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update

Insurance will cover damage in Silverdome roof collapse

PONTIAC, Mich.—An estimated $8 million in damages and loss of income as a result of a collapsed roof at the Pontiac Silverdome is covered under the city's all-risk policy written by Affiliated FM Insurance Co. of Johnstown, R.I.

The policy has a $130 million limit with a $100,000 deductible and will cover the cost of repairing 27 fiberglass panes in the roof that collapsed

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Hospitals scramble to buy malpractice coverage

By STEVE TARAVELLA and STACY SHAPIRO

The prognosis is poor for hospital risk managers struggling to cure their medical malpractice insurance ills.

Nearly all hospitals are facing hefty rate increases when they renew their medical malpractice insurance, many report they cannot find the same limits they purchased last year, and some say the coverage that is available comes with new restrictions.

. . . MARKET ALERT . . .

Double-digit rate increases for primary medical malpractice coverage are common, but those increases pale in comparison with rate hikes for excess coverage, which are typically 200% or more, report hospital risk managers.

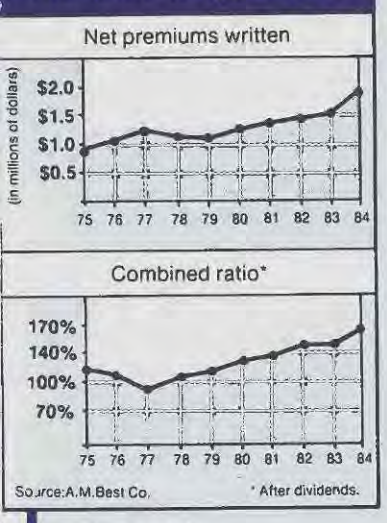
The latest medical malpractice insurance crunch has been spurred by the refusal of some reinsurers to accept medical malpractice risks, market observers say.

Reinsurers have "just about bowed out. They're doing what the primary carriers did in the 1970s," says one buyer, referring to the period a decade ago when hospitals and physicians were hard-pressed to obtain medical malpractice coverage because most insurers stopped writing it.

Hospitals are also finding it increasingly difficult to buy medical malpractice insurance written on an occurrence policy form (*BI*, Oct. 22, 1984). Occurrence policies respond to incidents that happen during the policy year, regardless of when the claim is filed, compared with claims-made policies, preferred by many underwriters, which only cover those claims first filed during the policy period.

Observers of the medical malpractice insurance market do not think any of these ailments will be cured in the near future as medical malpractice underwriting losses continue to increase (see chart).

Medical malpractice



Graphic: Amy Palmer

"I don't think it's going to get any better and, in a general sense, it's going to get worse," says one New York broker.

"The market is in complete disarray. There is substantially less market availability and capacity than there was last week, last month or even last October," says Richard G. Pfeiffer, senior underwriting officer of The St. Paul Cos. Inc., the largest medical malpractice insurer in the United States. St. Paul expects to write about $90 million in medical malpractice premiums for hospitals alone in 1985.

Mr. Pfeiffer points out a hospital could purchase maximum medical malpractice limits of $250 million as recently as last April. By August, the market's capacity had dwindled to approximately $100 million, and today the market can only provide a maximum limit of about $50 million, he says.

A hospital risk manager in Florida concurs, saying, "The bottom line is that the excess market is drying up. It's just going down the tubes."

Excess medical malpractice layers that would have cost about $1,000 two years ago might cost about $5,000 today, observes Allyn Hess, senior vp at INAPRO, CIGNA Corp.'s professional liability division.

One London observer notes as an example a U.S. hospital that last

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Doctors look to prevention to control medical malpractice coverage costs
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NEWSPAPER

Bank sues D&O insurers to recover $95 million loss

By MEG FLETCHER

SAN FRANCISCO—Bank of America says its $100 million of directors and officers liability insurance should respond to a $95 million loss triggered by the bank's involvement with allegedly fraudulent mortgage-backed securities.

The nation's second-largest bank holding company filed suit earlier this month against its two D&O underwriters—Employers Insurance of Wausau and First State Insurance Co.—even though spokesmen for the insurers say that they have neither received notification of a claim from the bank nor decided to contest coverage.

Officials at the San Francisco-based bank, however, say that it has notified the insurers of a possible claim. And, according to the suit, the bank "is informed and believes the insurer defendants dispute" the bank's interpretation of the D&O policies.

The bank contends in the suit, filed March 1 in Los Angeles County Superior Court, that the D&O policies should cover the bank's losses arising from the negligent acts of bank officers insured under the policies. These six officers, who have either been dismissed or demoted, are also defendants in the suit.

All of the employees named in the suit were covered by the D&O policies, the bank says.

The bank also has more than $95 million of fidelity coverage under a bankers' blanket bond led in London but says that coverage is not applicable because the employees have not been accused of dishonest acts.

"We certainly have evidence of gross negligence (by the employees) but not evidence that would support a claim under the fidelity policy," said Norman Wintemute, a Bank of America vp and head of its risk and insurance management section.

"There is no evidence of fraudulent acts by the employees," added Winslow Christian, Bank of America's director of litigation.

The bank's investigation into the scandal is continuing, Mr. Wintemute added.

The D&O policies would not respond to the losses if the officers are found to have acted dishonestly, while the fidelity bond would be triggered only if bank employees or third parties using the bank's premises acted dishonestly.

The bank's suit against its insurers and employees charges the employees with negligence, gross negligence and breach of fiduciary duty stemming from "acts and omissions" in their handling of the mortgage-backed securities.

The suit also asks that the employees reimburse the bank for its losses in the scandal.

D&O insurance experts say that it is not common for a company to sue its employees to recover for losses under D&O coverage, but Bank of America's action is not precedent-setting either.

nnIn addition, observers of the D&O insurance market say that the Bank of America claim could further tighten the already constricted market (*BI*, Sept. 3, 1984).

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Judge issues the final order apportioning Hyatt coverage

By DOUGLAS McLEOD

KANSAS CITY, Mo.—At least one insurer involved in the Kansas City Hyatt Regency Hotel skywalk litigation is planning to appeal a state court judge's final order allocating insurance proceeds for losses from the 1981 disaster.

Jackson County Circuit Court Judge Timothy D. O'Leary ruled last month that excess liability insurers for Hyatt Corp., operator of the hotel, must pay two-thirds of all the losses incurred by Hyatt, Hallmark Cards Inc. and Hallmark subsidiary Crown Center Redevelopment Corp., which owned the hotel.

The ruling requires Hallmark's excess liability insurers to pay the remaining one-third of all judgments, settlements and defense costs resulting from the July 17, 1981, collapse of two suspended walkways at the Kansas City Hyatt hotel.

The accident killed 114 people and injured at least 200 others.

Judge O'Leary's ruling makes final—and appealable—his October 1982 interlocutory order providing for the two-thirds/one-third proration. The 1982 order was not immediately appealable.

In reaching his decision, the judge rejected the suggestion of two of Hyatt's excess insurers—Columbia Casualty Co. and Highlands Insurance Co.—that the question of allocating insurance funds be settled by holding a new trial to determine the relative fault of Hyatt, Hallmark and other parties involved in construction of the hotel.

Judge O'Leary also rejected a motion by Commercial Union Insurance Co., Hallmark's primary and first excess insurer, and American Insurance Co., another Hallmark insurer, that they be allowed to argue for a "reformation" of allegedly ambiguous language in the insurance contracts.

The effect of such a reformation would be to make all of Hyatt's coverage primary and all of Hallmark's insurance excess.

Judge O'Leary's Feb. 28 order also resolves questions about how defense cost coverage is to be allocated.

Reversing a portion of his 1982 order, the judge limited the defense obligation of CU and Northbrook Excess & Surplus Insurance Co., Hyatt's first excess insurer. Judge O'Leary ruled that CU's and Northbrook's duty to defend ends with the exhaustion of their policy limits by both defense costs and indemnity payments.

The judge had ruled in 1982 that the two companies had an unlimited duty to defend claims arising from the accident, though both Northbrook and CU proceeded on the assumption that defense costs were included in policy limits despite the judge's order.

Judge O'Leary also ruled that American, which has declined to pay defense costs, must pay its share of the costs; and that Columbia Casualty's limits are only for indemnity payments.

Since defense costs are excluded under the terms of the Columbia Casualty policy, the insurers in the next layer—Pine Top Insurance Co., Federal Insurance Co. and Highlands—must cover the defense obligation.

A lawyer for American said the insurer will appeal

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update

Silverdome damage covered

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under the weight of a heavy snowfall last week. Owens-Corning Fiberglas Corp. in Toledo, Ohio, manufactured the stadium roof and will replace the damaged panes.

An official for the city of Pontiac, which with the Stadium Building Authority owns the dome, said repair costs would be finalized after a meeting with Owens-Corning late last week.

The roof began caving in March 4 after heavy snow followed by rain, said Donald P. Althoff, the city's risk management consultant. The next day, high winds caused more panes to break, he said.

The damage caused the Detroit Pistons' basketball games to be moved to the Joe Louis Arena in Detroit for the rest of the regular season, said Mr. Althoff. And, two concerts and a rodeo were canceled.

Figures were not available on how the shift to a smaller arena would affect Pistons ticket sales, but Mr. Althoff indicated that lost revenues would be covered by the Affiliated policy.

He said about 2,500 seats were damaged and the facility sustained some "superficial concrete damage, but no structural damage."

Two GAF punitive claims denied

SAN FRANCISCO—A state Superior Court judge has ruled that GAF Corp. cannot collect punitive damages from Insurance Co. of North America and certain Lloyd's of London underwriters for alleged bad-faith conduct.

Judge Ira A. Brown Jr. based his decision on the fact that punitive damages are not permitted either under the law in Pennsylvania, where INA is incorporated, or under British law.

The decision came in insurance litigation between five asbestos defendants and more than 75 insurers over the nature and scope of coverage for companies in asbestos litigation (*BI*, March 4).

It follows a recent decision by Judge Brown that Nicolet Inc., one of the plaintiffs, also could not collect punitive damages from INA.

Judge Brown's decision does not affect punitive damage claims by the five plaintiffs in the litigation against other insurers.

Bermuda reports 1983 results

HAMILTON, Bermuda—The assets of Bermuda-based international insurance companies, including captive insurers, totaled $17.1 billion at year-end 1983, up 26% from 1982 assets of $13.6 billion, according to the latest statistics from the Bermuda government.

These companies wrote gross premiums of $6.5 billion in 1983, up 5% from 1982 premiums of $6.2 billion. Net premiums in 1983 totaled $4.7 billion, up almost 10% from $4.3 billion in 1982.

The statistics are prepared by the government and based on the statutory financial reports insurers licensed in Bermuda are required to file. The contents of the individual reports are confidential, and the government releases only aggregate statistics.

In addition, Registrar of Companies A. Verbena Daniels reports that 66 new companies were registered in Bermuda in 1984, compared with 85 in 1983. Thirty-five companies canceled their registrations in 1984, compared with 29 in 1983. With a net gain of 31, 1,162 international insurance companies are registered in Bermuda. All are active, according to the government.

Carbide still working on renewal

DANBURY, Conn.—Union Carbide Corp. is still completing the March 1 renewal of its excess general liability insurance program, and it does not expect to find the $200 million in limits it had.

"Obviously we're having difficulties, but it's falling into place and we are confident we will end up with a satisfactory placement," said a Carbide executive who asked not to be identified. He would not say how much coverage had been arranged so far, but said he "doubts" the company will find its previous $200 million in limits.

He added "quite a few" of the company's previous liability insurers have renewed participations. But, some have dropped out.

Transit Casualty Co., which provided $15 million in capacity in two separate excess layers through National Underwriting Agency in Chicago, is no longer on the risk (*BI*, Jan. 26). Likewise, American Centennial Insurance Co., which took a $5 million participation on one excess layer, canceled the managing general agency contract of the company that produced the business, and is no longer participating, according to American Centennial Vp Jack E. Helms.

A toxic gas leak at Union Carbide's plant in Bhopal, India, last December killed an estimated 2,500 people and injured as many as 150,000 others (*BI*, Dec. 24-31, 1984).

Amoco Cadiz claims mount

CHICAGO—In a conference last week with U.S. District Judge Frank J. McGarr, attorneys for the Republic of France and a group of communities in Brittany served claims against Standard Oil Co.

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Superfund bill would permit individuals to sue polluters

By ROBERT A. FINLAYSON

WASHINGTON—Citizens would be permitted to bring suit to force companies to comply with Superfund cleanup orders under a reauthorization bill approved by the Senate Environment and Public Works Committee March 1.

The committee reported out S. 51, a reauthorization measure introduced by Committee Chairman Sen. Robert T. Stafford, R-Vt., that would extend the Superfund law for five more years and increase the size of the federal hazardous waste cleanup fund to $7.5 billion from $1.6 billion.

Prior to approving the bill, the committee voted favorably on an amendment to the bill, introduced by Sens. Max S. Baucus, D-Mont., and Gary Hart, D-Colo., that would allow citizens to sue polluters under the Superfund law. Committee members also approved as amendments to the bill two key provisions in the Reagan administration's reauthorization measure, which was unveiled Feb. 22.

Those provisions would limit the rights of companies named in Superfund lawsuits and cement the government's position on judicial review of government-ordered cleanup remedies (*BI*, March 4).

The bill now goes to the Senate Finance Committee, which is expected to consider possible changes in the existing Superfund tax mechanism.

Meanwhile, Rep. James J. Florio, D-N.J., will reportedly introduce a Superfund reauthorization measure in the House shortly. The House Commerce, Transportation and Tourism Subcommittee held hearings on the administration's bill March 7.

S. 51, as amended by the Senate Environment and Public Works Committee, would:

- Allow citizens to sue companies that do not comply with Superfund cleanup orders or any Superfund regulations and standards. This, in effect, would give citizens the power to force the government's hand in enforcing the Superfund law.
- Establish a $150 million victims' compensation demonstration project that would provide for health care for persons injured by exposure to hazardous substances, subject to a number of important limitations.
- Create a federal mechanism that would allow companies named in Superfund lawsuits to seek contributions for cleanup costs from other responsible parties not named in the suit—but only after the suit is settled.
- Prohibit judicial review of EPA cleanup orders until after the agency moves in federal court or in an administrative proceeding to enforce the order.

Although not as broad as language considered by the House and Senate last year that would have established a federal cause of action under Superfund, some Superfund experts say the Baucus-Hart citizen-suit amend-

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A&A to sell loss-riddled underwriters

By STACY SHAPIRO

LONDON—Alexander & Alexander Services Inc. says it will sell the underwriting units it acquired in 1982 along with Lloyd's broker Alexander Howden Group P.L.C. —which again are forcing the broker to post a loss.

Before the underwriting companies are sold, A&A will increase the subsidiaries' loss reserves. A&A has already increased the Howden units' reserves twice since the acquisition.

A&A announced last week that it will report a fourth-quarter 1984 loss stemming from its decision to strengthen reserves at the underwriting units, primarily London-based Sphere Drake Insurance Co. It did not specify how much would be added to the reserves.

Further, A&A said that selling the underwriting units, including Sphere Drake, also will result

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Older-worker pension rule would hike plan costs

By JERRY GEISEL

WASHINGTON—The Equal Employment Opportunity Commission is proposing that companies grant pension credits for workers who stay on the job after 65, a requirement that would increase employers' pension costs.

However, the Reagan administration may kill the proposal before it is adopted, pension experts say.

Last week, the EEOC, the federal agency in charge of age discrimination regulations, approved a proposed rule to require employers to recognize years of service for workers ages 65 through 69 in computing their pension benefits.

Currently, companies can stop pension accruals when a worker turns 65.

If the proposed rule is adopted, it could cost companies hundreds of millions of dollars.

According to the Employee Benefit Research Institute, a Washington-based benefits think tank, employers would spend more than $280 million a year to provide pension accruals for workers beyond age 65. And, that higher cost might discourage companies from hiring older workers, the EBRI says.

"This would be one more area where an employer will be hit with more benefit costs," said Douglas C. Borton, chief actuary at Buck Consultants Inc. in New York.

The EEOC is sending the proposed rule to the Department of Labor and the Internal Revenue Service for their comments, which

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Lloyd's brokers consider agency divestment options

By STACY SHAPIRO

LONDON—Facing an effective deadline just a year away, Lloyd's of London brokers are now seriously considering how they will sell their Lloyd's underwriting management agencies, London sources say.

And, according to the sources, many of the divestments could be made by the end of the year.

However, there is some disagreement over how the brokers should dispose of their managing agencies. Some observers, for example, worry that some independent underwriting management companies could become "mega-underwriters" by scooping up many of the agencies being divested by the brokers.

According to the Lloyd's Act of 1982, all Lloyd's brokers must divest themselves of their underwriting management agencies—the agencies that manage the affairs of Lloyd's syndicates—by July 1987.

Late last year, however, the Council of Lloyd's decided that all underwriting agencies will have to be re-registered by May 1986. Because a managing agency wishing to re-register cannot be owned by a broker, the actual deadline for brokers to divest their managing agencies is only a year away.

The re-registration process takes about six months, explains William David Robson, managing director of Creechurch Syndicate Managers Ltd., a subsidiary of Merrett Holdings P.L.C.

"So, now that end-of-the-year renewals are out of the way, more and more people are turning their minds to divestment," he said.

Fifty-five of the 114 managing agencies originally labeled by Parliament as broker-controlled still must be divested said a Lloyd's spokesman. Of these, 35 are wholly owned by Lloyd's brokers; 20 are only partially broker-owned but still must be sold.

Large agencies owned by some of the largest Lloyd's brokers that must be sold include Alexander Howden Group P.L.C., Minet Holdings P.L.C., Willis Faber P.L.C. and Hogg Robinson Group P.L.C.

One broker now considering the sale of its underwriting agency is Howden, a subsidiary of U.S. broker Alexander & Alexander Services Inc.

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errors & omissions

- All insurance brokers in the United Kingdom, including non-Lloyd's brokers, are required by the Insurance Brokers Registration Act to buy fidelity coverage and are offered the coverage by insurers that write brokers errors and omissions insurance, according to Nick Carter, managing director of Nelson Hurst & Marsh Ltd., a Lloyd's broker (*BI*, Feb. 18).

Future claimants to be represented in bankruptcies

By STEPHEN TARNOFF

Future asbestos claimants should be represented in the bankruptcy proceedings of asbestos producers, two federal courts have ruled.

But, neither court decision says that future claimants are entitled to share in any money set aside for asbestos victims in any reorganization plan. The rulings only say that a legal representative should be appointed to represent people who have been exposed to asbestos but have not yet developed any related diseases.

However, this is the first step toward providing for the compensation of future claimants through the bankruptcy proceedings. And, as such, the asbestos producers say the court decisions are a victory for them because the inclusion of future claimants is essential to developing a successful and final reorganization plan.

The decisions, reached late last month by U.S. Bankruptcy Court Judge Edward B. Toles in Chicago and the Third Circuit U.S. Court of Appeals in Philadelphia, involve former asbestos producers UNR Industries Inc. of Chicago and Amatex Corp. of Norristown, Pa.

Both companies, named as defendants in thousands of lawsuits by victims of asbestos-related diseases, filed for reorganization in 1982 under Chapter 11 of the Federal Bankruptcy Code.

The two recent court decisions overturned two earlier court decisions that said persons exposed to asbestos who have not yet manifested symptoms of asbestos-related diseases are not creditors under the bankruptcy law and, therefore, are not entitled to representation.

On the contrary, according to the most recent decisions, future claimants are "parties in interest" under the code, are vitally affected by the bankruptcy proceedings and should be represented in the reorganization proceedings.

The decisions come more than a year after U.S. Bankruptcy Court Judge Burton R. Lifland in New York also ruled that future claimants should be represented in reorganization proceedings for Manville Corp., another asbestos defendant that filed for reorganization in 1982 (*BI*, Feb. 6, 1984).

However, the appointment of a legal representative for future claimants in the case is being appealed by various Manville creditors.

Similarly, in the UNR and Amatex cases, committees representing the current asbestos litigants contend that only those claimants that already have symptoms of an asbestos disease should be represented and not those who have not yet manifested an injury.

The committees, one of which has decided to appeal the decision and the other which is considering an appeal, contend that future claimants are not creditors under the bankruptcy code, and, therefore, cannot participate in the reorganization plans.

