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Update

Lloyd's of London boosts underwriting capacity by 2.8%

LONDON—Lloyd's of London is increasing its underwriting capacity by 315 million pounds, or 2.8%, this year, but members continued to flee the market in record numbers following large losses in recent years.

Capacity for 1991 increased to a record 11.385 billion pounds from 11.07 billion in 1990. In dollar terms, capacity jumped 23.3% to $21.97 billion based on year-end 1990 exchange rates under Lloyd's currency exchange practices

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Punitive damage ruling mixed bag for business

AP/Wide World Photo

'The time has come to reassess the constitutionality of a time-honored practice.'

— Justice Sandra Day O'Connor

By STACY ADLER

WASHINGTON—While the U.S. Supreme Court has not provided Corporate America with the relief it sought from punitive damage awards, the justices are signaling a need for Congress and state legislatures to reform the current system of awarding punitive damages.

Having lost their battle in the courts, business leaders say they will now focus on convincing legislators to limit jury discretion over punitive damage awards.

Meanwhile, consumer groups are touting the Supreme Court's punitive damages decision, announced last week, as a major victory and a reaffirmation of the jury system.

The business community had hoped the Supreme Court would set specific limits on the ability of juries to award punitive damages. Some 80 business organizations had asked the court to draw a constitutional line limiting jury discretion.

But the Supreme Court ruled 7-1 that the due process clause of the 14th Amendment does not mandate such limits on juries. Justice David Souter had not joined the court when the case was argued.

In essence, the high court found "there is not a constitutional solution to every societal problem," said Bruce J. Ennis Jr., an attorney with Jenner & Block in Washington, D.C., who represented the plaintiff in the litigation.

Writing for the majority, Justice Harry A. Blackmun noted: "We cannot say that the common-law method for assessing punitive damages is so inherently unfair as to deny due process and be per se unconstitutional.

"One must concede that unlimited jury discretion—or unlimited judicial discretion for that matter—in the fixing of punitive damages may invite extreme results that jar one's constitutional sensibilities," Justice Blackmun continued.

But "we need not, and indeed we cannot, draw a mathematical bright line between the constitutionally acceptable and the constitutionally unacceptable that would fit every case," he wrote. "We can say, however, that general concerns of reasonableness and adequate guidance from the court when the case is tried to a jury properly enter into the constitutional calculus."

Specifically, the court found that the Constitution requires trial

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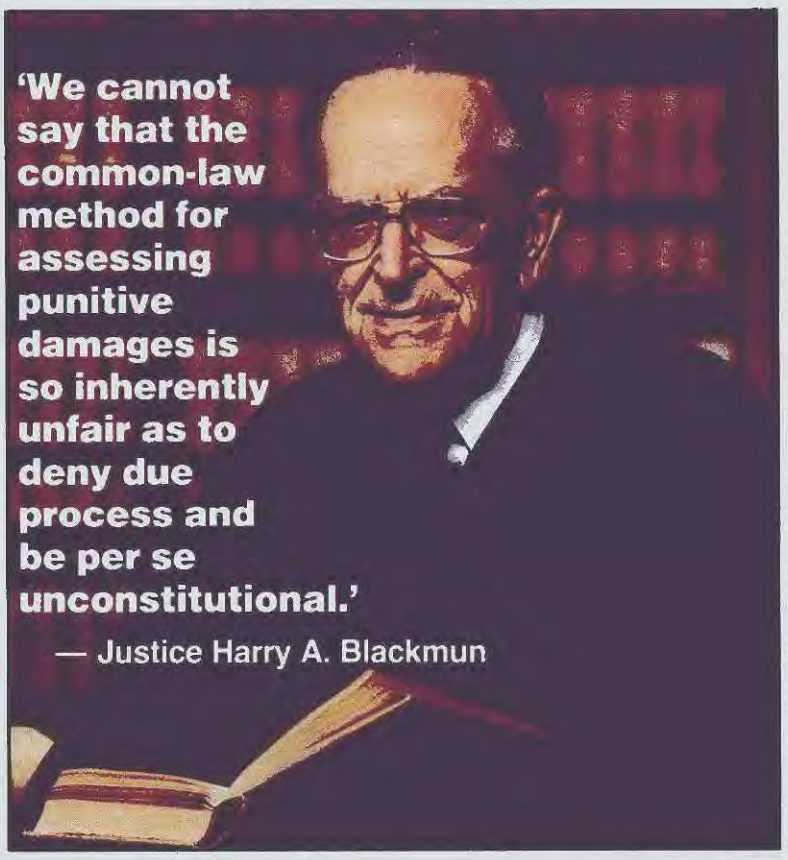

Few offer benefits to unwed couples

By JOANNE WOJCIK

A very small—but growing—number of employers are opening their health care plans to employees' unmarried "domestic partners."

So far mostly West Coast cities have made the move, but two private employers also have expanded benefits to workers' heterosexual and homosexual unmarried partners.

Holding employers back are fears of adding to their high health care plan costs—all to date contribute to the cost of the coverage as they contribute to spousal coverage (see story, page 30).

Also, most group health insurers are reluctant to write the coverage, fearing adverse selection and catastrophic claims related to acquired immune deficiency syndrome—despite no such proof.

While fewer than a dozen employers today extend health care benefits to domestic partners and only a handful of insured plans are available, "some companies, particularly those with young, diverse workforces, are looking at domestic partner benefits," said Dorothy McNaughton, a consultant in the San Francisco office of Hewitt Associates.

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Asbestos claims pact

U.K. insurers to get delayed reinsurance payments

By CAROLYN ALDRED

LONDON—London underwriters hope to receive what they regard as long-overdue reinsurance payments for asbestos claims following a recent agreement between six major European reinsurers and representatives of the London insurance market.

After years of protracted and often bitter discussions over the validity and accuracy of hundreds of millions of dollars of asbestos claims, senior claims officials from a group of European reinsurers and London ceding insurers have reached a compromise that should allow payments to start flowing.

London underwriters contend they are facing critical cash-flow problems because European, U.S., Japanese and other overseas reinsurers and retrocessionaires have not paid asbestos claims the London market submitted several years ago (*BI*, March 21, 1988; Nov. 16, 1987).

The "informal agreement" was worked out by the Asbestos Working Party, an association representing insurers throughout the London market, and six reinsurers: Mercantile & General Reinsurance Co. P.L.C. of London; Netherlands Reinsurance Group N.V. of Amsterdam; Swiss Reinsurance Co. of Zurich; and three German companies—Munich Reinsurance Co. of Munich, and Cologne Reinsurance Co. and Gerling Global Reinsurance Co. A.G., both of Cologne.

As part of the agreement, the London market will furnish the six reinsurers with detailed information on major asbestos accounts in an agreed-upon format.

The information is being compiled and presented centrally by London Market Services Ltd., which was known as Toplis & Harding (Market Services) Ltd. before its recent acquisition by the London market from parent company Toplis & Harding (UK) Ltd. T&H (Market Services) was set up in 1984 to gather and disseminate asbestos claims information for London underwriters.

For their part, the six European reinsurers have agreed to start making partial payments on claims as soon as they receive the information. In the past, many reinsurers have paid nothing if there

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Proposed Texas reforms could backfire, insurers say Page 2

Employers seek alternatives to traditional HMOs: Studies Page 3

Terrorism fears remain despite end of Gulf War Page 3

NEWSPAPER

Update

Lloyd's capacity grows

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from $17.82 billion at year-end 1989 rates.

Underwriters are using only 65% of the capacity, said Chief Executive Alan Lord. This may soon change, though, because of a hardening market and the recent strengthening of the dollar, he said. Seventy percent of Lloyd's incoming premium is in dollars, and 45% of its premium income comes from North America, so a higher-valued dollar consumes more capacity.

Resignations edged up to a record 2,345 from 2,316 in 1990. And new membership fell to 251 from 312 in 1990 and 951 in 1989.

However, 6,310 members increased their underwriting commitment this year by an average of 147,000 pounds ($283,710) each.

Members' premium income limit for 1991 rose 11.4% to 429,000 pounds ($827,970) on average from 385,000 pounds ($619,850) last year.

Eleven new syndicates began underwriting in 1990, but 58 ceased business, including 40 that merged with other syndicates. Total syndicates declined to 354 at year-end 1990 from 401 a year earlier.

Grace asbestos cover limited

NEW YORK—Only the comprehensive general liability policies in place at the time asbestos personal injuries occurred or asbestos property damage was discovered must respond to thousands of claims filed against W.R. Grace & Co., a federal judge has ruled.

And, Grace cannot tap its insurance to pay punitive damages awarded against it in asbestos litigation, the judge ruled.

The March 1 decision by U.S. Magistrate Leonard Bernikow stems from a lawsuit filed in 1984 by Maryland Casualty Co., which wrote primary liability coverage for Grace from 1962 to 1973. The insurer sought a declaration that it did not have a duty to defend or indemnify Grace for some asbestos-related lawsuits. By 1987, Grace faced 6,400 bodily injury lawsuits and 134 property damage suits.

"We've always maintained that the amounts paid in disposing of these cases would be recoverable from our insurance carriers," said Grace President J.P. Bolduc.

But, the decision "significantly reduces" the insurers' liability, said Maryland Casualty attorney Thomas Brunner of Wiley, Rein & Fielding in Washington, D.C. Other insurers named by Maryland Casualty as co-defendants are Continental Casualty Co., Royal Indemnity Co., Aetna Casualty & Surety Co. and General Insurance Co. of America.

Liability for worker investments

WASHINGTON—Proposed Labor Department rules scheduled to be published this week will make it easier for employers to avoid fiduciary liability for investment decisions made by employees in their 401(k) and other defined contribution plans.

Employers can be exempt from liability for such losses under Section 404(c) of the Employee Retirement Income Security Act. To qualify for that waiver, the new rules would require employers to offer at least three investment options with "materially different risk and return characteristics." And, participants would have to be allowed to switch from one option to another at least quarterly.

Firms could offer their own stock only as a fourth option, if shares are publicly traded and if participant shareholders have voting rights.

Taylor sentenced to prison

CHEYENNE, Wyo.—Gordon Taylor Jr., a former Wyoming insurance commissioner, was sentenced to 15 months in prison after he pleaded guilty to a bribery charge.

U.S. District Judge Clarence Brimmer also sentenced Mr. Taylor Feb. 21 to three years probation and ordered him to pay a $5,000 fine and perform 400 hours of community service.

Mr. Taylor pleaded guilty last fall to one count in an indictment that charged him with accepting bribes from officials of Commercial General Insurance Co. of Casper, Wyo., Lloyd's U.S. of Dallas and Laramie Insurance Co. of Laramie, Wyo. (*BI*, Sept. 24, 1990).

Roy E. Thigpen III, owner of the defunct Commercial General, also pleaded guilty to one bribery count and was sentenced in December to 41 months in prison, $250,000 in fines and three years probation.

Robert Davis, an official of Lloyd's U.S., was found guilty of bribery last year and was sentenced Feb. 13 to 27 months in prison and three years probation. Mr. Davis is free on bond pending appeal.

Plaintiffs' attorneys convicted

NEW YORK—A New York personal injury lawyer has been convicted of running his law firm as a racketeering enterprise that bribed witnesses, falsified evidence and induced perjured testimony.

A federal jury in Brooklyn last week convicted Morris J. Eisen and six others of racketeering and conspiracy charges stemming from fraudulent lawsuits filed in the 1980s against defendants including the city of New York and the city transit authority. Jury awards in some of those cases exceeded $1 million, according to the U.S. Attorney's office.

Also convicted were Joseph P. Napoli and Harold Fishman, lawyers with Mr. Eisen's firm; Geraldine G. Morganti, the firm's office manager; and Alan Weinstein, Dennis Rella and Marty Gabe, three investigators who worked for the firm.

Prosecutors charged, among other things, that the law firm won a $1.5 million award against New York City in a traffic death case using trumped-up physical evidence and a phony eyewitness.

In another case, prosecutors charged, the firm obtained a $15,000 settlement from an insurer of Aqueduct Raceway by persuading an employee of Mr. Eisen's to falsely claim he had fallen in a pothole in the

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Errors and omissions

• The Philadelphia Fire Department incorrectly stated that beneficiaries of firefighters killed in action are entitled to a $50,000 death benefit from the state of Pennsylvania as reported in the March 4 issue. The state pays a $25,000 death benefit, according to the state's office of risk and insurance management.

Right idea, wrong bill?

Insurers call Texas proposals unfair

By MICHAEL BRADFORD

AUSTIN, Texas—Sweeping regulatory reform proposals designed to stabilize the Texas property/casualty insurance marketplace and improve insurer solvency could backfire on insurance buyers, industry sources contend.

If a 236-page insurance reform bill is approved by the Texas Legislature unchanged, it could reduce competition in the state and push up insurers' cost of doing business and, subsequently, rates, insurers and agents warn.

For example, one provision that would require insurers to write all lines of business in Texas that they write in other states could scare insurance companies away, according to insurers.

Also, a proposed flex rating system could raise some insurance costs because the bill would extend rate and form regulation to all insurers—including surplus lines companies.

Proposed higher capital and surplus requirements also have drawn criticism. Insurers complain some small insurance companies would be forced out of business, while a proposed cap on the amount of capital that large insurers must have would permit those companies to become highly leveraged.

And, by restricting the role of ratemaking organizations, observers say, the reform bill would increase insurers' expenses.

Sharp criticism of insurers in Texas partly fueled Gov. Ann Richards' support for the legislation —H.B. 2 in the House and S.B. 2 in the Senate.

A state auditor's report recently warned that future insurer insolvencies could cost Texas $329.2 million in premium taxes (*BI*, Oct. 29, 1990). And a state grand jury concluded that insolvencies and fraud in Texas could cost taxpayers up to $400 million (*BI*, Oct. 8, 1990).

In her first State of the State address, Gov. Richards earlier this year said that while on the campaign trail she had heard "horror stories" of "Texans mistreated by high-handed insurance companies."

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Sudafed-type capsules hard to insure: Experts

By STACY SHAPIRO

TACOMA, Wash.—The manufacturer of Sudafed 12 Hour cold capsules, which issued a nationwide product recall after cyanide-contaminated capsules killed two people and injured a third, could have up to $60 million of malicious product tamper insurance.

However, brokers, underwriters and Sudafed manufacturer Burroughs Wellcome Co. would not comment on whether the company bought the coverage because the policies are voided if such information is revealed.

Malicious product tamper coverage—which has been available for only a few years—has not been widely sold, brokers say.

And, capsules are not easily insurable, underwriters and brokers say.

Insurance industry experts do not expect Burroughs to file any claims under general liability insurance because they do not expect the company to be found negligent in marketing the capsules.

Research Triangle Park, N.C.-Based Burroughs sells the decongestant capsules in packages with three barriers against product tampering.

The U.S. subsidiary of The Wellcome Foundation in London, a multinational pharmaceutical company, recalled the time-released decongestant last week after it was notified that cyanide-tainted Sudafed capsules had killed two consumers and seriously injured a third in the Tacoma and Olympia, Wash., area.

Subsequently, several other cyanide-laced Sudafed capsules have been discovered in the same area.

The FBI is investigating.

Burroughs President and Chief Executive Officer Philip R. Tracy immediately issued a statement that the company was "moving rapidly to alert the public" and retrieve all Sudafed capsules from retail stores. He expressed sympathy to the victims' families and assured them that the company would investigate the incidents

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401(k) investments in GICs may be hurt by FASB action

By JERRY GEISEL

NORWALK, Conn.—New rules that could possibly be implemented by the Financial Accounting Standards Board on valuing guaranteed investment contracts could reduce the use of the immensely popular GICs as a 401(k) plan investment option, some experts say.

But others caution that it is not clear whether the accounting board will even issue a new rule.

FASB could design a new rule so that many BICs—or bank investment contracts, a similar investment vehicle—would be largely unaffected.

"The honest answer is that what may be going on right now is very foggy," said Gary Blank, a vp and consultant with The Wyatt Co. in San Francisco.

At issue is whether a recent proposed change by FASB in the valuation of GICs held by defined benefit pension plans will be extended to defined contribution plans, like 401(k) plans.

In January, the board tentatively agreed to reverse an exception in a 1980 rule that allows defined benefit plans to value insurance contracts at a constant book value. Under the 1980 rule, known as FASB 35, other defined benefit plan assets must be listed at their current market value.

As a practical matter, the proposed change would have little impact on defined benefit plans because their GIC holdings are relatively small.

But benefit experts worry that FASB also could require defined contribution plans, which hold between $150 billion and $180 billion in GICs and BICs, to revalue them based on changing interest rates.

"How can FASB say there should be different rules for valuing GICs and BICs depending on whether

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Inside

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Terrorism fears remain despite end of Gulf War

By MICHAEL SCHACHNER and SARA J. HARTY

The cease-fire in the Persian Gulf should not signal the end of heightened risk management measures, including restrictions on international travel, experts warn.

Terrorism against U.S. concerns worldwide still is very much a possibility, say risk management and security consultants.

Because of the high threat of terrorism, the U.S. State Department has not revoked the travel advisories it issued at the outbreak of the war (*BI*, Jan 21). Travel warnings are still in effect for much of the Middle East, North Africa and Pakistan, among other places.

Most companies say employees are still not free to travel at will. But many add that tight restrictions are being loosened.

Airports, though, report that they are maintaining most of the beefed-up security measures they implemented as war loomed.

WAR in the GULF

"The war may be over for the soldiers, but for innocent people it's by no means over," according to Susan Brown, a senior analyst with International Risk Forecast, a division of Wackenhut Corp., a Coral Gables, Fla.-based security firm.

Ms. Brown said companies should take no comfort from the fact that there had been no large-scale terrorist acts on American interests either at home or abroad as of late last week.

"A big terrorist act takes months to plan and pull off, so we're advising businesses to keep up security," she said. Her firm recommends limiting travel to the Middle East and Europe to what is necessary.

In particular, Ms. Brown raised concerns about Palestinian-backed terrorism.

"The crushing defeat of Saddam (Hussein) will only inflame Palestinian frustration. They just can't seem to pick a winner. I think that we can expect some sort of terrorist response from them," Ms. Brown said.

"We're still telling our clients to make decisions on international travel based on absolute necessity," said Herb Clough, executive

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AP/Wide World Photo

Twenty-five people were killed when the United Air Lines jetliner crashed near the Colorado Springs, Colo., airport.

Latest disaster may fuel higher aviation rates

By STACY SHAPIRO and GAVIN SOUTER

COLORADO SPRINGS, Colo.—United Air Lines Inc. has $850 million in liability insurance to cover claims from the March 3 crash of a Boeing 737 jetliner that nose-dived into a Colorado park, killing all 25 people on board.

The latest aviation disaster, coupled with a jetliner crash last month, could put more pressure on aviation insurance rates, which recently began to rise after more than four years of decline.

Meanwhile, aviation hull war risk underwriters may recover at least a portion of a $340 million claim they paid to Kuwait Airways Corp. last year if the Iraqi government returns, as promised, Kuwait Airways jetliners and equipment taken following last August's invasion of Kuwait.

United Flight 585, en route from Denver with 20 passengers and five crew members, narrowly missed an apartment complex and a playground before crashing into a gully in Widefield Community Park four to five miles south of Colorado Springs Municipal Airport.

While the weather was clear at the time of the crash, there were high gusty winds. However, federal investigators said last week that it was too early to conclude that the crash was caused by wind shear, which is a sudden shift in wind direction and speed that can cause an aircraft to plunge to the ground.

In accidents caused by wind

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Asbestos firm's insurer to pay $142 million

Fibreboard settles suit

By DOUGLAS McLEOD

CONCORD, Calif.—Fibreboard Corp. stands to collect $142 million after settling litigation over insurance coverage for asbestos personal injury and property damage claims.

Concord, Calif.-based Fibreboard announced last week that it had reached an agreement with Pacific Indemnity Co., a unit of Chubb Corp., under which Fibreboard will receive a $35 million reimbursement of paid or outstanding bodily injury claims and defense costs.

In addition, Pacific Indemnity will pay $107 million into a trust fund to cover future asbestos-related bodily injury and property damage claims and defense costs.

The settlement is contingent upon the California Court of Appeal reversing an earlier state jury verdict against Pacific Indemnity on a specific coverage issue.

In the course of massive coverage litigation pitting Fibreboard and other asbestos producers against numerous insurers, a California Superior Court jury found that a 1956-1957 Pacific Indemnity general liability policy did not include an aggregate limit, according to Fibreboard attorney William R. Irwin of Brobeck, Phleger & Harrison in San Francisco.

The settlement between Fibreboard and Pacific Indemnity requires that the appeals court overturn this jury finding, effectively closing off the possibility that Pacific Indemnity could remain exposed to claims under that policy after the settlement, he explained.

Fibreboard and Pacific Indemnity will jointly file an application with the appeals court to reverse the jury verdict.

A decision by the court is expected to take several months, Fibreboard said.

"Both Fibreboard and Pacific Indemnity are optimistic that the Court of Appeal will implement the settlement of this long-standing coverage case," Fibreboard Chairman Lawrence C. Hart said

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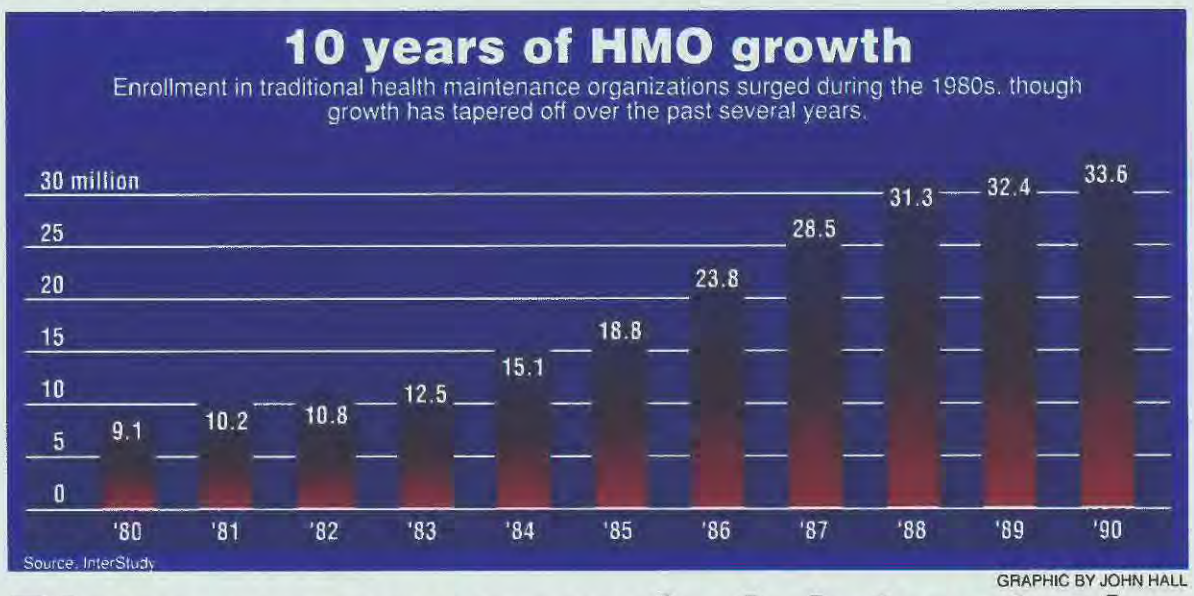
Growth of traditional HMOs slows



GRAPHIC BY JOHN HALL

Plans go open-ended: Interstudy

By JOANNE WOJCIK

With growth in traditional HMOs slowing, health maintenance organizations are trying to remain competitive by diversifying their offerings to include open-ended HMOs, a new study shows.

And, as the market appears headed toward a saturation point, HMOs also have stepped up mergers and acquisitions, according to InterStudy, a managed care research group in Excelsior, Minn.

Enrollment in traditional HMOs boomed in the 1980s, but has slowed significantly in recent years. For example, it grew 270% between July 1980 and July 1990, but only 3.5% between July 1989 and July 1990 (see chart).

Meanwhile, enrollment in open-ended HMOs has almost tripled to 1.04 million in July 1990 from 378,671 in December 1987, according to the study, "Managed Care: A Decade in Review 1980-1990."

Open-ended, or point-of-service, HMOs permit enrollees to seek treatment from providers outside the network, albeit for lower coverage of costs.

Based on information from 96 HMOs with open-ended plans, enrollment in open-ended plans rose 21.4% to 1.04 million on July 1, 1990, from 857,995 on Jan. 1, 1990. In the same period, traditional HMO enrollment grew only 1.6% to 33.6 million from 33.1 million.

"A lot of HMOs are interested in developing more hybrid products," such as open-ended plans, explained Michelle Porter, one of the InterStudy survey authors.

