

Business Insurance

Reporting weekly for corporate risk, employee benefit and financial executives / \$2.00 a copy; \$75 a year

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Chicago investigating abuse of self-insured health care plan

CHICAGO—The city of Chicago is investigating mismanagement in its self-insured, self-administered employee health care program.

A six-month study of the \$239 million health care program by Coopers & Lybrand revealed widespread poor record keeping, payment of improper medical claims and violations of city regulations.

Auditors found that city health benefit records were a shambles: Two-thirds
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Ruling limits auditors' liability

By CAROLYN ALDRED

LONDON—A landmark decision by England's highest court greatly reduces accountants' liability to third parties—like individual or corporate investors—that rely on auditors' reports.

In addition, the ruling could be applied to all professionals, not only accountants, lawyers say.

Moreover, the ruling could influence courts worldwide, including U.S. courts, according to lawyers, who noted that English case law often is cited in U.S. courts hearing insurance and accounting cases.

Five judges in the House of Lords unanimously ruled last month that auditors owe no duty of care to potential investors who base investment decisions on inaccurate accounts prepared by the auditor.

The five senior law judges also ruled that although auditors owe a duty of care to shareholders of client companies "as a

body," they owe no duty to individual shareholders as investors.

The ruling marks the first time the House of Lords has ruled on the liability of accountants and likely will be widely cited throughout all common law countries, including the United States, said Victor Earle, senior vp and general counsel for New York-based Minet Specialty Management Inc.

Minet International Professional Indemnity Ltd., a unit of Minet Specialty, places errors and omissions coverage for many of the world's leading accounting firms.

"The House of Lords, at last having grappled with this nettlesome issue precisely as it affects the accounting profession, has reached a result more protective of that profession than anything done judicially over the past half-century," Mr. Earle said.

The decision "is more protective (of the accounting profession) than any body of law in the United States," he commented.

"Equally protected (by the decision) are virtually all other professional and non-professional services whose advices are

apt to reach third parties," Mr. Earle noted in a statement he sent to Minet's clients.

"This is clearly a decision that is highly favorable to auditors and the accounting profession, and perhaps of importance to other professions," agreed Robert D. McLean, managing partner of the Washington, D.C., office of the law firm Sidley & Austin.

The judgment "probably is going to have implications throughout the Anglo-American legal system," he said, adding that he likely will cite the ruling in U.S. cases.

"The judgment has generated a lot of interest in the U.S. Although it has no binding value, it will be cited in U.S. courts" and will have a strong persuasive value, said Lindsey Marr, a partner in the litigation department of the London law firm Freshfields, which represented Touche Ross & Co., the accounting firm in the case.

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Pepper panel seeks universal coverage

Health benefit mandate

By JERRY GEISEL

WASHINGTON—Employers would be required to fund generous group health insurance plans or else pay a new, hefty payroll tax under a recommendation narrowly approved last week by a blue-ribbon commission studying the U.S. health care system.

Employers with more than 100 workers either would have to sponsor a health insurance plan providing federally specified benefits with cost sharing limitations or pay new payroll

taxes to fund a new public plan to provide coverage to the uninsured, according to a report of the Pepper Commission released Friday.

The annual cost to employers of meeting the federal requirements—to take effect three years after enactment of the legislation—is estimated by the commission at \$20 billion.

While the amount of the proposed payroll tax has not been disclosed, it presumably would be large since its intent is to compel employers to provide group health insurance benefits.

Smaller employers eventually also would be subject to the mandate unless a large proportion of them voluntarily provided group health plans to their employees. In some cases, small employers offering health care plans would receive generous tax credits.

In addition, the commission is recommending establishment of a massive new long-term health care program for the elderly and disabled. The program would be financed by federal and state revenues.

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Company-run clinics cutting health costs

By JERRY GEISEL

Southern California Edison Co. is taking the problem of soaring health care costs in its own hands—literally.

In an effort dating back to 1903, when Edison opened its first medical clinic—at Big Creek in the High Sierra—to provide medical care to employees building a hydroelectric plant, the Rosemead, Calif.-based utility now operates 10 medical clinics and first-aid stations for employees throughout Southern California.

With a \$15 million budget and staff of 70, those medical clinics and corporate pharmacies now rival a major medical center, handling more than 100,000 patient visits and dispensing more than 250,000 prescriptions annually to 55,000 Edison employees, dependents and retirees.

"We believe we are the largest corporate primary health care system," said Dr. Jacques Sokolov, Edison's medical director and vp of health care.

The clinics, which range from a huge 30,000-square foot facility at the company's headquarters at Rosemead to a 2,000-square foot site at Big Creek, are a boon to Edison and its employees.

Edison pays 90% of medical care charges and prescription drug charges that employees receive through the clinics, but only 70% of charges incurred by employees who receive care outside the clinics or a separate preferred provider network.

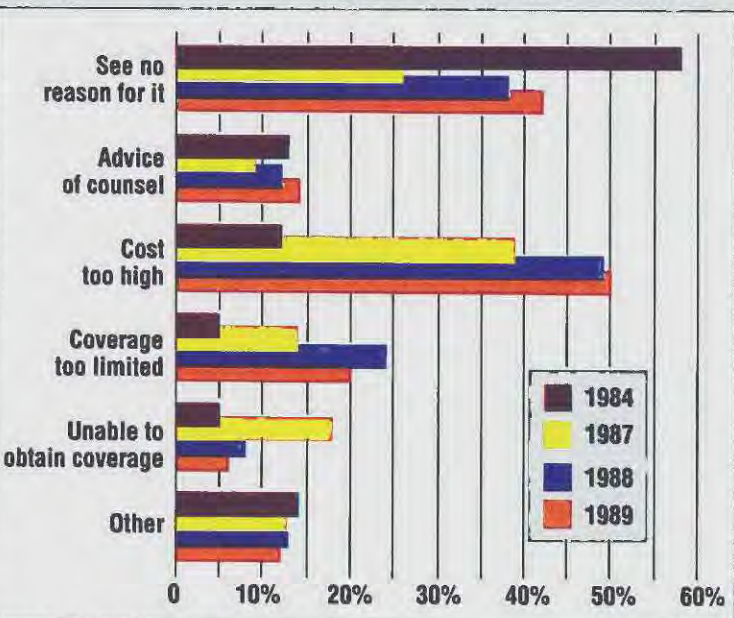
However, the cost of providing medical care at the clinics averages about 20% less than fees charged by outside health care providers, while the cost of prescriptions filled at Edison pharmacies is about 40% less than prescriptions sold by retail outlets.

The clinics and pharmacies save the company about \$4 million annually out of a total health care budget of about \$100 million. These facilities, along with a wide variety of other cost-containment steps, kept Edison's health care expenditures about even last year after

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Going without D&O coverage

In a softening D&O insurance market, a growing percentage of companies without the coverage are not purchasing it by choice.



D&O market soft in '89: Wyatt study

By MARK A. HOFMANN

CHICAGO—The directors and officers liability insurance market continued to shift to a buyer's market in 1989, according to a new study.

A growing number of companies that do not have D&O coverage are not seeking the coverage, rather than reporting trouble finding coverage, says a study by The Wyatt Co., which is based on 1989 data. However, half of those that do not buy D&O insurance still say the coverage is too expensive.

In addition, while companies generally are obtaining higher D&O limits, premiums and deductibles dropped or remained stable for the vast majority of D&O policyholders, according to the survey.

However, the average cost of a D&O claim continues to rise, with the cost of a claim filed in 1989

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High court hears arguments in LTV-PBGC pension dispute
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European windstorms may cost insurers more than \$7 billion
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Chicago health plan probed

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of files contained errors or were missing documents; and some workers who had been off the payroll for five years were listed as eligible for benefits.

Such abuse, the city says, has more than doubled its health care costs to a projected \$239 million in 1990 from \$115 million in 1984.

Private employers pay an average of \$2,700 per-employee annually for health care, but the comparable city figure is \$4,400. City employees are hospitalized more often, have longer terms of stay and pay more per visit than private sector workers, the study found.

More than 1% of city workers are hospitalized annually, compared, for example, to 0.87% of Blue Cross/Blue Shield policyholders, the city said. Average hospital stays for BC/BS policyholders are 6.9 days, 1.5 days less than the city worker average. And the average charge for a city worker's hospital stay is \$8,879, 25.4% more than the \$7,083 BC/BS policyholders average.

"It is clear that immediate action must be taken to reform the entire benefits process," said Mayor Richard M. Daley.

Retiree health bill proposed

WASHINGTON—Employers could make annual tax-deductible contributions to fund up to \$1,500 in annual retiree health care benefits and another \$1,500 in long-term care benefits per current employee under legislation introduced last week by Sen. Robert Packwood, R-Ore.

S. 2129 also would allow employers to transfer—on a tax-free basis—surplus pension plan assets into a special account to pay for retiree health care expenses.

In addition, the measure would allow employers to offer long-term health care coverage in a flexible benefits plan, which is not possible under current tax law.

Trial set for PRMC reinsurers

LOS ANGELES—A California state judge has set a Nov. 1 trial date to determine the scope of about 50 reinsurers' obligations to the defunct Pacific Reinsurance Management Corp. pool.

California Superior Court Judge Kurt J. Lewin also lifted a partial stay of discovery in the case that was entered after six reinsurers commenced arbitration proceedings with PRMC, the defunct reinsurance pooling unit of Mission Insurance Group Inc. The judge set a Sept. 1 deadline for additional discovery.

The stay affected any discovery that could affect the six reinsurers that were in arbitration with PRMC, said Dana Brooks, an attorney with Rubinstein & Perry in Los Angeles, which represents Mission's liquidator.

The six reinsurers that sought arbitration—Ohio Reinsurance Corp., Abeille-Paix Reassurances, Hamburg International Reinsurance Co., Hassneh Insurance Co. of Israel Ltd., Seguros America S.A. and Compagnie Transcontinentale de Reassurance—currently are asking a federal judge to vacate the ruling of the arbitration panel, which concluded that the six reinsurers owe PRMC \$94.5 million (*BI*, Jan. 15; Nov. 6, 1989).

These six reinsurers remain defendants in the broader litigation brought by Mission's liquidator to determine the obligations of PRMC's reinsurers, said Bruce Friedman of Kroll & Tract in New York, an attorney for the reinsurers.

In other action, Judge Lewin denied a motion by another PRMC reinsurer, Royal Belge Societe Anonyme D'Assurance of Brussels, Belgium, to grant summary dismissal of the case.

In addition, Judge Lewin heard arguments, but took no action, on a motion by Mission reinsurer Underwriters Reinsurance Co. of Woodland Hills, Calif., that seeks a ruling that Mission's liquidator has no right to the immediate payment of \$71 million in incurred-but-not-reported claims (*BI*, Jan. 29).

A ruling in the Underwriters Re case is expected in several weeks, said Daniel Lewis, of Washington-based Arnold & Porter, which represents the reinsurer.

Panel OKs reversion proposal

WASHINGTON—Employers would be effectively barred from recovering surplus assets after terminating overfunded defined benefit pension plans under legislation approved last week by the Senate Labor and Human Resources Committee, corporate lobbyists contend.

The bill, proposed by asset-reversion critic Sen. Howard Metzenbaum, D-Ohio, would, in a vaguely worded provision, impose a fiduciary responsibility on employers to determine whether a reversion was in the interest of plan participants.

Employers would be required to determine whether assets in a new replacement plan would be sufficient to provide "comparable future benefits" to all participants.

Before terminating overfunded plans, employers also would have a fiduciary responsibility to provide unspecified cost-of-living adjustments to retirees receiving benefits.

But after meeting their obligations under the proposal, approved by the committee on an 11-5 vote, there would be no excess assets left in a pension plan, consultants say.

Quake damage assessed

LOS ANGELES—The earthquake that rocked Southern California Wednesday caused \$12.7 million in total damage, the state Office of Emergency Services estimates.

That preliminary figure does not include three counties that had not reported damage estimates as of Friday.

According to the agency, 176 businesses and 101 homes were damaged by the quake, which registered 5.5 on the open-ended Richter Scale. By comparison, the Oct. 17 quake that shook Northern California registered 6.7 on the Richter Scale.

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Alaska rules for Insko

Not liable for broke primary insurer

By STACY ADLER

ANCHORAGE, Alaska—The Alaska Supreme Court has joined the ranks of courts that agree an excess insurer does not have to drop down and pay claims when a primary insurer becomes insolvent.

Examining the difference between the size of a primary insurance premium and an excess insurance premium, Alaska's highest court found that the excess insurer did not calculate into its premium the risk of being forced to drop down and provide coverage when a primary insurer became insolvent.

Therefore, "the excess insurer is not required to drop down upon insolvency of the primary insurer, absent policy language to the contrary," the court ruled.

Upon inspection of the language of an excess policy written by Insko Ltd. of Bermuda, the court in this case determined there was no language in the policy that would force the excess insurer to drop down.

The Jan. 26 ruling by the Alaska Supreme Court reflects what has become the majority view of courts nationwide ruling in similar cases, attorneys say.

"The overwhelming majority of courts rule that the excess insurer does not have to drop down when the primary insurer is insolvent," said Sanford Kingsley, an attorney with LeBoeuf, Lamb, Leiby & MacRae in San Francisco.

"Over 40 decisions in courts in 21 states and the Virgin Islands hold that the excess insurer is not obligated to assume an insolvent underlying carrier's indemnity and defense obligations," said Mr. Kingsley, who tracks this type of litigation nationwide.

"Alaska is another state in which the courts have looked at the excess insurer's policy language and the public policy considerations and have determined that the risk of an underlying insurer's insolvency is

not one which is insured against under an umbrella or excess policy," said Mr. Kingsley, who served as co-counsel for Insko in the Alaska litigation.

In addition to the Alaska Supreme Court, the supreme courts of New Jersey, Georgia, South Dakota, Nebraska and Alabama have issued similar rulings, he said.

However, there are some courts that will force an excess insurer to drop down when a primary insurer is insolvent, said Royal Oakes of Barger & Wolen in San Francisco. "There is still a split in the courts."

Currently, courts that do force excess insurers to drop down look at policy language that is either ambiguous or predicates the excess insurer's liability on amounts that are "recoverable or collectible" by the policyholder, according to John Morrison of Altheimer & Gray in Chicago.

For example, state supreme courts in California and Massachusetts have forced an excess insurer to drop down and pay claims against insolvent primary insurers.

However, since most excess policies currently being litigated do not contain this language, a majority of the courts do not force excess insurers to drop down and pay claims when the underlying insurer is insolvent, Mr. Morrison said.

In the Alaska litigation, the Alaska Rural Electric Cooperative Assn. Inc. was attempting to force its excess insurer, Insko, to drop down and pay claims because its primary insurer, Ambassador Insurance Co., had become insolvent. ARECA also has a claim pending with the liquidator of Ambassador, which was declared insolvent by \$40 million to \$45 million in 1984.

ARECA arranges liability coverage for member electric cooperatives in the state.

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BI boosts global coverage

With the rapid changes taking place in political and business climates around the world, today's risk and employee benefits managers cannot afford to ignore events in other countries.

A new, weekly "International" section in *Business Insurance* will consolidate and expand *BI*'s coverage of events and trends around the globe.

Our expanded coverage of international news debuts this week on page 23, with reports from from Australia, England, Ireland and Bermuda.

This new "International" section will draw on the expertise of London-based International Editor Stacy Shapiro and Associate Editor Carolyn Aldred as well as an expanded network of *BI* correspondents in nearly a dozen countries.

Hearings debate federal tort law

By ADRIENNE C. LOCKE

WASHINGTON—A federal product liability reform law would not smooth out all differences among current state laws or aid U.S. manufacturers in competition with foreign firms, some state legislators and a group of judges told a Senate subcommittee.

However, another group of state legislators told the subcommittee that while a federal product liability reform bill, introduced by Sen. Robert Kasten, R-Wis., would not resolve all perceived problems in state product liability laws, it is a step in the right direction.

The hearings before the Senate Consumer Subcommittee last month focused on how effectively the current product liability system compensates victims and deters the sale and manufacture of unsafe products, as well as on whether a federal product liability law would improve the civil justice system.

Sen. Kasten introduced S. 1400

last July, shortly after Rep. Tom Luken, D-Ohio, introduced similar legislation in the House (*BI*, July 31, 1989; June 26, 1989).

At the Feb. 22 hearing, the notion that a federal law could eliminate differences among state product liability statutes was criticized by Michael Box, chairman of the committee on law and justice of the Washington, D.C.-based National Conference of State Legislatures.

State courts, he argued, could still interpret a single federal law very differently.

"Federal standards, however well-crafted, will be applied in many different contexts and they will inevitably be construed and applied differently, not only by the state supreme courts, but by the 12 federal Circuit Courts of Appeal," agreed Vincent L. McKusick, chief justice of the Maine Supreme Court. He spoke on behalf of the Conference of Chief Justices.

But another group of state legislators at the hearing disagreed.

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✓ We strongly urge the Senate Commerce Committee and the full Senate to quickly pass federal product liability reform legislation, says this week's editorial. **PAGE 8**

✓ Environmental legislation is being enacted throughout the European Community reports Douglas N. Smith of Johnson & Higgins in International Issues. **PAGE 21**

✓ An Australian mining company has settled a coverage dispute with four insurers over losses it suffered during an insurrection on the South Pacific island of Bougainville. **PAGE 23**

✓ A new payroll tax on international companies operating in Bermuda could increase captive insurance management fees. **PAGE 23**

✓ Creating a Canadian-style national health care system in the United States would sock employers or employees with at least \$339 billion in additional taxes, according to a recent study. **PAGE 28**

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Vol. 24, No. 10—*Business Insurance* (ISSN 0007-6864) is published weekly by Crain Communications Inc., 740 N. Rush St., Chicago, Ill. 60611-2590. Second-class postage is paid at Chicago, Ill., and at additional mailing offices. Postmaster: Send address changes to *Business Insurance*, Circulation Department, 965 E. Jefferson Ave., Detroit, Mich. 48207; 313-446-1611. Copyright 1990 by Crain Communications Inc.

Regulators praise, blast Dingell committee report

By DOUGLAS McLEOD

WASHINGTON—A congressional report blasting failures in state insurance regulation is drawing qualified praise from some regulators for what they call "constructive criticism" of a flawed system.

But other regulators, stung by the report's critical tone, are attacking its conclusions as unfair.

Most regulators agree, though, that the report by the House Oversight and Investigations Subcommittee sounds a warning to state officials to improve solvency oversight or face further disastrous insurance company failures and possible federal intervention.

"The report represents a warning shot across the bow of state insurance regulators," observed Earl R. Pomeroy, North Dakota insurance commissioner and president of the National Assn. of Insurance Commissioners.

"If we intend to keep regulation at the state level, we need to act quickly to enhance the level of solvency regulation," he said.

The report—"Failed Promises: Insurance Company Insolvencies"—was released late last month following more than a year of hearings and investigation into several insurer insolvencies (*BI*, Feb. 26). These included the \$1.5 billion failure of Mission Insurance Co., the \$2 billion failure of Transit Casualty Co., the \$300 million collapse of Integrity Insurance Co. and the smaller failure of Carlos I. Miro's Anglo-American Insurance Co. of Louisiana (*BI*, April 24, 1989; April 17, 1989; April 10, 1989; Sept. 19, 1988).

The current state regulatory sys-

tem, the report concluded, is "seriously deficient" in its ability to prevent such insurer collapses.

"The parallels between the present situation in the insurance industry and the early stages of the savings and loan debacle are both obvious and deeply disturbing," warned Subcommittee Chairman John D. Dingell, D-Mich., in an introduction to the report.

The subcommittee found several similarities in the causes of these



Rep. Dingell

insolvencies, including reckless and incompetent management, heavy reliance on poorly supervised managing general agents, rapid expansion into unfamiliar product lines, excessive underpricing and underreserving, overreliance on weak reinsurers and outright fraud.

Although not advocating federal regulation or specific changes in state regulation of insurance, the report called for further study of several problem areas, including:

- Inadequate insurance com-

pany licensing procedures that—among other things—allow the formation of undercapitalized insurers and fail to prevent executives responsible for previous insolvencies from starting new companies.

- Inadequate regulation of agents, brokers and reinsurance intermediaries.

- Deficient regulatory monitoring of insurer operations, including failure to detect false or misleading financial statements.

- Inadequate monitoring of reinsurance programs.

- Failure to impose adequate civil and criminal sanctions against those responsible for insolvencies.

- Failure of insurance company liquidators to pursue evidence of fraud by the defunct insurer's executives for fear of jeopardizing reinsurance collections, a problem the report described as an inherent conflict in the liquidator's duties.

- Inadequate funding of state insurance departments.

Some deficiencies, the report noted, stem from the states' failure to follow model laws the NAIC has recommended.

The subcommittee has scheduled hearings for March 12 and March 19 to discuss issues raised in the report. Among those scheduled to testify are John J. Byrne, chairman of Fund American Cos. Inc., the parent of Fireman's Fund Insurance Co., and representatives of the National Assn. of Insurance Brokers and the Reinsurance Assn. of America.

State regulators and other trade group officials say they also hope to testify at future hearings.

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Justices question LTV's motives in PBGC dispute

By JERRY GEISEL

WASHINGTON—The chief justice of the United States asked LTV Corp.'s attorney last week whether the company's new pension program is really part of an effort to shift a huge pension debt to a federal agency.

During oral arguments in a case that centers on LTV's termination of pension plans with more than \$2 billion in unfunded liabilities, Chief Justice William Rehnquist questioned whether LTV is attempting to "fob-off" those liabilities onto the Pension Benefit Guaranty Corp.

Associate Justice Antonin Scalia also appeared skeptical about whether the PBGC should have to pick up LTV pension liabilities while LTV offers a new pension program.

"It would seem very strange indeed for the federal government to allow your company to compete with others... and have taxpayers fund it," Justice Scalia said.

The justices made their remarks in a case with major implications for the PBGC; employers with defined benefit pension plans, which support the PBGC through mandatory insurance premiums; and LTV, a Dallas-based aerospace and steel manufacturer that has been operating protected from creditors under Chapter 11 of the U.S. Bankruptcy Act for more than three years.

At issue is whether the PBGC has the authority to restore to a company a terminated pension program after the company sets up new "follow-on" pension plans.

In LTV's case, the PBGC in January 1987 terminated three LTV pension plans, which have more than \$2 billion in unfunded liabilities and about 100,000 participants, after LTV told the agency it no longer could afford to fund the plans.

However, in September 1987, the PBGC—in an unprecedented action—told LTV that it was returning the plans to the company. The PBGC moved to restore the plans after LTV, as part of a collective bargaining agreement with the United Steel Workers Union, established new follow-on plans to provide union members certain non-PBGC guaranteed benefits that were lost when the old plans were terminated.

The PBGC, charging that LTV was abusing the PBGC insurance program, argued that the new plans were, in effect, an illegal continuation of the old terminated plans, except that the PBGC, rather than LTV, would be paying the bulk of benefits to vested workers and retirees.

But federal courts have ruled against the PBGC. In June 1988, U.S. District Court Judge Robert Sweet in New York said the

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Satellite loss won't trigger big rate hikes for owners

By STACY SHAPIRO

LONDON—The destruction of two satellites insured for about \$95 million each is expected to halt any decrease in satellite launch insurance rates.

However, abundant capacity will stop rates from skyrocketing following last month's explosion of an Ariane rocket two minutes after launch (*BI*, Feb. 26).

Rates will remain about the level they are at now—between 16.5% and 20% of a satellite's insured value—brokers and underwriters contend.

Underwriters hope that the launch rates will hover in the 20% range, though they do not expect further increases.

"Market rates have been trending below 20%, and this loss will stop that and kick them back up to 20%," said an American underwriter.

"We should expect some reaction" following the Ariane explosion, said Benito Pagnanelli, director of Assicurazioni Generali S.p.A. in Trieste, Italy, one of the world's leading space insurance underwriters.

Mr. Pagnanelli hopes rates will increase or that "at least there will be no more reductions" following the Ariane loss.

But brokers believe satellite launch rates will remain fairly steady.

"We do not expect dramatic changes in the state of the market," said Mohammed Dahbi, head of the aviation and aerospace division of insurance broker Faugere & Jutheau S.A. in Paris. "This year rates were quoted at 16.5% to 17.5%, and we hope they will stay at that level."

"There has been a general softening in launch

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Pension asset control proposal

Business rips Visclosky bill

By ADRIENNE C. LOCKE

WASHINGTON—Legislation forcing employers to share control of pension assets with employees would erode employers' control over plans without limiting their liabilities, critics of the bill told a House subcommittee last week.

In addition, pension plans' investment income ultimately would suffer if employees were given joint control of plan assets, contended a congresswoman and employer representatives.

But labor union officials and other supporters of the bill, sponsored by Rep. Pete Visclosky, D-Ind., cited the "eroded security" of some plans and said joint oversight by employers and employees would dampen employers' enthusiasm for investing plan assets in risky ventures, including leveraged buyouts.

The House Subcommittee on Labor-Management Relations is holding hearings on the control of defined benefit and defined contribution pension plan assets and on the Visclosky bill, H.R. 2664.

Rep. Marge Roukema, R-N.J., widely praised by business groups for her role in defeating the proposal last year (*BI*, Oct. 2, 1989), urged committee members to remember that corporations are at risk if pension plan funds perform poorly.

"The question is who's going to guarantee who gets that money?" said Rep. Roukema, who has called

the Visclosky bill "misguided" and "unworkable."

Responsibility would continue to "rest with the employer," testified Robert C. Winters, chairman and chief executive of Newark, N.J.-based Prudential Life Insurance Co. of America, who heads a welfare and pension task force of the Business Roundtable, a group of large company chief executives.

"So long as the plan is in effect, the employer is responsible for providing those benefits," and employers must refund pension plans left "underfunded" by poor investments, Mr. Winters said.

In addition, critics of the Visclosky bill praised the performance of private pension plans and contended there is "no proof" that pension boards need employee policing.

Rep. Harris Farwell, R-Ill., pointed to the current level of pension fund assets and asked, "How can you do better than that?"

The Pension Benefit Guaranty Corp. estimates that private pension plans have \$1.7 trillion in assets.

In opposing the Visclosky bill, employer lobbyists also emphasized problems they say they have with joint trustee boards for defined contribution plans, which are more common than joint trustee boards for defined benefit plans.

For example, Chicago-based Inland Steel Industries Inc.'s union

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The Ariane rocket carrying two satellites exploded last month two minutes after it was launched.

New European storm boosts insured losses

By CAROLYN ALDRED

LONDON—European insurers expect to pay more than \$7 billion in storm-related losses suffered in the first two months of 1990 alone after yet another killer windstorm pounded huge stretches of Europe last week.

The losses are squeezing the catastrophe retrocessional market virtually dry, leaving some underwriters struggling to reinstate their reinsurance protection.

As a result, some underwriters will be "running bare"—without catastrophe reinsurance—for the rest of the year.

But while the retrocessional market is in disarray, the 1990 storm losses still are not expected to force primary insurance rates upward this year.

The windstorms last week swept across the United Kingdom, France, The Netherlands, Belgium, Denmark, East and West Germany, Italy and Switzerland. More than 40 people died in the winds, which gusted up to 100

mph in some areas.

In addition, huge waves of sea water—whipped up by high spring tides and the strong winds—flooded towns and villages in the United Kingdom, France and Denmark as flood barriers crumbled.

The Assn. of British Insurers estimates that the losses so far this year in the United Kingdom alone will cost insurers about 2.5 billion pounds (\$4.22 billion), or about the same amount as insured losses caused last fall in the United States by Hurricane Hugo (see related story).

"Insurance companies have been inundated with claims and it is likely that as many as 2 million storm and flood claims will be paid," said a statement by the ABI.

Meanwhile, in France storm-related insurance claims so far this year total at least 6 billion French francs (\$1.1 billion), according to a spokesman for the Centre du Documentation et d'Information sur l'Assurance.

In West Germany, the Assn. of Non-Life

Insurers in Cologne estimates that total damage in West Germany so far will exceed 3 billion deutsche marks (\$1.76 billion).

