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update

Congress hikes PBGC rates, extends group health benefits

WASHINGTON—President Reagan is expected to sign legislation that will boost employers' pension costs and require companies to open up their group health insurance programs to divorced and widowed spouses.

Under the legislation, H.R. 3128, the annual termination insurance premium employers with defined benefit plans must pay the Pension Benefit

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Senate panel passes Risk Retention Act bill

By JERRY GEISEL

WASHINGTON—Legislation to expand the federal Risk Retention Act is heading for the Senate floor unencumbered by amendments that buyers feared would gut the bill.

However, despite last week's 14-2 Senate Commerce Committee vote approving the bill, business lobbyists say agents' groups and other industry interests will again try to water down the legislation as it heads for a vote by the full Senate.

The legislation, S. 2129, would permit businesses, trade groups and municipalities to purchase all forms of commercial casualty coverage—except workers compensation—on a group basis or to form captive insurers, called risk retention groups, to pool their risks.

Under the legislation, these groups would be largely exempt from state regulation.

The current Risk Retention Act, passed by Congress in 1981, gives this exemption from state regulation only to groups established to purchase or self-insure product liability and completed operations coverage.

After a risk retention group meets the insurance requirements of the state it chooses as its domicile, the group can operate in the other 49 states without, among other things, having to receive state approval for rates and policy forms.

The purchasing group provision in the Risk Retention Act preempts state laws that generally bar the group purchase of insurance.

The approval of the legislation, introduced by Sen. Robert Kasten, R-Wis., is a major victory for insurance buyers, which convinced committee members not to consider the so-called killer amendments drafted by insurance agents' groups (*BI*, March 24).

One of these amendments would have required organizations wanting to set up risk retention groups to prove to insurance regulators in each state the groups were to operate that commercial insurance was not available on reasonable terms from admitted or licensed insurers.

Buyers had said the agents' proposal would gut the act by creating a bureaucratic nightmare for businesses hoping to set up risk reten-

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N.Y. probes seven insurers about underwriting practices

By DOUGLAS McLEOD

NEW YORK—The New York Insurance Department is reviewing the liability underwriting practices of seven major property/casualty insurers.

At the request of New York Superintendent James P. Corcoran, the seven insurers testified under oath about their underwriting activities—particularly in such capacity-starved casualty lines as municipal liability—in a series of closed-door hearings that concluded last Monday.

One reason for the hearings, a department spokesman said, was to address allegations that insurers colluded to raise the price and limit the availability of certain types of liability coverage.

"I think we either want to put to rest these kinds of allegations or determine that they were indeed true," the department spokesman says.

"I think we either want to put to rest these kinds of allegations or determine that they were indeed true," the spokesman said, adding that "we don't want it to be construed that there was any suspicion of wrongdoing" on the part of any of the insurers testifying.

The insurers' testimony also could be used to develop legislation that may be recommended by New York Gov. Mario Cuomo's Advisory Commission on Liability Insurance, the spokesman added.

The advisory commission—formed in response to the liability insurance capacity crunch—announced that it may recommend closer regulation of insurance rates as well as changes in the tort system.

The commission's final recommendations are expected April 7.

Meanwhile, the New York department is reviewing the information collected at the hearings, which began March 18, the spokesman said.

Although the New York department would not release the names of the seven insurers, six of the companies confirmed that they testified at the hearings, including Hartford Insurance Group, Aetna Life & Casualty Group, CIGNA Corp., Fireman's Fund Insurance Cos., Utica National Insurance Group and Chubb Group.

American International Group Inc. also was called to testify, sources say, though an AIG spokeswoman could not confirm its participation.

In addition, the Insurance Services Office was called to testify about its procedures for developing advisory rates, an ISO spokeswoman confirmed.

The insurers were asked questions in three areas, the New York department spokesman said. These covered:

- The financial condition of the company testifying.

These questions were meant to confirm that recent restrictive underwriting practices were necessary to preserve companies' financial health.

"There is the contention that they are possibly doing better than they say they're doing," the spokesman explained.

- The reasons for general business decisions involving entire lines of insurance, such as decisions to stop writing municipal liability or to raise rates across the board in a particular line.

Several of the insurers testifying have made such broad underwriting decisions since last year.

Utica National—formerly one of the largest munici-

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Health cost shifting's popularity wanes: Study

By ALISON KITTRELL

Managed care and utilization review programs are he latest trends in controlling corporate health care osts, replacing cost-shifting to employees, according to he fourth biennial survey by the Health Research Intitute.

"One of the most significant changes over the two-ear survey period—as well as compared to all earlier urveys—was the increase in use and effectiveness of anaged care/utilization review programs," the survey eports.

Respondents to the 1985 survey, like respondents to vious surveys, reported that they have incorporated ost-shifting such as higher deductibles and co-insurnce levels during the past two years.

But, the 633 respondents to the most-recent survey by ne Walnut Creek, Calif.-based research firm do not expect to ake similar cost-shifting changes during the next two years.

Relatively few of the 1985 respondents—less than 17%—anicipate making changes in the structure of the company's ealth care plan during the next two years. And, those comanies that do expect to make changes report a greater tenency to increase benefits, such as vision care, prescription rug coverage and dental care (see story, page 24).

William E. Hembree, director of HRI, says the move away from cost-shifting has occurred largely because employers have come to realize that its effect on health care costs is limited.

That is because employees fall into one of three groups, he says. The first group, which represents a significant number of employees, is comprised of those workers who never use the health care plan at all.

"So, it doesn't matter if you have a million-dollar deductible, it's not going to have any effect on an employee in this group except to make him mad," Mr. Hembree says.

The second group, which is probably the largest of the three, is made up of "fairly small" users of the plan. Cost-shifting is going to have an effect on this group, but they represent relatively small costs to the plan, Mr. Hembree says.

The third group is made up of those employees with serious health care problems. Cost shifting has relatively little effect on this group, which accounts for the largest medical bills, Mr. Hembree says.

Employees in this group are "too emotionally involved" to worry about comparative shopping for health care, he notes. "Deductibles don't matter as much—longevity becomes the issue," he says.

"And, many of these employees are comatose—how can you ask them to shop hospitals?"

In addition, Mr. Hembree notes that these employees usually exhaust the limits of their deductibles and co-insurance quickly.

So, he says, employers have realized that cost-shifting is only effective as a cost-containment approach for those em-

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PBGC premium hike approved

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Guaranty Corp. will rise to $8.50 per participant from the current $2.60. The increase is retroactive to Jan. 1 (*BI*, March 10, Jan. 6).

The legislation also will make it more difficult and expensive for companies to terminate underfunded plans. For example, most companies will have to fully fund promised benefits before they can terminate a plan.

Financially distressed companies still will be allowed to fold underfunded plans, but their liability to the PBGC will be much higher compared with current law.

In addition, the legislation will require employers with at least 20 full-time employees to extend their group health insurance plans for three years to former spouses of employees and for 18 months to employees who lose their jobs.

However, employers would be allowed to charge spouses and former employees a premium of up to 102% of the cost of coverage.

A company that failed to comply with this provision would lose its federal tax deduction for health care coverage expenses.

The legislation also will require companies to give workers and spouses age 70 and older the option of enrolling in their group health plans instead of Medicare to receive their primary health care coverage.

The legislation has drawn controversy all along its journey through the legislative process, and it almost was derailed at the last minute.

Several senators held up passage of a resolution making technical corrections in the bill until they received a "framework for agreement" involving pension plan terminations by Wheeling-Pittsburgh Steel Corp. in Pittsburgh. The technical corrections were needed for the PBGC to handle plan terminations between Jan. 1, 1986—the bill's effective date—and the date of enactment.

The agreement would allow Wheeling-Pittsburgh to start paying benefits to retirees under a new supplemental plan, while the PBGC would approve termination of the company's old plans and allow it to set up a successor defined contribution plan. The terminating plans carry an estimated $500 million liability the PBGC will have to shoulder.

Court rules on punitive damages

SAN FRANCISCO—A state appeals court says that GAF Corp. and Nicolet Inc. can pursue efforts to recover punitive damages for alleged bad-faith conduct from certain insurers in massive asbestos insurance litigation.

The decision overturns a lower court decision that the companies could not recover punitive damages from Insurance Co. of North America and certain underwriters at Lloyd's of London and other British companies known as Kemp & Cos. in the litigation.

State Superior Court Judge Ira A. Brown Jr. had ruled that because recovery for punitive damages against insurers is prohibited by the law in Pennsylvania, where INA is incorporated, and in Britain, GAF and Nicolet could not pursue efforts to recover them (*BI*, March 11, 1985).

The appeals court said California law, which permits recovery for punitive damages from insurers, applies.

GAF General Counsel Edward Shea said the company was pleased with the decision.

Philip Matthews, an attorney for Kemp & Cos., said, "I don't think this decision does anything to resolve the insurance crisis" or the asbestos litigation crisis. And, he noted that if GAF did recover punitive damages, the money would not have to be used to compensate asbestos victims, but instead could be used for any corporate purpose.

He said Kemp & Cos. did not engage in bad-faith conduct, but he said it has not yet decided whether to appeal the ruling.

Fireman's Fund acquisition

NEW YORK—Fireman's Fund Insurance Cos. is acquiring the stock of Manufacturers Hanover Mortgage Corp., the country's third-largest mortgage banker, from Manufacturers Hanover Corp. for $260 million in cash, according to a spokesman for Fireman's Fund.

Fireman's Fund will change the name of Manufacturers Hanover Mortage Corp. but will maintain the company's headquarters in Farmington Hills, Mich. The firm has a portfolio of $14.9 billion on 363,000 loans.

In a separate action, Fireman's Fund Corp. is buying 5 million warrants from American Express Co. for $25 million. The warrants entitle Fireman's Fund to buy 5 million shares of stock at $46 a share 2½ years from the date of purchase.

American Express announced earlier this month that it is seeking to sell 10 million units of Fireman's Fund common stock and common stock warrants in a public offering (*BI*, March 3). In filings last week with the Securities and Exchange Commission, American Express and Fireman's Fund say each of the 10 million units to be

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Du Pont says it has insurance to cover $39.2 million award

By STEPHEN TARNOFF

CHICAGO—E.I. du Pont de Nemours & Co. says it has enough liability insurance to cover a $39.2 million award to a 68-year-old man whose legs were amputated following a reaction to the drug Coumadin in 1977.

"We have adequate insurance," James Mitchell, Du Pont's manager of insurance, said last week after a Cook County Circuit Court jury on March 19 awarded $26.1 million in punitive and $13.1 million in compensatory damages to George Chelos of Park Ridge, Ill.

The company said the verdict will have "no appreciable impact" on its earnings.

Neither Mr. Mitchell nor a company spokesman would elaborate on Du Pont's insurance program. However, it is widely known that Du Pont has maintained a substantial self-insured retention for many years.

'It is the highest verdict for personal injury, the highest verdict for punitive damages and the highest combined verdict in Illinois history,' Mr. Schaffner says.

In 1975, two years before Mr. Chelos took Coumadin, an anti-coagulant, Du Pont self-insured up to $10 million of its property and casualty risks for all U.S. facilities. It purchased excess coverage over the retention (*BI*, Jan. 27, 1975).

The company would also not say if Du Pont is covered for punitive damages.

Coverage for punitive damages would depend upon whether Du Pont's coverage specifically excludes them and whether the applicable state law permits coverage, says Brian A. McKinsey, an attorney with Schumaier, Roberts & McKinsey in Clayton, Mo., who is knowledgeable about the insurability of punitive damages.

Mr. McKinsey said which state's laws apply to a particular case can depend upon a variety of factors, including where the insurance policy was signed and where the premium was paid.

Punitive damages are generally insurable in Delaware, where Du Pont is headquartered.

The verdict, reached by the jury after only slightly more than two hours of deliberation, is the largest in Illinois history, according to plaintiffs' attorney Howard Schaffner of the Chicago law firm of Hofeld & Schaffner.

"It is the highest verdict for personal injury, the higest verdict for punitive damages and the highest combined verdict in Illinois history," said Mr. Schaffner.

Du Pont offered to settle the case for $4 million just before the case went to the jury, attorneys in the case confirmed.

Last week, Du Pont vigorously denied any wrongdoing and said it would appeal the verdict.

"We feel Coumadin did not cause the injuries and that the award is excessive," a company spokesman said. "We will appeal."

"Du Pont believes that Coumadin did not cause the plaintiff's injury," H.L. Richardson, vp of biomedical products, said in a prepared statement. "We believe the assessment of damages to be grossly inappropriate. We intend to appeal the case."

An attorney for Du Pont said the company first will file post-trial motions, including motions to overturn the jury's verdict or reduce the award.

"We are very disappointed in the decision," said William E. Kelly, with the Chicago firm of Pope, Ballard, Shepard & Fowle.

According to Mr. Schaffner, Mr. Chelos was adminis-

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Carbide hopes India drops opposition

By JUDY GREENWALD

NEW YORK—Union Carbide says it is optimistic the Indian government will reverse its opposition to the agreement the company reached with lawyers representing victims of the 1984 chemical disaster in Bhopal, India.

Meanwhile, both the company and insurers said last week that Union Carbide has not yet received any funds from its $200 million excess liability insurance policy. One insurer said a number of key issues still must be resolved.

"Our position is that we are still hopeful that upon reflection" the Indian government will facilitate distribution of funds to victims, the Union Carbide spokesman said. Under the agreement, Union Carbide will make a contribution of $350 million, which would produce a fund of between $500 million and $600 million for the victims over a period of several years.

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RIMS study shows depth of market deterioration

NEW YORK—The commercial insurance market experienced "significant deterioration" during 1985, according to a new survey of U.S. and Canadian risk managers.

"The most severe problems pertain to the sudden and drastic change in limits and premiums over time," according to the survey by the Risk and Insurance Management Society Inc.

"Few signs indicate that the situation will improve soon—in fact, it may worsen in some areas," RIMS said.

A typical comment from respondents was, "We've had to assume considerable liability that previously was covered, and hope to God that nothing happens," according to a report accompanying the survey results.

More than 3,700 questionnaires were sent out in January, and the findings were based on responses received by Feb. 14 from almost 1,200 RIMS members in 46 states, the District of Columbia and Canada.

The members were asked about availability, cost, limits, deductibles, and terms and conditions for 13 commercial insurance coverages from the fourth quarter of 1984 through the fourth quarter of 1985.

Among the findings:

- Coverage problems affected virtually all sectors of the U.S. and Canadian economies, hitting large and small firms alike.
- Almost every coverage created serious problems for buyers.
- 28% of respondents had premium increases for umbrella/excess coverage of more than 500%, and 18% had limits decreases of more than 75%.

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Government role in terminations to rise

By JOEL CHERNOFF

Crain News Service

WASHINGTON—The Labor Department will take a more active role in evaluating employer decisions to terminate defined benefit pension plans.

In a letter to former U.S. Rep. John N. Erlenborn, who chairs the department's ERISA Advisory Council, the department said several employer decisions relating to pension plan terminations are considered fiduciary decisions, not management decisions.

Fiduciary decisions fall under the provisions of the Employee Retirement Income Security Act of 1974 and thus are regulated by the Labor Department and other federal agencies. Management decisions are not subject to ERISA regulation.

The employer decisions considered finduciary decisions include the choice of an insurer to provide annuities to plan participants after a termination, the selection of an interest rate for making lump-sum distributions and the allocation of plan assets.

But while the letter clarifies that certain actions relating to a plan termination are fiduciary decisions, th decision to start or terminate a pension plan still is c sidered a business decision and does not fall unde ERISA, the department says.

"We felt it was important that we clarify which typ of implementation actions are fiduciary in nature," sai David M. Walker, deputy assistant secretary for th Labor Department's pension program.

While pension experts agreed the department' March 13 letter to Mr. Erlenborn denotes greater gov ernmental involvement in the termination of pensio plans, they were split on its significance.

Key members of the ERISA Advisory Council's tas force on plan terminations touted the department's le ter as a major breakthrough, saying the department position reinforces the rights of plan participants an beneficiaries.

George W. Lehr, executive director of the Teamster Central States, Southeast and Southwest Areas Pensio Fund in Chicago and a task force member, called th letter "a very, very significant first."

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Public officials feeling insurance crunch

By MEG FLETCHER

A topsy-turvy legal environment and a shrinking market for public officials' liability insurance are prompting some officials around the country to resign and others to curtail high-risk community operations.

"I think these people are worried out of their minds that they will be personally liable" for their official acts, says Jim Toomey, an attorney with the Alliance of American Insurers.

"A lot of people are bailing out because all they have to do is offend rather than perform a tort," adds Mary Lou Emmert, president of the Public Risk & Insurance Management Assn. and risk manager for Monterey County, Calif.

Public officials' liability insurance typically covers "wrongful acts," excluding bodily injury, property damage and personal injury exposures. It typically excludes the non-administrative acts of law enforcement officers. The policies generally include defense costs and are written on a claims-made basis.

Claims against public officials are increasing in number and severity, according to a study released earlier this year by The Wyatt Co. and the International City Management Assn.

And the legal climate that officials face is uncertain, due to inconclusive court decisions, including six recent decisions from the U.S. Supreme Court that affect exposure to liability for public officials' administrative actions (see story, page 30).

No one knows for sure how many officials have resigned because of insurance problems, but the effects of the uncertain liability of public officials have been felt around the country:

'A lot are bailing out because all they have to do is offend rather than perform a tort,' says Ms. Emmert.

- A trustee on the seven-member board of Basalt, Colo., will not stand for election April 1 because of the potential liability exposure, according to Jerry L'Estrange, the town administrator.