It is pointed out that the inclusion of future claimants would reduce the amount of compensation available for current claimants.

In the UNR decision, Judge Toles, however, notes that future claimants are "parties of interest" that must be represented.

"Putative asbestos disease victims have a stake in the outcome of these proceedings. . .," he said.

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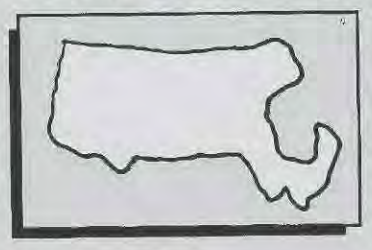
Work comp battles

Massachusetts weighs several reform bills

By CAROL CAIN

BOSTON—The battle lines are being drawn as the Massachusetts Legislature prepares to consider workers compensation reform.

Although three major reform bills introduced in the Legislature agree on about 75% of their provisions, Massachusetts lobbyists say, the areas of disagreement in the bills are expected to stir several months of debate.



Graphics: Donna DiBlase

Key items in the workers compensation package proposed by Gov. Michael S. Dukakis, which is likely to be the major legislative vehicle for work comp reform, include increased benefits to injured workers, changes designed to speed up administrative procedures, rehabilitation enhancements and a provision for group self-insurance, which is not currently allowed in the state.

However, the creation of a state fund and provisions for competitive rating—two typical features of most state reforms—are absent from the major proposals in Massachusetts.

The governor's bill, H. 5030, was based on information garnered during the past 1½ years by the 24-member task force he appointed to study workers comp (*BI*, Feb. 27, 1984).

The bill, as well as two other major reform measures and 50 to 100 more-limited work comp proposals, will be discussed for the first time April 4 by the Legislature's Joint Committee on Commerce and Labor.

One of the other two major reform measures—H. 2142—was drafted by the Associated Industries of Massachusetts. Some 3,000 businesses belong to Boston-based AIM. The bill's legislative sponsor is Rep. David Cohen, D-Newton.

And the third major reform bill—H. 3064—is organized labor's proposal. An identical bill was introduced late last session by Rep. Timothy A. Bassett, D-Lynn., but died in committee. Rep. Bassett also introduced this year's proposal, but he resigned Feb. 28, leaving the task of pushing the bill through debate to several co-sponsors.

Although three different bills have been introduced, all observers agree that the state's workers compensation system needs reform.

"It seems to me that every party to the workers compensation process is struggling with the system. . . .Although they may not agree entirely on what should be done, they do agree on what's wrong with the system," said John Harbison, counsel to the state's secretary of labor.

"The current law is fraught with inefficiencies, time

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Hawaii legislator blocks employers' proposals

By CAROL CAIN

HONOLULU—The emotionally charged issue of workers compensation is erupting in Hawaii, where workers compensation rates and claims frequency are among the highest in the country.

Efforts by business and insurance leaders to reform the workers compensation law have been sidetracked because a state representative has forced major changes in a workers compensation reform bill that had previously been agreed to by other legislative leaders.

Rep. Eloise Tungpalan, D-Pearl City, offered the amendments on March 1, only minutes before the deadline for the bill to be passed out of the House Employment Opportunity and Labor Relations Committee, which she chairs.

Rep. Tungpalan amended H.B. 463 by removing from the bill provisions that would have reduced workers compensation costs, such as changes in deadlines for the filing of claims and changes in compensability standards.

However, she left intact several benefit increases for injured workers, said Edwin Shimizu, director of government affairs for the Chamber of Commerce of Hawaii.

"Eloise came in about 11:10 p.m. and basically said, 'Take it or leave it,'" Mr. Shimizu said.

Other legislators on the committee voted to send the amended bill to the House Finance Committee to keep a workers compensation reform measure alive this session, Mr. Shimizu said, adding that the bill still can be amended.

In addition to the increase in benefits, H.B. 463 includes provisions that would:

- Call for a study of a competitive state fund and a competitive rating system for next year's legislative session.
- Establish guidelines and a medical advisory panel to contain medical costs associated with workers compensation benefits.
- Cap vocational rehabilitation benefits so that vocational rehabilitation programs would not exceed 26 weeks and payment for rehabilitation services would not exceed 52 weeks.

However, lobbyists note the bill does not explain the difference between rehabilitation programs and services. It also leaves unclear whether an employer would have to pay rehabilitation costs for 52 weeks or 78 weeks.

The amended bill was expected to be considered by the House Finance Committee last week, and committee Chairman Kenneth Kiyabu, D-Honolulu, was expected to amend the measure back to its original form, including the cost-reduction features.

The bill was expected to clear the House Finance Committee late last week, and the House is expected to vote on

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Benefit managers' pay increases shrink: Survey

By MARLA ANTELIS

Benefit managers report only moderate increases in salary compared with previous years, but they say their responsibilities are growing and they like the job they do.

The average salary for a benefit manager—including bonus—was $49,000 in 1984, compared with $45,000 in 1982, or an increase of 8.9% over the two-year period, the fourth biennial survey of benefit managers by Segal Associates reveals.

That increase slightly outpaced inflation, as the Consumer Price Index rose approximately 8% during the two-year period.

However, benefit managers' salaries increased much less in the past two years than they did between 1978 and 1982, said a spokesman for Segal Associates, a division of benefit consultant Martin E. Segal Co. in New York.

The average salary of benefit managers increased 22% between 1980 and 1982 and a total of 57% between 1978 and 1982, he said.

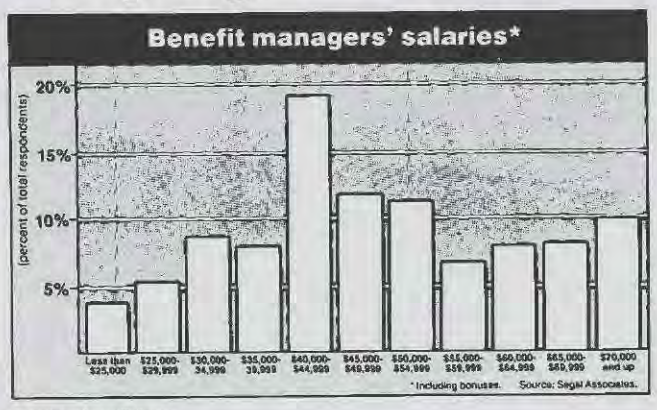
The 1984 salary survey was sent to benefit managers at the Fortune 1,000 companies and an additional 500 large non-industrial companies. The survey had an overall response rate of 11%.

Although the survey indicates that benefit managers' average salary has increased only moderately between 1982 and 1984, the percentage of benefit managers earning an annual salary—including bonus—of more than $50,000 has increased.

Forty-three percent earned more than $50,000 a year, compared with 27% in 1982; 10% in 1980; and 1.4% in 1978.

Not quite half—47.4%—reported earning salaries between $30,000 and $50,000 in 1984.

In a breakdown of salary groupings, the largest group of respondents—19.1%—earned betweeen $40,000 and $45,000.



Graphic: Amy Palmer

At the low end of the scale, 3.9% of benefit managers earned less than $25,000. At the high end of the scale, 9.8% reported they earned $70,000 or more.

In addition, 5.3% reported annual salaries ranging from $25,000 to $30,000; 8.6% from $30,000 to $35,000; 7.9% from $35,000 to $40,000; 11.8% from $45,000 to $50,000; 11.2% from $50,000 to $55,000; 6.6% from $55,000 to $60,000; 7.9% from $55,000 to $60,000; and 7.9% from $65,000 to $70,000.

Twenty percent of respondents to the 1984 survey who received a bonus reported they were awarded an additional 21% of salary or more; the average annual bonus reported was 39% of salary.

While the average annual bonus dropped in 1984 from 53% of average salary in 1982, the spokesman noted that this may reflect that managers' base salaries have improved since that time.

Although benefit managers have worked harder and received less-substantial salary increases, 98% of respondents reported a high level of job satisfaction. More than half—55.5%—of respondents said they found their jobs "very fulfilling," compared with 48.5% in 1982, 46% in 1980 and 54% in 1978.

"Fulfilling" was the word used by 42.6% of respondents to describe their jobs. This compared with 50.3% in 1982, 52% in 1980 and 43% in 1978. Only a few respondents—1.9%—described their jobs as unfulfilling. This figure was up only slightly from 1982, when 1.2% said they were unfulfilled. In 1980, 2% said they were unfulfilled, while 3% said they were unfulfilled in 1978.

"This attests to the professional level of benefit managers," who are dedicated to their jobs and do not view salary as the sole incentive for working hard, the spokesman said.

Nearly all, or 95%, of respondents reported their department's workload has grown since 1982, with 76% reporting an increase in areas of responsibility as well.

And, increasing responsibility was accompanied in most cases by an expanded budget and staff growth. More than 77% of respondents indicated that their budgets have risen since 1982. Almost 45% reported that the size of their professional staff had grown. Fifty percent reported that while departmental growth was restrained, clerical staff had grown.

More than 85% of the managers who responded to the survey said they had worked in the benefits field for three years or more. Forty-nine percent reported careers in the field that had spanned more than nine years.

Seventy-four percent reported they had been with their current employer for more than three years; 44% had been

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Pension proposal would hike plan costs

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The Employee Benefit Research Institute says employers would spend more than $280 million a year to provide pension accruals for workers beyond age 65. And, that might discourage the hiring of older workers, EBRI says.

are expected in the next 60 to 90 days.

After the EEOC reviews comments from the IRS and the Labor Department, the agency will send the proposal to the Office of Management and Budget. The OMB, acting on behalf of the administration, will decide what form the regulation will take. The OMB also has the authority to scuttle the rule altogether.

But, there is some doubt whether the EEOC proposal can gain approval from the other regulatory agencies.

Experts point out the proposed rule violates congressional intent when, in 1978, Congress amended the Age Discrimination in Employment Act. Those amendments raised the permissible mandatory retirement age to 70 from 65.

For example, a Senate Labor and Human Resources Committee report accompanying the ADEA legislation said that the amendments do not require the accrual of additional benefits for employees who work beyond the plan's normal retirement age.

In addition, Donald Elisburg, then an assistant secretary at the Labor Department, wrote to a congressional committee at the time it considered the ADEA amendments: "It is our view that nothing in ADEA or in the proposed amendments would require an employer to credit, for purposes of benefit accrual, those years of service which occur after an employee's normal retirement age."

Likewise, the Employee Retirement Income Security Act "does not require such an accrual," he wrote.

When Mr. Elisburg wrote his letter in 1977, the Labor Department had regulatory authority over age discrimination issues. In 1979, that authority was shifted to the EEOC.

Since the legislative history of the ADEA—including the committee report and Mr. Elisburg's letter—makes it clear that EEOC has no legal basis for its proposed rule, it's questionable whether the EEOC can gain approval of it from other agencies, said Richard Fay, a former Senate committee staffer and now a partner in the Washington office of the law firm Reed, Smith, Shaw & McClay.

"It is hard for me to believe that this kind of disregard of the law will be accepted by the other agencies," Mr. Fay said.

In fact, the OMB once before forced the EEOC to tear up another proposed benefit rule affecting older workers.

In that case, OMB rejected those rules EEOC was drafting that would have encouraged older workers to choose Medicare rather than their employer's plan for primary health care coverage (*BI*, Jan. 31, 1983).

Those rules were required by a provision in the Tax Equity and Fiscal Responsibility Act of 1982 that said employers were required to give workers 65 through 69 a choice of obtaining their primary health care coverage from either their employer or Medicare.

The intent of that TEFRA provision was to encourage employees to obtain their primary health care from companies and thus save Medicare hundreds of millions of dollars.

Aside from higher benefit costs, the EEOC pension rule, if approved, would saddle employers with additional expenses. For instance, employers would be forced to rewrite and distribute new pension plan documents to employees.

It isn't known exactly how many employers now give pension credits for workers 65 years of age and older.

A 1982 survey by the Bureau of Labor Statistics of companies with at least 100 employees found that about 42% of employees were covered by pension plans that gave at least some recognition of service after age 65 when computing pension benefits.

"Some companies recognize post-65 service and some don't," said Theresa Stuchiner, a partner at Kwasha Lipton, a Fort Lee, N.J., benefit consultant.

Not recognizing service after age 65 is a way companies can encourage workers to retire at 65, Ms. Stuchiner added.

Currently, few employees stay on the job after 65. According to the Bureau of Labor Statistics, employees 65 and older comprise less than 1% of the full-time private workforce. And, many of those workers retire within a few months of turning 65.

But in the future, many more employees could work after 65, experts say.

Under the Social Security Amendments Act of 1983, the age at which a worker can retire and collect full Social Security benefits will gradually increase to age 67 in 2027. ■

Lower-back claims subject of report

NEW YORK—The duration of lower-back claims does not rise with the age of the worker, according to a study of Illinois claims.

The results of the study of 1,418 Illinois claims was presented by co-author John D. Worrall of Rutgers University at a National Council on Compensation Insurance seminar on insurance research issues.

The study found no consistent pattern, and it found that the expected duration of temporary total lower-back pain workers compensation claims was virtually the same for workers under age 25 and for those 55 years old and older.

However, the study did confirm earlier findings linking benefit increases to increases in duration. As workers age, they become more responsive to benefit increases: A 10% benefit increase would increase the expected duration of the claim by about 10 days in the 55-and-over group. Wage levels also affect duration, and a 10% salary increase would decrease the average duration by about five days in the 23-to-34-year-old group. ■

Wausau's service helps Ferry-Morse weed out hazards.

"I've been impressed with how often the Wausau people visit our plant sites." An observation from George Allbritten, VP-Administration of the Ferry-Morse Seed Co., which sells vegetable and flower seeds in more than 100 countries. Wausau provides business insurance for this California-based company.

"They've been interested enough in us to learn about our exposures. So they understand our business, and their loss-control recommendations make sense. Recently, they suggested some measures relative to noise reduction, and we immediately implemented them. I'm pleased that Wausau brings these potential problems to our attention.

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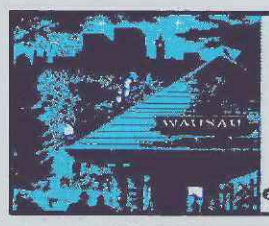

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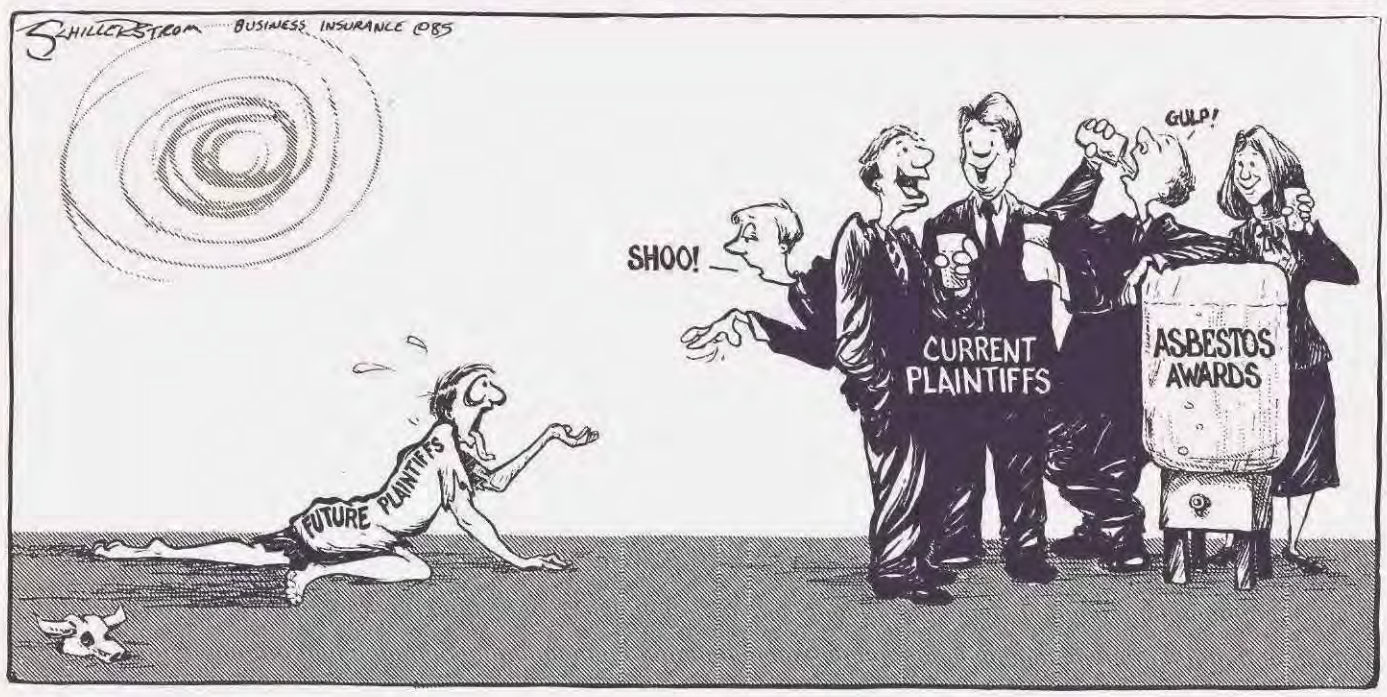

Two steps forward, and. . .

TWO STEPS FORWARD, and one step back.

That's our assessment of recent asbestos-related litigation developments.

Step forward: The organizers of the asbestos claims facility say they have the support of enough major asbestos producers and their insurers to proceed to establish the facility.

This is the best news we've heard about the facility since it was first proposed last May.

We've repeatedly urged asbestos producers and insurers to join this facility, which provides them with a mechanism for settling asbestos bodily injury claims outside of the court system and gives asbestos producers and insurers a basis for settling their disputes over which insurers are liable for claims payments. Not only will this facility solve the immediate problems, but it also will establish a blueprint for handling future massive toxic tort litigation.

Now, the organizers of the asbestos claims facility must clear the next hurdle: Securing final commitments from all those who have *conditionally* pledged their support, by the scheduled deadline of May 29.

We've never welcomed the herd-mentality that seems to seize the insurance industry sometimes, but this is one instance in which we'd be delighted to see it at work, driving all insurers into the facility.

Step forward: Two more courts rule that future asbestos claimants are entitled to representation in the bankruptcy proceedings of asbestos producers who have turned to the bankruptcy court to solve their asbestos liability problems.

The asbestos producers trying to hammer out reorganization plans for their companies want future claimants represented so that future asbestos damage claims will not send them back to bankruptcy court. But, attorneys representing current asbestos claimants have fought representation for future claimants.

Why? The judge in one of the cases explained it politely: "If future claimants are excluded from the reorganization plans, the current claimants will receive a larger portion of an obviously limited fund," he observed in his opinion.

We'll put it bluntly: The attorneys representing current asbestos claimants are greedy. They want the most for their clients—and their contingency fee.

Neither of the recent decisions states that future claimants are creditors and that money should be set aside to pay their claims, but they lay the groundwork for that necessary and proper development.

Step back: General Reinsurance Corp. files suit asking for a ruling that it doesn't owe any reinsurance payments to Aetna Casualty & Surety Co. for asbestos claims filed by one of Aetna's policyholders.

Regardless of who is right in this case, the dispute itself is unpropitious. It increases the amount of asbestos-related litigation, and worse, portends more litigation between ceding companies and reinsurers as asbestos claims are filed with reinsurers.

letters

Author's cheerleader remark indicates chauvinism

To the editor: Charles A. McAlear wrote in "Danger Lurks Behind Lure of Claims-Made CGL Form", (*BI*, Feb. 4): "The Insurance Services Office is proposing that these nice, average people underwrite and administer a new claims-made general liability policy and that they distinguish between claims-made and occurrence forms. This is somewhat akin to buying a chainsaw as a Christmas gift for a 4-year-old *or enlisting a Dallas Cowboys cheerleader as a pilot for the Concorde.*"

Shame, shame. This is a very chauvinistic remark. It's not necessary to compare the understanding of insurance to a cheerleader.

I know some producers (who, by the way, carry the designation Chartered Property & Casualty Underwriter) whose knowledge of various items in insurance is rated 2 on a scale of 1 to 10! I am also fortunate to have as a friend an ex-Seahawk cheerleader who is very bright, witty, and informed. My two daughters were cheerleaders in high school and they carried a 3.9 grade average.