In the Netherlands, the Assn. of Dutch Insurers estimates that insured damage from a Jan. 25 storm will total 600 million to 1 billion Dutch guilders (\$315 million to \$526 million).

The Netherlands was not hit as hard by last week's storm, with insurers classifying it as an "average" spring storm. Because of the direction of the wind, last week's storm damage was confined primarily to the nation's dunes and dikes, which are not insured.

In Belgium, the Belgian Professional Union of Insurance Companies, or UFEA, says that storms in January and early February alone caused 10 billion Belgian francs (\$285 million) of insured residential damage and 2 billion Belgian francs (\$57 million) of insured commercial losses. Estimates of damage from last week's storms were not available.

However, these totals only include claims filed under general fire insurance policies, said a UFEA spokesman. Additional losses are expected from auto and other types of coverage.

Belgian insurers' commercial losses may be lower than expected because many Belgian companies are insured by London underwriters under a 1976 law that allows foreign insurers to cover large Belgian industrial risks.

The series of devastating storms is severely straining an already greatly contracted catastrophe reinsurance market to the point of despair, some sources say.

Catastrophe reinsurers collect about \$1.25 billion in annual premiums worldwide but have been hit with several times that amount in losses in the past six months, one underwriter estimated. These losses include claims from the European storms and the major U.S. losses in 1989: the California

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'89 disasters cost insurers \$7.64 billion

RAHWAY, N.J.—Natural catastrophes caused a record \$7.64 billion of insured property damage in the United States and its possessions last year, according to insurance industry statistics.

The record insured catastrophe damages—which in large part are attributable to a hurricane that struck the Southeast and an earthquake that shook Northern California within weeks of each other—are more than 2½ times greater than the previous record of \$2.82 billion of insured catastrophe damage in 1985, says the Property Claims Services division of the New York-based American Insurance Services Group Inc.

The Rahway, N.J.-based Property Claims Services division defines a catastrophe as an event that results in at least \$5 million of insured property damage.

Last year was marked by the two costliest catastrophes recorded since the AISG's predecessor began keeping records in 1949: Hurricane Hugo and the California earthquake.

Insured damage estimates for Hurricane Hugo, which struck Puerto Rico and the U.S. Virgin Islands Sept. 17-18 and portions of Georgia, South Carolina, North Carolina and Virginia Sept. 21-22 were revised upward last week to nearly \$4.2 billion from an original estimate of \$3.98 billion (*BI*, Sept. 25, 1989; Oct. 2, 1989).

The hurricane hit South Carolina hardest, with damage there totaling an estimated \$2.3 billion.

Only four weeks after Hugo struck, an earthquake measuring 6.9 on the open-ended Richter Scale, rocked the San Francisco Bay area (*BI*, Oct. 30, 1989; Oct. 23, 1989). The Oct. 17 earthquake caused an estimated \$960 million of insured damage, according to the Property Claims Services division.

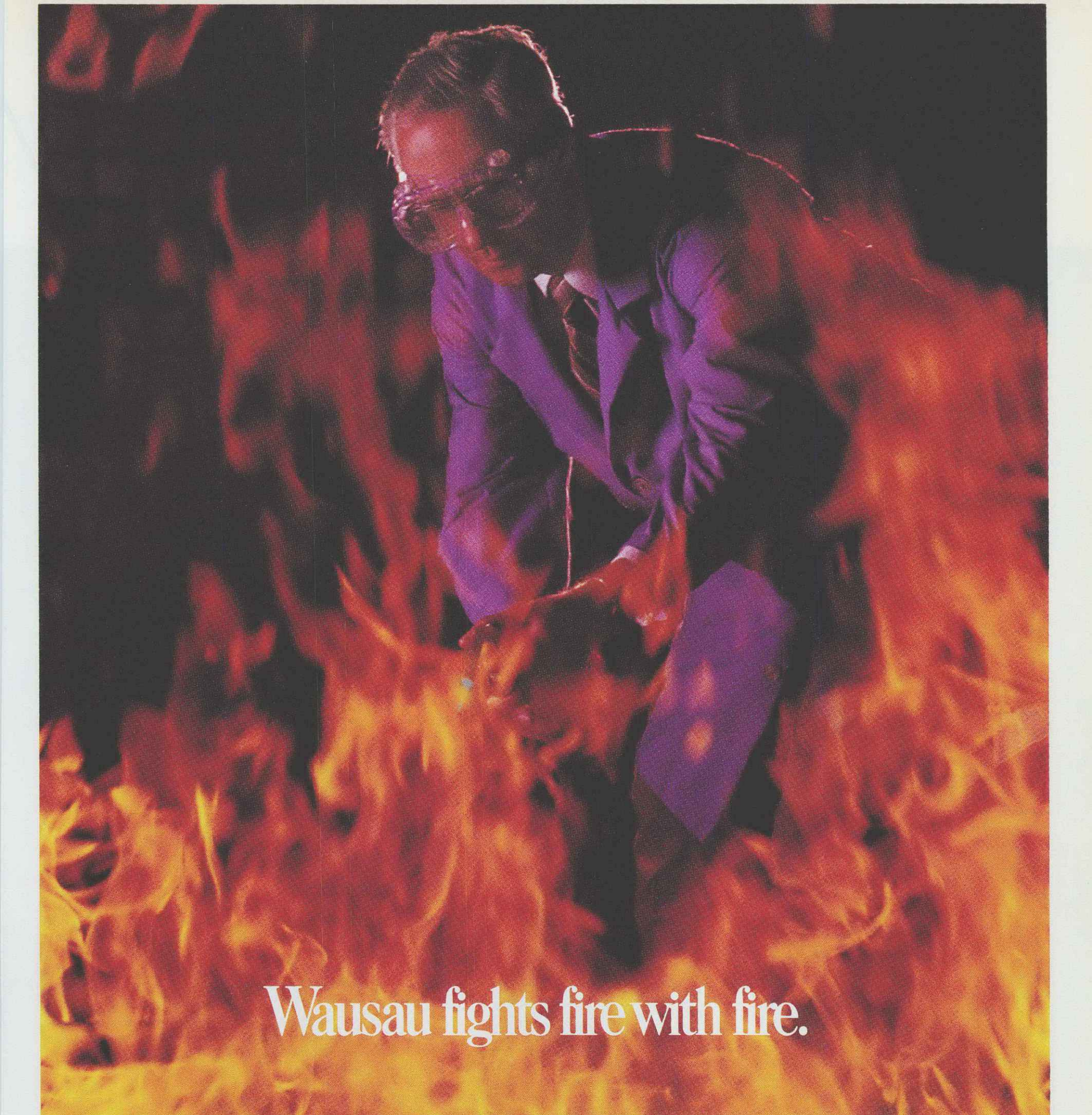
Each event would have broken the previous worst catastrophe record: the December 1983 arctic freeze that blasted most of the U.S. mainland east of the Rocky Mountains, causing \$880 million of insured damage.

Adding to record insured damage last year was extremely cold weather—reminiscent of the 1983 deep freeze—that gripped much of the nation in December, causing an estimated \$500 million of insured damage.

The Property Claims Services division already has declared three catastrophes in 1990, amounting to \$205 million of insured damages.

Most recently, wind, snow and freezing temperatures hit California Feb. 16-18, causing an estimated \$20 million of insured damage.

—By Mark A. Hofmann



Wausau fights fire with fire.

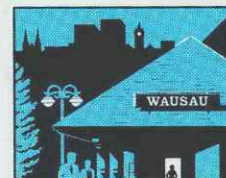
At Wausau's Fire Protection Laboratory, we've started and put out thousands of fires. That's how we teach our loss control specialists, policyholders, even fire departments about the causes of fire and the best ways to extinguish them.

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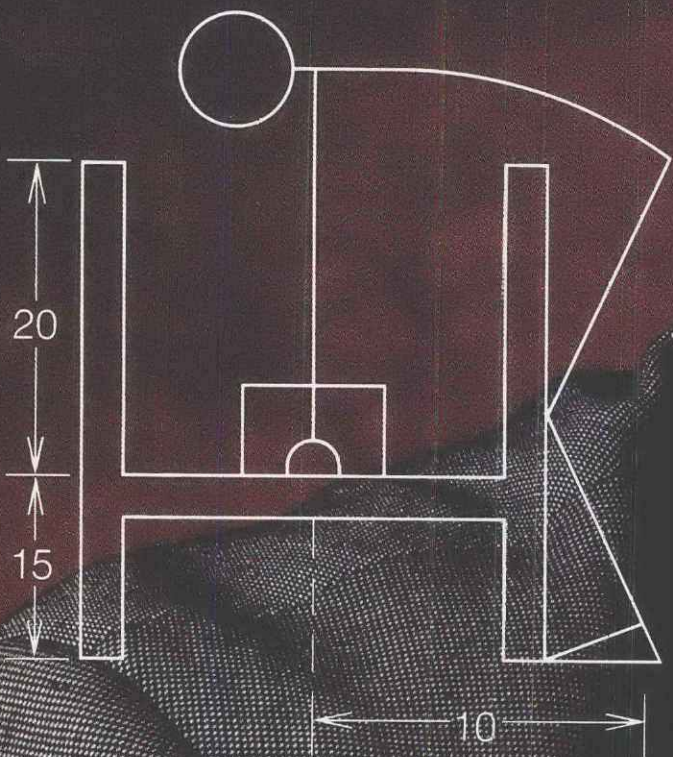
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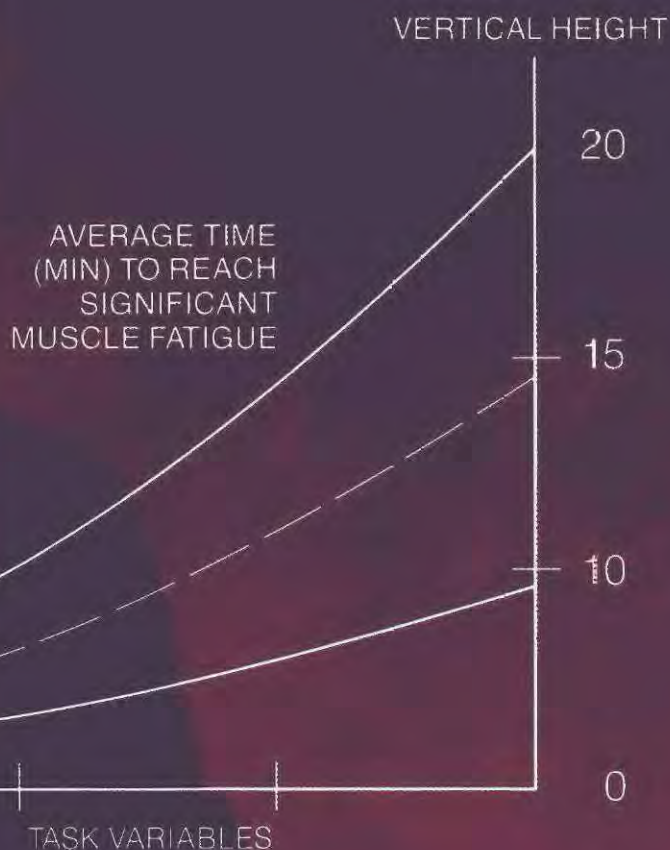
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Opinions

Act quickly on liability reform

WE STRONGLY URGE the Senate Commerce Committee and the full Senate to pass—quickly—federal product liability reform legislation.

By now manufacturers—understandably so—have become very impatient at the snail's pace with which Congress has considered various product liability reform proposals.

In fact, it has been more than eight years since business groups began their push for a uniform federal product liability law to replace varying state statutes.

After eight years of lobbying pressure and dozens of hearings, legislators still are not poised for action.

We can understand why legislators, at least initially, have been cautious about creating a federal product liability law.

Crafting legislation to balance the rights of manufacturers to a fair and predictable set of liability rules with the rights of consumers to access to the courts and sufficient compensation when injured by defective products is no easy task.

It is only reasonable to expect legislators to move slowly until they find that balance.

Certainly, in hindsight, it is fair to say that some of the earliest product liability reform bills lacked that balance and took away too much from consumers and gave too much to manufacturers.

That argument no longer can be made.

The latest product liability reform bill, S. 1400, introduced by Sen. Robert Kasten, R-Wis., is not by any reasonable standard a manufacturer's relief bill (see story, page 2).

Indeed, co-sponsor Sen. John D. Rockefeller IV, D-W.Va., describes the bill as "fair and balanced" and one that does not limit the rights of injured parties to receive fair compensation.

The reforms contained in the measure are slender, but vital to restoring balance to the legal system.

For example, by eliminating the doctrine of joint and several liability for non-economic damages, the measure would assure that manufacturers in a multiple-party suit only would be responsible for pain and suffering damages in proportion to their own negligence and not the wrong-doing of anyone else. How could any reasonable person argue against that?

The measure also contains such reasonable reforms



as permitting punitive damage awards only if there is clear and convincing evidence of negligence by the manufacturer or product seller and gives a defendant the opportunity to request that the amount of punitive damages be determined separately at a second trial.

Other reforms would protect manufacturers from liability in suits involving capital goods products that were very old—more than 25 years old—and would bar punitive damage awards for injuries involving drugs and medical devices that were approved by the Federal Drug Administration or aircraft that were certified by the Federal Aviation Administration.

Finally, the legislation would provide certain incentives to encourage parties to settle before a suit goes to trial. That is in everyone's interest.

Given how little time is left in the 101st congressional session, it is unreasonable to expect that Congress could complete action on the Kasten bill this year.

But passage of the measure by the Commerce Committee and then the Senate would prove the Senate's support for product liability reform and put pressure on the House in the next session to finally act on product liability reform legislation.

Letters

Change benefits with AIDS bias

The Insurance and Health Access Committee of ACT UP/NY (the AIDS Coalition to Unleash Power) commends your Dec. 4, 1989, editorial condemning insurance discrimination against people with AIDS.

Health insurance is the means by which most people with AIDS gain access to quality health care. Many employees consider their company's health insurance plan to be the most important part of their benefit package, but insurance that does not provide coverage for HIV-related illness is no "benefit."

Our committee has monitored the recent attempts of several companies to limit coverage for AIDS.

In 1988, for example, Circle K Corp. attempted to exclude health insurance cov-

erage for illnesses, primarily among them AIDS, that it considered to have been caused by "lifestyle" choices. Public outcry and negative publicity forced the company to rescind its exclusion policy (*BI*, Aug. 15, 1988).

In another recent case in Texas, H&H Music Co. lowered its health coverage's lifetime reimbursement for an individual's AIDS claims to \$5,000 from \$1 million. The company added the restrictive clause to its self-insured program after an employee submitted claims for an AIDS-related illness. The matter currently is in litigation (*BI*, Nov. 27, 1989).

Both companies attempted to limit coverage by claiming that, in some cases, AIDS is contracted voluntarily. No one acquires HIV disease voluntarily.

Most recently, Galaxy Carpet Mill Inc. in Chatsworth, Ga., placed a cap of \$10,000 on payments for HIV-related claims, a limit considerably below the cap for other major illnesses (*BI*, Feb. 19). The self-insured policy did make one crucial exception: The restriction did not apply to those people who contracted the disease "involuntarily." But, in response to protests, the company has dropped the HIV-related limitation.

Insurance discrimination against people with HIV disease and people perceived to be at risk for HIV disease must stop.

Insurance and Health Access Committee

AIDS Coalition to Unleash Power
New York

Judgment of Canada is misinformed

To the editor: In a Feb. 12 letter to the editor, Mark A. Mitchell says that during an apparently brief vacation in Montreal he learns enough about Canadian citizens to judge us as "too complacent" (*BI*, Feb. 12). How dare he!

I have known many U.S. citizens over my 68 years and have found few who I have not instantly liked. However, there are many adjectives that could describe the differences between Canadian and U.S. societies, and "too complacent" is correct only in a small way. Just observe some of our current debates and the effects of "gray power" up here.

I would far rather be a citizen of Canada than of the United States for many reasons. In the United States I would have to control my allergic reaction to sneeze lest someone 10 feet away decide to sue me for infecting him with a cold and demand punitive damages because I failed to cover my mouth and nose with a handkerchief.

Our society is far from perfect, but I know from experience the tremendous value of our health care system, which has always treated my wife and our three children with efficiency and great care. I suggest that Mr. Mitchell inform himself fully before judging.

Gordon Hird
Mississauga, Ontario

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Published weekly at 740 Rush St., Chicago, Ill. 60611, Telex 6871241, Fax 312/280-3174, Cable CRAINCOM. Offices: 220 E. 42nd St., New York, N.Y. 10017, Telex 640207, Fax 212/210-0704, CRAIN COM NYK; 1 Northpark, East Suite 114, 8950 N. Central Expressway, Dallas, Texas, 75231, Fax 214/696-1936; Suite 814, National Press Building, Washington, D.C. 20045, Fax 202/638-3155; 6404 Wilshire Blvd., Los Angeles, Calif. 90048, Fax 213/655-8157; 20-22 Bedford Row, London WC1R 4EB, England, Fax 01/430-2176. \$2.00 a copy. \$75 a year in U.S. Canada and all other foreign add \$32 for surface mail. Europe and Middle East only add \$88 for air delivery. First-class mail to U.S., add \$77; to Canada add \$87. Bermuda only, \$157 per year expedited delivery. WILLIAM STRONG, vp-circulation. SHEILA GORMLEY, circulation manager. LISA RIVERS, fulfillment director. Four weeks' notice required for change of address. Send subscription correspondence to Circulation Department, Business Insurance, 965 E. Jefferson Ave., Detroit, Mich., 48207, or phone 800-992-9970 or 313-446-1611, Fax 313/446-1650. Microfilm copies are available from University Microfilms, 300 Zeeb Road, Ann Arbor, Mich. 48103. Microfiche copies available: Bell & Howell, Micro Photo Division, Old Mansfield Road, Wooster, Ohio 44691. Portions of the editorial content of this issue are available for reprint or reproduction in other media. For information and rates to reproduce in general circulation media, contact: ART MERTZ, The Crain Syndicate, 740 Rush St., Chicago, Ill. 60611, 312-649-5303. For reprints or reprint permission contact: Reprint Department, Business Insurance, 220 E. 42nd St., New York, N.Y. 10017, 212-210-0229, Fax 212/210-0704.

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Why are CEOs afraid to bite?

Although managed health care offers real potential to slow dangerously ballooning costs, the very idea is enough to make even the boldest CEO a little uneasy. And for good reason.

Change, especially one of this magnitude, can be unsettling. Imagine, if you will, asking employees to switch to a new doctor. (Imagine asking your family.)

Setting up a managed care system, however, can be less traumatic than you may think.

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Ocean Spray pact includes cost shifting

By MICHAEL SCHACHNER

Benefit beat

Union employees at Ocean Spray Cranberry Inc.'s Middleboro, Mass., processing plant will soon pay higher monthly contributions for health care benefits based on the type of coverage and the level of deductibles they choose under the company's self-insured plan.

In addition, a new contract gives workers the option of coverage through a health maintenance organization.

The three-year pact ratified Jan. 25 ended a 17-day strike by 315 union members.

Full-time Teamsters will also receive wage increases in each year of the contract.

The strike began when Ocean Spray proposed raising monthly employee contributions for health care

benefits.

Union members ratified the contract because they could not afford to remain on strike, according to David Craig, business manager with Teamsters Local 653 in Brockton, Mass.

Under the contract, employees will continue to make monthly contributions equal to 10% of the total cost of the health care program through March 31, said Mr. Craig. The March contribution will be \$19 for workers with individual coverage and \$47.90 for those opting for family coverage, he said.

Under the expired contract, workers with individual coverage paid \$15.83 a month, compared with

\$38.25 for workers with family coverage, he said.

Deductibles of \$50 for individuals and \$100 for family coverage will also continue through March.

Ocean Spray pays all costs above the deductibles.

However, beginning April 1, individuals will have to contribute 4% of one week's gross earnings per month for health care, up to a monthly maximum of \$167.

Employees with full family coverage will pay 5% of one week's gross earnings per month, up to a maximum of \$208.

In addition, at some point before Jan. 1, 1991, the current \$50 individual and \$100 family deductibles

will be replaced by a range of higher deductibles. An employee's premium contribution will vary according to the deductible levels he or she selects.

Under one plan option, employees with individual coverage will pay a \$100 annual deductible and those with family coverage will pay a \$300 annual deductible. These employees will contribute 1% of weekly wages per month for individual coverage and 2% for family coverage under this option, Mr. Craig said.

Under another plan option, workers can further trim their contributions by choosing a \$500 annual deductible for individual coverage and a \$1,500 deductible for family coverage. Monthly contributions will be 0.25% of one week's earnings for workers with individual coverage and 0.75% for workers with family

coverage.

Ocean Spray will continue to pay all health care costs above the deductibles.

While the Teamsters ratified the contract, Mr. Craig criticized its provisions.

"What the company is doing is forcing employees to gamble, and you can't play around with children's lives," Mr. Craig said. "Having some corporate executive earning \$500,000 a year pay a couple hundred dollars per month for health care is okay, but these people can't really afford this. But, they have no choice."

Ocean Spray would not comment on the changes in detail.

It is a "good contract," according to Jim Lange, eastern division manufacturing manager. "There are no losers. With this contract, we are all winners. We are a team again."

Hartford, Conn.-based Aetna Life Insurance Co. administers Ocean Spray's self-insured health care program.

The contract also calls for the company to offer health care coverage through a local HMO before Jan. 1, 1991. Ocean Spray late last week had not yet contracted with an HMO.

Employees who enroll in the HMO will pay no deductibles, and the monthly contributions will be equal to 1.5% of one week's gross earnings for individual coverage and 3% of one week's gross earnings for family coverage.

New dental plan

Wal-Mart Stores Inc., the nation's third-largest retailer, is now offering dental care benefits to the 440,000 employees of four of its retailing subsidiaries and their dependents.

The new self-insured plan, which is administered by Delta Dental Plan of Arkansas, marks the first time the Bentonville, Ark.-based company has offered dental benefits to employees of any of its stores and distribution centers, according to Jerry Holcombe, vp of Delta Dental Plan of California in Oakland, Calif.

The dental plan, which became effective Jan. 1, extends coverage to employees and their dependents at 1,325 Sam's Wholesale, Hypermart, Wal-Mart Shoe and Wal-Mart Photo Lab outlets in 25 states.

Under the plan, annual deductibles are \$50 for individual coverage; \$100 for coverage for an employee and a dependent; and \$150 for family coverage. The deductible applies to all care except preventive, diagnostic and orthodontic work, which are exempt from the deductibles, according to Mr. Holcombe.

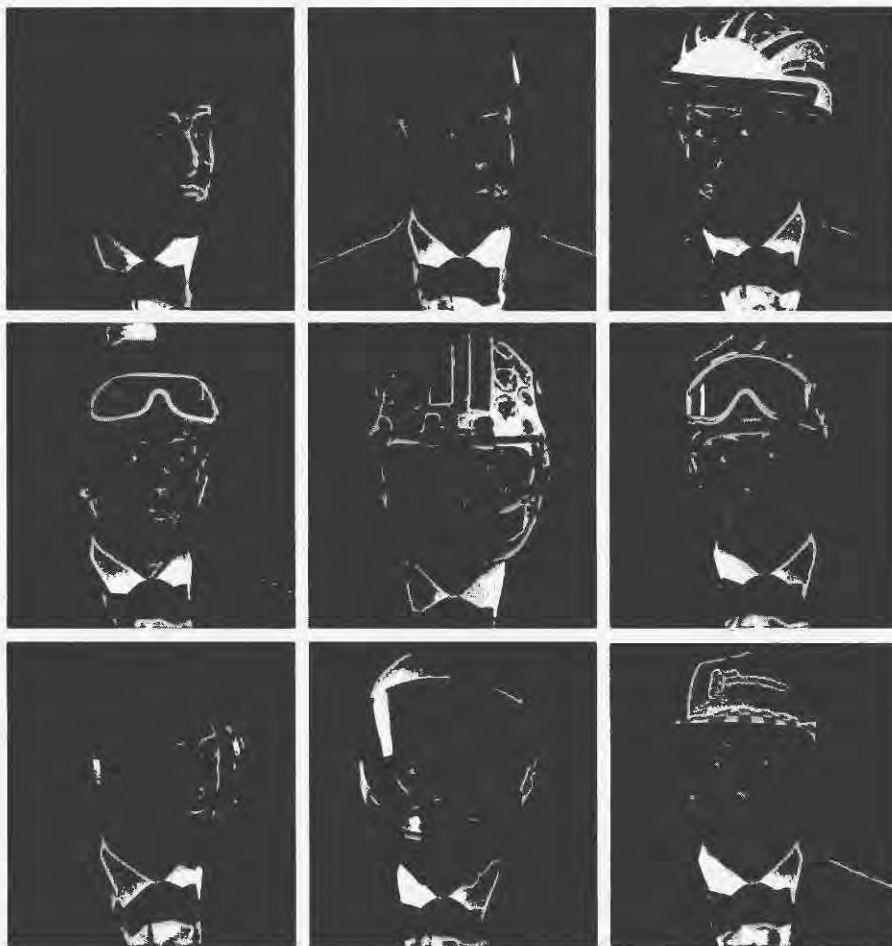
The plan pays 80% of all costs—including charges for preventive and diagnostic care—up to \$750 per person annually. In addition, the plan also pays 80% of orthodontic charges, up to \$750 annually.

The program allows employees to seek dental care from any of Delta's 106,000 participating dentists nationwide or through a dentist of their choice, Mr. Holcombe explained. However, employees often receive higher reimbursement if they seek coverage through a Delta dentist, he said.

"Employees in the Delta plan pay the same deductibles and receive the same benefits," Mr. Holcombe said. "However, care is reimbursed on a reasonable and customary fee schedule if they don't see a Delta dentist, which in many cases leaves employees paying more than 20% of their charges if the dentist's fee exceeded the reasonable and customary schedule, he explained.

Employees who enrolled in the Delta plan are required to remain in the program for two years, while employees who chose not to participate in the program during its original enrollment period must wait until Jan. 1, 1992, before they can participate, Mr. Holcombe said.

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Hetzler named president of United of Omaha

John W. Weekly has been named to replace **William J. Hetzler** as president and chief operating officer of United of Omaha Life Insurance Co. effective March 31.

Mr. Weekly will remain president and chief operating officer of parent Mutual of Omaha Insurance Co. of Omaha, Neb.

Mr. Hetzler, who is retiring, had been president of United of Omaha since 1987 and had been with the company for 42 years.

Other insurer changes:

Ray M. Perisho named president and chief operating officer of Union Fidelity Life Insurance Co., an Aon Corp. subsidiary in Trevoise, Pa. Mr. Perisho had been senior vp and chief financial officer for Connecticut Mutual Life Insurance Co. of Hartford, Conn.

Joseph K. Saad elected senior vp in charge of specialty claims for Transamerica Insurance Co. in Woodland Hills, Calif.

Richard Marsh named vp in the structured finance group of AMBAC Indemnity Corp., a municipal bond insurer in New York.

Robert A. Kerr promoted to senior vp-underwriting from vp at General Accident Insurance Co. of America in Philadelphia.

Comings & goings: industry

Fremont Compensation Insurance Co., a workers compensation subsidiary of Fremont General Corp., announced these promotions: **Jerry B. Katz**, **Steven K. Mayberry** and **Frank Hernandez** to senior vps; **Ronald F. Herzig** and **Brian O'Hara** to senior vp-regional managers; and **Randall L. Mark** to vp.

Robert E. Bean named vp-manager of the Boston operations of Allendale Mutual Insurance Co.

Michael F. Cook named senior vp of the new managed care division at Blue Cross & Blue Shield of New Hampshire. He had been senior vp of external operations.

D. Mark Weinberg promoted to executive vp of individual, small group and government services, and **Ronald Williams** promoted to executive vp of the health services and products group at Blue Cross of California.

Robert J. Glettler appointed regional vp of marketing and underwriting in Grand Rapids, Mich., for Calvert Insurance Co., a unit of Willis Faber P.L.C.

Ralph J. Duecker appointed

vp-property claims and **Alfred Shea** appointed vp-loss control at Atlantic Mutual Insurance Co. of New York.