The trustee resigned last summer during a month in which the town had no liability insurance. She was re-appointed to fill another vacancy, but decided not to run for re-election, he added.

Basalt, which has 750 residents living 18 miles north of Aspen, is paying Tudor Insurance Co. $2,611 for $100,000 in annual aggregate claims-made coverage with deductibles of $2,500 per loss and $500 for each official per loss each loss, Mr. L'Estrange said. Previously, it paid $550 for $500,000 in public officials liability coverage written on an occurrence basis, he said.

- The mayor of Shiloh, Ohio, resigned (*BI*, Dec. 2,1985).
- One of the nine members of the Cambria County Transit Authority in Pennsylvania stepped down.
- A few council members from at least three small California towns, including Amador City and Tehama, have resigned, said a spokeswoman for the League of California Cities.

And in Sykesville, Md., "there was a point when the whole government was going to resign because of this," said Mayor Lloyd R. Helt Jr.

He was able to defuse that move and obtain public officials liability coverage after Sykesville's went without coverage for a few days last September. The town of 2,000 residents obtained $1 million in coverage with a $20,000 deductible through National Union Fire Insurance Co. of Pittsbugh, Pa., for $7,990. Later, it was able to pay $3,400 to National Casualty Insurance Co. through Markel Service Inc. for $1 million in coverage with a $1,000 deductible, Mr. Helt said.

The town's total insurance bill climbed to $75,000 this year from $25,000 last year, despite eliminating plans to build an ice rink and a decision to end sponsorship of a fall festival.

Mr. Helt is now faced with finding an additional $50,000 in his budget, comparable to a 25-cent increase in a tax rate that is now 90 cents per $100 of assessed valuation.

"It's dismal," he said.

"If we don't provide protection for volunteers in small towns, the volunteers won't serve," Mr. Helt said. All that will soon be left are "idealistic fools," like himself, he added.

Public officials' liability primarily stems from civil rights cases filed under Section 1983 of the federal Civil Rights Act and an amendment to it, Section 1988, which awards attorneys' fees to a prevailing party, said attorney James R. Schirott of Itasca, Ill. He is the author of a newly updated handbook on public officials' liability exposures published

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Insurers must share blame: AIG head

By JUDY GREENWALD

NEW YORK—While noting that civil justice reform is "now on everyone's mind," the president of American International Group Inc. says the "plight" of the insurance industry "can't be laid totally" at the tort system's feet.

Maurice R. Greenberg, AIG's president and chief executive officer, blamed the industry's current problems on uncontrolled competition in the early 1980s that led to price cuts "to the point of absurdity."

Mr. Greenberg

If prices had remained relatively flat, Mr. Greenberg said, there would not be "all this hullabaloo" about the tort system, nor would a consensus about the need for tort reform have emerged.

But, while it may be wrong to blame all of the industry's problems on the tort system, he added, the system nevertheless does need reform.

Insurers cannot correctly price entire **classes of business, including** directors and officers and product liability, because they cannot predict how the courts will decide cases.

Mr. Greenberg made his comments at an insurance conference last week sponsored by First Boston Corp. Also speaking at the conference was Donald J. Greene, senior partner at the law firm of LeBoeuf, Lamb, Leiby & MacRae in New York, who predicted that at least the municipality capacity shortage problem would be solved through tort reform.

Mr. Greenberg announced during his remarks that AIG is now in the process of creating a new reinsurance company, which he expected to be operational by the "first part" of this year.

AIG officials would not provide details about the new reinsurer.

According to Mr. Greenberg, the problems with the tort system not only include the size of court awards, but also cases settled for amounts larger than they otherwise would be because of defendants' awareness of how much it would cost them if they went to court and lost.

Twenty-five cents out of every dollar that liability insurers spend goes toward payment of claims, according to Mr. Greenberg. The remaining 75 cents are spent either on attorneys' fees, defense costs or administration costs, he added.

By contrast, he pointed out, only 15 cents per $1 of workers compensation payments go toward the administration of the workers compensation system.

Mr. Greenberg predicted that tort reform changes will lead to a "checkerboard system" of varying state laws, which will make it very difficult to put a price on a national insurance program.

Expecting federal intervention would be "unrealistic" except possibly for product liability law, said Mr. Greenberg, though he added he would like the federal government to develop model laws for the states to enact.

Pointing to the federal government's control of highway funds, Mr. Greenberg said Washington can be "very persuasive."

Mr. Greenberg warned that even if tort reform is enacted, insurance rates will not immediately decline because insurers will not know exactly how the legislation will affect judgments.

"There will be a period of wait-and-see."

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Washington governor gets tort bill

By JULIE TRUCK

OLYMPIA, Wash.—A major tort reform bill and several other measures designed to ease the commercial insurance crunch in Washington state have been passed by the Legislature and are waiting the signature of Gov. Booth Gardner.

"This is probably the most comprehensive package of bills that has been passed in any state so far," said Richard Wiebe, regional director of public affairs in the San Francisco office of the Alliance of American Insurers.

The Legislature's passage of the bills illustrates the gravity of the situation and how severe the liability crunch really is," he added.

Gov. Gardner has until midnight April 4 to sign or veto the legislation. If he does neither, the bills automatically will become law. The governor has not indicated whether he plans to sign the bills.

However, supporters of the tort reform legislation, S.B. 4630, hope the strong public support it has garnered will prompt the governor to sign it.

The bill is backed by the Olympia-based Liability Reform Coalition. The coalition, which was formed in November, has a membership of about 70 business, government and professional groups.

"We've found overwhelming public support for what we are doing, and the Legislature clearly sensed that," said James Metcalf, the executive director of the Washington State Assn. of Counties.

Specifically, S.B. 4630 would:

- Limit payments for non-economic damages, such as pain and suffering. The bill provides for an inflation-adjusted sliding scale of limits based on the claimant's life expectancy.

Under the formula, the average award for non-economic damages would be limited to about $350,000. The maximum, which could be awarded to infants, is $573,000; the minimum, which would be awarded to people with 15 years or less of life expectancy, is $117,000.

The life expectancies would be taken from actuarial tables published by the state insurance commissioner's office.

- Modify the doctrine of joint and several liability. Under current state law, a plaintiff can collect full damages from one of several defendants, even if that defendant is judged to be only partly at fault. But, the bill would limit the liability of any defendant to the percentage of the total liability equal to its percentage of the fault.
- Allow for periodic payment of awards for future economic damages. Any award for future economic damages exceeding $100,000 could be paid periodically if requested by either party. Current law allows plaintiffs to be awarded lump-sum payments for damages including future loss of earnings and medical expenses.
- Authorizes a market assistance plan. The bill authorizes the insurance commissioner to form a MAP to assist people or entities that are unable to purchase casualty insurance from either the admitted or the non-admitted market.

The bill calls for the MAP to have at least 25 insurers willing to participate. If 25 insurers do not participate voluntarily, the commissioner may appoint them.

- Authorizes the insurance commissioner to require an existing task force to study the effectiveness of joint underwriting authorities throughout the

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London requiring claims-made form for non-U.S. buyers

By STACY SHAPIRO

LONDON—At least three major London underwriters are requiring many of their non-U.S. policyholders to purchase claims-made coverage for primary and excess general and product liability risks.

Previously, most non-U.S. companies have been able to insure their liability exposures in the London market on an occurrence form, although they have the option of purchasing claims-made coverage.

The three insurers pushing the use of the claims-made form for non-U.S. risks are Michael Payne, Lloyd's of London underwriter for syndicate 683; D.T. Carey, Lloyd's underwriter for syndicate 919; and Sun Alliance & London Insurance P.L.C.

Mr. Payne says he and Mr. Carey are the two largest non-U.S. liability underwriters at Lloyd's.

The move follows the growing use of claims-made liability forms for U.S. policyholders.

In the United States, the Insurance Services Office's controversial claims-made commercial general liability form is now available for use in at least 31 states and Puerto Rico (*BI*, March 17).

And, in the London market, there are two claims-made excess liability insurance policies for U.S. risks. They are:

- The Lloyd's claims-made excess liability policy, introduced last year by underwriters at Merrett Syndicates Ltd., Janson Green Ltd. and the F.R. White syndicate (*BI*, Sept. 23, 1985; Nov. 25, 1985). The three syndicates are the leading underwriters of U.S. casualty business at Lloyd's.
- The claims-made excess liability policy—dubbed the London 1985 form—used by H.S. Weavers (Underwriting) Agencies Ltd., another leading London underwriter of North American casualty risks (*BI*, Oct. 28, 1985).

The move in London toward the use of claims-made policy wordings has been fueled in part by intense pressure on London underwriters from reinsurers during year-end renewals to use claims-made forms for non-U.S. general and product liability exposures, Mr. Payne explains.

He said there was "considerable pressure" to make claims-made forms mandatory for companies that have long-latent exposures and export products to the United States.

These companies include pharmaceutical and chemical manufacturers, oil companies and automobile manufacturers, he said.

And, during year-end renewals, London reinsurers, under an endorsement called Expona 1986, banned from non-North American casualty reinsurance programs all North American operations except those that are strictly sales and distribution offices.

London reinsurers also are requiring that product liability coverage for exports to North America be written on a claims-made basis beginning Jan. 1, 1987

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Du Pont award

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tered Coumadin in February 1977 to prevent blood clots after he underwent a double coronary bypass surgery.

After three days, he developed a painful skin reaction in both legs that caused his muscles to deteriorate. Less than a month later, Mr. Chelos had to have both legs amputated below the knees, Mr. Schaffner said.

Among the allegations against Du Pont was that the company did not disclose all information to the U.S. Food and Drug Administration and the medical profession about the drug's potential dangers.

Doctors testifying on behalf of Mr. Chelos said that varicus periodicals in Europe carried articles for more than a decade about possible amputations associated with Coumadin but these were not included in the company's reports to the FDA, Mr. Schaffner said.

He added Du Pont knew of at least 60 other amputations related to Coumadin.

According to Mr. Schaffner, evidence also showed the information the company did supply to the FDA on amputations was buried in a report of several hundred pages.

Mr. Chelos also alleged in his suit that the Canadian equivalent of the FDA ordered Du Pont in 1973 to warn that death could result from use of the drug and that while Du Pont changed its Canadian labels, it did not inform the U.S. authorities about this action.

Mr. Schaffner said the $13.1 million in compensatory damages awarded to Mr. Chelos was for lost income, nursing care, medical expenses, pain and suffering, disability and disfigurement.

"The evidence at trial was dramatic," Mr. Schaffner said. "He (Mr. Chelos) laid in bed for 21 days and watched his legs die."

Mr. Chelos underwent 14 operations in the three-week period before amputation, his attorney said.

Mr. Chelos 'laid in bed for 21 days and watched his legs die,' says Mr. Schaffner.

"The real complaint was that if the warning was adequate, the doctor would not have used the drug," said Mr. Schaffner, adding that the need to use the drug in Mr. Chelos' case was only marginal.

Mr. Kelly, Du Pont's attorney, said Du Pont contended that the need to amputate Mr. Chelos' legs was caused by the blockage of a vein that led to a gangrenous condition, not the use of Coumadin.

The Du Pont spokesman noted that a major issue in the trial was whether the company had adequately informed the FDA of the drug's dangers. "It is our contention that we had," he said.

However, the spokesman acknowledged that while Du Pont filed various documents with the FDA concerning Coumadin, certain other documents that should have been filed were not.

"While some articles were not reported, there were others that were," said Mr. Kelly.

The Du Pont spokesman noted the Du Pont employee in charge of filing such documents in the 1960s and 1970s is now dead and added the FDA had access to some of the documents that were not filed.

Also, an insert placed in packages of Coumadin did contain warnings of some potential adverse reactions, primarily skin conditions, that could lead to more serious conditions, he said.

The spokesman added that Canada requires that more information about drug reactions be submitted to authorities than is required by the FDA in the United States.

Du Pont's Mr. Richardson said Coumadin has been a "lifesaving drug" for 32 years, that there is no adequate substitute for it as an anticoagulant and that more than 750,000 patients worldwide take the drug at any one time.

The Coumadin used by Mr. Chelos was manufactured by Endo Laboratories, which was purchased by Du Pont about 1969 and operated as a subsidiary until 1983 when it was merged with Du Pont.

The Du Pont spokesman added one or two other suits involving Coumadin are pending.

Mr. Schaffner acknowledged that under a contingent fee arrangement with Mr. Chelos, the law firm of Hoefeld & Schaffner would receive one-third of the award or approximately $13 million.

But, he noted the firm has spent a great deal of money and time on the case. Had the case gone against Mr. Chelos, the firm would have lost money, he said. ■

SmithKline recall to cost $8 million

PHILADELPHIA—SmithKline Corp. says its recall of three nonprescription capsule products in which rat poison was found will cost about $8 million.

A spokeswoman had no comment on what insurance, if any, SmithKline has to cover the cost of recall. But, observers say the market product recall coverage has largely dried up (*BI*, Feb. 24).

Trace amounts of warfarin, a substance used as rat poison, has been found in capsules of Contac cold remedy, Dietac appetite suppressant and Teldrin allergy reliever in Orlando, Fla., and Houston, the company spokeswoman said. The capsules would not have harmed humans, she added.

An anonymous caller who warned of the capsules also said he had distributed capsules containing cyanide, but none has been located, the spokesman said.

The spokeswoman said the company has not yet decided when or how the medications will be reintroduced. But, while the drugs may also be produced in non-capsule forms, the company says capsules definitely will be reintroduced.

Johnson & Johnson decided to stop manufacturing and distributing all of its Tylenol capsules in February after a Westchester, N.Y. woman died from cyanide-contaminated capsules in one bottle, and additional poison capsules were found in another bottle.

Robins reveals legal shakeups

RICHMOND, Va.—A.H. Robins Co., former manufacturer of the Dalkon Shield intrauterine device that filed for Chapter 11 reorganization last year, has dismissed the law firm that represented it in the bankruptcy and announced that its general counsel, W.A. Forrest Jr., is taking early retirement.

A Robins spokesman said the San Francisco firm of Murphy Weir & Butler was dismissed because it is "in the best interests of the company and in moving the Chapter 11 proceedings forward." He would not elaborate, but added a replacement firm has not been chosen.

Patrick Murphy, a partner with the firm, declined comment.

The Robins spokesman also said Robert P. Wolf, vp and general manager of its medical instrumen division, will succeed Mr. Forres as general counsel. Mr. Forrest said his decision to retire was "purely a personal one" and reflects no disagreement with management.

Robins filed for Chapter 11 reorganization last year because of the mounting costs of claims brough by women who used the Dalko Shield (*BI*, Aug. 26, 1985).

Risk retention bill

Continued from page 1

tion groups because each commissioner could establish different definitions of what constitutes reasonable terms.

In addition, buyers feared that state insurance commissioners, who are generally hostile to the concept of risk retention groups, could deny approval for groups to operate in their states even if there was a real market need.

"Even if commissioners established fair criteria of what was reasonable coverage, the burden of having to prove to each of the 50 commissioners that coverage was not reasonably available would have discouraged even the most desperate organization from setting up a risk retention group," a business lobbyist said.

But the committee didn't even consider the agents' proposal, which had been expected to be introduced by Sen. Wendell Ford, D-Ky. Despite vigorous lobbying by agent groups and some insurers, sources said the agents' proposal would have only received about five votes and was thus not introduced.

"The committee recognized that a needs test really was a killer amendment," a business lobbyist said.

Dirk Van Dongen, president of the National Assn. of Wholesaler-Distributors in Washington, noted that by passing the bill without major amendments, the committee said "it is good public policy to enable groups to cover their risks when the commercial market refuses to address their needs."

Those who backed the so-called killer amendments really "wanted to have their cake and eat it, too: 'We won't give you the coverage you need, and won't allow you to cover your own risks,'" Mr. Dongen added.

"The committee recognizes that the liability insurance crisis extends to a broad cross-section of American business and industry, like trucking and restaurants" and those groups should be able to protect themselves, according to Michael Mullen, an attorney with the Washington law firm of Crowell & Moring.

Despite the apparent lopsided margin of victory last week in committee—only Sen. Ford and Sen. James Exon, D-Neb., voted against the Kasten bill—lobbyists representing commercial insurance buyers say the measure could face a tough fight on the Senate floor unless more business groups give the measure support.

"These killer amendments aren't going away. Insurance groups are going to fight, kicking and screaming, to gut it. The battle is far from over," according to the business lobbyist.

Before passing the Kasten bill, the committee added a minor amendment by Sen. Slade Gorton, R-Wash. That amendment would require risk retention groups to notify insurance commissioners in states where it intends to operate of the number of members in the group.

In addition, the risk retention group would have to inform the commissioners of the lines of coverage it will offer to members in that state.

This notification would have to be made by certified mail.

Buyer groups said they do not foresee any problem in complying with this notification requirements.

Also, Sen. Kasten slightly modified his original bill to make it clear that the legislation would not interfere with the authority of state insurance commissioners to stop agents that offer coverage through a risk retention or purchasing group to employers and individuals not eligible for coverage.

In addition, as modified by Sen. Kasten, an insurance commissioner could order a purchasing group to cease doing business if coverage is underwritten by an insurer that is in a "hazardous financial condition."

The committee also spent some time discussing an amendment offered by Sen. Daniel Inouye, D-Hawaii, to allow risk retention groups to be established in Bermuda so long as they met the insurance requirements of at least one domestic state.

But Sen. Inouye withdrew his amendment after it became clear that it lacked enough votes for passage.

