a rare form of bladder cancer from chemicals used in rubber-making. The company would not disclose any details of its insurance coverage. . . .Vermont Gov. Madeleine Kunin has signed a law allowing **Vermont-domiciled captives** to directly write excess workers compensation coverage. Previously, captives could only reinsure workers compensation risks. . . .A status conference on the **antitrust suits** brought by eight attorneys general against property/casualty insurers, reinsurers, brokers and trade organizations has been moved up to June 23 from June 24 (*BI*, April 18). The conference, which is open to the public, begins at 9:30 a.m. before U.S. District Judge William Schwarzer in San Francisco.

Product liability reform

Continued from page 1
is expected to approve this week would establish a uniform standard of liability for manufacturers and several defenses that manufacturers and product sellers could use in product liability litigation.

However, the product liability reform bill would not modify or eliminate joint and several liability, and it would not establish a cap on non-economic damages (*BI*, June 6).

After the committee approves the bill, the legislation still has to go through several steps before reaching the House floor.

First, the Energy and Commerce Committee must draft a report on the reform bill, which could take up to a week or two.

Then, House Speaker Jim Wright, D-Texas, in conjunction with the House Rules Committee, must decide whether the bill should be referred for consideration to other House committees because these panels also have jurisdiction over portions of the bill.

Rep. Wright and the Rules Committee also must decide how long those referrals should be.

Observers agreed that the House Judiciary Committee will ask for a referral of the bill, though committee staffers could not be reached to confirm this.

However, a staff member from the House Education and Labor Committee confirmed that the committee plans to ask for a referral of the bill but has not yet decided how long a referral to request.

Such referrals can range from as little as 30 legislative days to as many as 90 legislative days.

Observers also point out that this year's legislative session is shorter than usual because of the Democratic and Republican national conventions this summer and the national election campaign this fall.

If the bill does not get to the House floor for a vote this year, sponsors of the proposal would have to begin all over again in the next session of Congress in January. That means that a bill would have to be introduced and go through hearings, markup and approval at the subcommittee and committee levels before the full House could receive it.

However, Ms. Mahshigian of the Product Liability Alliance said that because members spent so much time working on the bill this congressional session, the legislative process probably would not take as long in the next session.

The original version of the product liability legislation, H.R. 1115, sponsored by Rep. Bill Richardson, D-N.M., was introduced to the House more than 15 months ago (*BI*, March 2, 1987).

During last week's markup sessions, the House Energy and Commerce Committee, among other actions:

- Rejected by a tie vote of 21-21 a controversial amendment offered by Rep. Gerry Sikorski, D-Minn., that would have exempted from the bill manufacturers of any drug or medical device that could cause fetal malformation or death or that could be harmful to the human reproductive system.
- Approved a similar but more limited amendment offered by Rep. Tauke that would exempt manufacturers of any drug or medical device that is used as a contraceptive or abortifacient and "which has as one of its known effects the interference with implantation of a fertilized human ovum or embryo or the termination of a pregnancy after implantation with intent other than to produce a live birth."

The two amendments generated heated discussion among committee members, with many declaring themselves "pro-lifers" and supporting one or both amendments for reasons not related to product liability issues.

- Approved an amendment offered by Rep. Rick Boucher, D-Va., clarifying a provision addressing workers compensation offsets.

As originally drafted, the bill would have allowed an injured worker's product liability award to be offset by workers compensation benefits and at the same time allowed the employer to bring an action to recover from the plaintiff's damage award the amount of the workers compensation benefits paid.

This amendment provides for the reduction of the product liability award by only the amount of workers compensation benefits paid.

- Approved an amendment offered by Rep. Cardiss Collins, D-Ill., and Rep. Jim Slattery, D-Kan., that would prohibit the use in product liability litigation of secrecy agreements or protective orders, which prevent information presented in a lawsuit from being turned over to other parties.
- Rejected an amendment by Rep. Collins that would have required manufacturers to keep records on the initial development of a product for 25 years.