In other words, cheerleaders can have looks and SMARTS. . .smart enough to earn a pilot's license. . .or whatever!

Shirley Brown
Account Administrator
Seattle

■ *Editor's note: The editor of Business Insurance, a former high school cheerleader, agrees.*

Prescription drug costs can be controlled

To the editor: I enjoyed reading the Perspective article "Rx for Drug Plans: Halting the Runaway Cost of Prescription Coverage" by Michael J. Barberi (*BI*, Feb. 11).

It is interesting to note that the concerns expressed by Mr. Barberi are most prevalent in the drug-coverage portion contained in most major medical plans.

The runaway cost of prescription drugs tends to take place under major medical plans where little, if any, restraints are built in to control drug costs. Under properly designed drug card plans, plan design features and options—such as drug pricing below wholesale cost, mail order, generic incentives to cardholders and/or pharmacists, administrative fees averaging less than 20 cents per claim, dispensing fees set by plan sponsors and regular pharmacy auditing—allow for real cost containment.

These features allow a properly designed card-type plan to be substituted for major medical drug coverage, often with significant cost savings.

Donald B. Dahlin
President/Chief Executive Officer
Pharmaceutical Card System Inc.
Phoenix, Ariz.

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Amendments complicate Hawaii comp reform efforts

Continued from page 3
it this week. The bill would then go to the Senate, which has to act before the Legislature adjourns April 19.

A similar reform bill—H.B. 310—was not passed out of Employment Opportunity and Labor Relations Committee last week and therefore is dead for this session. And, still yet another bill—H.B. 687, which would have established a competitive state fund—also died in committee.

Lobbyists from business, labor and insurance industry groups, as well as legislators, are actively pushing for a workers compensation reform bill as Hawaii's legislative session draws to a close. Although workers compensation is not the only issue facing the Legislature, it has become one of the state's main legislative issues.

Business groups appeared at a press conference last week to express their disappointment in the "dictatorial" way the reform package was passed out of the House committee. "We've been telling (the Legislature) what we need and were ignored," said Bette Tatum, state director of the National Federation of Independent Business, which has more than 6,000 employer members.

An 87.3% increase in the state's workers compensation insurance rates from 1979 to 1983 prompted the Legislature two years ago to call for a moratorium on rate increases during 1984, in anticipation of reform legislation to be passed in 1985.

Even though that moratorium expired Dec. 31, insurers verbally agreed to hold rates at the same level while the Legislature is in session.

Employers fear that if a reform measure is not passed this session, rates will skyrocket once again.

In addition to the high insurance rates, Hawaii employers say the state's workers compensation system also is costly because state law requires workers to wait only two calendar days after an injury to file a claim. Since benefits are payable from the day a claim is filed, lengthening the claim deadline will save employers money, especially for minor injuries, employers say.

"We want this waiting period extended and we want a cap put on vocational rehabilitation benefits," the Chamber's Mr. Shimizu said.

Employer groups also want the burden of proof in workers compensation claims shifted more to the employee.

"Every accident and illness in Hawaii is (now) considered work-related," Ms. Tatum said.

Amendments to the state workers compensation act had been placed on hold for two years until the completion of a study by Haldi Associates Inc., the New York-based economics and managment consulting firm commissioned by the Legislature (*BI*, April 4, 1983).

Some of the provisions of H.B. 463 stem from the report, which was issued in December 1984 after 1½ years of work.

In the report, Haldi recommended that the Legislature modify the workers compensation system to achieve greater equity and improve performance by:

- Relating compensation more closely to the economic losses actually suffered by employees because of work-related injuries.
- Increasing the timeliness of payments to injured workers.
- Eliminating any medical treatment not required for rehabilitation.
- Having the Disability Compensation Division improve its case management system, including scheduling of hearings and adjudication of disputes. ■

Job safety rules

WASHINGTON—The Labor Department has extended the period for written comments and requests for public hearings on the proposed final approval of job safety and health plans in eight states.

The comment period was extended to March 22 from Feb. 20 for the plans in Arizona, Iowa, Kentucky, Maryland, Minnesota, Tennesee, Utah and Wyoming.

Comments should be sent to the OSHA Docket Officer, Room N-3670, U.S. Department of Labor, Third St. and Constitution Ave., Washington, D.C. 20210; 202-523-7894. ■

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Hospitals scramble to find excess coverage

Continued from page 1
year purchased $20 million limits excess of $5 million for a $55,000 premium; the same hospital this year was able to buy only $5 million excess of $5 million, and paid $125,000 in premium for it.

But St. Paul's Mr. Pfeiffer points out that hospitals haven't really been left in the lurch by the capacity crunch.

"Many facilities bought $100 million because it was cheap. Most of them are content to drop back; they don't seem that uncomfortable," he observes.

The pinch on excess medical malpractice insurance stems from the reduced capacity of the medical malpractice reinsurance market.

Says one U.S. broker, who asked not to be named, "It's common knowledge that many of the syndicates in London have simply ceased and desisted right now."

For example, Merrett Holdings syndicate at Lloyd's of London headed by Robin Jackson, the leading market at Lloyd's for medical malpractice reinsurance, stopped underwriting excess-of-loss medical malpractice reinsurance for both hospitals and physicians about three months ago, says Ken Barrett, non-marine underwriter with Merrett Syndicates Ltd., the manager of the syndicate.

The so-called Jackson Syndicate will resume writing the coverage in July when some of its existing clients renew their business, Mr. Barrett said. "We are saving capacity for these renewals."

Other medical malpractice reinsurance markets in London, which have written a large volume of medical malpractice reinsurance since the coverage crisis of the mid-1970s, also have stopped writing business or are much more picky about the risks they accept.

"I just finished a new one," said one London broker referring to a new placement of medical malpractice reinsurance. "But that will be the last new one for some time."

In the United States, Skandia America Group is another reinsurance market that has become increasingly reluctant to assume new hospital business.

"We've certainly reduced our involvement in med-mal in general. We haven't made any specific, announced corporate decision not to write it, but we've certainly altered our view about what we expect in premium," says Thomas M. Tobin, general counsel in New York.

Skandia is raising its medical malpractice rates across the board, though Mr. Tobin would not elaborate on the size of rate hikes because they vary widely according to the individual risk.

Rates are "much higher because payouts are so much higher," says Mr. Tobin. "It's impossible to squeeze a profit out of it."

Skandia is not canceling existing contracts, Mr. Tobin explains. "But if the prices aren't met, we're not renewing."

Although the reinsurance crunch is cutting the capacity available to hospital risk managers, medical malpractice insurance buyers face another headache: finding coverage that is written on an occurrence basis.

"We found a real lack of carriers willing to write occurrence policies. The majority are willing to write only claims-made," says David Machnovitz, director-risk management at Cincinnati's Jewish Hospital, which did obtain excess coverage on an occurrence basis during a recent renewal, but only after a long search.

"The feeling we had was that the occurrence market won't be there after 1985," he says.

Underwriters are apparently following the lead of New York-based General Reinsurance Corp., which stopped assuming medical malpractice risks on an occurrence basis last August.

Underwriters using a claims-made form can "get their business under better control and have a handle on the loss experience for a given year," explains Victor Blake, chairman and chief executive of CNA Reinsurance of London Ltd., which uses the claims-made form.

Some London reinsurers, like the Jackson Syndicate at Lloyd's, will write renewal business this year on an occurrence form with the proviso that subsequent renewals will be written on a claims-made form.

"No one wants to be the last occurrence market. . .I believe in a few years' time all these policies will be written on a claims-made basis," said Merrett's Mr. Barrett.

The combination of all these factors means that hospital risk managers have to dig deep into their pockets when they renew their

Continued on facing page

Primary rates also increasing

While the cost of excess medical malpractice insurance for hospitals is soaring, the price of primary coverage is increasing as well, though not nearly as much as excess layers.

Underwriters attribute the double-digit rise in primary medical malpractice rates to increases both in the frequency and severity of medical malpractice claims.

The St. Paul Cos. Inc., the nation's largest insurer of medical malpractice risks, expects to increase primary rates in May by about 30%, according to Richard F. Pfeiffer, senior underwriting officer.

That would be in addition to a 30% average increase last year, and would reflect a 30% combined annual increase in both claims frequency and severity, he says.

St. Paul expects to write about $90 million medical malpractice premiums this year for hospitals.

Rates are increasing "dramatically" this year for some of CIGNA Corp.'s 175 health care facility policyholders, says Allyn Hess, senior vp of INAPRO, CIGNA's professional liability division.

The company is not imposing an across-the-board increase but is looking at each hospital individually, so he cannot cite a specific figure, he says.

CIGNA wrote about $26 million in gross hospital malpractice premiums in 1984.

The Pennsylvania Hospital Insurance Co., which underwrites coverage for about 300 hospitals, will raise primary rates by 30% to 40% and more beginning in June, according to Paul F. Henning Jr., secretary and actuary of the company, based in Camp Hill, Penn.

PHICO, which writes up to $1 million in primary coverage and up to $10 million in excess coverage, is experiencing a combined annual increase in claims frequency and severity of 17.5%, he says.

The company expects its net written premiums to grow to about $92 million by the end of this year, up from $72 million last year. ■

Continued from facing page
medical malpractice coverage.

Blodgett Memorial Medical Center in Grand Rapids, Mich., renewed its excess malpractice coverage Feb. 1 and saw its excess medical malpractice rates rise 600%, reports Bill Devereaux, the hospital's director-risk management.

Broker Johnson & Higgins arranged the coverage for the 410-bed facility "with some difficulty," working on the renewal since last November, he says.

In November, Mr. Devereaux explains, one of the hospital's former excess underwriters—New England Reinsurance Corp. of Hartford, Conn.—threatened to cancel its coverage 54 days before it expired unless the hospital paid an additional $16,000 in premium.

The hospital chose to pay rather than lose the coverage, he said.

A spokeswoman for New England Re acknowledges that "it was a little unusual to do that mid-term," but added the hospital had been "getting a break" on its rates for the past three years.

New England Re has been "paring its book" of malpractice risks over the past year, raising rates and becoming more selective in underwriting, she explains.

Following its February renewal, Blodgett Memorial now has primary medical malpractice coverage of $1 million per occurrence and $3 million annual aggregate, plus a $1 million umbrella policy, all underwritten by Michigan Hospital Assn. Mutual Insurance Co. in Lansing, according to Mr. Devereaux. The cost of that coverage, which includes a $100,000 per-occurrence deductible, increased only 27% on Feb. 1.

Above that coverage, the hospital has two $5 million excess layers, whose cost rose 600% in February. The first excess layer is written by London underwriters and the second by Pacific Employers Insurance Co., a Los Angeles-based CIGNA Corp. unit.

The hospital currently pays a premium of $635,000 for the excess coverage, up from last year's premium of $78,600, Mr. Devereaux says.

The excess coverage was formerly written by other insurers, including New England Re, he notes.

Mr. Devereaux says it wasn't poor loss experience that drove the hospital's rates up, pointing out that Blodgett Memorial is "much better than the norm" and "absolutely not a poor risk."

Nor, apparently, is poor loss experience the culprit for higher rates for the Risk Management Foundation of Harvard Medical Institutions in Boston.

The organization, which arranges insurance coverage for Harvard University, its 14 hospitals and 4,500 physicians, offers insurers a favorable risk, says Daniel Creasey, president of the foundation. But, Harvard will still see a major increase in its general liability and medical malpractice insurance rates at April renewals, he says.

"Most of us are going from a Cadillac to a Chevy in terms of the product we're buying, but are paying three times as much for it. I don't know of anyone who's writing a check that's not 2½ times what they paid last year," he says.

Mr. Creasey estimates the premium he will eventually pay for excess general liability and medical malpractice coverage will be three times what he paid last year, and he attributes the bulk of the increase to the medical malpractice coverage.

He declined to say what limits he is shopping for, but in past years has purchased more than $70 million in excess medical malpractice and general liability coverage.

The foundation's primary coverage is placed through its Cayman Island captive, Controlled Risk Insurance Co. Ltd.

The primary coverage provides limits of $6 million per incident and $27.5 million annual aggregate. CRICO retains the first $1 million of each loss and 50% of the second $1 million, up to an annual aggregate of $22.5 million. It reinsures the rest.

But Mr. Creasey expects he will be asked by reinsurers to assume more of each loss at renewals.

With its broker Johnson & Higgins, the foundation is currently negotiating its April renewal and is already having difficulty arranging reinsurance.

"Some of our previous participants have withdrawn from this line or from the insurance business in total," he explains, citing Transit Casualty Co. in Los Angeles and Northbrook Excess & Surplus Insurance Co., a subsidiary of Allstate Insurance Co. (*BI* Jan. 28; Nov. 19, 1984; Nov. 26, 1984).

"It's clear that the total amount of insurance available to a hospital or medical malpractice program today is less than what it was a year or two ago," he says. "And if anyone is trying to buy occurrence (policies), it's even more difficult."

Tim G. Walters is one of those people.

Mr. Walters, director of risk management at Bethesda Inc., a 700-bed Cincinnati-based hospital system in Ohio, Indiana and Kentucky, is now trying to renew his occurrence coverage, which expires April 1.

He expects that the rates for Bethesda's primary coverage, underwritten by Hartford Insurance Group, will be relatively stable, but "the excess market is gloomy."

"It's available, which is promising compared to 1974. But it's a question of price," says Mr. Walters, who is working on the renewal with broker Marsh & McLennan Inc. in Cincinnati.

He hasn't received any specific quotes from excess insurers yet, but expects he will be asked to increase the limits of Bethesda's primary coverage to at least $4 million from the current $2 million.

"The number that seems to be magic to the excess carriers right now is $4 million," he says.

He is looking at excess limits of $50 million and expects about a 100% premium increase.

Mr. Walters will be pleased to obtain the coverage at that price, he says. He knows of other local hospitals that renewed their excess coverage in the last 45 days with bigger increases, some as high as 300%.

Jewish Hospital in Cincinnati, for example, received quotes from about 15 carriers during its recent excess renewal. The premiums represented increases ranging from 79% to 183%, says Mr. Machnovitz.

The hospital wanted to purchase excess coverage written on an occurrence basis, which complicated the purchase, Mr. Machnovitz says. Using three brokers and one local consultant, it took about three months to find $50 million in excess limits.

"What we thought would be a very mundane 30-day task turned out to be a major undertaking," he says.

Jewish Hospital's excess coverage with Pacific Employers Insurance Co., expired Jan. 1, and it wasn't until the last minute that replacement coverage was found with Ohio Hospital Insurance Co., which insures about 160 policyholders in seven Midwestern states.

Coverage was bound late on New Year's Eve—verbally. "It was just literally networking over the phone on Dec. 31," he recalls.

The 614-bed facility obtained the $50 million of excess coverage on an occurrence basis for a 42% premium hike. It self-insures its primary coverage, which Mr. Machnovitz will only say is "in the millions."

During negotiations, Jewish Hospital encountered a coverage restriction that it hadn't come across in the past, but one that other buyers say is becoming increasingly more common.

Before malpractice underwriters issue coverage to hospitals, many now insist on proof that a hosptial's attending physicians—those doctors who work with staff privileges but receive no compensation for the hospital—have their own medical malpractice coverage. Mr. Machnovitz says various underwriters would not even consider his risk, or might write it but assess a 10% premium surcharge, if he could not show that the hospital's 600 attending physicians had their own coverage.

One insurer, for example, required each attending physician on the hospital staff to carry personal medical malpractice limits of $1 million per occurrence and $1 million aggregate.

Like most other hospitals, Jewish Hospital doesn't cover its attending physicians under its medical malpractice policies, but does cover its 26 employed physicians.

Despite all the problems experienced by hospital risk managers, at least one buyer is trying to put the situation into perspective.

"It's clear that prices have been too low. We all got bargains we didn't deserve these last couple of years," reasons Mr. Creasey of the Harvard Risk Management Foundation. ■

Public sees role of insurance: Survey

NEW YORK—The American public believes that the insurance industry is crucial to economic development, according to a recent survey.

More than 70% of the respondents to the survey, conducted for the Insurance Information Institute by Cambridge Reports Inc., said that new products could not be developed and marketed without insurance protection against potential lawsuits.

Also, more than 60% said that many small businesses would not be able to operate without insurance

And, nearly 40% said the passenger airline industry also depends on insurance coverage.

Sean Mooney, vp and economist for the Insurance Information Institute, said it was gratifying to note that so many people realize the importance of insurance in new product development.

"Moreover, the insurance industry has helped to focus the attention of manufacturers on the need for increased attention to safety in design, improvement in quality control and inspection, and proper instructions and warnings to potential users," he said.

"The insurance industry also supports legislation at the state and federal level to reduce the enormous legal costs of administering the product liability system and to make the standards of legal liability more definite, predictable and equitable for all," Mr. Mooney commented.

The results of the survey have been published by the III in a new quarterly called Insurance Pulse. Yearly subscriptions to the publication are available for $800 from the III, Publications Service Center, 110 William St., New York, N.Y. 10038. ■

Doctors look to prevention as malpractice rates climb

By STEVE TARAVELLA

While physicians and surgeons nationwide continue to battle increases in their medical malpractice insurance costs, some are using preventive medicine to ward off hefty rate hikes.

Some doctors are participating in educational seminars designed to increase their awareness of medical malpractice exposures and reduce the number of suits filed against them. The seminars are often conducted by their insurers.

"We've done a great deal of loss prevention education with our physicians," says Steven C. Williams, vp-underwriting of State Volunteer Mutual Insurance Co. in Nashville, Tenn. He notes that the company last year conducted about 50 seminars across the state to educate physicians and their office employees on avoiding lawsuits.

Policyholders pay a nominal registration fee to attend the course, but receive a 10% premium reduction after they attend, Mr. Williams points out.

"Over the long term, we hope it will produce fewer losses and less severe losses," he says.

That seems to be the case for at least one class of medical practitioners.

Anesthesiologists, who became almost uninsurable at the height of the malpractice crisis of the mid-1970s, have benefited from improved loss prevention practices and can now breathe a small sigh of relief at insurance renewals, some underwriters say.

Dr. Joseph Sabella, president of Santa Monica, Calif.-based The Doctors Co., a major insurer of physicians and surgeons in the Western United States, points to anesthesiologists as one medical malpractice "success story."

The Doctors Co. has just lowered anesthesiologists' risk classification, upon which insurance rates are based, for a second time. Anesthesiologist policyholders in California and Nevada are among a handful of medical malpractice policyholders who will see only minimal increases this year, if any, Dr. Sabella predicts.

The experience of these practitioners has "improved dramatically," he says. Through safer methods of practice and use of more sophisticated equipment, "They've essentially cured their own problem."

A fellow California malpractice underwriter agrees, noting that the category "has greatly improved over what it was 10 years ago."

While malpractice rate increases are being felt by physicians across the country, some of the largest are being felt by policyholders in New York. The New York Insurance Department recently granted the Medical Malpractice Insurance Assn. a 52% rate hike for its 900 policyholders, and other underwriters in the state are expected to seek similar increases (*BI*, March 4, Jan. 21).

For example, Medical Liability Mutual Insurance Co., a captive of the New York State Medical Assn. with about 15,000 policyholders, filed March 1 for a 60% rate increase, according to Donald J. Fager, assistant secretary and treasurer.

Since that increase would put MLM's rates in line with those of MMIA, the Insurance Department is expected to approve the increase. The higher rates would be retroactive to the policy year beginning July 1984.

Mr. Fager says the company may ask for another increase in July 1985, but he can't estimate how much.

The company raised its rates 25% in 1983, 15% in 1982, and 26% in 1981. All the increases were less than had been requested, Mr. Fager points out.

The average paid medical malpractice claim for physicians and surgeons in New York cost $119,000 in 1983, up from $36,000 in 1976, Mr. Fager says.

As one New York underwriter puts it: "The severity is killing us. Emotionally-charged juries are handing over the world for pain and suffering awards."

However, increases in claims frequency and severity aren't limited to New York, and policyholders in many other states also are seeing their malpractice costs rise.

State Volunteer Mutual decided two weeks ago to raise rates an av-

Continued on facing page

Continued from facing page
erage of 15%, effective May 1, Mr. Williams says.

He points out that, depending on their specialty, some policyholders will see their rates increase by as much as 40%.

The doctor-owned company increased annual rates by about 18% last May, largely because of a 40% increase in claims frequency in the second half of 1983, up from the second half of 1982, explains Mr. Williams.