Sen. Albert Gore Jr., D-Tenn., said he may propose on the Senate floor a sunset amendment to give employers up to two years to establish risk retention groups. After that, the rules for establishing groups would stiffen.

Sen. Kasten said it might be more appropriate to give employers up to five years to establish risk retention groups. ■

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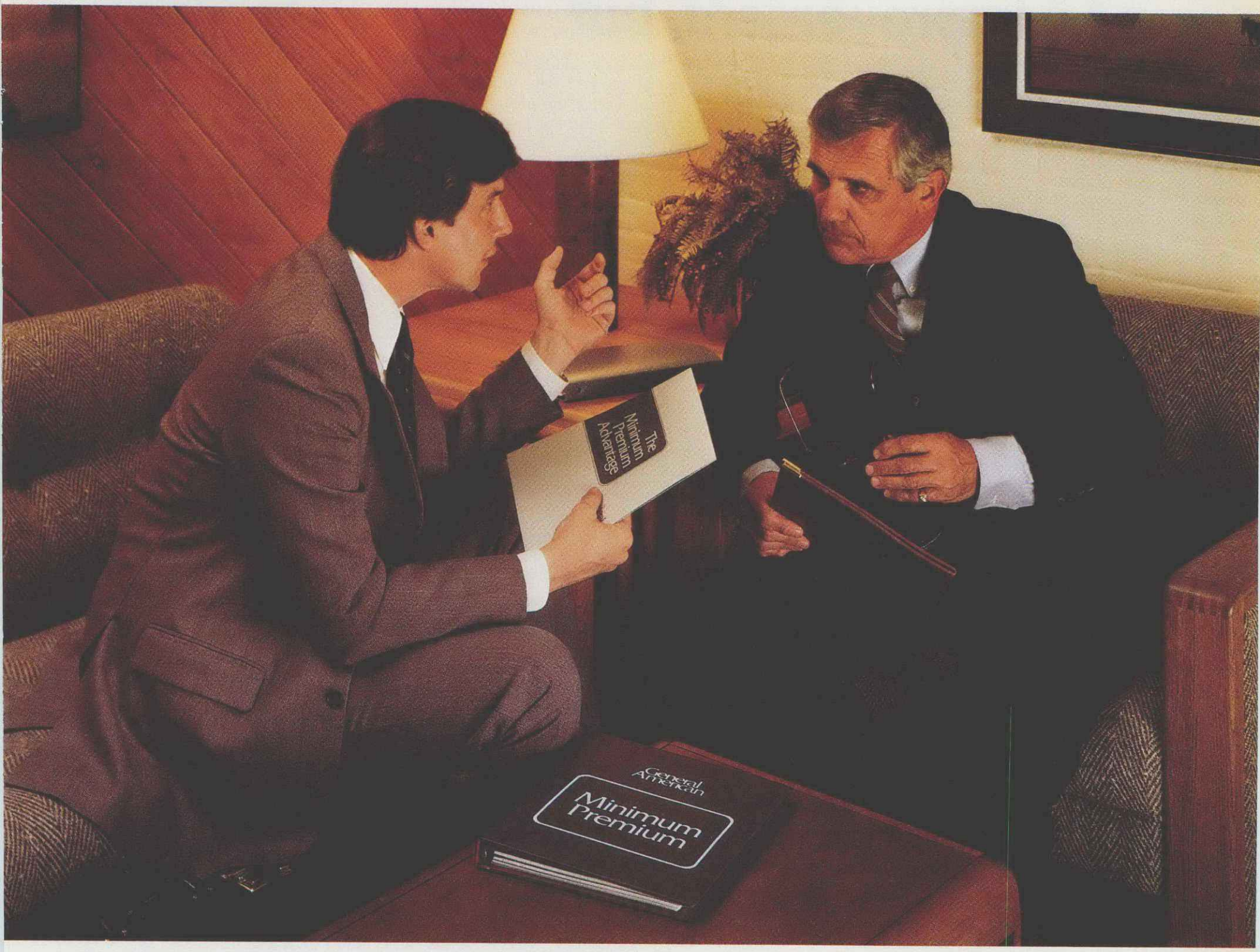

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* Fleishman-Hillard, Inc. Opinion Research Division, November, 1985

opinions

An improvement, but. . .

THE LATEST TAX PROPOSAL from Senate Finance Committee Chairman Robert Packwood, R-Ore., is a vast improvement over the House bill passed in December (*BI*, March 24).

Sen. Packwood wants to permit continued increases in maximum pension benefits and contributions, while the House bill would slash current maximums. He also wants to allow employees with both Individual Retirement Accounts and 401(k) plans to save $2,000 more than the House bill would. And, he would settle once and for all that educational assistance plans for employees are tax-free.

In the area of property/casualty insurance, Sen. Packwood would not hike the excise tax on reinsurance premiums paid to foreign insurers to 4% from the current 1%, which is a welcome relief to those concerned about easy access to foreign reinsurers.

One proposal, however, causes us some concern. Sen. Packwood wants to impose faster retirement plan vesting: full vesting after five years or scheduled vesting of 20% after three years with 20% annual vesting thereafter for full vesting after seven years.

The motivation is admirable: more pension benefits for more people. But we're not convinced the benefit is worth the cost.

The Employee Benefit Research Institute estimates that if five-year vesting were in effect in 1985, about 1.9 million more workers would have been vested. But what would those people get? Depending on the person's age and years of service, the amount would range from very little to significant. For example, EBRI calculated in a 1980 study that a 32-year-old separating from employment after 5.5 years with full vesting would be entitled to a present-value benefit of $730. A 22-year-old in the same circumstances would receive $405. But a 62 year-old would earn $4,871.

Since employers can cash out these obligations with a lump sum payment when the benefit is less than $3,500, the employees will certainly be given the cash.

And what would people do with the money? Experience shows that the younger the employee and the smaller the benefit, the more likely the money will be spent immediately and not saved for retirement. There is no mandate that employees save the money for retirement, only tax incentives not to spend it.

Meanwhile, five-year vesting would cost employers an average of 2% to 7% of current contributions, with the most expensive impact on defined contribution plans, EBRI says. Costs for employers with a young workforce and high turnover could rise as much as 40%.

Benefits and costs aside, consider retirement policy. If we move to five-year vesting now, is it just a step to three-year vesting? At what point is the government turning pension benefits into severance pay?

Change may help cure health care ills

THE TREND TOWARD managed care and utilization review to control health care costs is a welcome one.

A recent survey by the Health Research Institute shows that employers expect to move away from cost-shifting to employees, which is basically a reactive solution, toward reviewing charges and promoting competition among providers, which is the more proactive course of managing costs (see story, page 1).

This ultimately is the best course of treatment for hemorrhaging national health care costs.

While some cost-shifting was needed to reduce wasteful use of the system, as HRI Director William Hembree points out, employers have about exhausted the effectiveness of cost-shifting. For a large block of employees, those lucky ones who rarely need to see a doctor, adding to cost shifting won't save money and instead will damage employee morale.

And, for those seriously ill employees who rack up the major health care bills, cost-shifting has only limited use. Employees looking for a way to cheat death—parents with a premature infant, employees in need of major heart surgery or facing a diagnosis of cancer—are not going to shop around for cheap health care.

Short of drastically cutting policy limits or hiking employee stop-loss caps—steps that would indicate an abandonment of the philosophy of private-sector health care coverage that we cannot condone—cost-shifting will have little effect on these employees.

However, programs to manage and review health care and to promote competition can benefit everyone. They can ensure better care for employees and encourage providers to improve their quality of care.

And, they can save money for employers. In fact, in the long run, they will save more than cost-shifting did.

Such programs have the capability to change the health care provider system in this country from a bulky, wasteful, inefficient dinosaur to an efficient, modern, responsive and responsible system.

And, that is good news for everyone.

letters

Cost-containment also helps control stop-loss rates

To the editor: Your Jan. 27 issue included a report by Judy Greenwald on rate reductions for specific stop-loss coverage. That report indicated that there were four apparent reasons for reduced premiums being quoted to self-funded employers.

There is another factor that has contributed significantly to quotation reductions in stop-loss coverage of health benefit plans. That factor is the inclusion of effective health care cost-management programs, such as pre-admission and concurrent review, mandatory second surgical opinions and case management. Numerous stop-loss insurers have evaluated the programs offered by cost-containment firms and are acknowledging the excellence of some of those programs through reduced quotations to their self-funded clients.

Results-oriented cost-containment programs capable of producing reductions in days of care for their clients provide a measure of comfort to stop-loss insurers and employers alike.

And, this enables the insurers to provide more realistic premium quotations with less risk than would be expected in a program with no effective utilization monitoring mechanism.

B. Marc Allen
President
Medical Review Corp.
Morristown, N.J.

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

'Sexist' ad seen as an insult to professionals

To the editor: The Delta Dental ad that appeared on pages 10-11 of the Feb. 17 edition of *Business Insurance* represents a blatant sexist approach in its advertising. As business professionals, we hardly find this type of "exposure" appropriate or necessary.

We believe an apology to all conscientious professionals is in order.

Diane C. Vumbaco
Jacklyn D. Whalen
Daniel M. Rogers
Corporate Compensation
and Benefits Staff
MITRE Corp.
Bedford, Mass.

■ *Kim Elizabeth Smith, director of communications and corporate services for Delta Dental Plans Assn., responds: "We're glad they noticed the ad, but it certainly was not our intention to offend. We feel the ad is appropriate in the context of the campaign, which features different parts of the body that people insure. Sometimes the more striking the campaign, the stronger the reaction is to it."*

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It's the Unionmutual Seniors Golf Classic, our way of saying thanks to our top producers. You'll soon receive full details on how to qualify. If you haven't heard from us by April 10, 1986, contact your local Unionmutual office.

Golf, tennis . . .

For the past two years, our top producers have walked away from the Seniors Golf Classic Pro-Am with enough memories to last a lifetime. This year, you could find yourself practicing putts with Arnold Palmer or getting tips on your game from one of 20 other golf legends.

If you choose, you can stay on to watch the pros battle each other in another exciting cliffhanger, as they compete for $165,000 in Seniors Golf Classic prize money.

If golf's not your game, you can improve your skills with another exciting legend, tennis great Rod Laver, in our Tennis Clinic and Challenge Cup.

. . . And much more.

There's a lot more to the Unionmutual Seniors Golf Classic than golf and tennis. You're welcome to say 'the heck with sports!' and have a lobster. Go shopping at L.L. Bean. Take in the magnificent foliage along the Maine coastline. Or team up with other insurance professionals for some good conversation, terrific food, or a few laughs.

A special cause.

The Unionmutual Seniors Golf Classic is more than just a good time. It's a special event for a special cause. Because

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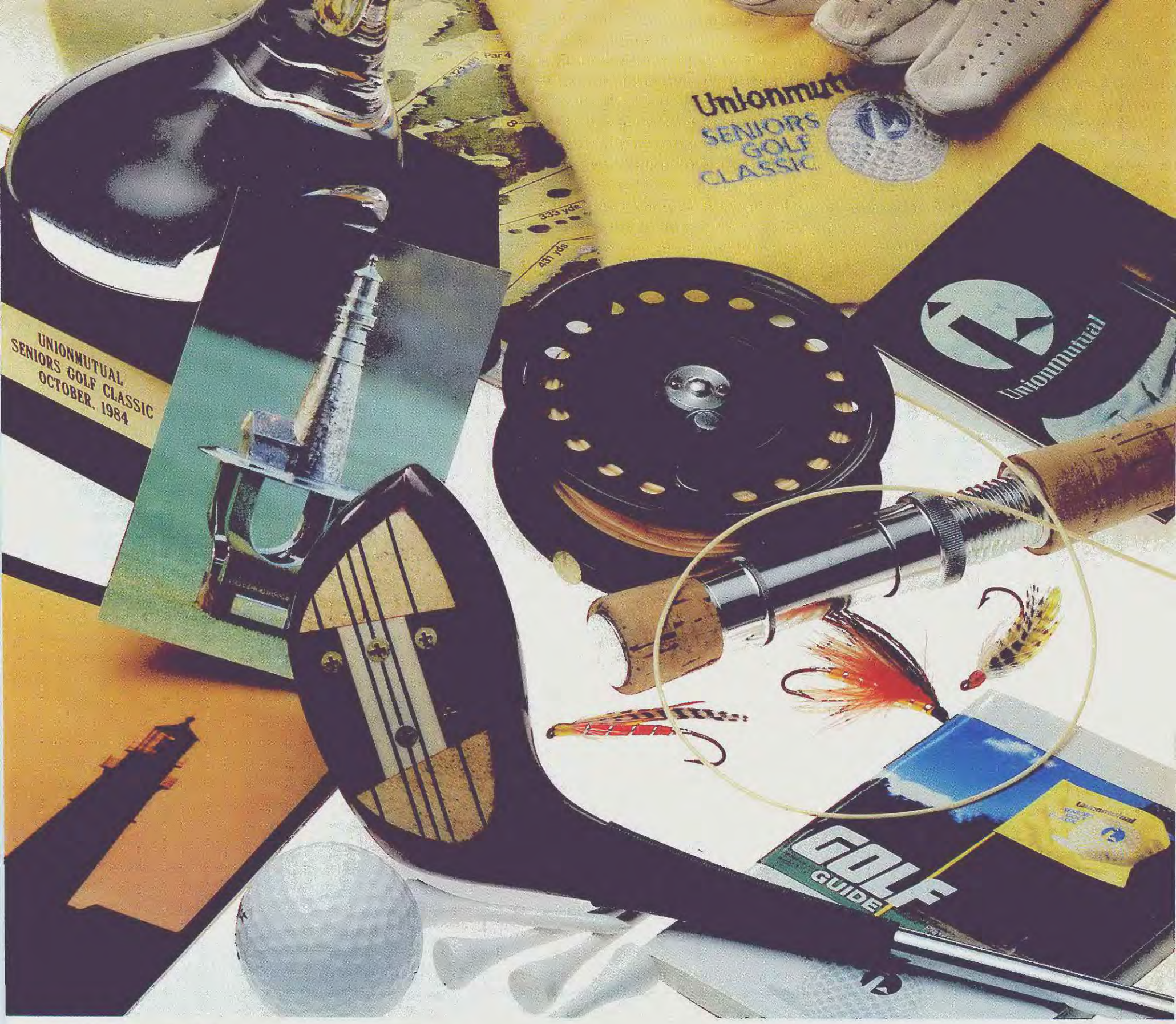
Individual Disability Division Contest: Only submitted Unionmutual Stock Life Insurance Co. of America individual disability policies will be considered in awarding prizes in the Individual Disability Seniors Contest.

Individual Life Division Contest: Only paid premium received in conjunction with the sale of Unionmutual Stock Life Insurance Co. of America universal life insurance outside of Wisconsin will be considered in awarding prizes in the Individual Life Seniors Contest.



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Golf Classic.

the net proceeds from Unionmutual Seniors Golf Classic ticket sales will be donated to the Maine State Chapter of the March of Dimes, with a guaranteed minimum donation of $10,000. We're proud to sponsor an event that will help prevent birth defects and save young lives.

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86

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Prizes are taxable as ordinary income.

RIMS surveys market deterioration

Continued from page 2

- 26% had premium increases for directors and officers liability coverage of more than 500%, and 10% had limits decreases of more than 75%.
- 24% of the respondents reported premium increases for product liability coverage of 200-500%, and 14% had limits decreases of 50-100%.
- 16% had premium increases for environmental impairment liability renewals of more than 500%, and 39% had limits decreases of more than 75%.
- 8% experienced premium increases for earthquake coverage exceeding 500%, while 17% reported limits decreases of more than 75%.
- 35% of the respondents bought no EIL coverage; 31% purchased no professional liability coverage; 24% bought no product liability coverage; and 12% bought no directors and officers liability coverage.
- 10% of survey respondents said they had to curtail or change their business operations because of problems in buying coverage.

"Many reported canceled expansions, discontinued product lines, fewer suppliers of needed raw materials, and much more time, energy and money devoted to insurance marketing, claims, defense and other expenses," the survey said.

Many respondents seem interested in alternatives to commercial insurance, the survey found. For example, 71% said they would like to explore alternatives to umbrella/excess insurance.

RIMS was assisted in the survey by the consulting firm of Tillinghast, Nelson & Warren.

A summary "Management Report" is available for $25 per copy. For information, call or write Anita Benedetti, director of research and education, RIMS, 205 E. 42nd St., New York, N.Y. 10017, 212-286-9292. ■

comings & goings: buyers

Nelson named risk manager at Jardine, Matheson unit

Lana L. Nelson, 34, has been promoted to risk manager at Theo. H. Davies & Co. Ltd. in Honolulu. She had been assistant risk and benefits manager. In her new position, she will be responsible for all lines of insurance, insured employee benefits and pensions and will report to Beverly C. Nagy, vp-administration. Theo. H. Davies, a subsidiary of Jardine, Matheson & Co. Ltd., is involved in the property development, insurance, wholesale merchandise, and oil and gas industries and also serves as steamship agents and air freight forwarders. Ms. Nelson has been with the company for eight years, the past four in risk management. She has a bachelor of science degree in political science from Utah State University in Logan and is currently studying for the Chartered Property Casualty Underwriter designation. Ms. Nelson is also the 1986 president of the Hawaii Chapter of the Risk & Insurance Management Society.