In fact, that growth has been so significant that InterStudy's July

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Firms seeking PPOs, new options: Hewitt

By CHRISTINE WOOLSEY

While employers are increasingly turning to managed care alternatives to contain rising medical plan costs, the most popular managed care initiative—the traditional health maintenance organization—is falling out of favor, a new survey says.

Employers new to managed care are instead leaning more toward preferred provider organizations and open-ended HMOs, the survey found, even though the survey reports that health care costs appear to be rising more slowly for employers with managed health care options like HMOs than for employers that offer only indemnity plans.

The "general mood among employers is that HMOs are less than effective in controlling costs," said Ken Sperling, a consultant in Rowayton, Conn., with Hewitt Associates, which sponsored the survey. "It's not that HMOs don't manage the care, it's just that employers feel like they don't get much in return."

Employers are fed up with rising HMO premiums, he said.

Hewitt surveyed 792 U.S. companies of various sizes from a range of industries to determine how those companies use managed health care plans.

According to the survey, the number of employers offering traditional HMOs is high—75% of the companies said they offer at least one HMO.

However, only 2% of the employers not currently offering HMOs said they plan to offer HMOs to their employees.

Dissatisfaction with traditional HMOs has led companies to seek managed care alternatives, Mr. Sperling said.

The survey found that 37% of employers offer at least one PPO and 7% offer at least one open-ended HMO.

Both PPOs and open-ended HMOs probably will grow in popularity, the survey found. Thirteen percent of employers said they plan to offer PPOs and 10% said they will offer open-ended HMOs.

Employers have been slow to embrace open-ended HMOs because of their expense and administrative complexity, Mr. Sperling noted.

In fact, according to the survey, 46% of employers that do not offer an open-ended HMO reported that one of the reasons they don't is because they are not convinced the plans are cost-effective. Another 31% cited concerns about adminis-

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Sudafed deaths

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"quickly and thoroughly."

The deaths occurred almost five years after a cyanide-laced Tylenol capsule killed a woman in Westchester County, N.Y., and nearly nine years after seven people died after ingesting cyanide-tainted Tylenol capsules in Chicago.

Authorities have never discovered who laced the Tylenol analgesic capsules in these killings.

Johnson & Johnson had stopped purchasing recall coverage years before the poisonings.

A federal judge later ruled that Johnson & Johnson's excess liability insurance did not cover the estimated $100 million cost of recalling the Tylenol after the 1982 deaths (*BI*, Sept. 22, 1986).

A federal appeals court also ruled that the recall costs were not covered by the company's property insurance as a business interruption expense (*BI*, June 23, 1986).

A trial is set for May 6 in Cook County Circuit Court over whether J&J is liable for damages to survivors of those killed in the Chicago incidents.

At the time of the Tylenol recall, only product recall and product extortion insurance were available. Product recall insurance covers only the cost of recall if a product is defective, and product extortion covers costs only if a ransom is paid.

After the second incident, capsules were eliminated from the Tylenol product line and replaced by solid, pill-like "caplets."

Drug companies, including Burroughs, have since made packages more tamper-resistant.

Three barriers are designed to alert consumers about possible tampering with Sudafed capsules:

- Capsules are sealed with a blue gelatin band, but the gel was missing from the cyanide-contaminated capsules the FBI has recovered.
- Capsules also are packaged in a so-called blister pack. The foil was slit on the packs that held the contaminated Sudafed capsules the FBI has recovered.
- The external carton containing the blister pack is sealed at both ends with tamper-evident tape. The FBI does not know whether the external cartons containing the contaminated capsules were tampered with, a spokesman said.

In addition, blister packs are marked with the same lot number printed on the external cartons. But the contaminated capsules were in blister packs with lot numbers that did not match the numbers on their external cartons.

Underwriters several years ago began offering malicious product tamper insurance to cover losses from products contaminated by third parties who do not demand a ransom.

The policy covers the cost of recall, scientific examination of the contaminated product and rehabilitation of the product, though rehabilitation costs are covered only up to 25% of the policy limit.

The policy also covers the cost of consultants that may be brought in during a crisis, particularly public relations and security consultants.

The leading underwriters of the coverage are American International Group Inc. of New York, which writes up to $30 million of limits, and Lloyd's of London syndicates led by underwriting agency Cassidy Davis Ltd., which write $20 million to $30 million of limits.

However, "no one will comment" on whether The Wellcome Foundation or Burroughs have the coverage, summed up Mark Drummond-Brady, director for Lloyd's broker Lloyd Thompson Ltd., which initially helped market the Lloyd's coverage.

Like kidnap and ransom or product extortion insurance, malicious product tamper insurance is voided if the policyholder reveals it exists, Mr. Drummond-Brady said.

"We can't say a client is insured even if it is," said Brian Street, a marketing manager for American International Underwriters in London.

Limits of about $50 million have been available only in the past year, said Jeffrey Green, chairman of Lloyd's broker Nicholson Chamberlain Colls Special Risks Ltd. Risk managers could only find about $30 million of limits about a year ago and only about $15 million two years ago.

Deductibles range from as little as $5,000 for a small company and as high as $5 million for some major manufacturers, Mr. Green said.

Premiums have dropped over the last two years by as much as half in some cases, Mr. Green said.

However, it is still not "common" for companies to buy malicious product tamper insurance, Mr. Drummond-Brady and Mr. Green agreed.

"It's not as common as we would like," Mr. Green said.

"It was slow to take off," Mr. Drummond-Brady admitted. "A lot of people sought quotes, but they didn't buy it."

In addition, capsules are not easily insurable.

"I shouldn't think that if they are capsules they are insured," said Mr. Street of AIU. Capsules "are one of the easiest targets."

While Mr. Green contended that "capsules are insurable," he agreed that capsules "are probably one of the least favorite products to insure. The underwriter would at least want tamper-evident packaging."

David Samuel, manager of the special services division at AIU, said product tampering coverage for capsules is very difficult—if not impossible—to obtain.

"Capsules are viewed as being very susceptible to tampering," he said.

Policyholders also could exclude capsules from the products insured because the risk may be too expensive to cover, Mr. Green noted. "A product may bring in 10% to 15% of turnover but cost the company 40% to 50% of the premium," he said.

"Capsules are insurable in theory," Mr. Drummond-Brady said. "But the underwriter is looking for a tamper-evident effort in the packaging of the product."

Insurers also will look at a firm's security program because disgruntled employees often are the culprits of product contamination, he said.

In addition, underwriters examine a potential policyholder's crisis management, especially how the company handles the media during a crisis, because that can affect the size of a loss, Mr. Drummond-Brady said.

AIU additionally would consider the history of the type of capsuled drug before deciding whether to write any coverage, said.

Meanwhile, some do not believe that Burroughs will be judged to be negligent in marketing the capsules.

"I think it would be a stretch of the imagination to say an insured was negligent if its product was stolen, tampered with and reinserted into the system. This scenario would only be covered under some sort of deep-pocket theory," said Peter Godfrey, a broker with Frank B. Hall & Co. Inc. in New York.

Burroughs would not comment about its general liability coverage.

However, a spokeswoman for The Wellcome Foundation in London said the three-barrier protection of the capsules exceeds that the Food and Drug Administration recommended after the Tylenol incident.

An FDA spokesman said that the agency recommends that sealed capsules, like Sudafed 12 Hour, be protected by at least one barrier and that unsealed capsules be protected by at least two barriers.

And, the company plans to discuss future protection procedures with the FDA, he said.

However, consumers must take some responsibility for checking packages, she added. "At the end of the day, the consumer wants to get into the packet, so you cannot put a 1,001 barriers in the way," she said.

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Associate Editors Adrienne C. Locke in Washington, D.C., Gavin Souter in London and Michael Schachner in New York contributed to this report.

THEY SAY LIFE HERE IS DIFFERENT THAN ANYWHERE ELSE. SO IS THE GROUP HEALTH PROGRAM.

The employees of Sun Studs, Inc. choose to live and work in the small towns of Oregon, because that suits their independent lifestyle. They don't fit the mold of the typical urban worker.

Independence is Sun Stud's way, too. That's why they chose self insurance as a way to provide attractive group health benefits for their employees while controlling costs for the company.

"Wausau's service contract enhances our group-health, self-insurance program," says Richard Sohn, Natural and Human Resources Manager of this forest products company. "We don't have the ability to self administer. When our employees have questions, we want them to ask their Wausau claims representative. We simply can't provide the quality services we see coming from Wausau." Every business is different. Some need full insurance coverage. Some only need services. Whatever your business needs, you need Wausau.

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HIAA, BC/BS issue small group proposals

Small employers would be able to obtain affordable health insurance for their workers under two separate proposals developed by the Health Insurance Assn. of America and the Blue Cross & Blue Shield Assn.

"The private insurance market has not been open to small business," said HIAA President Carl J. Schramm. The HIAA plan "would ensure that the health insurance market is open to those small employers."

The BC/BS proposal "is intended to guarantee availability of health insurance to the small employer market," said Bernard R. Tresnowski, president and chief executive officer at BC/BS.

The HIAA defines a small employer as having 25 or fewer workers. BC/BS defines a small group as those with three to 50 workers.

The HIAA's latest proposal is a

Benefit beat

fine tuning of the four-point plan it announced last year in response to the Pepper Commission's recommendations to ensure American's access to health care coverage (*BI*, March 12, 1990).

Under a section of the four-point plan that is separate from the section containing recommendations for making health insurance more affordable to small employers, the HIAA proposed allowing health insurers to offer small employers a low-cost product free from state mandates that covers basic benefits.

The new BC/BS proposal also contains this recommendation.

All 50 states require group health plans written by commercial insurers to cover specified minimum levels of health care. The requirements vary from state to state.

However, seven states allow insurers to market to small employers policies that do not meet all of the state's coverage requirements, while two states exempt certain small group policies from having to meet any state mandates.

Both the HIAA and BC/BS small employer market plans call for:

- Limiting how much a health insurer can increase premiums on renewal.

The HIAA proposal calls for limiting premium increases among employers with demographically similar groups of workers to 15 percentage points above the increase in the insurer's cost for these groups. However, premium would be capped at 135% of the average of the highest and lowest premiums paid by employers in that group.

In addition, the average premium paid by any group of small employers in a particular industry could not exceed 115% of the average premium paid by employers in any other industry group.

The BC/BS proposal endorses the model act adopted last December by the National Assn. of Insurance Commissioners that would cap rates for small group coverage (*BI*, Dec. 17, 1990).

- Guaranteeing that small employers that want to purchase group health insurance would not be denied coverage because of the group's experience.
- Guaranteeing that once coverage is written, an insurer cannot cancel coverage for a small group because of poor claims experience.
- Barring denial of coverage or imposing coverage restrictions for pre-existing medical conditions for a small employer that changes coverage or an individual who changes jobs.
- Creating a mechanism for spreading the cost of insuring high-risk persons.

The HIAA proposes establishing a private reinsurance pool in each state so a health care insurer could reinsure a policy written for a high-risk individual or small group. Each pool would consist of the health care insurers that write coverage for small employers in that state, and all of the insurers would share equally in the pool's losses. The reinsurance would be written on a three-year basis.

However, under the BC/BS plan, states would have the option of devising any type of health care reinsurance mechanism.

The HIAA is drafting a model bill that will be taken to the state legislators, Mr. Schramm said.

"We would like to see the whole thing in place within two years and through some states before the end of this legislature," he said.

BC/BS also plans to lobby state legislators to sponsor legislation adopting its recommendations.

—By Adrienne C. Locke

Early retirement plan

A special early retirement plan that Ford Motor Co. is offering to employees between the ages of 55 and 62 will increase monthly pension benefits 40% to 50% over regular early retirement benefits.

For example, monthly benefits would rise 43% for a 55-year-old retiree who worked at Ford for 25 years and whose salary was $60,000 on average during his last five years of service.

The Dearborn, Mich.-based automaker is enhancing early retirement benefits by waiving the so-called age reduction factor normally applied in calculating pension benefits for early retirees and increasing the Social Security supplement paid to retirees younger than 62, said Robert F. Tanner, director of compensation planning.

The move is part of Ford's previously announced effort to trim more than $3 billion from operating expenses and to avoid layoffs.

The increased early retirement benefits are available through March 31.

Under the plan, for workers who are off the payroll by April 30, Ford will waive the so-called age reduction factor that reduces monthly benefits about 3.33% for each year that the early retiree is younger than age 62, Mr. Tanner said.

Ford also will increase the multiplier used to calculate the Social Security supplement paid to early retirees.

Under the special plan, an early retiree will receive a monthly Social Security supplement equal to the individual's years of service multiplied by $25. Under Ford's regular early retirement plan, the multiplier is $11.

So, under the special plan, a 55-year-old retiree with 25 years of service and a $60,000 salary on average during the final five years of employment will receive $2,614 per month prior to age 62. After the retiree reaches age 62, the special Social Security supplement is eliminated, so the pension benefit is reduced to $1,989.

Under Ford's regular early retirement plan, which includes the age reduction factor and the reduced Social Security supplement, the same retiree would receive a monthly benefit of $1,827 until age 62. After that, the benefit would drop to $1,552.

The company has not forecast how many employees will retire early under the new plan, Mr. Tanner said.

—By Michael Schachner

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Opinions

Ruling not a complete loss

CONTRARY TO THE analysis reported in the general press, the business community can take heart in the U.S. Supreme Court decision last week on punitive damages.

The decision was not a complete loss for businesses because the court did not say that there are no constitutional limits on a jury's discretion to award punitive damages (see story, page 1.)

The court actually ruled that the Constitution requires proper instruction of the jury and significant judicial review of a jury's award of punitive damages.

Certainly businesses are disappointed that the court refused to draw a "mathematical bright line" on what constitutes excessive punitive damages that would fit every case. But hoping for such a clear definition was unrealistic, since this conservative court is not inclined to frame constitutional solutions to societal problems.

In requiring the proper instruction of juries and significant judicial review of jury-awarded punitive damages, the Supreme Court has sent an important message to judges around the country. Judges now know what the court considers proper instruction: that the jury must be told that the purpose of punitive damages is to punish and deter wrongful conduct, not to compensate the plaintiff, and that the imposition of punitive damages is not compulsory.

And, appellate judges now know that the Supreme Court expects them to consider more than whether a punitive award was manifestly and grossly excessive or the result of passion, bias or prejudice on the part of the jury, which have been the common considerations.

Furthermore, with every justice acknowledging there can be extreme results in the awarding of

•A NEW LINE IS DRAWN IN THE SAND•

punitive damages, the court has sent a signal to legislatures around the country and to Congress that this is a problem ripe for reform.

Most important, while somewhat fuzzy, the Supreme Court's limitation requiring significant judicial review draws a line that a punitive damage award must not cross.

In light of the court's ruling, business advocates are vowing to seek federal and state laws limiting punitive damage awards.

We agree with this tactic, but also recommend another: Promote the appointment, election and retention of competent judges who are responsible for instructing juries and reviewing punitive damage awards.

Letters

Looming Superfund threat shows need for reform

To the editor: It was good to read the report of the 1991 Harold H. Hines Jr. Memorial Symposium in your Feb. 18 issue, in which calls were made for Superfund reforms. If it is indeed true that we are faced with the prospect that either every major liability insurer in the country could be bankrupted or thousands of U.S. businesses could be forced to close, as suggested by Crum & Forster Inc., then certainly it is high time for Congress to act.

The London market also is concerned about these questions as a long-term coinsurer of American industry, as well as a reinsurer of domestic insurance companies. From this perspective, it seems that another item on the agenda must be an overhaul of American jurisprudence, since the way things are done now has a number of serious disadvantages. The impossible task of subjecting industrial companies operating in several states to numerous different court jurisdictions leads to a tremendous duplication of work and endless forum shopping. There is obviously little prospect of getting consistent rulings in state courts throughout the union, even though a comprehensive act like the Superfund law obviously needs to be comprehensively and consistently applied.

Moreover, there does appear in some jurisdictions to be evidence of bias against insurers, shown in a predisposition to find in favor of the policyholder regardless of policy language, to find non-existent ambiguities that have to be construed "contra proferentum" and generally to apply the deep-pocket theory.

The attitude in the courts does tend to encourage the presentation of claims that on the face of it have little merit, like claims against property insurers for the removal of asbestos from buildings. Insurers cannot shirk resisting such claims and inevitably find themselves again on the treadmill of litigation and forum shopping.

All of this leads to a serious waste of resources. The only beneficiary appears to be a class of persons who perhaps do not contribute greatly to the economic and industrial strength of the nation—namely the lawyers.

Returning to Superfund, we should all give our support to American International Group Inc.'s proposal under which a tax on insurance premiums would finance the cleanup of pollution from past waste disposal (*BI*, March 6, 1989). Insurers are ready to play their part and do their social duties, but if their reserves and capital are remorselessly looted, the end result will be a dead insurance industry.

Mark H. Tinsley
Non-Marine Underwriter
A.J. Whittall Syndicate
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'Juggling' the pension figures won't do

To the editor: The Dec. 10, 1990, Ask a Benefit Actuary Column by William J. Miner, "Stock Value Decline Affects Pension Costs," underscores how devastating an effect a mere 15% decline in stock values will have on pension costs.

Money managers should be aware that after eight years of market euphoria, the stock market is nearing record levels once again. When the market corrects and the next bear market begins, the risk is a lot more than 15% and potentially a lot more devastating to pension assets.

Mr. Miner's strategy is simply to accept the loss and then juggle the numbers to spread it out. The assumption is apparently that the market always goes back up and everything hopefully will be better next year. Amortizing losses and hiding losses through accounting principles, although perfectly legal, does not solve the real problem.

The real problem is that there is a huge risk in equity investments, now more than ever. And those who would never even consider leaving their plant, equipment, home, life or even their car uninsured often leave their largest asset—their pension fund—unprotected.

Exposing this asset to market whims, depressions, recessions and whatever is imprudent to the point of being negligent. With portfolio protection strategies based on derivative products readily available, why settle for amortizing losses? Someday, when the market suffers a decline and employers are called upon to explain what happened to the pension fund, the fiduciary is going to be held liable.

Michael D. Walsh
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HMO study

Continued from page 3

report will focus specifically on new product offerings, she added.

At the largest open-ended HMO, Physicians Health Plan of Minnesota with 211,158 members, enrollment rose by 9.5%, or 18,252, during the six-month period tracked.

Nine open-ended HMOs were formed between Jan. 1 and July 1, 1990, InterStudy reported. They are:

- American HMO of Little Rock, Ark., with 922 enrollees.
- HealthAmerica/Capital Care Inc. of Lincoln, Neb., with 2,200 members.
- HIP of New Jersey in Somerset with 735 members.
- M.D. Health Plans of North Haven, Conn., with 87 members.
- Physicians Health Plan of South Carolina in Columbia with 3,900 members.
- Qual-Med Oregon Health Plan Inc. in Portland with 8,536 members.
- Qual-Med Upper Arkansas Valley HMO of Pueblo, Colo., with 11 members.
- Rutgers Community Health Plan of Somerset, N.J., with 137 members.
- SHARE Health Plan of Illinois in Itasca with 230 members.
- SHARE Health Plan of Iowa in Des Moines with 87 members.

HMOs also have used mergers and consolidations to maintain their competitive edge, according to the InterStudy report.

"Rising health care costs underscore the importance of the economies of scale that HMOs can achieve through expansion and/or through enhanced market penetration rates," the authors wrote.

"Similarly, the increased clout of employers and other payers, as well as their interest in sole source vendors favors the development of multiple-site HMO firms that can cater to companies with employees in several different cities or states," the authors added.

Consolidation activity was particularly dramatic since late 1987, the survey authors point out.

InterStudy reported that 61 HMOs have merged or consolidated between Dec. 31, 1987, and July 1, 1990.

The average age of the 58 merging/consolidating HMOs for which characteristic information was available was 4.4 years.

Thirty-four, or 55.7%, were federally qualified, and the remaining 25, or 41%, were not federally qualified.

Forty-five, or 73.8%, of the merging/consolidating HMOs were for-profit, while 14, or 23%, were non-profit.

Merging HMOs included 40 independent practice association models, six staff models, 10 network models and three group models.

IPA model HMOs contract directly with physicians in independent practices, while staff model HMOs deliver health services through a physician group that is controlled by the HMO.

Network model HMOs contract with two or more independent group practices, while a group model HMO contracts with a single independent group practice.

The average size of the merging/consolidating plans was 24,800 members. Total enrollment for these plans was slightly more than 1.2 million members.

While Maxicare Health Plans Inc. accounted for only 12 of the plans involved in mergers or acquisitions, these plans' enrollment of 579,407 comprised more than 45% of the total enrollment for all plans involved in merger activity, the report noted.

Maxicare, once the nation's third-largest HMO operator with 2.4 million members, filed for protection under Chapter 11 of the Federal Bankruptcy Act after losses exceeded $250 million for the first nine months of 1988. A slimmed-down Maxicare emerged from bankruptcy last year.

Most merger/consolidation activity occurred in the South, where 19 HMOs were affected, followed by the Midwest at 17. Fifteen HMOs merged in the West, while 10 were involved in mergers or acquisitions in the Northeast.

The report also noted more frequent terminations.

A total of 76 HMOs with an average age of 3.26 years terminated operations between Dec. 31, 1987, and July 1, 1990, according to InterStudy.

Sixty-one, or 80.2%, of these terminated plans were not federally qualified plans, while 15, or 19.8%, were federally qualified.

And 58, or 76.3%, were for-profit organizations, while the remaining 18, or 23.7%, were non-profit.

By model type, 61, or 80.2%, of the terminating HMOs were IPAs; nine, or 11.8%, were network models; five, or 6.6%, were group models; and one was a staff model.

The average enrollment of the terminated HMOs between Dec. 31, 1987, and July 1, 1990, was 7,596, but the median enrollment for that period was only 3,650.

The problems at Maxicare account for five of the terminating plans between December 1987 and July 1990, and for a total of 164,470 terminating members—nearly 30% of the total enrollment of all of the terminating HMOs during the time period, the InterStudy report notes.

Twenty-eight, or 36.8%, of the terminating HMOs were located in the South; 27, or 35.5%, in the Midwest; 15, or 19.8%, in the West; and six, or 7.9%, in the Northeast. Taking into account both mergers and terminations, Interstudy reports a total of 556 HMOs as of the end of 1990, a 16% decline from 662 as of year-end 1987.

Managed health care is weathering the shakeout without major upheaval, the InterStudy survey authors observed.

"Health care purchasers may be more nervous now about financial stability because of Maxicare's and others' experiences and they may request more assurances of solvency as a result, but it is clear now that they are not shying away from managed care plans," the authors state in the report.

It is also notable that "most of the comings and goings over the past few years has been among younger, smaller firms with limited market penetration," the authors said. "Most of the fluctuations among national firms has occurred in the under-200,000 member category, with the obvious exception of Maxicare."

Maxicare's experience, they add, shows that sheer size does not necessarily translate into stability.

"A firm, no matter what its size, must be able to manage costs as well as manage care in order to survive in the decade ahead," the authors warn.

Despite the slower growth in traditional HMOs during the latter part of the decade, HMO enrollment has surged 270% since 1980, the InterStudy report said.

"In 1980, pure HMO enrollment in the United States and Guam totaled 9.1 million. In just 10 years enrollment would climb nearly 270% to 33.6 million," said the report in its summary of development and enrollment trends since 1980.

Annual growth rates peaked in 1986 when traditional HMO enrollment increased 25.2% to 23.7 million from 18.9 million in 1985.

While 1987 enrollment grew 21% to 28.6 million, it was the beginning of a decline. Enrollment grew just 9.7% in 1988, 3.6% in 1989 and 3.5% in 1990, InterStudy figures show.

But slower growth among traditional HMOs "must be interpreted in context," the authors assert. "Growth in managed care per se has not slowed; on the contrary, the cost containment techniques characteristic of pure HMO products are now spreading industry-wide into indemnity plans, PPOs, open-ended products and so on."

The InterStudy report also pointed out that HMO penetration in the Northeastern United States quintupled during the decade—from 3.1% in 1980 to 15% at the end of the decade.

In the West, which had a significantly greater proportion of its population enrolled in HMOs, penetration doubled during the decade to 24% from 12%.

But after rising sharply in the mid-1980s, penetration in both the Midwest and the South has plateaued since 1987.

Even so, 12.6% of the people in the Midwest were enrolled in HMOs last year, compared with only 2.8% in 1980. In the South,

Continued on next page

Continued from previous page
penetration reached 7% in 1990 compared with 1% in 1980.

The three largest HMOs have remained unchanged during the decade, according to InterStudy.

Kaiser Foundation Health Plan Inc. holds the No. 1 and 2 spots with more than 4.6 million members enrolled in its Northern and Southern California plans at midyear 1990.

Health Insurance Plan of Greater New York ranks third with 901,111 members enrolled in both traditional and open-ended plans.