Last year, frequency was up about 5%, and severity up about 10%, he estimates. The company generated $27.7 million in gross premium volume in 1984.

The company paid out about $10 million in losses and set aside an additional $22 million in reserves for unpaid losses, according to Mr. Williams' estimates.

Increases for physician and surgeon policyholders of The St. Paul Cos. Inc., the largest medical malpractice insurance market in the United States, will average about 25% to 30% this year, according to the company. This follows a 28% increase last year, a 16.5% increase in 1983 and a 14.5% increase in 1982.

The average physician or surgeon policyholder now pays St. Paul about $7,000 in premium annually for malpractice limits of $1 million per occurrence and $1 million aggregate, according to the company.

St. Paul expects to generate about $350 million in premium this year from physicians and surgeons.

St. Paul cites both frequency and severity as the stimulus for rate increases.

For instance, last June, the company reported 16 claims per 100 insured physicians, at an average cost per claim of $22,400. That's up from 10.5 claims per 100 physicians in 1980, when the average cost per claim was $15,000.

Chicago-based CNA Insurance Cos., which has about 10,000 physician and surgeon policyholders, is also raising its rates.

Effective Jan. 1, policyholders saw increases ranging from an average of 20% in San Diego County, Calif., to an average of 73% in West Virginia, said William G. MacLean, assistant vp-professional liability at CNA.

The company offers both occurrence and claims-made coverage. Most of its policyholders carry limits of at least $1 million per occurrence and $1 million aggregate, Mr. MacLean says. CNA wrote $75.4 million in physicians and surgeons malpractice premium last year.

CNA's rate increases in 1984 ranged from 8% to 17%.

Louisiana Medical Mutual Insurance Co. is raising rates paid by physicians and surgeons by about 17% this year.

This rate increase follows a 7.5% increase last year, and a 7% increase in 1983, according to Dr. Gerald R. LaNasa, president of the Metairie-based company.

The increases reflect rising defense costs and hikes in claims severity, Dr. LaNasa says.

Most of the company's 2,300 policyholders carry limits of $100,000 per occurrence and $300,000 aggregate, and about 60% carry excess limits of between $500,000 and $5 million, most commonly $1 million, he says. The company reported $10 million in written premiums last year.

The company issues policies on an occurrence but not a claims-made basis, and requires no deductible. The company retains the first $100,000 of each loss, after which the state's patient compensation fund pays losses up to $500,000. The remainder of the risk is reinsured by General Reinsurance Corp.

Although General Re is shying away from issuing medical malpractice policies on an occurrence basis (*BI*, Oct. 22, 1984), the Louisiana company convinced the reinsurer to stay on its risks, Dr. LaNasa says.

The Doctors Co. has recently mailed notices of rate increases to policyholders that will take effect April 1, according to Dr. Sabella.

"All the companies are increasing their rates now—both the commercial and the doctor-owned ones," according to Dr. Sabella.

The Doctors Co. is implementing across-the-board increases of 25% in Nevada, Wyoming Montana and San Diego, Calif.

Other policyholders in Southern California will see a 26% increase, and those in Northern California will see an 18.25% increase, Dr. Sabella says.

However, the company has lowered the risk classification of certain categories, among them urologists, dermatologists and anesthesiologists. These policyholders will not see increases as large as others.

The Doctors Co. has about 8,500 policyholders in California and about 1,000 others in Montana, Nevada and Wyoming. The company generated $71 million in direct written premiums in 1984.

The increases are attributable to about a 15% annual increase in both claims frequency and severity, Dr. Sabella points out.

The Medical Insurance Exchange of California, a San Francisco-based reciprocal, will also raise rates at the start of its next policy year on Aug. 1, reports William K. Scheuber, president of Medical Underwriters of California, which manages MIE.

The actual increase has not yet been determined, he says, but will likely be only 5% to 15%, and might only be applied to certain claim-prone professionals, such as obstetricians.

MIE, which has 3,500 physician and surgeon policyholders, raised rates last year 15% to 20% in Idaho and Nevada and about 10% in Hawaii, Mr. Scheuber says. The 10-year-old company also writes in California and Alaska, and took in about $20 million in direct written premiums last year.

While reinsurance cutbacks are affecting availability of malpractice insurance for hospitals (see story, page 1), they are not affecting physicians and surgeons, sources say, primarily because doctors seek much lower limits than do hospitals.

Dr. Sabella says The Doctors Co. recently renewed its reinsurance treaties at the same rate it paid last year. Its reinsurance is written on a claims-made basis by non-U.S. underwriters.

He has not encountered difficulties in obtaining reinsurance or providing desired limits. "There's no problem in capacity or availability of insurance in California," he says. ■

AMA plan to cut malpractice rates opposed

The American Medical Assn.'s recent proposals to lower malpractice insurance costs are meeting with opposition from leaders in the legal community.

An AMA task force on medical malpractice and insurance recently proposed four major judicial reforms aimed at reducing the insurance premiums of both physicians and hospitals.

The changes the AMA is seeking are:

- Limiting the percentage of awards that plaintiffs' attorneys receive as contingency fees in malpractice suits.
- Eliminating punitive damage awards in malpractice suits.

Limiting awards for mental anguish and pain and suffering.

- Permitting or requiring courts to award damages through structured settlements rather than in one lump sum.

The AMA is encouraging its members to garner public support for these measures and to lobby for them at the state and local level, explains Dr. James E. Davis, the speaker of the AMA's House of Delegates. Dr. Davis is also president of Medical Mutual Insurance Co. of North Carolina, a physician-owned medical malpractice insurer in Raleigh.

But the group is receiving opposition from two prominent law groups, the Washington-based American Trial Lawyers Assn. and the Chicago-based American Bar Assn., both of which object to changes in the judicial process to address the medical malpractice dilemma.

"It looks like there is a serious problem, but not a tort system problem. If an individual doctor is paying a large percentage of his income for insurance, it's an insurance problem," says an ATLA spokesman.

"We think insurance companies aren't in as dire shape as they say, and are making a whole lot more money than they're willing to talk about," he says. "If they've been losing money as long as they say they have, why are they still in it?"

John C. Shepherd, president of the ABA, says some of the AMA's proposals are "narrowly focused" and "so exaggerated and so critical of our legal system that I have to disagree (with them)."

For example, Mr. Shepherd, a defense attorney with Shepherd, Sandberg & Phoenix in St. Louis, says that establishing standards that apply only to the medical profession is "not well thought out and not warranted."

Dr. Davis, however, contends that the AMA's proposals are valid. "Physicians are held to a standard of care that no one else is held to. The public expects a perfect result the first time out," he explains.

Mr. Shepherd of the ABA maintains that punitive damages are applicable in malpractice litigation. "The concept of punitive damages is to act as a deterrent to inappropriate conduct," he says.

But the AMA's Dr. Davis says, "We really don't think punitive damages have anything to do with professional liability." It's inappropriate to subject professionals who work in "a continually changing, inexact science like medicine" to punitive action, he says.

However, Mr. Shepherd says punitive awards have not really been troublesome for the AMA's member-physicians, noting that the ABA's recent five-year study of malpractice cases couldn't find one appellate decision in the United States that upheld a punitive damage award against a doctor.

Mr. Shepherd also contends that limiting the size of an attorney's contingency fee violates constitutional rights to contract. Plaintiffs have the right to enter any type of agreement with an attorney that they wish, he says.

And, according to the ATLA, "The contingency fee is the only way for the injured poor person to take on a legal issue with talented help. It opens up the door to both poor and middle-class plaintiffs."

But, the AMA's Dr. Davis says contingency fees are placing an increasingly smaller portion of the award into the plaintiff's hands. The AMA wants a cap placed on the lawyer's fee, with the percentage decreasing as the size of the award increases.

The AMA also wants to limit awards for pain and suffering, whose amounts Dr. Davis says have been "blown out of proportion."

But doing so would be "inherently unjust" and would limit compensation only to those plaintiffs whose injuries are apparent and physical, the ATLA says. ■

Chicago RIMS honors Hines in symposium

CHICAGO—The Chicago Chapter of the Risk & Insurance Management Society, in conjunction with the Insurance School of Chicago, will present an insurance economics symposium in memory of the late Harold H. Hines Jr., former president and chief executive officer of Rollins Burdick Hunter Co.

The symposium will be held from 3 to 5 p.m. April 11 at the Union League Club, 65 W. Jackson Blvd. in Chicago.

The symposium will feature an informal seminar for financial officers, risk managers and other members of the financial community on the crisis in insurance costs, followed by a presentation of formal papers on the subject of insurance economics written by speakers at the seminar.

Speakers will include Robin A.G. Jackson, director, Merrett Holdings P.L.C.; Donald E. Harder, vp, National Accounts Department for the CNA Insurance Cos.; Ed Overman, president of the American Institute for Property and Liability Underwriters Inc.; and C. Arthur Williams, professor of economics and insurance at the University of Minnesota.

The symposium is being held in memory of insurance executive Mr. Hines, who died suddenly last summer.

In addition to the post of president of Rollins Burdick Hunter, Mr. Hines had served as president and chief operating officer of Ryan Insurance Group Inc. and executive vp of Combined International Corp. Before joining Ryan, Mr. Hines held several positions with broker Marsh & McLennan Inc., including president and vice chairman.

After the symposium, Patrick G. Ryan, president and chief executive officer of Combined International Corp., will host a reception for those in attendance.

There is no charge to attend; reservations can be made by calling the Insurance School of Chicago, 312-427-2520. ■

Benefit managers find job fulfilling: Survey

Continued from page 3

with their company for nine years or more.

"Not only are they satisfied with their jobs, but with their companies as well," the Segal spokesman noted.

More than 90% of the benefit managers who responded to the survey said they hope to still find themselves in the benefits field a year from now, and 66% reported they expect to remain in the field for at least five years.

Fifteen percent of respondents in 1984, however, reported that they would rather be in a different profession, compared with 12% in 1982 and 21% in 1980. Of this group, most said they were interested in the closely allied fields of personnel and consulting.

The No. 1 concern of benefits managers still appears to be—as it was in 1982—health care cost containment. The increase in health care costs was ranked second in importance in 1980, and it was ranked ninth in 1978.

Nearly all the respondents reported their department's workload has grown since 1982, with 76% also reporting an increase in responsibilities, accompanied in most cases by an expanded budget and staff growth.

Communicating benefit problems was the second-most important concern in 1984. Keeping abreast of changes in the law ranked third.

Tied for the fourth-most important issue was compliance with both the Employee Retirement Income Security Act of 1974 and the Retirement Equity Act of 1984, along with benefits design and coordination and company mergers, acquisitions and spinoffs.

In fifth place was compliance with the Deficit Reduction Act of 1984.

The spokesman noted that several well-publicized issues were not listed as concerns by many benefit managers, like the issues of age discrimination, day-care benefits and group legal services.

This was unusual, "given the attention that has been given to these areas," the spokesman noted.

The profile of the "average" benefit manager has remained, for the most part, unchanged between 1978 and 1984. The typical manager is most likely to be a college-educated male in his late 30s or 40s.

The number of female benefit managers has increased significantly since the last survey in 1982, the spokesman said. Some 29.5% of the benefit managers surveyed in 1984 were women, compared with 17.6% in 1982.

The average benefit manager is slightly younger than in previous years, the survey indicates, with the average age of respondents dropping to 40.3 years in 1984 from 42.2 in 1982.

Almost 80% of those surveyed were either in their 30s or 40s; 12% were in their 50s; and only 3% were over age 60. Five percent were in their 20s.

Ninety-three percent of respondents were college graduates, compared with 87% in 1982. Slightly more than half—50.5%—reported they had degrees in business and related subjects, including finance, economics or management. The largest single group, 16.8%, however, reported they had majored in the humanities.

More than one-third of respondents indicated they had graduate degrees. Of those with graduate degrees, 63.3% pursued business-related subjects. An additional 8.3% earned law degrees, and 11.6% earned advanced degrees in the humanities or psychology.

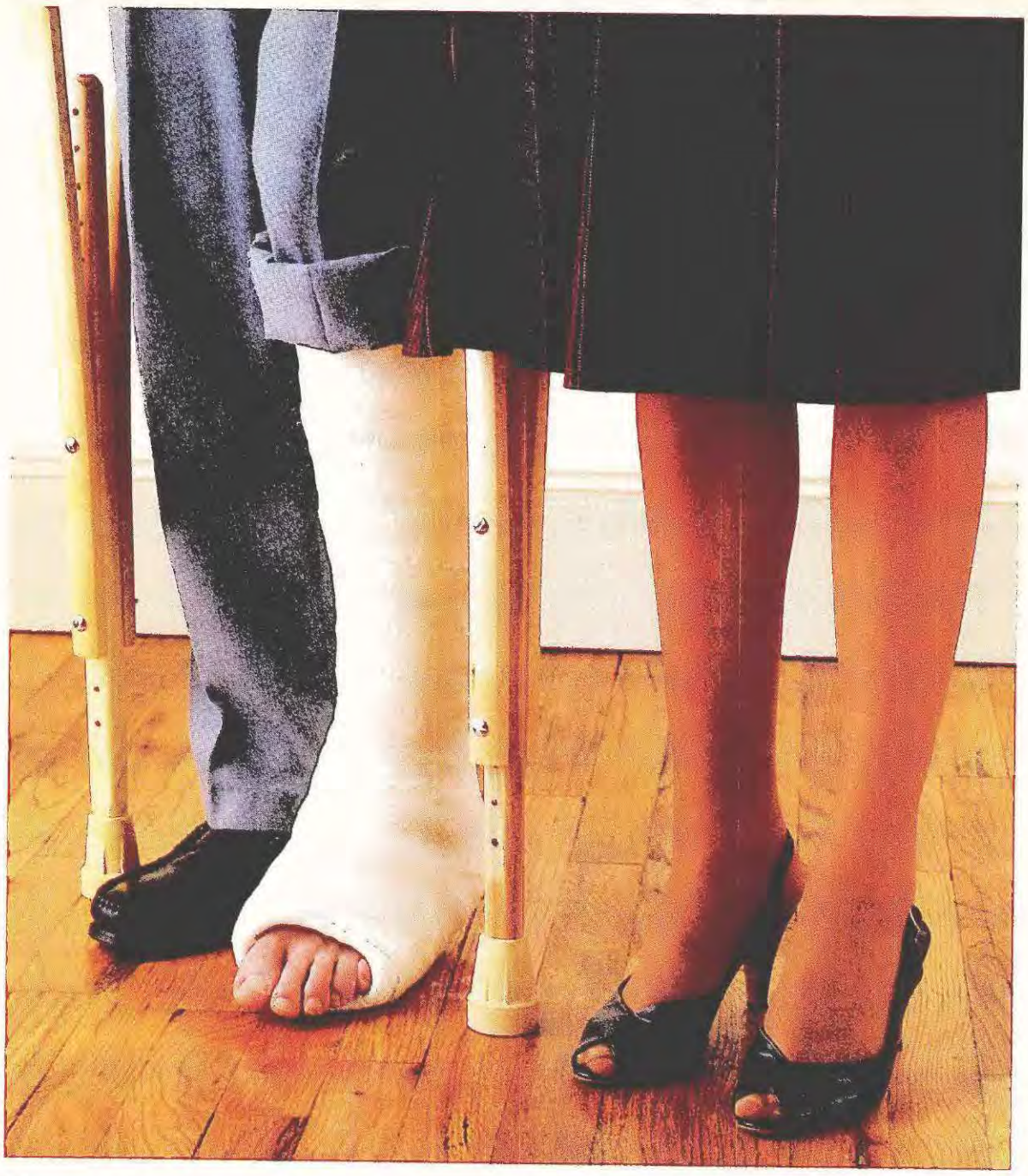
A large number of respondents—42%—entered the benefit management profession via jobs in personnel management or industrial relations. Other springboards indicated in the survey were insurance companies, 19%, and accounting, 12%. A small number also reported entering benefit management after leaving financial institutions, consulting, actuarial and data processing and the legal profession.

Close to half of the respondents—48.6%—worked for manufacturing companies. The next-largest employer category was finance, 14.3%, followed by retail trade, 7.9%.

Respondents worked for companies with annual average sales of $1.9 billion and an average of 16,040 employees.

●

Free copies of "A Confidential Survey of Benefit Managers" are available by writing to Jack J. Friedman, director of information services, Segal Associates, Martin E. Segal Co., 730 Fifth Ave., New York, N.Y. 10019.



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ALIVE AND WELL

Tight market fosters captives, despite tax changes

Illustration: Roger Schillerstrom

By Sidney Pine

I PREDICT THAT we will see in 1985 and 1986 a considerable increase in the number of new captives. These will include both wholly owned and group captives. At the current time, management companies, as well as lawyers and accounting firms involved in this area, are reporting a sharp increase in both the number of inquiries and in the number of retainers.

I make this prediction in spite of a number of published articles that have forecast the demise of the captive. (It is not surprising that several of the authors are the same persons who ridiculed the captive movement in the 1950s and who forecast then an early death for the movement.)

The captive movement had its greatest growth in the 1960s for property coverage and in the 1970s for casualty coverage. During that time, hundreds of multinationals and large industry groups formed Bermuda-based and other offshore captives. These included almost half of the Fortune 500 companies. Today, the total number of captives worldwide is almost 2,000.

Why did these companies adopt the captive? What was the primary purpose and motivation? The answer is clear. Companies, especially in the 1970s, were either unable to get the coverage they needed or, if coverage was available, the cost was considered unreasonable.

Included in the exposures that the commercial market would not or could not insure were confiscation, strikes, product guarantee, product recall, environmental risks, pollution, nuclear fallout and numerous other risks.

Many companies were unable to get any coverage for such exposures as professional liabilities for malpractice, oil operations, certain marine and aviation risks, utilities and others.

Finally, large companies and industry groups found that where some insurance was available the price was, in their opinion, exorbitant. For example, for product liability and malpractice exposures, the premiums often increased to ridiculous levels that exceeded the aggregate limits provided.

Those who predict the doom of the captive base their predictions upon the loss of tax advantages. They state or infer that the sole or, at least, the primary reason why multinationals formed captives was to obtain tax advantages.

This is just not so.

Although many of the parents of captives did enjoy some tax advantage, the real reason—the primary inducement—was to obtain needed coverage at reasonable prices.

A crisis had developed. The undercapacity of the market forced these companies and groups to seek some other alternative.

I have been involved completely or, at least to some degree, in the formation of captives for more than 200 multinationals and numerous group captives. I dealt with top management of these companies and groups and know from our meetings and conversations that their reasons were as stated above, i.e., the inability of the commercial market to perform.

These companies and groups were forced to find adequate protection at reasonable cost. After investigation and study, they chose as the alternative the captive insurance company.

Approximately 2,000 companies with captives (some for as long as 30 years) have enjoyed:

- **Reduced insurance costs.** This was most often mentioned as the primary reason for the formation of the captive during the capacity crunches of the 1960s and 1970s.

The captive eliminated or sharply reduced such costs as broker or producer commissions and other acquisition or sales costs, including expenses for marketing, advertising and administration, and the duplication, in many cases, of engineering and inspection services performed by both the commercial insurer and the policyholder.

Insurance experts familiar with the past operations of captives estimate these costs alone have accounted for about 35% of the standard commercial premium. Also, experience has shown that a captive, especially an offshore captive, can usually obtain cheaper excess loss coverages and, often, on better terms.

- **Insurance for risks not obtainable in the commercial market.** In most cases, this was either the first- or second-most important reason for the captive during the 1970s. Even during the soft market of the last seven years, captives, often with the help of the more flexible reinsurance market, were able to insure risks otherwise uninsurable. In addition, broader coverage has been available to the captive.

Most companies prefer a consolidated insurance program for the parent and all of its subsidiaries. A captive makes possible the same coverage for all countries. The captive accomplishes this by providing direct insurance in those countries that legally permit it, difference in conditions coverage in other countries and reinsurance of fronting companies in countries with mandatory stated perils or restrictive laws.

- **Increased cash flow and investment income.** This has been and continues to be one of the more important inducements for the formation of the captive

Continued on next page

Sidney R. Pine is counsel to the law firm of LeBoeuf, Lamb, Leiby & MacRae in its New York office. Mr. Pine has advised numerous clients on the establishment and operation of captive insurance companies.

perspective

Tax changes won't be the death of captives

Continued from preceding page
and for its continuance. This advantage has been most appealing to financial vps and treasurers.