The product liability bill, as currently drafted, would:

- Allow a plaintiff to sue a manufacturer for negligence or for producing a product that was unreasonably dangerous.
- Allow manufacturers to use a state-of-the-art defense in product liability litigation.
- Prohibit punitive damages in cases involving drugs and medical devices that were approved by the federal Food and Drug Administration.
- Establish a 25-year time limit on bringing lawsuits that are connected with capital goods used in the workplace.
- Require manufacturers to provide warnings to consumers about dangers discovered after a product has been sold.
- Require a plaintiff to file a lawsuit against a manufacturer within two years of discovering the harm and its cause.
- Allow damages to be reduced if a plaintiff was under the influence of drugs or alcohol and that was determined to be more than 50% responsible for the harm.
- Allow damage awards to be reduced by the amount attributable to misuse or alteration of a product.
- Allow penalties to be assessed against plaintiffs or defendants for frivolous actions in a product liability lawsuit.
- Direct the U.S. Commerce Department to collect information on product liability-related actions from state insurance departments.

Long-term health care bill

Continued from page 1
the advice of the legislative committees so that we might fully comprehend what is in the legislation and see to it that the legislation has been adequately and properly corrected," Rep. Dingell said.

"The rule is odious. Its stench includes stolen jurisdiction, no debate, waivers of regular rules and the special odor of favoritism," charged Rep. Bill Frenzel, R-Minn.

Amid those admonitions and the threat of a presidential veto, the House rejected a rule allowing limited debate and no amendments to the bill, effectively killing the Pepper bill.

But the defeat by no means assures that the measure, or something similar, won't resurface next year, observers say.

In fact, the defeat has generated an enormous amount of publicity, assuring that it will be high on the congressional calendar.

The defeat even may have been part of Rep. Pepper's strategy, some say.

"Even by losing, long-term health care moves to the top of the congressional agenda next year," commented Cathy Amkraut, director of public policy for the Washington Business Group on Health.

Even congressional opponents of the Pepper bill promised that long-term health care will be a priority issue next year.

"Providing for the long-term care of elderly Americans is one of the most serious problems we face. The committee on Ways and Means intends to address this issue and expects it to be a priority issue on the committee agenda in the next Congress," Rep. Rostenkowski promised.

There also is widespread interest in the Senate in meeting the long-term health care needs of the elderly.

Senate Labor and Human Resources Committee Chairman Edward Kennedy, D-Mass., is crafting a bill to provide nursing and home health care services to the elderly (*BI*, March 28).

And, Sen. George Mitchell, D-Maine, already has introduced long-term health care legislation (*BI*, May 2).

Neither the Kennedy nor the Mitchell proposals are expected to be considered by the Senate during this year's session.

Presumably, after the defeat of the Pepper bill, long-term health care legislation introduced in the next session of Congress will receive scrutiny at the committee level.

Those that did study the Pepper bill did not like what they saw.

Perhaps the biggest flaw in the bill—despite its $30 billion price tag—was its failure to cover nursing home care expenses.

"Nursing home care is where you truly can have catastrophic expenses. That is where you have the $30,000-a-year bills. This bill would not have provided catastrophic health care bill expenses," explained Linda Havlin, a consultant with Hewitt Associates in Lincolnshire, Ill.

The bill would have provided coverage for long-term home health care expenses.

Elderly people unable to perform at least two of six functions of daily living—such as bathing, dressing or eating—would have been eligible for a range of home health care services. Those services include:

- Nursing care by or under the supervision of a registered nurse.
- Medical social services under physician supervision.
- Physical, occupational, speech or respiratory therapy to restore or preserve an individual's functional skills.
- Certain medical supplies and durable equipment.

But some congressmen questioned whether a sufficient number of professionals exist to provide the range of services promised by the Pepper bill.