Health Net of Woodland Hills, Calif., which held the No. 16 spot at the beginning of the decade, has since catapulted into the No. 4 position with membership of 762,000. The 11-year-old network model HMO has recorded a steady growth of 20% to 30% per year since 1980, with the one exception of 6.3% in 1986-87.

Rounding out InterStudy's list of the 10 largest HMOs are:

- HMO of Pennsylvania in Blue Bell with 542,000 members as of July 1, 1990, which entered the decade in 21st place.
- PacifiCare of California in Cypress with 474,472 members, which ranked 104th in 1980.
- Group Health Cooperative of Puget Sound in Seattle with 456,000 members, which held fourth place in 1980.
- Harvard Community Health Plan of Massachusetts in Brookline with 415,336 members, which was the 17th-largest HMO in 1980.
- Health Alliance Plan of Michigan in Detroit with 386,888 members, which ranked 20th in 1980.
- HMO of New Jersey Inc. in Paramus with 378,000, which was formed only seven years ago.

Because InterStudy ranked plans individually, the consolidated plans of CIGNA Healthplan Inc., PARTNERS National Health Plans, U.S. Healthcare Inc. and Pru Care did not make it into the Top 10. *Business Insurance*, on the other hand, includes all plans operated by the same company when ranking the largest HMOs in its annual Managed Care Market Report (*BI*, December 1990).

Despite the drop in the number of traditional HMOs over the past few years, the number of traditional HMOs more than doubled during the 1980s. The 556 traditional HMOs as of 1990 was a 135.6% jump from 236 plans in 1980, InterStudy reported.

The most dramatic growth was seen in individual practice association model HMOs. InterStudy reported 350 IPA model plans in 1990, a rise of 260.8% from 97 in 1980.

InterStudy did not begin tracking network model HMOs until 1981. There were 82 network model HMOs last year, up 290.5% from 21 in 1981.

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Single copies of "Managed Care: A Decade in Review 1980-1990" are available for $120 from InterStudy, P.O. Box 458, Excelsior, Minn. 55331; 612-474-1176.

HMO premiums increase faster than inflation

Increases in family HMO premiums either matched or exceeded inflation through most of the 1980s, a study shows.

Price wars brought annual premium hikes closely in line with inflation during 1987 and 1988, but premiums were raised an average of 19% in 1989 to compensate for collective industry losses of $887 million, according to InterStudy's report, "Managed Care: A Decade in Review 1980-1990."

And although 1990 HMO premium increases averaged 15.9%, "it was still more than double the rate of increase observed in the Consumer Price Index that year," the authors observed.

The CPI rose just 6.3% in 1990, according to the Bureau of Labor Statistics.

The lowest annual HMO premium increase recorded during the decade came in 1987, when the average family premium grew just 3.4% to $216.82 per month from $209.67 the year before.

The Consumer Price Index rose 3.6% that year.

Inflation outpaced HMO premium hikes in only two other years during the decade. In 1980 the average HMO premium rose 7.1% while the CPI rose 13.5%. And in 1981 the average HMO premium rose 9.9% while the CPI jumped 10.3%.

The average 1990 family HMO premium of $311.30 per month was nearly triple the $112.32 average in 1980, InterStudy reported.

—By Joanne Wojcik

United crash

Continued from page 3

before impact," but this did not happen in the March 3 crash, a spokesman for the National Transportation Safety Board said, adding that wind shear had not been completely ruled out.

And, "there's no evidence to suggest sabotage," he noted.

Investigators noted last week that the plane appeared to be functioning normally just seconds before the crash, which occurred during the approach to the airport.

The spokesman said the crash investigation is continuing and could not predict when a preliminary report would be released. "Nothing is ruled out, nothing is ruled in" in terms of cause, he said.

Poor quality of the voice recorder tape, limitations of an older flight recorder and lack of survivors or physical evidence are complicating the investigation, he said. A final report is not expected for nine to 12 months.

The Boeing 737-200 is insured for $14.2 million, and United carries $850 million in liability insurance, London sources confirm.

Underwriters had not set up a liability reserve as of midweek.

United's hull and liability coverage, renewed Oct. 1 for 12 months at marginally lower rates, is led in the United States by Associated Aviation Underwriters, in the London company market by The Orion Insurance Co. P.L.C. and at Lloyd's of London by syndicates managed by Janson Green Management Ltd.

About 40% of the coverage is placed in London.

Broker Rollins Burdick Hunter Co. of Chicago placed the coverage in the United States, while Sedgwick Aviation Ltd. placed the London portion.

This is the fourth mishap for United since December 1988, when a McDonnell Douglas DC-10 ran off the runway in Denver. There were no injuries, but hull damage was about $10 million.

Nine passengers and crew were killed in February 1989 when the fuselage of a United Boeing 747 tore open on a flight to New Zealand from Honolulu (*BI*, April 16, 1990; Feb. 27, 1989).

And 112 passengers and crew were killed in July 1989 after a United DC-10 lost its hydraulics and crash-landed in Sioux City, Iowa. More than 180 passengers and crew members survived (*BI*, Nov. 5, 1990; July 24, 1989).

The NTSB concluded that the crash probably was caused by a crack in the jet's engine that went undetected by the airline or by General Electric Co., the engine's manufacturer. The $19 million jetliner was declared a total loss and insurers set up a liability reserve of $270 million for passenger losses.

However, insurers for United and two manufacturers—McDonnell Douglas Corp., which built the DC-10, and General Electric Co., the aircraft's engine manufacturer—each put up a third of the liability reserve, meaning that United's insurers have only set aside $90 million for the Sioux City crash, London sources say. That sharing agreement among the three parties only lasts until a court case determines how liability should be apportioned among them.

Meanwhile, aviation rates in the London market are still too low, despite recent hikes, said Peter Crawford, managing director of British Aviation Insurance Co. Ltd.

Aviation claims experience in 1990 was much better than in the previous three years, but aviation insurers' loss ratios will still deteriorate this year if there is an average number of claims because of low rates that were negotiated last year, Mr. Crawford said.

"There have been significant increases in rates for hull and liability, but even if these are maintained in 1991, they are still inadequate," Mr. Crawford said at the Sixth International Airline Insurance Conference held last week in London.

Consequently, airlines will have to pay significantly more for insurance in the future, he warned.

According to Mr. Crawford, airliner claims totaled nearly $770 million in 1990, broken down into:

- Hull war risk losses: $409.6 million.
- All-risk total hull losses: $159 million.
- Partial hull losses: $118 million.
- Liability losses: $82.7 million.

"One has got to remember that the premiums against which these loses were set were substantially reduced in 1990," said Mr. Crawford.

Aviation insurance experts last year expected total airline premiums of about $500 million in 1990.

In addition, although 1990 was labeled a "good year" by the aviation insurance market, it showed much worse claims experience than 1981, 1984 and 1986, which were also deemed good by the market, Mr. Crawford said.

When the rising costs of aviation claims are taken with the rising cost of reinsurance, rate increases must follow, Mr. Crawford said.

"We must be able to achieve an efficient and technically sound business," he said.

Airline premiums are already increasing. For example, USAir Group Inc.'s hull premium increased 119% and its liability insurance premium increased 135% when it renewed its coverage on Feb. 1, according to one London broker (*BI*, Feb. 11).

That coverage went into effect the same day that a USAir 737 crashed into a commuter plane at Los Angeles International Airport, killing 34 people.

To reduce its premium increase, USAir reduced the value of its fleet, effective Feb. 1. The insured value of the 737 was cut to about $16 million from $33 million.

USAir is one of the few major airlines to have renewed its aviation coverage this year. Coverage for most major airlines will be renegotiated in the fall.

Meanwhile, aviation hull war risk underwriters are waiting to hear whether the Iraqi government will return nearly $700 million in aircraft and spare parts to Kuwait Airways following the end of the Persian Gulf war.

If the jetliners and equipment are returned, the underwriters could recover nearly $340 million, one of the largest aviation hull war risk losses ever paid.

The aircraft were confiscated by the Iraqis after Saddam Hussein's army invaded Kuwait on Aug. 2. Late last year, aviation hull war risk underwriters led by Stephen Merrett agreed to pay Kuwait Airways about $300 million, the limit of the policy for ground losses, for the loss of the aircraft (*BI*, Sept. 24, 1990). Other underwriters said another $40 million was paid by insurers to the airline for loss of spare parts.

Although the underwriters' money was originally held in escrow, the claim has since been paid in full to Kuwait Airways, Mr. Merrett said last week.

Mr. Merrett said that he has heard "rumors" that the Iraqis will return the aircraft to Kuwait but that he has not been officially notified that they will be returned.

However, Kuwait Airways would receive aircraft valued at at least $350 million before underwriters were entitled to any repayment, according to Mr. Merrett.

Once the airline recovers equipment that equals the amount of its loss not covered by insurance, underwriters would be entitled to recoveries, Mr. Merrett said.

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Associate Editor Colleen Johnson contributed to this story.

Insurer appeals award covering investor losses

By MARK HOFMANN

TULSA, Okla.—Continental Casualty Co. says it will appeal a federal court order to pay most of a $52 million award to cover claims against lawyers and accountants that worked for Home-Stake Production Co., whose 1973 collapse led to the fraud convictions of several executives.

Continental Casualty and two other insurers also could have to pay up to $35 million in post-judgment interest, said an attorney for some of the 1,500 investors who have sued the oil and gas exploration company and its advisers.

U.S. District Judge Manuel L. Real ruled Feb. 19 that Continental Casualty, a CNA Financial Corp. unit in Chicago, should pay about $46.8 million to cover investor losses. Home-Stake marketed its leasing ventures to many high-profile investors as high-yield investments and, later, tax shelters.

A CNA spokesman called Judge Real's ruling "inappropriate" and said Continental Casualty will appeal. The two other insurers, units of Chubb Corp. and American International Group Inc., would not say whether they would appeal.

Home-Stake promised 300% returns to attract about $140 million from investors.

Continental Casualty had written professional liability coverage for accountants Elmer M. Kunkel and Norman C. Cross and a law firm, Kothe & Eagleton, all in Tulsa.

Some of the Continental Casualty policies, issued between 1964 and 1972, had no aggregate limits, according to William H. Hinkle, a Tulsa attorney who has represented some of the approximately 1,500 plaintiffs since 1974. The policies did specify a limit per claim, which the court interpreted as meaning a limit per claimant, he said.

A second liability insurer for the lawyers and accountants—American Home Assurance Co., an AIG unit in New York—was ordered to pay $3.3 million

And Federal Insurance Co., a Warren, N.J.-based Chubb unit that wrote excess coverage for Mr. Cross, was ordered to pay $2 million.

The three insurers also were ordered to joint and severally pay court costs of $390,560.

The judge also ordered the insurers to pay post-judgment interest that could hit $35 million, depending on how long the appeals process lasts, said William Wineberg of Broad, Schulz, Larson & Wineberg ir. San Francisco.

However, Federal Insurance was given several key exemptions. Under Judge Real's ruling, it will not have to pay post-judgment interest until American Home pays all it owes, including post-judgment interest.

From 1955 to 1973, Home-Stake used promises of 300% returns and tax savings to attract about $140 million from investors that included prominent business, entertainment, sports and political figures. Prosecutors later called the company a Ponzi scheme that used proceeds from the sale of new shares to give "dividends" to early investors.

Five company officers, including Mr. Kunkel, pleaded no contest to a variety of federal securities law and mail-fraud charges in a series of trials that began in 1976.

Judge Real awarded $132 million —about $101 million of which was to come from the two accountants and the law firm—in damages and interest to the plaintiffs on Nov. 16, 1989. Post-judgment interest is levied at 7.9% a year from that date. ■

Travel rules

Continued from page 3

vp of Paul Chamberlain International, a security firm in Beverly Hills, Calif.

"In the past when Arabs have been humiliated, it has resulted in terrorism. I anticipate severe crosscurrents and eddies as a result of the tidal wave of military success by the Allies," said Mr. Clough.

"There's no question that the threat remains, even though the motives may have changed," said Frank Johns, senior analyst with Business Risks International Inc. in Arlington, Va.

Iraqi sympathizers are no longer seen as the primary threat. Groups with different agendas may attempt to launch terrorist attacks in hopes that security measures may have been relaxed following the cease-fire, according to Mr. Johns.

"The Middle East was not a place you wanted to go to during the Iraqi occupation of Kuwait. But now, a lot more Americans will be going there as part of the reconstruction process. Thus, there'll be a lot more targets, and that's a problem," he said.

Mr. Johns emphasized that travelers to war-ravaged Kuwait and other Middle East nations should exercise "extreme caution." He advises remaining constantly alert and taking direct flights to minimize the possibility of security breakdowns.

Other terrorism experts are more optimistic. They emphasize that the threat from Iraqi-sponsored terrorist groups as well as Iraqi sympathizers may have been reduced with the overwhelming defeat of Saddam Hussein's army.

"I think we are seeing more and more Iraqi acceptance of the coalition's peace terms and it seems as though they wouldn't want to do anything to jeopardize the peace," said Philip Huntley, vp of Argen Inc. of New York, an anti-terrorism consultant.

'In the past when Arabs have been humiliated, it has resulted in terrorism,' says Herb Clough, a security consultant. 'I anticipate severe crosscurrents and eddies as a result of the tidal wave of military success by the Allies.'

Mr. Huntley said Americans probably can resume all travel but should keep a low profile and pick airlines known for security.

Blanket prohibitions on air travel were never really necessary, he added.

The Ackerman Group Inc. in Miami also never advised clients to completely eliminate air travel. Instead, it recommended traveling to certain Middle Eastern nations only when absolutely necessary.

However, E.C. Ackerman, the consulting firm's managing director, acknowledged: "We're concerned about a possible vengeance campaign from the Palestinians."

Many U.S. companies are not abandoning travel restrictions, though some are relaxing them.

Indeed, travel agencies report increased domestic and international airline bookings since the cease-fire.

At the London office of Corporate Travel Consultant Travel Agency in Oakbrook Terrace, Ill., international travel, excluding the Middle East, dropped about 40% beginning in January, but is quickly recovering, said Joel Timmel, executive vp.

Domestic business travel began to increase about two weeks ago, said Roger Bowman, executive vp of Richfield, Minn.-based Corporate Travel Twin Cities Inc.

However, he hasn't noted any increase in international travel.

Corporate Travel normally handles a fair amount of travel to the Middle East, all of which still is on hold, Mr. Bowman said.

Trans World Airlines Inc. of Mount Kisco, N.Y., and Pan American World Airways Inc. of New York report increased domestic and international bookings since the cease-fire.

The two airlines are reviewing their suspension of service to cities in the Middle East and eastern Mediterranean countries.

TWA curtailed service in mid-January to Tel Aviv, Israel; Cairo, Egypt; Istanbul, Turkey; and Athens, Greece, a spokesman said.

Pan Am suspended service to Riyadh, Saudi Arabia, and Tel Aviv in early January and service to Athens, Istanbul and Ankara, Turkey, shortly before the Allied ground offensive last month.

The airline hopes to decide by the end of this week whether to resume service to those cities.

Some companies are relaxing their travel restrictions more than others.

Gillette Co. of Boston is still banning travel to the Middle East.

But travel in and and around Europe and between Europe and North America is again allowed, if it is essential, said William L. Mather, director of risk management.

New levels of administrative approval have been set up for such travel and Gillette employees are told to use only airlines not affiliated with any of the coalition countries.

However, the travel policy, which took effect in late January, is being reviewed, Mr. Mather said.

No changes were reported in the travel policy that Holiday Inns Inc. set in January. Domestic travel remains unrestricted, but "international travel is prohibited unless critical," said Anthony Rodolakis, vp of risk management and insurance at the Memphis, Tenn.-based company.

Those restrictions will remain until management feels the threat of terrorism has reduced, Mr. Rodolakis said.

American Telephone & Telegraph Co. has relaxed its travel restrictions, said a spokesman at its New York headquarters.

AT&T banned international travel on Jan. 16, when the air war began, and discouraged domestic travel when the ground war began last month.

Under the relaxed policy, approval by a high-level executive is necessary only for employee travel to the Middle East.

While the company still is asking employees to re-evaluate all domestic and foreign travel plans, this to some extent is part of a travel cost-containment program begun in 1987, the company spokesman said.

Frank B. Hall & Co. of New York has not officially changed its travel restrictions since war broke out in the Persian Gulf, said Thomas V. Hallett, executive vp.

Officially, all travel to the Middle East, between Europe and North America and within Europe has been deferred unless there is a compelling business reason for the trips.

For example, a management awards meeting in April was moved to Hawaii from Italy for safety purposes.

Mr. Hallett concedes that administration of the policy has been somewhat relaxed recently.

Other employers are allowing greater travel.

Nearly all travel restrictions imposed by Hartford Group Inc. of

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Hartford, Conn., which were issued by parent ITT Corp. before the war broke out, have been lifted. Company policy stated international travel should be undertaken only if necessary.

However, a Feb. 12 addition to the policy still stands: No more than four employees can be on the same commercial flight, a spokesman said.

At American International Underwriters, a unit of New York-based American International Group Inc., employees are again traveling relatively freely, though no official policy has replaced the international travel ban implemented in January, said Brian Street, manager of city production in London.

Employees are traveling with "due care," Mr. Street said.

Just before war broke out, Boehringer Ingelheim Corp., a Ridgefield, Conn.-based pharmaceutical manufacturer, prohibited international travel except for emergency business.

Such travel was at the discretion of executives, said Douglas S. Williams, associate director of corporate insurance for Boehringer Ingelheim.

Travel to Western Europe has resumed since the cease-fire. But the continued threat of terrorism has prompted the pharmaceutical company to prepare safety tips for employees.

The tips, which are scheduled to appear in the company newsletter, include:

- Pick flights carefully. Select non-stop flights when possible and avoid airlines based in coalition countries.
- Never leave luggage unattended.
- Try to blend in with the population of the destination country. Do not dally in bars that Westerners frequent, and avoid wearing cowboy boots and flashy jewelry.

Company restrictions are being reduced, but security at airports, train and bus stations and ports is not.

U.S. airport and transit authorities responsible for safety, which significantly beefed up security at the onset of the Persian Gulf crisis, are leaving all security measures in place for the foreseeable future, officials report.

For example, the Federal Aviation Administration is not lifting its Jan. 17 orders prohibiting curbside baggage check-ins at airports and barring people without tickets from passing airport security checkpoints.

In addition, many U.S. airports continue to instruct security personnel to quickly pick up all unattended baggage and packages as well as ticket and tow all unattended vehicles in front of terminal buildings.

The Washington Airport Authority in Washington, D.C., which oversees both Washington National Airport and Washington-Dulles International Airport, began taking additional security measures last fall. More steps were added in January.

Bomb-sniffing dogs continue to roam the airport and trash cans that were removed from in front of the terminals have not been replaced, said an airport authority spokesman.

"We're not going to relax now, and neither are the rest of the airports around the country," he asserted. "I don't foresee any changes in security in the near future."

At the Metropolitan Atlanta Rapid Transit Authority, the police force has been instructed to continue taking all precautions against terrorism, a spokesman said.

"With or without the war, there is always the threat of terrorism," he said.

"You're always guarding against the obvious. We move more than half a million people every day, so we're very careful. If there's a package left around, it's removed and examined immediately," he said.

A spokeswoman for the Washington Metropolitan Area Transit Authority also said security is not being relaxed.

"We have always advised employees to be vigilant and report anything unusual. Since the war, we have picked up a number of lost briefcases and packages, but none have contained bombs," she said.

The Massachusetts Bay Transit Authority in Boston also increased security with the outbreak of the war. "Unresolved issues in the Middle East still exist, so we're not relaxing," a spokesman said.

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Associate Editor Meg Fletcher in Chicago also contributed to this story.

Asbestos claims

Continued from page 1

were areas of dispute. From now on, the reinsurers have agreed to hold back only that part of a claim they are disputing.

"From now on we will argue about the contentious 10% or so of each claim rather than 100% of it," said Robin A.G. Jackson, chairman of the Asbestos Working Party and a former Lloyd's of London underwriter.

"Cedants have accepted the right of reinsurers to receive adequate information and reinsurers have realized that London has done a good job and are prepared to speed up claims payments," Mr. Jackson told *Business Insurance.*

"Progress has been made as to how to present losses," agreed Wilhelm Zeller, a director of Cologne Re. "We have agreed upon a set of information that has to be provided by a cedant to his reinsurer and on that basis we (the reinsurers) have declared our intention to pay" the agreed portion of every claim thus presented, he said.

As a result, claims payments will start flowing more freely, predicted Mr. Zeller.

Mr. Jackson also says the discussions have helped to resolve two major areas of contention between London underwriters and their reinsurers: whether claims paid through the former Asbestos Claims Facility should be reimbursed by reinsurers; and how to treat aggregated asbestos claims.

However, Mr. Zeller cautioned that those "substantive issues" were not part of the recent agreement and will continue to be dealt with individually by reinsurers and cedants.

The agreement "will hopefully assist London market cedants in the collection of their reinsurance claims and will undo what had been built up into a not insignificant bottleneck," Mr. Jackson wrote in a letter to London underwriters Feb. 13.

The key to this is an agreement that all major asbestos accounts in the future will be presented to reinsurers in a format known as London Asbestos Reinsurance Information.

"London market and European reinsurers representatives have reached common ground on this range of information described as LARI," said Mr. Jackson.

Among the details prepared by London Market Services for each LARI profile will be:

- A schedule of coverage for the asbestos producer.
- Details of those policies, including policy periods, sums insured, self-insured retentions, whether defense costs are included within policy limits and the existence of any exclusions.
- All aggregate limits contained in the chain of coverage and whether they are linked by drop-down provisions.
- Separate limits regarding bodily injury and property damage claims.
- Details of any buy-outs and coverage settlements.
- Totals of allocated indemnity and policyholder defense costs.
- Amounts of costs other than indemnity and defense costs—like administrative costs—and the basis for their allocation.
- Documentation of policy wordings, including the wording of of underlying policies.
- Details of exposed reinsurance contracts and documentation of wording from such contracts.

The six major reinsurers each will be provided with a "LARI profile" for all major asbestos accounts, which also will be made available in summary form for reinsurers worldwide. Individual cedants will continue to present their own claims on standard asbestos claims forms, referring their reinsurers to the relevant LARI profiles.

"London intends to deliver presentations which are still outstanding on all London direct and indirect accounts exposed to asbestos losses on the basis of the LARI concept," Mr. Zeller explained in a letter sent last month to more than 100 reinsurers.

In his letter to London underwriters, Mr Jackson said that "reinsurer representatives confirmed their intention . .that substantial payments on account be made subject to production of information that will enable them to follow the settlements rationale."

However, while the London market and its leading reinsurers have reached agreement over the presentation of claims information, an accord on certain coverage aspects remains subject to individual interpretation.

The agreement will hopefully undo what had built up into a 'bottleneck,' says Mr. Jackson.

In the past, many reinsurers have argued that they are not legally bound to pay claims settled by insurers through the now-defunct Asbestos Claims Facility. They also have disagreed with London's interpretation of contract wording concerning asbestos claims aggregation (*BI,* Dec. 19, 1988).

The Asbestos Claims Facility was formed in June 1985 when 34 asbestos producers and 16 insurers signed the so-called Wellington Agreement (*BI,* July 1, 1985). Those insurers agreed to settle coverage disputes in asbestos bodily injury cases and to provide a joint defense against claims by victims. The facility was dissolved in early 1988, and later succeeded by the Center for Claims Resolution (*BI,* Oct. 17, 1988).

The issue of aggregating asbestos losses arises from clauses in reinsurance contracts that allow a ceding underwriter to add together all claims paid to one policyholder under one aggregate policy and treat it as one loss (*BI,* Jan. 25, 1988). Claims paid to another policyholder are treated separately as another loss.

Wording, however, varies considerably among contracts. And reinsurers claim such aggregation is only possible if the underlying policy contains similar aggregate clauses.

Mr. Jackson told *Business Insurance* he believes that reinsurers are now prepared to "respond positively" to claims processed through the Asbestos Claims Facility and its successor, the Center for Claims

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Resolution. In addition, the aggregate extension clause is not expected to continue to be a stumbling block to settlements, he said.

Following the recent talks, these coverage issues "have basically been put to bed," he said.

Yet Mr. Zeller said that such "substantive issues" were not part of the recent agreement and will still need to be resolved on an individual basis.

"We have reached agreement as far as the presentation of losses are concerned, but substantive issues should be left to be solved by bilateral agreement. We cannot bind other reinsurers to a set of rules which must be applied to each and every situation," he said.

Cologne Re and other leading reinsurers, adds Mr. Zeller, will be willing to take "a commercial view of such matters rather than a strictly legal interpretation."

Therefore, he explained, if reinsurers agree that cedants settled claims cost effectively, they will be more willing to pay their share of the claim even if legally their liability could be disputed.

Mr. Jackson acknowledged in his letter to London underwriters that "in discussions concerning substantive matters, only personal views were expressed on a confidential basis."