The captive has the use and enjoyment of the premiums paid by its parent and subsidiaries. The cash flow thus generates benefits for the corporate family rather than a commercial insurer.

An increased cash flow is possible even where the captive reinsures part or most of the risk with a commercial reinsurance company. Reinsurance premiums are generally payable as earned, at the close of a predetermined period, usually quarterly. Because gross premiums are traditionally paid in advance, the captive retains the investment income on the premium payable to the reinsurer during the period of this "float."

• **Direct access to reinsurance markets.** Reinsurance is the keystone of an effective operation of a captive. Since reinsurance companies generally deal only with other insurance companies, a captive is one way of gaining access to the reinsurance market, which often means lower-priced insurance. Reinsurers are the "wholesalers" of the insurance industry. Reinsurers are flexible and creative.

Access to this market opens up possibilities for financing risks that are not available or permitted in the primary market. Loss reserve discounting, portfolio transfers and sliding scale profit participations are a few of the examples.

Increased savings through pooling risks with other captives also involves reinsurance techniques.

Among the other advantages the captive enjoys are: complete freedom of investment; centralized insurance management; and the ability through reinsurance to move funds across national borders.

As I have said above, tax factors played a non-controlling role in the decision to form the captive. Although desired, tax advantages were not, except to a few companies, the reason for the captive.

The elimination of a captive's tax advantages has had no impact on widely held group captives. Group captives, especially those with a sufficient number of shareholders (to avoid being classed as a "controlled foreign corporation"), continue to enjoy substantial tax advantages.

Among other benefits, premiums are deductible when paid, there is no current Subpart F tax, they can accumulate certain income tax-free and shares can be sold or redeemed or the captive liquidated and all gain taxable on a capital gains basis rather than as ordinary income.

With reference to wholly-owned captives, the tax situation is quite different.

Before Jan. 1, 1963, there were valuable tax advantages available to the multinational owning a captive. After that date, the captive of a multinational was deemed a "controlled foreign corporation" and under Section 953 of the Internal Revenue Code all of the captive's income from the insurance or reinsurance of U.S. risks was taxed each year to the parent multinational.

It has been estimated that more than 95% of all risks insured by captives in Bermuda, Cayman, the Bahamas and other countries in the Western Hemisphere are, in fact, U.S. risks. Thus, U.S. multinationals have, for years, been paying taxes on the income of their captives. Income from the insurance or reinsurance of foreign risks did escape current taxation under Section 953 of the tax code.

In 1972, the IRS adopted its position (later published as Revenue Ruling 77-316) that premiums paid by a U.S. company to its wholly-owned captive were not tax deductible under Section 162 of the code at the time of payment. It thus appears that at the time of the major increase in captives, the most significant tax advantages had already been eliminated. This, alone, would demonstrate that very few companies were motivated by tax advantages.

There remained some tax benefits for insuring or reinsuring foreign risks and for those international companies with substantial excess foreign tax credits. But these companies were relatively few in number, and these remaining tax benefits were largely eliminated by the Tax Reform Act of 1984.

If companies were formed solely because they had substantial excess foreign tax credits or to avoid taxes on income from the insurance of their foreign risks, they have by now discovered that they have been stripped of almost all these tax benefits. I would expect that such companies, if they have no other purpose, would or should liquidate their captives or cease operations.

There is, in addition, incontrovertible proof that avoidance of tax was not the primary reason for forming captives.

It is a fact that not a single captive writing primarily the parent's risks has been liquidated or ceased to function as an insurance company for tax reasons.

Why should they? They are generally well managed, obtain the capacity they need and have a combined ratio of well below 100%. Compare this with the commercial insurance industry with an average combined ration of about 120%.

I repeat my predictions that during the new few years, at least, there will be a subsequent aggregate increase in the number of new captives.

Look at the commercial market today. There is a severe undercapacity. Premiums have increased substantially. Insurance companies are demanding higher and higher retentions. Insureds are finding it impossible to obtain all of their needed insurance not only in the products liability and malpractice areas but for many other coverages.

Does this sound familiar?

They are exactly the conditions that existed in the commercial market in the early 1970s. Again, large companies and substantial groups must find an alternative. The captive, in my opinion, is the logical choice. ■

No benefits for asthma caused by emotional trauma

Asthma attacks allegedly brought on by emotional trauma after discovering an employer's alleged defalcations were not compensable injuries entitled to an award of workers compensation, a Florida appellate court ruled.

Betty Warren was employed as the legal secretary, office manager and bookkeeper for a law firm. Ms. Warren had suffered from non-disabling chronic asthma since 1968, and her condition was well-controlled with medications.

On Nov. 27, 1981, while Ms. Warren undertook to balance and reconcile the firm's trust account, she discovered certain discrepancies and irregularities that led her to believe that one of the partners might have improperly withdrawn approximately $16,000 from the account funds. She attempted to discuss this with the partner, but to no avail.

Immediately, Ms. Warren's asthma worsened to the point that her medications were not controlling it. On the morning of Dec. 1, 1981, while she was on the way to see her doctor, Ms. Warren stopped at her law firm's office in order to attempt to speak to the partner, but again he refused to talk to her.

Ms. Warren proceeded to her doctor's office, but the doctor was unable to relieve her attack. Ms. Warren then was hospitalized for five days, and she required several months of treatment thereafter. Ms. Warren filed for and was awarded payment of past medical bills. The employer appealed the award.

The appellate court concluded that because Ms. Warren's attack was not precipitated by any physical condition to which she was exposed in the workplace and because no unusual physical effort or event occurred, the emotional strain alone was an insufficient causal connection to establish a compensable injury. *Wolbert, Saxon & Middleton vs. Warren*, District Court of Appeal of Florida, Jan. 20, 1984; rehearing denied, Feb. 13, 1984 (*BI*/01/M.-$5)

These abstracts were prepared by Cases Unlimited Inc. A copy of an entire decision may be obtained by sending a check for $5 made out to Cases Unlimited to Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. List the number for each opinion.

legal briefs

Montana court rules on punitive damages

The Supreme Court of Montana ruled that public policy permitted insurance coverage of punitive damages in that state.

A bank was named as a defendant in three wrongful repossession cases. Transamerica Insurance Co. undertook the defense of the bank under an insurance policy issued to the bank.

However, Transamerica reserved its rights under the insurance contract with the bank and denied any coverage for punitive damages under the insurance contract.

Transamerica argued that Montana public policy forbids such coverage for punitive damages. The federal trial court, where the repossession suit was filed, requested the Montana Supreme Court to determine what the Montana law was on the question.

The state Supreme Court said that it found nothing in the state Constitution declaring a public policy on the question of punitive damages. Nor could the court find anything in the state statutes amounting to an express statement on this public policy issue.

The court rejected Transamerica's argument that because punishment is an explicit aim of punitive damages there can be no punishment if a defendant is permitted to, in effect, "shift" the financial burden of the imposed punishment to his insurer.

In addition, the court observed that empirical observation informed it that many kinds of willful and wanton conduct are never successfully deterred by punitive damage awards. *First Bank (N.A.)—Billings vs. Transamerica*, Supreme Court of Montana, April 3, 1984 (*BI*/02/M.—$5)

Unborn child's domicile is that of his mother

The domicile of a child not yet born at the time of his father's injury was the mother's domicile at the time of the child's birth, according to a ruling by a New Mexico appellate court.

Therefore, the court ruled that since the domicile in this case was outside the United States, the child was not entitled to dependent benefits.

On March 19, 1981, Guillermo Ponce was employed as a ranch hand on a New Mexico ranch. While shaking a rabbit out of a 30-foot movable aluminum irrigation pipe, the pipe came into contact with a high-line electric line. Mr. Ponce died of electrocution.

At the time of the accident, Mr. Ponce lived on the ranch with Marcelina Herrera who, although she was not married to him, was pregnant with his child. Following the death of Mr. Ponce, Ms. Herrera returned to Mexico. There she gave birth on Oct. 4, 1981, to the child, Guillermo Gomez.

This claim for dependent's benefits was filed on the child's behalf. The trial court ruled in favor of the child.

The appellate court reversed, stating that a minor at the time of birth has the same domicile as the parent with whom he lives.

According to the court, it was undisputed that the mother's domicile at the time of her child's birth was Mexico. Thus, that was her child's domicile, according to the court.

Since his domicile at birth related back to the time of the injury, the child was not resident or domiciliary of the United States at that time, the court said, and had no claim for benefits. *Gomez vs. Snyder Ranch*, Court of Appeals of New Mexico, Dec. 6, 1983; *Certiorari Quashed*, March 20, 1984 (*BI*/03/M.-$5) ■

The Ask a Benefit Manager column by Joseph Duva, regularly scheduled for this issue, will appear instead in the March 25 issue.

1984 retirement law to boost pension plan participation

By JERRY GEISEL

washington

WASHINGTON—More liberal pension plan participation and vesting rules laid down by the 1984 Retirement Equity Act (*BI*, Aug. 20, 1984) will add several thousand people to the nation's pension plans, according to the Employee Benefit Research Institute, a Washington-based benefits think tank.

An REA provision that lowers the age at which a pension plan must allow workers to participate to 21 from 25 will add about 583,000 new plan participants in 1985, EBRI estimates.

Also, an REA provision that lowers the earliest age at which vesting credit must be given for service to 18 from 21 will add 325,000 vested workers this year.

Another provision, which requires pension plans to offer to all workers who have vested the option of electing a survivors' benefit, will result in 44,000 people collecting survivors' benefits this year.

Before the REA's enactment, many retirement plans only offered the survivors' benefit option to vested workers who also had reached the plan's early retirement age, which usually was 55.

More information on the REA is contained in an EBRI issue brief "Impact of Retirement Equity Act," available for $10 from EBRI, 2121 K St., N.W., Suite 860, Washington, D.C. 20036.

Pension study urged

House Ways and Means Committee Chairman Daniel Rostenkowski, D-Ill., says Congress should take a broader look at pension plans.

"Too often in the past, we have looked at individual vehicles in isolation and from strictly a tax policy perspective rather than in conjunction with Social Security program issues," Rep. Rostenkowski says.

Rep. Rostenkowski says he wants to learn "whether there is a retirement income policy in this country" and to what extent the tax law and Social Security are meeting retirement income goals.

IRAs surveyed

Some 23 million households have opened Individual Retirement Accounts, but many more IRAs would be set up if Congress liberalized contribution and withdrawal rules, according to a new survey.

For example, if Congress allowed IRA funds to be withdrawn without penalty for the purchase of a home, education expenses or financial emergencies, some 19 million more households might set up an IRA, according to the Investment Co. Institute, a Washington-based association of mutual funds. An IRA owner who withdraws funds for any reason before age 59½ now incurs a 10% tax penalty.

Also, if Congress increased to $4,000 from $2,250 the maximum annual amount an employee with a non-working spouse could contribute to an IRA, some 5 million more households might open or expand IRAs, the Institute says, based on survey projections.

Data for the survey was obtained from 3,500 households that responded to a questionnaire developed by the Institute and Market Facts Inc., a market research firm.

Group coverage varies

The extent of group health insurance coverage varies by race, national origin and geography, the U.S. Bureau of the Census reports.

Some 78.1% of whites were covered by employer-provided health insurance plans during the last three months of 1983, the Census Bureau says in a population report "Economic Characteristics of Households in the United States."

However, just 54% of blacks and 52.1% of those of Spanish origin were in employer health care plans during the same period.

Geographically, coverage in employer-provided health care plans was highest in the Northeast, where 89.7% of the population had coverage. Elsewhere in the country, 87.9% of those in the Midwest were covered by employer plans, 81.7% of those in the West were covered and 81.3% in the South were covered. ■

Howden Insurance Services promotes Clay

Robert B. Clay has been promoted to president and chief operating officer of Atlanta-based Alexander Howden Insurance Services, an excess/surplus lines unit of Alexander & Alexander Services Inc. He had been executive vp.

Mr. Clay succeeds **Dave Wolf Jr.**, who has been elected vice chairman of Howden Insurance Services. Mr. Wolf, who had been president of the company since it was formed in 1981, continues in his post as chief executive officer.

Other excess/surplus changes:

Patrick S. O'Flynn named chairman, president and chief executive officer of Interstate National Corp. in Chicago and its subsidiaries. Mr. O'Flynn remains executive vp-specialty lines for Fireman's Fund Insurance Co., Interstate's parent. He succeeds Donald E. Jeffers, who retired.

Richard E. Stone named chairman and chief executive office of L.W. Biegler Inc., following the retirement of **Louis W. Biegler**. Mr. Stone joined the Chicago-based underwriting manager as vice chairman in 1984. He had been president of First State Insurance Co.

Robert M. Plunk promoted to executive vp at Preferred Risk Mutual Insurance Co. in West Des Moines, Iowa.

comings & goings: industry

Insurers

Shepard P. Pollack named president and chief executive officer of Fire man's Fund American Life Insurance Co. in Novato, Calif.

James W. Cannon and **Roger H. Eigsti** named executive vps at SAFECO Corp. in Seattle. Mr. Cannon will continue as president of SAFECO's property and casualty insurance subsidiaries, and also assume responsibility for SAFECO's administrative services. Mr. Eigsti, previously president of SAFECO's life and health insurance subsidiaries, will be responsible for the company's investment, credit, surety and controller's departments. Replacing him as president of the life and health units will be **Richard E. Zunker**. Mr. Zunker served most recently as senior vp in charge of group and pension operations.

At SAFECO Insurance Co. of America in Seattle, **James Burkett** and **Dan McLean** elected senior vps. Also, three regional vps named: **Karl Kreitzer**, Northeast Region in St. Louis; **Michael Whitely**, Southwest Region in Denver; and **Wesley Malcolm**, Southeast Region in Atlanta.

Liberty Mutual Insurance Co. in Boston has made the following executive-level changes: **Gary L. Countryman**, presiden: of the company since 1981, given the additional designation of chief operating officer. **William E. Commack** also named executive vp. He had been vp and manager of Liberty Mutual's Southwest Division, headquartered in Dallas. And, **James L. Walker** replaces Mr. Commack as vp and manager of the Southwest Division. Mr. Walker had been assistant vp and assistant manager of the company's Middle Atlantic Division, headquartered in Bala-Cynwyd, Pa.

Justin N. Tierney named president and chief executive officer at NORCAL Mutual Insurance Co. in San Francisco. Mr. Tierney succeeds **Stuart D. Menist**, who retired. Mr. Tierney previously had served as president of British-American Insurance Co. Ltd. in Nassau, Bahamas.

Mr. Tierney

Frank Ceraolo promoted to vp of Beaver Insurance Co. in San Francisco. Mr. Ceraolo, who joined Beaver in September 1979, previously was a resident vp. He also will continue to be responsible for operations in Southern California.

Steven J. Smith appointed executive vp-Office of the Chairman of the Continental Corp. Mr. Smith, who joined Continental in 1982, had been senior vp in the chairman's office.

Reinsurance

C.E. Erickson named executive vp of Reinsurance Underwriters Corp. and RUC's parent company, Signet Reinsurance Co. in Convent Station, N.J., units of the W.R. Berkley Group of Cos. Mr. Erickson, who will continue to perform the duties of secretary of the corporation, joined RUC and Signet Re in 1977.

Brendan M. Finn and **Joseph P. Pazdan** named principals of Towers, Perrin, Forster & Crosby in Philadelphia. Mr. Finn most recently served in the casualty facultative department at the company's San Francisco office. Mr. Pazdan worked in the casualty facultative department at the company's Hartford, Conn., office.

Also, **Stewart H. Steffey Jr.** joins Towers, Perrin, Forster & Crosby in Philadelphia as vp and senior administrative officer. Mr. Steffey was senior vp of CIGNA Corp.'s Property Casualty Group.

Agents/brokers

Richard K. Kerr named partner with Arthur L. Owen Co., a Dallas-based retail insurance firm that specializes in petroleum, real estate, banking and mercantile risks. ■

Deadline to sell Lloyd's agencies nears

Continued from page 2

Howden's underwriting agency, Alexander Howden Underwriting Ltd., is one of the largest at Lloyd's. It manages about a dozen Lloyd's syndicates, whose members include about 4,000 of the 23,438 names at Lloyd's. The syndicates have a 1985 premium capacity of about 185 million pounds (about $198 million).

Howden, the company spokesman said, has three options when it finally sells its managing agency:

- Howden can sell some or all of its managing agencies to its own underwriting management team.

Underwriters at AHUL, led by A.J. Fred Archer, have already presented a proposal for a management buyout to Howden executives, which is being considered, the spokesman noted.

Under the management buyout, the senior Lloyd's underwriters of AHUL would form a partnership and acquire outside financing, according to reports in the market. Sources say the price for the agencies offered in the buyout is 10 million pounds to 12 million pounds ($10.7 million to $12.8 million).

- Howden can court other bids for AHUL from other large Lloyd's underwriting agencies like the two largest independent agencies, Sturge Holdings P.L.C. and Creechurch Underwriting, the Merrett subsidiary.
- Howden may decide that AHUL should be bought by another financial institution outside of Lloyd's or be converted into a publicly traded company.

"No decision has been made," said the Howden spokesman.

Like other brokers, Howden executives have decided that the group will retain its Lloyd's member agency, which manages the affairs of individual Lloyd's names, a Howden spokesman confirmed. Under the Lloyd's Act, brokers may keep these members' agencies.

Lloyd's has not yet issued statistics on how many agencies have been sold to their underwriting managements or sold to other Lloyd's agencies.

So far, no agency has been sold to a company outside Lloyd's, "though one or two are in the wind," said the Lloyd's spokesman.

Although many of the large managing agencies have yet to be sold, some large divestments have taken place.

Lloyd's broker C.T. Bowring & Co. Ltd., for example, favored the management buyout alternative for its underwriting agency.

Negotiations began as early as 1983 to sell the agency to senior underwriters led by Murray Lawrence, said Bowring Chairman Gilbert Cooke.

While the sale of the Bowring managing agency to the group headed by Mr. Lawrence for an undisclosed sum was not finalized until earlier this year (*BI*, Feb. 4), "We never seriously contemplated doing anything else," said Mr. Cooke.

"It was the best thing for the Lloyd's market and the underwriting team and ourselves," Mr. Cooke said. "If the agency had gone to a third party, the underwriters may not have been comfortable and might have left and the whole thing could have crumbled."

"It is a question of whether the underwriters want to be sold to another body," said Paul Archard, a partner in Murray Lawrence & Partners, the group that bought the Bowring agency. "If you are sold to another agency, the syndicates may be fragmented, some going one way and some going another. We felt it was best to still be in one chunk."

Murray Lawrence & Partners independently manages 11 syndicates with a total 1985 premium capacity of 146 million pounds ($156.2 million). The agency employs about 200 people.

Several observers in the Lloyd's community say they are wary about another divestment option: selling managing agencies to large independent underwriting companies like Merrett and Sturge. They fear that divestment will breed "mega-underwriters" if the large independent agencies buy the divested companies.

But Creechurch, the Merrett subsidiary formed specifically to buy divested agencies, does not plan such action, said Mr. Robson.

"That is very far from the truth," he said. "I hope Creechurch might get a dozen syndicates, and we are very quickly reaching that. But we are very nervous about the fact that people might think we will bully the market, which is far from Merrett Holdings' plan.

'We are nervous that people might think we will bully the market,' said Mr. Robson.

So far, Creechurch has bought Pulbrook Underwriting Management Ltd. for 1 million pounds from Lloyd's broker Stewart Wrightson Holdings P.L.C. With the purchase of Pulbrook, Merrett now employs a total of 227 people and manages 10 syndicates with a 1985 aggregate premium capacity of 335 million pounds ($358.5 million).

Mr. Robson said he hopes that Anton Underwriting Agencies—the underwriting agency he headed before joining Merrett last year—will also come under the Creechurch wing when it is sold by Gibbs Insurance Holdings Ltd. He notes, however, that this is not a foregone conclusion.

Sturge also discounts fears that it will become a "mega-underwriter" by buying divested agencies from brokers. Sturge recently bought an 88% share in Edwards & Payne (Underwriting Agencies) Ltd. from Britain's largest broker, Sedgwick Group P.L.C., for 4.5 million pounds ($4.8 million).