Ms. Nelson

* * *

Larry G. Watson, 34, has been promoted to vp-risk management for Federal Industries Ltd. in Winnipeg, Manitoba. In his new position, Mr. Watson will be responsible for all aspects of the company's risk management activities, including property and casualty insurance, loss prevention and safety, benefits and pensions. He will report to the company's executive vp. Federal Industries is a diversified management company that is involved, through its operating groups, in transportation, aerospace and industrial distribution. Mr. Watson received a bachelor of commerce degree from the University of Western Ontario in London and holds the Associate in Risk Management designation. Mr. Watson is also a deputy member of the Risk & Insurance Management Society.

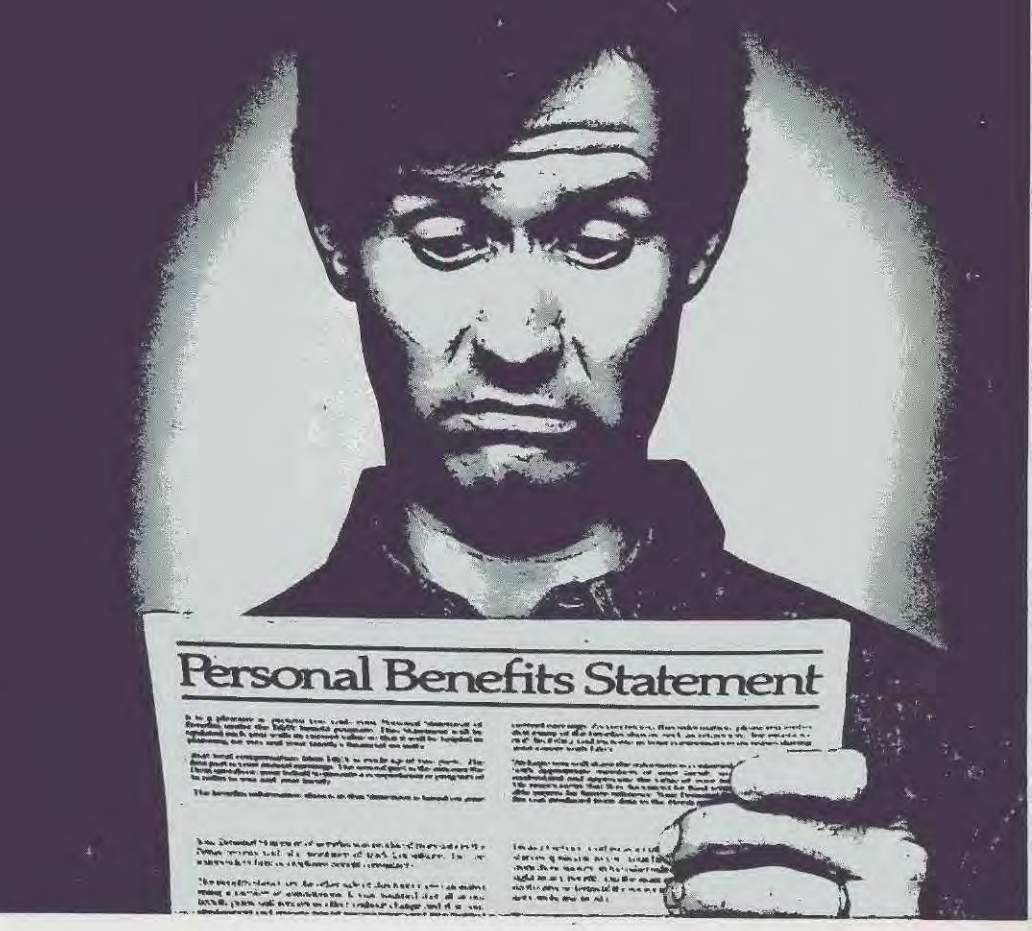
Mr. Watson

* * *

Barbara Reiff, 26, has been promoted to director of risk management at United States Surgical Corp. in Norwalk, Conn. In this new position she will be responsible for directing United States Surgical's property and casualty insurance programs, benefits and car fleet administration. She will report to Robert Lynch, vp-administration. Ms. Reiff joined the company in 1981 and had served as manager of insurance since 1984. Prior to joining United States Surgical Corp., she was a buyer with AVCO-Lycoming Inc. in Stamford, Conn. Ms. Reiff received a bachelor of science degree in business administration from Boston University and is a deputy member of the Risk & Insurance Management Society.

•

We'd like to report on staff changes in your company's risk management, safety or employee benefits department. Just drop a note to Paul Winston, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611, or call 312-649-5442. Please send a photograph, too.



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*MetLife SHOWCASE Communications Service—Patent Pending

Pension plan terminations

Continued from page 2

"Many of these decisions, which were viewed in the past as management decisions, will be viewed as a fiduciary decision," said T. Timothy Ryan Jr., task force chairman and a partner in the Washington law firm of Pierson, Ball & Dowd.

Other observers questioned however, whether the letter actually added much to previous department positions.

"I think this letter says a lot less than it appears," said Richard Fay, a pension lawyer with Reed Smith Shaw & McClay in Washington.

Steve Sacher, a partner with the law firm of Pepper, Hamilton & Scheetz in Washington, agreed that the position of the department did not add anything new in substance.

However, Mr. Sacher said, "I would take this as a signal that the department is going to become more active in regard to terminations, and particularly reversion terminations."

The letter notes that the selection of an insurer from which an employer purchases annuities to cover accrued benefits is a fiduciary decision.

In recent months, several pension experts have questioned what would happen to participants' pension benefits if the insurer chosen for the purchase of annuities later went bankrupt.

Similarly, the Labor Department said the choice of interest rate used in valuing lump-sum distributions in a termination is a fiduciary decision because the plan administrator has discretion in the area.

Several pension plan terminations, notably one involving Harper & Row Publishers Inc. in New York, used rates that later were challenged by plan participants.

Meanwhile, the task force has delayed until April 30 its recommendations on dealing with terminations of overfunded pension plans.

The date was pushed back by one month because a key study on the issue's policy implications will not be completed until sometime in April, Mr. Erlenborn explained.

The study, which is being performed by Hay/Huggins Co. Inc. in Philadelphia, has been expanded to include terminations in which the terminated plan was succeeded by a defined contribution plan or by no plan at all.

Originally, the study was going to review only terminations in which a defined benefit plan had been replaced by a similar plan.

'I would take this as a signal that the department is going to become more active in regard to terminations,' says attorney Steve Sacher.

The task force is expected to determine whether the terminations affect participants' benefit security and whether the Reagan administration's guidelines on asset reversions are adequate.

It also will propose legislative and regulatory changes, if needed.

Observers expect that the task force will recommend some method to allow employers to retrieve all or a portion of the surplus assets without terminating their plans.

Preliminary results, which have been made available to the task force, support the department's position that defined benefit plans that succeed terminated plans have provided as good or better benefits than the ones they replaced and that new plans are well-funded, said Mr. Walker.

Results weren't available on how participants fared under successor defined contribution plans.

At a March 14 meeting of the task force, however, a number of participants in terminated plans complained that ERISA did not adequately protect their pension benefits.

Vi McCallister, former benefits administrator for Superior Oil Co., whose overfunded pension plans were terminated after the company was acquired by Mobil Corp. in 1984, said Superior Oil retirees will not receive cost-of-living increases in the future.

In addition, he said, those employees who were forced to opt for early retirement have received drastically reduced benefits.

Fred Kelso, formerly a chemical engineer for FMC Corp., said he and other employees were induced to take early retirement in 1982, only to see the company recapture $250 million to $400 million recently through a spinoff/termination of its plan.

Mr. Kelso also had questions about the security of his annuity.

"What would happen if this were another Baldwin-United situation or a case where a subsidiary is set up whose only assets are those received from FMC?" Mr. Kelso asked. ■

LTV trades profit-sharing for wage, benefit cuts

A proposed 40-month contract between the United Steelworkers of America and LTV Corp. offers workers profit-sharing benefits in return for benefit and wage reductions.

Combined benefit and wage reductions are equal to $3.15 per hour, said an LTV spokesman in Cleveland.

Under the contract, 40,000 union members will receive either convertible preferred stock, cash or a combination of both equal to the dollar amount of benefit and wage reductions in a given year, the spokesman said.

First, each employee will receive cash from a fund consisting of 10% of the first $100 million of LTV's earnings and 20% of any profits exceeding $100 million.

If the cash fund does not equal the amount of the wage and benefit reductions, employees will receive LTV preferred stock, with a minimum value of $16 per share, to make up the difference, said the spokesman.

The stock will be placed in a trust account in the name of each employee and can be converted to common stock after two years, said a spokesman for the United Steelworkers Local No. 1157 in Cleveland.

The LTV spokesman said benefit changes will include:

- A switch to a prepaid dental plan from a fee-for-service plan.
- A mandatory pre-admission certification program for all hospital admissions.
- An increase in the individual deductible under the group medical plan to $150 from $75 and an increase in the family deductible to $300 from $150.
- Elimination of vision coverage.
- A 17% decrease in long-term disability payments.

LTV's benefits are underwritten by several insurers, depending upon plant location.

Details of the benefit plan changes were not available, because the changes will not be finalized until the contract is ratified by the union's members, according to both the LTV spokesman and union spokesmen.

The proposed contract was approved by union negotiators 31-6, said a spokesman for the union Local 1033 in Chicago.

He said that if ratified by the union membership this week, the "wage impact of the contract will be effective April 1, and the benefit changes will be effective sometime in May." The current contract expires July 31.

Disability data base

Minneapolis-based General Mills Inc. is managing and analyzing long-term disability claims with the help of a new data base management system.

"With BeneCALC, for the first time we can put disability into perspective—from both a cost and utilization standpoint," said Geof Workinger, manager, health and disability cost management for the Minneapolis-based company.

The system, developed by Health Risk Management Inc., a Minneapolis-based utilization review firm, was implemented about six months ago, he said.

To create the BeneCALC data base, Health Risk Management enters claims data into the system, said Bruce Kelley, director of technical services for HRM. In addition, data containing regional health care cost and utilization norms compiled by Health Risk Management are entered.

"So, for each case that a company has in their claims file, they can compare their cases to the appropriate norms," said Mr. Kelley.

With the system, Mr. Workinger said he can track cost information such as aggregate or per-employee costs of disability and number of days of disability payments.

The frequency of certain illnesses and injuries as well as utilization information—like the names of attending physicians and the facilities used by employees—can be tracked by the system.

"We provide this system as a service to our 12 operating locations," which use the data to manage their disability cases on a plant-by-plant basis, said Mr. Workinger.

"The system lets us know where and how to implement health promotion programs to increase productivity and help employees return to work faster."

Since the system has only been in operation for six months, Mr. Workinger said savings statistics are not available.

"We're just now in the final stages of getting management used to the system," he added.

For now, he said the system is used mainly to monitor off-the-job illnesses and injuries and does not include workers compensation claims data.

Mr. Workinger said disability claims cost General Mills about $1.2 million a year. Both the company's long-term and short-term disability benefits are underwritten by Prudential Insurance Co. of America, with claims administered by General Mills, he said.

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perspective

Market calls for accounting refinements

Continued from previous page
line code in the annual statement may not be indicative of a particular company's results. For example, commercial vs. private passenger auto liability coverages would individually differ from a single auto liability industry aggregate.

Another difference would be regional differences, such as workers compensation in California, which has a rating system significantly different from that of the NCCI rating approach used by many states.

Management should be prepared to explain any significant deviations of its company results from industrywide aggregates.

A second component of risk-derived surplus would be an allocation of surplus applicable to off-balance sheet commitments of an insurer.

In recent years there has been a dramatic increase in these kinds of exposures for all financial institutions. In the insurance industry, such off-balance sheet contingencies include exposures related to financial guarantees, earthquake, investment put options, interest rate swaps, etc.

The underwriting of financial guarantees and earthquake coverages anticipate a longer accounting period than one year. The annual premiums would not be adequate to cover a major loss.

The current statutory accounting model aggravates this condition in that it does not provide for a rational accumulation of reserves over a reasonable accounting period to provide for the permissible loss contemplated in the premium rates for these kinds of exposures.

The supplemental report attempts to allocate reasonable surplus to these kinds of off-balance sheet concerns.

Current regulatory standards breed insurer complacency as to investment activities. We need to move from the 1930s mentality inherent in most investment sections of insurance codes.

Investment restrictions and limitations usually are a function of total assets and surplus. Such limitations should be a function of policyholder reserves.

We should demand the highest degree of fiduciary care as to investment activities relating to policyholder reserve funds. Such fiduciary care would include such matters as investment quality, diversification, liquidity, yield, immunization and so forth.

Many insurers have done a remarkable job in redeploying their invested assets and reworking their balance sheets. They have capitalized on realizing economic values, restructuring maturities and using sound investment hedging techniques.

The well-managed insurers are postured to capitalize on the investment opportunities available in this marketplace. But, some insurers have not yet fully appreciated that they are financial risk intermediaries as well as traditional insurance risk intermediaries.

The supplemental report requires the insurer to demonstrate that it has reasonably matched maturities of its invested assets with the expected payout of its unpaid loss and loss expense reserves on both a discounted and undiscounted basis.

Although not illustrated, the company presented in the exhibits has a significant mismatch of its invested assets/reserve liabilities during the next 10 years. Unless its bond values improve, the company will have to either recognize significant premature investment portfolio losses or forgo investment opportunities with regard to future investable revenues.

The financial risk significance of unrealized losses present in bond portfolios diminishes as the invested assets/reserve liabilities match—immunization—improves.

It is perhaps informative to add that for the 1986 statutory financial statement filing, the California Insurance Department plans to require most liability and multiline admitted property and casualty insurers to provide certification by an actuary of a professional society of its reported loss reserves and the related expected payout schedule using a line of business approach.

Reinsurance is the final area of concern that the supplemental report addresses. Tragically, reinsurance in the last five years has become like an astronomical black hole, and unfortunately many primary companies will not be able to withstand its vacuum-like pull into insolvency.

Reinsurers currently have excessive influence over the day-to-day insurance activities of some primary insurers. Many insurers have over-exposed their primary underwriting obligations to unsound reinsurance arrangements.

Financial accountability and disclosure of the financial operations of alien reinsurers is inadequate, and the capital resources of retrocessionaires are grossly deficient.

The reinsurance black hole must be closed and primary companies must return to the basics of sound and secure risk-sharing in their reinsurance transactions.

The supplemental report suggests that the sum of paid and unpaid reinsurance recoveries on losses and expenses to surplus should not exceed 100%. Balances in excess of 100% unduly expose an insurer's surplus and suggest that the company is in substance a brokerage business.

Additionally, any recoverable balances applicable to a single reinsurer in excess of 5% of actual statutory surplus, regardless of security—such as letters of credit—would be separately summarized for purposes of this supplemental report analysis.

If significant excess balances are present, satisfactory surplus analysis may require a similar analysis of such reinsurer(s) having such excess obligations.

As discussed earlier, this supplemental report has limitations and will be vulnerable to criticism. Multiline companies will argue that more leverage of premiums and losses to surplus should be permitted, on the theory that diversification suggests lesser capital requirements.

Specialty and regional insurers will argue that industrywide aggregates should not apply to them. Some will argue that certain long-term lines of insurance should be permitted additional premium and loss leverage because there is reasonable predictability in such long lines as auto liability, workers compensation and certain other liability coverages.

Despite the merits of these arguments, the supplemental report is a beginning for regulators, it is relatively simple to prepare, and it is akin to the internal analyses preformed by many well-managed insurers. We should err toward conservatism.

The supplemental report also includes a management discussion section. This section affords management the opportunity to discuss in narrative form its interpretation of events, circumstances and transactions that either have financial impact or will have financial impact on liquidity and leverage.

Such discussions might include causes for material changes from the prior period and anticipated rate changes, capital plan and product mix changes.

Also, the management discussion can serve to explain the unique aspects of the company and the reasons for any deviatins from industrywide results.

It is our hope that this supplemental report will be favorable received by the industry and serve as a positive step toward modernizing regulatory financial analysis.

Now is the time to better focus analytically on the economics of insurer balance sheets. As one leading industry executive publicly admonishes, "We need to insist on balance sheet discipline." ■

Bruce Bunner is the insurance commissioner for the state of California.

Worker hurt on lunch run entitled to benefits

A secretary who slipped and fell while she was getting her office manager's lunch was performing a task that was of benefit to her employer and was entitled to workers compensation benefits, a Georgia appellate court ruled.

Queenie Edwards worked as a secretary for the state Labor Department. On March 18, 1982, she slipped and fell at a nearby fast-food restaurant while she was getting lunch for her office manager. Ms. Edwards regularly obtained lunch for the manager and considered the task as one of her normal duties.

The manager acknowledged that, although Ms. Edwards regularly got his lunch so he could remain working at his desk, he considered this service to be a personal favor and not one of her assigned job duties.

Ms. Edwards applied for and was awarded compensation. But a trial court reversed the award.

The appellate court concluded that Ms. Edwards was injured while performing a task from which her employer derived benefit, and thus was covered under the workers compensation act.

However, Justice Deen dissented, believing the act's language must be construed as contemplating that to find coverage, Ms. Edwards' activities must concern the running of the employment security office in which she worked and not be those of a delivery service.

The justice said that it could not "seriously be contended that providing such a food service is reasonably necessary to be done in order to perform those specified secretarial duties for which the appellant was hired." *Edwards v. State*, Court of Appeals of Georgia, Nov. 28, 1984, *rehearing denied* Dec. 17, 1984, *certiorari denied*, Jan. 24, 1985 (*BI*/05/F.—$5).