However, he noted that the reinsurers involved in the discussions responded "positively to cedants' presentations" relating to the Asbestos Claims Facility payments and the aggregate extension clause. "I believe that the leading European reinsurers have responded positively to our demonstration of good faith and that a major breakthrough has been achieved," he wrote.

"This should certainly open the way now not only to a greater understanding of the problem by reinsurers but also enable cedants to collect properly presented reinsurance recoveries without the need to pursue their reinsurers by either litigation or arbitration both of which are expensive and time consuming," he added.

"The understanding that we have come to with these few European reinsurers obviously only represents the views of those reinsurers. However, we hope that others who were watching what those companies were doing will now find it easier to respond to their legitimate and properly presented reinsurance claims," Mr. Jackson wrote, adding that "it would be a pity if some people continue to dispute over minutiae in wordings which really goes against the whole principle of the way in which reinsurance has been transacted internationally for so many years."

Further talks are scheduled with reinsurers in Scandinavia and the Far East by the end of May "so that other markets will fully understand the results of these European discussions," Mr. Jackson said. ■

GIC rules

Continued from page 2
they are held by a defined benefit or defined contribution plan?" asked Randolph Root, a partner with Kwasha Lipton in Fort Lee, N.J.

Donald Delaney, a FASB project manager, acknowledges that FASB is now examining the issue. But he said no decision has been made and that it is possible no recommendation will be made.

GIC participants may not realize that they may not necessarily receive the return that has been promised by the GIC issuer, Mr. Delaney noted.

For example, if the insurer that issues the GIC collapses, participants might not receive their full principal, FASB officials explain. And, some GICs have provisions in which penalties are imposed if a contract is terminated prematurely.

"Will FASB issue a rule in this area? That is an open question right now," said Murray Becker, president of Becker & Rooney, a GIC consulting firm in Teaneck, N.J.

Alternatively, the accounting board could decide that fair value is not an appropriate way to measure GICs that are "benefit-responsive." A GIC is benefit-responsive if plan participants can withdraw or transfer the full principal and accumulated interest.

'Will FASB issue a rule in this area? That is an open question right now,' Mr. Becker says.

If employers were required to adjust GICs on pension plan statements—like Form 5500, the annual statement filed with the federal government—based on prevailing interest rates, the GICs' values could gyrate as interest rates bounce up and down.

Some experts believe that if plan sponsors' Form 5500s had to reflect these revaluations, plans also would have to disclose those changes on account statements to participants.

"You can't have two different sets of books," commented Brian Ternoey, a principal with A. Foster Higgins & Co. Inc. in Princeton, N.J.

Others are not sure. "It is not clear that market value reporting would translate down to the participant statement. At this point, we don't know," said John Allen, a consultant with Hewitt Associates in Lincolnshire, Ill.

If revaluations showed up on account statements, employees might shun GICs in favor of less-volatile but lower-yielding investment options like money market funds, some experts say.

"Participants, psychologically, can't handle market volatility," explained James Hiner, a principal with William M. Mercer Inc. in Chicago.

"You could have participants receiving less retirement income," said Kim McCarrel, a Wyatt consultant in Portland, Ore.

Experts also note that it is not clear how GIC values would be adjusted since there is no secondary market for them.

Others question why a valuation rule is necessary.

"GICs are an instrument that offers a real benefit to participants. Current accounting treatment seems an accurate reflection of value for the participants. It would be tragic if that was lost," said Judy Markland, a vp with John Hancock Mutual Life Insurance Co. in Boston. ■

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Cumulative trauma disorders

As claims increase, firms eye prevention and early diagnosis

By Peter C. Madeja

REHABILITATION PROFESSIONALS and their services have always been influenced by trends in the insurance industry. This has proven especially true in the nature of cases that, as liberalized policies of claims acceptance have occurred, are directed to rehabilitation firms. Claims of this type include heart attacks or myocardial infarctions, which years earlier would not have been accepted as compensable but today are managed with less emphasis on contesting and more emphasis on controlling. The same may be said for many occupational disease claims that have undergone a similar evolution.

The same trend has resulted in a relatively new type of claim, known as cumulative trauma disorder or repetitive motion syndrome. Today these claims are more readily accepted by the insurance claims industry. This fact has left employers, insurers and rehabilitation professionals faced with the task of learning more—not only about CTD, but about how to control and manage the claims once they have occurred.

CTD represents a serious challenge for the insurance industry, and has left employers and the medical community scrambling for effective treatment plans to provide quality care in a cost-effective fashion. The impact of this new trend is certainly more far-reaching compared with those previously noted because of the large population that is exposed to this occupational hazard.

Cumulative trauma disorders arise in the workplace when a person, as part of his or her daily tasks, must repeat movements of hands, fingers or arms thousands of times a day (*BI*, Sept. 10, 1990). Those most affected are industrial workers on automobile assembly lines or manufacturing production lines, but CTDs know no boundaries. Meat cutters, supermarket checkers, casino card dealers and even typists using video display terminals are vulnerable.

If there is any doubt about the pervasiveness of CTDs, numbers tell the story. In 1988, 115,400 cases were reported to the Bureau of Labor Statistics—five times as many as in 1981. It has also been determined that repetitive motion disorders now account for at least half of all workplace illnesses.

This silent hazard in the workplace has become so serious that the Occupational Safety and Health Administration has released voluntary federal guidelines on how U.S. employers should take steps to prevent contributing situations by modifying work stations and jobs to reduce physical strain (*BI*, Sept. 1, 1990).

Over the past 10 years, we have seen a rising percentage of referrals attributable to the growth of CTDs. Identifying the disorder and taking steps to alleviate its effects has become a major concern. Although with CTDs there are no visible signs of injury, the damage to nerves, tendons and joints can be severely painful.

One of the most common and serious disorders is carpal tunnel syndrome, a compression of the median nerve that causes pain, tingling or numbness in the hand. Some industries have been particularly hard hit by this problem. The average rate of occurrence of carpal tunnel syndrome in general U.S. industry is 0.8 cases per 1,000 workers. But in the automotive and electronics industries, where highly repetitive tasks are common, the rate is 25 cases per 1,000 workers. Carpal tunnel syndrome also has been linked to typing on VDTs. Today, 46 million people use VDTs on the job, compared with 675,000 in 1976.

These statistics certainly suggest that CTDs are on the rise. Despite a shift from an industrial to a service-oriented economy, the problem can only become more challenging unless employers take serious steps toward prevention.

Although the OSHA guidelines suggest recommendations on how employers can make the workplace less physically straining, most employers are in the predicament of trying to cost-effectively implement these preventative programs without losing productivity.

Here is where rehabilitation professionals can assist the employer and employee, and mitigate the physical and financial problems associated with CTDs. Rehabilitation nurses and vocational counselors are educated to work with all parties to remedy existing cases and aid in prevention of potential ones. They should also be able to provide important objectivity when confronting the precarious balance of productivity vs. physical demands.

The rehabilitation professional's ability to personally meet with employee, employer and physician allows a common focus of recovery and return to employment. A case management approach that advocates only telephone contact with these parties will offer some form of control, but won't prevent today's more serious cases from becoming the problematic high-cost cases of tomorrow.

Recent independent studies have shown that every dollar invested in rehabilitation services will return $8 to $14 in claims savings. This is a potential savings that most employers can't ignore, especially in industries in which CTDs now account for a high percentage of workers compensation claims. Loss ratios for workers compensation have been 117% to 118% for the last several years, and as high as 120% in the early 1980s.

Without effective rehabilitation management, employers are at great risk, not only because of escalating claims, but because of an inability to retain and attract quality workers. Workers in high-risk occupations are becoming selective in joining firms that don't take a progressive approach in the treatment of its employees. In fact, one of our largest clients adopted an intensive rehabilitation program covering more than 100,000 employees, as agreed upon by management and the union.

There are many steps employers can take to prevent CTDs. One is to implement ergonomic principles in the workplace. An ergonomic study evaluates table height and physical levels of chairs and machinery to ascertain angles of impingement on nerves. Without ergonomic studies, workers using VDTs for eight hours a day could be straining hands, fingers, backs and necks.

The larger automobile companies have begun to implement ergonomics programs to adapt workplace conditions to accommodate employees, rather than try to change worker behavior to match the work environment—all in the name of CTD prevention.

Another preventive measure is job rotation. This practice has been especially successful with assembly or production line workers who can be rotated so they are not spending 100% of their time doing the same task. For example, a worker in quality control for a major automobile company may open and close a car door 1,000 times a day, causing strain to the wrist and hand. Another worker in the same area may be responsible for testing all of the buttons or knobs on the instrument control panel, causing finger strain. The solution is to rotate these workers so they are not straining the same extremities throughout the work day. If job rotation is not feasible, physical braces can be used to protect arms, hands, necks and other vulnerable areas from repetitive motion or carpal tunnel syndrome.

These strategies are instrumental elements of any prevention program. However, despite an increased interest in prevention, the reality is that employers and insurers are faced with managing the care as well as the cost of treatment associated with CTDs. The key here is recognizing the problems early and utilizing the expertise of the medical community and disability management firms. Together, their experience and familiarity with CTDs should promote a high level of care for the injured worker, as well as reduced costs in the medical and indemnity benefits areas.

Early diagnosis and treatment is just as important as prevention. Physicians and therapists agree that when CTDs are caught in the developmental stage, workers can be successfully treated through relatively inexpensive therapy. As soon as an employee reports vague symptoms, he should be examined by a doctor for systemic causes of pain and start receiving therapy. This is not only more cost-effective than surgery or long-term rehabilitation, it is the best method of care for the employee.

The likelihood of a fast recovery is best with a quick diagnosis of the condition. For example, employees complaining of symptoms associated with carpal tunnel syndrome should be sent to a hand specialist immediately. If a hand specialist is not accessible, the employee should be directed to an orthopedist or neurologist familiar with CTD.

There are two tests that are frequently used in early diagnosis of carpal tunnel syndrome. The first is an electromyogram, which pinpoints the location of the injury. In an EMG, an electrical stimulus is applied to the muscles of the forearm to assess nerve damage. The other test, using a vibrometer, sends an electronic stimulus through the arm and wrist to the fingers. The test determines whether there is an absence or dulling of sensation in the fingers resulting from compression of the median nerve.

Once an early diagnosis is made, the next step is starting the employee in a conservative therapy program. This approach entails immobilizing the wrist with a splint to allow the swelling within the carpal cavity to subside. This regimen is complemented with a selection of anti-inflammatory drugs like aspirin or ibuprofen.

Employees who consent to this conservative therapy for three to four weeks must be able to return to work gradually, under modified conditions to prevent aggravating the injury. Here the rehabilitation professional plays a major role in working with the physician and employer to accelerate return to employment. But, they must be careful to time the return and establish conditions for the return, so the ailment and subsequent disability do not recur. If, however, nerves and muscle fibers are damaged to the extent that surgery is required, it remains important to closely monitor the employee's progress and establish a return-to-work plan.

Preventive care, early diagnosis and conservative treatment not only save employers money in medical and indemnity benefits, they also promote a positive image among employees. By taking an early and sincere interest in the rehabilitation of employees, employers create a better work environment because employees do not feel abandoned.

CTDs have forced all parties to take a hard look at workers compensation benefits. The effect on employees and the costs to employers are as great as any industrial accident.

To successfully combat the impact of CTDs, employers and insurers must make disability management—along with prevention, ergonomic engineering and early diagnosis—one of the cornerstones of their risk management program. By doing so, they will assure employees and policyholders an effective balance of quality care and cost containment. ■

Peter C. Madeja is senior vp of General Rehabilitation Services Inc. of Berwyn, Pa., an independent provider of rehabilitaion services.

Workers compensation costs

Qualified self-insurance provides maximum control

By Catherine D. Bennett

CONTROLLING WORKERS compensation costs is one of the most difficult issues confronting risk managers today. Rising medical costs, increasing litigation, uncontrolled growth in the assigned risk pool population and broadening definitions of insurability are among the major forces driving the workers compensation cost spiral.

Searching for ways to control these escalating workers compensation costs, many risk managers are re-evaluating their current risk management strategy. A key component of such a strategy is determining the most effective way of financing losses. One of today's more frequently evaluated risk funding alternatives is qualified self-insurance.

Qualified self-insurance is a carefully designed plan in which a firm elects to retain losses up to a predetermined limit. Excess insurance is generally purchased to lessen the effect of any catastrophic occurrences, thus lending a certain degree of financial stability to the program. Among the services for which a self-insured company is responsible for providing, either internally or through an outside service provider, are program administration, claims handling, loss control, a risk information system and actuarial analysis. Self-insurance bonds and excess insurance are also generally required by most programs.

Although a qualified self-insurance plan entails a high degree of involvement on the part of a risk manager, such a program can be uniquely tailored to fit a company's needs and provides maximum control of program costs.

Qualified self-insurance is generally viewed as an appropriate alternative for a firm with a geographical concentration of exposures in a small number of states. This is because self-insurance requirements vary considerably among the states, and the increased administrative responsibility associated with maintaining a self-insurance program in many states could diminish any potential savings. It is, however, possible to establish a split program consisting of a qualified self-insurance component and a commercially insured component.

In essence, a self-insurance program is established in those states where the majority of operations are located, and the workers compensation exposure in the remaining states is rolled into a commercially insured plan. Thus, a qualified self-insurance plan may prove to be an effective program design even for those companies with operations widely dispersed in a large number of locations across the country.

Qualified self-insurance offers a number of potential advantages:

- Qualified self-insurance may achieve significant cash flow benefits. Some of the more traditional risk financing plans, like a guaranteed-cost program or incurred-loss retrospectively rated plan, require full premium payment on Day One or over the course of the policy year. Under a qualified self-insurance plan, no prefunding of losses is required.

Furthermore, workers compensation readily lends itself to self-insurance because of the extended payout schedule which is typically associated with this line of coverage. Industry data indicate that only 25% of ultimate losses are expected to be paid out during the first 12 months of the policy period. Moreover, workers compensation payments for a single policy year are expected to extend over 10 years. If a firm's payout pattern reflects industry trends or is determined to be lower than industry averages, the cash flow benefits achieved by a self-insurance program may be very meaningful.

- Loss reserves are held and generate investment income for the self-insured. This investment income can, in turn, be used to offset other costs associated with maintaining the program. Under most commercially insured plans, it is the insurance company that retains the loss reserves and benefits from the resulting investment income.
- Qualified self-insurance provides an immediate opportunity to capitalize on potential savings resulting from favorable loss experience. If a self-insurer manages to control losses, the positive impact of this achievement is reflected in the operating results of the current year. While favorable loss experience may be recognized by the commercial market in terms of more competitive pricing and a lower experience modification factor, it generally takes much longer for it to have a noticeable impact.
- Qualified self-insurance may achieve substantial savings due to the elimination of certain insurance expenses. For example, a self-insurer is not subject to the payment of premium taxes, rating bureau fees, residual market loadings or insurance company profit and acquisition costs. Depending on the specific circumstances, these costs may be extensive. For example, in some states and for certain insurers, residual market loadings run in excess of 100% of premium.
- A qualified self-insurance program can be tailor-made whereby the self-insurer purchases only those services needed. Again, this provides an opportunity for achieving potential savings. Although virtually all of the administrative services provided by a commercial insurer must still be maintained, a self-insurer may be able to provide those services internally or contract externally much more efficiently.
- Qualified self-insurance provides the risk manager maximum control over the program. For example, the risk manager decides whether services like program administration, claims handling or loss control are handled internally or by an outside service provider. If the services are to be provided on an external basis, it is the risk manager who selects the parties with whom he will deal and negotiates the terms and conditions of the contracts.

Although a qualified self-insurance plan entails a high degree of involvement on the part of a risk manager, such a program. . .provides maximum control of program costs.

- Qualified self-insurance provides a strong incentive to control losses, and this may result in long-term savings. A corporate philosophy that emphasizes on-the-job safety is critical to the success of a qualified self-insurance program.

While there are many areas in which potential savings may be achieved by a qualified self-insurance program, there are also a number of disadvantages associated with this type of loss funding mechanism:

- A self-insurer bears the burden of adverse loss experience. If a self-insured firm has not carefully and realistically selected its level of risk retention, unanticipated losses may have a harsh impact on the financial health of the organization.
- Qualified self-insurance entails increased administrative responsibilities for a firm's risk management department. Self-insurance requirements vary from state to state, and the required filings and periodic reports needed in some states can consume a considerable amount of time. In addition, the risk management department must administer the program or contract with outside service providers. This can result in considerable contract negotiations, and the program must be monitored on a continual basis.
- It may be difficult for a risk manager to budget for a qualified self-insurance program because a self-insured company must absorb year-to-year fluctuations in loss costs. Also, state fees and assessments are subject to change, which may introduce additional cost variability into the program.

It should be noted that, at times, aggregate excess insurance coverage may be unavailable or very expensive. Specific excess coverage may be available only in limited amounts. Many traditional insurance programs provide statutory benefits. Given the litigious nature of today's society and the increasing number of occupational disease claims reported, full coverage is generally desirable. The risk manager should carefully evaluate the firm's occupational disease exposure before implementing a qualified self-insurance program without aggregate protection or insufficient aggregate limits.

Similarly, the market for self-insurance bonds, which are required by some states, may be limited. For those bonds that are available, it is sometimes necessary to collateralize the full amount with a letter of credit. Thus, the unavailability or excessive costs associated with the required bonds may diminish the attractiveness of a qualified self-insurance program.

Qualified self-insurance provides no certificates of insurance. If certificates are required for operational purposes, qualified self-insurance may not be a viable option.

Another potential disadvantage is that establishing a qualified self-insurance program for workers compensation may increase the cost of commercial insurance or other lines of coverage. Often underwriting a package program may be more desirable from an insurance company's standpoint, as opposed to providing coverage only for the more volatile and less desirable lines.

Another consideration particularly relevant to private companies is that a qualified self-insurer must file its financial statements with the state, thereby making the information accessible within the public domain. Because of the sensitivity associated with financial information, this requirement alone may cause a company to opt for some other type of risk funding mechanism.

The decision to self-insure should be made with a long-range view toward the firm's future objectives because terminating a self-insurance program can prove to be costly. The financial and reporting requirements do not stop when a firm discontinues its self-insurance program, but rather those obligations remain with a self-insurer for as long as there are outstanding losses. Because of the high costs associated with abandoning such a program, a self-insurer may find that it must forego a more competitively priced commercial plan in any given year.

Finally, there are no significant tax advantages to be gained from implementing a qualified self-insurance program. Losses and expenses are deductible only as paid while loss reserves are not deductible. In essence, a qualified self-insurance program does not result in the loss of a tax deduction but simply delays the ability to take the deduction until losses and expenses are paid.

In contrast, a guaranteed-cost insurance program allows a policyholder to deduct the full premium amount, assuming it is fully paid, during the current year. As with any tax-related matter, the firm should seek the advice of tax counsel when considering alternative risk funding mechanisms.

Obviously, qualified self-insurance is not the most effective risk financing alternative for every organization. However, the number of self-insurers and the interest generated by this alternative program continue to grow.

The key to establishing a successful program is a complete evaluation of the feasibility of such a plan ahead of time. It is necessary to determine how a qualified self-insurance program compares to other risk funding alternatives, as well as how compatible it is with the firm's philosophy and objectives. By carefully addressing these types of issues, qualified self-insurance may ultimately prove to be the most effective risk financing plan available and a critical component in a firm's overall risk management strategy. ■

Catherine D. Bennett is assistant vp at Johnson & Higgins of Tennessee Inc. in Nashville.

Texas reform

Continued from page 2

When Texans turned to the State Board of Insurance, she added, "they found no relief."

When the insurance reform bill was introduced, supporters indicated that its main objectives were to stabilize rates, reduce insolvencies, eliminate insurance fraud and protect consumers (*BI*, Feb. 25).

"Those are our objectives as insurance agents" as well, said Bob Huxel, director of governmental affairs for the Independent Insurance Agents of Texas.

But the reform bill, as it stands, will do little to promote those goals, he contends. "An immense amount of work needs to be done."

"We're very much in favor of the stated purposes of the bill," agreed Forest Roan, Texas counsel for the American Insurance Assn. "Having said that, we don't believe the bill accomplishes legislators' goals."

"The insurance industry in Texas wants to assist the governor in attaining her goals of stable insurance rates," said Tom Bond, legislative chairman of the Texans for Responsible Insurance Reform in Austin, which represents several property/casualty insurer and agent trade groups and individual insurers.

But the bill "as currently drafted may do as much harm as good to both consumers and the industry," he said.

Paul Brown, director of governmental affairs for the Risk & Insurance Management Society Inc. in New York, concurred. "In general, it's a fairly good effort. I appreciate what they are trying to do. But I think they have a lot to clean up."

Observers also are concerned that the legislation would apply to workers compensation insurance, even though a sweeping workers comp law took effect Jan. 1. A trial is to begin March 25 on a suit filed by AFL-CIO charging that that law violates workers' due process rights (*BI*, Dec. 31, 1990; Dec. 10, 1990; Dec. 18, 1989).

"Our understanding is it was the intention of the law's framers to exclude workers compensation," said Charles Johanns, senior vp of Kemper National Insurance Cos. of Long Grove, Ill. "But the language we are concerned with would seem to sweep it in."

Both Messrs. Johanns and Bond said they would ask legislators to explicitly exempt workers comp insurance from the legislation.

Committee hearings on the bill began last week. Insurers and other businesses say they expect major changes before it comes up for a vote.

Indeed, Gov. Richards' staff was "very receptive" to industry complaints in meetings last week, Mr. Bond said. The staff "wants to understand" those complaints, said Mr. Bond, who was state insurance commissioner from 1982 to 1985.

"The governor has said—and I believe her—that she doesn't want to damage the state's insurance industry," said Mr. Bond, who is now an attorney with Akin, Gump, Strauss Hauer & Feld in Austin.

One industry complaint centers on a proposal to make insurers write in Texas all lines of business that they write elsewhere. Insurers claim that requirement would discourage companies from entering the state.

"If you're a company that is thinking about expanding to Texas, in all likelihood, you're not going to bring the kitchen sink with you. You're going to get started small. . .and expand if it looks like you can get your feet on the ground," said Rick Gentry, regional vp of the Insurance Information Institute in Austin.

Yet the proposal would bar any company "not willing to bring everything," he said. "I think that those kinds of requirements would be resisted by any kind of business."

Mr. Brown of RIMS warned of a capacity crunch if insurers balk at writing all lines in the state. Insurers that are forced to write unprofitable business in Texas are "not going to come at all," he said.

The AIA's Mr. Roan said he has "serious questions about the constitutionality" of the proposed requirement. "It's not only an onerous provision, it's a punitive provision," he asserted.

Careful to avoid suggestions that insurers are thinking of leaving Texas, Mr. Roan did say he could not "imagine that a prudent businessman" who had lost money in Texas and then "saw a provision like this, would want to stay."

Richard Geiger, a Dallas attorney and lobbyist for insurers, contended the measure would "take away management discretion, which doesn't seems to be in anybody's interest."

Some insurers could be exempt from the all lines of business requirement. Under the reform bill, the requirement would be waived for companies that show compliance would endanger their solvency.

Another provision calls for implementing a new flex rating system for property/casualty insurance. Rates would have to be within a still-to-be-determined range of a benchmark set by the three-member Texas State Board of Insurance.

Some insurer expenses—like those for lobbying and certain "perks"—could not be included in rate calculations. And investment income, which the state board does not currently take into account, would be considered in setting rates.

The legislation also would extend rate and form regulation to all insurers, including currently unregulated insurers and surplus lines insurers.

"Rates for an awful lot of people are going to rise," said Mr. Geiger, the insurance company lobbyist.

Critics complain that extending the regulation would force up rates for rural residents and homeowners generally because the state's 24 farm mutual companies and the Texas Lloyd's insurers have been exempt from rate and form regulation.

And that waiver has allowed the mutuals to hold down prices, said Edwin Schmid, legislative chairman of the Texas Assn. of Mutual Insurance Cos., a trade group for farm mutual insurers.

Requiring those insurers to charge rates set by the state—which historically are much higher than those set by the mutuals—would leave many of their mostly rural policyholders unable to afford insurance, claims Mr. Schmid.

And taking away the Lloyd's companies' freedom to set property rates will lead to higher rates for homeowners, said Mr. Geiger.

Texas Lloyd's companies are formed under Chapter 18 of the Texas Insurance Code, which allows individual underwriters to share risks and a common attorney-in-fact to bind contracts. Freedom from property rate regulation is their traditional advantage.

Mr. Geiger pointed out that many large insurers in Texas also own Lloyd's companies. Insurers often underwrite homeowners coverage through those companies, he said.

Homeowners rates charged by Lloyd's companies are 25% to 50% below those the state sets for other insurers, said the AIA's Mr. Roan.