Including that purchase, Sturge now controls 16 syndicates with about 440 employees and manages 470 million pounds ($502.9 million) in premium capacity, said Sturge Secretary Alexander Johnston Brown.

Sturge is not planning to make staff changes at its newly acquired agency, said Mr. Johnston Brown, adding, "The agencies are just reporting to a different holding company."

Although they say they are not attempting to become mega-underwriters, officials at Sturge and Merrett say their acquisitions of managing agencies make sense.

They note that the large, independent underwriting companies have the money to buy the agencies, while others, like the agencies' current management, may not have sufficient funds.

And, the independent companies say they can provide the backup support for syndicates that were formerly provided by the Lloyd's brokers. ■

Massachusetts to consider work comp reform proposals

Continued from page 3

delays and too many attorneys in the system," noted William J. McCarthy, general counsel to AIM.

AIM's proposal, which addresses every aspect of the system, is expected to add $40 million to the business community's work comp costs if enacted, he said. By comparison, the governor's proposal would add more than $125 million to workers comp costs, according to initial figures compiled by the National Council on Compensation Insurance.

However, under the current system, Massachusetts' work comp premium volume is estimated at $730 million in 1985 and is expected to increase at a rate of $100 million annually, Mr. McCarthy noted.

"We feel (some added initial cost) is sensible and necessary...to reform, stabilize and eventually reduce the cost of workers compensation," he added.

AIM, like the state's AFL-CIO, currently is scrutinizing the governor's package in preparation for the April hearing.

"We have continually collaborated with the governor on his bill....But, his benefit structure is open-ended," Mr. McCarthy said noting one of the many provisions upon which the AIM and the governor disagree.

Under the governor's bill, the cap on benefits to injured workers would be removed, "effectively making an injured worker a permanent total (disability case) from the beginning," Mr. McCarthy said.

Another aspect of the governor's proposal calls for changes to the administrative process, but the AFL-CIO maintains that many of these provisions are just additional layers of bureaucracy. "It's a system of delays now, but I'm not sure the governor's proposal will speed it up," said Martin Foley, the group's legislative director.

Although labor has its reform bill in the hopper for consideration, Mr. Foley said that, "in my deepest moments of despair" he believes the state's workers compensation act should be repealed and replaced with a return to the exclusive use of the tort system.

"When they put the Massachusetts workers compensation system into effect (in 1911), the business community was supposed to be protected from tort action, and the worker was supposed to get a paycheck," Mr. Foley said, noting that in most cases the business community still is protected from torts, but the workers are "starved."

Concerns about the long delays in the system—six to 12 months for a hearing on contested cases—also are shared by business, the insurance community and the governor.

In his bill, the governor calls for the establishment of at least three regional offices to end the bottleneck of a single centralized bureau. The governor's bill also calls for:

- An expansion of the Industrial Accident Board to 17 members from the current 12.
- The establishment of a direct pay system in which insurers must either begin payments immediately or notify the injured worker of a decision not to do so within 14 days of the receipt of a notice of injury.
- The creation of an expedited claims process, including the initiation of an active conciliation process designed to bring the parties to agreement before the first stage of adjudication.
- The establishment of specific deadlines at each level of the process for both the scheduling of conferences and hearings and the filing of orders and decisions.
- The establishment of a tightly controlled attorneys' fee structure, which includes the use of caps on all fees paid to attorneys by injured workers themselves.
- The establishment of a roster of impartial physicians to help end the battle of "experts."
- An annual assessment of insurers and self-insurers to adequately fund the Industrial Accident Board.
- The creation of a workers compensation advisory council to evaluate, monitor and file legislative proposals concerning all aspects of workers comp.

Like AIM and the labor group, the insurance industry also agrees with the need for workers compensation reform, but not on all aspects of the governor's proposal.

"We're in favor of the governor's general thrust....It's just in the specifics that we disagree," said Joseph P. Hegarty Jr., senior vp for the Alliance of American Insurers.

The Alliance will be among the various interest groups to testify before the joint legislative committee, and it is expected to stress the need for tougher credentials for members of the Industrial Accident Board. "We need good decision-makers," Mr. Hegarty said.

The industry also disagrees with a provision in the governor's package calling for a six-month moratorium on rate filings.

"If everyone agrees that the bill will cost money, then why should the insurance industry wait six months to make a rate filing?" asks Joseph DiGiovanni, vp with the Boston office of the American Insurance Assn.

"We favor reform of the system; we always have," he said.

But, the AIA says there are "good points and bad points" to each proposal that need to be worked out in the coming months.

Besides the provisions to speed up the system's administration, the governor's bill also calls for several changes in the benefits structure, including:

- A benefit supplement for totally disabled workers injured prior to 1982, which would be tied to the current state average weekly wage. The supplement would increase benefits 10% to 400%, depending on how long ago the injury took place.
- A cost of living allowance capped at a maximum of 5% a year for workers totally disabled for more than three years.
- The doubling of benefits for workers who suffer from loss of limb or bodily function.

It also calls for enhancements to the rehabilitation process:

- A mandatory referral of an injured worker to the state Office of Rehabilitation within 90 days after the injury.
- A guarantee of eight weeks of continued benefits after an injured worker completes rehabilitation and obtains new employment.
- A provision that maintains full benefits while an employee is being paid for participation in rehabilitation-related work training.

Other changes in the governor's proposal includes provisions for group self-insurance and the elimination of suits for loss of consortium and emotional distress brought by relatives of injured workers. ■

Report reveals lawsuits becoming more complex

SANTA MONICA, Calif.—In Los Angeles County, fewer lawsuits were filed per capita and judges' caseloads were smaller in 1980 than in 1930.

However, the cases have become more complex, according to a report by the Rand Corp.'s Institute for Civil Justice.

In 1930, the court "functioned largely as a debt collection agency," according to the report. But, the report said the system now "is preoccupied with personal injury suits," and these lawsuits are more complex and take more up of a judge's time.

As a result, the time for a case to come to trial has increased significantly, according to the study, which is called "Managing the Unmanageable: A History of Civil Delay in the Los Angeles Superior Court."

For example, the report says, "time-to-trial has increased dramatically from six months in 1940 to 40.5 months in 1941."

However, the report said, "Despite the persistent concern about delay in Los Angeles, there has been little or no consensus within the local legal and judicial community as to the optimal interval of time between the request for trial and the trial itself."

And, the authors of the report pointed out that, "Moreover, no matter what the actual time-to-trial was at any given point, we encountered widespread complaints that it was too long." ■

A&A to sell its insurers

Continued from page 2

in a "fourth-quarter estimated loss on disposal."

The company will announce the size of the losses, which A&A says will "substantially" impact its year-end earnings, on March 29.

It's not known whether the fourth-quarter losses will wipe out the net income of $17.9 million posted by A&A for the first nine months of 1984.

Although the underwriting units to be sold will continue their regular business operations, A&A will now report their results as discontinued operations.

According to Peter M. Densen, A&A's senior vp of finance, the Howden underwriting units to be sold include Sphere Drake, a London-based reinsurer, and Atlanta International Insurance Co., a domestic property/casualty insurer.

Sphere Drake booked net premiums of $73.6 million in 1983, but suffered underwriting losses of $23.8 million that were only partially offset by $19.4 million in investment earnings. Overall, Sphere Drake produced a 1983 net operating loss of $4.4 million.

Atlanta International reported $13.6 million in net premiums in 1983. Net operating losses totaled $7.1 million, created by $20.2 million in underwriting losses and only $6.1 million of investment income.

Mr. Densen said A&A will not sell Trent Insurance Co. Ltd. or Hemisphere Marine & General Insurance Co. Ltd., two Bermuda-based insurers whose business is being run off.

And, A&A will not sell Evanston Insurance Co., an excess and surplus lines insurer managed and partly owned by A&A subsidiary Shand, Morahan & Co. of Evanston, Ill., he said. Evanston Insurance Co. reported $3.6 million in statutory net income in 1983.

A&A has hired the investment banking firm of Smith Barney, Harris, Upham & Co. to assist in selling the underwriting units.

In addition to the sale of these companies, A&A also is seeking buyers for its Lloyd's of London underwriting agencies, which manage Lloyd's syndicates (see story, page 2).

While the sale of the Lloyd's underwriting agencies is required by Lloyd's regulations, A&A is selling all its underwriting operations because, "We are a service company and we are better off concentrating our capital on the service business," Mr. Densen said.

A&A and Sphere Drake officials would not say how much is being added to the reserves of Sphere Drake. However, John A. Bogardus Jr., A&A's chairman and chief executive officer, noted that some of the reserves are for asbestos-related claims and an "increased frequency of claims on other non-marine lines."

Reserves have been added because of "heavy frequency" of losses on two reinsurance contracts written by Sphere Drake that generated 6.8 million pounds of premium and were canceled two weeks ago, noted Ian Dean, chairman and chief executive officer of Sphere Drake.

A&A officials noted last week that the reserve increase was in no way connected with the previous problems reported at the Howden underwriting subsidiaries.

A&A took a $40 million extraordinary charge against its third-quarter 1983 earnings to boost reserves at underwriting units after Alexander & Alexander sued former Howden officials for allegedly diverting $55 million in corporate assets including reinsurance funds from Sphere Drake.

Then, early last year, A&A announced that it would be forced to bolster the reserves of the Howden underwriting units, including Atlanta International, Trent and Capital Marine Insurance Co. Ltd. (*BI*, June 25, 1984).

The charge was made to the fourth quarter of 1983, and although A&A did not say how much was added to the reserves, most of the company's $21 million net loss in the fourth quarter of 1983 is believed to be traceable to the reserve strengthening.

Mr. Densen said the latest increase in reserves, charged to the fourth quarter of 1984, is due to "the overall state of the insurance market, new claims and deteriorating loss history. It is no longer anything to do with the Howden affair.

"We said that if we sold the companies they would have to be in a better position, and we have done that. Good management is in place and the turning point in the market is now."

A&A also commented that while its underwriting units are producing losses, its insurance brokerage and other operations are profitable.

"Net income from continuing operations for 1984, after segregating the subject underwriting companies, should meet our expectations," said Mr. Bogardus.

"Changed market conditions have produced gains in operation revenue in A&A's broking and consulting companies. We have also controlled operating expenses in those companies. Consequently, there were significant increases in 1984 fourth-quarter operating income over the fourth quarter of the comparable year," Mr. Bogardus said.

A&A reported a $3.3 million operating loss in the fourth quarter of 1983—before adding to the reserves of its underwriting units. ■

Future asbestos victims to be represented

Continued from page 3

And, he says, these future claimants are not now adequately represented by UNR or by the committees of unsecured creditors, even though the litigation has reached an advanced stage. A motion is pending to liquidate the company.

"These circumstances warrant the appointment of a legal representative for these putative victims of asbestos disease, who can work toward the involvement of these putative victims in these proceedings, and who can act as amicus curiae regarding matters of vital and immediate importance to these people," Judge Toles said.

He said that the representative will advise future claimants of their interests in the bankruptcy proceedings and will have a chance to comment on any proposed reorganization plan or any motions to liquidate UNR.

In effect, the representative would exercise the powers and responsibilities similar to an official creditors' committee, Judge Toles said.

But, he points out that his ruling itself does not designate the future claimants as creditors with a claim to any funds eventually set aside for asbestos victims through the reorganization process.

"The determination of whether putative asbestos disease victims are creditors of these estates, or whether their interests could be represented in these proceedings in a manner analogous to a class action, or whether these parties would be entitled to vote on a plan of reorganization, or whether their claims might be discharged in this bankruptcy proceedings, are all questions which can properly be addressed after putative asbestos disease victims commence actual participation in these cases," the court added.

"The court's order today is intended only to remove a. . .barrier which might have hindered the involvement of putative asbestos disease victims in these cases, and to give these victims some voice regarding the ultimate fate of these debtors which they currently do not possess."

Similarly, Judge Arlin M. Adams of the Third Circuit U.S. Court of Appeals said the court was not required to decide whether future claimants were "creditors" under the bankruptcy code.

"We need not reach the merits of these conclusions in order to ascertain that future claimants do have a sufficient interest to require some representation during the reorganization proceedings," the court said.

"Whether or not future claimants have claims in the technical bankruptcy sense that can be affected by a reorganization plan, such individuals clearly have a practical stake in the outcome of the proceedings."

"We conclude that future claimants are sufficiently affected by the reorganization proceedings to require some voice in them," the court added.

"Moreover, none of the parties currently involved in the reorganization proceedings have interests similar to those of future claimants, and therefore, future claimants require their own spokesperson."

The court added that it does not know at this point whether future claimants can or should be considered "creditors" under the code, whether constitutionally adequate notice can be provided to such a class or how best to solve a number of other problems that have not been argued.

However, attorneys for both UNR and Amatex say the recent decisions are still important because they lay the groundwork for resolving all asbestos claims—present and future—through the reorganization process. The asbestos producers want to cap all current and future liabilities by reorganizing.

The attorneys point out that it will not do much good if they resolve all of the present claims and emerge from reorganization only to face thousands of claims all over again.

When they filed for reorganization, UNR was facing nearly 17,000 claims and Amatex more than 10,000. But UNR estimates it may face between 48,000 and 68,000 future claims.

According to Amatex corporate counsel Victor Drexel, Amatex is "very pleased" with the Third Circuit decision.

"What it means for Amatex is that we now know we will get a guardian or representative whose duty will be to represent future claimants," he says.

"It means there will be somebody to speak in their behalf, and, therefore in my judgment, it makes an effective plan of reorganization that much more possible and probable. . .

"As a practical matter, without such a person in place, all you have is liquidation as an alternative," he added.

"Given the number of existing claimants and the amount of money that is available, there is clearly not enough (money) to go around" for future claimants, too.

Likewise, UNR attorney Malcolm Gaynor said Judge Toles' decision "facilitates coming up with a reorganization plan" for UNR.

"This is really the first step in being able to sit down with all the parties and come up with a reorganization plan," Mr. Gaynor said.

Mr. Gaynor of the Chicago firm of Schwartz, Kolb & Gaynor, says it is essential that future claims against UNR be discharged in bankruptcy.

He cited a recent report prepared for the bankruptcy court that shows UNR will face 48,000 to 68,000 future claims with an estimated present value of $210 million to $325 million.

Conservatively estimating the cost of present and future claims and the company's unsecured debt, total liabilities come to approximately double the $200 million book value of UNR's assets, according to Mr. Gaynor.

"We're not very satisfied with the decision," said Pace Reich, an attorney for the committee of creditors representing asbestos litigants in the Amatex case. He said it is uncertain whether the committee will file a petition for rehearing before the full Third Circuit Court of Appeals.

"I really do not know what is intended to be done other than the appointment of some sort of representative."

"What that representative is going to do and whether these people have rights in the proceedings or rights to distribution, I don't understand," Mr. Reich added.

According to the Third Circuit appellate court's decision, the committee's position is that future claimants "are not 'creditors' under the bankruptcy code and thus cannot participate in the reorganization. Of course, if future claimants are excluded from the reorganization plans, the current claimants will receive a larger portion of an obviously limited fund."

William Cuncannan, an attorney for the committee representing asbestos litigants in the UNR case, said the committee is appealing Judge Toles' decision to the U.S. District Court in Chicago.

Judge Tole's ruling in the UNR case differs from an original ruling by a U.S. District Court in Chicago. In the Amatex case, the three-judge panel overturned a decision by U.S. District Court Judge James Giles in Philadelphia. ■

Photo: David M. Spindel, New York City

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Final order issued in Hyatt case

Continued from page 1
the judge's ruling, both on the issue of defense obligation and on reformation of the policies.

Lawyers for Northbrook, CU and Highlands said the companies have not decided yet whether to appeal.

At the time of the accident, Hyatt had $201 million in liability insurance through 23 insurers, including a $1 million primary policy with Occidental Fire & Casualty Co. of North Carolina; a $25 million first excess policy written by Northbrook; another $25 million excess layer divided among Pine Top, Centaur Insurance Co. and Insco Ltd., all represented by underwriting manager Baccala & Shoop; a $25 million excess layer written by Columbia Casualty; and another $25 million layer divided among Pine Top, Federal and Highlands.

Hallmark had $101 million in liability insurance, with a $1 million primary policy and a $10 million first excess policy written by CU; a $50 million excess layer written by American; and a $40 million excess layer divided between Continental Insurance Co. and Republic Insurance Co.

Insurers on the Hyatt and Hallmark lines have already paid out roughly $90 million in judgments and settlements, according to John Aisenbrey, a lawyer with Stinson, Mag & Fizzell in Kansas City, representing Hallmark.

Jury awards to two victims of the collapse totaling $16.5 million are being appealed to the Missouri Supreme Court and have not yet been paid.

Only one injury case is still to be resolved. Moen L. Phillips, a Kansas City fireman called to the scene of the disaster, is suing Hallmark in Jackson County Circuit Court for $735,000 in actual damages and $426 million in punitive damages, claiming the accident caused him physical and mental injuries.

A motion by Hallmark to dismiss the suit is pending.

The two insurers whose layers are active for payment of indemnity claims are Columbia Casualty and American, which still has $29 million remaining on its limits. Most observers expect that the insurers in layers above these two will not be tapped for indemnity payments.

The insurance litigation began when Hyatt filed suit in state court in 1981, asking for a ruling on which insurers should indemnify it and in what order they should pay.

After Judge O'Leary entered his October 1982 order, both Hyatt and Hallmark insurers filed motions asking him to reconsider.

However, the judge maintained that since the Hyatt line comprised two-thirds of the total available excess coverage it should assume two-thirds of the losses, while the Hallmark excess insurers should assume one-third.

On the primary level, where both the Hyatt and Hallmark policies carried limits of $1 million, Judge O'Leary ruled that coverage should be shared on a 50/50 basis.

Commercial Union had argued that its policies were intended to cover "ongoing construction," and that since the accident occurred during operation of the hotel, its coverage should be considered excess of the Hyatt line.

Occidental, on the other hand, argued that since the likely cause of the accident was a defect in the design of the skywalks, the CU policies should be considered primary and the Hyatt line excess.

In his opinion, Judge O'Leary said he found nothing in either policy to limit coverage to "operation" or "ongoing construction" risks.

"Under this scenario it would be impossible to apply coverage responsibility responsibly," the judge wrote. "Overlapping coverages provided in these two broad form comprehensive policies and the duty of each insurer to respond in good faith to each of their several insureds. . .leaves only one rational choice fair to the insurers, the insureds and the victims. That is, that we treat the two lines as concurrent insurers—both responsible for settling and defending."

At the same time, Judge O'Leary rejected Columbia's and Highlands' arguments for a fault trial to settle the apportionment questions, an idea that was opposed by Hallmark, Crown Center, Hyatt and all the other insurers.

"Both lines of carriers owe their allegiance to both insureds equally," the judge wrote. "How then can they set one against the other for apportionment of fault? Whose yoke would Columbia bear?

"Indeed, why should the answer be that difficult in a case where all insureds purchased the broadest form of coverage to cover all hazards of exposure from the building and operation of this hotel? Why should anyone be required to separate the inseparable—to divide the indivisible? The answer is, we need not," the opinion reads.

If the idea of a fault trial was rejected, Columbia and Highlands argued that coverage should then be apportioned on a layer-by-layer basis depending on the limits available in that layer. For example, if Hyatt's second excess layer was for $25 million and Hallmark's for $50 million, the Hyatt insurers would pay one-third of the losses in that layer and the Hallmark insurer two-thirds, reversing the apportionment actually approved by the judge.

Such a scheme would probably insulate Columbia from any liability for losses resulting from the skywalk collapse.

Judge O'Leary rejected the idea —along with an argument by Northbrook that coverage should be shared on a 50/50 basis throughout both lines—saying there was no authority in prior cases for such proposals.

The judge also rejected a request from CU and American, a unit of Fireman's Fund Insurance Cos., that they be allowed to argue for the "reformation" of an endorsement to the Hallmark coverage that added Hyatt as a named insured.

CU and American had hoped to argue that the endorsement adding Hyatt was ambiguous. They also had planned to argue that Marsh & McLennan Cos. Inc., the broker for Hyatt and Hallmark, and Robert Duty, Hyatt's director of risk management, intended the Hyatt coverage to be primary and the Hallmark line to be excess, according to William H. Sanders, a senior partner with Blackwell, Sanders, Matheny, Weary & Lombardi in Kansas City, representing American.