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

legal briefs

Stress compensation

The Supreme Court of Oregon ruled, in a workers compensation case, that stressful events accompanying discharge from employment can make a resulting illness compensable, but that illness resulting from the mere act of discharge and loss of job was not.

Olive Elwood had worked as a registered nurse in a nursing home for 10 years when she was discharged in 1976. She filed a claim for compensation in 1980 for occupational disease caused by emotional stress, which she attributed to a demanding work schedule, employer pressure on her to quit and her eventual discharge.

Her claim was denied by the Workers Compensation Board. However, an appellate court ordered acceptance of the claim.

The Supreme Court of Oregon said that the occupational disease law did not make illness from losing a job a compensable risk of the job.

According to the court, the line between a compensable event and a non-compensable claim ran between illness resulting from the stress of actual or anticipated unemployment, which was not compensable, and illness resulting from the circumstances and manner of discharge, which could lead to compensation.

As the court was uncertain what the lower court had considered regarding the circumstances surrounding the request for Ms. Elwood's resignation, it reversed the lower court decision and remanded the case for further proceedings. *Elwood vs. SAIF*, Supreme Court of Oregon, Jan. 8, 1985 (*BI*/03/J.-$5). ■

markets

Illinois Exchange gains new member

CalFed Insurance Syndicate Inc., the newest member of the Illinois Insurance Exchange, expects to be capitalized at $10 million and open for business by this week.

However, LWB Syndicate Inc., which wrote about 42% of the IIE's 1985 premium volume, has petitioned to withdraw from the exchange.

The new syndicate, approved earlier this month by the IIE's board, will be managed by NUA Management Inc. in Chicago, which also manages NUA Syndicate Inc. on the exchange (*BI*, July 8, 1985; Sept. 2, 1985).

CalFed will write excess liability insurance and some property insurance, the same type of business written by NUA Syndicate, said Richard Foss, president of both NUA Syndicate and NUA Management.

He explained that each piece of business handled by NUA Management will be split evenly between the two syndicates.

"We're the only U.S. market offering first and second layers to larger accounts," Mr. Foss said, adding that by year-end a third syndicate may be capitalized and then managed by NUA Management.

Financial backing for CalFed Syndicate comes from CalFed Inc., a Los Angeles-based holding company, said George P. Rutland, vice chairman and chief executive officer of the holding company, as well as president of the new syndicate.

Mr. Rutland also is president and chief executive officer of California Federal Savings & Loan Assn., one of the companies owned by CalFed Inc.

Other units include Beneficial Standard Life Insurance Co., Trust Services of America and California Thrift & Loan Co.

"We feel with the lack of capacity in the property/casualty insurance industry and with premiums where they are, there is an opportunity to write excess coverage," Mr. Rutland said.

The addition of CalFed Syndicate to the IIE brings the total number of syndicates to 16; however, only 11 of those, including CalFed, are active. The other five syndicates, including LWB Syndicate Inc., have petitioned the IIE's board to withdraw.

LWB Syndicate, which has been managed by L.W. Biegler Inc., historically has written the bulk of business on the exchange.

LWB Syndicate stopped writing business as of Dec. 31, 1985. Crum & Forster, Biegler's parent, decided to concentrate its efforts on Beigler, which has been renamed Crum & Forster Managers Corp. (Ill.), rather than on the exchange, said Norman R. Reid, who was the underwriting manager and vp of LWB Syndicate (*BI*, Feb. 24).

LWB Syndicate wrote gross premiums of $33.6 million in 1985, or about 42% of the exchange's overal premium volume of $79.9 million (*BI*, Feb. 10). In 1984, LWB Syndicate wrote $12.4 million, about 80% of the IIE's gross premium volume that year.

Although five syndicates have asked to withdraw, there is a possibility that some of them may reactivate, said James M. Skelton, the IIE's executive director.

"I can't tell you which ones will reactivate. . .but it looks good."

New administrator

Eagles' Administrators Ltd. is a new joint venture formed to offer administrative services to employers with self-funded health care plans.

Lexington, Ky.-based Eagles' was created by Whitehall Insurance Holdings Ltd. in Lexington and Professional Administrators Ltd. in Cincinnati. Whitehall is the parent of Bradford National Life Insurance Co. in Lexington and Professional is a third-party administrator of employee benefits.

Eagles' will acquire business currently administered by Whitehall and Professional and will operate from offices in Lexington; Cincinnati; Dayton, Ohio; and Jacksonville, Fla.

Richard Cooley, president of Eagles', said plans are eventually to make the new company "a national organization."

Eagles' is located at 771 Corporate Drive, Lexington, Ky. 40503; 606-223-2386.

Hancock PPO

John Hancock Mutual Life Insurance Co. is joining with seven Chicago-area hospitals to create a network that will offer services as part of the insurer's preferred provider organization, John Hancock Preferred Health Plan.

The hospitals have formed a separate organization called Preferred Health Systems of Mid-America Inc., which plans to recruit an additional 20 hospitals and about 2,000 physicians to serve as providers.

Preferred Health Systems will organize and manage the plan, while Hancock markets the program, negotiates prices with providers and represents plan customers.

The plan is structured so that the network of hospitals and physicians will provide services at agreed-upon prices in exchange for increased market share.

The hospitals that have agreed to act as providers are Ravenswood Hospital and Medical Center, St. Francis Hospital, Northwestern Memorial Hospital, Louis A. Weiss Memorial Hospital, Westlake Community Hospital, Swedish Covenant Hospital and Resurrection Hospital.

Ryder acquires MGA

Ryder System Inc. is expanding its insurance management business with the acquisition of Kennell & Co., a Houston-based managing general agency.

Ryder, the transportation services company that also owns agencies in Florida and Alabama, is acquiring Kennell for an undisclosed amount.

Kennell places property/casualty coverages for 3,900 independent agents throughout Texas. The firm also provides claims adjusting services.

New offices

Professional Insurance Publications has relocated its operations from San Francisco to 2495 Campus Drive, Irvine, Calif. 92715; 714-955-2267.

Key Life Insurance Co. in Indianapolis has moved its corporate offices to Market Square Center, Suite 1170, Indianapolis, Ind. 46204; 317-635-6200.

Tillinghast, Nelson & Warren Inc. has opened an office in the Washington area at 8330 Boone Blvd., Suite 460, Tysons Corner, Vienna, Va. 22180;703-356-5210. ■

HRI survey

Continued from page 1

ployees in the middle group, who do not account for the largest drain on the medical plan.

As an alternative, he says, employers are looking at other ways to manage the cost of health care.

Survey respondents reported that they plan to continue their efforts in controlling health care costs primarily by:

- Reviewing health care expenses currently being paid.
- Encouraging employees to use health care more cost-effectively.
- Taking measures to promote competition among health care providers and control health care costs over the long term.

The reasons for employer concern are obvious: They are experiencing a severe and painful increase in health care costs.

The 1985 survey shows that the respondent's medical care cost per employee was $1,770, an increase of 12.1% from the $1,579 per-employee cost reported in 1983.

And, the cost reported in HRI's first survey, which was released in 1979 and covered costs for 1976, was only $598 per employee, meaning employers have had to absorb an increase in health care costs of nearly 300% in eight years.

As a first line of attack on health care costs, employers are reviewing the bills they are asked to pay. These review programs include:

- Coordination of benefits. The proportion of respondents reporting a COB provision in their health care plan continues to increase, growing to 96.9% of respondents in 1985 from 95.6% in 1983, 95% in 1981 and 92% in 1979.

And, 62.7% of the respondents to the 1985 survey reported using a non-duplication of benefits approach, which prevents a secondary plan from paying more than allowed under the primary plan.

The level of annual savings reported among respondents with such programs in 1985 was 9.6% of paid claims for COB programs overall and 8.8% using a non-duplication of benefits approach.

- Subrogation. The 1985 survey reveals a significant jump in the number of employers that include a subrogation clause in their health care plan. The percentage rose to 71.6% in 1985 from 59.4% in 1983.

In addition, 66.5% of the respondents reported that they actively pursued subrogation recoveries in 1985, compared with 65.1% in 1983.

And, the level of annual savings reported as a result of subrogation was 1.8% of paid claims in 1985.

- Administration and administrator audits. Survey respondents reported an increase in internal audits of plan eligibility, claims processing efficiency and other adminstrative audits. Some 67.7% said they had conducted such an audit during the past two years, compared with 64.5% in 1983.

However, only 49.5% of the respondents reported conducting an audit of an external plan administrator during the past two years, down from 55.1% in 1983.

- Utilization review. The trend toward all kinds of health care utilization review continued in 1985. For example, 45.3% of the respondents reported using concurrent utilization review, up from 17.3% in 1983 and 10.6% in 1981.

And, the reported level of savings was 6.5% of paid claims in 1985, up from 6.1% in 1983.

In addition, 29.6% of the respondents in 1985 reported using retrospective review, up from 18.8% in 1983. The level of annual savings was 2.3%, up from 1.2% in 1983.

And, 18.4% of the respondents in 1985 reported using physician diagnosis and treatment review, up from 6.6% in 1983.

- Patient management. The survey also reported an increase in the use of various patient management programs. For example, 7.2% of the respondents reported using pre-discharge planning programs, up from 1% in 1983. And, the percentage of respondents with a patient advocacy program grew to 3.9% in 1985 from 1% in 1983.

Some 18.9% of the survey respondents also reported having a case management program, and 5.2% reported having a disability rehabilitation management program.

The annual savings level reported was 5.5% of paid claims for the case management programs and 0.5% for the disability rehabilitation management programs.

In addition to reviewing health care bills, employers are encouraging their employees to use health care more efficiently through a variety of programs, including:

- Pre-admission testing. Some 95.7% of the survey respondents reported that their health plans provide coverage for pre-admission testing, up from 91.8% in 1983 and 76% in 1981.

Continued on next page

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And, an increasing number of plans are providing higher reimbursement levels for outpatient than for inpatient pre-admission testing. Some 41.7% of the 1985 respondents reported higher reimbursement levels for outpatient testing, up from 10.1% in 1983.

The annual savings for pre-admission testing was 2.4% of paid claims in 1985, up from 1.4% in 1983.

• Ambulatory surgery. All the respondents provide coverage for ambulatory surgery, up from 98% in 1983 and 92.3% in 1981.

As with pre-admission testing, more employers are reimbursing employees at a higher level for ambulatory surgery than for the same surgery done on an inpatient basis. The percentage of employers providing higher reimbursement for ambulatory surgery rose to 48.9% in 1985 from 20.7% in 1983.

"This shift reflects employer awareness that inducements beyond equal payment may be necessary to change employee purchasing behavior, and especially, providers' practice patterns," the survey says.

The reported annual savings from ambulatory surgery was 4.3% of paid claims for 1985, up from 3.1% in 1983.

• Second opinions. Some 90.1% of the 1985 respondents provide coverage for second surgical opinions, up from 73.2% in 1983 and 66.9% in 1981. Nearly all employers that cover second opinions reimburse for 100% of the cost.

Also, 65.6% of the respondents require second opinions for some surgical procedures, and 15.3% require them for all procedures. In 1983, 34.3% required second opinions for some procedures, and 3.6% required them for all procedures.

The annual savings reported from mandatory second opinions was 2.3% of paid claims.

• Pre-certification. In 1985, 37.1% of the respondents used pre-certification to determine the length of non-emergency hospital stay, up from 16.3% in 1983.

And, the annual savings reported from pre-certification was 8.1% of paid claims in 1985, up from 3.6% two years earlier.

• Home health care. Questions about the coverage were first asked in the 1985 survey. Some 89.5% of the respondents cover home health care, and the reported savings level was 1.4% of paid claims.

• Hospice care. The number of employers providing coverage for hospice care has grown significantly. In 1985, 54.5% covered home-based hospice care, and 59.2% covered hospital-based hospice care. Hospice care was covered by 35.2% of the respondents in 1983 and by 12.6% in 1981.

The level of savings reported was 1.8% of paid claims in 1985.

• Alternative delivery systems. "Respondents to the 1985 survey recognize that use of various types of alternative delivery systems will encourage present and future competition" the survey says.

The most-frequently offered alternative delivery system is the health maintenance organization. HMOs were offered by 70.4% of the respondents in 1985, up from 67.4% in 1983 and 68.9% in 1981. And, 10.3% of the 1985 respondents that do not currently offer an HMO expect to do so within two years.

1985 survey respondents with HMOs reported an employee participation level of 18.4% and annual savings of 2.9% of paid claims.

The fastest-growing alternative delivery system is the preferred provider organization, offered by 9.5% of the survey respondents, up from 2.3% in 1983. In addition, 21% of the 1985 respondents that do not currently offer a PPO plan to do so within the next two years.

PPOs also have significantly higher levels of employee participation and provide greater health care cost savings than HMOs, according to the survey. Respondents with a PPO reported 27.3% of employees participate, and annual savings were at 8.8% of paid claims.

• Employee hospital bill review. Some 70.9% of the survey respondents reported that they encourage employees to review their hospital bills for errors, up from 53.9% in 1983. As an incentive to review bills, employees are given a percentage of any overcharge found, 26.2% of the respondents said.

However, only 7.6% of the 1985 respondents provide any training to help employees with the review. And, annual savings were estimated at only 0.7% of paid claims.

Employers also are taking steps to control health care costs over the long term. These actions include:

• Negotiating fees with providers. In 1985, 11.7% of the respondents negotiated with hospitals for discounts for prompt payments, up from 10% in 1983. The savings reported was 4.7% of paid claims, up from 3.7% in 1983.

And, 6.9% of the 1985 respondents negotiated fees with physicians, up from 3.3% in 1983. Not enough information was available to calculate the savings.

• Participation in coalitions. The number of employers reporting participation in a health care coalition grew to 66.8% in 1985 from 61.8% in 1983. And, respondents participated in an average 1.8 coalitions.

• Joint union/management efforts. Increasingly, employers are seeing unions as allies rather than adversaries in the war on high health care costs.

One-third of the respondents have tried joint union/management cost-containment efforts, up from 18.9% in 1983.

And, 76.9% of the 1985 repondents reported that unions were cooperative, up from 68.4% in 1983.

• Appointing a cost-containment manager. More than 16% of the 1985 respondents had a full-time cost-containment manager on staff, up from 11.6% in 1983.

"The timing for innovative health care cost-containment efforts has never been better," the survey concludes.

"Employees and providers have generally accepted initial changes like cost sharing, 'lean' plans, increased deductibles and additional payroll deductions. Now they are more willing to accept outpatient incentives, medical expense accounts. . .etc."

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The full copy of the survey is available only to respondents. But, summaries are available free from Survey Coordinator, Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

Wellness efforts interest employers

By ALISON KITTRELL

Health improvement efforts are gaining the attention and support of corporate management, according to the Health Research Institute's fourth biennial survey on health care cost containment.

In the 1985 survey of 633 employers nationwide, almost one-third—32.4%—said they had developed a statement of policy or objectives for a health improvement program.

And, most of those—69.7%—said they planned to expand their existing efforts, compared with only 38.2% in the 1983 survey.

Some 38.6% of the employers that have set objectives plan to add a health communications campaign, compared with 23.9% in 1983.

"A sizable proportion of respondents are becoming more active in providing early detection, health risk assessments. . .and prevention programs," the survey reports.

For example, 24% of the respondents provide on-site screening programs for early detection of health problems, and an additional 9.4% reimburse employees for such screening.

And, 16.3% of the respondents provide on-site lifestyle and health assessments. An additional 2.1% reimburse employees for these studies.

However, "in most instances, respondents reported little change or a decline in the use of alternative care treatments," the survey reports.

For example, the percentage of respondents providing or reimbursing employees for biofeedback training decreased to 13.4% from 22.6% in 1983. The percentage providing coverage for home births declined to 15.3% in 1985 from 20.9% two years earlier.

However, counseling services fared better among the respondents: The percentage covering stress management counseling increased to 23.6% from 11.6% in 1983. And, 25.8% covered counseling for cancer and other terminal illnesses in 1985, up from 23.3% in 1983.

The number of respondents offering health education programs increased significantly, according to the survey.

Some 77% of the respondents provided first aid training, including cardiopulmonary resuscitation, up from 67% in 1983. And, 44.1% of the 1985 respondents offered programs to help employees stop smoking, up from 27.6% in 1983.

The survey also reported an increase in the number of companies offering their employees physical fitness programs; in contrast, the 1983 survey reported a decline in fitness programs from the 1981 study.

For example, the number of respondents offering on-site exercise facilities grew to 28.3% from 16.9% in 1983 and 20% in 1981. And, the percentage of respondents reimbursing employees for off-site fitness programs rose to 11.1% from 8.2% in 1983. But, the figure falls slightly short of the 1981 figure of 11.7%.

More companies also are offering employees incentives to maintain healthy lifestyles. Some 10.7% of the survey respondents rewarded employees with time off, cash or some other incentive for sick time not taken, up from 7% in 1985.

Nearly the same number of respondents—9.4%—offered payments or contests as incentives for employees to stop smoking, up from 5.3% in 1983. And, 4.9% offered similar incentives for employees to lose weight, up from 4% two years earlier.

Respondents also reported an increase in the rate of employee participation in health improvement programs. The companies with such programs reported a 26.7% participation rate, up from 8.2% in 1983.

"It is expected that this rate will continue to increase as programs become more widely available and greater attention and support (as well as communication) are given to the promotion of health improvement programs," the survey reports.

The survey also revealed an increase in the number of companies with an established system to communicate a health education program to employees.

"Since the 1983 survey, there has been an overall increase in the proportion of respondents using nearly all types of communications materials and activities," the survey notes.