Pamela V. Riccio promoted to vp-operations at Insko/Dico Group, a surety bond insurer unit of Dico National Corp. in Anaheim, Calif.

Agent/Broker

James B. Wiertelak named senior vp and director of finance and **Donald K. Morford** named senior executive vp at Sedgwick James Inc. in New York.

David A. North joined Johnson & Higgins as a vp for self-insurance operations in Chicago.

Robert A. Wasserman appointed senior vp and **Barbara Friedman Strauss** appointed vp with Owens Group, an agency in Englewood Cliffs, N.J.

Rosemary DeCamp named vp of the hospitality division—which places liquor liability coverage in New York and Pennsylvania—at Rhulen Agency Inc., a Markel Services Inc. unit in Monticello, N.Y.

Raymond S. Sheldon named senior vp in the Seattle risk management department of Marsh & McLennan Inc.

Rod Skrypek named vp at Lee F. Murphy Inc. in St. Paul, Minn.

Frederic R. Holbrook appointed vp at Andreini & Co. in San Mateo, Calif.

James P. Smith appointed vp of William Gallagher Associates in Boston.

Henry F.G. Wey appointed senior vp of Roanoke Insurance Agency Inc., a Roanoke Agency Inc. subsidiary in Schaumburg, Ill.

John P. Folsom elected president and chief executive officer of Mann & Powell Insurance Brokers Inc. in Tacoma, Wash.

Thomas J. Drag named director of the global account services unit of Alexander & Alexander Services Inc. in New York. Mr. Drag had been a senior vp.

Fred Seeley named managing vp of the Hartford, Conn., office of Alexander & Alexander Inc.

Excess/surplus lines

Patricia A. Myers named vp of the lawyers professional underwriting department of Shand Morahan & Co. Inc. of Evanston,

Ill. **Hedda Ritter** named vp in marketing services and new product development with Shand Morahan.

Raymond A. Johnson joined J.H. Blades & Co. Inc., a wholesaler in Houston as vp.

David Campbell named vp-surety division at Frontier Insurance Group Inc. of Monticello, N.Y.

Ron Bertrand appointed regional vp and manager of Continental Excess & Select, the specialty casualty underwriting unit of Continental Corp. in New York.

Other suppliers

Daniel A. Byrne elected vp of Byrne, Byrne & Co. of Chicago.

James E. Dunn Jr. joined Hazlehurst & Associates Inc. of Atlanta as principal and managing consultant.

LeRoy A. Loseke joined consultants L.E. Ziminisky & Associates Inc. of Irvine, Calif., as vp.

Clark J. Yaggy joined Martin E. Segal Co. as vp-Southeastern division in Atlanta.

David J. O'Brien named vp of employee assistance programs at Open-Door Services Inc., a consulting firm in Evanston, Ill.

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Insurers to pay award against Texas hospital

FORT WORTH, Texas—Insurers for Cooke-Fort Worth Children's Medical Center will pay a \$17.2 million medical malpractice award against the facility even though they wrote only \$11 million in malpractice insurance limits for the hospital.

Insurers "have assumed full responsibility" for any award if one is upheld, according to a source.

Hospital attorneys would not say whether they planned to appeal.

The hospital's \$1 million in primary medical malpractice coverage was written by United States Fire Insurance Co., a unit of Morristown, N.J.-based Crum & Forster Inc. Crum & Forster would not comment about the case.

In addition, the facility has \$10 million of coverage excess of \$1 mil-

lion written by Houston-based Ranger Insurance Co., ultimately owned by American Ranger Inc.

The excess coverage was reinsured by Employers Reinsurance Corp. of Overland Park, Kan.

Ranger and Employers Re officials could not be reached for comment.

A state court jury in Fort Worth awarded the damages last month to a family of a boy who suffered permanent brain damage after he underwent surgery in 1983 for a head injury. The boy's temperature rose to 108 degrees and the jury found the hospital staff negligent for not summoning doctors for several hours to treat the fever, said plaintiff's lawyer Darrell Keith of Murphy, Moore & Bell in Fort Worth.

—By Michael Bradford

Jewel parent reserves \$32.5 million for claims

SALT LAKE CITY—American Stores Co. is setting aside \$32.5 million as the second and last installment in a \$44.8 million reserve to cover costs stemming from a salmonella epidemic triggered by the sale of tainted milk produced in 1985.

About \$12.3 million was set aside in 1988 to cover claims costs and litigation expenses stemming from sale of the tainted milk from its Jewel Foods Stores Inc. dairy, said a spokesman for American Stores.

An independent actuarial analysis of pending claims helped determine that the \$44.8 million reserve "should be sufficient to cover the remaining claims and expenses," the company said.

Because of the \$32.5 million reserve, American Stores took a \$19.5 million aftertax charge, or 61 cents per common share, against its 1989 fourth-quarter earnings. However, the company has not yet released its fourth-quarter of year-end earnings.

American Stores exhausted its \$70.9 million in liability insurance excess of a \$100,000 retention it had at the time of the poisonings in March 1985 (BI, April 27, 1985).

An Illinois jury ruled in 1987 that American Stores not liable for puni-

tive damages stemming from the tainted milk (BI, Jan. 26, 1987).

Plaintiffs' attorneys, American Stores and Jewel subsequently established a facility to analyze more than 24,000 complaints and pay legitimate claims (BI, May 4, 1987).

American Stores reported early last year that settlements were in the works with thousands of plaintiffs that were members of a class action, while 15,500 other claimants had already settled. However, the company did not disclose how much it had paid out in settlements.

American Stores also was named as a defendant in 325 additional lawsuits involving 1,800 people.

Meanwhile, a decision is expected in late March in an insurance coverage dispute in which American Stores, Jewel and The American Insurance Co., a Fund American Cos. Inc. unit that was one of American Stores' several excess insurers, are suing The Home Insurance Co. over its obligation to provide defense costs. The defense costs exceed the \$900,000 primary liability insurance layer written by The Home at the time of the salmonella outbreak (BI, May 5, 1986).

—By Meg Fletcher

Excess coverage

Continued from page 2

In 1980, the Mantanuska Electric Assn. obtained through ARECA \$900,000 in primary liability insurance from Ambassador above a \$100,000 self-insured retention. Mantanuska also purchased \$9 million of liability coverage from Inco excess of the underlying \$1 million of coverage.

During 1980, Mantanuska was hit with two bodily injury claims for a total of \$205,000. Due to the financial impairment of Ambassador, ARECA sought coverage directly from Inco on behalf of Mantanuska.

In denying the claim, the Alaska Supreme Court first noted that the policyholder paid a \$150,000 premium for the \$900,000 primary policy, but paid only \$43,992 for the \$9 million excess policy.

"Excess coverage policies have relatively low premiums because excess insurers are only obligated to pay claims to the extent they exceed the amount of primary coverage," said the court.

"Given these premiums, ARECA's expectation that Inco would cover losses down to ARECA's SIR if Ambassador became insolvent is not objectively reasonable," said the court.

It is unusual for a court to determine the reasonable expectations of the parties to a contract as a matter of law, explained Mr. Morrison. More often a court will determine the reasonable expectations of the parties after more lengthy discovery, he explained.

After determining it was not reasonable for the policyholder to expect the excess insurer to drop down, the court looked at public policy considerations of its ruling.

The court disagreed with ARECA's position that it was unfair to force the policyholder to assume the burden of the primary insurer's insolvency.

"It is not unfair to leave the risks of insolvency with the insured since the insured selected the primary carrier," the court said. "Inco should not bear the risk of insolvency of a carrier it did not choose."

Inco attorney Mark Sandberg of Sandberg & Smith in Anchorage praised the court's ruling. "The excess carrier doesn't select the primary insurer and often doesn't know who they are," he said.

"If anybody ought to be checking these people out it is those who buy the coverage or their broker," Mr. Sandberg said.

However, many excess insurers do assess the quality of primary insurers because, among other things, the primary insurer generally controls the defense of claims.

Attorneys also point out that policyholders often have access to state guaranty funds for reimbursement.

However, Ambassador wrote coverage on a surplus lines basis in Alaska so guaranty fund coverage was not available to ARECA (BI, Sept. 1, 1986).

ARECA attorney Don Ellis of Kempel, Huffman & Ginder in Anchorage maintains: "Either the individual or business that buys insurance and spends a good deal of money should be entitled to receive insurance. The question is: Who should bear the burden of a risk that neither party foresaw."

He asserted that the excess insurer should bear the burden since it "could have easily drafted around" the risk if it wanted to avoid liability in such a situation.

Mr. Ellis also said the excess insurer is more financially capable of shouldering the risk of the primary insurer's insolvency and in a better position to foresee the risk.

Alaska Rural Electric Cooperative Assn. Inc. vs. Inco Ltd.; Supreme Court of Alaska, No. S-3068, 3549.

At issue

How can employers more effectively communicate benefits plans to employees?



Hugh E. Becker
Director-human resources
Robbins & Myers Inc.,
Dayton, Ohio

Future employee communications should include more interactive technologies, like voice response systems and touch-screen computer programs, so communication can take place at the recipients' level. And, we should learn to develop our communications programs using marketing techniques, like face-to-face meetings and slide shows with pizzazz.



John Thompson
Group benefits manager
Rollins Inc.,
Atlanta

Benefits explanations should be as explicit as possible, written in laymen's terms and perfectly clear and up front in regard to any limitations or controls.



Denise E. Rayfield
Manager-employee benefits
The Hearst Corp.,
New York

You must know your employee population so you'll be able to choose the most appropriate method of communicating, for example a video or a newsletter. And, depending on the method you use, be sure to eliminate wordiness and fluff. Make the communication as concise as possible; employees will ignore it if it seems too lengthy and complex.

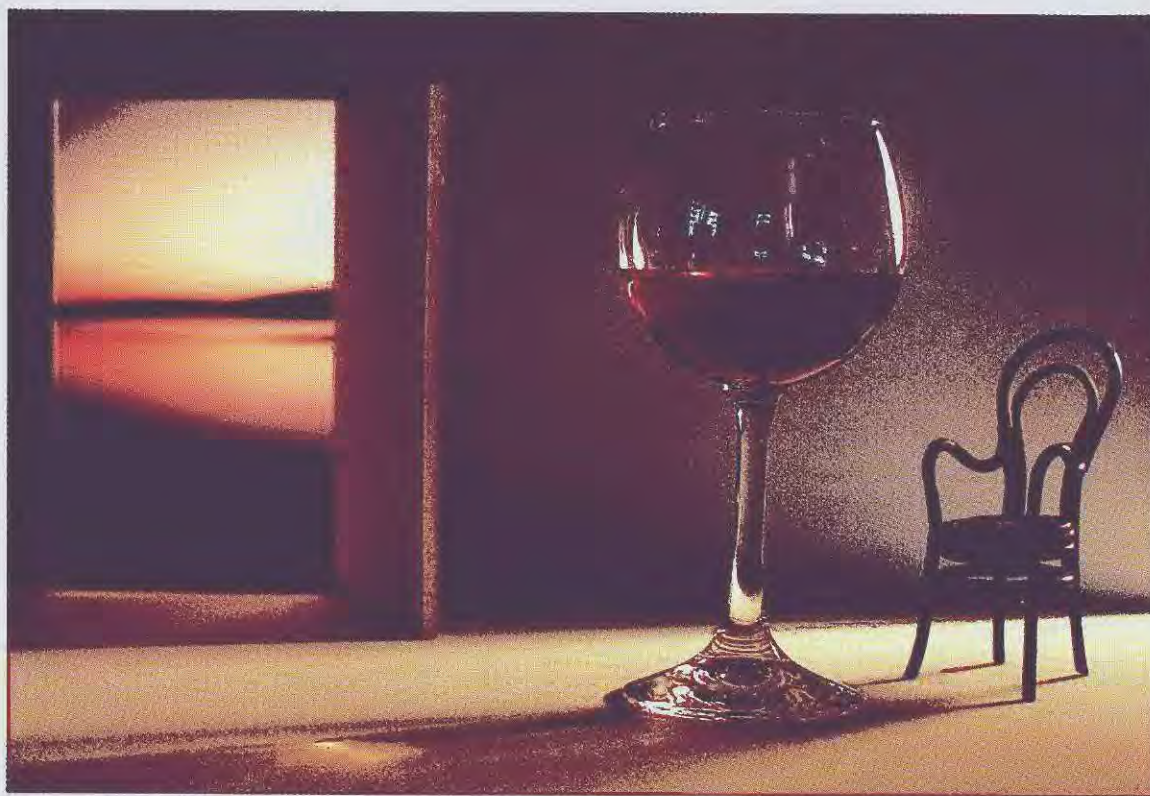


Carrie Bounds
Vp-corporate benefits
PNC Financial Corp.,
Pittsburgh

Employers should provide orientation programs for newly hired employees. At PNC, we provide a "decision guide" each year during the open enrollment process that includes guidelines to help employees make benefit choices. Also, you should ensure benefit counselors are always available to help employees understand plan provisions and procedures.

Compiled by Christine Woolsey

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Company clinics

Continued from page 1

years of double-digit increases.

"Employers can't be passive players. Companies have to take responsibility so that they can better manage their health care costs and needs," said Dr. Sokolov.

While Edison may operate the largest employer-provided network of primary care clinics, the utility is not the only company that has racked up savings by delivering health care services through its own facilities.

The Gillette Co., which opened its first medical care clinic in the early 1950s, estimates that its Boston-area clinics alone save the company about \$650,000 a year. Gillette also operates clinics in St. Paul, Minn., and Santa Monica, Calif.

"The clinics are immensely popular with employees, while there are cost containment features which make the clinics attractive to management," said Dr. William Greer, Gillette's director of corporate health care services in Boston.

Goodyear Tire & Rubber Co. projects that clinics in Lawton, Okla., and Gadsden, Ala., together saved the company \$400,000 last

year. And savings through 1990 could be substantially higher with the recent opening of a large medical clinic that could serve 31,000 employees, dependents and retirees at corporate headquarters in Akron.

"We set some very modest goals and those goals have quickly been exceeded," said Dr. Clifford A. Johnson, recently retired Goodyear medical director and a consultant to the company.

About a dozen employers—including Edison, Gillette and Goodyear—now sponsor full-fledged corporate primary medical care clinics. And, corporate interest in becoming true providers of health care—rather than forking over premiums to insurance companies or paying escalating physician and hospital bills—is on the rise, benefit experts say.

"A number of companies are interested. It is the wave of the future," predicts Thomas R. Burke, a former Department of Health and Human Services chief of staff and now a principal with benefit consultant A. Foster Higgins & Co. Inc. in Washington, D.C.

"You can't manage health care costs until you begin to manage health care by hiring physicians or

bringing them in on contract," Mr. Burke adds.

Edison, Gillette and Goodyear are among companies identified by the National Assn. of Manufacturers as using innovative strategies to control rising health care costs. Over the next several weeks, *Business Insurance* will profile the steps these companies are taking to manage their health care expenditures.

In 1988 and 1989, U.S. employers' health care costs climbed an average of more than 35%, compared with an increase of only about 15% from 1986 through 1987, according to Foster Higgins (BI, Jan. 29).

And, signs on the horizon indicate that health care inflation will not abate any time soon.

For example, health maintenance organizations this year expect to raise rates an average of 16%, about the same rate increase as in 1989, according to a survey by the Group Health Assn. of America, an HMO trade group in Washington, D.C.

With health care costs soaring, pessimism is growing over whether it will be possible to put the brakes on health care expenditures, which now exceed \$600 billion and are rapidly headed toward the \$1 trillion-mark.

Indeed, some employers say time is running out for companies to convince Congress that they can win the war against health care inflation and avert federal intervention into the private health care delivery system.

Congress is increasingly concerned that rising health care costs are making health insurance unaffordable for too many Americans. An estimated 31 million to 37 million Americans do not have health insurance.

But a majority of employers doubt the federal government would be more successful in holding down health care costs.

More than 80% of major employers do not think the federal government would better manage health care costs than the private sector, says a survey conducted by

Buck Consultants Inc. of New York.

Employers, such as Edison, say their strategies for holding down costs are working and they do not want to give responsibility for offering and designing health care programs to the government.

"As an employer that has been providing health benefits for our workers, retirees and their families for many decades, Edison does not want to abdicate this responsibility to government. We think we are better able to manage the health care benefits of our workforce as we can more readily design our plans to meet our employees' unique characteristics and to respond to their changing requirements," Dr. Sokolov testified last year to Senate Labor and Human Resources Committee Chairman Edward Kennedy, D-Mass.

Clearly, medical care clinics will not be every employer's choice as a weapon against soaring health care costs.

"You have to be fairly large and have large concentrations of employees at specific geographic areas," noted Larry Tucker, a consultant with Hewitt Associates in Santa Ana, Calif.

Dr. Johnson of Goodyear said the company would not consider opening a clinic in an area where Goodyear had fewer than 1,500 employees.

The cost of opening a clinic is harder to quantify, Dr. Johnson said. The investment required will depend upon such factors as whether the company owns a building that could be used as a clinic as well as the required staff and equipment to serve the employee population.

Costs aside, many employers will shy away from anything that is not directly related to their primary business.

"How many employers even self-administer their health care claims? And self-administering a health care plan takes 1% of the expertise of running a medical care clinic," Mr. Tucker says.

A new survey by Foster Higgins reports that only 6% of employers self-administered their health care plans in 1989.

But for companies willing to obtain the expertise, Mr. Tucker says, medical clinics appear to be working.

The Edison, Gillette and Goodyear medical clinic programs all give employees strong financial incentives to use the clinics.

Gillette, for example, pays for all medical care services delivered through the clinics, including a wide range of primary care, minor surgery, vision care and hearing tests. By contrast, employees who receive primary care services delivered outside the clinics through a health care plan administered by Blue Cross/Blue Shield must pay a \$100 deductible for individual coverage and a \$300 deductible for family coverage and face a 20% coinsurance requirement.

At Goodyear clinics, employees pay \$15 for an office visit, while many services and tests like X-rays are free. Goodyear pays 85% of charges for services delivered outside the clinics.

Because clinics at Goodyear, as well as Edison and Gillette, deliver services at a much lower cost than other medical care providers, companies can provide richer benefits and still save money, notes Dr. Johnson, Goodyear's former medical director.

For example, it costs Goodyear about \$3 to take an X-ray at its Lawton clinic compared with about \$35 for the same service elsewhere in that Oklahoma community.

If an employee chose to have an X-ray at his own doctor's office, he would have to pay—assuming a \$35 charge—\$5.25 out of his pocket, while Goodyear would pay \$29.75.

By having an X-ray taken at the Lawton clinic, the employee saves \$5.25 and Goodyear saves \$26.75.

Gillette realizes similar savings. "We can do a throat culture for about \$3 that might cost \$12 on the outside," said Dr. Greer.

True employer control of health care delivery makes such low costs possible, the companies say.

Both Gillette and Edison own and operate the medical care clinics, while employing salaried physicians. They also contract with specialists who work part-time.

While Goodyear owns its medical equipment and owns or leases the buildings where its clinics are located, physicians are recruited and employed by Medcenter Inc., a Lawton-based medical management company.

The key to the success of corporate medical care clinics is employing or using salaried physicians, according to Foster Higgins' Mr. Burke.

"Put a physician on salary and he has no incentive to perform unnecessary tests. He wants to provide quality medicine, not building income," Mr. Burke said.

None of the companies report any difficulties in recruiting physicians. Gillette, in fact, has had such low turnover in its medical care staff that it has a waiting list of applicants, said Dr. Greer.

In addition to saving on physician costs, big employers operating clinics and pharmacies save money because of their buying clout and because they do not have to mark up services and goods to make a profit.

For example, Edison, which says it is the third-largest wholesale purchaser of prescription drugs in California, is able to provide medication at an average of 40% less than retail pharmacies.

In some cases, the savings are even greater. For example, Edison's Dr. Sokolov notes that a prescription for a 10-day supply of tetracycline, an antibiotic, would cost about \$2.50 at an Edison clinic compared with \$8.50 at a retail pharmacy.

The clinics also save time.

Typically within walking distance of corporate manufacturing or employment centers, they also offer convenient operating hours. For example, Gillette's clinic in South Boston is open 24 hours a day, six days a week and is also open six hours on Sunday.

"There is very little waiting," said Dr. Greer.

Edison, Gillette and Goodyear medical officials all stress that employees' medical records maintained at the clinics are kept strictly confidential.

"Employees have never had any concern about confidentiality of records. The medical department does not share records with management. Records are private," Dr. Greer said.

The medical officials also say that the quality of care provided at their companies' medical centers is as good, if not better, than services offered elsewhere.

Edison, in fact, is seeking accreditation for its facilities from the Joint Commission on Accreditation of Health Care Organizations, the organization that accredits hospitals and other health facilities.

The medical centers and services offered by Edison, Gillette and Goodyear have not gone unnoticed by other employers.

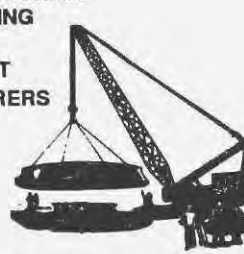
"The concept has generated a lot of interest among companies," said Dr. Johnson, who estimates that he and other Goodyear officials have fielded between 15 and 20 calls from other employers over the last year.

"We've had about dozen calls from companies asking for advice. We think the program has worked well for us and we are happy to share our experience," Gillette's Dr. Greer said.

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Product liability

Continued from page 2

The Kasten bill "would establish uniform rules applicable to all plaintiffs, ending the current incentives for plaintiffs to file their claims in the courts of some states but not in others," said Fred C. Noye of the Washington, D.C.-based American Legislative Exchange Council, an organization of legislators from the 50 states and Puerto Rico.

Warren W. Eginton, a U.S. District Court judge in Connecticut, praised the Kasten bill's uniform approach to areas of product liability law that are often treated differently by individual states, such as when punitive damages can be sought, statutes of limitations and repose and the collateral source rule.

Sen. Kasten's proposal would:

- Permit punitive damages only if there is clear and convincing evidence of negligence by a manufacturer or product seller. A defendant also could request that the amount of punitive damages be determined separately at a second trial.

- Bar punitive damage awards when injuries were caused by drugs or medical devices approved by the Federal Drug Administration or aircraft certified by the Federal Aviation Administration.

- Generally restrict the filing of lawsuits to within two years of the discovery of an injury or its cause.

In addition, the bill generally would bar product liability suits involving capital goods products that are more than 25 years old.

- Reduce the amount of a product liability award by the amount of workers compensation benefits received by the plaintiff.

"The proposed legislation will establish clarity and uniformity and will substantially reduce transaction costs, both direct and indirect, associated with product liability litigation to date," Judge Eginton said.

But Mr. Box of the National Conference of State Legislatures said that states, rather than Congress, can best respond in these areas.

"The issue of proper compensation for injured persons and suitable protection for businesses are matters of social values and public policy that should be addressed at the state level," he said.

Others said the bill is an important step in the right direction.

Sen. John D. Rockefeller IV, D-W.Va., said the product liability system must be reformed immediately. "You don't wait for the world to become perfect before you take a step."

The Committee for Economic Development, a New York-based non-profit research and educational organization of business executives and educators, agreed.

"Manufacturers, facing enormous uncertainty about their potential exposure to product liability claims, understandably often respond by deciding not to introduce a new product, or to drop a promising product line, or to curtail research in areas where product liability risks are unclear," testified CED President Robert Holland.

Thus, U.S. companies are less able to compete with foreign manufacturers, "American jobs are lost and American consumers are denied the benefits of socially desirable products," Mr. Holland said.

Wendell L. Willkie II, the Commerce Department's general counsel, also testified that the current product liability system "diminishes U.S. businesses' ability to compete."

President Bush, he said, considers federal product liability reform a "legislative priority." The administration endorsed product liability reform late last year (*BI*, Dec. 4, 1989) and is now ready to work with the Commerce Committee to strengthen the Kasten bill, Mr. Willkie said.

However, Sen. Kasten said he will discourage any changes at the committee level so that amendments can be debated on the Senate floor.

The Kasten bill also would:

- Eliminate joint and several li-

ability for non-economic damages.

- Encourage attempts at settlement before the case goes to trial.

Under the bill, either party would be able to make a settlement offer. If the defendant rejects an offer and the subsequent verdict is for an amount greater than the settlement offer, the defendant would also be required to pay the plaintiff's legal fees.

If the plaintiff rejects an offer and the subsequent verdict is for an amount less than the settlement offer, the defendant's legal fees would be subtracted from the award.

- Shield a manufacturer from liability if the plaintiff was under the influence of a drug or alcohol and that condition was at least 50% responsible for the accident.

- Make product sellers responsible for harm only caused by their own negligence. Product sellers would be responsible for a manufacturer's negligence only if the manufacturer could not be brought to trial or did not have the funds to pay an award.

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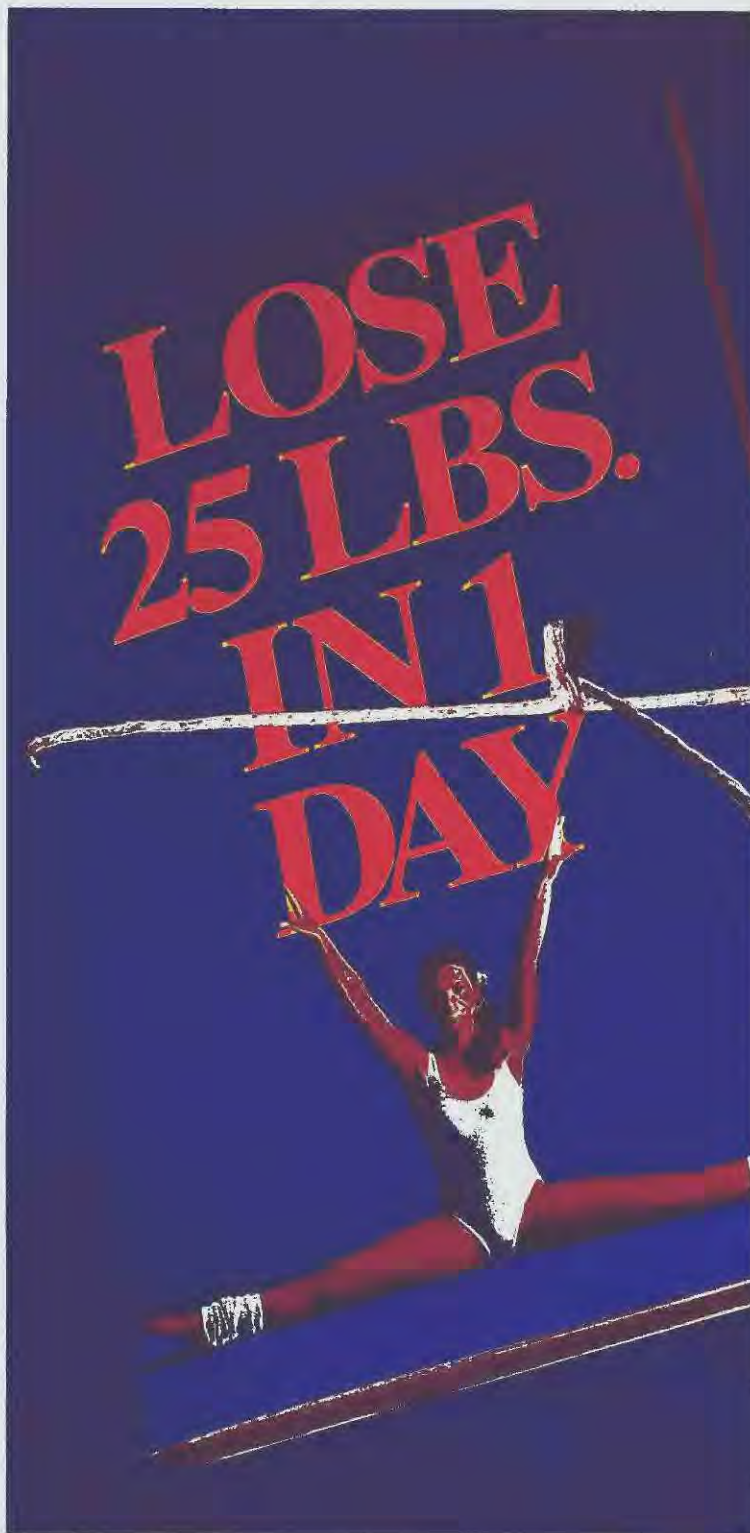
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D&O survey

Continued from page 1
expected to reach an average of nearly \$3.5 million, according to the "1989 Wyatt U.S. Directors and Officers Liability Survey," which is being released today.