However, Judge O'Leary ruled that even if the endorsement were reformed to make the CU line excess for the purpose of Hyatt's claims, it would be in conflict with provisions of other policies and would be rejected.

At the same time, the judge granted partial summary judgment to Hallmark and Crown Center declaring them to be additional insureds under the Occidental policy and the rest of the Hyatt line.

American objects to Judge O'Leary's ruling both on the reformation issue and defense costs, though its argument for reformation will be more heavily stressed, says Mr. Sanders.

"I think that's going to be the major issue on appeal," he noted, explaining that although American feels that the judge "misconstrued American's purported duty to defend," the amount of money involved in the defense costs argument is far smaller than that tied up in the reformation argument.

In ruling that American has a duty to defend Hyatt and Hallmark in the skywalk cases Judge O'Leary reversed his earlier ruling that American had no duty to defend.

That first decision was based on a clause in the American policy that appeared to exclude the coverage. But, all the other insurers and Hallmark objected, and the judge reversed the order based on another clause in the American policy that was interpreted as granting defense cost coverage.

In the absence of defense cost coverage from Columbia and American, Hallmark has been paying its defense costs out of a fund established by insurers for companies involved in construction of the hotel, according to a source who asked to remain nameless.

The amount of these costs has been "pretty insignificant" since most of the injury cases had been litigated by the time Hallmark started drawing from the construction defendants' fund, the source said.

Although American is the only insurer so far to decide to appeal Judge O'Leary's decision, lawyers for several other insurers are unhappy with the opinion for various reasons.

"It's quite apparent that there are at least two sections of the order that do not comport with our view of what the law is or what the facts are," said Stephen A. Cozen of the Philadelphia law firm of Cozen, Begier & O'Connor, representing CU.

Mr. Cozen objected to Judge O'Leary's refusal to hear arguments on reformation and to his reversal of the 1982 order making the CU primary policy excess of the Occidental primary policy.

Anthony Katauskas, a lawyer with Jacobs, Williams & Montgomery in Chicago, representing Highlands, objected to the application of a two-thirds/one-third proration for both indemnity and defense coverage.

Since some Hyatt insurers, including Columbia Casualty, have no defense cost obligation, the total available limits for defense on the Hyatt line are lower and their share of defense cost coverage should be commensurately lower, Mr. Katauskas argues.

He added that if a company the size of Hyatt chose not to buy defense cost coverage from Columbia, it should not be allowed to collect the coverage from an upper layer insurer while the Columbia layer pays indemnity claims.

"You are not talking about a little old lady from Dubuque. You are talking about a sophisticated insurance buyer," Mr. Katauskas observed.

Some of those involved in the case expect appeals of the judge's ruling from many of the insurers involved.

Patrick McBride, assistant vp-claims for Fireman's Fund, American's parent, said he expects all the insurers to appeal.

"I do not see this coming to rest until it goes through every possible means of due process," Mr. McBride said. ■

update

Amoco Cadiz claims mount

Continued from page 2

(Indiana) totaling $551.2 million as a result of damages caused by the wreck of the supertanker Amoco Cadiz.

Two other attorneys representing individuals are also seeking damages totaling around $147.2 million in the 1978 shipwreck, putting the total amount of damages sought at $698.4 million.

The judge ruled last year the oil company was negligent in maintaining the supertanker and was liable to French claimants for expenses related to the accident, which dumped the tanker's entire cargo just off Brittany's coast. Standard said a faulty steering mechanism caused the ship to run aground and break up in a storm.

Standard has said it has $50 million in pollution liability coverage written by London Steamship Owners' Mutual Insurance Assn. Ltd., managed by A. Bilbrough & Co. Ltd. (*BI*, April 30, 1984).

Attorney Benjamin E. Haller of the New York firm of Hill, Betts & Nash, said he is seeking $263.5 million on behalf of France. The New York firm of Curtis, Mallet-Prevost, Colt & Mosle represents more than 100 French fishing communities known as the "Cotes Du Nord" parties, which seek $287.7 million.

Court rules on airline liability

WASHINGTON—The liability of airlines is limited under international treaties to passenger injuries that are caused by unusual or unexpected events, the U.S. Supreme Court says.

Last week, the justices ruled 8-0 that the Warsaw Convention does not make an airline liable for all passenger injuries that occur on board. In order for an airline to be liable, the injury must be caused by an "unexpected or unusual event or happening that is external to the passenger," the court said.

The decision reverses a 9th U.S. Circuit Court of Appeals ruling that another agreement on airline liability, known as the Montreal Agreement, imposed "absolute liability on airlines for injuries caused by air travel." The case involved a suit against Air France by a woman who suffered permanent hearing loss during alleged changes in cabin pressure.

Robins' reserve not complete

RICHMOND, Va.—A.H. Robins Co., former manufacturer of the Dalkon Shield, says its attempt to work out a reserve for pending and future liability claims is taking longer than expected.

"At least several more weeks will be required to finalize the reserve which will be charged against 1984 income," President and Chief Executive Officer E. Claiborne Robins Jr. said in a letter to shareholders last week. "Until the reserve has been finalized, it will not be possible to determine the results of operations for 1984 or address the matter of a first-quarter dividend."

In a related matter, a report prepared by two special masters, attorneys appointed by the court to assist in Dalkon Shield litigation in federal court in Minnesota, says Robins has engaged in "ongoing fraud by knowingly misrepresenting the nature, quality, safety and efficacy" of the intrauterine device. The report, which has not yet been accepted by the judge, says there is "at least a prima-facie case of a massive fraudulent scheme perpetuated on the public," which occurred with the knowledge of in-house counsel.

A Robins spokesman said the company takes "strong exception" to the masters' report.

As of late last year, Robins faced more than 3,600 Dalkon Shield claims, and an additional 30 lawsuits a week were being filed. Robins and its primary insurer, Aetna Casualty & Surety Co., have paid about $259 million for 7,700 claims and about $70 million in defense costs for pending claims. Last Oct. 31, Robins entered into a settlement with Aetna, increasing its coverage by $70 million but capping the insurer's liability for defense costs (*BI*, Nov. 26, 1984).

Playtex loses toxic shock suit

WICHITA, Kan.—A federal court jury says International Playtex Inc. must pay more than $11 million in actual and punitive damages to the estate of a woman who allegedly died from toxic shock syndrome.

The jury made the award Feb. 25 in a suit by the estate of Betty L. O'Gilvie. The plaintiffs contend she contracted toxic shock syndrome and died because she used Playtex Super Deodorant Tampons.

The verdict is the largest ever in a toxic shock case. The previous record was a $300,000 award against Procter & Gamble Co. in 1982.

Although the jury awarded more than $1.5 million in compensatory damages, Playtex, based in Stamford, Conn., will have to pay only 80% because the jury found that the woman's physician was 20% liable for her death. The division does not apply to the punitive damage award of $10 million, however.

A spokesman for Playtex said "we do not feel the verdict is supported by the evidence, and we will appeal." He would not comment on Playtex's insurance coverage.

Citicorp renews try for S.D. bank

NEW YORK—Citicorp has reactivated its application to the Federal Reserve Board for approval to purchase controlling interest in American State Bank in Rapid City, S.D.

The purchase would enable Citicorp to sell and underwrite insurance both outside and, to a limited extent, within South Dakota because of a loophole in South Dakota law that enables state-chartered banks to circumvent federal regulations prohibiting banks from conducting a full range of insurance activities (*BI*, Jan. 28).

Citicorp first applied with the Fed to acquire the South Dakota bank in 1983. Bank of America and First Interstate Bankcorp also applied to buy South Dakota state banks in 1983.

In January 1984, the Fed withdrew the banks' applications to give Congress a chance to act on the loophole. But, Congress did not act, and Citicorp is again seeking approval of its application.

Superfund bill

Continued from page 2

ment is so vague that it could have the same effect, depending on how the courts decide to interpret the language.

According to the amendment, citizens may file a civil action against any company that violates the Superfund law and associated regulations or fails to comply with a federal cleanup order. However, citizens must give potential defendants a 90-day notice of the intent to sue them.

And, further, citizens would not be allowed to sue if the federal or a state government "has commenced and is diligently prosecuting an action" under Superfund to require compliance.

Thus, in effect, the amendment would give citizens a hammer with which to force companies to comply with the Superfund law.

In addition, the amendment could act as a tool which citizens could use to prod the government into requiring action on cleanup orders.

On its face, the Baucus-Hart amendment seems to imply that citizens could only bring suit to force compliance with a government-issued cleanup order or regulatory requirement. But, Robert S. Farow, a Washington attorney who advises risk managers and insurers on Superfund lawsuits, says the courts may interpret the amendment much more broadly.

Mr. Farow, a member of the firm of Brown, Roady, Bonvillian & Gold, says the language of the amendment does not clearly limit it to situations in which the federal government has already taken an enforcement action. And, he says, the amendment would open the door for citizen participation in settlement negotiations with Superfund defendants. Currently, settlement of Superfund lawsuits involves only the polluter and the government.

Mr. Farow says such participation by private citizens could turn government lawsuits into a forum for citizens to raise personal injury and property damage claims under Superfund. Currently, such claims must be raised in private actions using state common law, which does not provide the same level of liability as does the Superfund statute.

The language considered by the House and Senate last year establishing a federal cause of action more explicitly provided a mechanism for citizens to raise personal injury and property damage claims in Superfund lawsuits, but the new language may have the same effect, depending on how the courts view it, Mr. Farow says.

The committee also accepted an amendment offered by Sen. George J. Mitchell, D-Maine, that would establish a victim-assistance demonstration program. The program would be funded through general tax revenues and would cost $30 million a year for five years—a total of $150 million.

Under the Mitchell amendment, at least five states, but no more than 10, could apply for victim-assistance grants. However, eligibility would be limited to those areas that have been identified by the Agency for Toxic Substances and Disease Registry as having a population that has been placed at "substantially increased risk" of contracting a disease or injury from the release of hazardous substances.

Further, such disease or injury must have been demonstrated by scientific studies to be associated with the substance released.

In eligible areas, the program would provide for medical screening, examination and testing to determine the presence of disease or injury.

For individuals with symptoms of disease or injury, the program would provide reimbursement for immediate medical costs not recovered from another source.

Further, it would pay for group medical insurance to provide reimbursement for long-term treatment and care necessary as a result of the disease or injury. Such policies would have a $500 deductible with no co-payment required or lifetime limitation on expenditures.

The same type of insurance would be made available to persons exposed to a toxic substance but who do not show symptoms of disease or injury. Coverage would be secondary to any other benefits, public or private, for which the person is eligible.

Sen. Mitchell's amendment, which was a compromise worked out with several other committee members, is much more restrictive than a similar program considered by the committee last year. It seems to require the establishment of a cause-and-effect relationship between a hazardous substance and a disease in order for an area to qualify for a grant under the program.

Spokesmen for both risk management and insurer groups say they have not yet developed a position on the victim compensation provision, but suggest that the program could result in another federal entitlement program of enormous proportions.

"It's the classic foot-in-the-door," says Leslie Cheek, vp of federal affairs for insurer Crum & Forster. "After five years, what are you going to do, cut off the life support system?" he asks.

Another key amendment to the Superfund bill approved by the committee essentially embodies a provision of the administration's bill. It would give companies found liable for abandoned hazardous waste dumps the right of contribution, which would allow them to sue other potentially liable parties for their share of the cleanup costs. However, the amendment would prohibit such lawsuits until after a judgment or settlement is reached in a civil or an administrative action seeking cleanup of a dump site.

Insurers complain that this amendment would increase court costs because defendants would be involved in two suits: the EPA cleanup suit and a suit to recover from other responsible parties not named by the EPA.

"It may reduce the government's transaction costs (i.e., legal costs) in that it can deal with only the deep-pocket defendants, but it vastly increases the transaction costs of the private sector," says Mr. Cheek.

The committee also included in its Superfund reauthorization measure an amendment offered by Sen. John H. Chafee, R-R.I., which is similar to a provision of the administration's bill affecting judicial review of EPA cleanup orders.

The amendment prohibits judicial review of EPA cleanup orders until after the agency moves in federal court or takes an administrative action to enforce such an order.

Thus, if a company disagrees with an EPA-required cleanup plan, it must wait to object until after the EPA takes action against it to enforce the order. Companies named in cleanup orders often contend that the remedies sought by the EPA are not cost effective.

During consideration of S. 51 by the committee, Sen. Stafford and other committee members voiced concern over the availability of environmental impairment liability insurance. As a result of that concern, the committee has scheduled hearings March 19 to consider the "availability of environmental impairment liability insurance and its relationship to the implementation of Superfund and the Resource Conservation and Recovery Act."

The committee is particularly interested in the problems experienced by contractors hired to clean up Superfund waste sites in obtaining EIL insurance. Some of these contractors contend that their inability to obtain this insurance has resulted in a delay in Superfund cleanups.

According to some congressional sources, Sen. Stafford may introduce an amendment to S. 51 to assist contractors in obtaining insurance or even indemnify them under the Superfund law.

The American Insurance Assn. hopes to use the March 19 hearing as a forum to discuss its contention that the insurance industry is effectively financing cleanup of the nation's hazardous waste dumps because of courts' misinterpretation of general liability policies.

A group of seven of the nation's largest property/casualty insurers, which is operating under the auspices of AIA, is expected to present the committee with proposed Superfund amendments that would absolve insurers of any potential liability for cleaning up Superfund sites (*BI*, Jan.21).

James Kimble, senior counsel for the AIA, says the group hopes to have the plan ready in time for the hearing. ■

Bank sues to recover mortgage losses

Continued from page 1

Bank of America announced last month it would take a $95 million charge against its 1984 earnings after it was forced to repurchase certain securities from other financial institutions because the securities were allegedly fraudulently issued and overvalued.

Bank of America acted as trustee and escrow agent for $133 million in mortgage-backed securities marketed and issued by National Mortgage Equity Corp. of Palos Verdes, Calif. The securities were purchased between 1982 and 1984 by more than a dozen financial insitutions (see related story, page 30).

Bank of America's lawsuit contends that its losses arise from the negligent actions of its employees who performed or managed the bank's escrow or trust services.

"The bank has been victimized in this affair and we intend to go after every appropriate source of recovery," said Samuel H. Armacost, president and chief executive officer.

Representatives of Wausau and First State last week said they were surprised by Bank of America's allegations against them.

"I'm mystified, and we all are," said a spokesman for First State, a Boston-based unit of Hartford Insurance Group.

"It was rather surprising to see they brought a suit alleging what they did here," said Wausau's attorney Anthony M. Lanzone of the New York-based firm of Lanzone & Kramer. "It somewhat violates the spirit of the directors and officers policy."

"I don't think the complaint sets forth any meritorious basis for bringing suit against the insurance companies," he added.

But, Mr. Christian of Bank of America counters that the bank wasn't jumping the gun by filing suit against the insurers. He says the bank expects there may be differing opinions over the insurers' liability, although he acknowledges it may be too early for the insurers to have considered the matter.

"We are going to move these cases very rapidly," Mr. Christian added.

The insurers must respond to the complaint within 30 days of the date they are served with the suit. Representatives of Wausau and First State said last week they had not yet been served.

Bank of America has two layers of D&O coverage totaling $100 million, court papers state.

Employers of Wausau wrote the first $80 million in D&O coverage under a three-year, claims-made policy, issued in May 1983.

For directors' and officers' losses not reimbursed by the bank, the insurance policy requires a $5,000 self-insured retention for each director or officer for each loss, capped by a $50,000 aggregate retention. When the directors' and officers' losses are reimburseable by the bank, the bank's self-insured retention is $200,000 in the aggregate.

If Bank of America prevails in its lawsuit, it appears the $50,000 deductible would apply.

Bank of America paid a $938,040 premium for the three-year policy, according to the documents.

Wausau's $80 million policy is "heavily" reinsured, according to a Wausau spokesman.

First State wrote a $20 million excess policy above the Wausau's $80 million layer, according to the court papers.

That policy was issued in May 1984 and originally scheduled to expire in May 1986. Bank of America paid a premium of $30,784 when the policy was issued and was scheduled to pay an additional $32,000 on May 15, 1985.

However, First State notified the bank in January that it would terminate the coverage on May 15.

"We have reduced our exposure in this product line," explained Lawrence Doyle, vp and liaison officer for Hartford Insurance Group, parent of Cameron & Colby Co. Inc., First State's underwriting manager.

Bank of America is currently seeking another underwriter to replace the First State excess policy when it expires, said its risk manager, Mr. Wintemute.

The bank's D&O and fidelity insurance policies were brokered by Johnson & Higgins, according to a J&H spokesman.

In its suit against the insurers, Bank of America "alleges that any and all liability of (the employee defendants) arising out of the claims in this litigation is insured under the respective insurance policies up to the aggregate policy limits.

"Bank of America is informed and believes that the insurer defendants dispute this interpretation of the coverage afforded the bank and the individual defendants under the insurance policies," the suit continues.

"By reason of the foregoing, a justiciable controversy has arisen and now exists between the insurer defendants and Bank of America with respect to the respective rights, duties and legal relations under the terms of the insurance policies."

The bank asks the court for a declaratory judgment that "any and all liability of the (employee defendants) is insured under the insurance policies up to the insurer defendants' respective limits of liability."

The suit also seeks "indemnity from the insurer defendants in the amount of loss presently estimated at $95 million."

D&O insurance experts note that it's not common for a corporation to sue its officers to collect on its D&O coverage, although it has been done in the past.

Chase Manhattan Bank, for example, sued six former officers for negligence in connection with the bank's losses on energy loans purchased from the failed Penn Square Bank of Oklahoma City.

Questions are bound to be raised about the responsibility of insurers to compensate the bank for losses caused by its employees, said one D&O coverage expert.

D&O insurance is usually intended to protect officers from lawsuits by outsiders and not the company itself.

According to First State's Mr. Doyle, there is a "growing trend" among D&O insurers to exclude coverage for claims filed by the corporation itself—instead of shareholders—in an attempt to recover losses caused by employee actions.

In the last six months, First State has excluded that exposure from the policies it writes, he said. However, the Bank of America coverage did not contain this exclusion, according to bank officials.

The bank's lawsuit against its D&O insurers is expected to add to the upheaval in the D&O insurance market, one observer said.

"I think it has negative ramifications throughout the marketplace," said Terry Van Gilder, manager of the executive protection department for Chubb Corp. in Warren N.J.

D&O insurance rates rose from 15% to 50% last fall and even stiffer rate hikes this year have been predicted by some brokers and underwriters (*BI*, Sept. 3, 1984).

D&O underwriters are also reducing the limits they offer and scrutinizing risks much more closely, said James E. Moore, a vp with broker Marsh & McLennan Inc. in New York.

"They are doing more individual underwriting on a per-risk basis," he said.

In addition, D&O coverage capacity is in such a state of flux that M&M is calling D&O underwriters weekly for updates, Mr. Moore said. ■

Bank also suing other companies

SAN FRANCISCO—Besides suing its directors and officers liability insurers to cover its loss, Bank of America is pressing a separate suit against the companies and individuals it charges were involved in the mortgage-backed securities scandal.

The bank has taken a $95 million charge against its 1984 earnings as a result of the alleged fraud.

Filed earlier this month in U.S. District Court in Los Angeles, Bank of America's suit names as defendants:

- National Mortgage Equity Corp., which marketed and issued the $133 million in mortgage-backed securities for which Bank of America provided escrow and trust services.
- David A. Feldman, NMEC's president.
- Lord, Bissell & Brook, a Chicago-based law firm that acted as NMEC's principal counsel in the servicing, marketing and packaging of the securities.
- Leslie W. Michael, a partner in the law firm and Mr. Feldman's cousin.
- West-Pac Corp., the mortgagor on a large number of the loans placed by NMEC.
- Kent B. Rogers, West-Pac's president.

In the suit, the bank seeks damages for violations of the federal Securities Exchange Act of 1934, the federal Racketeer Influenced and Corrupt Organization Act and the California Corporations Code "for fraud and deceit and for breach of contract," according to the suit.

The suit seeks treble damages under RICO stemming from the $95 million loss, as well as $100 million in punitive damages.

Bank of America's federal court lawsuit represents the bank's "determination to pursue vigorously all parties who were responsible for perpetration of this massive fraud," the bank's Mr. Christian said.