'In most places, the home health services promised under the bill are not available, and nowhere is there the administrative mechanism to determine who is eligible for what services,' says Rep. Daniel Rostenkowski, D-Ill.

"In most places, the home health services promised under the bill are not available, and nowhere is there the administrative mechanism to determine who is eligible for what services," Rep. Rostenkowski said.

"In other words, the bill makes a lot of promises and raises a lot of taxes to provide non-existent home health services through a non-existent administrative structure," he concluded.

The program would pay all costs, with no copayments or deductibles, up to about $45 a day.

While the bill was designed to be self-supporting through higher FICA taxes, congressmen said the $30 billion cost estimate was way too low.

For example, Rep. Hal Daub, R-Neb., put the five-year cost estimate at $72.3 billion, while other experts said it would be difficult to estimate costs because it would be impossible to measure demand. If costs outstripped revenues, the beneficiaries would have been slapped with copayments to make up the difference.

Those copayments could have become so substantial that the benefits provided under the bill would be insignificant, some said.

The bill also was objectionable because it failed to distinguish between those who could afford to pay for coverage and those who could not, said Kathleen Glynn, a health care consultant with The Wyatt Co. in Washington.

A better, non-bureaucratic approach would be to give individuals tax incentives to purchase long-term health care coverage and establish a more limited government program for those who truly cannot afford to buy coverage, Ms. Glynn said. ■

Brokerages are jockeying for a competitive edge

By LEONARD M. WILSON
Special to Business Insurance

While expectations for 1988 in terms of premium rates are guarded and costs will be watched carefully, brokers are taking a longer view. We think this is quite constructive even though it may be impossible to isolate any concrete impact on earnings from strategies and rearrangements adopted in 1987.

SOFT MARKETS HAVE a way of diverting attention from the day-to-day initiatives pursued by insurance brokers for the companies' long-term benefit.

The publicly held brokers' annual reports, which began to file past our desk several months ago, provide an antidote to the preoccupation with premium rates. Insurance brokerage managements are thinking about future competitive position. This is clear in reading the annuals.

Mr. Wilson

For instance, Marsh & McLennan Cos. Inc.'s insurance brokerage subsidiary was organized into three entities during 1987. M&M Inc. now provides brokerage services to the Western Hemisphere and Japan. M&M Bowring, based in London, has responsibility for international insurance brokerage. M&M Worldwide Services furnishes specialized facilities for clients in particular industries and for global insurance marketing. This restructuring addresses the ongoing issue of managing a global insurance broker effectively.

M&M subsidiary William M. Mercer-Meidinger-Hansen Inc., now the leading worldwide benefit consultant with 1987 revenues of $482 million, solidified its position through the acquisition of A.S. Hansen Inc. early in the year. Expertise seems to be the name of the game in benefit consulting, and skilled professionals are in short supply. Acquisition is one approach to securing the necessary capabilities.

M&M also acquired management consultant Temple, Barker & Sloane Inc. Further diversification in consulting is consistent with past strategies.

M&M will remain primarily an insurance broker, we believe, but other professional services for corporations seem to be a sensible direction for profitable growth.

Alexander & Alexander Services Inc. formulated strategic objectives in 1987. Corporate resources will be directed toward retail insurance brokerage, international brokerage, wholesale and reinsurance brokerage, risk management and benefit consulting. Underwriting is conspicuously and reassuringly absent from this roster.

In addition, The Alexander Consulting Group was formed by A&A with a distinct identity to foster growth in benefit consulting.

A&A also faces the challenges of managing a global enterprise. The company's new operations board will assume high-level responsibility for broad-scale planning and coordination. Tinsley H. Irvin, A&A's chairman, will lead this unit.

The firm has continued to expand internationally through acquisitions. A position in Belgium was attained through acquisition of an existing broker. In the Netherlands, the company increased its ownership share in an affiliate, while in Spain a merger strengthened operations.

Corroon & Black Corp. kicked off a new training program designed to develop professional staff from within. As the national insurance brokers have grown, they have faced increasing difficulties in securing needed skills. Training is one answer to the problem.