Furthermore, there was a "dramatic" increase in defense costs as a percentage of total costs, the survey points out.

As was the case in 1988 when Wyatt published its last D&O survey (BI, Dec. 19, 1988), companies are more susceptible to D&O claims if they are engaged in merger, acquisition and divestiture activity or if they report aftertax losses, the survey found.

But, a comparison of 1989 survey results with findings in earlier Wyatt D&O surveys indicates that state laws designed to narrow the personal liability of directors and officers that were enacted beginning in the mid-1980s may be slowing the increase in the number of suits brought by certain types of plaintiffs, said Kenneth S. Wollner, the Chicago-based Wyatt consultant involved in preparing the survey.

The 1989 survey polled 1,333 corporate respondents, 120 hospitals and 84 educational institutions. Data was gathered during the summer of 1989, and for the most part, the survey respondents' D&O insurance programs were negotiated between mid-1988 and mid-1989.

The 1989 survey encompassed 2,135 separate accounts, generating \$431.2 million in primary and excess D&O premiums. The 1988 survey encompassed 1,967 corporate accounts generating \$513.1 million in total premiums.

Respondents reported on 625 claims made in 1980 through 1988. Of those, 350 claims, or 56%, were closed claims while 245 claims, or 39.2%, were open. There was no in-

formation on the status of 30 claims, or 4.8%.

Overall, 80% of the corporations surveyed reported they had D&O coverage in 1989, compared with 74% in 1988.

Broken down by type of companies, utilities are the most likely to purchase D&O coverage, with 96% of those companies buying the coverage. Transportation and professional services companies were the least likely to purchase D&O coverage, with 56% of those companies obtaining the coverage.

In addition, 87% of the hospitals surveyed and 80% of the educational institutions surveyed reported having D&O insurance in 1989. Neither group was surveyed separately in 1988, though some for-profit hospitals were included among 1988 corporate respondents.

"Among the survey participants who did not purchase D&O insurance, only 6% said they were unable to obtain coverage, down from 18% in 1986-1987 and 8% in 1988," Mr. Wollner pointed out (see chart, page 1).

However, 15% of the for-profit companies without D&O coverage that reported an aftertax loss at some point during the past five years said they could not obtain coverage.

And, 13% of the for-profit companies without D&O coverage that reported engaging in merger, acquisition or divestiture activity during the past five years said they were unable to obtain coverage.

Fifty percent of the 1989 corporate respondents without D&O coverage said they did not obtain the coverage because it was too expensive, up slightly from 49% in 1988 and 39% in 1987.

On the other hand, 42% of the corporate respondents that reported no D&O coverage in 1989 said they did not buy D&O insurance because they saw no need for it, compared with

38% of the respondents in the 1988 survey and 26% of the 1987 respondents.

Fourteen percent of the 1989 corporate respondents without coverage said they did not obtain the coverage on the advice of legal counsel, compared with 12% a year earlier and only 9% in 1987.

Twenty percent of the 1989 respondents without coverage said they carried no D&O insurance because they believed the coverage available was too limited, compared with 24% in 1988 and 14% in 1987. The percentages do not total 100% because some respondents in each survey gave multiple answers.

The survey also demonstrates that capacity in the D&O marketplace is increasing.

Twenty-one percent of survey respondents reported they increased their limits, 77% reported no change and only 2% said they had decreased limits.

On average, companies increased their coverage limits by about 8% to \$25.5 million in 1989 from \$23.6 million in 1988, the survey found.

However, limits varied greatly according to company assets. For example, companies with fewer than \$50 million in assets reported purchasing an average of \$4 million in D&O limits, while companies with \$1 billion to \$2 billion in assets purchased an average limit of \$27.9 million and companies with more than \$10 billion in assets purchased an average limit of \$61.3 million.

One survey participant, which reported more than \$10 billion in assets, bought \$215 million in D&O limits, the highest reported to Wyatt.

Most D&O policyholders also paid less for their coverage in 1989, according to the survey: 58% reported paying less for coverage, while 24% reported that their premiums were unchanged. Only 18% reported paying more for D&O insurance in 1989.

On average, corporate survey respondents paid \$399,327 in D&O premiums in 1989, 7.6% less than the \$432,389 they paid a year earlier.

However, premiums, like coverage limits, varied greatly depending on the size of the company. For example, companies with fewer than \$10 million in assets paid an average of \$33,116 in D&O premiums in 1989, a whopping 47.9% decrease from \$63,614 in 1988; companies with \$250 million to \$400 million in assets paid an average of \$170,730 in premiums last year, a 2% increase from \$167,431 in 1988; and companies with more than \$10 billion in assets paid \$1.42 million in premiums in 1989, a 2.6% decrease from \$1.46 million during the previous year.

The survey also found that about 67% of respondents maintained the same deductibles they had a year earlier and about 27% had lower deductibles.

Only about 7% increased deductibles in 1989.

But, despite a somewhat softening D&O market, the survey found that the average cost of D&O claims continues to climb.

The survey projects that the average total D&O claim cost—defined as the average payment to claimant plus the average defense cost—will total nearly \$3.5 million for claims brought in 1989. The average ultimate claim cost for claims brought a year earlier was estimated at slightly more than \$3 million.

The survey found that the average defense cost for closed claims was \$1.3 million in 1989, a 13.6% increase from \$1.14 million in 1988. But, the survey notes that the "true trend is still (as in past surveys) around 10%."

The report also found that D&O claims frequency continues to rise and that policyholders' susceptibility to D&O claims varies depending on company actions.

Claim frequency measures the total number of claims filed against directors and officers of all companies. For example, if in a sample of 10 companies one company's directors and officers were hit with two claims, the frequency would be 0.2, or two claims reported per 10 companies.

The D&O claim frequency rate for all companies was 0.47 in 1989, a slight increase from 0.45 in 1988.

Wyatt estimates that claim frequency is continuing to rise at a rate of between 5% and 15% per year.

Susceptibility refers to the probability that a corporation's directors and officers will be hit by one or more claims during the previous nine-year period. For example, if in a sample of 10 companies one company's directors and officers was hit with any number of claims, the susceptibility of companies in that group would be 10%.

Overall, claim susceptibility inched up to 22% from 21% in 1988.

The survey found that merger, acquisition and divestiture activity continues to be a major cause of D&O claims.

Companies with merger, acquisition and divestiture activities demonstrated a claim frequency of 0.6 in 1989, compared with 0.57 in 1988. During the same period, the frequency for companies without merger and acquisition activity remained steady at 0.23.

Companies involved in merger and acquisitions had a claim susceptibility of 28% in 1989, compared with 26% in 1988.

Those without such activity maintained a claim susceptibility of 13%.

In addition, "companies with an aftertax loss in the last five years showed about one-third greater susceptibility and frequency to D&O claims than those companies with no aftertax loss," the survey found.

The frequency of D&O claims

Continued on next page

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Industry woes strain relations with insurers

By LAURA MAZZUCA

Charles Dickens' famous epigram for the French Revolution—"It was the best of times, it was the worst of times..."—aptly describes the current state of producer-insurer relations.

Some producers, especially those with preferred agency contracts, have never had it so good.

For others—squeezed by volume demands by insurers, cut-rate commercial insurance premiums and insurers that are fleeing unprofitable markets—things have never been worse.

It all depends on whom you talk to and where they're talking from.

For instance, in states where consumer advocacy groups remain dormant and onerous regulations like Proposition 103 have not been proposed, producers and insurers can get along famously.

"Companies see Illinois as a good marketplace and are more than willing to write here," said Jack Payan, president of Payan-Stitt Corp., an agency in Palos Heights, Ill.

Payan-Stitt has maintained a contract with one insurer since Franklin D. Roosevelt's early years in the White House and with two others since the 1940s.

However, in some Sun Belt states, where lackluster economies exacerbate already-low property/casualty rates or where restrictions on insurers' rates have been passed or are pending, many producers are cultivating surplus lines connections in case standard insurers desert their markets (see story, page 16F).

And in some states like New York, market conditions vary widely, from brokerage-laden Manhattan, where insurers actively court good commercial business, to rural areas where agencies are clustering in record numbers in an effort to survive (A/BT, Feb. 5).

Such regional disparities, however, are overshadowed by industrywide problems—especially mounting pressure from consumer advocacy groups for reforms and preparation for an impending but elusive hard market (see story, page 16D).

And those problems have overwhelmed the traditional insurer-agent relationship, leaving it "worse now than it's ever been," said Carol A. Hammes, president of The Middleton Group, an agency consulting firm in Lisle, Ill.

Insurers are turning up the heat on agencies not only to produce more volume, but also to improve loss ratios, develop specialized lines, and improve agent education and skills, said Patricia A. Borowski, vp-government and industry affairs for the National Assn. of Professional Insurance

Agents of Alexandria, Va.

And, the soft market has made those requirements more difficult to meet, said L. Merritt Jones Jr., president of Moore & Johnson Agency Inc. in Raleigh, N.C., who headed the agency/insurer task force for an Independent Insurance Agents of America study last year.

Hampered by cost-cutting measures of their own, insurers want agencies to electronically enter policy information, perform on-site property inspections and perform other tasks insurers traditionally handle themselves, added Mr. Jones.

Producers say they usually do not mind picking up that slack, but they do resent what they consider insurers' failure to explain why changes are necessary or even to solicit agents' opinions on contract cancellations or commission reductions.

"Agents do not enjoy the closeness or confidence they did in the past," Mr. Jones pointed out. "Explanations were not coming, just edicts from the companies. There seemed to be no room for negotiation."

Aetna Life & Casualty Co., for example, will lower personal lines automobile commissions from 15% to 10% in California beginning in April due to Proposition 103's restrictions on rate increases.

Even in states with negligible consumer movements, producers worry about meeting insurer premium quotas, niche marketing needs and life insurance "tie-in" demands, said Josiah H. Welch, president and treasurer of Chase & Lunt Inc., a Newburyport, Mass., agency with \$8.5 million in premium volume.

Insurers' overall lack of support and understanding of the independent agency system makes this especially difficult, he added.

In his 30 years as an agent, trust and cooperation between agents and insurers has "deteriorated," said Mr. Welch. Insurers have sustained large losses on bad risks and unstable investments and are increasingly run by people who do not understand the agency system, he said.

"Sometimes they forget their real customer is the agent," contended Mr. Welch.

Because most insurers hold the power to retain or cancel a contract, true agent-insurer parity cannot exist and "the partnership issue is just so much conversation," said Daniel J. Blum, president of The Insurance House Inc., a Lafayette, La., agency.

Insurer preparations for a hard market may be further upsetting relations with agents and driving a wedge between competing agencies, agents say.

Continued on next page



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Insurer-agent alliances pay off in hard market

By LAURA MAZZUCA

While agents and brokers cannot accurately predict when the commercial property/casualty insurance market will turn, they agree that relationships developed over the years with top insurers will pay off when the market does tighten.

"If the market turns hard tomorrow, we've got the companies in here that could ride it through for us," said Jack Payan, president of the Payan-Stitt Corp. agency in Palos Heights, Ill.

Both producers and insurers seem to have learned from problems that arose during the last hard market and are doing their best to keep lines of communication open (see story, page 16A).

For instance, insurers are "spending more time with us and courting our good business," through regular office visits and keeping agents abreast of new products offerings, said Conrad Foa, president of Foa & Son Corp., a New York brokerage.

Many agents and brokers are trying to improve their standing

with insurers by focusing on their insurers' niche marketing targets, submitting accurate and complete information, and educating and training their staffs.

Other producers, however, say that coming hard market or not, it's just business as usual.

"I'm in a real wait-and-see mode" since the overall market remains soft in Idaho, said Owen D. Pipal, president of the Pipal-Anderson Inc. agency in Boise.

"We're just maintaining our insurers rather than jumping to the next hot market on the street," Mr. Pipal said.

Producers actively preparing for a market hardening are stressing communication with insurers.

"We have a responsibility to listen to companies and not just ignore them," said Clay Tucker, president of Leick, Marshall, Neal & Associates in Dallas.

"Agents can be very insensitive to a company's problems, too," Mr. Tucker noted.

Good relations, fostered by participation on insurers' agency councils, will help Mr. Tucker's agency retain its markets when the cycle hardens, he says. "We're confident they'll stay, but it's because of the hard work we've done in the soft market."

Other producers prefer to deal with insurers individually rather than go through agency councils or agent associations.

"Right now we're just trying to maintain good contact with the management of the companies we deal with," said Richard Baker, chief executive officer of Myers Baker & Co. Inc., an agency in Chicago.

His staff meets regularly with insurance underwriters and service staff as well as insurer executives, said Mr. Baker. Each producer keeps tabs on a particular insurer. So far, he said, companies seem receptive to the agency's overtures.

"If there is a problem, we'll sit down, discuss and evaluate where the system is breaking down," said Robert Nicosia, president of Pilgrim Insurance Agency in Nutley, N.J.

Rather than wining and dining executives, he said, "talking business" is the order of the day.

"Agents are no longer afraid to speak their minds as long as it benefits both sides of the relationship," Mr. Nicosia said.

Such dialogue, say insurers and producers, can ensure that both sides are focusing on the same thing, such as specialized niche business.

For instance, the principal of a large Atlanta-based agency invited each of his top insurers to discuss what lines of business they were interested in writing (see story, page 16A).

"We've broadened the base of what we write in commercial lines," added Daniel J. Blum, president of The Insurance House Inc. in Lafayette, La.

For example, Mr. Blum's agency agency now places specialized property/casualty coverages for alligator, catfish and crawfish farmers in Louisiana.

Agents and brokers also emphasize that they must improve their performance on behalf of their insurers.

"The bottom line is loss ratios," and the best way to maintain good ones is to deal consistently with insurers and provide them with accurate information about the risk,

said Mr. Payan.

His agency concentrates on sending complete histories on applications, including losses; being on time with premium payments; submitting accurate, complete applications and underwriting information; and answering insurer questions within 24 hours, he said.

He also recommends agency employees pursue continuing education and sends representatives to seminars offered by preferred insurers, "not only to learn, but to make contacts."

"This is an area that's sometimes ignored by agents," said Mr. Payan.

Communication with clients is also important, said L. Merritt Jones Jr., president of Moore & Johnson Agency Inc. in Raleigh, N.C. He prepares customers for the hard market by explaining new pricing or capacity developments.

Instructing clients on loss control methods is also important, noted Mr. Tucker.

Some producers are preparing for a market turn by either increasing or decreasing the number of insurers they represent.

Adding insurers, some believe, is a safe hedge against loss of capacity in a hard market.

Mr. Jones, who says he lacked

'Agents can be very insensitive to a company's problems, too,' Clay Tucker says.

confidence in several of his regular insurers, added two last year to provide solid markets for preferred clients.

Others contend solidifying and deepening relationships with a small number of companies will assure insurer fidelity in a hard market.

"We have cemented relations and placed our business with a lot fewer companies," said Mr. Foa, who has concentrated his brokerage's business with eight insurers today, compared with 15 markets in 1984.

"The people you're going to offer your capacity to are your major producers," so it doesn't make sense to keep too many around, he said.

Producers would do well to consolidate markets to emulate insurers, which have focused almost exclusively on their preferred agents and culled out the unprofitable ones, said Mr. Payan.

Although his agency recently added a fourth personal lines insurer, it was only because the other three insurers were not performing to the agency's liking, Mr. Payan said.

Adding companies, with the attendant bookkeeping and processing, increases agency costs, he said.

While many agents agree that cutting back to one or two insurers in a tight market would be virtually impossible, they say they are more selective when choosing insurers.

Agents are "looking very hard at the companies for a product or a competitive edge," said Mr. Nicosia, whose agency just added another insurer because it offered a product that a client needed. ■

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NAI

Lesson learned, insurers rebuild ties with agents

By MARK A. HOFMANN

Insurers do not want a future hard market to cause the same sort of hard feelings between agents and insurers that the hard market of the mid-1980s fostered.

When the property/casualty insurance market suddenly turned in 1984 after a prolonged soft market, agents often could not renew business that had been placed with the same insurer for years for any price. Coverage simply wasn't available, and agents often were left alone to face angry policyholders.

Agent/company relations soured.

Now, as agents wait for a soft market to harden, insurers say they have learned from their mistakes.

"We learned a lot," said Chuck Dudek, vp and director of marketing-standard lines for Schaumburg, Ill.-based Zurich-American Insurance Group.

To beef up ties with agents, insurers now are stressing long-standing and consistent relationships and on-going communication with agents.

"It's not so much what you do at the time of the market change as it is what you've done consistently over time," explained Greg Georgiess, senior vp and managing director of Chubb & Son Inc., a subsidiary of Warren, N.J.-based Chubb Corp.

Long-term relationships with agents are solidified when top Chubb managers visit agencies for one-on-one discussions with producers and underwriters accompany producers on client calls, he said.

"We're in constant communications with our agents," said Bruce W. Herrick, president of American Reliance Insurance Co., a Lawrenceville, N.J.-based insurer active in five Mid-Atlantic states and Florida.

Mr. Herrick's company won national acclaim from agents in the mid-1980s for "EZ-One," a program in which senior company executives, including Mr. Herrick, spent time in agents' offices to learn how to ease friction between agents and the company.

"We've never stopped that process," said Mr. Herrick. "It's just working and building relationships and understanding." He termed the effort "in the trenches work."

Mr. Herrick noted, however, that companies like American Reliance might have a slight advantage over some national companies when dealing with agents.

"Our agents know we're fairly stable in our underwriting philosophy," he said.

American Reliance targets Main Street commercial accounts and small contractors that generate annual premiums below \$25,000, Mr. Herrick said. The prices for such accounts simply don't swing as violently as the prices charged very large commercial accounts, he said.

John King, national marketing manager-commercial insurance for Woodland Hills, Calif.-based Transamerica Insurance Co., also stressed pricing stability in keeping agent/company relations on even keel.

"We haven't been a player in the soft market, so the impact (of a harder market) won't be as significant on our agents," said Mr. King.

Still, even given the best efforts of insurers to avoid market dislocations, disruptions—including decisions to withdraw from certain territories or lines of business—occur.

"It's very, very difficult to prepare your producer," said Bill Watt, senior vp-field operations for Charlotte, N.C.-based Royal Insurance Group.

Insurers find they cannot produce an adequate return on certain lines of business in some areas, said Mr. Watt. If the returns aren't there, the

insurer withdraws. "It's something we don't relish," said Mr. Watt.

"The underlying principle is we value our agency relationships. The last thing we want is to be arbitrary," he said.

Zurich-American's Mr. Dudek said that when retrenching workers compensation business in some states, his company has attempted to enlist the help of agents in lobbying for reform legislation.

"We work with agents to influence reform in the legislatures" and encourage them to write letters to state representatives on the subject, Mr. Dudek said. "We're taking a very active role."

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Agents woo wholesalers before market turns

By LAURA MAZZUCA

Securing markets for hard times

North Side Insurance, an Atlanta agency, increased the premium volume it placed with one of its three wholesale brokers to about \$100,000 last year from \$16,000 the previous year.

Big deal, you may say.

North Side President Jerry Hargrove believes it could be.

While the \$84,000 in premium is an amount "that an ordinary (insurance) company would have considered an insult," he conceded, the wholesaler broker was grateful and will probably remember Mr. Hargrove when the market hardens and the agency increases from 5% the portion of its business that goes

to surplus lines brokers.

North Side is one of many agencies anticipating a hard market and hedging their bets by increasing the amount of business they place with wholesalers.

"If you've got good relations with a surplus lines broker, you can get on the phone in a hard market and call them," explained Daniel J. Blum, president of The Insurance House Inc. in Lafayette, La. "It's definitely not an area for an agent to overlook."

The benefits of placing more business with surplus lines brokers

are manifold, agents say. Besides being able to place specialized coverage, they offer stability in a hard market, the ability to deal with a top manager rather than a field underwriter for an insurers, and lower turnover of underwriters and management.

"We have a good relationship with these people," said L. Merritt Jones Jr., president of Moore & Johnson Agency Inc. in Raleigh, N.C. "They stop by our office and tell us what their new products are."

His agency placed a great deal

of coverage with surplus lines brokers like Swett & Crawford Group in Los Angeles during the last hard market. Now those brokers still get 5% to 10% of Moore & Johnson's business, especially in specialty liability lines like directors and officers liability.

Wholesalers are becoming more of a "major player" since many standard insurers still refuse to write certain lines of business, said Josiah H. Welch, president and treasurer of Chase & Lunt Inc., an agency in Newburyport, Mass.

And, while agents concede that

placing business through a wholesale broker means splitting the commission with the wholesaler, they say the good will is worth the price.

"We rather have 10% to 15% of something than 20% of nothing," Mr. Hargrove said. "Our primary concern is to write the business competitively and wisely."

Other producers, however, warn that wholesale brokers may not turn out to be a savior in a hard market.

"We used them in the last hard market, but that's just a temporary respite," said Conrad Foa, chief executive officer of Foa & Son Corp., a New York City brokerage. He noted that surplus lines brokers, just like standard brokers, find it tough to find capacity in a hard market.

Another problem, said Richard Baker, chief executive officer of Myers Baker & Co. Inc. in Chicago, is that most surplus lines insurers are subsidiaries of admitted insurers—or "pups of other major markets you do business with"—so most agencies dealing with wholesalers are really as reliant on the standard market as they had been previously.

Also, relationships with surplus lines brokers, as with any insurers, must be maintained in the soft market, which can present problems.

"Relationships take time and commitment," said Clay Tucker, president of Leick, Marshall, Neal & Associates, an agency based in Dallas. "You must have that established no matter what the market is."

Leick, Marshall—which specializes in product liability, ocean marine, frame building coverage and other "volatile classes of business"—has about four "special relationships" with surplus lines brokers with which the agency maintains monthly contact.

About 15% of its business is now placed through several surplus lines brokers, though Mr. Tucker expects that figure to more than triple when the current market hardens.

Mr. Blum's agency, which specializes in offshore and oil-related business, deals with five surplus lines brokers on a regular basis, including Acadiana Special Risks Inc. in Lafayette; Montgomery & Collins Inc. in Los Angeles; and Agency Management Co., a subsidiary of American International Group Inc. in Baton Rouge, La.

He stressed the importance of finding only a workable number of surplus lines brokers and cultivating the relationship with them.

"I'm going to get preferred treatment with the five guys I deal with, a different treatment than the agents who scramble to them in the hard market," he said.

North Side Insurance does business with only three surplus lines brokers, primarily for start-up businesses and low-value commercial property risks that admitted insurers shun, said Mr. Hargrove.

He says the surplus lines share of his agency's business—now about 5%—will increase when the market hardens and good relationships with his three surplus lines brokers will serve him well.

"All are time-tested within the marketplace and the framework of our own agency," he said.

The three surplus lines brokers that North Side deals with are Southern Insurance Underwriters in Atlanta; Continental Special Risk in Roswell, Ga.; and The Insurance House in Marietta, Ga., said Mr. Hargrove, "and two of those I go back 20 years with." ■

April

Compensation & Incentives

Agency principals are becoming innovative when it comes to luring new producers to their firms as well as for retaining their current employees. BI will review these innovations, look at compensation and the employee benefits most often offered to producers.

Issue: April 2
Ad Closing: March 20

May

Advertising/Sales Promotion IMS Conference Report

What strategies are used by successful agencies to promote their firms? Returning from the recent Insurance Marketing Services Conference, BI will report on how agents can improve their marketing and advertising efforts to generate more business.

Issue: May 7
Ad Closing: April 24

June

Niche Marketing

Want to increase your business? You've got to find that niche that sets you apart from your competition. BI will look at how niche marketing works for agents and brokers, how they can specialize by type of coverage they offer as well as by targeting their clients demographically or by nature of business.

Issue: June 4
Ad Closing: May 22

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Agent/Broker Topics

Quality control prevents E&O claims

By Demmie Hicks

IT'S LATE Friday afternoon and Bill, the risk manager for your largest customer, calls to tell you his company has purchased a new building.

You take down the specifics quickly, preoccupied with the dinner meeting you're rushing to get to. "Don't worry," you tell Bill, "I'll take care of it." You slip the note pad into your briefcase, hang up the phone and head for your appointment.

Forty-eight hours later, you're in your den watching "60 Minutes" when Mike Wallace introduces a segment on arson. Your heart begins to race as you remember Bill and his building—and that you forgot to bind the coverage.

As an insurance agent or broker, you're bound to know the feeling. Few of us haven't had to sweat out a night worrying about errors and omissions exposures.

But such nightmares and big losses can be avoided if you're willing to institute quality control standards that ensure a well-run operation.

To start with, senior management must support the notion of quality control and commit the money, time and personnel to achieve it. Secondly, someone experienced, knowledgeable and assertive must bear the responsibility for coordinating your program.

Third and most importantly, quality control discussions cannot be kept in the boardroom. Success depends on the participation and support of your entire staff. After all, quality control should permeate all aspects of your agency, from technical expertise and efficient work flows, to satisfied customers and generating new business.

To begin implementing a quality control program, first evaluate how well your staff understands the implications of the E&O exposure. Do they recognize the importance of good customer service? Do they follow your standard procedures in processing business? One way to measure their attitudes and expertise is through a simple survey asking key questions. This survey should help you identify some of the areas that need attention.

Next, your quality control plan should include:

- Job descriptions.

These should define the requirements, responsibilities and expectations you have of employees. Good job descriptions help establish a standard of performance. Once written, they should be reviewed annually during your performance appraisal process and, if warranted, amended with employee input.

- Written procedures.

A review of the agency's procedure manual is next. Do you have written procedures for each department? Are they simple and practical? Do they include the way you use your computer and identify such E&O checkpoints as expiration control, binder processing, and use of a coverage checklist?

If you don't have written procedures, put together development teams within each department to write the applicable sections. The most usable manuals identify the steps necessary to complete each process including prospecting, quotation, new business, renewal and other steps.

A procedure manual also can be the most effective training tool your agency has. It should be used during regularly scheduled procedure classes within each department.

One-hour classes can be conducted on a monthly or quarterly basis. These classes will ensure staff understanding and adherence to your quality control procedures.

- Work flows.

Examine your information trail. Is it streamlined and efficient, or are there endless bottlenecks? Though time-consuming, tracing the steps used to process various transactions can help you determine whether these merely need fine-tuning, or if they should be changed.

Your analysis also should include a review of your computer system to determine if it is being used to full

capacity.

If used properly, it can help standardize procedures and reduce your exposure to E&O claims.

- Auditing.

The best way to ensure the effectiveness and staff adherence to your quality control procedures is to use internal audits. Audits should include a random sampling of hard copy files, computer files and procedures followed to process business.

When auditing procedures, review such processes as binders, expirations, suspense, claims and date stamping. When conducting a client coverage audit, look for neatness and orderliness of your file and whether oral communications have been properly documented, client change requests have been confirmed in writing, and coverage checklists have

been used. These identify only a few of the things you should look for during your audit process.

If your computer system plays an integral role in your daily processing, audit the accuracy of the data within it. Audits should be conducted at least on a quarterly basis and can be completed by one person or a committee of two or three.

- Professional development.

Your staff's knowledge of your insurance product, your carriers and your current and prospective clients will be vital to the long-term success of your organization.

The only way to ensure this process is through a commitment to ongoing professional development for everyone.

A corporate commitment should be established that includes require-

ments and expectations, your financial support, time commitment, reward and ongoing opportunities for advancement. Each employee should have a specific program developed outlining the requirements necessary for their position.

Ensuring quality control is a never-ending process. It takes an ongoing commitment by you and your staff. The creative use of internal memos, staff meetings and award programs should be used to heighten your staff awareness to the E&O exposure and maintain your company's commitment to quality control.

Quality control should become a corporate philosophy that touches all aspects of your organization. The benefits: professionalism, productivity, client satisfaction and E&O peace of mind.