The rate and form regulation provision also would apply to surplus lines insurers.

"Extending state regulatory control to surplus lines carriers would destroy a very necessary safety valve in the insurance marketplace because this type of insurance requires great flexibility in rates and coverages," said the Texans for Responsible Insurance Reform, which represents insurers and agents.

The surplus lines market, said Mr. Bond, is "very important" to buyers with aviation and environmental risks—particularly oil producers.

Insurance companies also criticize proposed increases in capital and surplus requirements. Those standards could cause smaller companies to cease underwriting, they say.

The reform bill would raise the minimum capital requirements for property/casualty companies 150% to $2.5 million from $1 million. Minimum surplus would be set as $2.5 million or 10% of total liabilities, whichever is greater, up from the current $1 million. However, the new surplus would be capped at $100 million, no matter the level of liabilities.

Insurers that do not currently meet the minimums, as well as new companies, must meet the capital and surplus requirements according to a sliding scale by Jan. 1, 1994.

Mr. Roan and others claim that the surplus cap would allow large companies to become highly leveraged.

An insurer with $2 billion of liabilities needs only $100 million of surplus or 5% of liabilities, Mr. Roan explained, rather than 10%. "I really think 10% is too low, but if it is set at 10%, then they shouldn't cap it at $100 million."

Some observers say that smaller insurers may not be able to survive under the proposed capital and surplus requirements.

Requiring at least $5 million in capital and surplus would probably eliminate nearly all 24 farm mutuals in Texas, said Mr. Schmid.

Under the reform bill, insurers would face added administrative burdens like developing their own rate and form filings, rather than relying on outside groups. That added work will lead to higher rates, claims Mr. Roan.

Data used to set auto, property and general liability rates would be collected by an unspecified state agency, rather than the advisory bodies. All insurers would have to have rate data audited by an independent certified public accountant.

Observers say the impact of those requirements is unclear.

"It's too early in the legislative process to tell what's involved," said a spokeswoman for the Insurance Services Office Inc. of New York.

Roy Wood, NCCI director of government, consumer and industry affairs for Texas, said: "We haven't looked at it in depth to know what the impact will be."

Conceding that it's unclear whether workers compensation coverage would be included in the new bill, Mr. Wood adds that the bill is aimed primarily at other coverages.

Requiring independent audits of all data concerning rates would be very expensive, Mr. Roan pointed out. "If we have to do that on every piece of data, the cost will be tremendous."

Because the data submitted to Texas regulators would be different from that submitted to other states, it will have to coded separately, also adding more operating expenses, he said.

The section of the bill dealing with prompt payment of claims also drew complaints from industry observers.

Insurers would be required to pay claims within 30 days or pay an 18% penalty to the policyholder.

Agreeing that most claims should be paid within that time, Mr. Huxel of the state insurance agent trade group said that he does favor some exceptions.

Claims from hail storms, hurricanes and other catastrophe "couldn't possibly all be closed within 30 days," he asserted.

He added that the bill does not clearly say whether the 30-day period should begin when ar. insurer is notified or when proof of loss is submitted.

"This is one of the most objectionable features" of the legislation, Mr. Geiger said. "In one place it says claims must be paid within 30 days, and in another place it says claims can't be paid without policyholder permission and the policyholder has 30 days to think about it."

Mr. Roan of the AIA also complained about proposed cuts in guaranty fund tax credits to insurers.

The bill would set up a pre-funded property/casualty guaranty fund of at least $150 million. Insurers would be able to claim premium tax credits of 40% for the initial assessment and any later assessments needed to maintain that minimum.

Insurers are now allowed 100% in premium tax credit for guaranty fund assessments.

"Now they want us to perform this function for society and they are making us eat 60% of it," charged Mr. Roan. "That's unfair. We're talking about some real dollars here."

Because insurers could begin taking a premium tax credit for prefunding the guaranty fund, the state treasury would incur an immediate loss of $60 million, or 40% of the $150 million requirement, said Mr. Bond of the Texans for Reasonable Insurance Reform.

The reform bill would also repeal insurers' exemptions from state antitrust law.

Even long-time champions of the McCarran-Ferguson Act say the time may have come for antitrust reform.

RIMS "realizes that revision or repeal of it is probably inevitable," Mr. Brown said. The reform move in Texas "is not a surprise," he said.

The Texas bill also would:

- Require that all policies be written in plain language.
- Require insurers to notify policyholders 45 days in advance of cancelling coverage or raising premiums.

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SET YOUR DATES

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closing:	March 6
conference report:	International Captive & Reinsurance Forum
demographic section:	Insurer Topics: Insurer-Agency Relations
issue:	March 25
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issue:	April 1
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demographic section:	Agent/Broker Topics: Compensation & Incentives
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Texas reform

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Policyholders typically have 30 days' warning under current law and industry practices.

- Extensively alter the State Board of Insurance. The name would be changed to the Texas Department of Insurance. The three-member board would remain in place and would continue to be called the State Board of Insurance, while the insurance commissioner's title would be changed to executive director.

The executive director would have greater day-to-day administrative authority over the agency.

Board members, the executive director and other high-level employees would be prohibited from working in the insurance industry for two years and from representing the industry for one year after leaving the department.

- Establish an anti-fraud unit within the department. The bill provides for criminal penalties for insurance fraud. Such crimes must now be prosecuted under a general criminal fraud statute, which outlines no specific penalties for insurance fraud.
- Strengthen the state Office of Consumer Protection. The law calls for separating the office from the insurance department and renaming it the Office of Public Insurance Counsel. The office would have the right to appeal any rate decision by the state board and recommend reform measures to the state board and the Legislature.

The office's authority would extend to all lines of insurance—including group health and workers compensation coverage—rather than just property/casualty as is the case under current law. ■

Wharton honors Danzon

By SARA J. HARTY

PHILADELPHIA—Patricia M. Danzon, who has researched the liability insurance underwriting cycle and health care for the uninsured, is the first Celia Z. Moh Professor at the University of Pennsylvania's Wharton School.

In addition, Ms. Danzon is the first woman named to an endowed professorship at Wharton.

Ms. Danzon

Laurence Za Yu Moh, a Wharton alumnus, established the chair with a $2 million gift in honor of his wife.

The professorship "recognizes the contributions of Pat Danzon," said Jerry S. Rosenbloom, chairman of Wharton's insurance and risk management department.

"I think it will enable her to continue her extensive research in the areas of health care and legal liability," he said.

Ms. Danzon "has made substantial contributions in administering the Ph.D. program, teaching health economics and pursuing a very important research program," said Mark V. Pauly, chairman of Wharton's department of health care systems.

Among other projects, Ms. Danzon served as project director for the Committee for Economic Development's 1989 study that found the U.S. tort system counterproductive (*BI*, May 15, 1989).

Ms. Danzon also has researched the effect of tort reform on medical malpractice claim frequency and severity.

The endowed chair "gives me additional resources to support my research in health care insurance and liability issues," she said.

Ms. Danzon, a member of the Wharton faculty since 1985, anticipates that her teaching and research schedule will not change.

Before joining Wharton, Ms. Danzon was an adjunct professor for the department of economics and an associate professor for the Center for Health Policy and the Institute of Policy Sciences at Duke University in Durham, N.C., from 1984-1985.

From 1980 to 1984, Ms. Danzon was a senior research fellow at the Hoover Institute at Stanford University in Palo Alto, Calif.

From 1974 to 1980, she was a research economist at the Rand Corp. and conducted research for Rand's Institute for Civil Justice.

After receiving a bachelor's degree from Oxford University in 1968, Ms. Danzon attended the University of Chicago, receiving a master's degree in economics in 1969 and a doctorate in economics in 1973.

—By Sara J. Harty

INTERNATIONAL

Worst year ever for British insurers

By GAVIN SOUTER

LONDON—A huge increase in weather and subsidence claims in 1990 virtually wiped out profits for four major British insurers.

In what has been described as the worst year ever for British non-life insurers, profits were also hit by rising reinsurance costs and an overall increase in general claims, say insurers.

And despite the insurers' promise to push up premiums this year, prospects for 1991 and 1992 remain gloomy, says a leading analyst.

All but one major British insurer have posted losses or are expected to within the next few weeks.

Only Commercial Union P.L.C. finished in the black. And most of its slender profit—1.4 million pounds in 1990($2.7 million), down from 150.5 million pounds ($242.9 million) in 1989—is attributable to strong life business in the United Kingdom and in The Netherlands.

General Accident P.L.C. posted a pre-tax loss of 121.3 million pounds ($234.1 million) last year, compared with a profit of 147 million pounds ($237.3 million) in 1989. The company said it will take strong action to cut its U.K. costs and raise rates.

Royal Insurance Holdings P.L.C. reported 1990 pre-tax losses of 187 million pounds ($360.9 million), compared with a 126 million pound profit ($203.4 million) the previous year.

"The results have been dominated by the exceptional level of weather-related losses and a marked increase in the number and size of large property losses," said Ian Rushton, the group chief executive.

At Eagle Star Group P.L.C., 1990 pretax losses were 127.9 million pounds ($246.8 million), compared with a pre-tax profit of 307.8 million pounds ($496.8 million).

"The levels of general business losses being declared for 1990 by us and the industry as a whole are unacceptable. Resolute action must be taken to achieve realistic levels of premium," said Michael Butt, chairman and chief executive of Eagle Star.

Storms early in the year were a major factor in the deterioration.

Those storms and the high number of subsidence claims after the unusually hot summer accounted for almost two-thirds of the 145.4 million pound ($280.6 million) non-life underwriting loss at Commercial Union, said Peter Ward, the insurer's general manager.

The storms alone cost the company 55 million pounds ($106.2 million) after reinsurance, he added.

Also contributing to the losses were more theft claims, higher motor claims costs and "a general increase in the number of large claims from major fires and severe personal injury cases," he said. More than 53,000 theft claims cost an average of 600 pounds ($1,158) each, up 50% from the 1989 average.

Commercial Union also paid 132 industrial fire claims exceeding 100,000 pounds ($193,000), compared with 90 in 1989. Those claims cost the company 58 million pounds ($111.9 million) in 1990, up nearly 60% from 24 million pounds ($39.1 million) in 1989, he added.

Total fire damage in the United Kingdom increased by 25% in 1990, said Mr. Ward.

However, competition among non-life insurers remains intense, Mr. Ward said.

"The major insurance companies are competing in an effort to maintain their market share," he noted.

Generally, companies need to raise revenues 15% to 20% to return to

Continued on next page

AXA sets sights on U.S. but rejects Equitable

By WILLIAM PITT

PARIS—Although it recently rejected an investment overture from The Equitable Life Assurance Society of the United States, AXA Midi Assurances S.A. says it still is interested in acquiring a suitable U.S. insurance company for $6 billion to $8 billion.

Paris-based AXA last month rejected an offer to acquire a small stake in Equitable, the huge American mutual that is seeking investors to help it convert to a stock company.

After talks with Equitable representatives, Claude Bebear, the chairman of AXA, decided against investing because it was being offered only a minority stake, said an AXA spokesman.

Mr. Bebear

Equitable, for its part, will not comment on talks with potential investors. The mutual company, which is among the largest U.S. life insurers and issuers of guaranteed investment contracts, announced in December that it was planning to raise a $500 million by converting to a stock company (*BI*, Dec. 17, 1990).

An Equitable spokeswoman said responses to that move have been "very positive," but she said it is "much too early to name" any interested investors.

AXA is much less shy. Since his $4.5 billion bid for Farmers Group Inc. fell through last summer, Mr. Bebear has made no secret of his wish to make a major U.S. investment (*BI*, May 21, 1990).

The AXA spokeswoman said that while the "U.S. insurance industry has its problems," it is a "good time to invest—to benefit from the recovery prospects."

No particular type of insurer—life, property/casualty, personal lines or commercial—has been targeted by AXA, she said. "It's a question of opportunity. We have our eyes open to all markets."

AXA's only U.S. holding is its reinsurance unit, AXA Reinsurance Co. of New York, which wrote gross premiums of $50.9 million in 1989. That limited role hurt the company's bid for Farmers. Opponents of the bid seized on the argument that AXA's limited U.S. experience made it an unworthy custodian for a major personal lines insurer like Farmers.

Expansion-minded Mr. Bebear is not setting his sights only on U.S. companies. Western European and Southeast Asian companies have also caught his eye, the spokeswoman said.

But investment in Eastern Europe, which has been widely discussed by major U.S. and European insurers, holds little appeal for AXA, she said. "There's nothing insurable there. It may be interesting in 10 years."

With a joint venture company designed to expand in Europe sitting idle, AXA will pursue its own strategy in Western Europe, she said.

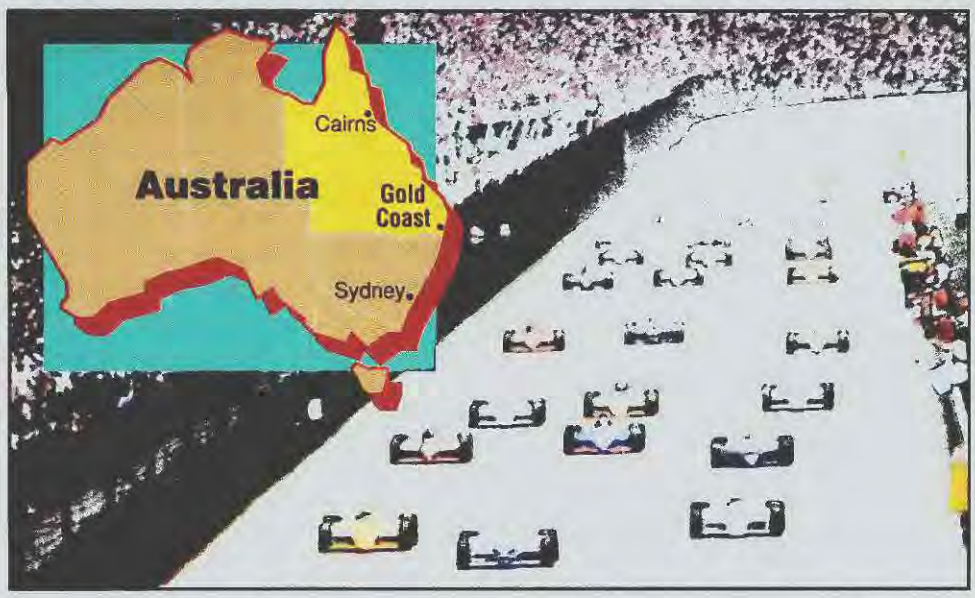
The venture, Generali-Midi Expansion, was capitalized with 6 billion French francs ($1.18 billion at year-end exchange rates)—60% from Assicurazioni Generali S.p.A. of Trieste, Italy, and 40% from AXA. Its avowed aim was to buy stakes in other European insurers. So far, though, it has done "nothing at all," the spokeswoman said.

AXA's strategy is to aim for control of companies, she explained. In this way, the company is more like Allianz Holdings A.G. of Munich, Germany, Europe's largest insurer, than like France's largest insurer—Union des Assurances de Paris S.A.

Under the chairmanship of Jean Peyrelevade, UAP has developed a network of minority holdings in major insurers like Colonia Versicherungs A.G. in Germany and Sun Life Assurances P.L.C. of London (*BI*, March 19, 1990).

In recent months Mr. Bebear has confronted various upheavals at home. AXA Vice Chairman Pierre Barberis has resigned, as has the general manager of AXA Re France, Jean-Marie Nessi.

Mr. Barberis has not been replaced. Instead, three new managing directors have been appointed to oversee AXA's insurance business in France, international insurance business and non-insurance interests. ■



Indy race cars, shown here at their premier event, the Indianapolis 500, will make their debut outside North America this weekend in Queensland, Australia.

Racers start their engines with liability cover in place

By KATE McILWAINE

GOLD COAST, Australia—A multimillion-dollar package of liability and contingency insurance is in place for the first Indy Car race ever held outside of North America.

The Gold Coast, a major oceanfront tourist destination, will be the site of this weekend's first Gold Coast Indy Car Grand Prix. The race is part of the 17-race series that includes the Indianapolis 500. All other races will be run in the United States and Canada.

Before the race could be held on the Gold Coast, its promoter had to meet insurance requirements set by the body that organizes Indy Car racing, said Paul D. French, manager of the local office of Alexander Stenhouse Ltd., the Alexander & Alexander Services Inc. unit that placed the coverage.

However, the promoter, Gold Coast Indy Car Grand Prix Co., requested coverage that exceeds those specifications, Mr. French said.

Championship Auto Racing Teams Inc., the company that organizes Indy car racing in the United States, required $10 million U.S. in liability coverage. But the promoters sought $100 million Australian ($78.6 million U.S.) in limits per occurrence, he said.

The insurance indemnifies the promoter, a joint-venture partnership between the Queensland State Government and four private shareholders; CART; Pittsburgh-based PPG Industries Inc., which sponsors the Indy Car race series; other sponsors, the Gold Coast city council; and race participants.

C.E. Heath Casualty & General Insurance Ltd., a C.E. Heath P.L.C. unit in Melbourne, writes the $20 million Australian ($15.7 million U.S.) primary layer of liability coverage.

A second layer of $30 million Australian ($23.6 million U.S.) excess of $20 million

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Feltrim syndicates seek huge cash calls

By STACY SHAPIRO

LONDON—More than 2,000 members who belong to syndicates formerly managed by Feltrim Underwriting Agencies Ltd. face cash calls for the 1987 through 1990 underwriting years.

Altogether, Feltrim syndicate losses are expected to far exceed $250 million for the 1987 through 1990 underwriting years.

The members have been informed by Feltrim's runoff company, Additional Underwriting Agencies (No. 7) Ltd., that cash calls will be made on March 31 and possibly again on June 30 because the syndicates are overdrawn by more than $45 million at their London banks and on their Lloyd's American Trust Funds.

LONDON

Syndicates 540, 542 and 847 were all managed by WMD Underwriting Agencies Ltd. until 1987, when Feltrim took over the management of the syndicates.

According to a letter to members from T.R. Berry, director of AUA No. 7, members of syndicates 540 and 542 face cash calls on March 31 of 25% of their written premium income for 1987; 15% of 1988 premiums; and 75% of 1989 premiums.

On June 30, they may be asked to pay another cash call for 25% of 1987 written premium income; 25% of 1988; and 50% of 1989.

On March 31, members of syndicate 847 face cash calls of 25% of their premium income limit for 1987, and 100% for 1989. On June 30, the members may face another 25% cash call on 1987 and 25% on 1989.

Interest will be charged on all cash calls that have not been paid by March 31 at 2% above the base rate at Lloyds Bank, which is unrelated to the insurance marketplace.

Members of the three syndicates last month formed a committee to investigate the causes of the failures (*BI*, Feb. 25).

E.C. rules

A British trade official hopes that the European Community will finalize legislation within a year to allow one single European insurance market for all classes of risks.

He also hopes that national trade barriers soon will be removed, allowing British insurers to operate in most parts of the world.

John Redwood, minister of corporate affairs at the British Department of Trade and Industry, spoke at a recent dinner sponsored by Sedgwick Underwriting Agents Ltd. to commemorate its fifth anniversary.

Mr. Redwood began his remarks by telling hundreds of assembled underwriters, brokers and accountants that "I'm a strong admirer of self-regulation and the best of luck

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British insurers

Continued from previous page
profitability, Mr. Ward added.

Commercial Union will increase its non-life rates, he said, "and if the impact of that is to reduce our market share, then so be it."

Higher reinsurance costs also hit hard, said Tony Brend, Commercial Union's chief executive. The company's coverage for 1991 is similar to its 1990 package, but rates jumped 200%, he said. "Reinsurance has gone from being a minor item of expenditure to a major item."

Mr. Brend adds that lack of capacity in catastrophe reinsurance will be reflected throughout the market in the next year. "Change in capacity starts at the reinsurance end and then works its way back through all the major markets," he said.

Commercial Union's results were not uniformly weak. In the United States, it posted an operating profit of 12.9 million pounds ($24.9 million), compared with a loss of 39.5 million pounds ($63.8 million).

"Our return to profitability (in the United States) reflected the benefits of the careful restructuring of the portfolio, a reduction in the charge for discontinued business and a lower level of catastrophe claims," Mr. Brend said.

At General Accident underwriting losses more than doubled to 461.7 million pounds ($891.1 million) in 1990 from 203.8 million pounds ($328.9 million) a year earlier. It was, said Nelson Robertson, chief general manager, "the worst year we have ever experienced."

Mr. Nelson cites a range of factors including "storms in the United Kingdom, Europe and Australia, subsidence and escalating losses in motor, property and other classes affected by the worsening economic climate in the United Kingdom."

General Accident fared somewhat better in North America, particularly Canada, where the company claims it outperformed the market.

After reinsurance, General Accident paid 71 million pounds ($137 million) in weather-related claims and has made a 40 million pound ($77.2 million) provision for subsidence claims.

Losses on its commercial property account were 65.7 million pounds ($126.8 million) in 1990, compared with a profit of 11.9 million pounds ($19.2 million) in 1989.

General Accident blames the loss on an increase in large fire losses and a significant rise in arson.

The company has increased commercial property premiums by 15% on average.

In 1990, General Accident actually cut its U.S. losses to 79.9 million pounds ($154.2 million) from 84.4 million pounds ($136.2 million) a year earlier. Losses in Canada fell to 4.8 million pounds ($9.3 million) from 20.4 million pounds ($32.9 million).

Even an intensified drive to increase premiums and reduce its costs will not produce a profit until 1992, said Mr. Robertson.

At Royal, weather losses hit 159 million pounds ($306.9 million) in 1990, and subsidence losses doubled to 126 million pounds ($243.2 million).

Deteriorating results have prompted the company to raise rates, enforce stricter underwriting standards, cut staff and strengthen financial controls, said Mr. Rushton, the group chief executive. "These steps, together with some firming in the U.K. marketplace, are beginning to bring benefits." He predicts a significant improvement in 1991.

Royal's pre-tax U.S. losses fell somewhat to 89 million pounds ($171.8 million) in 1990 from 98 million pounds ($158.2 million) in 1989.

And the company attributes some of the 1990 loss to a 21 million pound ($40.5 million) payment made to withdraw from the Massachusetts personal automobile market.

Eagle Star lost 32.5 million pounds ($62.7 million) on its U.K. commercial account in 1990, compared with a profit of 27.5 million pounds ($44.4 million) in 1989.

Weather claims following the January and February storms last year and subsidence claims were both major factors in the overall loss, the company said. However, the loss also includes a provision, allowed under U.K. insurance accounting rules, for losses from last month's cold snap and losses on financial insurance business as a result of the depressed property market, the company said.

At least one leading analyst does not share insurers' confidence that lower costs and higher premiums will produce profits in 1992.

Both 1991 and 1992 will be more difficult years for insurers than is widely believed, said Chris Pountain, executive director at Morgan Stanley International in London.

All of the multiline insurers except Sun Alliance & London Insurance P.L.C. and Commercial Union will report pre-tax losses in 1991 and U.K. underwriting losses will still be substantial in 1992, he said.

He gives several reasons for his pessimism:

- No sign of rate increases in the United States.

"By 1992 we should return to the familiar position whereby Commercial Union, General Accident and Royal have higher underwriting losses in the United States than the United Kingdom."

- Continental European markets will remain very competitive as companies try to position themselves for the single European market.
- The threat of government control of Ontario automobile insurance has prolonged competition in other Canadian lines.
- Investment income growth is likely to be sluggish, reflecting lower interest rates, lower dividend growth and the impact of poor underwriting experience upon cash flow. ■

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LONDON

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with it." That remark drew applause, as did his statement that he had no intention of regulating any part of the London insurance community.

Mr. Redwood pointed out, however, that the European Community is adopting its own directives to regulate a single European insurance market that will affect the London insurance market.

E.C. insurance directives, Mr. Redwood noted, "have memorable names": the first life and second life directives; and the first, second and third non-life directives.

At least in the field of insurance, European commissioners have showed they can count, Mr. Redwood said.

The European Commission also is drafting an insurance accounts directive, he observed.

That directive reportedly will be considered by the commission's Internal Market Council at the end of this month, he said.

The insurance accounts directive "makes the most exciting bedtime reading," Mr. Redwood quipped.

More seriously, though, he said that Lloyd's of London's unusual accounting system presents problems for the European Commission, which wants to incorporate Lloyd's into the aegis of the insurance accounts directive.

"Lloyd's is part of this directive," he said. "Now we are locked into how this can come to pass."

One proposal that has already been vetoed was for each Lloyd's member to file his or her own syndicate results, said Mr. Redwood.

The commission, he said, still has to deal with other anomalies of Lloyd's accounting like:

- How syndicates account for assets.
- Lloyd's three-year accounting system.
- How Lloyd's closes syndicate accounts via a reinsurance premium in the closed year being paid into the next open year of account.