With a view toward greater productivity in new business and client service, Corroon & Black targeted several industries for special attention in 1987. This focused program was directed toward construction, health care and employee benefits. In addition, a national employee benefit unit was organized.

These strategies apparently paid off in a strong new business. Last year's new business in brokerage services amounted to 20% of revenues. This momentum is especially relevant in a soft market.

Management succession, not always handled smoothly by insurance brokers in the past, was effectively achieved with the planned retirement of Robert F. Corroon as chairman and chief executive officer and Richard M. Miller's ascent to that position. Other seasoned managers assumed new responsibilities as well. These shifts should enable the company to handle future growth.

Frank B. Hall & Co. Inc. implemented a number of steps to restore profitability. Expenses were pared with the elimination of redundancies. Operations with a poor fit were divested and, as a result, Hall's claims adjusting subsidiary was sold.

In line with the industry trend, Hall formed an employee benefit unit, Godwins International Holdings Inc. In addition, domestic reinsurance was placed under the aegis of a new entity, Madison Intermediaries Inc. Better organization and focus should be the result of having specific identities for discrete operating segments.

Arthur J. Gallagher & Co. continues to emphasize what it calls an integrated approach to risk management. Gallagher Bassett Services Inc., the firm's self-insurance services unit, enjoyed significant gains in 1987. Vital statistics include $459 million of losses adjusted, 688 clients and 72 offices. Self-insurance has not wilted in the face of the soft market.

Mergers were also on the front burner at Gallagher. Acquisitions were consummated in California and New York, the latter in the facultative reinsurance area. Gallagher's expansion drive no doubt will continue to be supported by acquisitions.

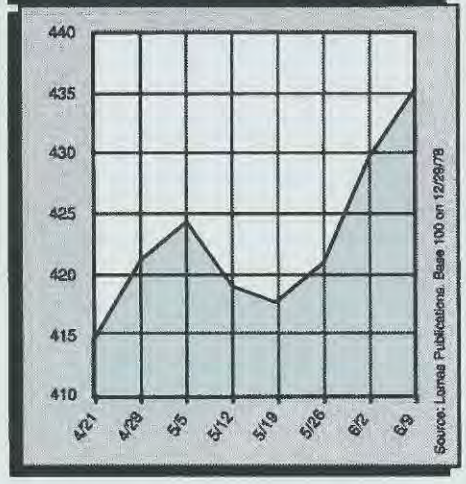
The company has grown significantly outside the United States and can now claim international revenues of $20 million. Global insurance brokerage generates significant opportunities for growth both domestically and outside the United States.

This recapitulation portrays vividly the continuing evolution of the public brokers, whether markets are soft or hard. While expectations for 1988 in terms of premium rates are guarded and costs will be watched carefully, brokers are taking a longer view. We think this is quite constructive even though it may be impossible to isolate any concrete impact on earnings from strategies and rearrangements adopted in 1987.

Future prospects and stock prices will be well-served by this continuum of management initiatives. ■

Leonard M. Wilson is a senior vp with Lazard Asset Management Inc. He is a member of the New York Society of Security Analysts.

BI Insurance Index



Insurance industry stocks continued to climb last week as the *Business Insurance Index* jumped 5.6 points to 435.7 on June 9, from 430.1 on June 2. Advancing issues were led by Phoenix Re Corp., up 15.2%; The Home Group Inc., up 9.4%; Fremont General Corp., up 7.5%; Lawrence Insurance Group, up 6.7%; and Hartford Steam Boiler Inspection & Insurance Co., up 5.8%. Declining issues were led by American Indemnity Financial Corp., down 10.9%; Hilb, Rogal & Hamilton, down 6.4%; Frank B. Hall & Co., down 5.9%; Statesman Group Inc., down 4.8%; and Provident Life & Accident Insurance Co., down 3.7%. Issues showing the most activity during the period were: USF&G Corp., 5.1 million shares traded; Farmers Group Inc., 3.3 million shares traded; and ITT Corp. (Hartford Insurance Group), also 3.3 million shares traded. The *Business Insurance Index* gained 1.3% for the period, lagging behind the leading market indicators: The Dow Jones 30 Industrials gained 2%; the Standard & Poor's 500 gained 1.8%; and the New York Stock Exchange Composite also saw a 1.8% rise.