According to the suit, West-Pac and Mr. Rogers obtained properties in Texas and California and then allegedly inflated their values through false appraisals.

West-Pac and Mr. Rogers then used the inflated valuations as a basis for mortgage loans that were fraudulently packaged by NMEC and sold in the form of mortgage-backed certificates to the more than a dozen financial institutions, the complaint alleges.

Bank of America later repurchased the securities from the institutions at a cost of about $133 million, which resulted in the $95 million loss.

The suit also alleges that Mr. Michael—who with his family are former owners of one-third of NMEC's stock—and Lord, Bissel & Brook prepared false and misleading private placement memoranda used in the marketing of the securities.

In addition, the suit alleges that the documents prepared said that mortgage insurance or financial guarantee bonds would be obtained to back each mortgage.

However, the suit continues, the surety insurance secured for the NMEC mortgage loans exceeded the financial capacity of the two insurers that wrote the coverage: Pacific American Insurance Co., which was allegedly controlled by Mr. Rogers, and Glacier General Assurance Co. (*BI*, Feb. 18).

Neither insurer had reinsured portions of their policies with other companies, according to the complaint.

In addition, Glacier General was not legally qualified to write insurance in California, where many of the properties were located, the suit alleges.

Pacific American is currently being liquidated by the Delaware Insurance Department. In addition, Bank of America is suing the insurer for $27 million in compensatory damage and $50 million in punitive damages to recover on surety bonds issued on the mortgage-backed securities by Pacific American.

The California Insurance Department last week took control of Glacier General's California assets and operations. In Montana, where Glacier General is domiciled, the state Insurance Department is seeking similar authority from a court.

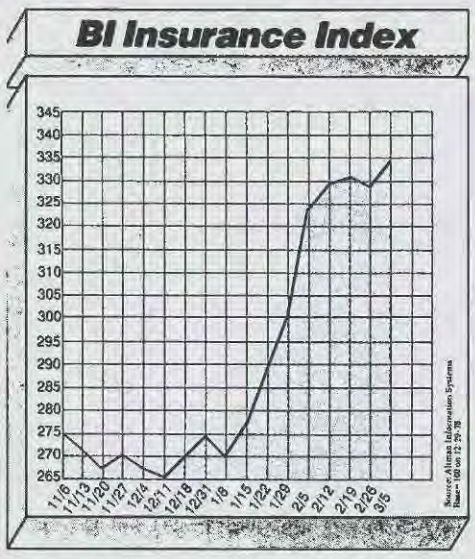
NMEC attorney Charles Wehner, a member of the firm of Wehner & Perlman in Beverly Hills, Calif., declined to comment on the lawsuit because he hadn't seen it.

Joseph Coughlin, a partner at Lord, Bissell & Brook, denied the allegations of wrongful conduct. "We performed our duties in a proper, prompt and ethical manner," he said. ■

Moran can't appeal

LONDON—Christopher Moran lost a chance to appeal his forced expulsion from Lloyd's of London in the British courts last week.

The Court of Appeal for Britain rejected Mr. Moran's application for a judicial review of his expulsion from Lloyd's in October 1982. Mr. Moran, former chairman of Christopher Moran Ltd., was expelled for discreditable conduct (*BI*, Nov. 1, 1982). ■



The *Business Insurance* stock index rallied strongly after posting a slight decline in the last trading period, and set its sixth record in seven weeks. The *Business Insurance* index of insurance industry stocks closed at 334.1 on March 5, up 5 points from 329.1 on Feb. 26. This also is 2.4 points higher than the previous record of 331.7 set on Feb. 19. A total of 28 stocks posted gains, 20 stocks were down and 10 stocks were unchanged. The largest gains were posted by Mission Insurance Group Inc., up 21.6%; Alexander & Alexander Services, up 12.6%; Corroon & Black Corp., up 11.9%; AVEMCO Corp., up 9.2%; and The Crump Cos. Inc., up 8.7%. The largest losses were posted by Zenith National Insurance Corp., down 8.9%; SRI Corp., down 8.7%; Provident Life & Accident Insurance Co., down 4.5%; SAFECO Corp., down 4.4%; and Statesman Group Inc., down 3.7%. The *Business Insurance* index gained 1.5% for the trading period, outdistancing the New York Stock Exchange composite and the Standard & Poor's 500, both of which gained 0.6%, and the Dow Jones 30 Industrials, which gained 0.4% for the same period.

British Issues

6 March Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	179	N/M	16.9	9.4	179—	176
Genl Accident	535	90.7	28.6	5.3	538—	522
Gdn Royal Exch	653	18.1	36.4	5.6	653—	622
Royal	575	N/M	33.9	5.9	575—	555
Sun Alliance	442	49.1	21.4	4.8	442—	423
Brokers						
CE Heath	620	10.6	30.0	4.8	623—	615
Hogg Robinson	285	16.3	11.6	4.0	285—	271
JH Minet	273	18.8	8.0	2.9	273—	263
Sedg Grp	362	16.8	12.8	3.6	362—	355
Stew Wrightson	574	16.4	24.0	4.2	574—	566
Willis Faber	641	22.9	17.6	2.7	641—	617

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

Fourth-quarter results are welcome news for brokers

By LEONARD M. WILSON

Special to Business Insurance

IT IS quarterly reporting time, and all the largepublicly owned brokers but Alexander & Alexander Services Inc. have posted their final results for 1984. A&A now has indicated that additional financial trauma from Sphere Drake Insurance Co., a reinsurance subsidiary, will mar the fourth quarter, so results will not be available until late March (see story, page 2).

In general, brokers' fourth-quarter results gave strong confirmation of the new era in pricing for commercial lines of insurance. Indeed, we think that the insurance brokers themselves may have been pleasantly surprised at the strength of rates and the impact on commissions and fees.

Mr. Wilson

Essentially, fourth-quarter results signaled that insurance brokerage operating numbers are moving into double-digit territory. Double-digit gains in revenues and double-digit advances in expenses contrast with the soggy process of the past several years.

How did the reporting public brokers perform in the fourth quarter of 1984? We are ignoring the full-year results to focus on the most-recent effects of changing insurance markets, mirrored in the fourth quarter.

Here is the percentage gain in revenues over 1983 for each of the reporting public brokers in the fourth quarter of 1984: Marsh & McLennan Cos., 15%; Frank B. Hall & Co. Inc., 6%; Corroon & Black Corp., 28%; and the newcomer on the block, Arthur J. Gallagher & Co., 31%. These figures justify some interpretation.

In each instance, pure domestic insurance brokerage commissions exceeded the total revenue gains. Frank B. Hall, for example, despite rather anemic overall revenue growth, achieved gains in domestic insurance brokerage fully comparable with its peer group. Similarly, Corroon & Black's domestic brokerage was about as strong as the overall revenue advance.

Gallagher's striking increase owes in part to premium rates, but mostly to the momentum of what could be the industry's most aggressive new business effort.

But, new business momentum for all participants remains strong. Tight markets may tax brokerage ingenuity, but the major brokers with clout in the realm of placing are well-situated. Consequently, we expect new business to roll on in 1985.

A surprising number of observers look upon insurance brokerage as a business with relatively fixed expenses, at least in the intermediate term. In our view, expenses tend to follow the direction of revenues, particularly on the upside.

This is clear when looking at Marsh & McLennan at one end of the spectrum of size and Gallagher at the other. M&M's fourth-quarter expenses rose about 18% in 1984; Gallagher's increased roughly 22%.

When the revenue stream accelerates, several expense factors come into play. Raises, deferred because of austerity for several years, get more generous. Bonuses and incentives escalate, bolstered by formulas that are more leveraged than the total rise in commissions. Finally, programs on the slow track get accelerated in the interest of either new business generation or internal efficiencies.

We saw this phenomenon in the fourth quarter. Despite a low inflation rate, we expect brokerage costs to advance at a pace well into the double-digit range in 1985 and 1986.

Fourth-quarter revenue growth in brokerage is clearly a window on 1985. More of the same is in store. We estimate that premium rates across a book of business provided seven to eight percentage points of fourth-quarter progress. The contribution from premium rates is likely to be higher in 1985, and earnings, of course, should rise much more than anticipated powerful advances in revenues.

Right now, investors have clasped the brokerage stocks to their bosoms. Valuations have gotten much higher, and no one sees a cloud in the sky. This about-face is almost stupefying, considering the gloom and indifference in early 1984. However, there is no denying the positive outlook, and investors are quick to seize on the change for the better.

Moreover, the insurance brokers are largely recession-proof. Their progress will not be materially affected by an economic slowdown, unlike most public companies.

The qualities that endeared the brokers to investors in the 1970s are again extant. Growth, high levels of free cash flow, dividend growth, difficulty of entry, scarcity of alternatives and the possibility of acquisitions at generous prices are all factors that have revitalized investor appraisals.

Leonard M. Wilson, a special limited partner at L.F. Rothschild, Unterberg, Towbin in New York, specializes in insurance brokerage stocks. He is a member of the New York Society of Security Analysts.

Lincoln National income

Lincoln National Corp. reports operating income of $168.2 million for 1984, virtually unchanged from the $168.1 million reported in 1983. Fourth-quarter 1984 operating income declined 23% to $37.8 million in 1984 from $50.1 million in 1983.

Ian M. Rolland, president and chief executive officer, said losses in property/casualty and reinsurance were offset in 1984 by a strong showing in group life and health and title insurance. Earnings for life/health insurance and annuities rose to $183.2 million in 1984 from $151.1 million in 1983. The property/casualty operations, however, posted a loss of $16.4 million in 1984, after earning $25 million in 1983.

Bitco Corp. loss

Bitco Corp., headquartered in Rock Island, Ill., reported an operating loss of $36.2 million for 1984, compared with a loss of $9.1 million for 1983.

Gross premiums written by Bitco's insurance subsidiaries increased 11% to $216.5 million in 1984 from $194.5 million in 1983. They reported an underwriting loss of $59.9 million after policyholders' dividends in 1984, compared with a loss of $37.2 million for 1983. The companies had a combined ratio of 134.8% in 1984, compared with 120.6% in 1983.

Fremont General income up

Los Angeles-based Fremont General Corp. reported net income of $20.4 million for 1984, up from $1.2 million in 1983. Fremont General,s fourth-quarter net income was 691,000 in 1984, compared with a net loss of $1.9 million in the fourth quarter of 1983.

The company had an underwriting loss of $89.3 million for 1984, compared with a loss of $73 million for 1983.

HealthAmerica earnings up

HealthAmerica Corp. in Nashville, Tenn., an independent operator of health maintenance organizations, reports net income of $12.6 million for 1984. In 1983, net income was $6.4 million, including an extraordinary credit of 8 cents a share as a result of an income tax benefit. The company's fourth-quarter net income was $3 million for 1984, compared with $1.9 million for 1983.

The company also reported revenues of $183.9 million for 1984, compared with $104.2 million for 1983. The fourth-quarter revenues were $56.6 million for 1984, compared with $31 million for 1983.

As of Dec. 31, 1984, the company operated HMOs in 29 markets in 11 states with 539,000 enrollees, Chairman Philip N. Bredesen said.

Royal profits plunge

Royal Insurance P.L.C. in London reported its pretax profit dropped 89%, to 11.2 million pounds ($11.9 million) in 1984 from 98.4 million pounds ($104.3 million) in 1983. The company said its aftertax loss for 1984 was 6 million pounds ($6.4 million), compared with an aftertax profit of 80.2 million pounds ($85 million) in 1983.

Much of Royal's decline in profits was attributed to its business in the United States, where the company's premium volume was 946.7 million pounds ($1 billion) in 1984, up from 807.6 million pounds ($856 million) in 1983. The company said unfavorable currency exchange rates accounted for a 7 million pound ($7.4 million) pretax loss.

However, the company also said its results were hurt by weather claims in Britain. ■

BI Industry Stock Report

March 5, 1985 — 2/27/85 thru 3/5/85

		Price	% Chg.	P/E	$ Div.	% Yld.	High	Low	Vol.(000)
Brokers									
Alexander & Alexander Svcs	NYSE	30.25	12.6	335.1	1.00	3.3	30.25*	26.88	1,740.5
Baldwin & Lyons Inc	OTC	53.00	1.9	13.9	0.80	1.5	56.00*	50.00	0.1
Corroon & Black Corp	NYSE	43.63	11.9	34.4	1.00	2.3	43.63*	39.00	331.3
Crump E H Cos Inc	OTC	26.50	8.7	22.3	0.44	1.7	26.50*	24.13	48.2
Emett & Chandler Cos Inc	OTC	14.75	1.7	0.0	0.00	0.0	14.75	14.50	2.2
Gallagher Arthur J & Co	OTC	37.00	0.7	23.3	0.28	0.8	37.00	36.75	50.8
Hall Frank B & Co Inc	NYSE	26.88	0.9	51.7	1.00	3.7	26.88	26.25	374.5
Marsh & Mclennan Cos Inc	NYSE	64.13	-3.2	39.6	2.40	3.7	66.50	64.13	227.2
Poe & Assoc Inc	OTC	8.25	0.0	0.0	0.00	0.0	8.25	8.25	9.6
Reed Stenhouse Cos Ltd	OTC	23.88	8.5	34.1	0.60	2.5	23.88*	22.25	926.1
AGENTS/BROKERS	AVERAGE			30.4		2.3			
Conglomerates & Holding Cos.									
American Express(Fireman's Fd)	NYSE	42.75	0.6	15.3	1.28	3.0	43.50*	42.50	3,464.2
Anderson Clayton(Ranger/PanAm)	NYSE	37.75	2.0	19.5	1.32	3.5	37.88	36.88	33.9
Armco Inc	NYSE	10.00	-8.0	0.0	0.00	0.0	10.50	9.88	449.4
Berkley W R Corp	OTC	15.63	4.2	0.0	0.32	2.0	16.00*	15.00	68.0
CIGNA Corp	NYSE	49.75	2.3	452.3	2.60	5.2	50.75*	48.75	1,089.4
City Investing Co. (Home Ins.)	NYSE	38.38	-1.6	9.2	0.00	0.0	39.00	38.38	509.1
CNA Finl Corp (CNA)	NYSE	37.88	1.0	15.7	0.00	0.0	37.88	37.00	76.1
General Re Corp	NYSE	74.63	2.2	46.6	1.56	2.1	75.25*	74.13	540.1
ITT (Hartford Group)	NYSE	32.13	2.0	8.8	1.00	3.1	32.13	29.63	7,250.5
Optimum Hldg Corp	OTC	0.50	0.0	0.0	0.00	0.0	0.50	0.50	2.0
Sears Roebuck & Co. (Allstate)	NYSE	35.63	-0.3	8.9	1.76	4.9	35.88	35.50	2,420.3
Teledyne Inc (Argonaut)	NYSE	264.75	0.3	14.5	0.00	0.0	270.75	264.75	164.0
Transamerica Corp (Occidental & Fred S. James)	NYSE	29.13	-1.7	12.6	1.64	5.6	29.63	29.13	585.1
CONGLOMERATES/HOLDING COS.	AVERAGE			21.7		1.7			
Insurers									
Aetna Life & Cas Co	NYSE	41.25	1.2	25.9	2.64	6.4	42.25*	41.13	929.9
American General Corp	NYSE	30.25	3.0	10.1	1.00	3.3	30.38	29.50	1,397.6
Amern Heritage Life Invt Co	NYSE	31.50	1.6	12.5	1.08	3.4	31.50	31.00	4.5
American Indty Finl Corp	OTC	18.00	0.0	0.0	1.12	6.2	18.00	18.00	0.5
American Intl Group Inc	NYSE	71.38	-0.2	14.0	0.44	0.6	72.75	71.38	554.8
Aneco Reins Ltd	OTC	1.63	8.3	0.0	0.00	0.0	1.63	1.50	1.7
Avemco Corp	NYSE	26.75	9.2	13.0	0.60	2.2	27.38*	25.63	14.6
Bitco Corp	OTC	13.50	-0.9	0.0	0.40	3.0	13.63	13.50	11.6
Business Mens Assurn Co Amer	OTC	52.00	2.2	6.5	2.08	4.0	52.00	51.00	41.9
Chubb Corp	NYSE	59.63	0.0	16.9	2.20	3.7	61.00	59.63	244.8
Combined Intl Corp	NYSE	44.75	2.3	9.0	2.08	4.6	45.38*	43.50	395.9
Continental Corp	NYSE	42.00	-1.5	21.8	2.60	6.2	42.75*	42.00	439.6
Crown Life Ins Co	OTC	125.00	0.0	12.9	5.00	4.0	125.00	125.00	0.0
Durham Corp	OTC	40.75	1.9	7.9	1.28	3.1	40.75	40.00	8.3
Farmers Group Inc	OTC	57.25	-1.3	10.4	1.76	3.1	57.75	57.25	404.0
Fremont Gen Corp	OTC	25.13	2.0	0.0	0.48	1.9	25.13	24.75	463.0
Great West Life Assurn Co	OTC	350.00	0.0	9.4	14.00	4.0	350.00	350.00	0.0
Hanover Ins Co	OTC	36.75	-0.7	17.5	0.56	1.5	36.75	36.75	42.5
Hartford Steam Boiler Inspctn	OTC	70.50	4.4	31.5	3.00	4.3	70.50*	67.50	21.7
Kans City Life Ins	OTC	81.50	-0.6	9.4	2.88	3.5	82.00	81.50	2.5
Kemper Corp	OTC	52.00	0.0	30.2	1.80	3.5	52.25	51.13	115.2
Liberty Corp S C	NYSE	31.00	2.9	14.9	0.72	2.3	31.00*	30.25	23.5
Lincoln Natl Corp Ind	NYSE	42.13	-2.6	11.1	1.84	4.4	43.50	42.13	217.3
Mission Ins Group Inc	NYSE	7.75	21.6	0.0	0.50	6.5	7.75	6.75	336.0
Monumental Corp	OTC	30.13	-0.4	12.6	1.30	4.3	30.25	30.00	36.7
Northwestern Natl Life Ins	OTC	34.50	0.0	8.0	0.80	2.3	34.75	34.38	110.5
Ohio Cas Corp	OTC	52.50	3.4	19.7	2.80	5.3	52.88*	51.75	98.5
Old Rep Intl Corp	OTC	35.13	-0.7	6.8	0.88	2.5	35.38	35.00	94.7
Orion Cap Corp	NYSE	24.38	-0.5	270.8	0.76	3.1	24.50	24.38	44.5
Protective Corp	OTC	22.00	2.3	10.4	0.62	2.8	22.00	21.00	158.2
Provident Life & Acc Ins Co	OTC	95.00	-4.5	6.8	3.38	3.6	97.00	95.00	58.1
St Paul Cos Inc	OTC	56.88	-0.4	0.0	3.00	5.3	57.00	56.50	1,912.4
SAFECO Corp	OTC	35.63	-4.4	11.7	1.50	4.2	36.63	35.63	372.7
SRI Corp	OTC	17.00	-8.7	28.8	0.68	4.0	17.75	16.75	49.8
Seibels Bruce Group Inc	OTC	25.75	0.0	0.0	0.80	3.1	25.75	25.50	57.6
Statesman Group Inc	OTC	6.50	-3.7	9.7	0.15	2.3	6.75	6.38	42.7
Tokio Marine & Fire Ins Co	OTC	158.50	5.1	27.4	1.05	0.7	162.75*	158.50	24.1
Torchmark Corp	NYSE	42.00	-3.2	10.0	1.00	2.4	44.75	41.00	234.6
Travelers Corp	NYSE	43.63	-2.0	10.6	2.04	4.7	44.88*	43.63	1,219.8
United Fire & Cas Co	OTC	24.00	0.0	0.0	0.80	3.3	24.00	24.00	0.0
United States Fid & Gty Co	NYSE	31.88	1.6	18.5	2.08	6.5	31.88	31.63	1,456.9
Uslife Corp	NYSE	38.50	-0.3	8.8	1.04	2.7	38.50	38.75	715.7
Washington Natl Corp	NYSE	27.75	6.7	8.6	1.08	3.9	28.00	27.25	153.6
Zenith Natl Ins Corp	OTC	12.75	-8.9	23.2	0.68	5.3	13.75	12.50	45.0
INSURANCE COMPANIES	AVERAGE			15.9		3.5			

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