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Insurers, brokers tout E&O loss control

By LAURA MAZZUCA

While underwriters differ on whether the frequency of errors and omissions claims against agents and brokers is continuing to rise, they do agree that more agencies should adopt E&O loss prevention programs.

"We have seen a steady rise in the rate of lawsuits against independent agents in general," said James D. Wallace, underwriting administrator for E&O Professionals in Kansas City, Mo., the underwriting administrator for SAFECO Insurance Co. of America in Seattle.

The number of claims filed against E&O Professionals' policyholders has increased 9% annually since 1985, said Mr. Wallace, whose company wrote about 3,500 association and individual policies last year.

On the other hand, the frequency of E&O claims is decreasing among policyholders of Utica Mutual Insurance Co., which underwrites E&O coverage for about 12,000 National Assn. of Professional Insurance Agents members, said Frank Mure, vp and manager of Utica Mutual's errors and omissions department.

Mr. Mure attributes the declining number of claims filed with Utica Mutual of New Hartford, N.Y., to improved underwriting procedures and the soft commercial property/casualty insurance market, which enables agents to more easily place coverage and, thus, reduces the likelihood of

Programs can save premium dollars

errors.

But, he notes, claims severity has increased.

Average payments for the 418 losses paid by Utica Mutual in 1989 totaled \$37,700, compared with an average of \$27,600 for 528 paid losses in 1988.

At Employers Reinsurance Corp., which underwrites E&O coverage for about 12,000 members of the Independent Insurance Agents of America, "the frequency of claims has leveled off," said Daniel J. Torpey, assistant vp for the Overland Park, Kan.-based insurer.

Mr. Torpey could not provide severity statistics for recent years, noting the long tail involved with E&O claims.

Many observers point to a variety of elements, including a hostile consumer movement and inflation, in explaining the rise in frequency and severity. However, some observers also blame producers for any increase in E&O problems.

"Some of them don't handle their business like professionals," said Utica Mutual's Mr. Mure, who believes that insufficient documentation among agency employees are major contributing factors to the number of claims filed.

Other factors that could increase E&O claims include inadequate administration of agency procedures and follow-up systems, employee turnover and poor training and monitoring of staff, he said.

Agents and brokers, for their part, seem to be more aware of E&O prevention than ever, which observers hope will eventually improve their performance.

"Any education on professionalism and internal procedures is bound to help," said Employers

'Some (agents) don't handle their business like professionals,' says Frank Mure of Utica Mutual.

Re's Mr. Torpey, who pointed out that the insurer has been conducting E&O seminars since the mid-1970s (A/BT, Aug. 7, 1989).

Results of such efforts are virtually impossible to quantify, but they can't hurt, added Mr. Wallace, who frequently conducts seminars and compiles a claims prevention newsletter for E&O Professionals.

Agents and brokers are taking advantage of such sources and can choose among a variety of agency procedures manuals and loss control seminars available to them.

For example, Hilb, Rogal & Hamilton Co. uses a customized risk management manual prepared by consultant Kurdziel & Associ-

ates, said Robert J. Hilb Jr., risk and marketing manager of the Glen Allen, Va.-based brokerage, the nation's 12th largest.

Hilb chose the Kurdziel manual after reviewing about six other systems over almost two years, Mr. Hilb said. "We swear by it."

At American Business Insurance Inc. in San Francisco, "we don't have to reinvent the wheel," said Bernard H. Mizel, president and chief executive officer of the nation's 13th-largest brokerage. ABI, which like Hilb has grown rapidly through acquisitions, uses a variety of commercially available E&O prevention material.

Despite its acquisition pace, including four purchases within the last year, ABI has had no problems with E&O claims, Mr. Mizel added.

E&O loss control procedures are particularly important for acquisition-driven agencies and brokerages like Hilb and ABI. For instance, both require prospective acquisitions to have current E&O coverage of their own prior to an acquisition.

"It's a prerequisite for purchase. They must show proof of current E&O coverage or we won't even proceed," Mr. Hilb added.

Hilb and ABI also require acquisitions to comply with their internal E&O standards. And they have legal, financial and operation consultants conduct due diligence be-

fore purchase.

Hilb's E&O premiums have risen more gradually than they would have had the company not adopted the manual two years ago, said Mr. Hilb.

In fact, E&O premium savings alone can be incentive enough for an agency or brokerage to implement a standardized loss prevention system.

"When you're paying premiums in the middle six figures, you tend to take things pretty seriously," said Frederick J. England Jr., president of Hastings-Tapley Insurance Agency Inc. in Cambridge, Mass.

At many larger agencies and brokerages, a full-time employee is assigned primarily to oversee E&O procedures and prevention, noted E&O Professionals' Mr. Wallace.

Bernadette McGlynn-Davis develops and monitors quality control programs to reduce exposure and improve client service at Hastings-Tapley. She joined the broker as a commercial account representative in 1978, was promoted to quality control director in September 1988 and given additional duties of commercial account manager in July 1989.

Ms. McGlynn-Davis works with department heads in developing standard procedures, and is currently working on a program to establish internal procedures and client audits to ensure the agency's employees are adhering to the program, she said.

"It's an ongoing program because you're always changing your procedures," she noted.

CIGNA phasing out COMPAR program

PHILADELPHIA—CIGNA Corp. will phase out its controversial COMPAR preferred agency program over the next two years, in part to allow the insurer to withdraw from unprofitable markets.

"If we decide we don't want to write a product in California, and we have 10 COMPAR agents there, we're stuck," said Jim Beattie, assistant vp of property/casualty.

A requirement that participating agents place nearly all their business with CIGNA has made 19-year-old COMPAR one of the industry's more controversial preferred agency programs (A/BT, Mar. 6, 1989). In return, the insurer provided a guaranteed and consistent market as well as higher commission rates and other benefits.

The decision was part of the Philadelphia-based insurer's "strategy for the '90s" in which it will increase specialization rather than trying to be "all things to all people and markets," said Mr. Beattie.

Preferred agreements vary, but most have two-year notice clauses allowing either CIGNA or the agency to terminate, said Mr. Beattie. The insurer will continue to honor preferred agent benefits such as loans, financial agreements and commission structures in the two-year interim before the program is phased out, he said. Agents also have the option to cancel the contract.

Terminating the program, he said, does not reflect problems with the 220 COMPAR agencies, and CIGNA hopes the agencies will continue to represent it as their main insurer.

Fraudulent claims

OAK BROOK, Ill.—A small but rapidly increasing portion of the general public believes padding an

A/BT briefs

insurance claim to cover the cost of premiums they pay is "all right," a recent survey found.

A growing number of Americans also believes that false claims for several types of coverage, including health and personal auto, are "very common," says a study released by the All-Industry Research Council in Oak Brook, Ill.

Six percent of respondents—up from 1% in 1981 and 2% in 1983—"strongly agree" that padding claims to recover premium costs is acceptable, the study found.

Also, 35% thought fraudulent malpractice claims are "very common," nearly double the 18% who said so in 1983, the study found.

President's award

ALEXANDRIA, Va.—Edward J. Noha, chairman, president and chief executive officer of Chicago-based CNA Financial Corp., is this year's recipient of the President's Award from the Independent Insurance Agents of America.

IIAA President Southgate Jones cited Mr. Noha's and CNA's efforts to enhance the reputation of independent insurance agents through its advertising campaign.

A CNA corporate ad campaign urges small business owners to consult independent agents when buying insurance. The ads are broadcast on radio and appear in various newspapers and magazines.

The campaign was designed and executed by CNA and Frank C. Nahser Inc. of Chicago.

Public relations

VAN NUYS, Calif.—Insurance

executives Paul Boulet and Robert Chodowski received the Professional Insurance Agents of California & Nevada's first public relations "Awards of Merit," which recognize outstanding service to community and consumers as advisers, educators and insurance professionals.

Mr. Boulet, president of Marlin Insurance Center, a Panorama City, Calif., agency, recently gave a presentation to the San Fernando Valley Board of Realty on how insurance rates are affected by outside factors like litigation costs and insurance fraud.

Mr. Chodowski, president of Lacey & Associates in Santa Ana, Calif., regularly contributes articles to insurance trade publications.

Charity marathon

LOS ANGELES—Members of the insurance industry in California are trying to "earn their wings" as good guys by participating in their first Jimmy Stewart Relay Marathon April 1.

The marathon benefits St. John's Hospital & Health Center in Los Angeles.

Los Angeles' popular 9-year-old charity run traditionally includes groups from real estate, food, entertainment, and not-for-profit agencies, said Alan Troop, president of Risk Management Inc. a subsidiary of Jardine Emmett & Chandler Inc. in Los Angeles.

Ten teams, fronted by six different insurance entities from the state, are scheduled to participate, said Mr. Troop. Sponsors are Johnson & Higgins' Los Angeles branch; Risk Management Inc.;

Jardine Emmett & Chandler of San Francisco; Industrial Indemnity Co. of San Francisco; and surplus lines brokers Sherwood Insurance Services and Montgomery & Collins, both of Los Angeles.

Companies pay \$500 to back a team of their own employees or an unsponsored group.

"We felt very good about sup-

porting the hospital, but it's also really a fun thing for our employees," said James W. McElvany, executive vp of J&H and one of the directors for the event.

For more information, contact Alan Troop at Risk Management Inc., 11845 W. Olympic Blvd., Fifth Floor, Los Angeles, Calif. 90064; 213-444-3359.

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Business Insurance

D&O underwriters increasing focus on niches: Wyatt

By MARK A. HOFMANN

The trend toward "niche underwriting" directors and officers liability insurance based on account size and industry showed no sign of reversing in 1989, according to The Wyatt Co.'s most recent D&O insurance survey.

In addition, despite increased competition in the D&O marketplace, policyholder-owned insurers are holding their own against traditional commercial counterparts, the survey found.

"As reported last year, the overall market remains stable, but there continues to be movement to specialized or niche underwriting by account size and industry. Perhaps the best example of the latter trend is the emergence of Aetna Casualty in the health-care D&O market," said Kenneth S. Wollner, the Chicago-based Wyatt consultant involved in preparing the report.

Hartford, Conn.-based Aetna Life & Casualty Co.'s Executive Risk Management Associates, which wrote less than 5% of the primary D&O coverage for health care institutions in the 1988 survey, wrote 17% of that coverage in the 1989 survey.

Warren, N.J.-based Chubb Corp., which provided primary D&O coverage to 42% of the 1988 participants in the publishing and communications category, was the D&O insurer for 54% of these respondents in the 1989 survey.

Aetna, which wrote less than 5% in the same category in 1988, increased its share to 8% in 1989.

Chicago-based CNA Financial Corp. now holds an 8% share of the primary D&O coverage in the publishing market, up from less than 5% in 1988. Meanwhile, CNA increased its leading market share among banking, financial and leasing companies to 29% from 27%.

And, New York-based American International Group Inc. moved into a dominant position among underwriters of primary D&O insurance for insurance companies, writing 45% of those policies, a whopping increase from 17% a year earlier.

Chubb continued to dominate merchandising and transportation industries, writing 38% and 41% of primary D&O policies purchased by companies in those industries, respectively.

However, AIG increased its market share among transportation companies to 19% from 14%, while policyholder-owned captive Corporate Officers & Directors Assurance Ltd.'s market share fell to 3% from 14% among transportation companies.

The 1989 Wyatt survey of D&O insurance includes information on 1,346 primary D&O accounts generating \$263 million in premiums, compared with the 1988 survey of 1,235 accounts generating \$324.5 million in primary D&O premiums.

Overall, AIG remains the leading underwriter of primary D&O insurance in terms of premium volume with a 30.74% market share in the 1989 survey, down from 32.68% in 1988. AIG, though, remained second in terms of policy count, writing 23.92% of D&O policies in the 1989 survey, down from 24.94% in 1988.

Chubb remains the second-largest underwriter of primary D&O coverage in terms of premiums written, accounting for 21.4% of the market in 1989, compared with 20.84% in 1988.

But Chubb leads in policy count, with 26.3% market share, down from 29.07% in 1988.

Directors & Officers Liability Insurance Ltd., a group captive for utilities that merged with AEGIS Ltd. early last year, remains the third-largest underwriter of primary D&O

coverage in terms of premiums written despite a significant drop in market share to 12.78% from 17.06% in 1988. However, in terms of policy count, DOLI remains sixth, writing only 4% of D&O policies, compared with 4.37% in 1988.

Lloyd's of London syndicates and other London underwriters remained the fourth-largest D&O insurance market with 6.49% of premium volume last year.

In terms of policy count, Lloyd's and other London underwriters ranked fifth, writing 4.1% of policies, down from 5.02% in 1988.

Aetna moved ahead of Great American Insurance Co. of Cincinnati in 1989 to become the fifth-largest D&O insurance market with 5.44% of premium volume.

Aetna is now the fourth-largest in terms of policy count, writing 5.57% of policies, nearly double its 3.72% marketshare in 1988.

CNA also moved ahead of Great American last year in D&O premium volume and is now the sixth-largest underwriter with 3.8% of the market, up from 3.39% in 1988.

CNA also remained the third-largest D&O underwriter in terms of policy count, with 6.09% compared with 7.37% in 1988.

Great American is now the seventh-largest D&O underwriter in terms of premium volume, with 3.86% in 1989 compared with 5.59% the previous year. Great American also is now the seventh-largest D&O underwriter in terms of policy count, writing 2.89% of all policies in 1989, down from 4.27% in 1988.

The survey also found that Chubb continued to be the D&O insurer of choice for companies with less than \$2 billion in assets.

However, AIG moved ahead of Chubb in insuring corporations with less than \$50 million in assets.

Among corporations with more than \$2 billion in assets, AIG ranked first, followed by Chubb.

On the excess side, Bermuda-based A.C.E. Insurance Co. Ltd. remains the leading excess D&O underwriter in terms of premium volume, writing 14.27% of the market's excess premium volume in 1989, down from 16.61% in 1988.

The 1989 survey covered \$168.2 million in excess D&O premiums, down from \$188.6 million in 1988.

AIG remains the second-largest excess D&O underwriter, writing 13.69% of the premium volume compared with 15.3% a year earlier.

Chubb remains the third-largest excess D&O underwriter, writing 9.98% of excess premium volume compared with 10.82% a year earlier.

Aetna is now the fourth-largest excess D&O underwriter, writing 9.41% of premium volume compared with 8.8% a year earlier.

And, Bermuda-based X.L. Insurance Co. now ranks fifth among excess D&O underwriters, writing 9.35% of premium volume compared with 8.23% in 1988.

But AIG and Chubb have swapped positions in terms of the number of excess D&O policies written.

AIG ranked first in 1989, writing 12.43% of the excess D&O policies, compared with 13.6% in 1988, when it ranked second.

Chubb slipped into second place in 1989, writing 11.89% of excess policies, compared its top-ranked 14.7% in 1988.

A.C.E. remains the third-largest excess D&O underwriter in terms of policy count, writing 9.84% of the excess policies in 1989, compared with 12.36% in 1988.

The 1989 survey covered 789 excess accounts compared with 732 in 1988.

D&O survey

Continued from previous page
against companies with an aftertax loss was 0.57 in 1989, compared with 0.54 a year earlier.

Companies without an aftertax loss had a D&O claim frequency rate of 0.41 in 1989 compared with 0.4 in 1988.

Companies with aftertax losses had a 1989 claims susceptibility of 26%, compared with 25% in 1988. Companies without an aftertax loss had a susceptibility rate of 20% in 1989, compared with 19% in 1988.

In addition, the larger the company, the greater its claim frequency and susceptibility, the survey found.

"Companies with assets greater than \$2 billion have about 150% the frequency of D&O claims of those companies with assets between \$1 billion and \$2 billion," the report noted.

Companies with more than \$2 billion in assets had a frequency rate of 1.01 in 1989, compared with a frequency rate of 0.69 for companies with between \$1 billion and \$2 billion in assets.

In contrast, companies with less than \$25 million in assets had a frequency rate of 0.02 in 1989, a decrease from 0.06 in 1988.

Companies with more than \$2 billion in assets had a susceptibility rate of 43% in 1989, unchanged from 1988.

However, companies with fewer than \$25 million in assets had a 2% susceptibility.

The number of shareholders a company has also made a difference in a company's D&O claim frequency and susceptibility, the survey found.

Companies with fewer than 500 shareholders had a 0.21 D&O claim frequency in both 1989 and 1988. And, their susceptibility rating was 12% in 1989, a slight drop from 13% a year earlier.

But, companies with more than 500 shareholders that do not publicly trade stock had a 0.7 D&O claim frequency in 1989, up from 0.53 a year earlier. And, their susceptibility rating climbed to 30% in 1989 from 19% a year earlier.

Publicly traded companies with more than 500 shareholders had a D&O claim frequency of 0.65, unchanged from 1988. And, their susceptibility rating inched up to 30% in 1989 from 29% in 1988.

As has been the case in past surveys, companies involved in banking, finance, leasing, utilities and petroleum are more susceptible to D&O claims than companies involved in other businesses.

Petroleum companies had the highest D&O claim frequency and susceptibility rating: 0.86 and 40%, respectively.

Publishing and communications companies had the lowest claim frequency and susceptibility rating: 0.16 and 8%, respectively.

Mr. Wollner said that extrapolation

of the data contained in recent Wyatt surveys indicates that state laws limiting the liability of directors and officers may have helped slow the growth in D&O claims from sources like suppliers, customers and employees.

For example, under Ohio's law, enacted in 1986, a director is liable for damages only if there is clear and convincing proof that the director intended to harm the corporation or recklessly disregarded its interests (B1, Feb. 1, 1988).

"One of the most important developments in D&O liability during the late 1980s is the enactment of remedial legislation in most states narrowing the personal liability of directors and other corporate managers. These amendments to the state corporation laws respond to a series of court decisions creating a tenuous liability environment for corporate management," Mr. Wollner said.

However, "the protection varies state to state, but, in general, the statutes do not change the susceptibility of directors and officers to claims brought by governmental agencies," Mr. Wollner noted.

"Moreover, since federal laws prevail in any conflict, the state statutes do not afford much protection to claims brought by shareholders alleging violations of securities and exchange laws and other federal laws. This explains, in part, why the frequency of claims by shareholders and government agencies continues to escalate, while no increase is recorded in the 1989 survey for claims brought by other sources," he said.

Mr. Wollner noted that claim frequency for claims brought by shareholders and governmental agencies rose to 0.25 in 1989 from 0.22 in 1988 and 0.15 in 1986/1987.

Meanwhile, claim frequency from all other sources declined somewhat to 0.22 in 1989 from 0.23 in 1988 and 0.26 in 1986/1987.

Mr. Wollner also said that "the surge in claims against directors and officers has caused increased atten-

tion to be focused on personal liability concerns and the protective steps that can be taken. A new service is being introduced (by insurers and consultants)—D&O loss prevention. The starting point for loss prevention is exposure identification and quantification."

However, Mr. Wollner added that loss prevention must be tailored to the exposures faced by individual industries and companies.

For example, highly regulated industries, like utilities, tend to face "more than their fair share of consumer claims," while financial institutions are facing increased exposure to lender liability claims, he said.

Meanwhile, directors and officers of high-tech companies "have been the targets of a growing number of financial reporting, antitrust and copyright or patent infringement suits," he said.

"Since the susceptibility of directors and officers to personal liability depends on several factors specific to each organization, a need exists to adjust loss prevention efforts to the precise exposure characteristic particular to that organization," he said.

Copies of "1989 Wyatt U.S. Directors and Officers Liability Survey" are available for \$500 for organizations that did not participate in the study and \$250 for survey participants from The Wyatt Co., Connie Johnson, Risk Management Services, 303 West Madison St., Suite 2400, Chicago, Ill., 60606-3308; 312-704-2719 or 312-704-0600.

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Theft of property poses liability questions

By The Insurance Institute of America

The following question and answer are drawn from the curriculum for the Associate in Risk Management designation awarded by the Insurance Institute of America. They represent the type of question asked—and the possible answers—in one of the three examinations for the A.R.M. designation.

This month's exercise, drawn from a recent national examination in ARM 56—Structure of Risk Management Processes—focuses on differences between a bailee's losses arising from theft of its own property and those arising from theft of customers' property.

Q: Because one of the employees of Jones Auto Dealership failed to lock a gate to its parking lot one night, thieves stole 20 automobiles from the dealership, and some of the cars were owned by the dealer. The other stolen vehicles were owned by customers who had left them with Jones for service or repair.

• Describe the significant differences between the dealership's exposures to theft loss of the vehicles it owns and the vehicles owned by others.

• Assume that one of the stolen vehicles was owned by a customer who had installed special equipment in the vehicle that was used to demonstrate a

product sold by the customer. Describe an appropriate procedure for valuing the extent of:

✓ The customer's property loss from this theft.

✓ The customer's net income loss from this theft.

• Assume that the vehicles stolen from the dealership included two identical cars, one belonging to the dealer and the other to a customer. Give three reasons why the dealer's liability losses for theft of the car the dealer did not own are likely to be greater than the dealer's property losses from the theft of the vehicles it owned.

A: • The first of at least three significant differences is that the vehicles the dealership owns represent a known property loss exposure to Jones. The other vehicles are a much less clearly definable liability and/or net income loss exposure for Jones.

Second, Jones' loss on its owned vehicles can be valued as the dealership's loss of use—whether that be for sale or for providing transportation—while its loss on the bailed vehicles is determined by the extent of the harm to their owners from the theft.

Third, as a dealer Jones probably

could replace the vehicles it owned at wholesale cost, while it could expect to pay retail prices to replace most of the bailees' vehicles.

• Here, the perspective shifts to one of Jones' customers, whose losses are quite different from Jones.

✓ The customer's property loss may be either the vehicle's replacement cost or its actual cost value. The procedure for determining replacement cost is to price comparable new vehicles. Determining cash value requires examining receipts for the vehicle's original purchase price, adjusting this amount to current price levels and then subtracting depreciation.

✓ The customer's net income loss from this theft is his loss of revenues (less non-continuing expenses) plus any extra expenses the customer incurred until the stolen vehicle was recovered or replaced. Determining these reductions in income and increases in expenses requires comparing the customer's actual post-loss income and expenses as a salesperson with what these would have been had the vehicle not been stolen.

• The dealer's property loss on an owned vehicle is only its wholesale value (for any vehicle that cannot be recovered) or the cost of renting a

comparable vehicle (for those that can be recovered). This property loss will almost certainly be less than the dealer's liability losses attributable to a customer's stolen car because those liability losses are increased by:

✓ Compensation for the customer's mental anguish.

✓ The likelihood that the customer's vehicle will have greater use value to him than the dealer's vehicles have to the dealer.

✓ The probability the dealer will have to pay retail prices to replace most customers' vehicles.

✓ The greater loss adjustment costs of settling liability losses when compared with property loss settlement costs.

✓ The possibility that the dealer will have to pay punitive damages for failing to properly care for customers' vehicles. (Any three of these five reasons, or perhaps other valid answers, would have earned full national examination credit.)

The sample questions and answers used in this column are taken from the Associate in Risk Management designation curriculum of the IIA. For more information on the content of the A.R.M. program, write Dr. G.L. Head, Vp, Insurance Institute of America, P.O. Box 314, Malvern, Pa. 19355.

Unsigned endorsement binding, court rules

An unsigned endorsement to a business liability policy excluding coverage for liability for employment discrimination was valid and binding, a Kansas appellate court ruled.

Topeka Tent & Awning Co. contracted with Glen Falls Insurance Co. for basic insurance coverage for a three-year period from Oct. 1, 1980, until Oct. 1, 1983. In addition, Glen Falls issued an umbrella policy effective for one year that was renewed two additional times.

In 1983, three former employees filed suit against TTA claiming racial

Legal briefs

discrimination. TTA requested Glen Falls to either defend the suit or provide coverage. The request was denied based on an endorsement attached to the umbrella policy that excluded coverage for liability arising from discrimination. This endorsement was not signed but was specifically referred to by number on the signed declaration page of the policy. Although this endorsement was unsigned, the original endorsement was

properly countersigned by the insurer as were the renewal endorsements. The trial court ruled for the insurer.

On appeal, TTA argued that an unsigned, but attached, endorsement was invalid. But, the court said that it could find no authority to sustain the claim. A signing of the policy is a signing of all riders properly attached to the policy at the time of the signing, the court said, adding that after two renewals TTA

should not be allowed to claim the endorsement was not binding. *Topeka Tent & Awning Co. vs. Glen Falls Insurance Co.*, Court of Appeals of Kansas, June 2, 1989 (BI/04/Jan.-\$10). ■

These abstracts were prepared by Cases Unlimited Inc. Copies of these decisions are available by sending a \$10 check payable to Cases Unlimited to Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590. List the number for each opinion.

GASB rules

Continued from previous page
payments for workers compensation and over five times current year payments for liability claims.

In deriving these numbers, we have assumed a typical payout pattern for public entities and a steady 10% growth in losses from one year to the next—from all causes (e.g., inflation, growth in exposures, etc.).

While the new GASB rules call for the establishment of a reserve at a higher confidence level than expected, discounting is also allowed. We have not shown these additional calculations here because they would complicate the presentation considerably.

Often, the margin for adverse fluctuations is about the same as the value of discounting, so these two added factors should not change the reserve-to-payments ratios significantly.

The other charts have been included in order to give you a feel for the magnitude of the effects of the changes in the accounting standards. In order to make a very rough, and I do mean very rough, estimate of the impact of these changes on your financial statements, I would suggest the following:

• How old is your self-insurance program? If it is about 2 years old, refer to the figures in the top of the chart. If it is a more mature program, about 10

years old or older, refer to the bottom figures.

• Note the relative size of calendar year paid losses to those shown in the appropriate figure. For example, if your program is about 10 years old and your calendar year paid losses are now about \$15 million, then your program is about 10 times bigger than the one depicted in the bottom chart.

• Multiply all the figures in the appropriate table by the factor you determined above. For example, if your program is 10 times bigger in its 10th year, then your booked expenses would increase from \$17.5 million under your old pay-as-you-go standard to about \$24.5 million under the new GASB rules. Additionally, you would probably need to establish loss reserves in the vicinity of \$62.5 million to meet the new standards.

Again, please bear in mind that these figures are only approximate at best, and that any program will probably differ significantly from the typical assumptions which are behind these figures. The only way to estimate these effects with any degree of accuracy is to have an actuarial study performed on your program, based on the types of information that I cited in the first part of the article.

Nevertheless, these rough calculations should give you a feel for the sheer magnitude of the changes that will be required by the new GASB standards. ■

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

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



Mr. Sherman

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

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

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

EC toughens pollution regulations

By Douglas N. Smith

IN EUROPE, pervasive pollution problems like acid rain, global warming, ozone depletion and toxic waste have come of age. Indeed, mounting ecological activism in the European Community is forcing manufacturers to adopt an offensive stance toward continentwide environmental standards.

To be sure, environmental protection is not a new issue within the EC, which has adopted more than 100 legislative measures since 1973. But insufficient regulatory pressure by the EC Council of Environmental Ministers has led member states to ignore some directives or treat them as guidelines. As a result, the EC Commission has more than 200 proceedings pending against member states that have failed to enact enabling legislation (*BI*, Nov. 27, 1989).

In contrast, the urgency of today's environmental action is being prodded by the Single European Act and its commitment to integrate environmental considerations into all areas of EC economic policy. For example, in a bid to harmonize member states' access to data, the Council of Environmental Ministers agreed last November to establish a European Environmental Agency to collect information on air, noise, water, soil, waste management, natural resources, dangerous substances and coastline protection. Future EC environmental policy will be based on published agency findings.

Another important development is a recent EC draft proposal which, if adopted by the Council of Environmental Ministers, would make producers of waste strictly liable for damage or injury to the environment. Based on the "polluter pays" principle, the proposal applies to all wastes generated by commercial activities, except nuclear waste, household waste or environmental pollution already regulated by other legislation.

Without doubt, environmentalism has begun to affect cross-frontier products in Europe. Thus, U.S. multinationals who want to compete effectively within the single internal market must learn to ride the environmental wave.

A quick glance at Europe's environmental legislation may help in the process.

• Belgium.