British Issues

June 9 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Commi Union	390	14.4	21.9	5.6	390—375	
Genl Accident	900	10.4	47.9	5.2	919—885	
Gdn Royal Exch	888	13.2	55.2	6.2	898—875	
Royal	408	10.8	26.4	6.3	419—403	
Sun Alliance	930	15.2	43.1	4.4	936—916	
Brokers						
Bradstock	215	12.1	6.8	3.1	221—215	
CE Heath	424	16.2	34.5	8.1	424—416	
Hogg Robinson	153	12.2	9.6	6.1	153—150	
Lloyd Thompson	160	13.9	6.8	4.2	160—160	
PWS Holdings	186	7.8	14.4	7.5	189—186	
Sedgwick Grp	230	14.3	16.4	7.0	233—230	
Steel Brrl Jones	197	12.2	13.7	6.8	197—197	
Willis Faber	255	13.4	15.4	6.0	259—254	

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

BI Industry Stock Report

JUNE 9, 1988 **6/3/88 THRU 6/9/88**

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander Svcs	NYSE	22.38	1.1	26.1	24.50	17.75	195	1.00	4.5	14.2	3.40	6.58
Baldwin & Lyons Inc.	OTC	15.00	0.0	25.0	15.50	12.00	0	0.20	1.3	5.8	18.31	0.82
Corroon & Black Corp.	NYSE	32.13	3.6	13.7	34.75	28.00	270	1.08	3.4	4.9	5.43	5.92
Gallagher Arthur J. & Co.	NYSE	17.13	1.5	7.1	18.00	13.88	3	0.48	2.8	11.3	5.16	3.32
Hall Frank B. & Co.	NYSE	4.00	-5.9	38.9	5.50	2.88	60	0.00	0.0	11.3	0.00	N/A
Hilb, Rogal & Hamilton	OTC	11.00	-6.4	12.8	12.75	9.75	106	0.00	0.0	11.3	0.00	N/A
Marsh & McLennan Cos. Inc.	NYSE	53.88	1.2	8.8	55.63	45.25	455	2.40	4.5	13.2	6.74	7.99
Poe & Assoc Inc.	OTC	9.00	0.3	28.6	9.25	6.75	0	0.40	4.4	8.7	0.57	15.79
BROKERS	AVERAGE		-0.5	20.1					2.6	9.6		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	25.88	2.5	7.8	29.00	23.50	345	0.36	1.4	6.4	17.63	1.47
Berkshire Hathaway Inc.	OTC	3975.00	-1.2	34.7	4050.00	2755.00	133	0.00	0.0	19.4	69.38	10.76
CIGNA Corp.	NYSE	46.00	-3.7	4.8	51.88	42.75	-1319	2.96	6.4	6.3	49.19	0.94
CNA Fin'l Corp.	NYSE	58.25	-0.2	4.7	64.25	51.00	178	0.00	0.0	8.4	46.40	1.26
General Re Corp.	NYSE	55.00	0.2	-1.6	56.38	45.50	697	1.20	2.2	10.9	26.21	2.10
ITT Corp. (Hartford Group)	NYSE	50.63	5.5	12.5	50.75	43.25	3270	1.25	2.5	6.4	52.23	0.97
Sears, Roebuck & Co. (Allstate)	NYSE	35.38	0.7	5.2	39.88	32.25	2538	2.00	5.7	8.7	34.74	1.02
Transamerica Corp.	NYSE	33.88	0.4	13.9	36.75	29.75	486	1.84	5.4	6.8	24.94	1.36