"I am determined that Lloyd's should survive a European directive," said Mr. Redwood, adding that he will work with members of the Lloyd's community to make sure this directive takes their needs into account.

The E.C. insurance accounts directive could be passed into law by the Council of Ministers as early as June, commented Tony O'Dowd, Lloyd's E.C. Representative, in an interview.

Mr. O'Dowd added that the directive will change very little of the market's accounting system.

The only major change involves dates of inception, he said.

The new directive defines a policy's inception as the date the underwriter and policyholder agreed to the policy. But Lloyd's now defines the inception as the date the policy passes through Lloyd's Policy Signing Office, said Mr. O'Dowd.

Within the next few years, Lloyd's will probably change its standard to conform with the directive, Mr. Dowd added.

Meanwhile, Mr. Redwood said at the Sedgwick dinner that the E.C. "insurance directives are making slow progress in the right direction. I hope that within a year or so we will have a (European) common market in many areas of insurance."

Britain seeks both a non-restrictive global insurance market and a free market in Western Europe, Mr. Redwood commented.

Toward that end, he added, the British government is pressing ahead to:

- Encourage the continuation of the Uruguay round of GATT talks that stalled last year (*BI*, March 4).

This round is "more ambitious and more important that any other" for the U.K. insurance industry, because it tries to break down trade barriers for financial services, said Mr. Redwood.

"There are more prizes to win" if these negotiations succeed, Mr. Redwood commented.

- Work to open specific markets that British insurers have had trouble entering. Mr. Redwood will soon be visiting South Korea and Japan to build "ever bigger contacts" to allow bilateral insurance trade.

Meanwhile, at home Mr. Redwood tried to dispel fears in the London market that the Financial Intermediaries, Managers & Brokers Regulatory Assn., the U.K. regulatory body for investment consultants and brokers, is insolvent from paying out compensation for life insurance and investment fraud.

The "insolvency is greatly exaggerated," he said. "FIMBRA is in good shape."

Mr. Redwood said he is now working with regulators to establish some basic principles that all financial services companies should follow, such as "wherever possible, disclosure should be required." ■

Indy Car race

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Australian is shared by Suncorp Insurance & Finance of Brisbane, which is owned by the Queensland government, and Royal Insurance Australia Ltd. of Melbourne, a Royal Insurance Holdings P.L.C. unit.

Five underwriters have varying portions of the top layer of $50 million Australian ($39.3 million U.S.) excess of $50 million Australian: CIGNA Insurance Australia Ltd., a CIGNA Corp. unit in Melbourne; and four companies based in Sydney—QBE Insurance Group Ltd.; Harbor Pacific Holdings Pty. Ltd.; Switzerland General Insurance Co. Ltd., a Swiss Reinsurance Co. unit; and Municipal Mutual Holdings Ltd.

Insurance covering race participants for actions taken by other participants was the hardest to place, said Mr. French. Participants include drivers, track officials, crew members, marshals and 1,000 volunteers doing promotional work.

Some insurers could not participate in the liability package because "they did not have the capacity or treaty protection in place to do so because of the wording" in the section on participant-to-participant liability, he said.

Along with general liability coverage, the package also includes errors and omissions liability coverage for any breaches of duty by anyone involved in the race.

Meanwhile, contingency insurance that will cover loss of revenues, should the race be canceled, has been placed with 35 European insurers, Mr. French said.

Societe Commerciale de Reassurance S.A. of Paris was "one of the main players" in the contingency coverage, Mr. French said. While Australian underwriters had been approached, none was able to provide contingency coverage, he said.

He said he could not give details of the contingency coverage without violating the coverage agreement.

"Like kidnap and ransom cover, there is a requirement that no one is to know details of the contingency covers," he said, explaining that "people may be more likely to cause a disruption if they knew the insurance cover existed."

Alexander Stenhouse was chosen as the broker for the race, which will be run on city streets, because it was the only international brokerage with a Gold Coast office, said Mr. French. Alexander Stenhouse also is broker for the Gold Coast City Council, the four private shareholders in the race promotion group and the engineering company that prepared the roadway for the race. ■

INTERNATIONAL

Suit against Bercanus officials goes to trial

By ROGER SCOTTON

BERMUDA

HAMILTON, Bermuda—The liquidator of Bermuda-based Bercanus Insurance Co. Ltd. is preparing for a trial to recover $10 million from the insolvent insurer's former president and his wife.

Barring a last-minute settlement, the trial is expected to commence this month in the U.S. District Court for the Northern District of Texas in Dallas.

Former Bercanus President Neill Portermain and his wife and co-director Florence, who live in McKinley, Texas, are being sued by the liquidator of Bercanus for fraud, breach of fiduciary duty, mismanagement and violations of the Racketeer Influenced and Corrupt Organizations Act.

The company, which wrote medical malpractice insurance and excess-of-loss reinsurance, argues that the Portermains committed these acts while they were serving as officers and directors of Bercanus, a wholly owned subsidiary of United Nebraska Investors, which is controlled by Mr. Portermain.

Bercanus, which was formed in 1970, put itself into liquidation in March 1985 when it was found to be insolvent by about $35 million, though the insolvency is now thought to be closer to $60 million.

The Portermains filed for protection under Chapter 11 of the Federal Bankruptcy Act in September 1989.

Bercanus' liquidator Chris Whittle recently resigned as managing partner of Ernst & Young in Bermuda but will complete the liquidation of the company and several other insolvent companies.

Pretrial court papers, issued three months ago and setting out Bercanus' nine-count complaint, charge that the Portermains defrauded the insurer and took money from it under false pretences by "causing and approving payments to be made by the company to another Bermuda firm known as South Rock Ltd."

According to the pretrial filing, the Bercanus liquidator intends to show that the payments covered "largely non-existent services" and that Mr. Portermain pocketed $3.4 million of a total of $4.4 million in fees and commissions Bercanus paid to South Rock between 1979 and 1983. He did so, alleges the pretrial document, by devising a complex stock purchase agreement as a "device to get the money from Bercanus to Neill Portermain."

The liquidator contends that the transactions with South Rock were not a result of legitimate business but were "merely shams" contrived to generate a specific level of payments to Mr. Portermain.

The Portermains deny those allegations in their own pretrial filings. They contend that the Bercanus liquidator cannot prove all the elements of breach of fiduciary duty or fraud in their dealings with South Rock. They say they "expressly or implicitly" disclosed their interests in South Rock to Bercanus and that the relationship between the two companies was conducted in good faith and was beneficial to all parties.

Revealing details of board meetings held in Bermuda and naming several local lawyers as "disinterested directors and officers" of both companies, the Portermains assert that Bercanus was fully aware of their allegedly wrongful acts, court papers show.

According to their filing, the Portermains also say that Bercanus had full knowledge of an investment the company made in a cattle ranch—an operation that the Bercanus liquidator has described as nothing more than an imprudent and unprofitable personal hobby of Mr. Portermain that was bankrolled by Bercanus to the tune of $1 million.

Nor do the couple accept Bercanus' allegation that they caused the company to pay money to a group of six bogus Caymans-based reinsurance companies.

The Bercanus liquidator alleges that the firms were used to siphon funds from the company under the guise of reinsurance premiums and to give authorities the impression that Bercanus was adequately protected, the liquidator's filing shows.

The liquidator charges that substantially all of the reinsurance premiums received by the six firms, collectively referred to as the Avis Companies, "were promptly distributed as unsecured personal loans to Florence Portermain and other business acquaintances of the Portermains and were never repaid."

By the end of 1984, the liquidator alleges, Mrs. Portermain owed more than $600,000 in personal debts to Panamanian-registered Avis Insurance, a newly formed company that had by then assumed all the liabilities of the Caymans group.

The Portermains, though, contend that the Avis Companies provided "legitimate" reinsurance to Bercanus and that the Portermains "only received proceeds from the Avis Companies to which they were entitled."

They also say that the liquidator cannot prove all the elements necessary for a RICO violation, including the use of interstate or international mails or wires to perpetrate a scheme to defraud, court papers show.

The Portermains also say that

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The professional marketplace

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Garamendi fires comp panel's director

By LOUISE KERTESZ

SAN FRANCISCO—The work of a state commission set up to study workers compensation ratemaking is in jeopardy after the state insurance commissioner fired the panel's executive director, an insurer group charges.

And Californians for Compensation Reform, a business group that supported the 1989 bill that established the panel, has written to Insurance Commissioner John Garamendi to urge that the commission be free to act independently in conducting its study and in choosing staff members, a source said.

A spokeswoman for the business group confirmed it wrote to Mr. Garamendi, but would not confirm the contents of the letter.

Mr. Garamendi, who took office in January as the state's first elected commissioner, terminated the contract of New York-based financial industry consultant Orin Kramer as executive director of the Workers' Compensation Rate Study Commission. The study group was created by a workers comp reform law that took effect Jan. 1, 1990 (*BI*, Oct. 2, 1989).

Mr. Kramer's dismissal may have been a political move to ensure that the Legislature extends the life of the commission, said the California Workers' Compensation Institute, a research group supported by most of the state's workers comp insurers.

The commission is scheduled to be dissolved Sept. 28 under the workers comp reform law.

Mr. Kramer's departure puts the ratemaking study in jeopardy, the WCCI claims. State law requires that study to be submitted to the Legislature by June 30.

Because the last appointment to the eight-member commission was not made until last month—more than a year after the deadline set by the legislation—the commission is unlikely to meet its June 30 deadline, the WCCI said. "It will take some time to replace (Mr. Kramer), and the clock is ticking—and what happens if the Legislature does not extend the deadline?" asked Alan Tebb, the WCCI's general manager.

Political observers told the WCCI that extending the commission's life would require the support of Assemblyman Burt Margolin, D-Los Angeles, who sponsored the workers comp reform act.

At the commission's organizational meeting last December, Mr. Margolin challenged Mr. Kramer's proposed agenda for the ratemaking study, which included examination of the legal and medical costs that he said are driving up workers comp rates.

"The commission may be seeking a legislative extension" to the June 30 deadline and the life of the commission, an Insurance Department spokesman noted.

The department's official position is that Mr. Kramer was dismissed because of a potential conflict of interest. "Some of Mr. Kramer's other clients included a number of insurers," said the spokesman.

For example, Mr. Kramer wrote a study released in January that concluded there is no evidence that the insurance industry faces a solvency crisis (*BI*, Jan. 14). That study was commissioned by the Insurance Information Institute, which is funded by property/casualty insurers.

The spokesman also said that Mr. Kramer's salary, $416,000 for him and an assistant, "was perhaps a bit excessive."

Mr. Kramer noted in an interview that his actual billings had been substantially below levels authorized in his contract. But he would not comment on his dismissal.

Meanwhile, California insurance regulators have fined Transamerica Corp. $75,000 as part of a settlement of charges that three of its insurance units violated state rating and underwriting rules.

The 13 charges stem from a 1989 investigation "which uncovered numerous problems in the three companies' rating and underwriting practices" affecting commercial lines coverage, the Insurance Department said.

Woodland Hills, Calif.-based Transamerica also agreed to change those practices and subject itself "to a reexamination that could result in an additional $25,000 in fines," the department said. Regulators did not allege that violations were intentional.

Transamerica, for its part, dismisses the agreement as "much ado about nothing," said a spokesman.

There "was no investigation," the spokesman maintained. "There was a routine market conduct examination. . .There was never any allegation of wrongdoing."

The company blames "clerical errors" for its failure to provide adequate documentation of credits, as well as for sending out an "outdated dividend form." Neither premiums nor dividends were affected by the violations, the company said. ■

BERMUDA

Continued from previous page
the liquidator's action is barred by applicable statutes of limitation.

Naming Bermuda and U.S.-based directors of both Bercanus and South Rock, the Portermains contend that Bercanus "did know and should have known" of their interest in South Rock and the Avis Companies four years before the suit was begun. They also claim that because Mr. Whittle was once the auditor of South Rock, he, too, "had knowledge of these alleged wrongful acts as they occurred and knew of the Portermains' interest in South Rock."

However, the liquidator, who began its action in January 1988, says he will show that even if a two-year limitation period is applied to its claims, none would be barred under the appropriate statutes.

According to the liquidator's filing, "Bercanus will establish that none of the Portermains' wrongful conduct was discovered or should have reasonably been discovered before January of 1986."

The Portermains also argue that Bercanus' former directors and officers knew of the Portermains' alleged conflicts of interest and self-dealings, "but did nothing," according to court papers. They say that because the company therefore knew, approved or subsequently ratified these acts, it cannot now complain that it was injured by them.

The Bercanus liquidator, though, says he will counter that this argument does not excuse the Portermains from liability. Says the pretrial brief, "The Portermains controlled and dominated Bercanus such that it is impossible that Bercanus can be said to have ratified the Portermains' misconduct and self-dealings which financially destroyed Bercanus."

Mr. Whittle says Bercanus' biggest creditors are Fremont Insurance Group Inc. of Los Angeles and Wilmington, Del.-based American Centennial Insurance Co. Others include members of the American Podiatry Assn., who purchased malpractice insurance from Bercanus.

ACE profit down

ACE Ltd., the Cayman Islands-based excess liability insurance group, last week unveiled a sharply lower first-quarter underwriting profit of $8.8 million for the three months ending Dec. 31, 1990.

The figure, the first of its kind to be released under a new company initiative to issue regular quarterly results, is in marked contrast with an underwriting profit of $45.2 million during the same period in 1989.

ACE's fiscal year begins Oct. 1.

ACE blamed the decline on a $40 million provision for losses, compared with no loss provision in the corresponding quarter a year ago.

Settlements for a Texas school bus accident in 1989 led to one of ACE's first losses (*BI*, May 7, 1990). And, ACE agreed last year to pay $9 million if it lost an arbitration case with the shareholders of Philadelphia Electric Co., for which it wrote excess D&O coverage (*BI*, Nov. 5, 1990).

President Walter Scott said that premiums written during the first quarter rose 54% to $82.9 million, from $53.9 million in the comparable period of 1989, as a result of new business, policyholders buying increased limits and "most importantly, the fact that 1989's figures were depressed as a result of ACE's decision to return all reserve premiums to policyholders at the policy anniversary date."

Earned premiums increased 8% during the quarter to $57.6 million from $53.3 million in 1989, which Mr. Scott attributed to "the growth in policies in force and the increase in limits purchased."

As of Dec. 31, ACE had 389 excess liability and 220 D&O policies in force. Eighty-five excess liability policyholders had purchased the full $200 million of limits available since March 1990.

ACE's first-quarter investment income was flat at $28.5 million, while net income fell 32% to $51.4 million from $75.6 million the previous year.

Commenting on the state of the market, Mr. Scott pointed to evidence of significant hardening in isolated segments, noting that D&O coverage had experienced "dramatic" hardening for financial institutions. "We have been advised of policies being canceled in mid-term, as well as significant rate increases and reduced limits," he said.

Aneco injunction lifted

Bermuda-based Aneco Reinsurance Underwriting Ltd. intends to continue running off its business now that a court-imposed freeze on its assets has been lifted.

London's High Court of Justice on Feb. 28 lifted a mareva injunction that froze up to $430,000 of the Bermuda insurer's assets in Britain as well as Bermuda. The injunction was requested last month by Cayman Islands-based American Professional Assurance Ltd. after it failed to resolve a reinsurance dispute with Aneco (*BI*, Feb. 18).

A statement released jointly by Aneco and APAL said that the two companies had "reached agreement to discharge the mareva injunction."

Aneco Chairman Mark Hardy said last week that the way was now clear for Aneco to continue the runoff of its "disastrous London book of property catastrophe business without further interruption."

And, he added, "the system to secure the significant cash benefits of our retrocessional recoveries was dependent upon the spirit of goodwill between Aneco and the London market. This spirit seems to survived the difficulties created by the mareva."

Aneco is owned by Forum Re Group (Bermuda) Ltd., which is controlled by Mr. Hardy.

Aneco also is running off the reinsurance it had written for captive insurers.

Mr. Hardy, however, is presently litigating on several fronts, the most recent being an action filed against former Aneco President Jonathan Crawley, who is now president of newly formed Sphere Drake Underwriting Management (Bermuda) Ltd.

The suit, which was filed March 6 by Mr. Hardy and Aneco in the 11th Judicial Circuit Court for Dade County, Fla., alleges fraud, breach of fiduciary duty, unjust enrichment, breach of contract and interference with business relationships.

In addition to Mr. Crawley, the suit names Sphere Drake Underwriting Management (Bermuda) Ltd. and Bermuda-based broker Julian Griffiths. It seeks $10 million in damages.

The suit alleges that before leaving Aneco on July 2, 1990, Mr. Crawley began a "long-running scheme and artifice by which he would ultimately destroy the plaintiffs Aneco and Hardy professionally and financially, and personally in the case of plaintiff Hardy.

The "intermediate steps" in Mr. Crawley's alleged scheme involved taking over Aneco's clients, "poaching" Aneco's staff and "driving Aneco and Hardy from the reinsurance business," according to the suit.

Mr. Crawley's attempted management buyout of Aneco in March 1990 was nothing more than a calculated ruse "designed to lull the plaintiffs," the suit also alleges.

The suit also alleges that Mr. Crawley secretly entered into unauthorized endorsements on reinsurance treaties involving professional liability insurance for anaesthesiologists in Florida. The endorsements are alleged to have had the effect of canceling the treaties and terminating Aneco's right to its share of treaty premiums.

In addition, the suit claims that in the spring of 1990, Mr. Crawley entered into four cut-through endorsements with Ohio-based Oil & Gas Insurance Co. and its affiliate Millers National Insurance Co., putting Aneco in the position of being "doubly liable to the original insurer for Aneco's reinsurance risk, while Aneco remained simultaneously liable to OGICO" under the terms of the original treaty.

Mr. Crawley at the time was underwriting captive reinsurance for OGICO, which was owned by The Group Inc., the majority of which also is owned by Mr. Hardy. OGICO now is in liquidation in Ohio.

Mr. Hardy's suit alleges that the cut-throughs, some of which were effected in Dade County, did not benefit Aneco but merely doubled its reinsurance risk.

Mr. Griffiths, now a partner in his own brokerage business, is alleged to have acted as the broker between Aneco and OGICO/Millers. He is accused of conspiring with Mr. Crawley to conceal the cut-throughs and of "distributing secret, proprietary information about aneco to the press."

Mr. Griffiths previously was a broker with Amberco Brokers Ltd., which was owned first by The Group and later by Forum Re Group (Bermuda).

Mr. Griffiths last week described the suit as "a completely ridiculous action which cannot be taken seriously" and said that Mr. Hardy has "sent copies of it to just about everybody he knows."

Mr. Crawley said in a statement: "The allegations of Mark Hardy and Aneco Reinsurance against me are without the slightest foundation of truth, and I will be retaining attorneys to challenge the jurisdiction of the Florida court."

Other legal proceedings loom for Mr. Hardy's flagship Forum Re Group (Bermuda).

The chief justice of Bermuda's Supreme Court is questioning the directors of Focus Insurance Co., which is a wholly owned subsidiary of Forum Re Group (Bermuda) that was recently placed into court-supervised liquidation (*BI*, Dec. 31, 1990).

The private proceedings, which are taking place in the justice's chambers, began Feb. 22 with Focus Director David Thirkill. Mr. Hardy is also due to be questioned March 15 by the chief justice in connection with Focus' statutory certificate of solvency.

But, Mr. Hardy said last week that he believed the chief justice's study was being widened.

"It has been expanded at the request of (Focus liquidator) Peter Mitchell to include lawyer Douglas Pullen and Julian Ashby," who served as a shareholder-appointed liquidator of Focus before the court assumed control of the liquidation, Mr. Hardy said. ■

Fibreboard

Continued from page 3
in a statement.

The settlement "maximizes Fibreboard's long-term prospects of successfully coping with the financial demands of the asbestos litigation," Mr. Hart added.

Pacific Indemnity was fully reserved for the settlement amount, and the payments will not affect Chubb's earnings, according to Chubb.

If the agreement is approved, Fibreboard will have finally settled asbestos bodily injury claims against all of its insurers except two CNA Financial Corp. units with which it has reached interim settlements, according to Mr. Irwin.

The interim settlements—with Continental Casualty Co. and Columbia Casualty Co.—provided defense cost coverage and limited indemnification while the insurers appealed rulings by California Superior Court Judge Ira A. Brown Jr. in the coordinated coverage litigation (*BI*, Nov. 14, 1988).

Separately, a San Francisco federal judge ruled last month that Continental Casualty must cover punitive damage awards against Fibreboard in courts outside California even though California law bars coverage for punitive damages (*BI*, Feb. 25).

Fibreboard's agreement with Pacific Indemnity would be its first settlement of asbestos-related property damage claims, Mr. Irwin said.

The settlement comes as insurers pursue appeals of several landmark rulings by Judge Brown expanding coverage for asbestos producers in the massive coordinated coverage litigation in San Francisco.

In Phase III of the multi-phase litigation, for example, Judge Brown ruled that asbestos bodily injury claimants were entitled to coverage from the time they were exposed to the hazardous substance to the time they filed a claim or died (*BI*, June 1, 1987).

Each bodily injury claim also represents a separate occurrence under the policies, the judge ruled on an issue raised in Phase IV of the trial.

In Phase V, the judge ruled that asbestos in buildings constitutes property damage from the time it is installed until it is removed or a claim is made, triggering coverage on a continuous basis in the interim (*BI*, Sept. 12, 1988).

The rulings were considered the broadest possible coverage interpretations applying to asbestos bodily injury and property damage claims.

Appeal briefs covering issues raised in all phases of the trial are due to be filed with the appeals court in San Francisco by April 5, according to Mr. Irwin.

Additional briefs are due in September and November, after which the court will hear oral arguments, he said. ■

Managed care

Continued from page 3
tration.

Consultants and insurers argue that increased administrative costs associated with open-ended HMOs don't outweigh the savings that can be achieved (*BI*, Feb. 18).

Employees in a typical open-ended HMO enroll in the managed care portion of the plan and select a primary care physician—or gatekeeper—just as they would in a traditional plan. To receive network benefits, an employee must first contact that doctor concerning any health problem. The primary care physician then coordinates care for that employee.

Open-ended HMOs allow enrollees to make a choice at the point of service either to stay within the HMO network of providers or to use other doctors. Employees choosing outside doctors receive lower levels of benefits and pay higher out-of-pocket expenses.

The open-ended HMOs described in the Hewitt study, however, differ from the comprehensive point-of-service plans pioneered by Allied-Signal Corp. and Southwestern Bell Corp. in that they are not the only health care plan available to employees but are one of several options available, including HMOs, PPOs and indemnity plans.

Only 26% of employers with open-ended HMOs offer them as the only option, the survey noted. More than a third—37%—of those employers with open-ended HMOs offer them as part of a flexible benefits program.

Among eligible employees, a median of 38% are covered by an open-ended HMO network, the survey reported.

Participation rates in open-ended HMOs vary. For example, 23% of employers with open-ended HMOs said between 76% to 100% of eligible employees participate in the network and 19% said between 51% and 75% of employees participate. Seventeen percent reported a employee participation rate of 26% to 50%, and 12% reported a participation rate of 11% to 25%. Twenty-nine percent of plans said the participation rate was 1% to 10%.

"In the first year of an open-ended HMO, employers target about a 60% participation rate," Mr. Sperling said. Because employees always resist such change, he said, companies should expect participation to grow in future years.

Most importantly, even given lower participation levels, those employees who do participate in open-ended HMOs are likely to seek care through network providers rather than opting to go outside the network, Mr. Sperling said.

According to the survey, a median of 89% of the claims of employees enrolled in open-ended HMOs are submitted by network providers. And two-thirds of the employers with open-ended HMOs reported that 76% to 100% of the claims were submitted by network providers.

That's "a very positive sign for the future of the open-ended HMO model," Mr. Sperling said. "The fear has always been that people would use the network for little things—like preventative services—and would go outside the network for major operations. This has not been the case."

But, he said, employers can't expect immediate savings from an open-ended HMO like those common during the first year an employer uses a traditional HMO or PPO. "The evidence that open-ended HMOs save money is really anecdotal," he said. And, he noted, because employers have gotten burned in the past by "innovative" health care plans, many are taking a wait-and-see attitude.

The Hewitt survey also reported that employers that offer HMOs or PPOs remain unsatisfied with the results of these plans. A significant number—14%—of surveyed employers reported that their PPOs had not reduced costs.

And less than a third—31%—of employers said that HMO premium increases were rising more slowly than indemnity plan increases. In fact, 37% of employers with HMOs said HMO premium increases exceeded those charged by indemnity plans, while 26% said HMO premium increases were on par with indemnity plan increases.

Insurance companies and independent HMOs are aware that employers are dismayed that promised savings never materialized, Mr. Sperling said. As a result, "there is a significant portion of HMOs that are offering alternative financing and self-insured arrangements. It's a direct response to market demand."