Environmentally, regional administrations have both legislative and executive powers, with a measure of responsibility shared by the national Environment Ministry.

In practice, a "framework" law will set forth the basic principles of an act, while royal and regional decrees are used to implement legislation.

The main body of Belgian environmental legislation includes:

✓ The 1964 Clean Air Act covers emissions from any source that may harm human health, animals or plants, or cause damage to goods or locations. The act empowers the government to forbid specific types of pollution, control or prohibit equipment and devices that may cause pollution, and regulate the type of equipment used in pollution prevention.

✓ The 1971 Protection of Surface Waters Against Pollution Act forbids throwing or depositing objects or matter, introducing gas, or allowing polluting liquids to run into public or coastal waters.

✓ The 1971 Act on the Protection of Groundwaters covers all waters that do not qualify as hydrographic—or surface—water and all water intended for water supply. The act empowers public health authorities to conduct quality control tests on drinking water.

✓ Belgium's 1978 law implementing the Oslo Convention was extended in 1983 to cover incineration of wastes at sea, as well as all other polluting operations.

✓ The 1973 Noise Control Act allows the government to prohibit or restrict the generation of specific noises and the manufacture, import, sale or distribution of noisy equipment.

✓ The 1974 Toxic Waste Act controls the disposal of unused or unusable products or byproducts, residues

International issues

and waste from industrial, commercial, craft, agricultural or scientific activities that might cause intoxication in humans, animals, or of the environment. The act prohibits dumping; in other words, placing waste outside the place where it is used or made. Waste may be destroyed, neutralized or disposed of on sites owned by the producer of the waste, or at a government-approved center.

In general, criminal penalties for environmental polluters are considered to be too low to motivate compliance with the laws. For example, the largest fine—up to \$28,500—can be imposed on violators of the Oslo Convention. Infringement of all other acts is subject to a maximum fine of \$5,700 and imprisonment for a period of eight days to six months, except for the Toxic Waste Act, which permits a fine of up to \$3,000 and a prison term of eight days to one year.

• Denmark.

The Ministry of the Environment controls five specialized national agencies, including environmental protection (Miljøstyrelsen), the national heritage (Fredningsstyrelsen), physical planning (Planstyrelsen), forestry (Skovstyrelsen) and food (Statens Levnedsmiddelinstitut).

The 1973 Environmental Protection Act is the framework law that empowers the Minister of the Environment to regulate activities within Denmark. Recent amendments to the act include Law No. 329 of 1985-06-04, which sets forth new regulations for the protection of the environment, and Law No. 355 of 1987-05-13, which amends certain environmental and planning laws.

The 1985 law prescribes either fines or imprisonment for violators but, to date, only fines—ranging as high as \$50,000—have been imposed. Government incentives and grants are available for new equipment, recycling equipment and research and development facilities for new anti-pollution tactics.

• France.

The French Environment Ministry was created in 1981 to oversee environmental policy and incorporate EC directives into national implementing legislation. All environmental laws or decrees are carried out by local administrative agencies—such as the Interdepartmental Industry Divisions, or the Departmental Directorates for Agriculture, Equipment and Health and Social Action—or by independent agencies such as the six Regional River Basin agencies, the Agency for the Quality of the Air and the National Agency for the Recovery and Elimination of Wastes.

Main French environmental legislation includes:

✓ The 1975 Waste Disposal and Material Recovery Law controls the collection, transport, storage, sorting, treating, dumping and discharging of most types of waste. Although Article 2 makes waste generators strictly liable for safely eliminating waste products, Article 9 allows for the possible transfer of liability to operators of officially approved highly toxic waste facilities.

✓ The Interdepartmental Industry Division's environmental inspectors are responsible for enforcing the law. Infringement fines range from 2,000 French francs (\$352) to 120,000 French francs (\$21,120) and a prison term of two months to two years.

✓ The 1976 Law on Installations Classified for the Purpose of Environmental Protection provides administrative control over environmentally dangerous activities such as explosions, toxic discharges or waste generation. The law also sets rules for opening, operating and closing waste generation facilities.

Unauthorized facility operators can be fined from 2,000 francs to 30,000 francs (\$5,280). In "irretrievably harmful" situations, the environment minister may invoke Article 15 and shut down the facility.

✓ The 1964 Water Law divided France into six regional river basins and established six regional river authorities to control general water use and discharges into waterways. The regional river authorities collect a

levy, which is used to finance anti-pollution equipment.

In conjunction with Article 434.1 of the Rural Code and the Public Health Code, the law prescribes fines of 500 to 8,000 francs (\$88 to \$1,408) and a prison term ranging from 10 days to one year for polluters of waterways.

✓ The 1961 Air Pollution Law controls airborne emissions from stationary incineration, combustion or heating installations. Ensuing implementing decrees have established the technical specifications for related equipment that is manufactured, imported or sold in France.

✓ The 1977 Law on the Control of Chemical Products aims to protect humans and the environment against risks resulting from chemical substances.

• West Germany.

The five divisions of the Federal Ministry for Environment, Nature Protection and Nuclear Safety (1986) have responsibility for administration, basic environmental policy and international issues, water and waste management, health and environment, air, noise and chemical risks, nature and soil, and nuclear safety and radiation. The federal environment minister issues technical regulations, but all regulations are administered by the states.

Main German environmental legislation includes:

✓ The 1974 Federal Emission Control Law aims to prevent environmental pollution, protect people, animals, plants and objects from environmental pollution damage, and protect water and soil from pollutants that are transported through the air. TA-Luft, the law's First General Administrative Regulation, was broadened in 1986 to cover almost all industrial installations that emit air pollutants in the FRG.

TA-Luft also requires that air pollution controls meet state-of-the-art technology standards and prescribes remedial steps for reducing and controlling emissions from existing installations.

✓ Amendments passed in 1986 to the 1980 Act on Protection Against Dangerous Substances establish a testing and notification system for new chemical substances marketed after Sept. 18, 1981.

✓ Amendments passed in 1986 to the 1972 Law on the Avoidance and Disposal of Wastes widen the categories of highly toxic wastes to include polychlorinated biphenyls, waste oil and sewage sludge and oblige producers to reduce both toxic and non-toxic wastes through recovery and recycling activities. Further, regulations cover 300 dangerous chemicals and call for inspections at 5,000 company sites; they also require the government to publish guidelines for safely disposing of environmental wastes.

✓ The 1976 Law for the Management of Water, and its 1986 amendments, allow the states to administer a two-tier system of permits covering the direct discharge of pollutants into surface waters, the indirect discharge of pollutants into municipal sewage systems, and harmful activities such as thermal pollution.

The law requires state-of-the-art technology for purifying and disposing of wastewater, as well as for storing and transporting toxic substances.

In addition, the 1986 amendments provided increased groundwater protection powers to the states, and drastically reduced the allowable discharge of toxic substances into water.

In summary, a knowledge of environmental legislation in European countries can help you to ride the environmental wave. Stay tuned for future columns that will highlight environmental legislation in the remaining EC countries.



Douglas N. Smith is vp and manager of the International Department of Johnson & Higgins in New York. His column appears the first Monday of every month.

Liability ruling

Continued from page 1

The judgment also will have a "considerable influence" in British Commonwealth countries like Canada, Australia and New Zealand, Mr. Marr said.

"When the highest court of the land, after thoughtful and deliberate consideration, announces what it plainly conceives to be a landmark decision, it usually succeeds for a generation or so," Minet's Mr. Earle pointed out.

Even if British or European Community legislation essentially overturns the recent ruling, "that rationale will have radiated out to all of the other common law countries, including the United States, where, depending on its strength and eloquence, it will have taken root and flourished," Mr. Earle said in the letter to clients.

In a Feb. 8 decision, the Law Lords overturned a Court of Appeal decision that London-based Caparo Industries P.L.C. could sue Touche Ross in London. Caparo alleged it sustained monetary losses when it acquired another company based on the company's annual accounts as audited by Touche Ross.

Caparo acquired electrical goods manufacturer Fidelity P.L.C. in 1984 after release of Fidelity's results for the year ended March 31, 1984.

Following announcement of the results on May 22, 1984, Caparo began to purchase Fidelity shares. On June 8, 1984, Caparo purchased 100,000 shares, but Caparo was not registered as a shareholder until after June 12, 1984, when the annual accounts were sent to shareholders. Caparo purchased another 50,000 shares on June 12 and bid for the remaining shares on Sept. 4, 1984.

Fidelity's operations were shut down in 1988 after Caparo saw Fidelity "was not capable of making a profit," said Caparo Chairman Paul Swraj.

"We bought what appeared to be a profitable company, not a losing company," he said.

Caparo alleged that its purchases of Fidelity shares after June 12 and the subsequent bid for all remaining shares of the company were "all made in reliance upon the accounts and that those accounts were inaccurate and misleading in a number of respects and in particular in overvaluing stock and underproviding for after-sales credits, with the result that an apparent pre-tax profit of

some 1.3 million pounds (\$1.5 million at year-end 1984 exchange rates) should in fact have been shown as a loss of over 400,000 pounds (\$464,000)," said Lord Bridge of Harwich in the judges' ruling.

Caparo sued in July 1985, alleging that "Touche Ross, as auditors of Fidelity carrying out their functions as auditors and certifiers of the accounts in April and May 1984, owed a duty of care to investors and potential investors, and in particular to Caparo, in respect of the audit and certification of the accounts."

During a pretrial hearing in High Court in July 1987, Sir Neil Lawson ruled that Touche Ross owed no duty under common law to Caparo as a potential investor or as an individual shareholder that would enable Caparo to recover damages for losses sustained by relying on the audited accounts.

However, the Court of Appeals subsequently ruled that even while there is no contractual relationship between an auditor and a potential investor, there is a sufficient relationship between an auditor and an individual shareholder to impose a duty of care on the auditor under common law.

As a result, an auditor is liable to an individual shareholder that suffered a loss by relying on negligently prepared annual accounts, the Court of Appeal ruled.

But all five judges in the House of Lords agreed that an auditor owes no duty of care to a potential investor or to individual shareholders.

In their ruling, the judges noted that court decisions throughout the world have extended the duty of care that professionals owe to third parties if professionals can foresee that third parties would use improperly prepared information in a way that could cause the third parties damage and if there is some sort of relationship between the professionals and the third parties.

However, "it is almost always foreseeable that someone, somewhere and in some circumstances may choose to alter his position upon the faith of the accuracy of a statement or report which comes to his attention, and it is always foreseeable that a report—even a confidential report—may come to be communicated to persons other than the original or intended recipient," said Lord Oliver of Aylmerton.

Therefore, "to apply a test of liability only (on) the foreseeability of possible damage without some further control would be to create a liability wholly indefinite in area, duration and amount and would open up a limitless vista of uninsurable risk for the professional man," he ruled.

In Lord Oliver's judgment, "the purpose for which the auditors' certificate is made and published is that

of providing those entitled to receive the report with information to enable them to exercise" certain powers, such as voting for the company management at annual general meetings. It is "not for the purposes of individual speculation with a view to profit," he ruled.

In addition, "the duty of care is one owed to the shareholders as a body and not to individual shareholders," he said.

"To widen the scope of duty to include loss caused to an individual by reliance upon the accounts for a purpose for which they were not supplied and were not intended would be to extend it beyond the limits which are so far deductible from the decisions of this House," he concluded.

In agreeing with Lord Oliver's decision, Lord Bridge of Harwich stated that "the auditors of a public company's accounts owe no duty of care to members of the public at large who rely upon the accounts in deciding to buy shares in the company."

"If a duty of care were owed so widely, it is difficult to see any reason why it should not equally extend to all who rely on the accounts in relation to other dealings with the company as lenders or merchants extending credit to the company," Lord Bridge said.

"The only support for an unlimited duty of care owed by auditors for the accuracy of their accounts to all who may foreseeably rely upon them is to be found in some jurisdictions in the United States of America where there are striking differences in the law in different states," he noted.

However, Lord Bridge added: "In this jurisdiction I have no doubt that the creation of such an unlimited duty would be a legislative step which... would be for Parliament, not the courts, to take."

Lord Roskill also commented on the decision "because of the importance of this case."

Several courts this century have ruled that professionals owe a duty of care to "third parties in cases where there was no contractual relationship between them, a view of the law long denied" last century, Lord Roskill noted.

"But subsequent attempts to define both the duty and its scope have created more problems than the decisions have solved," Lord Roskill observed.

"The submission that there is a virtually unlimited and unrestricted duty of care in relation to the performance of an auditor's statutory duty to certify a company's accounts, a duty extending to anyone who may use those accounts for any purpose such as investing in the company or lending the company money, seems to me untenable," Lord Roskill said.

"Advice to individual shareholders in relation to present or future investment in the company is no part of the statutory purpose of the preparation and distribution of the accounts," wrote Lord Jauncey of Tullichettle.

"If the statutory accounts are prepared and distributed for certain limited purposes, can there nevertheless be imposed upon auditors an additional common law duty to individual shareholders who choose to use them for another purpose without prior knowledge of the auditors? The answer must be no," he asserted.

Caparo's Mr. Swraj said: "We're very disappointed in the ruling. I am concerned that the lack of responsibility owed by accountants who can charge such fancy fees.

"Company accounts should carry a health warning that they are not to be trusted," Mr. Swraj said.

Others, though, praised the ruling. Minet's Mr. Earle said: "Under any view of the matter, this was the best day in court for the business community since 1931," when the New York Court of Appeals ruled in *Ultramares Corp. vs. Touche Ross*, which also

centered on an accountant's liability to third parties with which it does not have a contractual relationship.

In that case, cited by several of the law lords, the New York chief justice issued a warning against "liability in an indeterminate amount for an indeterminate time to an indeterminate class."

The judgment by the House of Lords likely will influence many U.S. jurisdictions, including those in which courts have widened professionals' liability to third parties, attorneys believe.

"A very responsible—and one of the highest—courts has rejected some of the new theories of professional liability and makes it clear that (recent) litigation has gone far enough and shouldn't go any further" in extending professionals' liability, said Mr. McLean of Sidley & Austin.

The judgment "could further militate toward California going back to the traditional role that auditors only hold duty of care to their clients," said Jeff Leo, a partner of Los Angeles law firm Wolf & Leo.

For example, the California Supreme Court refused to hear an appeal of the January 1986 ruling by the California Court of Appeals in the case of *International Mortgage Co. vs. John P. Butler Accountancy Corp.* that an accountant has a duty to any third party the accountant could have reasonably foreseen would rely on audited or reported financial statements (*BI*, March 3, 1986).

The International Mortgage case was later settled out of court.

However, the California appellate court's decision to extend accountants' liability "sometime in the next few years is likely to be rolled back by the Supreme Court" of California, Mr. Leo predicted, adding that the House of Lords ruling likely will hasten that reversal.

"There have been lots of lower courts which have been expanding professionals' liabilities" that may be reversed, Mr. McLean agreed. ■

British ruling may cut accountants' costs

LONDON—Last month's House of Lords decision limiting accountants' liability to third parties could lead to lower accountants' professional liability insurance costs, predicts a leading broker for the coverage.

"There's a good chance that the decision will be beneficial on the insurance market. It will take time for underwriters to evaluate the impact, but it has to be helpful in containing or reducing rates," said Peter Christie, chairman of Minet Specialty Management Inc. in New York.

Mr. Christie, whose clients include most of the major world accounting firms, refused to comment on the amount of capacity currently available in the market for accountants' liability cover.

The judgment also could influence outstanding litigation filed against auditors, observers said.

For example, British electronics and defense equipment manufacturer Ferranti International P.L.C. of London likely will examine the judgment closely before deciding whether to pursue litigation against accounting firm KPMG Peat Marwick McLintock.

Ferranti has filed a lawsuit in London's High Court seeking unspecified damages from Peat Marwick for alleged breach of contract and negligence in the accounting firm's audit of International Syndicate & Control Technologies of Lancaster, which Ferranti acquired in late 1987.

Market analysts estimate that Ferranti has sustained about 215 million pounds (\$365 million at current exchange rates) of losses because of the acquisition, which includes the price Ferranti paid to acquire ISC.

Ferranti also is suing several former ISC employees for \$198 million in damages, alleging fraudulent misrepresentation and breach of fiduciary duty, including an alleged dishonest scheme to abscond with funds.

Ferranti and Peat Marwick would not comment on decision. —By Carolyn Aldred

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Business Insurance

INTERNATIONAL

Bougainville

Continued from previous page
(\$84.3 million and \$111.9 million).

BCL filed three claims totaling \$400 million Australian with its insurers for property damage and business interruption losses stemming from the closure of the mine under an insurance policy in force from Oct. 31, 1988, to Oct. 31, 1989.

The first claim was for damage that occurred between Nov. 26 and Dec. 7, 1988, when buildings, a helicopter hangar, a guest house, a radio repeater station and mine vehicles were burned and two power pylons were toppled. BCL also estimated business interruption totaled 11 days and cost 1 million Papua New Guinea kina (\$1.1 million) per day.

The second claim was for damage from May 15 to July 1, 1989, when several vehicles, a pump station and four power pylons were burned, toppled or otherwise damaged. Business interruption extended to Sept. 5, 1989, from May 21, 1989.

Damage to two more power pylons and a BCL-owned house that was burned Sept. 6, 1989, were covered in a third claim. Business interruption began Sept. 6, 1989, and is continuous as the mine as not reopened.

BCL says business interruption claims for 1988 and 1989 amounted to \$325.7 million Australian (\$249.6 million). And business interruption losses this year totaled \$59.3 million Australian (\$45.5 million) up to the Feb. 12 start of the trial.

Property damage losses, a relatively minor portion of BCL's claims, totaled nearly \$20 million.

CRA's Singapore-based captive, Metals & Minerals Pte. Ltd., writes 88.5% of BCL's coverage. The remainder is written by: GRE Pacific Insurance Pty. Ltd., a Lae, Papua New Guinea-based unit of Melbourne-based Guardian Royal Exchange Assurance Group, which writes 10%; American Home Assurance Co. of New York, a unit of American International Group Inc., which writes 1%; and Tokyo-based Taisho Marine & Fire Insurance Co. Ltd., which writes 0.5%. The coverage has a 2.5 million kina (\$2.6 million) deductible.

Reinsurance for the captive is led

by Melbourne-based Royal Insurance Australia Ltd., a wholly owned subsidiary of Royal Insurance Holdings P.L.C. in London. Between 40 and 50 European and Australian companies also participate in the reinsurance.

BCL's coverage was placed through brokers for Sedgwick James Ltd. in Melbourne, a unit of Sedgwick Group P.L.C., which also placed reinsurance for the captive.

During the five days of hearings in Victoria's Supreme Court, Ken M. Hayne, the barrister representing BCL, said there were four issues outstanding in the dispute:

- Whether the physical loss, damage and destruction of BCL property was directly caused by or was a result of insurrection, rebellion, civil war, revolution or usurped power.

- Whether the policy's deductible was applicable to each of three separate claims filed by BCL or to the claims in the aggregate.

- Whether there was a defense of non-disclosure available to insurers.

- And how long BCL would be able to claim business interruption losses under the policy.

Insurers said coverage was barred by an exclusion for damage or business interruption caused by "insurrection, rebellion, revolution, civil war, usurped power or action taken by a government to prevent such an occurrence."

BCL claimed that rebel activities were civil commotion, but lacked an element of political motivation to fall within the terms of the exclusion clause.

Mr. Hayne said for the exclusion to apply, rebel actions had to be politically motivated and aimed at overthrowing the government or resisting a government using violence. BCL contends the actions were not so motivated.

On the issue of the deductible, Mr. Hayne said BCL's view was that the deductible applied only once for all claims.

"The fact that there is differing property damage does not lead to as many deductibles as there are separate items of property identified," he said.

Insurers also argued that when the policy was renegotiated before Oct. 31, 1988, BCL failed to disclose

threats made by rebel landowners on Bougainville to close the mine.

But Mr. Hayne downplayed those threats.

Warnings had been issued by landowners for many years, he noted, and "demands couched in colorful language were not uncommon in the correspondence" between Bougainville landowners and BCL officials, he said.

In addition, Mr. Hayne said BCL had complied with provisions of the Australian Insurance Contracts Act of 1984 in disclosing every matter it considered relevant.

Incidents on Bougainville before BCL's policy renewal were not serious enough to warrant informing brokers or underwriters, Frank Hoffman of Hoffman Consulting Pty Ltd. in Sydney, a leading Australian insurance law expert, said in court.

A broker seeking disclosure on the formation of a rival landowners group or threats of strikes and picketing would be "laughed at," he said. "An underwriter would not expect communication on those matters."

Mr. Hoffman also noted that a report prepared for BCL by risk management consultant Riskex Pty Ltd. of Melbourne prior to the policy's renewal indicated that riot was not considered a significant risk on Bougainville.

BCL also contended that policy wording allowed coverage for ongoing business interruption losses to extend beyond the Oct. 31, 1989, policy limit.

Mr. Hayne said the policy defined business interruption as being from the time of any physical loss or damage to property until repair or replacement to the same or restoration of equivalent conditions as before the damage. BCL argued, therefore, that the period of interruption extended beyond the October 1989 end of the policy term.

Since rebel activity began on the island, there have been about 100 deaths and the Papua New Guinea government has declared a state of emergency and has sent troops to restore order. The BCL mine, which is the island's major employer and only supplier of electricity to native villages, is 19.1% owned by the Papua New Guinea government.

Insurers rejecting claims from unrest on Pacific island

By KATE McILWAINE

PORT MORESBY, Papua New Guinea—At least two insurers in Papua New Guinea say they will not pay claims stemming from damage or loss of profits caused by insurrection on the island of Bougainville, an insurance industry official says.

Circumstances on Bougainville had "dramatically altered the risk under which the local and international insurance market accepted exposure," said Peter Miller, executive officer of the Insurance Underwriters' Assn. of Papua New Guinea in Port Moresby.

Bougainville, which is in the Papua New Guinea territory of the Solomon Islands, is the site of ongoing civil insurrection by factions that want the tiny South Pacific island to secede from Papua New Guinea (BI, Dec. 4, 1989).

Two of the eight insurance companies operating in Papua New Guinea have told Mr. Miller they will not pay claims and other insurers are "considering their options," he said. He would not identify the two companies.

Mr. Miller said the underwriters' association has viewed the deteriorating situation on the island in the North Solomons with "increasing concern over the last 16 months."

"The escalation of destructive activities is now affecting non-Bougainville Copper Ltd. properties and personnel, forcing evacuation and the abandonment of properties," he said. Rebel attacks have forced the closing of a BCL mine (see story, page 23).

Facing severe economic losses from the closed mine, the Papua New Guinea government has asked the Australian government for \$20 million Australian (\$15.3 million) in aid. Papua New Guinea, an Australian territory until 1975, held a 19.1% stake in the mine, which generated 17% of its revenues.

Mr. Miller said a normal, stable commercial environment no longer exists on Bougainville.

"The so-called revolutionary army has denied the will of the government, causing tragic loss of lives and widespread destruction of property by violent terrorism for more than 16 months," he said.

In response, Papua New Guinea has sent about 550 troops to track down members of the Bougainville revolutionary army and try to restore order on the island.

Losses due to civil war, rebellion, insurrection or war are internationally recognized as standard exclusions in property insurance policies, Mr. Miller said, noting that such incidents represent a material alteration to the risk underwritten.

"The losses may become unpredictable, excessive and therefore uninsurable," he noted. "On this basis, insurance claims for such losses would not be paid."

An "appropriate and responsible commercial response" was the attitude the insurers had adopted, according to Mr. Miller.

Mr. Miller said he did not know how many property/casualty claims from Bougainville companies already had been paid by insurers and that attracting adjusters to the island is now very difficult.

Mr. Miller's association represents Queensland Insurance (PNG) Pty. Ltd., a unit of Sydney-based QBE Insurance Group Ltd.; Southern Pacific Insurance (PNG) Ltd., a unit of National Pacific Corp. Ltd. of Dunedin, New Zealand; American Home Assurance Co., a unit of American International Group Inc. of New York; GRE Pacific Insurance Pty. Ltd., a unit of Melbourne-based Guardian Royal Exchange Assurance Group; the government-owned New Guinea Insurance Corp.; Tokyo-based Taisho Marine & Fire Insurance Co. Ltd.; and Auckland, New Zealand-based NZI Corp. Ltd.

Mr. Miller said an eighth insurer—MBS Assurance, a unit of the Malaysian-based MBS Finance—was licensed in New Guinea last year, but it was not affiliated with the group. Two insurers, Queensland Insurance and Southern Pacific, maintained offices on Bougainville.

U.S. to contest air crash liability

By STACY SHAPIRO

LONDON—The U.S. government will no longer accept partial responsibility for airline crashes without a legal fight, says a former Justice Department attorney.

Following the government's victory in a case involving the 1985 crash of a Delta Air Lines Flight 191 in Dallas in which a court ruled that the airline's crew members—not government employees—were at fault, federal agencies are more willing to litigate, he said (BI, Sept. 11, 1989).

The Delta case "is the first time in about 10 years that the U.S. government has fought completely through start to finish at a trial of an air crash case in which it believed it might have some responsibility," said Roy T. Kreiger, a Washington, D.C., attorney who was government co-counsel in the Delta trial.

"I think it demonstrates a willingness of the U.S. government to litigate cases rather than share in settlement agreements with insurance companies," he said at an Aviation Insurance Assn. meeting last month. "I think that is something to bear in mind for better or for evil."

Mr. Kreiger explained that the captain of Delta Flight 191, on his final approach to Dallas/Fort Worth International Airport, told the control tower that "out here in the rain it feels good."

But about two minutes later, the plane crashed short of the runway, killing 137 people—including a motorist hit by a jet engine.

Flight 191 was the victim of a "microburst," an intense, isolated thunderstorm with winds gusting up to 60 mph.

"The search for what went wrong during that 1-minute, 56-second period resulted in the Delta 191 trial, which was the longest aviation trial in U.S. aviation history," said Mr. Kreiger.

The government contended that the pilot had enough information to avoid the microburst and abort the landing. It also argued that he had enough knowledge and training to land safely once he was in the microburst. Delta claimed Federal Aviation Administration air traffic controllers and meteorologists were at fault.

About 100 lawsuits were filed on behalf of the passengers or their relatives against Delta, Lockheed Corp. and the government. For every suit against Delta, the airline filed a third-party action against the government, said Mr. Kreiger.

In addition, Delta's hull insurers sued the government for the \$25 million hull loss, he said. And Delta sued the government for \$11 million for the loss of two pilots, he added. Total claims against the government came to around \$175 million, according to Mr. Kreiger.

Although U.S. District Court Judge David O. Belew Jr. said that

federal air traffic controllers and meteorologists breached their duties, he ruled that they were not responsible for the crash.

"The debate about Delta 191 continues until this day even though the court handed down its decision on Sept. 1, 1989. The case is now on appeal and I'm quite certain we have not heard the last of Delta 191," Mr. Kreiger said.

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INTERNATIONAL

A.C.E. increases limit to \$200 million

By ROGER SCOTTON

HAMILTON, Bermuda—A.C.E. Insurance Co. Ltd., the huge policyholder-owned excess liability insurance facility, is boosting its maximum limit by \$50 million to \$200 million and plans to reinsure a London excess liability line slip being formed by C.T. Bowring & Co. Ltd.

A.C.E., which previously offered \$150 million in coverage excess of \$100 million, said that policyholders seeking additional coverage limits from A.C.E. must purchase the full \$50 million in coverage, which must be either the top layer or a portion of the top layer of the policyholder's excess liability insurance program.

"This new \$50 million is an all-or-nothing layer," said A.C.E. President and Chief Executive Officer Walter Scott. "You buy it all or you buy none of it."

Mr. Scott, who noted that A.C.E.'s minimum attachment point will remain at \$100 million, said the in-

creased limit was intended to meet the needs of many A.C.E. policyholders while increasing the company's profits. A.C.E.'s net income fell 12% last year to \$222 million.

"A lot of companies out there still have less casualty cover than they did in 1984," he said.

A.C.E. is writing the additional \$50 million limit net.