CONGLOMERATES	AVERAGE		0.5	10.3					3.0	9.1		
INSURERS												
Aetna Life & Cas Co.	NYSE	45.00	1.1	-0.6	49.88	39.50	1106	2.76	6.1	6.4	53.56	0.84
American General Corp.	NYSE	30.13	0.0	-5.1	36.38	27.50	1021	1.40	4.6	8.2	27.99	1.08
Amer Heritage Life Invt	NYSE	25.00	1.0	3.1	26.00	24.00	4	1.08	4.3	11.3	20.98	1.19
Amer Indty Fin'l Corp.	OTC	10.25	-10.9	13.9	11.75	8.25	8	0.56	5.5	15.8	15.26	0.67
American Int'l Group	NYSE	57.50	1.5	-4.2	65.38	49.00	1348	0.40	0.7	9.4	33.56	1.71
Aneco Reins Ltd.	OTC	3.13	0.0	-7.4	4.00	3.13	1	0.00	0.0	4.3	2.51	1.25
Aon Corp.	NYSE	25.13	1.0	9.8	27.00	21.88	206	1.28	5.1	8.8	15.13	1.66
Argonaut Group	OTC	44.75	1.1	50.4	49.00	29.50	229	0.00	0.0	7.3	29.19	1.53
AVEMCO Corp.	NYSE	24.63	2.1	25.5	25.25	17.88	69	0.34	1.4	12.0	7.74	3.18
Belvedere Corp.	AMEX	4.75	-2.7	8.4	6.00	4.38	14	0.04	0.8	6.9	7.87	0.60
Business Mens Assurn Co.	OTC	35.00	-0.7	30.8	36.75	25.50	51	1.20	3.4	63.6	27.39	1.28
Chubb Corp.	NYSE	57.63	0.7	3.1	63.38	51.25	337	2.16	3.7	6.6	46.13	1.25
Continental Corp.	NYSE	37.63	0.0	-2.9	41.63	34.75	533	2.60	6.9	7.2	42.10	0.89
Durham Corp.	OTC	26.25	0.0	22.1	28.00	21.50	12	0.92	3.5	27.1	26.00	1.01
Farmers Group Inc.	OTC	61.50	0.6	52.8	65.75	40.50	3278	1.44	2.3	15.0	22.02	2.79
Fireman's Fund Corp.	NYSE	28.38	0.5	9.2	31.00	25.75	171	0.50	1.8	473.0	26.17	1.08
Fremont Gen Corp.	OTC	10.75	7.5	11.6	13.50	8.75	47	0.60	5.6	473.0	16.75	0.64
Home Group Inc.	NYSE	13.00	9.4	9.4	14.38	11.50	424	0.20	1.5	2.8	17.65	0.74
Hanover Ins Co.	OTC	24.00	4.3	3.2	26.25	20.50	88	0.36	1.5	5.3	25.10	0.96
Harleysville Group Inc.	OTC	15.00	-0.9	14.3	16.38	13.38	15	0.40	2.7	6.7	16.65	0.90
Hartford Steam Boiler	OTC	27.50	5.8	19.6	29.25	22.50	150	1.20	4.4	10.2	10.65	2.58
Kansas City Life	OTC	30.50	0.0	16.2	30.75	25.25	0	0.00	0.0	10.2	0.00	N/A
Kemper Corp.	OTC	24.63	2.6	20.1	25.25	20.75	210	0.72	2.9	7.7	26.50	0.93
Lawrence Ins. Group	AMEX	15.88	6.7	135.3	16.38	6.88	19	0.32	2.0	16.4	4.35	3.65
Liberty Corp. S.C.	NYSE	40.00	0.0	12.7	47.25	34.50	14	0.80	2.0	14.8	17.40	2.30
Lincoln Nat'l Corp.	NYSE	46.63	2.5	16.2	48.75	40.25	192	2.36	5.1	9.0	36.62	1.27