For example, 9.4% of the respondents reported a comprehensive communication campaign, up from 5% in 1983.

Some 21% respondents reported distributing single-purpose health memos, up from 12% in 1983. And, 13.3% reported distributing health education newsletters, up from 1.7% in 1983.

However, companies still are not gathering data on whether their health improvement programs actually result in any savings. No more than 3.4% of the respondents reported conducting any sort of study to determine the effect of their health improvement program. ■

Retiree benefits inflate health costs: Survey

By ALISON KITTRELL

The trend toward "lean" health care plans continued among employers over the past two years, although the area of retiree benefits may threaten the move toward fiscal fitness.

The fourth biennial health care cost-containment survey by the Health Research Institute reveals that retiree health care costs are a serious part of the continuation of the inflation in health care costs.

Some 633 employers responded to the Walnut Creek, Calif.-based research organization's survey, conducted in late 1985.

Overall medical care costs per employee have risen 12.1%, to $1,770 from $1,579 in 1983, according to the survey.

"But what's more important than the overall magnitude. . .is the disproportionate rate of cost increase attributable to retirees," the survey reports.

"Although overall costs increased 12.1%, the cost increase was 6.9% for actives and 28.8% for retirees over the same period.

"In addition, the under-age 65 retirees represent costs per unit which are about 3.2 times greater than active employees, and the number of under age-65 retirees has grown by over 21% in the two-year period," the survey says.

"There probably is not a single issue that we have identified over the eight years of the survey that I see as more important than this one," says HRI Director William E. Hembree.

And, he adds that retirees under 65 represent a liability that is "growing and largely unrecognized."

Such retirees represent a special liability not only because of the relatively high costs of care for people in that age group, but also because of the potential for abuse.

"The real difficulty is that the administrative structure for handling claims at most companies is just not up to checking to see if these people go to work somewhere else," and thus are covered by another employer's health care plan.

Of retiree health care liability, Mr. Hembree says, "It's just as though we were sitting on a time bomb and hearing the ticking, but just not doing much about it."

'It's just as though we were sitting on a time bomb,' says HRI Director William E. Hembree.

For example, the survey shows that 48.3% of the respondents have taken no action to determine or attempt to control the cost of medical care for retirees.

Some 23% currently are conducting a cost analysis, and 11.7% list retiree medical plan liabilities in their accounting statements.

For retirees and active employees, the survey also indicates employers are continuing to move away from fully insured plans.

The percentage of respondents reporting a fully insured, insurer-administered health care plan fell to 14.5%, from 17.3% in 1983, 27.8% in 1981 and 45% in 1979.

However, the percentage of respondents reporting a minimum-premium, insurer-administered plan rose to 45.7%, from 42.9% in 1983. Other arrangements reported were self-funded, third-party administered arrangements, up to 28% from 24.8% in 1983; and self-funded, self-administered, up to 11.4% from 10.7% in 1983.

And, the annual level of savings reported from the use of alternative funding and administration techniques was 6.5% of paid claims.

"The significant shift away from the fully insured, carrier-administered approach to financing and administering health care plans is having an effect which extends well beyond administrative/tax savings," the survey notes.

"Because employers become more fully aware they are responsible for, and can have a direct impact on, the costs of medical care, far more attention is paid to analyses of utilization and other containment/prevention/promotion steps when the financing arrangement is shifted away from the fully insured approach," the survey says.

The 1985 survey results also indicate that employers are continuing to move away from combination basic/major medical plans, which usually have no deductible, to comprehensive plans with a deductible.

The percentage of employers offering a base/major medical plan fell to 39.7% from 46.4% in 1983. The percentage of employers offering a comprehensive plan rose to 60.3% from 53.6% in 1983.

And, 51.1% of the respondents in 1985 reported that they had increased the plan deductible for individuals; 43.3% reported an increase in the family deductible during the last two years.

Also, 18.5% reported they had increased the coinsurance level since 1983, and 24.9% had increased employees' out-of-pocket limit.

However, the survey respondents also reported that they intend to make fewer cost-shifting changes during the next two years. Instead, they plan to concentrate on plan management and utilization review (see story, page 1).

The 1985 survey also revealed an increase in coverage for some less-traditional coverages, including:

- Home health care. Some 60.2% reported full coverage and 29.2% reported limited coverage; in 1983, 46.5% reported full coverage and 34.2% reported limited coverage.
- Birthing centers. Some 67% provided full coverage and 8% provided limited coverage; in 1983, 44% provided full coverage and 12.3% provided limited coverage.
- Coverage for mental or nervous conditions. Some 31.5% provided full coverage and 68.1% provided limited coverage; in 1983, 22.1% provided full coverage and 76.1% provided limited coverage.
- Extended care facilities. Half provided full coverage and 40% provided limited coverage; in 1983, 44.2% provided full coverage and 33.3% provided limited coverage.
- Transplant coverage. The survey first asked about this coverage in 1985, when 52.8% of the respondents reported they covered heart transplants, 45.7% covered heart/lung transplants, 76.8% covered kidney transplants, 39.2% covered liver transplants, and 23.1% covered bone marrow transplants. ■

Union Carbide

Continued from page 2

The spokesman said the agreement must win the approval of federal Judge John F. Keenan. He said he was uncertain as to when the judge will decide on the agreement.

One of the attorneys for the victims, Lee Kreindler of Kreindler & Kreindler in New York, who was not a party in the negotiations, said he doubted the agreement would be approved as long as the Indian government still opposed it.

"I think it's a can of worms," he said of the agreement. "I can't conceive of there being a settlement without the government's approval." Mr. Kreindler said he believes the court will dismiss the case and send it to India.

As to the insurance, the Union Carbide spokesman said, "I don't believe that we've received the money yet." This was confirmed by several insurers contacted by *Business Insurance*.

"We haven't heard anything from them and we're still waiting," said Kurt Gruenberg, claims manager for Integrity Insurance Co. Integrity wrote $5 million of coverage in the $20 million excess of $23.5 million layer, and $1 million of coverage in the $25 million excess of $175 million layer.

"Everything I know about the settlement, I heard on TV," he said. "We have not been contacted about asking for the money, or what the deal is, or anything." The full $6 million of Integrity's coverage already has been put in reserves, said Mr. Gruenberg.

"We're waiting to determine what the deal is, and then they're going to present it to us," said Nick Furlong, vp of property/casualty claims for American Centennial Insurance Co. American Centennial wrote $5 million in the $50 million excess of $100 million layer, although its net retention is only $100,000. The insurer established a reserve as soon as it heard about the accident, he said.

"We're kind of waiting to see what happens on this thing," said a spokesman for the Hartford Insurance Group. "We're waiting for the dust to settle." Hartford's New England Reinsurance Co. wrote $5 million in the $50 million excess of $100 million layer. It also wrote $5 million in the $25 million excess of $150 million layer, while First State Insurance Co. wrote $10 million and Twin City Fire Insurance Co. wrote $5 million in the same layer. The spokesman said the insurer's exposure is "minimal," with most of the coverage reinsured.

Among insurers who had no comment were Royal, which had the lead excess policy. Underlying the Royal policy was a $2 million umbrella policy written by American Motorists Insurance Co., a Kemper Group unit. But the policy contains a $2 million deductible per occurrence, making it a fronting policy for a self-insured retention. There is also said to be an Indian insurance policy, possibly for as much as $2 million, written by an Indian insurance company (*BI*, Dec. 24, 1984).

One insurer who asked that his company's name not be used said a number of issues will have to be settled before Union Carbide receives any insurance funds. The agreement announced publicly is between Union Carbide and attorneys for the victims, he said. "We don't really know what is the constitution of that agreement."

The question is whether the entire $350 million settlement is all for damage to objects and persons covered under the policies, or whether it is for things not covered. The likely answer, he said, is that it is for a mixture of the two, which means the insurance industry won't know its obligations to Union Carbide until it also knows "how much is being paid for what purpose."

Theoretically, he said, part of the settlement could be for forests damaged in the accident, and the insurers must know "if 98% of the loss is for that purpose."

Other issues, he said, are how the money will be paid, how it will be accounted for, who will verify this, and what other controls will be in place. The insurers want matters to be clear, said the insurer.

"We don't want to be in a position of settling with the wrong party, or one that does not get the funds to those who are supposed to receive them. It's a very large question," he said. There may be a simple, straightforward answer, he said, but this must be determined.

The insurer said there are no serious disputes among the insurers although there are "some differences of opinion" as to how to proceed. "We're not a single, solid unified front," he said. "I think some people are leaning one way, and some people are leaning the other way." ■

Claims-made

Continued from page 3
(*BI*, Dec. 16, 1985)

Mr. Payne added insurers as well as reinsurers are moving to extend the claims-made concept to any risk with a U.S. exposure.

In the most recent development, Sun Alliance is updating its 12-month-old primary claims-made form and expects to require that most liability coverage for major British policyholders with long-latent injury exposures be written on the form upon renewal this year, says Harry Driver, casualty manager at Sun Alliance.

The primary claims-made insurance policy has limits of up to 1 million pounds ($1.47 million) and excludes employers liability risks, the British equivalent of workers compensation.

Mr. Driver, who is responsible only for Sun Alliance's U.K. casualty business, says the new form is designed to provide coverage for British companies' total worldwide activities outside the United States, including any U.S. exports.

Last year, Sun Alliance offered the form to companies with pollution, medical malpractice and long-tail, long-latent liability exposures, Mr. Driver said.

As part of the revision, Sun Alliance is planning to alter the policy's coverage trigger, Mr. Driver said. Currently, the policy is triggered when the underwriter is notified of a claim in writing. But, Mr. Driver says this trigger is "too harsh," and he says the company may drop the requirement that the underwriter be notified in writing.

However, under the revised policy, the retroactive date will remain the inception date of the first claims-made insurance program.

The revised policy, like the current one, does not specifically exclude coverage for pollution risks, Mr. Driver said. Any pollution exclusions are made on a "case by case" basis, he said.

'We are surprised at what little difficulty we have had' getting clients to accept the claims-made form. 'We have had an easier ride than we expected,' says Harry Driver, casualty manager at Sun Alliance & London Insurance P.L.C.

And, the revised policy probably will offer a longer extended reporting period. Currently, the policy includes a 12-month extended reporting period if Sun Alliance does not renew coverage.

"We are looking to go beyond that," Mr. Driver said, though he did not say how long the reporting period would be extended.

Mr. Driver said the response has been good since the claims-made form was introduced last year. So far, he has issued claims-made coverage under the form to buyers representing about 5%, or 3 million pounds ($4.4 million), of the company's total British casualty premium volume.

"We are surprised at what little difficulty we have had," he said. "We have had an easier ride than we expected."

He added the claims-made form is "the best way to write liability business" because it limits underwriters' liability for claims that are presented years after the policy period expired that were never anticipated by the insurer.

"Liability losses are not yet a serious problem (outside the United States), but in the next 40 years they may be," he explained.

Mr. Payne and Mr. Carey, the two Lloyd's underwriters, have offered a claims-made policy for general and product liability coverage since 1977. But, this year they are making the wording more restrictive and requiring all non-U.S. clients with U.S. exposures and those with long-latent exposures, like pharmaceutical and oil companies, to switch to the claims-made form during renewals, Mr. Payne says.

The policy provides primary limits up to 5 million pounds ($7.35 million), although the average limit written is 2 million pounds ($2.9 million), he said.

Mr. Payne added he may require use of the claims-made form for any excess layers he leads up to 100 million pounds ($147 million).

The Payne/Carey claims-made form is triggered when a claim is made against the policyholder during the policy period. The underwriter does not have to be notified in writing during the policy period to trigger the coverage.

The policy will provide coverage for all subsequent claims for damage or injury resulting from one cause that occurred during the policy period, provided the policyholder notifies the underwriters during the policy period of one specific event or circumstance that may give rise to future claims.

However, the underwriter must agree to the extension of coverage.

This Payne/Carey form for non-U.S. risks is much less restrictive than the Lloyd's form for North American risks, Mr. Payne says.

Like the Lloyd's U.S. form, the Payne/Carey form includes defense costs in the policy's aggregate limits. However, it does not include many of the restrictions included in the Lloyd's form. For instance, under the Lloyd's U.S. form, a policyholder's retention is exhausted only by indemnity payments, not by any money paid by the policyholder for defense costs.

And, unlike the Lloyd's U.S. form, the Payne/Carey form includes coverage for pollution incidents , if it can be proved that the pollution was the direct result of a specific and identifiable event occurring during the policy period and was not the result of a failure to take reasonable precautions to prevent such pollution.

In addition, Mr. Payne says that if a policyholder wants to include North American risks in the coverage, the policyholder must accept the North American jurisdiction extension clause in the policy.

This clause includes many of the restrictions in U.S. claims-made policies, including:

- A specific retroactive date applying to North American risks. This date may or may not be the same as the retroactive date for non-North American risks.
- Exclusion of coverage for pollution and punitive damage awards.

Mr. Payne says that he will follow the Lloyd's U.S. form if he agrees to underwrite specific U.S. exposures.

While London underwriters are pushing the use of their claims-made forms for non-U.S. risks, some European countries, including West Germany, continue to require that all policies be written on an occurrence basis until new claims-made forms are approved by regulatory bodies. ■

Panel to help set retirement policy

WASHINGTON—Labor Secretary William E. Brock will chair a new interagency group designed to aid the development of a national retirement income policy and improve current administration of the pension law.

The new ERISA Coordinating Committee represents the first major effort at coordinating retirement income policy under the Reagan administration.

President Reagan asked Mr. Brock to serve as chairman of the new group.

The committee will be compriced of six Cabinet secretaries and the chairman of the Council of Economic Advisers, and will report to the Economic Policy Council. The council includes almost all Cabinet members and is headed by Treasury Secretary James A. Baker.

In addition to Mr. Brock, the members of the new group are Mr. Baker; Attorney General Edwin Meese III; Commerce Secretary Malcolm Baldrige; Health and Human Services Secretary Otis Bowen; James C. Miller III, director of the Office of Management and Budget; and Beryl W. Sprinkel, chairman of the Council of Economic Advisers.

"The establishment of this committee reflects the growing importance to American workers and retirees—and to our economy—of private pension and welfare benefit plans," Mr. Brock said in a statement.

"We now have a single forum for discussing national retirement income policy and other critical issues involving employee benefits," he said.

"We also have an effective means of coordinating the government's information and enforcement programs that are essential to a healthy private pension system," Mr. Brock said.

Pension experts generally were unfamiliar with the new group and what significance it will hold. ■

Photo: David M. Spindel, New York City

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Secretaries, treasurers, controllers and other financial personnel . . . 6,484

Risk/employee benefits:

Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations 8,111

Sub-total 22,354

Associations 483
Government, unions and educational systems 1,252

Commercial Consumers

Sub-total 24,089

Insurance agents and brokers 10,285
Insurance companies 6,739
Financial institutions 748
Actuaries, attorneys, adjusters, appraisers and consultants 3,808
Others allied to the field 1,308

TOTAL 46,977

* Source Business/Occupational breakdown of qualified circulation, Nov. 25, 1985 issue, as submitted to BPA for December 1985 BPA Publisher's Statement

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Insurers testify

Continued from page 1

pal liability insurers in New York—announced last August that it would not renew any of its 229 municipal policies in the state or any of the 85 policies it had written in 13 other states.

Aetna also decided last October not to renew any of its approximately 300 municipal liability policies, though the insurer still provides municipal coverage through market assistance programs in New York and Connecticut, a spokesman said.

- The reasons for specific underwriting decisions.

Insurers may have been asked, for example, why a particular policy was not renewed, or why one risk warranted a 300% premium increase while another received a 50% increase.

Mr. Corcoran's letter requesting testimony was accompanied by a dozen pages of questions that were intended to outline the scope of the hearings, according to Fred Marziano, executive vp with Fireman's Fund.

The questionnaire listed 30 or 40 classes of liability risks and asked insurers if they were a market for those risks between 1981 and 1985, what their market strategy was and whether that strategy had changed.

Liability classes on the list included amusement risks, contractors' liability risks, products and completed operations liability risks, errors and omissions, liquor liability, pollution liability, day-care center liability and municipal liability risks, Mr. Marziano said.

Another insurer spokesman confirmed that the department had asked the insurers to justify more restrictive underwriting postures.

"We were asked to walk the superintendent and his people through the thought process" behind the underwriting decisions, the spokesman explained.

"We understood it to be a sincere effort on the part of the department to get a handle on the liability situation," a Utica National spokesman added.

Mr. Marziano said that while the department's questioning was "antagonistic" at first, department officials were more understanding of the insurer's position by the end of its testimony.

"I didn't feel they were on a witchhunt," he said. "I never felt like I was being boxed in a corner."

Officials of the New York department and the insurers declined to provide any further details of the testimony, noting that the hearings were closed.

"This was part of our continuing effort to get as much hard information as possible on what's happening in the property/casualty marketplace," a department spokesman said.

Another department spokesman, noting allegations of possible collusion among casualty insurers, added that regulators wanted to "confirm or deny suspicions that have cropped up from time to time that this was a manufactured crisis."

Information from the hearings also may be used to develop new insurance regulatory legislation, the spokesman added.

One proposal being considered by the governor's advisory commission calls for "flex-rating" of casualty business. Under flex-rating, base premium rates would be established for various casualty lines, and insurers would be allowed to deviate above or below the base rate only by a defined percentage without getting prior approval from the insurance department.

If the commission's final recommendations include flex-rating and if it is later adopted through legislation, the insurers' testimony may help the Insurance Department decide what appropriate base rates should be and what percentage deviations should be allowed, the spokesman said.