In addition, Mr. Scott said A.C.E. has reached an agreement in principle to provide reinsurance for a London line slip that will utilize the A.C.E. excess liability insurance policy form. The slip—to be organized by Bowring—will offer a \$100 million limit excess of an attachment point expected to be above \$200 million.

A.C.E. is offering to reinsure 10% of the slip.

Marsh & McLennan Cos. Inc., Bowring's parent, was the catalyst

behind the formation of A.C.E.

Mr. Scott also said that A.C.E. is expected to pay its first claim soon. While A.C.E. has been notified of possible claims, it has never had to write a claims check.

Peat sues law firm

Peat Marwick Main & Co., the accounting firm that audited Mentor Insurance Ltd. before it collapsed in June 1985, is suing the Bermuda law firm that represents Mentor's liquidators.

The action against the Bermuda firm of Appleby, Spurling & Kempe alleges that the firm's representation of the Mentor liquidators conflicts with the interest of Peat Marwick as a former client and breaches the legal profession's code of conduct.

The proceedings stem from a professional liability lawsuit filed against Peat Marwick last year by the Mentor liquidators. The suit names about 2,600 Peat Marwick partners in the United States and Bermuda in an attempt to name any partner who ever was involved with a Mentor audit.

The suit was filed in Bermuda in September after a New York state court earlier dismissed a January 1988 suit filed by the liquidators against Peat Marwick in the New York court. The original suit alleged that Peat Marwick had breached its duty to Mentor to render services in accordance with the prevailing standard of care.

Now, Peat Marwick is arguing that Appleby, Spurling & Kempe, which has represented the Mentor liquidators since the liquidation began, should not represent them in their suit against Peat Marwick.

The law firm represented Peat Marwick in a "previous action"

and so is disqualified from bringing the current suit, Peat Marwick says. No details about the previous case were released.

Peat Marwick, which is represented by the Bermuda firm of Milligan-White & Smith, alleges that Appleby, Spurling & Kempe will violate Section 24 of the 1981 Bermuda Barristers Code of Professional Conduct if it represents the liquidators in the suit against Peat Marwick. That section states: "A barrister shall not act for an opponent of a client, or of a former client, in any case in which his knowledge of the affairs of such client, or former client, may give him an unfair advantage."

However, Geoff Bell, the law firm's managing partner, says there is no conflict. "Normally conflict problems are resolved by referral to the Bar Council and we have said on more than one occasion that we would be happy for the complaint to go this route," he said.

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LONDON

Continued from page 23

billion from \$1.08 billion. Those revenues would leave the broker's No. 3 position unchanged in the ranking of the world's largest insurance brokerages, following Marsh & McLennan Cos. Inc. and Alexander & Alexander Services Inc. (BI, Feb. 26; June 26, 1988).

Using an average 1989 exchange rate of \$1.65 to the British pound, Sedgwick's brokerage revenues and fees, excluding investment income, reached \$939 million last year, while the next largest broker, A&A, posted brokerage revenues and fees of \$1.17 billion, according to Finance Director Stuart Tarrant.

Sedgwick's pretax profits increased 2.5% to 85.2 million pounds (\$140.6 million) from 83.1 million pounds (\$137.1 million) in 1988.

"Sedgwick has come out of 1989 with a very credible result stacked up with its three competitors," said Mr. Tarrant.

Considering that the market was "difficult" for all brokers in 1989, "we think it's been a good year for profit achievement," said Sedgwick Chairman David Rowland. But, it's been an even better year for restructuring the group and working "like a team," which will only benefit the company in the future, he said. Sedgwick restructured its operations earlier this year to focus on types of business rather than geographic regions (BI, Jan. 15).

Sedgwick also reported that:

- Investment income and interest increased 12.9% to 64.1 million pounds (\$105.8 million) in 1989 from 56.8 million pounds (\$93.7 million) the previous year.

- Expenses also increased 2.9% to 559.1 million pounds (\$922.5 million) last year from 543.6 million pounds in 1988 (\$896.9 million).

- Operating profit stayed flat at 88.2 million pounds (\$145.5 million) in 1989, up only 0.2% from 88 million pounds (\$145.2 million) in 1988.

Lloyd's members sue

Lawsuits filed by more than 800 Lloyd's of London members were expected to be served last week on R.H.M. Outhwaite (Underwriting Agency) Ltd. and about 80 Lloyd's members' agencies.

The members are claiming unspecified damages relating to the loss of hundreds of millions of dollars from Outhwaite syndicate 317/661 (BI, Dec. 25, 1989).

John Heynes, chairman of the panel representing members' agents with names on the Outhwaite syndicate during 1982, expressed regret that some members are suing their agents over underwriting losses.

"Underwriting insurance at Lloyd's is a risk business and all members are well aware of this. Whilst they trade at Lloyd's with the hope and expectation of an underwriting profit, losses regrettably do occur from time to time," said Mr. Heynes.

"Wherever possible members' agents will continue to assist names through what must be a difficult and worrying period. However, names must understand that by bringing these proceedings they will involve their members' agents in a very considerable diversion of time, money and commitment," Mr. Heynes said, adding that "members' agents must defend vigorously the allegations made with a view to having their role in this matter analyzed and cleared from legal responsibility."

Meanwhile, syndicate 317/661 has capped its liability for another runoff policy it wrote for syndicate 660, managed by Birrell Smith Underwriting Agencies Ltd.

The runoff policy was written by Outhwaite in 1982 and reinsured syndicate 660's past liabilities exceeding \$330,000 in the aggregate. Outstanding liabilities at year-end 1987 were \$2.25 million.

Outhwaite said the settlement will cap its liability under the policy but would not disclose other details.

Birrell agency officials were not available for comment.

Largest pollution fine

Shell U.K. Ltd. must pay a record fine for spilling 150 tons of crude oil into the River Mersey last August, a Liverpool Crown Court ruled late last month.

The 1 million-pound (\$1.68 million) fine—the largest ever assessed for pollution in the United Kingdom—stems from the first case taken to court by the National Rivers Assn., a government agency formed last year to monitor Britain's newly privatized water and sewage industry.

The subsidiary of Royal Dutch Shell Ltd. spent 1.4 million pounds (\$2.4 million) cleaning up the oil that spilled Aug. 19 from a corroded pipeline and settling related claims, said a company spokesman.

Losses were covered by Shell's London-based captive insurance company, Mytilus Insurance Co. Ltd. (BI, Oct. 16, 1989).

Meanwhile, Shell International Marine Ltd. last month told shipping brokers and tanker owners that its contracts now require shippers to carry \$700 million in pollution coverage.

Shell's action follows a move by members of the International Group of P&I Clubs to increase standard pollution liability insurance limits to \$500 million, with \$200 million of additional coverage available directly from the International Group (BI, Jan. 8).

"Recent events have shown that costs of pollution prevention/cleaning can on occasion substantially exceed the cover presently available and it is our view that responsible tanker owners would wish to avail themselves of this additional cover," Shell International said.

Loss prevention prize

A major transport and shipping mutual insurance company is inviting loss prevention ideas from around the world in a bid to reduce claims and lower members' insurance costs.

Transport Mutual Services, the London agent of Bermuda-based Through Transport Mutual Insurance Assn., is offering \$20,500 in prizes for ideas that will improve loss prevention for shippers, port authorities, terminal operators and others in the transport industry.

Launching the "StopLoss 90" campaign last week, Director Mark Holford said the TT Club hopes to attract ideas from every level of the transport and shipping industry—from the shop floor to the board room.

For more information, contact Through Transport Mutual Services, Holland House, 1-4 Bury St., London, England EC3A 5AE; 01-283-8686.

Stolen art data base

Lloyd's of London and several fine art dealers are creating a data base of stolen art in an attempt to reduce the amount of stolen art resold throughout the world.

A central computerized register of stolen items was formed by the Art Trade Liaison Committee and the Corporation of Lloyd's in consultation with various police forces, customs agencies and Interpol.

The International Art & Antique

Loss Register Ltd. will be available to dealers and auctioneers and its graphic capabilities will facilitate recognition of stolen works.

"The alarming incidence of fine art theft has dictated the need for an international data base of this kind. I am particularly pleased that the fine art and insurance industries have combined in a unique effort to establish this aid against crime," said Anthony Coleridge, chairman of the ATLCL.

The International Foundation for Art Research, a non-profit association based in New York, lists more than 1,000 objects stolen a year, up from about 500 in the early 1980s.

Among the dozen groups planning to invest in the project are: the Corporation of Lloyd's, through its subsidiary Lloyd's of London Press Ltd.; Hogg Robinson & Gardner Mountain Insurance Brokers Ltd.; auction houses W & F.C. Bonhams, Christie's, Phillips and Sotheby's; and several fine art industry associations including the IFAR.

Negotiations also are under way with potential institutional investors and insurance companies in the United States, Europe and the Far East.

The art research foundation is negotiating an agreement for the new company to take over maintenance and computerization of its 32,000 paper files on stolen art. The IFAR also will provide a New York office to support the London data base.

Data base searches will be available beginning Jan. 1, 1992, Lloyd's estimates.

Stolen works will be registered by insurance companies and uninsured owners for a fee, and auction houses and art dealers will be charged a fee for system searches.

Members' agent bought

Sturge Holdings P.L.C., Lloyd's of London's largest underwriting agency, has purchased Lloyd's members' agency Hall Harford Jeffreys Langdale Ltd. for 2.15 million pounds (\$3.7 million at current exchange rates).

HHJL represents 168 Lloyd's underwriting members with an allocated underwriting capacity of 76 million pounds (\$129 million).

It "will be merged as soon as is practicable" with Sturge subsidiary Oxford Members' Agency Ltd., the company reports. HHJL Chairman John Harford will become chairman of the combined operation and will also become a director of Oxford Agency Holdings Ltd., Oxford's parent.

The acquisition will increase the number of Lloyd's members represented by the Oxford Group to 794 with an underwriting capacity of 286 million pounds (\$485.5 million).

Sturge Chairman David Coleridge notes in the Sturge's annual report published this month that Sturge "continues to explore opportunities to purchase other agencies within the Lloyd's community."

"The more syndicates that we can manage within the group and the more names whose affairs are managed within the group, the easier it will be to command the sort of overall capacity necessary to fulfill our long terms," he said.

Sturge also is looking to expand abroad, according to the annual report.

The forthcoming single trading market within the European Community "will offer greater opportunities to all U.K. insurers to expand into a marketplace of 320 million people where the average per capita expenditure on insurance is only 36% of that in the U.S.," the report notes.

"The group is examining the opportunities and has established a

European Planning Group to determine the returns from this potential market... (and is) exploring ways of bringing further business to the group," the report adds.

New Minet unit

A new unit of London broker Minet Holdings P.L.C. will provide insurance brokerage and risk management services to British hospitals.

In particular, Minet Medical & Risk Control Insurance Services' target market will be National Health Service hospitals that opt for self-governing status under health service reforms proposed by the government.

Under the proposal, NHS hospitals will be able to operate independently from the Department of Health, which now governs the hospitals, and form National Health Service Hospital Trusts.

NHS Hospital Trusts "will have full responsibility for the hospital's assets and liabilities. Full responsibility for the protection of those assets must follow," according to MinMed.

"The management of risk will provide a considerable new challenge for hospital trusts," commented Peter Mill, a director of MinMed.

"No NHS hospital administrator has had to buy significant insurance cover... MinMed has been formed specifically to deal with this problem," he said.

Zurich restructures

Swiss insurer Zurich Insurance Co. is restructuring its U.K. opera-

tion into three main business divisions: commercial lines; international and special risks; and personal lines.

Each division will be a profit-center with its own claims, technical underwriting, servicing, marketing and sales resources. Local underwriting and claims authorities are being increased to facilitate on-the-spot decisions, according to Zurich.

"Our long-term business goal is to be in the Top 10 of U.K. insurers, with premium income exceeding 1 billion pounds (\$1.69 billion). The restructuring is the first step towards achieving this objective," said Dennis White, chief executive of Zurich Insurance (U.K. and Ireland).

Heading the three new U.K. divisions will be: Alan Ridding, head of personal lines; David Sandoe, in charge of commercial lines; and Edward Hester, overseeing international and special risks.

Comings and goings

Mark R. Massie will succeed Jimmy Archer as underwriter for Lloyd's of London marine syndicate 868 beginning Jan. 1, 1991. Mr. Archer will continue as chairman of underwriting agency A.J. Archer Holdings P.L.C. In addition, he will continue as underwriter for marine syndicate 741 at least until Dec. 31, 1990, or until a successor is appointed.

Thomas G.V. Roberts has been appointed chairman of the Marine and Energy divisions of Bain Clarkson Ltd. He previously worked for Lloyd's of London broker Leslie & Godwin Ltd.

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Canadian health plan too costly: Study

By MICHAEL SCHACHNER

Creating a Canadian-style national health care system in the United States would require at least \$339 billion in additional taxes, according to a recent study.

And the tax increase required to finance such a system, combined with the loss of corporate tax deductions for employers' health care contributions, would devastate many companies, the study charges.

Industries, like automobile manufacturers, that typically pay high wages and benefits would be hard hit, while retailers and other low-wage, low-benefit businesses would be less seriously affected, according to the study.

Establishing a national health care system based on the Canadian model would make the United States one of the most heavily taxed industrial nations, the study further asserts.

Some employee benefit consultants, though, criticized the study for what they said were unrealistic assumptions.

Options for financing a national health care plan other than increasing taxes are not considered.

The study, "What a Canadian-style Health Care System Would Cost U.S. Employers and Employees," was prepared by Fiscal Associates in Washington, D.C., for the National Center for Policy Analysis, a public policy research organization in Dallas.

"Those calling for national health insurance have focused only on the benefit side. They have forgotten to look at what costs would be and why," Gary Robbins, president of Fiscal Associates, told reporters last month in New York.

Canada's health care system gives citizens access to physicians of their choice. In addition, most tests and treatments, the services of specialists and the cost of any ensuing surgeries or hospital stays are free if recommended by the general practitioner.

The Canadian federal and provincial governments share the cost of the system.

But, applying the Canadian model to the United States, Mr. Robbins remarks: "With national health insurance, the responsibility is transferred to the central government and you have to give them the funds to pay for it. That takes more taxes."

For example, funding a national U.S. health care program solely by increasing Social Security payroll taxes paid by employers would raise employers' share of payroll taxes by 13.9 percentage points, the study says. That would hike the overall payroll tax rate—paid by employers and employees—to 28.9% from the current 15.3%.

Or, if the system were funded solely by an increase in corporate income taxes, employers' current income tax rates would have to increase by 14.4 percentage points, boosting the highest tax rate to 47% from the current 33%, the study projects.

If the financial burden for the new system were to be placed solely on employees, one of the following scenarios would occur, according to the study: their FICA payroll tax rate would increase 15 percentage points or their federal income tax rate would climb 15.7 percentage points.

If a consumption, or value-added, tax were used, the study says, the price of all goods and services would jump by 9.8%.

Mr. Robbins pointed out that his conclusions are conservative. Projections assume that health care costs would remain at their current level even if a Canadian-style plan were implemented.

"Any rise in health care spending—which is virtually inevitable—would require even more tax revenue," the study notes.

John C. Goodman, president of NCPA, which commissioned the study, underscored that the financial burden of national health insurance would not be spread evenly among all types of employers and employees.

"Retailers would benefit, but manufacturers would get killed," Mr. Goodman said. "And the auto industry could be the hardest hit."

Automakers now pay \$3,055 per year for each production worker covered under their private health insurance programs, according to Mr. Robbins.

However, if employers' taxes are increased

to finance a national health care program, the per-production worker cost of health care soars, the study shows. For example:

- If payroll taxes are increased, the per worker cost would rise by \$3,524.
- If income taxes are increased, the cost would rise by \$3,019.
- If a consumption tax is levied, the cost would increase by \$1,018.

Assuming a payroll tax increase borne by employers is used to fund a Canadian-style system, the study determined that the tire, petroleum and coal industries each would see per employee costs for health care increase by more than \$3,200.

"Companies with generous health care plans currently receive large tax subsidies because of the deductibility of health insurance costs—subsidies that would vanish under a government-funded health care system," Mr. Robbins said. "Once they account for the loss of current tax subsidies and the probable effects of new taxes needed to pay for national health insurance, many U.S. employers will find that the cost to them of national health insurance is greater than their current health care costs," he said.

By contrast, certain industries that provide lower wages and less comprehensive health benefits would benefit from a national health insurance system, the study contends.

For example, assuming a payroll tax increase on employers, the study says retailers, hotels, recreation services and even textile manufacturers will see health care costs per worker drop by more than \$1,000 per year.

David Young, a Wyatt Co. consultant in Washington, D.C., disagrees that industries with generous benefit and compensation packages would suffer the most from a national health insurance program.

If employers were held entirely responsible for funding the system, businesses that provide lower compensation would see the biggest increases in taxes, he says.

"I am skeptical about the assertion that the auto industry and similar industries will be hit hardest. What you have now is employers paying for very rich welfare programs without any employee contributions," Mr. Young said.

However, by switching the responsibility

to the federal government, the cost of the program would be eliminated, and the tax increases for funding the new national health care system probably wouldn't be greater than the original cost of providing private health care plans, he added.

In addition, Mr. Young said it is highly unlikely, as the study suggests is possible, that only employees would be required to finance the system through increased payroll or income taxes.

Employers would never be off the hook, Mr. Young insisted.

"Employees would demand wage enhancements if they were forced to cover themselves through income tax increases," he said.

However, the study's authors say they presume that under a scenario where workers alone shoulder the burden of financing the system, "employees receive a salary equal to the value of their lost private health insurance fringe benefit."

Thomas R. Burke, a principal with employee benefit consultant A. Foster Higgins & Co. Inc. in Washington, D.C., said he believes the \$339 billion total-cost figure is excessive.

"I've heard \$235 billion, but in any matter, the number is big. This type of system would carry a horrendous price tag, and with the economy in its present state, we can't afford an additional \$100 billion in taxes," said Mr. Burke.

Mr. Burke said the biggest strain on the system would come from covering the 31 million to 37 million Americans that are presently uninsured.

And, he said a national health care system would hit corporate pocketbooks the hardest.

"You can't give this type of benefit and not have corporate America pay for it. I cringe when I hear corporations saying they think national health insurance will save them money," he said.

Copies of "What a Canadian-Style Health Care System Would Cost U.S. Employers and Employees," are available for \$10 from the National Center for Policy Analysis, 12655 N. Central Expressway, Suite 720, Dallas, Texas 75243; 214-386-6272.



Bermuda payroll tax

Continued from page 23

ness as a location for insurance business," he told Parliament. "Indeed, for small insurance companies, the combined fees payable under the Companies and Insurance Acts will actually be slightly lower than at present."

Brian Hall, president of captive manager Johnson & Higgins (Bermuda) Ltd., agrees that costs for some captives will be lower under the new budget.

Most J&H clients will accept the fee structure, but the manager will reassess its activities "in the light of this budget to see whether we

can achieve greater efficiencies," he said.

"I cannot discount layoffs, but we're not considering any," said Mr. Hall. "It would be negligent of me not to be looking at our service functions in Bermuda and seeing whether any can be carried out in less expensive cost centers."

With a staff of about 150, J&H is one of the largest international employers in Bermuda.

"In the first year of this new budget, Johnson & Higgins' operating costs will rise by \$107,000 and we cannot simply allow that to go through to our

bottom line," said Mr. Hall. "We're facing an escalating tax bill for the next five years. Five years from now, when we're paying the full rate of payroll tax, our costs alone will be about \$300,000."

Mr. Hall is chairman of the statutory Insurance Advisory Committee, an influential group that advises the Ministry of Finance.

"The minister has inherited a balance of payments problem and is tackling it. My responsibility is to make sure we're operating as efficiently as possible and that means careful study of what we do and where we do it. Because of our

investment in technology, we're able to run our business from other domiciles if we need to," Mr. Hall pointed out.

He praised three provisions in the proposed budget: a \$50,000 increase in government spending on promoting Bermuda's insurance industry; a nine-month freeze on new government jobs and a promise by Mr. Saul that the fees will not be raised for two years.

But abolishing the stamp duty, he said, would not likely attract

corner."

The timing also was strongly criticized by Robin Spencer-Arscott, president of captive manager Rollins Burdick Hunter (Bermuda) Ltd. Mr. Spencer-Arscott, who heads a newly formed industry marketing group to sell Bermuda as a captive domicile, says the new tax could not have come at a worse time for the promotional effort.

He would not rule out layoffs among his firm's 42 employees and predicted competing captive domi-

'It would be negligent of me not to be looking at our service functions in Bermuda and seeing whether any can be carried out in less expensive cost centers,' says Brian Hall of captive manager J&H (Bermuda) Ltd.

new insurance business to Bermuda. "You might see it attracting new business in other sectors like mutual funds and trusts, but it's not likely in insurance where, since 1984, we've had a \$25,000 cap on maximum stamp duties payable on a company's capital."

Insurance management firms would have preferred to pay higher company fees and retain stamp duties rather than pay the payroll tax, he said.

"The timing of all this was very unfortunate," Mr. Hall said, noting that the annual Risk & Insurance Management Society Inc. conference and the annual captive forum sponsored by the Tillinghast division of Towers, Perrin, Forster & Crosby Inc. "are just around the

ciles would try to use the payroll tax to their advantage.

Captive managers also warn that more companies might follow a recent move by International Risk Management Group, which said it would transfer some activities from Bermuda to its new office in Dublin, Ireland.

The Bermuda government's new budget also will double the current \$10,000 annual fee paid by multiline insurers that write domestic property/casualty insurance.

These 30 or so companies "occupy a privileged position in our economy," Mr. Saul said.

According to the Finance Ministry, applying the payroll tax to international firms will raise \$2.4 million.

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European storms

Continued from page 4

earthquake, the explosion at a Phillips Petroleum Co. plant in Texas and Hurricane Hugo.

The losses are quickly draining capacity in the catastrophe retrocessional market, leaving underwriters struggling to reinstate retrocessional limits that have been depleted by the storm losses.

The recent storms have constituted at least four separate major losses, said Robert Robinson, assistant general manager of Swiss Reinsurance Co. (U.K.) Ltd.

According to the Lloyd's of London Underwriters' Non-Marine Claims Office, storms that hit the United Kingdom and Europe on Jan. 25 were designated as Catastrophe 90A; storms that hit Britain on Jan. 28 were designated 90C; storms that hit France and other continental European nations on Feb. 3-4 were designated 90D; and storms that swept across huge areas of Europe on Feb. 25-26 were designated 90G.

Reinsurance contracts commonly offer ceding companies coverage for one event, with one or two free reinstatements before underwriters charge an additional premium for further reinstatements.

Having exhausted their automatic reinstatements, many insurers and reinsurers are "finding it extremely difficult" to purchase additional reinstatements, said Mr. Robinson.

The reinstatement "market is getting very tough and insurance and reinsurance companies are now running bare," he said, adding that "lots of brokers are running around scratching their heads."

Swiss Re is offering reinstatements to only a limited amount of its clients, according to Mr. Robinson.

"There's a limit to how many times we are prepared to be hit," said Mr. Robinson, noting that there are contracts "that haven't been burned" yet that still have more than nine months to run.

Several underwriters probably have "run out of cover" because of the massive storm losses so far this year, agreed Dave King, an excess-of-loss reinsurance underwriter at Lloyd's.

Derek Walker, a leading Lloyd's non-marine London market excess-of-loss retrocessional underwriter, pointed out that he has virtually pulled out of the market for now because he has very little capacity remaining to write coverage for the rest of the year.

Huge rate increases for renewal contracts or for reinstatements in the London excess-of-loss retrocessional market and increasing demand because of recent catastrophes are causing many other LMX syndicates to run out of capacity, he said.

Meanwhile, because much of Europe has been constantly pummeled by severe winds since January, insurers and reinsurers could spend months debating how to aggregate the storm-related claims.

Most catastrophe reinsurance policies contain "hours" or "hourly" clauses that state that a single "event" for purposes of the contract cannot exceed a specified number of hours, typically 72 hours.

Ceding insurers usually have the option of choosing exactly when a 72-hour period begins when filing claims with reinsurers.

While Lloyd's has classified only four severe European storm events this year, the storms could constitute even more events depending on the time at which a 72-hour period begins.

For example, Belgium has now been hit with six or seven storms since the first major storm of the year hit on Jan. 25 and 26, according to the UPEA.

"It's very difficult to quantify how many catastrophes we've had and (as a result) many underwriters do not know how much exposure or cover they may have. This is making it very difficult to trade," the UPEA spokesman said.

Meanwhile, it will be difficult for primary insurers to identify when a particular loss occurred because many policyholders' storm-related claims now stem from damage sustained during several different storms, brokers and underwriters point out.

There is no way that insurers can say exactly which claims should be assigned to the four designated storm periods in Europe this year, said Jim Payne, chairman of London-based reinsurance broker E.W. Payne Cos. Ltd., a unit of Sedgwick Group P.L.C.

Many homeowners and commercial property owners that sustained damage on Jan. 25 and 26, when the first wave of storms struck the United Kingdom and continental Europe, would not have had time to repair that damage before the subsequent storms battered the already-damaged properties, he said.

While the storms have left the catastrophe reinsurance market in disarray, underwriters and brokers say rates still won't rise in the primary insurance market in 1990.

"People have lost sight of the fact that catastrophic losses are a problem insurers are here to cope with," said Jason Frangoulis, a general manager of Perth, Scotland-based General Accident Fire & Life Assurance Corp. P.L.C.

"If we get upset about losses like these, we shouldn't call ourselves insurers," he said.

While the storm losses will cause a further contraction of capacity in the retrocessional market, it will not directly impact the primary insurance market, he said.

Insurers will assess their rates at the end of 1990 when they have their annual results and know whether they will be paying increased reinsurance premiums, said a spokesman for the CDIA in Paris.

"Whether or not general rate increases are required as a result of the storms is too early to say and will depend on several different factors, not the least of which is

competition between the insurers," said Mike Jones, chief executive of the Assn. of British Insurers.

The major losses of the past six months—including the San Francisco earthquake, the Phillips Petroleum fire, Hurricane Hugo and the storms in Europe—will have no immediate effect on flat insurance rates, says Sedgwick Chairman David Rowland.

Although the catastrophe losses are hitting the reinsurance market hard, it will "take time" for the losses to force primary insurers to increase rates, he said.

"I expect this year to be flat" in terms of rates, Mr. Rowland said last week as Sedgwick announced its 1989 results (see story, page 23). "There is too much capital in the insurance business... and too much capacity for too little business. So a flat rate is the most likely outcome. Worldwide it is a very competitive marketplace."

"You'll see a change when you see the 1990 results at the end of the year. 1991 is the earliest you will see primary rates increasing," said Mr. Payne of E.W. Payne.

Mr. Payne added that despite the recent string of catastrophic losses, there still is plenty of capacity available in the primary insurance market. The capacity is fueled by high interest rates producing high investment income and a strong stock market supporting insurers' capital base, he explained.

"Unquestionably rates will increase" in the reinsurance market, added Tony Brend, chief executive of Commercial Union Assurance Co. P.L.C., when he announced CU's 1989 results last week.

However, he added that it is unlikely that primary insurance rates will increase before the end of the year.

"It is too early to say" what will happen to rates, added Peter Ward, U.K. manager for CU.

CU's 1989 results—like those of other U.K. insurance companies—suffered from weather losses like Hurricane Hugo, which cost CU 20 million pounds (\$32.2 million) in profits, including the cost to reinstate CU's reinsurance for two months following Hugo, said Mr. Brend.

CU reported that 1989 pretax profits dropped 25.4% to 150.5 million pounds (\$242.3 million at year-end 1989 exchange rates) from a record high in 1988 of 201.8 million pounds (\$365.3 million at year-end 1988 exchange rates).

The "severe windstorms" in January and early February already have cost CU 40 million pounds (\$67.4 million at current exchange rates), including a 20 million pound (\$33.7 million) premium to pay for two additional reinsurance reinstatements, Mr. Brend said.

If CU burns through that coverage, it still has one reinstatement remaining this year, he noted.

International Editor Stacy Shapiro in London and freelance reporters Denise Claveloux in Brussels, Belgium, and Don Kirk in Bonn, West Germany, contributed to this article.