NAC Re Corp.	OTC	24.25	2.1	36.6	24.50	18.50	78	0.00	0.0	14.1	19.92	1.22
Nobel Ins Ltd.	OTC	5.13	-2.3	-41.4	9.50	4.50	29	0.44	8.6	24.4	9.37	0.55
Northwestern Nat'l Life	OTC	27.88	3.3	21.9	29.25	22.63	57	1.12	4.0	7.2	35.05	0.80
Ohio Cas Corp.	OTC	33.75	0.0	-6.9	38.25	32.25	159	1.88	5.6	8.0	27.86	1.21
Old Rep Int'l Corp.	OTC	23.88	4.4	19.4	24.63	19.13	267	0.74	3.1	5.5	27.82	0.86
Orion Cap Corp.	NYSE	16.63	0.8	23.2	17.25	13.13	61	0.76	4.6	5.8	9.34	1.78
Phoenix Re Corp.	OTC	9.50	15.2	46.2	9.50	6.75	203	0.00	0.0	6.8	11.08	0.86
Protective Life Corp.	OTC	13.00	0.9	6.1	15.13	12.25	32	0.70	5.4	12.4	17.25	0.75
Provident Life & Acc Ins Co.	OTC	19.50	-3.7	24.8	21.88	15.63	772	0.84	4.3	150.0	27.45	0.71
St. Paul Cos. Inc.	OTC	43.50	1.8	-5.4	51.00	38.25	507	2.00	4.6	6.2	35.83	1.21
SAFECO Corp.	OTC	25.00	1.0	-9.9	30.00	22.75	989	1.08	4.3	7.9	21.39	1.17
SCOR US Corp.	OTC	9.00	-2.7	-2.7	9.50	7.25	106	0.00	0.0	6.5	9.20	0.98
Seibels Bruce Group Inc.	OTC	13.00	0.0	15.6	14.25	11.00	60	0.80	6.2	8.4	12.51	1.04
Selective Ins Group Inc.	OTC	23.75	0.0	25.0	24.50	19.25	224	1.24	5.2	5.4	19.52	1.22
Statesman Group Inc.	OTC	3.75	-4.8	-20.0	5.56	3.56	36	0.05	1.3	5.4	3.48	1.08
Tokio Marine & Fire Ins	OTC	80.25	5.2	21.8	85.88	63.25	62	0.19	0.2	71.7	0.00	N/A
Torchmark Corp.	NYSE	32.13	4.0	31.1	32.38	24.50	510	1.00	3.1	10.3	12.24	2.63
Travelers Corp.	NYSE	36.75	3.9	4.6	40.00	33.00	899	2.40	6.5	9.4	45.28	0.81
Trenwick Group Inc.	OTC	12.50	4.2	22.0	12.50	9.75	8	0.16	1.3	10.8	15.41	0.81
United Fire & Cas Co.	OTC	26.50	3.9	1.9	27.00	24.00	1	1.08	4.1	5.0	22.56	1.17
United States Fid & Gty	NYSE	32.75	1.6	14.9	34.38	28.88	5132	2.64	8.1	7.3	19.53	1.68
UNUM Corp.	NYSE	23.00	5.7	24.3	22.75	17.88	501	0.48	2.1	11.4	28.53	0.81
USLIFE Corp.	NYSE	37.00	4.2	29.8	39.00	28.00	125	1.28	3.5	9.6	46.77	0.79
Washington Nat'l Corp.	NYSE	27.75	0.4	16.2	28.63	24.00	10	1.08	3.9	21.9	32.33	0.86
Zenith Nat'l Ins Corp.	NYSE	22.25	-1.1	48.3	23.88	15.00	79	0.88	4.0	9.9	12.26	1.81
INSURERS	AVERAGE		1.6	16.0					3.4	24.8		
ALL COMPANIES	AVERAGE		1.2	15.8					3.2	21.3		

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