"It's all going to be part of determining what kind of legislation should be proposed," another department spokesman explained.

Meanwhile, the governor's commission announced last month that it is "seriously considering" several proposals to address the liability insurance crisis. In addition to flex-rating, these include:

- Supporting current legislative efforts to regulate insurers' ability to cancel municipal and commercial liability policies midterm.
- Authorizing New York municipalities to form a statewide reciprocal insurance association that would have to grant membership to any municipal applicant and that would be regulated by the Insurance Department.
- Authorizing insurers licensed in New York to issue group property/casualty policies to homogeneous groups of public entities.
- Allow the insurance superintendent to mandate a joint underwriting association for New York municipalities and to direct the State Insurance Fund to start writing municipal liability insurance.
- Requiring insurers to refile rates with the Insurance Department following passage of commission-recommended changes in the tort liability system. These refiled rates would presumably reflect the impact of the tort law changes.

The commission said it is considering several recommendations for changes in the tort system, including:

- Restricting the application of the joint and several liability rule.
- Authorizing structured settlements for all tort actions that generate verdicts of more than $250,000.
- Extending to all tort actions the sanctions against frivolous suits that were enacted in New York for medical malpractice actions.
- Limiting the liability of directors and officers of non-profit organizations.
- Capping pain and suffering damages against public entities to $250,000.
- Encouraging courts to divide all tort trials into separate proceedings to determine liability and damages. ■

Pretax operating loss up 42%: ISO/NAII study

The U.S. property/casualty insurance industry's pretax operating loss grew 42% in 1985 to $5.4 billion from $3.8 billion, say the Insurance Services Office and the National Assn. of Independent Insurers.

But, the industry's net income totaled $2 billion in 1985, more than double the industry's $800 million in 1984 net earnings, according to the ISO/NAII figures, which account for 97% of U.S. property/casualty insurance business.

Earlier this month, *Business Insurance* reported that aftertax operating income among a group of 23 major property/casualty insurers declined 21.6% to $1.3 billion in 1985. *BI* does not track pretax operating income or net income.

ISO/NAII shows the industry's pretax underwriting loss grew 14.9% in 1985 to $24.7 billion. The underwriting loss of the *BI* insurers rose 10.9% to $10.5 billion.

Pretax investment income among the insurers surveyed by ISO and the NAII grew 10.2% to $19.5 billion, while the large insurers generated $7.3 billion in investment income, up 10.6% from 1984.

The industry reported a 21.7% increase in net written premiums to $144.3 billion. Premiums written by the large insurers surveyed by *BI* grew 23.6% to $55.8 million.

The industry's consolidated policyholders surplus rose 20% to $76.3 billion at year-end 1985, while the large insurers reported a 27.3% increase in surplus to $18.4 billion.

The ISO/NAII industry survey revealed an aggregate combined ratio of 116.4% for 1985, better than the 118.0% posted in 1984. The insurers surveyed by *BI* posted a 1985 aggregate combined ratio of 119.6%; the 1984 ratio was 121.7%. ■

update

Fireman's buys mortgage firm

Continued from page 2

offered would consist of one share of Fireman's Fund stock and one warrant, with two warrants entitling the holder to buy one additional share of stock.

RAA lobbies on reinsurance tax

WASHINGTON—The Reinsurance Assn. of America is lobbying the Senate Finance Committee to keep the federal excise tax on reinsurance premiums paid to foreign reinsurers at 1%.

However, the RAA wants the tax to apply to all foreign reinsurers.

Currently, reinsurers in certain countries are exempt from the reinsurance excise tax under tax treaties with the United States. The countries are Great Britain, France, the Soviet Union, Romania and, most recently, Barbados.

Searle IUD case dismissed

BALTIMORE—A U.S. District Court judge has ruled in favor of G.D. Searle & Co. in a suit brought by 17 women seeking to recover for injuries allegedly caused by their use of the CU-7 intrauterine contraceptive device.

In a 22-page opinion dismissing the case, U.S. District Judge Joseph H. Young said the plaintiffs "failed to present sufficient evidence of causation and a verdict must be entered in favor of the defendant."

Late last year, Judge Young declared a mistrial in a case brought by the same plaintiffs when the jury could not agree that the injuries alleged by the women were caused by the use of the CU-7 (*BI*, Dec. 30, 1985).

In a prepared statement, Searle Vp and General Counsel Roger C. Thies said the company was "gratified" by the decision and hopes that it will discourage "future unwarranted litigation."

Mr. Thies said that the case was the "lead effort of the organized plaintiffs' bar to attack this product and it failed," adding the decision brings Searle's record in IUD cases to nine victories and two losses.

This is the sixth consecutive court victory for Searle, he added.

In February, the Skokie, Ill.-based Searle, a unit of Monsanto Co., announced it no longer will sell the CU-7 in the United States because of escalating product liability litigation costs and the company's inability to obtain product liability insurance for the IUDs (*BI*, Feb. 10).

Plaintiffs allege the CU-7, also called the Copper-7, causes pelvic inflammatory diseases, ectopic pregnancies, perforated uteruses, infertility and other problems. The company still faces more than 300 suits.

An attorney for the plaintiffs could not be reached for comment.

Lloyd's syndicates stop writing

LONDON—Lloyd's of London has told two underwriting agencies that four of their syndicates must curtail underwriting so that the syndicates do not exceed their premium limits.

The agencies affected by the order are Bankside Syndicates Ltd., which manages syndicates 561 and 566, and Patrick Underwriting Agencies Ltd., which manages syndicates 197 and 726. Other syndicates managed by Bankside and Patrick are not affected by the directive.

Both agencies were warned by Lloyd's that they cannot accept business that represents more than 85% of the total capacity of the syndicates.

Lloyd's last month ordered aviation syndicate 800, managed by E.R.H. Hill (Agencies) Ltd., to stop writing all new and renewal business because it was approaching its premium limit. Syndicate 800 most likely will not write any more business for the rest of the year, Lloyd's says.

In addition, Lloyd's says it is investigating about 10 syndicates that soon may exceed their premium limits.

Public officials

Continued from page 3
by PRIMA.

Mr. Schirott said areas of potential liability continue to be failure to properly train and supervise public employees, discharging employees, disclosure of personnel records, zoning cases, refusing to issue licenses, placing limitations on commerce, failure to award a bid to the lowest bidder and stop-work orders issued by a local government's building or health department.

Chicago attorney Clifford L. Weaver said, "Developments in constitutional, civil rights and antitrust law, combined with increased public regulation of land use, have spawned a flood of claims for money damages in a field where such claims were all but unknown just a decade ago."

"The ultimate success of such claims remains uncertain. The law governing such claims, though now voluminous, remains confused and inconclusive," he said in the draft of a book he is writing on the subject.

While court decisions as a whole are inconclusive, public officials were heartened by a March 19 U.S. District Court decision that reversed a landmark $28.5 million antitrust and civil rights jury verdict awarded to a developer against Lake County and the village of Grayslake, Ill., and several of their officials (*BI*, March 24).

The jury's award of $9.5 million, which was tripled under antitrust law to $28.5 million, was a main impetus behind passage of the Local Government Antitrust Act of 1984 (*BI*, Oct. 14, 1984), according to Mr. Weaver, who represented the public entities involved in the case.

The federal law makes local governments and officials immune from monetary damages and attorneys' costs involved in antitrust litigation.

Inconclusive court decisions make it difficult for public officials to know how to perform their liability-prone duties, and limited or non-existent commercial insurance coverage puts pressure on the officials, too.

The insurance market for public officials' coverage is "chaotic," said James A. Swanke Jr., the Wyatt consultant who analyzed the data from the Wyatt/ICMA survey and wrote the report.

'U.S. towns and cities are experiencing liability insurance rate increases of up to 900% and, in some cases, total policy cancellations,' according to a spokesman for the National Assn. of Towns & Townships.

The public officials liability insurance market has been "very dynamic," with many insurers entering or leaving the market from 1979 to 1984, he said.

Wyatt also offers consulting services to public entities through an ICMA program.

A mid-1985 *(Business Insurance)* survey of the market for public officials' and police professicnal liability insurance found that 12 insurers had stopped writing one or both coverages since 1983 (*BI*, July 8, 1985).

A recent *Business Insurance* survey found that Forum Insurance Co., Colonial Penn Insurance Co., Republic Insurance Co. and Vanguard Insurance Co. stopped writing any new or renewal public officials' liability policies at the end of last year or the beginning of this year.

Meanwhile, Tudor has been accepting for submission only renewal policies since September, 1985. However, it expects its direct written premium for public officials' risks to climb to $8 million in 1986 from $5 million in 1985, according to Thomas Mulligan, who is Tudor's underwriting marketing manager.

At least four insurers are still writing new and renewal policies, usually with limits of $1 million. These insurers are National Casualty, Scottsdale Insurance Co., Hartford Insurance Co. and at least one American International Group Inc. unit.

International Surplus Lines Insurance Co. and International Insurance Co. are probably also writing some public officials liability coverage, insurer sources said. A spokesman for the Crum & Forster units could not be reached for comment.

A "seller's market" exists "where cities desiring to purchase insurance must hope, first, that a carrier is willing to offer coverage at all, and second, that the price quoted by the carrier can be met," the United States Conference of Mayors said following a survey of 40 cities last year.

"U.S. towns and cities are experiencing liability insurance rate increases of up to 900% and, in some cases, total policy cancellations," said a spokesman for the National Assn. of Towns & Townships.

Insurer spokesmen support those findings.

"We are almost at the point of being saturated with business," said Connie Tidwell, underwriting supervisor for Nashville, Tenn.-based PENCo, a wholesaler specializing in municipal risks.

An AIG spokesman said despite the company's policy of charging high rates and writing only medium- and small-sized risks, customers are flocking to AIG. He said that he expects AIG to write $16 million in direct written premium for public officials liability coverage in 1986, up from $10 million last year.

Kurt Foerster, marketing manager with broker Alexander & Alexander Inc. in Richmond, Va., notes that most of the policies that are now available are "very restrictive."

Those that can find the coverage buy it to protect themselves from defense costs, he said.

In addition, there is confusion about what constitutes a valid public officials' liability claim because when insurance was cheap, those claims were sometimes covered by a comprehensive general liability policy, according to Mark Ferraro, who is the risk manager for the city of Dallas.

Despite the limitations of public officials' liability policies, some public entities, including Dallas, are still seeking insurance coverage.

The climate for public officials' liability has spurred a variety of reactions.

States are establishing market assistance programs to help public entities find insurance, public entities are adopting ordinances to indemnify their public officials and greater emphasis is being placed on loss control (*BI*, March 10; Dec. 16, 1985).

Public entities are also adopting self-insurance programs, individually or through pooling arrangements, and some are advocating tort reform to reduce public officials' liability exposures.

However, the MAPs "don't seem to be getting a lot of applications," Mr. Toomey said.

In the dozen or so states that have established MAPs for municipal and other coverages, only about 200 applications had been received since the programs began, according to his figures.

With commercial insurance coverage limited or not available, public officials are turning to other means of protection.

"Many municipal officers think they can avoid personal exposure to liability by putting their homes in land trusts," according to Mr. Schirott. "This is not true; assets cannot be protected by putting them in trusts.

"Another method of avoidance, granting title of the home to a sister or spouse, may work against you," he said.

"Such transfers may be subject to gift tax, and to be effective, they must be based upon a relationship able to withstand familial and domestic squabbles."

Instead, Mr. Schirott recommends that public boards pass resolutions at the start of each new board year that promises, "insofar as is permitted by law or statute, to defend and indemnify" public officials and employees in the performance of their official duties.

Many public entities are apparently considering the indemnification approach, judging from the number of requests he has had to send copies of draft resolutions, he said. Mr. Schirott said he has had about 10 requests in just the past two months.

Indemnification arrangements may be easier for many entities to accept before a loss, rather than after one.

However, Georgia was faced with making a post-loss arrangement after its insurer, Transit Casualty Co., was placed in liquidation in Missouri. The state has promised to indemnify University of Georgia officials for a $2.58 million judgment awarded Jan Kemp, a university teacher who was dismissed after she refused to give college athletes passing grades that they did not earn.

Other communities that have adopted indemnification ordinances include Seattle and Dallas.

Meanwhile, other public entities plan to post-fund any loss through the use of post-loss judgment bonds.

No matter what method of payment, the crisis in municipal insurance is causing public officials to be more conscious of the need for loss control, sources say.

"The city council is asking better questions," Dallas' Mr. Ferraro said.

One loss-control program includes the use of ombudsmen to hear and settle complaints before they become lawsuits, said Nestor Roos, a professor of insurance at the University of Arizona and PRIMA's director of education and training.

"However, the problem is the insurance industry doesn't recognize it," he said.

Many public officials feel the key is for municipalities to insulate themselves from swings in the insurance market through self-insurance, and pools are frequently being established to provide some protection from large judgments (*BI*, July 15, 1985; Feb. 24, 1986).

The South Dakota Legislature has approved establishing a voluntary statewide pool for public entities effective March 1, 1987, if the state cannot obtain a master insurance contract to protect the entities Oct. 1.

Others are working on tort reform measures that would cap a public entity's or official's liability for any state court judgment.

However, insurers do not seem to acknowledge the existence of caps in deciding whether to make insurance available, Mr. Ferraro said. In addition, caps do not apply to federal lawsuits where a lot of exposure exists, attorneys say.

Also adding to the confusion about caps is that some monetary limits in Texas do not apply if a city is engaged in "proprietary" as opposed to "governmental" functions, Ted C. Willis, executive director of the Texas Municipal League, said earlier this year. Governmental functions are those activities a city undertakes pursuant to state requirements to provide for the health, safety and general welfare of citizens, while proprietary functions include all other functions.

Questions about the legality of caps have been raised by at least one state supreme court. The Montana court ruled that a state law limiting tort liability of state and local governments was discriminatory.

The Montana Legislature is considering action it can take to help public entities limit their liability. ■

High court decisions affect officials' liability

Six decisions in the past year by the U.S. Supreme Court have both expanded and contracted public officials' legal liability under either the Constitution or antitrust laws.

Last week, the high court ruled in *Pembaur vs. City of Cincinnati* that local governments may sometimes be held liable for the actions of individual officials. In the ruling, the justices expanded a 1978 ruling that made local governments vulnerable to lawsuits for damages when an official policy violates a person's civil rights.

The high court ruled that Hamilton County, Ohio, in which Cincinnati is located, may be a defendant in a $20 million lawsuit filed by a doctor whose office was searched without a warrant by county police seeking two of his employees.

The judge reversed a lower court's decision and returned the case to the district court for trial.

On Feb. 26, the Supreme Court decided that a Berkeley, Calif., ordinance allowing the Rent Stabilization Board to impose rent ceilings on residential property violates neither the 14th amendment nor antitrust laws.

Landlords who opposed the initiative-sponsored ordinance brought the suit in *Fisher et al. vs. City of Berkeley, Calif.*

In two earlier prisoner-related cases, the Supreme Court decided that plaintiffs cannot sue state and local officials in federal court for negligence under the due process clause of the 14th Amendment (*BI*, Jan. 27).

In *Davidson vs. Cannon*, a prisoner in New Jersey sought damages against the state alleging that state officials negligently failed to protect him from another inmate.

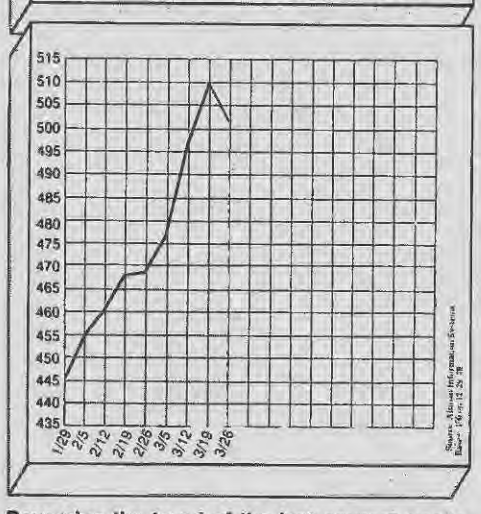
In *Daniels vs. Williams*, a prisoner in Virginia injured his back and ankle when he slipped on a pillow that was left on a staircase by a sheriff's deputy.

In *Williamson County Regional Planning Commission vs. Hamilton Bank of Johnson City*, the court in June 1985 threw out a $9.5 million civil rights award because the developer's constitutional claim was premature. Despite an eight-year struggle, the developer had never received a final governmental rejection of his development plans.

In *Town of Hallie vs. City of Eau Claire*, the Supreme Court said in March 1985 that Eau Claire, Wis., was immune from antitrust lawsuits because state-granted authority to construct sewage treatment facilities empowered the city to refuse to serve unannexed areas (*BI*, Oct. 14, 1985).

In addition, the high court paved the way for states to enact limits on awards when it refused last fall to hear a challenge to a California law that limits pain and suffering awards in medical malpractice lawsuits.