Despite this dissatisfaction, the survey suggests that medical costs are rising more slowly for employers with managed care options than for those with only traditional indemnity plans.

The average medical plan cost per employee at the responding companies—including HMO costs—was approximately $2,823 in 1990, up 14% from $2,476 in 1989. And the 1989 figure represents a 14% increase over $2,176 in 1988.

A. Foster Higgins & Co. Inc. reported earlier this year that medical indemnity plan costs climbed 21.6% in 1990 among the employers it surveyed. Inc. According to the Foster Higgins survey, indemnity plan costs per employee reached $3,161 in 1990, up from $2,600 in 1989 (*BI*, Jan. 28).

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For a copy of "Managed Care Initiatives 1991," contact Rick Maddox or Diana Reace, Hewitt Associates, 100 Half Day Road, Lincolnshire, Ill. 60069; 708-295-500. The cost is $75.

Punitive damages

Continued from page 1
judges to properly instruct jurors about the purpose of punitive damages and requires significant judicial review of jury awards.

"As long as the discretion (of the jury to award punitive damages) is exercised within reasonable constraints, due process is satisfied," Justice Blackmun wrote.

And, "appellate review makes certain that the punitive damages are reasonable in their amount and rational in light of their purpose to punish what has occurred and deter its repetition," he added.

The case before the Supreme Court involved Pacific Mutual Life Insurance Co. of Newport Beach, Calif. A jury awarded $1.1 million in punitive and compensatory damages for the fraud of Lemmie Ruffin Jr., a Pacific Mutual agent who pocketed premiums he received from four employees of Roosevelt City, Ala.

As a result of Mr. Ruffin's fraud, the employees lost their group health insurance. The coverage for one plaintiff, Cleopatra Haslip, was canceled shortly before she was hospitalized for kidney treatment.

The jury hearing the case was instructed that if it found Pacific Mutual liable, it could award punitive damages at its "discretion," but did not have to award any at all.

Jurors were told that punitive damages were designed to punish and deter future wrongful conduct —not to compensate victims. In addition, the jury was told to consider "the character and degree of the wrong" of the defendant's actions and "the necessity of preventing similar wrongs."

The jury found that Pacific Mutual was legally liable for the fraudulent acts of its agent and awarded $1.1 million in damages. It did not break down the amount into compensatory and punitive damages.

The Alabama Supreme Court then reviewed the jury's decision in accordance with specific factors it had outlined in an earlier decision. These factors include:

- Whether there is a relationship between the punitive award and the harm likely to result from the defendant's conduct, as well as the harm that actually has occurred.
- How reprehensible the conduct was and how long it continued; whether the defendant concealed the conduct or even knew of it; and whether and how often similar actions had occurred previously.
- The profitability to the defendant of the wrongful conduct and the desirability of removing that profit and of having the defendant also sustain a loss.
- The "financial position" of the defendant.
- The costs of litigation.

The Alabama Supreme Court also considered two possible mitigating factors: whether criminal penalties or other civil awards already had been imposed on the defendant for the conduct.

"The application of these standards, we conclude, imposes a sufficiently definite and meaningful constraint on the discretion of Alabama fact finders in awarding punitive damages," Justice Blackmun said in his decision. "The Alabama Supreme Court's post-verdict review ensures that punitive damages are not grossly out of proportion to the severity of the offense and have some understandable relationship to compensatory damages.

"While punitive damages in Alabama may embrace such factors as the heinousness of the civil wrong, its effect upon the victim, the likelihood of its recurrence and the extent of the defendant's wrongful gains, the fact finder must be guided by more than the defendant's net worth," wrote Justice Blackmun. "Alabama plaintiffs do not enjoy a windfall because they have the good fortune to have a defendant with a deep pocket."

In a footnote, the court noted that review in Alabama is much stricter than in some other states. A Vermont appeals court, for example, can only set aside a punitive damage award that it finds "manifestly and grossly excessive." And an award in Mississippi may be set aside only if it "envinces passion, bias and prejudice on the part of the jury so as to shock the conscience," the decision said.

"We are aware that the punitive damage award in this case is more than four times the amount of compensatory damages, is more than 200 times the out-of-pocket expenses. . .While the monetary comparisons are wide and, indeed may be close to the line, the award here did not lack objective criteria. . .it does not cross the line into the area of constitutional impropriety," Justice Blackmun also wrote.

The Supreme Court concluded that $840,000 was the punitive portion of Ms. Haslip's award.

The Supreme Court also held that there is nothing unconstitutional in holding Pacific Mutual liable for punitive damages for the fraudulent acts of its agent.

"Before the frauds in this case were effectuated, Pacific Mutual had received notice that its agent Ruffin was engaged in a pattern of fraud identical to those perpetuated against respondents," Justice Blackmun wrote. Even many lawyers who participated in this case say they did not realize that Pacific Mutual knew Ruffin was pocketing premiums.

As a result of these egregious facts, the high court ruled that holding Pacific Mutual liable for punitive damages for the acts of its agent "creates a strong incentive for vigilance" against wrongful conduct.

In a concurring opinion, Justice Antonin Scalia chastized the majority for engaging in a fact-specific discussion of whether Alabama's system of awarding punitive damages violates due process. Rather, Justice Scalia wrote that the court should "categorically affirm" the validity of punitive damage awards.

The fact that juries have been awarding the damages for more than 200 years proves that they meet due process, Justice Scalia wrote.

In another concurring opinion, Justice Anthony M. Kennedy agreed that "history should govern the outcome in the case before us." State judges and legislators, rather than the Supreme Court, ought to establish standards for punitive damage awards, he wrote.

Justice Sandra Day O'Connor filed the lone dissenting opinion. "The time has come to reassess the constitutionality of a time-honored practice," she wrote.

She argued that requiring appellate review of punitive awards would not adequately protect due process. Instead, she wrote, juries should be given specific criteria for assessing punitive damages.

Attorneys who represent business organizations say they are pleased that seven justices at least recognized a constitutional "line" that punitive damage awards cannot cross.

"A line no matter how murky" is useful for the business community, said Victor Schwartz of Crowell & Moring in Washington, D.C.

"The court set an outer perimeter on the way courts can set punitive damage awards," he explained. "This is the first decision in history where any court has found constitutional limits on tort law.

"Pacific Mutual lost its case, but the business community did reasonably well in getting a fundamental principle established that due process sets outer limits on punitive damage awards," added Mr. Schwartz.

Martin Connor, president of the American Tort Reform Assn., a business-backed advocacy group, agreed: "The Supreme Court clearly said there are constitutional limitations on the discretion of juries to award punitive damages."

Each justice has now said that the punitive damage system needs reform, said Mr. Connor.

"But there is a difference between acknowledging something is bad policy and holding that it violates the Constitution," he added. "The Supreme Court cannot legislate for the states."

Business leaders say they will turn their energies toward legislatures.

"This issue is not dead by any means," said Paul Brown, director of governmental affairs for the Risk & Insurance Management Society Inc. in New York.

Business groups will continue to push for both federal product liability reform and state tort reform laws, he said.

"Business focus has to be on the legislature and not the courts," agreed Quentin Riegel, deputy general counsel for the National Assn. of Manufacturers in Washington, D.C.

"The Supreme Court's decision highlights the need for a federal standard or multiple state standards" for punitive damages, he said.

Attorneys for consumer groups praised the Pacific Mutual ruling as a reaffirmation of the jury system.

"The Supreme Court found that the jury is the best, most effective way to handle damages—both compensatory and punitive," said Michael Maher, president of the Assn. of Trial Lawyers of America.

"This is a strong endorsement of the jury system," agreed Mr. Ennis, who represented Ms. Haslip in the litigation. "The court found it is fine to allow the jury to be the conscience of the community."

The Supreme Court's reaffirmation of the jury system could discourage state and federal legislators from restricting jurors' discretion, said Linda Lipsen, legislative counsel for Consumers Union in Washington, D.C.

The ruling could, for example, influence Senate debate over implementing Montreal Protocol 3, which would ban punitive damage awards in aviation disasters.

"The Senate may say that if the Supreme Court ruled in favor of punitive damages, then the U.S. should not be party to a protocol that would ban them," said George Tompkins, senior partner at Washington law firm Condon & Forsyth, last week at an airline insurance conference in London.

While no observer can fully understand the inner workings of the Supreme Court, some suggested that the quality of the oral arguments may have been a factor in this case.

Some attorneys believe that Mr. Ennis, who represented the plaintiffs, outmaneuvered Bruce Beckman, who represented the insurer.

"Pacific Mutual's position could have been expressed better," said Kenneth S. Geller, an attorney with Mayer, Brown & Platt in Washington, D.C., who represented the Business Roundtable in the litigation.

One legal publication, the Legal Times, wrote a scathing critique the week after Mr. Beckman's arguments. Many in legal circles believe that Mr. Beckman, who handled the case in its early stages, should have let a veteran Supreme Court attorney handle the arguments.

Mr. Beckman could not be reached for comment.

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Pacific Mutual Life Insurance Co. vs. Cleopatra Haslip, U.S. Supreme Court; No. 89-1279.

Update

Plaintiffs' attorneys convicted

Continued from page 2
raceway's parking lot. Mr. Gabe photographed a pothole in the parking lot after enlarging it with a pickax, prosecutors charged.

The defendants, who are scheduled to be sentenced June 21 but are expected to appeal, face up to 40 years in prison and fines equal to twice the proceeds of their fraudulent conduct, says the U.S. Attorney's office. Mr. Eisen already has agreed to forfeit $500,000.

AIA devising McCarran reform

WASHINGTON—The American Insurance Assn. is developing an alternative to legislation introduced in Congress that would overhaul the McCarran-Ferguson Act.

Describing those bills, H.R. 9 and S. 430, as destructive and unacceptable, AIA Vp-Federal Affairs David Pratt said the AIA proposal under development would protect the insurance industry's essential business interests, like the development of common policy forms, joint pooling arrangements and maintenance of data bases.

"We see the development of a constructive alternative as an appropriate way to respond to the threat posed by the legislation," he added.

The AIA will develop the proposal as quickly as possible, though no fixed timetable has been set, officials say.

Citgo covered for loss

SULPHUR, La.—Citgo Petroleum Corp. "has insurance in place" to cover losses stemming from a fatal explosion of a catalytic cracker at its Sulphur, La., refinery, a company spokesman said.

Neither the cause of the accident nor a damage estimate is expected for several days, he said.

The spokesman for the Tulsa, Okla.-based oil company declined to provide coverage details. However, Citgo is a member of Bermuda-based Oil Insurance Ltd., a policyholder-owned facility that writes $200 million of property coverage excess of at least $5 million for petroleum companies. Citgo, however, is not a member of sister insurer Oil Casualty Insurance Ltd., which provides excess liability coverage for its members. A spokesman for Frank B. Hall & Co. Inc. confirmed that the brokerage placed coverage for Citgo.

Four workers died and 11 were injured in an explosion and fire on March 3 as Citgo brought back into operation a catalytic cracker used to make gasoline. It had been shut down for maintenance for weeks.

Louisiana's workers compensation system provides families of workers killed on the job with a maximum death benefit of $282 per week.

J&H to buy Dutch broker

NEW YORK—Johnson & Higgins is negotiating with ABN Bank to acquire its insurance brokerage unit, R. Mees & Zoonen Assurantien B.V. of Rotterdam, The Netherlands.

Mees & Zoonen is a member of the UNISON brokerage network to which J&H also belongs.

Meanwhile, J&H has acquired Willis Corroon P.L.C.'s 20% share of Johnson & Higgins Willis Faber Ltd. in Toronto, which will be renamed Johnson & Higgins Ltd. The Toronto broker's employee benefits division will operate as a unit of J&H's A. Foster Higgins & Co. Inc.

London-based Willis Corroon also acquired J&H's 50% interest in Willis Faber Johnson & Higgins Ltd. of Sydney, Australia, and will rename it.

In the two deals, J&H paid 1.4 million pounds ($2.6 million at current exchange rates), a Willis Corroon spokesman said.

Briefly noted

Two lawsuits filed in Philadelphia County Court seeking class-action status each demand $1 billion in punitive damages and more than $100 million in compensatory damages from the owners of **One Meridian Plaza** in Philadeplphia, which sustained severe fire damage last month (*BI*, March 4). Thousands of plaintiffs—including building tenants and area businesses—charge that the building owners were careless and reckless in not installing sprinklers on all floors. . . .No successor has been named for Jack H. Blaine, who resigns as president of the **Reinsurance Assn. of America** effective Friday. Mr. Blaine succeeded Andre Maisonpierre in May 1990. Mr. Blaine, a former vp of American Council of Life Insurance, joined the RAA as executive vp in October 1989. . . .**Philip Morris Inc., Liggett Group and Lorillard Inc.** have joined a tobacco liability plaintiff in asking the U.S. Supreme Court to decide whether federally mandated health warnings on cigarette packages protect tobacco companies from certain product liability claims. The high court was asked to review the issue in December by lawyers for the estate of the plaintiff, whose wife died of lung cancer in 1984 (*BI*, Jan. 14). . . .Walter A. Scott has been named chairman of the board and chairman of the executive committee of **ACE Ltd.** and its two insurance company subsidiaries in addition to his previous title of president and chief executive officer. John Cox remains a member of the boards of the companies. . . .The House Labor-Management Relations Subcommittee last week approved a **family leave bill**, H.R. 2, that would allow employees up to 12 weeks of unpaid job-protected leave and guarantee that employer-provided health insurance would continue as if the employee were still working (*BI*, Jan. 14). The full Education and Labor Committee is scheduled to vote on the bill March 19. . . .The **Illinois Insurance Exchange** last week refused to rescind its cease-and-desist order against Alliance Syndicate Inc., but the IIE board outlined a new procedure for the syndicate to submit its records and the board to consider lifting the order (*BI*, Feb. 25). . . .The federal government late last week sought an emergency ruling to block a federal judge's temporary ban on efforts to settle civil litigation over the **Exxon Valdez oil spill** because native Americans' claims were excluded from the bargaining. The government argued the ban has jeopardized negotiations. . . . **Eastern Air Lines Inc.** will pay a $3.5 million fine and plead guilty to criminal charges it falsified aircraft maintenance records and conspired to defraud the Federal Aviation Administration.

Domestic partners

Continued from page 1

"Employers typically want to do something for employees' domestic partners, but they're apprehensive about paying" for partners' health care coverage, said Jane R. Ginsberg, a consultant with The Wyatt Co. in San Francisco.

For example, while San Francisco-based Levi Strauss & Co. studied opening the company's self-insured health plan to 3,000 U.S. employees' domestic partners, it decided against it because of cost.

"There was one other issue to be resolved—whether to extend coverage to members of extended families," like relatives who live with the employee, a spokeswoman said.

While some firms are concerned that domestic partners may be a high-risk group, "they mostly don't want to increase the size of their health plan group," Ms. Ginsberg explained.

And, she asked: "How do you define what a domestic partner is? How many domestic partners can a person have? How can you prove that they're not an employee's neighbor or good friend who needs health insurance?"

Some employers define "domestic partner" in their plans. For instance, employees of Ben & Jerry's Homemade Inc., the ice cream maker in Waterbury, Vt., must show proof of cohabitation for at least three months to be eligible for benefits.

More employers are beginning to recognize domestic partners in their benefits programs through "time-off" plans, like sick leaves and bereavement leaves. For example, since 1985, Levi Strauss has offered bereavement leaves to employees for the death of domestic partners.

The question of how the Internal Revenue Service will treat employer contributions to domestic partners' health care plans also has stopped many from offering the coverage.

For example, in a May 1990 private letter ruling to the city of Seattle, the IRS said that if an employee receives health benefits for a domestic partner or such a partner's child and the partner or child is not a dependent as defined by the IRS, the employee must pay federal income taxes on the value of the benefit.

The IRS defined the taxable value of the health benefit as the amount it would cost the employee to obtain individual health insurance policies for his or her domestic partner and each of the partner's children.

However, in December 1990, the IRS revised its position and ruled that the city should withhold taxes based on the group cost of health benefits provided to non-dependent partners and children, as opposed to individual policy costs. The ruling was made retroactive, thus affecting both 1990 and 1991 tax years.

More domestic partner health care programs are expected as management attitudes and the makeup of the workforce changes.

"The impetus is the changing workforce composition," said Hewitt's Ms. McNaughton. "And some employees are asking for it."

According to the U.S. Census Bureau, 2.8 million of the nation's 93.3 million households contained so-called "POSSLQs," or "persons of the opposite sex sharing living quarters," as of year-end 1989, up 75% from 1.6 million in 1980 and five times the 523,000 in 1970.

Hewitt is compiling a research paper on domestic partner health care programs scheduled to be released later this month.

Some predict it is only a matter of time before state laws prohibiting discrimination against sexual orientation or marital status force employers to open health plans to domestic partners.

For example, California passed legislation last year, A.B. 1721, that prohibits discrimination in insurance underwriting based on sexual orientation, marital status or gender.

And, California's anti-discrimination movement already has helped change the state's workers compensation law to permit domestic partners to recover survivor benefits as long as the partner was "household dependent" on the employee killed on the job, said Thomas F. Coleman, a executive director of the city of Los Angeles' Family Diversity Project.

A California employee also can receive unemployment benefits if forced to leave because a domestic partner relocates, he added.

Two lawsuits pending in New York Superior Court could set legal precedent for domestic partners' benefits.

In one suit against the New York City Board of Education, the Gay Teachers Assn. argues that domestic partners of city employees should be treated as spouses for benefit purposes.

And, in a suit against American Telephone & Telegraph Co., a plaintiff alleges AT&T discriminated against her and her children by not paying death benefits after a female AT&T employee with whom the plaintiff had a long-term relationship had died (*BI,* Sept. 17, 1990).

Employers already offering health care coverage for domestic partners recently have been deluged with inquiries from other employers.

"East Lansing (Mich.) and Boston are really into this, and they're calling every other day," said Sally Fox, benefits manager for the city of Seattle, which began offering health benefits to domestic partners last May.

Officials of those cities could not be reached for comment.

"I've received at least 12 or 13 phone calls in the last month" inquiring about Ben & Jerry's plan, said Kathy Chaplin, personnel operations manager.

One of those inquiries came from University of Iowa Professor Reta Noblett-Feld, who is spearheading a report on how much it will cost the Iowa City-based institution to provide domestic partner coverage to its 8,000 employees.

The city of San Francisco has contracted with TPF&C, the benefits consulting subsidiary of Towers, Perrin, Forster & Crosby Inc. in San Francisco, to conduct an actuarial study to determine "both the long- and short-term cost implications" of extending domestic partner benefits to its 33,500 active employees and 14,000 retirees, said Randy Smith, executive director of the city's Health Service Plan.

The study should be completed in May, and a July 1 target has been set for extending coverage.

The city decided to examine extending health benefits to employees' domestic partners following a June 1990 report by the Mayor's Task Force on Family Policy and last November's election when voters approved an ordinance permitting unmarried domestic partners to register with the city.

Health care coverage issues are particularly sensitive among the gay community, Mr. Smith added. Approximately 15% of the city's workforce is homosexual.

A random survey conducted by the Mayor's Task Force estimated that approximately 2,600 employees would enroll their domestic partners in such a plan, he said.

An earlier study by the Mayor's Task Force estimated that it would cost $1.1 million per year, or $3 per month for each enrollee, in administrative expenses to extend health benefits to city employees' domestic partners. The city will not contribute toward the cost of the coverage because it does not pay for other dependents' coverage, Mr. Smith said.

Officials at Pacific Gas & Electric Co. in San Francisco have been working with the National Leadership Coalition for Health Care Reform in Washington, D.C., to address domestic partners coverage on a national level, said a PG&E spokesman.

Other members of the employer coalition include AT&T, Chrysler Corp., Ford Motor Co., Lockheed Corp. and Xerox Corp.

However, while PG&E has a formal domestic partner bereavement policy, "at this point we have not finalized anything regarding extending health benefits to domestic partners," the spokesman said.

And the San Francisco Chamber of Commerce, which already has endorsed a domestic partner bereavement policy for its members, is assembling a task force to discuss other domestic partner benefits, said Vp Jim Lazarus.

Insurers' unwillingness to underwrite domestic partner coverage is one reason so few employers offer it.

The city of West Hollywood, Calif., was forced to self-insure domestic partner health care coverage after failing to find an insurer to underwrite it. "We were turned down by 18 companies," said Janet L. Murphy, executive assistant and personnel officer in the city's Department of Administrative Services.

"Virtually no insurance company in the state will touch domestic partner coverage because there's no formal definition of what constitutes a domestic partner relationship," explained a spokesman for Blue Cross of California in Woodland Hills.

"If a state passed a law that said employer groups would have to provide coverage to domestic partners, our insurance companies would have to change the way they do business," said Harvie Raymond, a director of the Health Insurance Assn. of America in Washington, D.C.

But early claims experience from employers with domestic partner insurance programs have not borne out insurers' fears of adverse selection and catastrophic AIDS claims.

Hewitt's soon-to-be-released report concludes "the health of a non-working domestic partner is similar to that of a non-working spouse." None of the plans Hewitt studied reported any catastrophic AIDS claims, as had been feared since young, male homosexuals are the highest-risk group for the disease.

And, more than two-thirds of employees signing up for domestic partner coverage when it is available are involved in heterosexual relationships, Hewitt found.

The claims experience of the 350 domestic partners enrolled in the city of Seattle's indemnity plan has been "better than for spouses to date, and much less than what was budgeted," Ms. Fox said. For May through December 1990, domestic partner benefits cost the city $225,000, or 1.1% of the city's total medical and dental coverage expenses of approximately $20 million, she said.

Kaiser Foundation Health Plan Inc. of Oakland, Calif., lowered health maintenance organization premiums for the city of Berkeley after three years of experience failed to justify the need for a so-called "loading factor" to cover expected additional claims from domestic partners, a Kaiser spokesman said. If annual rate hikes are subtracted, the new premium—calculated using adjusted community rating—"is lower than it was three years ago," he said.

The loading factor was added because "there was a lot of concern by a lot of people about the lack of underwriting experience related to the city of Berkeley," he explained. "We didn't feel justified in spreading the risk across other insureds, so we added a loading factor for that particular group to be a hedge against any adverse selection."

In addition to Kaiser, some insurers and a few other HMOs have been more receptive to underwriting domestic partner coverage.

Consumers United Insurance Co. of Washington, D.C., offers three plans providing health benefits for domestic partners, said Marketing Director Steve Slaterbeck.

Two plans are available to members of affinity groups, while the third can be purchased either by individuals or on a group basis.

One of Consumers United's largest commercial clients is Ben & Jerry's.

Kaiser also has offered to underwrite the city of San Francisco's domestic partners plan and is submitting a bid on a union-sponsored plan in Sacramento, the spokesman said.

However, still concerned about the claims experience of domestic partners, Kaiser will add a "loading factor" as it did for Berkeley, which may be subtracted in later years.

Foundation Health Corp., an HMO in Sacramento, Calif., also is preparing to bid on the city of San Francisco's coverage, said a spokesman. ■

Newspaper first to offer domestic partner plan

By JOANNE WOJCIK

Most employers now providing health care benefits to employees' domestic partners are public entities, but the first to do so was a private firm.

A program at the Village Voice, the New York weekly, is the nation's oldest. It was negotiated as part of a 1982 labor contract with District 65 of the Distributive Workers Union.

Employees pay nothing for coverage for domestic partners. The paper self-funds the program and the union administers it, said Terry West, personnel manager for the Village Voice.

Eighteen of the paper's 231 employees participate in the plan. Thirteen of the partners enrolled are heterosexual; five are homosexual.

Another private employer offering domestic partner benefits is Ben & Jerry's Homemade Inc., the ice cream maker in Waterbury, Vt.

"Named partner" coverage underwritten by Consumers United Insurance Co. of Washington, D.C., was first offered to its 360 employees in November 1989, said Kathy Chaplin, personnel operations manager. Most of the 14 who have signed up so far are heterosexual, she pointed out.

To qualify for coverage, employees must prove they have lived with their partners for at least three months. Ben & Jerry's pays the full premium for salaried employees and their partners enrolled in the plan.

Salaried employees' domestic partners are also eligible to receive employer-paid dental coverage, also written by Consumers United.

Hourly employees pay 25% of dependents' premiums for both medical and dental coverage.

Others offering domestic partner coverage are public entities.

Since the city of Berkeley, Calif., began offering the benefits in 1985, 125 of its 1,515 employees have signed up, said Ray Bolerjack, senior personnel analyst.

Employees choose from four plans:

- A self-insured indemnity program with a preferred provider option. The city retains the first $75,000 of risk per individual and purchases stop-loss coverage from Life Insurance Co. of North America, a CIGNA Corp. unit, to pay claims exceeding that amount up to a lifetime maximum of $1 million per individual.
- Two HMO options administered by San Francisco-based HEALS, the Personal Care Physician Health Plan, which were opened to domestic partners in 1987.
- An Kaiser Foundation Health Plan Inc. HMO that has provided first-dollar coverage to domestic partners since 1987.

The city's monthly contributions are $132.70 for single coverage, $264.40 for employee-plus-one coverage and $351.34 for family coverage. Those amounts cover the Kaiser HMO in full, but employees must contribute toward the cost of the indemnity plan or the HEALS plans.

The city of Seattle extended medical and dental benefits to domestic partners and their children in May 1990. Human rights officials earlier said the city was violating an anti-discrimination law by not offering benefits to partners (*BI,* May 14, 1990).

To qualify for the benefits, city employees must complete an affidavit of marriage/domestic partnership and file it with their department head within 30 days of the commencement of employment, marriage or domestic partnership. Employees are required to attest to certain facts, including their responsibility for the partner's common welfare.

Employees that divorce or terminate a domestic partnership must file a statement within 30 days.

While employees who divorce can file a new marriage/partnership affidavit as soon as the divorce is final, those who terminate a domestic partnership must wait 90 days.

As of October, 361 affidavits were on file—about one-third for homosexual partners and two-thirds for heterosexual.

The city employs 10,000 workers. As of October, 170 of the employees filing affidavits enrolled their partners in the health care plan and 187 enrolled partners in the dental plan.

In addition, 18 employees enrolled 20 children of domestic partners in the medical plan, while 23 employees enrolled 29 children of domestic partners in the dental plan, said Sally Fox, the city's benefits manager.

For most employees and dependents, the city pays the full cost of medical and dental coverage. Uniformed police and fire department employees pay 20% of HMO premiums.

The city offers three health care programs:

- An indemnity plan underwritten by King County Medical Blue Shield of Seattle.
- Group Health Cooperative of Puget Sound, a Seattle-area HMO.
- Pacific Health, another Seattle-area HMO.

While the two HMOs agreed to insure the domestic partners by increasing the premium for all active employees about 2%, Blue Shield refused to cover the domestic partners, Ms. Fox said. So the city is self-insuring the medical benefits of employees' domestic partners in the indemnity plan. Blue Shield is administering claims, she said.

Employees and domestic partners are also offered a dental plan underwritten by Washington Dental Service of Seattle.

The benefits for domestic partners and their children are identical to those for employees' spouses, Ms. Fox said.

Turned down by 18 insurers fearing claims related to acquired immune deficiency syndrome, the city of West Hollywood, Calif., asked its broker to develop a self-funded plan when it extended health benefits to domestic partners in 1989.

"We created eligibility rules in order to fit around the city's 1985 domestic partner registration ordinance," said Jeffrey Miles, senior vp of Insurance Design Associates of Los Angeles, which also acts as claims administrator. "And when we couldn't find stop-loss insurance for the domestic partners, we capped the coverage."

Under West Hollywood's self-funded plan, the city self-funds 100% of employees' and dependents' health care expenditures up to $20,000 per year. A specific stop-loss policy underwritten by Manufacturers Life Insurance Co. pays non-domestic partners' claims above that level.

To be eligible for coverage, the employee and the domestic partner must file a "Statement of Domestic Partnership" with the city. Both people must also sign an "Affidavit of

Continued on next page

Investment yields key to insurers

By MYRON M. PICOULT

Special to Business Insurance

IN THE RECENT PAST, the new year has always begun with the hope of a turn in pricing, which would lead to a turn in the underwriting cycle. However, as each year progressed, the pricing turn always seemed to be pushed out in six-month increments.

While we hope that 1991 will break the pattern, the start has not been encouraging. Year-end 1990 premium volume statistics and company commentary about "flat-tish" and "stable" pricing suggests that by holding their own, most companies continue to fall further behind on basic pricing strategies.

Mr. Picoult

No chief executive officer wants to hang his company's dirty linen on the line unless everybody else is doing the same thing. Hence the reticence to address loss reserve and other balance sheet deficiencies. However, there is a factor lurking on the sidelines that could shake industry pricing into reality. Over the years, the property/casualty industry's salvation has been net investment income growth, which has generally offset recurring spates of underwriting red ink.

Our current thesis for the underwriting cycle calls for a slow rolling recovery as opposed to a sharp recovery. A key element of the thesis is a much-labored rate of investment income growth. Our screens show that net investment income rose 4.1% through the first nine months of 1990. With a good portion of the full year data in, it looks like the full year net investment income figure will be about the same or a tad higher than the Sept. 30 figure.

Part of the problem is the slowdown in cash flow. More important is the lower yield curve and the fact that chunks of the bond portfolios (about 60% of the industry's asset base) are rolling over and being reinvested at yields less than half what they were in the early- and mid-1980s, when the bonds were acquired.

In 1985, a one-point swing in the stock insurance industry's combined ratio was equal to about $1 billion ($500 million after taxes). Net investment income of nearly $15 billion was equal to a 30-to-1 coverage ratio. By year-end 1989, the same relationship was reduced to a 26-to-1 level of coverage due to changes in tax laws and a slowed growth of investment income. If an insurer was in the alternative minimum tax mode, the coverage declined to a 23-to-1 level. Underwriting losses will continue to grow given the industry's deficient rate structure.

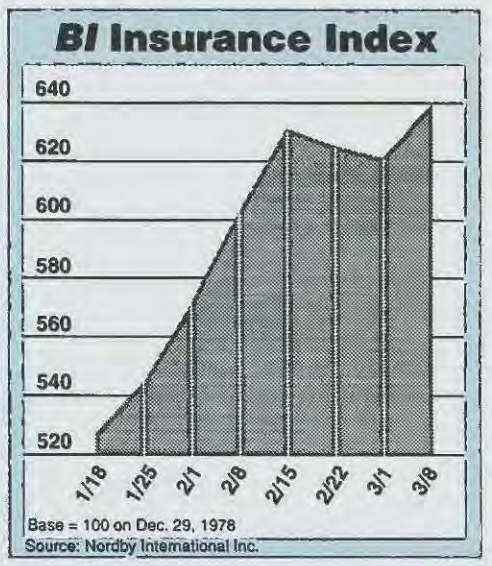
The fostering of higher retentions, which were acquired over the past several years, could also hurt underwriting results. Furthermore, the tight London retrocessional market, where completion of property catastrophe covers is virtually impossible at 1989 levels, could exacerbate the situation should 1991 be another unusually bad year for catastrophes.

In essence, we are looking at the distinct probability of higher underwriting losses in the face of a declining rate of growth in net investment income. Simply put, it's getting harder to sweep things under the rug.

Insurance stocks have been exceptional stock market performers in recent weeks. The main reason for the surge has been the age-old surrogacy theory, which says the value of bond portfolios rises as interest rates decline. For the most part, this concept of enhanced economic values is only realized if and when an insurer sells the bond above its cost and secures the gain.

This gain may or may not be sufficient to offset the yield differentials that exist between the old (sold) bond yield and current yields. Anything that lets a property/casualty management team feel healthier and wealthier could detract from the pressures felt to correct pricing deficiencies. Indeed, the recent stock market euphoria surrounding property/casualty stocks may be music to investors, but it could well be poison in terms of any near-term meaningful change in pricing. ■

Myron M. Picoult is senior vp and senior insurance analyst with Oppenheimer & Co. in New York. He is the past president of the Assn. of Insurance & Financial Analysts and a member of the New York Society of Security Analysts.



Insurance industry stocks surged ahead last week as the *Business Insurance* Index went up 17.4 points to 638.9 on March 8, from 621.5 on March 1. Advancing issues for the week were led by Fremont General Corp., up 17.7%; Poe & Associates, up 17.7%; and AmBase Corp., up 16.7%. Declining issues followed Chandler Insurance, down 11.5%; Washington National, down 4.4%; and Belvedere Corp., down 4.4%. The most active issue was Sears, Roebuck & Co. (Allstate), with 4.0 million shares traded. The *BI* Index was up 2.8%; The Standard & Poor's 500 was up 1.2%; the Dow Jones 30 Industrials were up 1.6%; and the New York Stock Exchange Composite rose 1.3%.

British Issues

March 7 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	527	n/m	30.7	5.8	529—527	
Genl Accident	570	n/m	35.7	6.3	570—560	
Gdn Royal Exch	221	n/m	15.9	7.2	224—217	
Royal	477	n/m	34.7	7.3	478—468	
Sun Alliance	371	n/m	18.7	5.0	376—371	
Brokers						
Bradstock	145	16.5	6.0	4.1	145—143	
CE Heath	507	15.0	34.5	6.8	507—491	
Hogg Group	181	12.1	10.6	5.8	181—178	
Lloyd Thompson	335	22.4	10.0	3.0	335—330	
PWS Holdings	95	11.6	4.7	4.9	95—89	
Sedgwick Grp	250	24.0	16.0	6.4	254—238	
Steel Brrl Jones	294	16.3	16.0	5.4	294—280	
Willis Corroon	295	15.5	17.6	6.0	297—293	

Source: Philip Olsen, Insurance Industry Analyst London

Partner benefits

Continued from previous page

Employee/Domestic Partnership" under penalty of perjury.

Domestic partners are required by law to notify the city clerk when a relationship terminates.

Six of the city's 125 employees have opted for domestic partner coverage.

Contrary to insurers' assumptions that most partners would be homosexuals—a group considered at high risk of contracting AIDS—most of those enrolled are heterosexual, observed Kevin M. Fridlington, the city's senior administrative analyst.

The city of Laguna Beach, Calif., began offering domestic partner benefits in October.

When, like West Hollywood, it could not find stop-loss coverage for domestic partners, Laguna Beach also decided to cap partners' benefits, said Phil Hofmann, personnel officer.

However, Laguna Beach's cap is higher—$50,000. After that point, Hartford Life Insurance Co. provides stop-loss coverage for employees and regular dependents up to $1 million lifetime.

To qualify, employees must sign an affidavit that states they have lived together as domestic partners for at least six months. Three of the city's 210 employees have signed up, he said.

The city pays 100% of the premium for the employee's coverage and contributes the same amount for domestic partners as for spouses: $260 per month.

Dental coverage is offered to employees, though not to domestic partners. Mr. Hofmann would not explain why.

Santa Cruz County, Calif., began offering domestic partner benefits under its self-insured indemnity plan April 30, 1990.

Only 25 of 1,950 employees have signed up, said Pruit Tully, employee relations manager.

At least one association-sponsored insurance program has been open to members' domestic partners for nearly a decade.

The American Psychological Assn. Insurance Trust has been providing health care benefits to members of the APA and their domestic partners since 1983, said a spokeswoman for the Washington, D.C.-based organization. Of the 1,500 policies currently in force, approximately 10 domestic partners are covered, she said.

APA members' domestic partners are subject to a one-year waiting period for coverage; spouses are covered immediately. ■

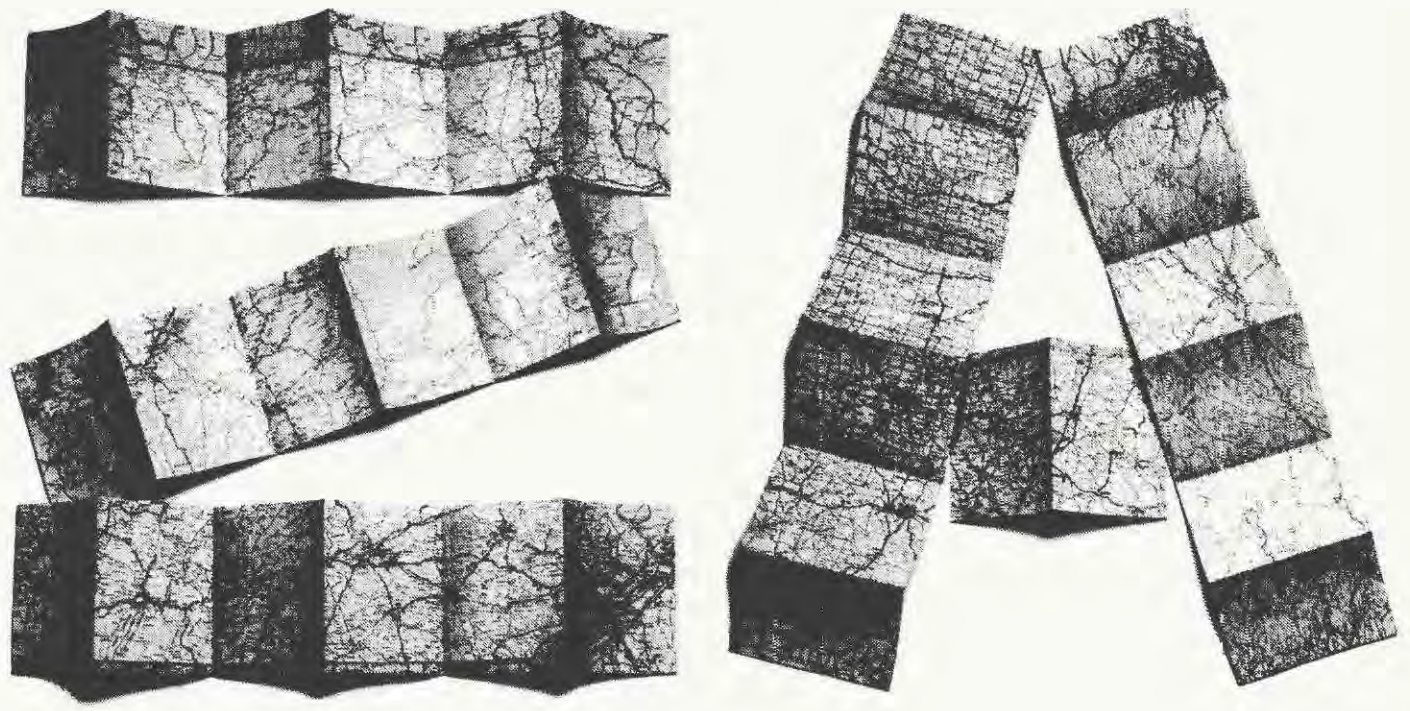
BI Industry Stock Report

MARCH 4, 1991 THROUGH MARCH 8, 1991

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander	NYS	26.00	-3.26	12.43	28.88	16.13	541	1.00	3.85	19	9.18	2.83
Gallagher Arthur J. & Co.	NYS	28.00	8.74	20.43	28.25	19.75	122	0.64	2.29	20	5.33	5.25
Frank B. Hall	NYS	3.50	0.00	-3.45	4.25	2.00	109	0.00	0.00	-7	-2.80	-1.25
Hilb, Rogal & Hamilton	OTC	15.00	7.14	1.69	16.50	11.25	396	0.36	2.40	21	4.60	3.26
Marsh & McLennan	NYS	79.75	5.28	2.24	82.00	59.75	1045	2.60	3.26	19	10.56	7.55
Poe & Associates	OTC	10.00	17.65	25.00	13.00	7.75	0	0.40	4.00	10	2.40	4.17
BROKERS	AVERAGE		5.1	8.3					2.3	12		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W R. Corp.	OTC	46.25	4.52	23.33	45.50	28.50	477	0.44	0.95	15	25.06	1.85
Berkshire Hathaway Inc.	NYS	7900.00	-2.77	18.35	8900.00	5675.00	0	0.00	0.00	25	2869.00	2.75
ITT (Hartford Group)	NYS	56.75	-0.66	18.23	60.88	40.25	1702	1.72	3.03	8	56.33	1.01
Sears (Allstate)	NYS	32.00	2.81	26.11	41.88	22.00	3975	2.00	6.25	12	37.75	0.85
CONGLOMERATES	AVERAGE		1.0	21.5					2.6	15		
INSURERS/REINSURERS												
Aetna Life & Casualty	NYS	45.50	0.83	16.67	54.38	29.00	990	2.76	6.07	8	58.11	0.78
Ambase Corp.	NYS	0.88	16.67	179.55	8.25	0.16	1214	0.00	0.00	0	29.08	0.03
American General	NYS	38.50	5.12	25.20	50.63	23.50	935	2.00	5.19	8	34.68	1.11
American Heritage	NYS	23.88	0.00	13.69	24.13	19.63	6	1.00	4.19	11	22.60	1.06
American Indemnity/Finl	OTC	6.75	8.00	107.69	7.25	2.75	1	0.08	1.19	-20	17.38	0.39
American International	NYS	93.75	1.21	21.95	96.25	57.00	1630	0.44	0.47	14	41.92	2.24
Aon Corp.	NYS	37.13	7.61	6.83	41.38	26.75	271	1.52	4.09	10	19.62	1.89
Argonaut Group	OTC	76.00	1.33	18.75	78.00	53.00	34	1.60	2.11	8	36.83	2.06
AVEMCO Corp.	NYS	29.38	5.38	16.34	30.13	21.13	18	0.44	1.50	18	9.52	3.09
Baldwin & Lyons Inc.	OTC	23.25	8.14	24.00	24.25	17.00	7	0.28	1.20	8	20.80	1.12
Belvedere Corp.	ASE	2.75	-4.35	10.00	4.75	1.75	3	0.04	1.45	69	8.03	0.34
Chandler Insurance	OTC	2.88	-11.54	-58.18	10.00	2.75	75	0.00	0.00	2	9.53	0.30
Chubb Corp.	NYS	69.38	3.54	27.88	70.25	34.63	1010	1.48	2.13	11	55.49	1.25
CIGNA Corp.	NYS	48.63	0.00	18.96	55.50	33.25	694	3.04	6.25	11	66.64	0.73
CNA Financial Corp.	NYS	84.00	-3.45	22.40	92.50	49.50	94	0.00	0.00	15	54.87	1.53
Continental Corp.	NYS	28.00	-1.32	12.56	31.38	15.75	1043	2.60	9.29	11	41.36	0.68
Durham Corp.	OTC	28.00	0.00	0.00	34.00	23.00	8	0.92	3.29	14	26.32	1.06
Fund American Corp.	NYS	61.25	1.45	18.07	61.75	29.50	764	0.68	1.11	25	32.74	1.87
Fremont General Corp.	OTC	18.25	17.74	25.86	21.13	10.13	286	0.80	4.38	6	19.09	0.96
Frontier Insurance Group	NYS	22.25	10.56	17.11	33.00	15.38	25	0.00	0.00	9	7.29	3.05
General RE Corp.	NYS	96.88	0.13	4.17	99.88	69.00	1074	1.68	1.73	14	29.04	3.34
Hanover Insurance Co.	OTC	28.75	-0.86	8.49	30.25	21.00	15	0.44	1.53	11	32.03	0.90
Harleysville Group	OTC	28.50	5.56	24.59	30.00	13.50	65	0.64	2.25	9	18.94	1.50
Hartford Steam Boiler	NYS	56.13	-1.10	15.13	62.13	43.50	91	1.80	3.21	15	18.94	2.96
Kansas City Life Ins.	OTC	33.50	0.00	8.50	36.50	30.00	0	1.20	3.58	9	39.22	0.85
Kemper Corp.	NYS	32.25	6.61	35.79	43.13	17.13	404	0.92	2.85	124	29.97	1.08
Lawrence Insurance Group	ASE	7.00	1.82	0.00	9.13	6.38	3	0.36	5.14	11	4.40	1.59
Liberty Corp.	NYS	43.00	2.69	4.56	50.25	39.00	17	0.92	2.14	14	31.82	1.35
Lincoln National	NYS	49.75	0.51	15.70	56.50	30.75	274	2.72	5.47	12	49.19	1.01
NAC Re Corp.	OTC	38.25	3.38	15.91	38.50	25.50	317	0.20	0.52	16	22.81	1.68
Navigators Group	OTC	39.75	-0.31	21.37	41.00	24.75	19	0.00	0.00	15	15.22	2.61
Nobel Insurance LTD.	OTC	3.13	0.00	4.17	3.75	1.88	33	0.00	0.00	-	7.76	0.40
NWNL Companies	NYS	27.88	1.83	65.19	34.50	11.75	388	1.32	4.74	6	37.50	0.74
Ohio Casualty Corp.	OTC	41.50	-0.60	1.22	50.75	26.75	250	2.48	5.98	9	33.30	1.25
Old Republic Int'l	NYS	28.00	3.23	22.40	29.00	19.00	77	0.76	2.71	6	30.70	0.91
Orion Capital Corp.	NYS	22.75	13.04	30.00	23.00	13.00	120	0.92	4.04	8	19.72	1.15
Phoenix RE Corp.	OTC	9.00	-2.70	16.13	12.00	5.00	57	0.20	2.22	113	12.99	0.69
Protective Life Corp.	OTC	17.50	9.38	17.65	17.50	10.25	345	0.76	4.34	8	14.54	1.20
Provident Life	OTC	22.00	7.32	25.71	26.25	12.00	630	0.92	4.18	6	23.24	0.95
Re Capital Corp.	ASE	16.25	9.24	26.21	17.00	11.75	105	0.00	0.00	11	14.43	1.13
RLI Insurance Corp.	NYS	16.25	7.44	12.07	16.13	9.50	52	0.44	2.71	8	12.42	1.31
St. Paul Companies	OTC	66.75	-0.74	6.37	70.25	47.00	1254	2.60	3.90	8	43.47	1.54
SAFECO Corp.	OTC	39.25	-0.32	19.39	40.50	25.13	1148	1.36	3.46	9	24.87	1.58
SCOR U.S. Corp.	NYS	14.38	6.48	16.16	15.25	8.38	78	0.20	1.39	10	10.61	1.35
Seibels Bruce Group	OTC	6.50	-1.89	52.94	11.75	4.25	48	0.36	5.54	20	13.75	0.47
Selective Ins. Group	OTC	16.50	3.13	24.53	18.75	12.50	158	1.04	6.30	7	15.72	1.05
Statesman Group Inc.	OTC	2.25	0.00	43.95	3.00	1.25	228	0.00	0.00	4	4.19	0.54
Tokio Marine & Fire	OTC	49.00	0.00	3.70	56.50	34.50	15	0.26	0.53	29	70.93	0.69
Torchmark Corp.	NYS	55.63	-0.22	13.81	56.13	38.00	742	1.40	2.52	13	13.23	4.20
Transamerica	NYS	36.50	0.00	11.88	41.00	23.25	992	1.96	5.37	11	34.63	1.05
Travelers Corp.	NYS	22.63	7.10	36.09	34.88	11.50	1552	1.60	7.07	-12	44.85	0.50
Trenwick Group Inc.	OTC	26.50	0.95	14.59	27.50	16.25	111	0.60	2.26	11	16.91	1.57
United Fire & Casualty	OTC	42.75	1.18	21.71	43.00	28.75	2	1.32	3.09	7	22.56	1.89
USF&G Corp.	NYS	9.63	-1.28	28.33	30.13	7.00	2628	0.20	2.08	-2	22.87	0.42
UNUM Corp.	NYS	58.75	0.43	26.01	63.00	32.13	314	0.80	1.36	11	31.20	1.88
USLIFE Corp.	NYS	34.75	0.00	24.11	41.75	23.25	210	1.48	4.26	8	54.34	0.64
Unitrin	OTC	38.50	0.65	25.20	38.50	24.50	250	0.80	2.08	16	33.99	1.13
Washington National	NYS	13.50	-4.42	24.14	24.63	9.38	182	1.08	8.00	-15	32.90	0.41
USLICO Corp.	NYS	20.00	3.90	25.98	23.00	14.75	11	1.00	5.00	9	27.73	0.72
Zenith National Ins.	NYS	17.50	6.06	28.44	18.13	9.88	80	1.00	5.71	-34	13.81	1.27
INSURERS/REINSURERS	AVERAGE		2.7	23.6					3.2	13.5		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	22.25	5.95	45.90	23.25	9.75	918	0.00	0.00	18	3.54	6.29
HMO America Inc.	OTC	9.00	4.35	38.46	9.38	4.25	742	0.00	0.00	13	1.12	8.04
Pacificare Health Sys.	OTC	21.88	-2.23	34.62	26.00	12.00	428	0.00	0.00	15	6.35	3.44
Safeguard Health Enter.	OTC	5.38	10.26	13.16	7.63	4.00	8	0.00	0.00	12	2.99	1.80
Sierra Health Services	ASE	22.63	13.84	64.55	22.00	5.50	360	0.00	0.00	67	0.62	36.49
United Healthcare Corp.	OTC	31.25	4.17	34.41	33.88	9.13	2664	0.06	0.19	25	0.34	91.91
United Medical Corp.	ASE	9.50	5.56	18.75	11.38	6.63	11	0.20	2.11	12	5.70	1.67
U.S. Healthcare	OTC	40.75	5.16	38.72	43.25	10.88	3756	0.48	1.18	25	3.07	13.27
HMOs	AVERAGE		5.9	36.1					0.4	23		
ALL COMPANIES AVERAGE			3.1	22.8				2.7	14			

System design: Nordby International Inc.

Who Knows Your Territory Like The Back of Their Hand?



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