BI Insurance Index



Reversing the trend of the last several weeks, the *Business Insurance* stock index closed lower during the most-recent trading period. The *BI* index of insurance industry stocks closed at 501.5 points on March 26, a drop of 7.5 points from the record high of 509 points set March 19. A total of 13 stocks posted increases, 40 stocks were down and seven stocks were unchanged during the trading period. The biggest gains were posted by Tokio Marine & Fire Insurance Ltd., up 26%; Baldwin & Lyons Inc., up 9.2%; Crown Life Insurance Co., up 5.9%; Zenith National Insurance Corp., up 4%; and Monumental Corp., up 3.8%. The biggest losses were posted by Business Men's Assurance Co. of America, down 14.2%; Aneco Reinsurance Co. Ltd., down 13.6%; Provident Life & Accident Insurance Co., down 6.6%; Kemper Corp., down 6.5%; and Fireman's Fund Corp., down 6.4%. The *Business Insurance* stock index declined 1.5% during the period, while the other major market indicators posted slight increases. The New York Stock Exchange composite rose 0.8%, the Standard & Poor's 500 rose 0.7% and the Dow Jones 30 industrials rose 1.3% for the trading period.

British Issues

25 March Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Commi Union	302	N/M	16.9	5.5	310—302	
Gent Accident	888	43.3	31.4	3.5	898—870	
Gdn Royal Exch	865	75.2	40.7	4.6	880—853	
Royal	878	72.0	36.7	4.1	898—878	
Sun Alliance	696	69.6	23.6	3.3	720—696	
Brokers						
CE Heath	645	9.8	36.0	5.5	650—645	
Hogg Robinson	338	13.8	13.4	3.9	340—334	
JH Minet	258	13.8	10.7	4.1	258—245	
Sedg Grp	370	17.1	15.7	4.2	375—370	
Stew Wrightson	405	16.2	15.7	3.8	405—395	
Willis Faber	415	20.8	12.5	3.0	445—415	

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

Insurers look at court reform

Continued from page 3

Mr. Greene, in his discussion of tort reform, said the present system in reality has one economic purpose, "and that is to support lawyers and the judicial process."

"The present system is obscene, and you lay people must change it. It is beyond the lawyers to change it" for many reasons, including "human frailty," he said.

But Mr. Greene said reforms affecting governmental liability will probably be implemented "because it's politician calling to politician across the great void."

Mr. Greene also predicted a "modest amount" of medical malpractice law reform will be forthcoming.

Mr. Greenberg told the audience that the insurance industry must deal with a variety of problems besides tort reform, including insufficient capitalization, reserve inadequacy and the collectibility of reinsurance.

"We're going to have this kind of marketplace for some time," he said.

While Mr. Greenberg said capacity problems will ease gradually, he could not precisely pinpoint when the cycle would turn. "I certainly don't look for it over the next couple of years, anyway."

He noted "there simply has been a very sharp reduction" in the amount of reinsurance available because some reinsurers have cut capacity, some are now avoided by ceding companies because of "heightened concern about security" and some have "simply disappeared."

Sixty reinsurers worldwide stopped doing business in 1985, Mr. Greenberg said.

Hardly anyone, he continued, predicted the market upswing would be so sharp and rates would have risen so quickly. But, while he admitted that stories of 300% to 500% rate hikes are true, "you have to put that in perspective."

Many classes of business, he said, had been discounted 50% to 70% from Insurance Services Office advisory rates during the competitive market. He said many rates now charged by insurers are close to the rates charged in 1978 and 1979 when adjusted for inflation.

In other cases, he added, rates have risen dramatically because the exposures in question are unpredictable.

He noted that because of affordability and availability problems, many companies today are searching for alternative ways to distribute risk, including self-insurance and captives. However, Mr. Greenberg contends, these companies will be "happy to go back" to commercial underwriters when rates again moderate.

Mr. Greene, however, disagreed, explaining that companies that form captives and use other risk financing alternatives will not not return to the commercial insurance market, though some captives eventually may become licensed insurance companies in the United States.

Mr. Greene also noted that conflicting regulations concerning financial reporting will cause confusion in the industry.

He described the pending legislation that would require insurers to discount their loss reserves for tax purposes as "a dilemma in gestation" because of the opposition of insurance regulators in any form of reserve discounting (*BI*, March 24).

He noted the California Insurance Department is already rejecting insurers' financial statements because they have discounted loss reserves, "so perhaps the dilemma is already upon us."

In addition, the Securities and Exchange Commission has decided that stock insurers' financial statements should have "elaborate disclosure appendices," particularly concerning reserves.

Even after many years in the insurance business, Mr. Greene confessed, "I can't understand the exhibits."

"It's going to be a major potential for further confusion in the industry" with the Treasury, regulators and the SEC all demanding different numbers.

Mr. Greene also said "there is a dire threat of insolvency" in the industry today.

He noted that a rehabilitation plan was worked out for Mission Insurance Co. because it was recognized that if Mission went under, "the hemorrhaging could be more severe than anyone expected."

For instance, Mission's ceding insurers would have had to adjust their reserves and reduce their surplus, he said. ■

Washington bills

Continued from page 3

United States.

- Releases directors and officers of nonprofit corporations and school directors and superintendents from liability unless they act with "gross negligence."

The section of the bill that would release school officials from liability would take effect immediately upon signing. All other sections of the bill would take effect Aug. 1.

In testimony on hearings on the bill, the American Insurance Assn. estimated that enactment of the bill would result in a premium decrease of 10% to 15% for municipality liability cover.

And, the Washington State Physicians Insurance Assn., which is a non-profit captive insurer, estimated the bill would result in a rate decrease of about 23% to 28% for malpractice coverage for its policyholders.

In addition to S.B. 4630, the other insurance legislation passed by the Legislature is:

- S.B. 4749, which requires insurers that write product liability, attorney malpractice, architects and engineers malpractice, municipal and day-care policies to file detailed annual income and expense reports with the state insurance commissioner's office beginning March 1, 1987.

The insurers would be required to submit information on 15 separate elements of business, including the amount of premium written, net investment income, incurred claims and reserves. This information would be available to the public.

- S.B. 4540, which would require insurance companies to give a 120-day notice to insurance agents before the cancellation of any written agreements or contracts between the agent and the company. The bill also requires an insurance company to accept renewal policies from a canceled agent for up to one year.
- H.B. 1972. This bill will allow cities and governmental entities to self-insure their property risks. Under current law, they can self-insure only their liability risks. The bill also allows fraternal organizations to self-insure both their property and liability risks.
- S.H.B. (substitute House bill) 2080, which requires the insurance commissioner to approve a plan for a joint underwriting association for day-care center coverage by July 1. The bill requires all admitted property and casualty insurers to join the JUA.
- S.H.B. 2083, which would allow day-care associations to set up a self-insurance program for its members. ■

Stopgap measure extends Superfund

WASHINGTON—A two-month, $150 million extension of the federal Superfund law will prevent a shutdown of the hazardous waste cleanup program while conferees try to work out differences between House and Senate Superfund reauthorization bills.

The president last week was expected to sign the stopgap funding measure, which was approved by Congress March 21.

The federal tax that supports the Superfund expired Sept. 30, 1985. The Environmental Protection Agency warned Congress on Jan. 31 that the program would have to be shut down by April unless a measure to extend the tax and reauthorize Superfund was signed into law before the end of March.

Both the House and Senate have passed five-year Superfund reauthorization measures, but to date congressional conferees have been unable to iron out differences.

The sticking point in the negotiations is the funding mechanism for Superfund, although conferees are also trying to resolve differences in liability provisions.

Both bills would greatly expand the Superfund: The House approved a $10 billion fund, while the Senate approved a $7.5 billion bill. But, while the House bill simply increases the current Superfund tax on oil and chemicals, the Senate bill would impose a new broad-based tax on most U.S. industries.

Because of this new tax, the Superfund reauthorization bills have been caught up in the House-Senate battle over tax reform, congressional staffers explain.

A House Energy and Commerce Committee staffer says squabbling over the tax portion of the legislation is delaying resolution of the environmental policy differences.

"If the tax piece starts moving, we will resolve our differences on the policy issues very quickly," the staffer says.

Staff members of the Senate Environment Committee did not return telephone calls.

Even though a compromise has not been reached, Leslie Cheek, vp of federal affairs for Crum & Forster in Washington, says he is optimistic conferees will iron things out before the end of spring. "I think significant progress is being made, even though it's not visible at this point," he says.

Mr. Cheek says Sen. Robert T. Stafford, R-Vt., chairman of the Senate Environment Committee, is putting together several "packages" that would resolve differences between the bills and allow conferees to deal with the major provisions of the bills in "huge chunks, rather than trying to wade through it on a section-by-section basis."

There is a good chance that conferees will adopt the Senate's language in several key areas of concern to insurers and risk managers, Mr. Cheek says. The House bill is generally considered to impose more stringent liability than the Senate measure (*BI*, Dec. 9, 1985; Dec. 16, 1985). ■

BI Industry Stock Report

March 19, 1986 3/13/86 thru 3/19/86

Brokers		Price	% Chg.	P/E	$ Div.	% Yld.	High	Low	Vol.(000)
Alexander & Alexander Svcs	NYSE	35.63	-5.0	0.0	1.00	2.8	37.00	35.25	388.1
Baldwin & Lyons Inc	OTC	95.00	9.2	365.4	0.80	0.8	102.00*	87.00	2.3
Corroon & Black Corp	NYSE	63.00	-4.2	20.0	1.30	2.1	65.88	63.00	41.7
Crump E H Cos Inc	OTC	24.25	-3.0	23.1	0.25	1.0	24.75	23.75	144.7
Emett & Chandler Cos Inc	OTC	18.13	0.0	27.1	0.00	0.0	18.13	18.13	16.4
Gallagher Arthur J & Co	OTC	55.50	-0.9	25.2	0.40	0.7	55.50	54.00	4.9
Hall Frank B & Co Inc	NYSE	22.38	-2.2	0.0	0.00	0.0	23.75	21.88	300.3
Marsh & Mclennan Cos Inc	NYSE	101.25	-1.2	45.4	3.00	3.0	102.50	101.13	385.1
Poe & Assoc Inc	OTC	18.75	1.4	0.0	0.80	4.3	18.75*	18.50	3.7
AGENTS/BROKERS	AVERAGE			774.8		1.7			
Conglomerates & Holding Cos.									
American Express(Fireman's Fd)	NYSE	68.00	-0.5	19.2	1.36	2.0	68.25	65.50	4,505.3
Anderson Clayton(Ranger/PanAm)	NYSE	52.63	-2.5	30.1	0.00	0.0	53.63	52.63	163.8
Armco Inc	NYSE	11.00	-1.1	0.0	0.00	0.0	11.13	11.00	940.0
Berkley W R Corp	OTC	52.00	2.0	36.6	0.32	0.6	53.50*	50.25	486.2
CIGNA Corp	NYSE	74.25	-2.6	0.0	2.60	3.5	76.38*	73.13	1,651.2
CNA Finl Corp (CNA)	NYSE	73.63	2.3	24.5	0.00	0.0	74.38*	71.63	312.6
General Re Corp	NYSE	121.50	-2.8	87.7	1.76	1.4	125.50	119.13	502.8
ITT (Hartford Group)	NYSE	47.25	2.7	25.0	1.00	2.1	47.25*	46.00	3,612.5
Sears Roebuck & Co. (Allstate)	NYSE	48.75	3.4	13.8	1.76	3.6	48.75*	46.00	4,582.0
Teledyne Inc (Argonaut)	NYSE	341.75	-5.6	7.3	0.00	0.0	362.50*	341.75	198.1
Transamerica Corp (Occidental)	NYSE	36.13	-3.7	16.8	1.68	4.7	37.50	35.50	1,033.4
CONGLOMERATES/HOLDING COS.	AVERAGE			18.0		1.1			
Insurers									
Aetna Life & Cas Co	NYSE	64.38	-0.8	16.8	2.64	4.1	65.13	62.75	2,369.4
American General Corp	NYSE	41.00	-1.2	12.7	1.12	2.7	42.63*	40.38	2,074.0
Amern Heritage Life Invt Co	NYSE	42.63	0.0	16.0	1.20	2.8	43.00	42.50	3.3
American Indty Finl Corp	OTC	22.50	-1.1	0.0	1.12	5.0	23.00	22.50	15.7
American Intl Group Inc	NYSE	134.00	-3.2	27.3	0.44	0.3	138.38	133.25	574.5
Aneco Reins Ltd	OTC	1.19	-13.6	0.0	0.00	0.0	1.31	1.19	27.3
Avemco Corp	NYSE	36.38	1.7	14.3	0.60	1.6	36.38	35.88	44.4
Business Mens Assurn Co Amer	OTC	27.25	-14.2	12.6	1.10	4.0	31.75	27.25	57.1
Chubb Corp	NYSE	72.63	-3.0	0.0	1.56	2.1	75.75	72.38	400.4
Combined Intl Corp	NYSE	62.00	-3.1	12.8	2.24	3.6	65.50*	61.25	320.6
Continental Corp	NYSE	51.38	-4.6	0.0	2.60	5.1	54.25	51.38	475.5
Crown Life Ins Co	OTC	270.00	5.9	16.3	0.00	0.0	270.00	255.00	0.2
Durham Corp	OTC	43.75	1.2	12.0	1.36	3.1	43.75	43.00	9.0
Farmers Group Inc	OTC	85.38	-5.1	15.7	2.00	2.3	89.88	84.75	322.4
Fairmont Finl Inc	AMEX	23.25	-4.1	19.4	0.00	0.0	23.75	22.38	46.0
Fireman Fd Corp	NYSE	40.13	-6.4	0.0	0.30	0.7	43.13*	40.00	417.5
Fremont Gen Corp	OTC	32.00	-4.1	0.0	0.48	1.5	34.00*	32.00	266.9
Great West Life Assurn Co	OTC	500.00	0.0	5.0	18.00	3.6	500.00	500.00	0.0
Home Group Inc	AMEX	29.38	-0.4	0.0	0.00	0.0	30.50*	28.50	1,315.6
Hanover Ins Co	OTC	64.50	-0.8	63.2	0.56	0.9	65.00	63.75	101.3
Hartford Steam Boiler Inspctn	OTC	70.50	-2.1	13.0	2.00	2.8	72.50	70.50	29.8
Kans City Life Ins	OTC	32.50	0.0	12.8	0.87	2.7	32.50	32.50	11.0
Kemper Corp	OTC	93.00	-6.5	20.1	1.80	1.9	99.38	91.50	381.2
Liberty Corp S C	NYSE	41.50	-1.2	17.4	0.72	1.7	42.75	41.50	12.3
Lincoln Natl Corp Ind	NYSE	59.88	-1.8	13.9	2.00	3.3	62.25	59.63	540.0
Mission Ins Group Inc	PAC	4.00	0.0	0.0	0.00	0.0	5.87	2.00	7.5
Monumental Corp	OTC	37.50	3.8	12.7	1.40	3.7	37.50*	36.13	33.0
Mac Re Corp	OTC	36.25	-4.6	0.0	0.00	0.0	37.75	36.25	36.1
Nobel Ins Ltd	OTC	16.50	-5.7	21.7	0.25	1.5	17.75	16.50	152.9
Northwestern Natl Life Ins	OTC	27.63	-1.8	13.7	0.80	2.9	28.25	27.13	275.5
Ohio Cas Corp	OTC	85.00	-5.6	24.9	3.00	3.5	90.75*	85.00	286.6
Old Rep Intl Corp	OTC	40.88	-2.4	11.0	0.74	1.8	41.88	40.50	402.0
Orion Cap Corp	NYSE	38.13	-2.6	0.0	0.76	2.0	40.00*	38.13	249.6
Protective Corp	OTC	21.25	-4.5	12.3	0.66	3.1	22.00	20.25	306.5
Provident Life & Acc Ins Co	OTC	29.88	-6.6	10.3	0.84	2.8	31.88	29.13	216.9
St Paul Cos Inc	OTC	101.00	-5.8	44.7	3.00	3.0	106.50	99.25	781.2
SAFECO Corp	OTC	56.25	-4.7	17.1	1.60	2.8	59.25*	56.13	473.8
Sri Corp	OTC	22.25	3.5	0.0	0.80	3.6	22.50	22.00	251.2
Seibels Bruce Group Inc	OTC	22.25	0.0	12.4	0.80	3.6	22.25	22.00	188.2
Statesman Group Inc	OTC	7.50	0.0	0.0	0.05	0.7	7.63	6.75	156.3
Tokio Marine & Fire Ins Co	OTC	388.50	26.0	73.2	1.05	0.3	388.50*	343.50	46.6
Torchmark Corp	NYSE	33.25	1.5	15.3	0.60	1.8	33.25	32.50	398.9
Travelers Corp	NYSE	57.25	-2.8	14.3	2.16	3.8	58.75	56.88	1,471.9
United Fire & Cas Co	OTC	23.00	0.0	766.7	0.80	3.5	23.00	23.00	0.1
United States Fid & Gty Co	NYSE	43.50	-5.2	0.0	2.32	5.3	45.75	42.75	3,197.1
Uslife Corp	NYSE	46.63	3.0	12.6	1.12	2.4	46.63*	44.63	672.3
Washington Natl Corp	NYSE	33.25	-2.2	15.1	1.08	3.2	34.75*	33.25	203.7
Zenith Natl Ins Corp	OTC	32.50	4.0	0.0	0.68	2.1	33.00*	31.88	454.6
INSURANCE COMPANIES	AVERAGE			17.0		2.2			

System design: Altman Information Systems

Q. The Hartford—isn't that the company with the moose?
A. It's a stag. They launched an investigation and found the problem fast.
Q. Is The Hartford known for great loss prevention?
A. You bet. They can really help limit and even prevent losses from accidents and disasters.
Q. I assume your broker's a Hartford fan, too?
A. Sure—we've seen eye-to-eye on The Hartford for years.
Q. Smart. So tell me, are your rocket skis being well received?
A. Oh yeah. They're very big with the jet set.

PIA

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