Exxon indicted for '89 spill

ANCHORAGE, Alaska—Exxon Corp. could face more than \$600 million in fines if convicted on federal criminal charges of violating two federal acts in the massive March 1989 oil spill in Alaska's Prince William Sound.

A federal grand jury in Anchorage, Alaska, returned an eight-page indictment charging Exxon and subsidiary Exxon Shipping Co. with two felony and three misdemeanor violations of the Dangerous Cargo Act and the Ports and Waterways Safety Act.

Talks between the U.S. government and Exxon over a tentative plea bargain agreement under which Exxon would have been required to establish a \$550 million environmental restoration fund and would have been immune from federal prosecution for the spill broke down last week after Exxon refused to admit guilt for the massive spill. The state of Alaska vehemently opposed the tentative agreement, claiming the agreement

was drafted without the state's input (BI, Feb. 26).

Exxon would not comment on the indictment, but Exxon Chairman Lawrence G. Rawl said the company believes "there is no statutory basis for the amount of the fines mentioned."

Separately, the New York state attorney general is investigating a spill of more than 25,000 gallons of heating oil into the Kill van Kull waterway between New Jersey and Staten Island that occurred last week when an Eklof Marine Corp. barge began taking on Exxon oil. The barge had a hole in one of its tanks.

A U.S. Coast Guard spokesman said Eklof has assumed responsibility for damages, but Eklof would not comment.

Exxon is not liable for the spill, a spokesman said. "Once oil is loaded onto another vessel, it is no longer ours," he said.

—By Michael Schachner

Update

Quake damage assessed

Continued from page 2

The Property Claim Services Division of the American Insurance Services Group had not classified the Southern California quake as a catastrophe as of Friday "since the insurance loss does not seem in excess of \$5 million" and the quake did not involve "a significant number of insureds and insurance companies."

The Oct. 17 earthquake in the San Francisco area caused an estimated \$960 million of insured damage, making it the second-costliest U.S. natural disaster on record, according to the Property Claim Services division (see story, page 4).

California sues Farmers

LOS ANGELES—California Attorney General John K. Van de Kamp is suing Farmers Group Inc. for allegedly refusing to comply with provisions of Proposition 103 that mandate private passenger auto insurance charge rollbacks for policyholders with good driving records.

The suit, filed Friday in Los Angeles Superior Court, also alleges that Farmers is refusing to write auto insurance for applicants with good driving records, a violation of Proposition 103.

Mr. Van de Kamp, who is seeking a \$2,500 penalty for each violation, says there may be thousands of violations.

The suit is the first Proposition 103-related action taken by the attorney general's office independent of the California Insurance Department. Mr. Van de Kamp said he is investigating similar practices by other insurers.

A Farmers spokesman said: "We feel that we have always been in complete compliance with the law, since we are in a standstill agreement with the Department of Insurance and under the guidance of the department while awaiting final regulations."

Meanwhile, Voter Revolt, the group that sponsored Proposition 103, and Insurance Commissioner Roxani Gillespie have separately petitioned the California Supreme Court to consolidate and rule on the one dozen lawsuits filed by insurers challenging various provisions of the law pertaining to private passenger auto insurance.

The department also said last week that hearings on a fair rate of return for insurers will not be completed until mid-March.

County appealing VDT ruling

RIVERHEAD, N.Y.—Suffolk County, N.Y., will appeal a state trial judge's ruling that overturned the county's controversial law requiring protection of workers who regularly use video display terminals.

New York Supreme Court Judge John Copertino ruled Dec. 27 that the law was invalid because it superseded state labor and workers compensation laws (BI, Jan. 1). The law required employers with 20 or more VDTs to implement safeguards to protect workers who operate terminals for 26 or more hours per week.

"The court erred in stating that the county lacked jurisdiction in passing the legislation," said a Suffolk County spokesman, explaining that there were no state regulations pertaining to VDTs prior to passage of the county law.

"The case could have wide-ranging implications as far as legislating health and safety in the workplace," he added.

Meanwhile, Mitchell H. Pally, director of legislative and economic affairs for the Suffolk and Nassau counties Chamber of Commerce, which opposed the original law, said: "We had hoped that the county would work toward a resolution." But in light of the decision to appeal, "we will continue the battle," Mr. Pally said.

The county has until Aug. 15 to file an official appeal with the State Court of Appeals in Brooklyn.

Store settles accident claims

BROWNSVILLE, Texas—Insurers are paying \$33.1 million to the families of 14 people killed in a 1988 department store accident and to others who were injured.

The settlement will pay death claims stemming from the collapse of a roof at Brownsville's La Tienda Amigo store during a heavy rainfall (BI, July 18, 1988). Other families who have not filed claims but are clients of attorneys already suing the store also will be paid, said Mark Blakemore, a Brownsville attorney for Amigo Stores Inc.

Suits were filed against Amigo Stores, the city and its Public Utilities Board, local builders and building material suppliers.

Insurers of the defendants participating in the settlement include Crum & Forster Inc. in Morristown, N.J., Mr. Blakemore said.

A Crum & Forster spokesman confirmed the insurer is participating in the settlement, but he would not disclose details.

Cairo hotel fire coverage

LONDON—Sheraton Corp., which manages the Heliopolis Hotel on the edge of Cairo where 19 people died in a March 1 fire, is covered by a global casualty insurance program underwritten by Zurich Insurance Co. in London, a Zurich spokesman said.

However, sources in London say the hotel's owners, whom they did not identify, may insure 100% of the hotel's liability coverage with Al Chark Insurance Co. of Egypt.

A Zurich representative was sent to examine damage the day of the fire, but the insurer would not comment on the extent of coverage, the ownership of the hotel or whether other liability insurance for the hotel exists.

Sheraton's insurance program covers certain international hotels and is placed by Alexander & Alexander Services Inc. in Boston and Lowndes Lambert Ltd. in London, other sources say. Lloyd Thompson Ltd., a London broker, is a consultant on the coverage, they noted.

Three British journalists were among those who died when fire swept through the 597-room hotel, which was built in 1980. Reports

Continued on next page

Visclosky bill

Continued from page 3

401(k) plan has been difficult to manage and costly to administer as well as having a disappointing investment record compared with the employer-run 401(k) plan for salaried workers, said Jay E. Dittus, treasurer at Inland Steel.

"Recent experience with the union 401(k) plan suggests that the joint trusteeship provisions would greatly complicate management and oversight of plan assets, would increase costs and are likely to cause investment performance to suffer," he said.

But, Charles P. Valdes, an administrative joint board member of the California Public Employees' Retirement System, said that both employer and employee pension plan trustees may make bad investment decisions.

After questioning by committee chairmen Rep. William L. Clay, D-Mo., Mr. Dittus admitted that Inland Steel does not contribute to

the union 401(k) plan, though it pays plan administration costs, while the company does contribute to salaried employees' 401(k).

When asked why employees have not negotiated a joint trustee agreement for the union 401(k) plan, Morton Bahr, president of the Communications Workers of America, said many attempts to put the issue on the negotiating table have been to no avail.

"Unless companies are forced," they will not appoint employee representatives, he said.

Critics of the Visclosky bill also claimed that the Employee Retirement Income Security Act of 1974 adequately protects workers and retirees from abuse of pension funds.

ERISA requires pension plan trustees to act prudently and solely in the interests of plan participants and beneficiaries, said Mr. Dittus of Inland Steel.

"If trustees are doing wrong, then they should be sued," Mr. Winters of the Roundtable told the

subcommittee.

However, supporters of the Visclosky bill, who alleged abuses of pension plan assets by employers, said joint supervision of plan assets by employers and employees would better serve the plans.

'Unless companies are forced,' they won't appoint employee trustees, says Morton Bahr.

"Intense discussion" between joint trustees would mean pension plan investment strategies "are more thought out and geared to meeting specific objectives which are solely in the interest of plan participants," said Larry Jacobson, investment director of the Joint Industry Board of the Electrical Industry. That 31-member

board, which includes representatives from both the International Brotherhood of Electrical Workers and electrical contractors, manages pension plan investments for electrical contractors.

Oversight and scrutiny of pension plan assets by employee trustees would check some of the abuses that have "eroded the security of pension funds," said Teresa Ghilarducci, a professor of economics at the University of Notre Dame and a private pension specialist.

For example, she cited Texaco Inc.'s 1986 termination of Getty Oil Co.'s pension plan to help finance Texaco's debt from its buyout of Getty.

Employers increasingly have used pension assets to finance LBOs, mergers and other ventures that could result in plan termination, agreed Mr. Valdes of the CalPERS.

Mr. Valdes said that if employees in those cases had been allowed to participate in managing pension plan investments, they "may have

thwarted some of the excessive enthusiasm" for such endeavors.

The University of Notre Dame's Ms. Ghilarducci charged that, strapped for cash, some employers have reduced contributions or terminated plans.

But, in other cases, employers have invested excess pension assets in their businesses, benefitting employees and shareholders, she conceded.

Rep. Farwell charged that supporters of joint trusteeship are "involved in a takeover" themselves: of corporate pension plans.

But, Mr. Jacobson of the Joint Industry Board dismissed the notion that supporters of the Visclosky bill believe they would do better—only that they wanted "broad participation in the decision making process."

Employees "are not asking for a takeover," said the CWA's Mr. Bahr. "We are asking for equal participation. You can't make all of the decisions on where our money is invested." ■

Pepper commission

Continued from page 1

These recommendations are being sent to Congress by the Pepper Commission, a 15-member bipartisan panel of 12 members of Congress and three presidential appointees.

The mandate of the commission, established as part of the now-repealed 1988 Medicare Catastrophic Coverage Act, was to make specific recommendations to Congress to assure comprehensive health care coverage for all Americans. The commission was renamed last year following the death of Rep. Claude Pepper, D-Fla., a champion of the elderly and disadvantaged.

"We have made recommendations that begin to transform the nation's health care system," said Sen. John D. Rockefeller IV, D-W.Va., who unveiled the recommendations last Friday. Sen. Rockefeller succeeded Rep. Pepper as chairman of the commission.

But Sen. Rockefeller failed to win broad support among commission members for the recommendations, which is necessary to promote early congressional consideration.

The recommendation to impose a payroll tax on employers that fail to provide federally mandated group health benefits was passed only by an 8-7 margin, with Republicans leading the opposition.

Under the commission's minimum benefit requirements, employers would be required to pay 80% of the cost for individual and family coverage.

This requirement would greatly increase many employers' health plan costs since few employers now pay such a large portion of family health plan premiums.

Only 40% of employers pay more than 80% of the cost of family health care coverage while 24% of employers pay 71% to 80%, accord-

ing to a study by employee benefit consultant Hewitt Associates.

However, 51% of employers pay more than 80% of the premium for individual health coverage, and another 28% of employers pay between 71% and 80%, according to Hewitt.

Other specifics of the recommended benefit mandate would force many companies to upgrade their health care benefit programs.

According to the commission's report, a benefit package would have to include:

- Deductibles of no more than \$250 for an individual and \$500 for a family.
- Coinsurance requirements of no more than 20%. The maximum annual out-of-pocket expense for an individual or family could not exceed \$3,000.
- Full coverage for prenatal care, well child care, mammograms and pap smears.
- Coverage for at least 45 inpatient days of mental health care and 25 outpatient mental health visits. However, employees could be asked to pay up to 50% of the cost of mental health treatment.

These benefit requirements would supersede state benefit requirements for group health insurance—some consolation for multistate employers that complain that varying state benefit mandates drive up group health care costs and make it impossible to offer a uniform health plan.

To encourage employers with fewer than 100 employees to provide group health plans meeting the same standards, the commission is recommending special tax breaks.

Starting in the second year after enactment of the legislation, employers with up to 25 employees and a payroll averaging less than \$18,000 per worker would become

eligible for a 40% "tax credit/subsidy" to offset the cost of their health care plan. This subsidy would be available for five years.

If by the fifth year after enactment, 80% of workers at businesses employing fewer than 25 people do not receive employer-provided health care coverage, these firms would be required to offer a health care plan or pay the payroll tax.

In addition, if by the fourth year after enactment, 80% of workers at companies with between 25 and 100 employees are not insured by their employers, these companies would be required to provide the coverage or pay the new payroll tax. These employers are not eligible for tax credits.

Other recommendations made by the commission Friday include:

- Barring employers and insurers from denying coverage on the basis of a pre-existing medical conditions.
- Mandating that insurers set fully insured rates on the same terms to all groups in specified geographic areas.
- Requiring insurers to offer managed health care plans to small employers if such plans are available to larger employers in a geographic area.

The benefit package that employers would have to offer under the Pepper Commission's recommendations is similar to the one proposed by Sen. Edward M. Kennedy, D-Mass., in his mandated benefits legislation, S. 768.

Sen. Kennedy's bill also would give tax breaks to small employers if their health care costs exceed a certain percentage of the company's gross revenues.

Sen. Kennedy, whose bill passed the Senate Labor and Human Resources Committee last July (BI, July 17, 1989), is a member of the Pepper Commission. ■

Update

Cairo hotel fire coverage

Continued from previous page

say the fire, which injured about 70 others, started when a clay oven ignited a tent in the hotel's foyer.

A Sheraton spokeswoman in Boston said officials had not determined what caused the fire and would not comment on how commercial insurance might apply to losses.

Sheraton, which previously owned the San Juan Dupont Plaza hotel in Puerto Rico before the 1986 New Year's Eve fire there, agreed last year to a \$36 million settlement with plaintiffs.

The San Juan fire killed 97 people and injured more than 100 others.

The Sheraton settlement in that fire included recoveries under excess liability insurance written by American International Group Inc. (BI, May 15, 1989). Sheraton paid the out-of-court settlement after the Dupont Plaza fire Plaintiffs Steering Committee argued that Sheraton had the authority to make fire protection improvements at the hotel under a clause in its mortgage contract.

Dentist arrested for horse scam

MIAMI—A Kentucky dentist was arrested at a Miami race track last month for allegedly scheming to kill racehorses in exchange for a portion of the bloodstock insurance proceeds.

Dr. Joseph James Brown of Shelbyville, Ky., was charged with wire fraud last month after he schemed during telephone calls to an undercover agent with the Thoroughbred Racing Protective Bureau to kill a thoroughbred by lethal injection, according to the Federal Bureau of Investigation. Dr. Brown was arrested at Calder Race Course as he prepared to kill the horse, the FBI confirmed.

According to FBI documents, the dentist allegedly plotted to kill the horse for \$15,000. The fee included a \$2,500 deposit with the remainder to be paid after insurers settled the claim with the horse's owner.

Dr. Brown was released on \$5,000 bond by a U.S. magistrate in Miami.

FBI documents indicate Dr. Brown has admitted killing horses in exchange for insurance payments, but an FBI spokesman could not say how much he has collected.

Briefly noted

The **Federal Deposit Insurance Corp.** last week filed a \$560 million suit against accounting firm Ernst & Young, seeking damages connected with the audit of Western Savings Assn. of Dallas, a savings and loan that was declared insolvent by an estimated \$1 billion. The FDIC's suit, filed in the U.S. District Court for the Southern District of Texas, alleges that Arthur Young & Co., which merged with Ernst & Whinney last year, should have recognized the S&L's questionable loan practices during 1984 and 1985 audits. . . . **Transerv**, a Vermont-domiciled risk retention group providing auto liability coverage to taxi cab operators, is winding down operations after failing to meet growth targets. The insurer has sufficient assets to pay claims, said the Vermont Department of Banking and Insurance. . . . **Pfizer Inc.** says its "reserves and insurance are adequate for any potential liability" stemming from a flawed heart valve manufactured by Pfizer's Shiley Inc. unit. More than 82,000 heart valves were sold between 1979 and 1986, when the valve was pulled from the market, and between 300 and 400 are known to have malfunctioned, resulting in more than 200 reported deaths. The Food and Drug Administration is following up on complaints about the heart valve, said an FDA spokeswoman, who could not say whether the agency was conducting a formal investigation. . . . James E. Saxton Jr., 49-year-old vice chairman and corporate director of Texas Commerce Bank in Austin, is the new chairman of the **Texas State Board of Insurance**. Mr. Saxton, who will serve until Jan. 31, 1995, replaces Paul T. Wrotenberry, who resigned. . . . **A.M. Best Co.** is placing Executive Life Insurance Co. in Los Angeles and Executive Life Insurance Co. of New York, subsidiaries of First Executive Corp., on its watch list due to uncertainties about the insurers' future operating results. First Executive Corp., which has junk bond holdings with a face value of \$8 billion, took a \$515 million charge against fourth-quarter 1989 earnings to reflect defaults and declines in the value of the securities.

Datebook

MARCH

MARCH 13. Balancing Costs and Compliance of Employee Welfare Benefits workshop in Chicago, sponsored by the Illinois State Chamber of Commerce; \$120 for chamber members; \$180 for non-members. Illinois State Chamber of Commerce Center for Business Management, 20 N. Wacker Drive, Chicago, Ill. 60606; 312-372-7373.

MARCH 13-15. Reasoning Reinsurance Seminar in Dallas, sponsored by the University of Dallas Graduate School of Management; \$750. Bruce Evans, Reinsurance Management Institute, University of Dallas, Irving, Texas 75062; 214-721-5360.

MARCH 13-16. 14th International Captive Insurance and Reinsurance Forum in Hamilton, Bermuda, sponsored by Tillinghast; \$900; \$750 each for any subsequent registrants who are from the same organization. Eileen B. Callahan, Conference Director, Tillinghast, 695 E. Main St., Stamford, Conn. 06901-2138; 203-326-5400.

MARCH 14-15. CAOHC Approved Training Course in Occupational Hearing Conservation in Kansas City, Mo., sponsored by Impact Hearing Conservation Inc.; \$325 for certification; \$150 for recertification. Impact Hearing Conservation Inc., 406 W. 34th St., Suite 400, Kansas

City, Mo. 64111; 816-531-4848.

MARCH 14-16. Flex 2000: Employers Council on Flexible Compensation Annual Conference in Arlington, Va.; \$595 for ECFC members; \$645 for non-members; \$50 late fee after March 1. ECFC Conference Center, Department 5063, Washington, D.C. 20061-5063.

The Datebook is compiled from notices sent to Business Insurance. Notices should be sent at least eight weeks in advance to Datebook, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590. Please include the price, if any, of the meeting and information on registration for interested readers.

State regulation

Continued from page 3

While calling the report's warnings of a possible insurance industry crisis "unduly apocalyptic," Mr. Pomeroy said the subcommittee's investigation was "substantive and fair" and offers state regulators a "window of opportunity" to correct regulatory lapses before the federal government considers stepping in.

Mr. Pomeroy is pushing a "solvency policing" agenda within the NAIC that includes several steps intended to tighten state regulation.

Under one of these, the NAIC would begin certifying state insurance departments that meet NAIC-established minimum performance standards, including adoption by the state of various NAIC model insurance regulations (*BI*, June 19, 1989).

The association also is reviewing insurer examination procedures with the idea that a regular triennial exam may not be necessary for some companies and that insurance department resources can be better allocated by targeting problem companies for exams, Mr. Pomerov explained.

In addition, the NAIC is re-evaluating its "cumbersome" Insurance Regulatory Information System to determine if the financial information it provides on insurers can be

insurance industry if standards aren't improved, he suggested.

"If anything can put the fear of God into us, the Dingell report should," Mr. Pomeroy said.

James E. Long, North Carolina insurance commissioner and NAIC vp, agreed that the congressional hearings into insurance regulation are a "healthy process" and a "good starting point for an ongoing dialogue" between Congress and state regulators.

However, Mr. Long—who supports the NAIC solvency policing agenda—said he sees little threat of federal involvement in insurance industry regulation.

"I think the feds have enough to say grace over now with the S&L problem," he observed.

Other regulators were more critical of the House subcommittee's report.

While allowing that the report contained a number of "constructive criticisms," Nebraska Insurance Director William H. McCartney objected to several of its conclusions.

The subcommittee "looked at four or five



Mr. Pomeroov

"You are going to bring the system to its knees if you base it on the (assumption) that everyone in the industry is a crook and shouldn't do anything without checking in with their friendly regulator," he said. "You've got to do everything you can to guard against the crooks, but you can't have a fail-safe system."

Iowa Insurance Commissioner William Hager was more pointed in his criticism of the report, calling it "totally unfair."

The insurance industry is "extremely stable, on balance—certainly 1,000 times more stable than the savings and loan industry," Mr. Hager said.

"There have been insolvencies and there will continue to be insolvencies," he added, noting that with roughly 6,000 insurance companies operating in the United States, "a small degree of insolvency is predictable. In fact, it's inevitable."

The record of state insurance regulators compares favorably, Mr. Hager added, with the "pretty inept" performance of federal agencies regulating the S&L and commodities industries.

Mr. Pomeroy agreed: "I point to the S&L debacle as forever debunking the notion that there is something superior about the federal regulatory framework."

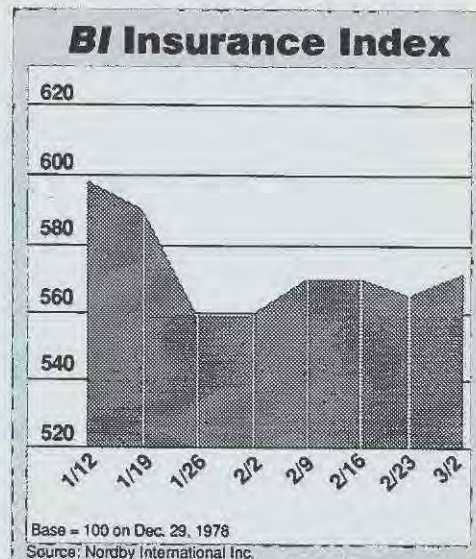
Meanwhile, the American Insurance Assn. and the National Assn. of Independent Insurers praised the subcommittee's report as a useful examination of solvency issues and noted the subcommittee found no evidence of "an overall crisis threatening the existence of the insurance industry at the present time."

Pointing to the report's assertion that solvency must be the first priority of regulators, AIA Vp Phillip Schwartz charged that this priority is being undermined by mandatory rate rollback legislation or initiatives like California's Proposition 103. "Unjustified price-cutting mandated by insurance departments is not compatible with effective regulation for solvency," Mr. Schwartz said.

While noting his group's support for the NAIC model act governing managing general agents, Mr. Schwartz was skeptical about the subcommittee's call for stricter regulation of insurer operations.

"I'm not sure how one requires effective management control. We would all like to see it, but if management is not going to be effective, I'm not sure what you can do."

RAA president Andre Maisonnier applauded the report's intentions but criticized its "broadly erroneous" characterization of the reinsurance business as unregulated. U.S. reinsurers, he noted, are regulated as any other insurer would be. ■



Base = 100 on Dec. 29, 1978

Source: Nordby International Inc.

Insurance industry stocks turned upward last week, as the *Business Insurance Index* rose 7.4 points to 571.8 on March 2, from 564.4 on Feb. 23. Advancing issues were led by Ohio Casualty Corp., up 14.1%; Berkley W.R. Corp., up 10.4; and Frank B. Hall & Co. Inc., up 9.1%. Declining issues followed American Heritage Life Insurance Co., down 25.6%; United Healthcare Corp., down 11.9%; and FHP International, down 11.6%. The most active issue during the period was United Healthcare Corp., 3.5 million shares traded. The *BI* Index gained 1.3% for the week; the Dow Jones 30 Industrials was up 3.8%; the Standard & Poor's 500 gained 3.5%; and the New York Stock Exchange Composite was up 3.1%.

British Issues

March 1 Companies	Price pence	P/E	Div. pence	Yield %	1 Week
					High—Low pence pence
Comm Union	474	21.8	28.7	6.0	487—474
Genl Accident	1037	15.9	66.7	6.4	1123—1037
Gdn Royal Exch	226	18.8	15.3	6.8	240—226
Royal	483	26.0	34.0	7.0	506—483
Sun Alliance	289	10.7	17.0	5.9	311—289
Brokers					
Bradstock	244	17.2	10.0	4.1	246—244
CE Heath	528	14.9	34.5	6.5	538—528
Hogg Robinson	154	10.8	9.7	6.2	160—154
Lloyd Thompson	269	17.9	9.3	3.5	271—269
PWS Holdings	60	9.4	3.3	5.6	60—58
Sedgwick Grp	262	19.9	16.0	6.1	272—263
Steel Brl Jones	287	17.9	15.3	5.3	287—283
Willis Farr	262	18.5	15.3	5.9	262—260

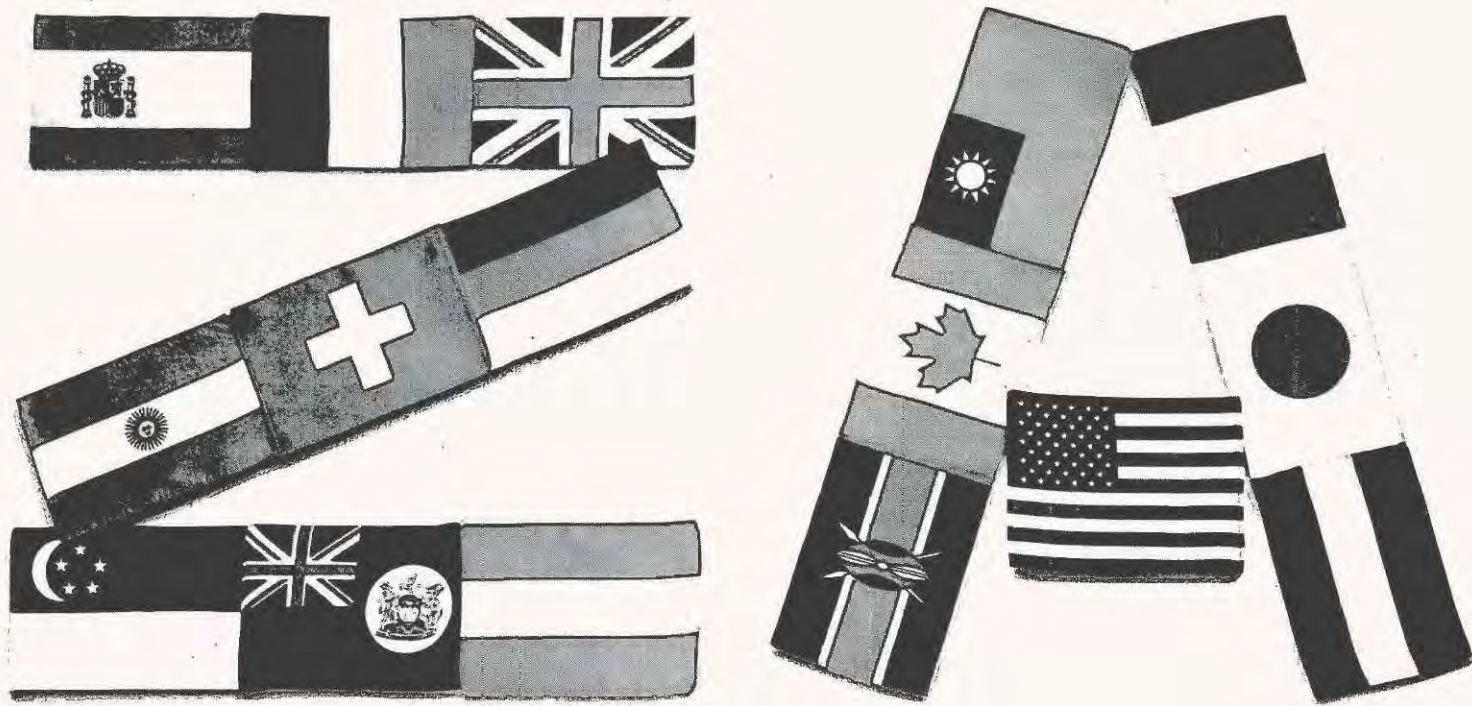
Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

BI Industry Stock Report

FEBRUARY 26, 1990 THROUGH MARCH 2, 1990

BROKERS													CONGLOMERATES & HOLDING COMPANIES													INSURERS/REINSURERS													HEALTH MAINTENANCE ORGANIZATIONS												
		Price	% change	Year to Date % change	Annual High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk value			Price	% change	Year to Date % change	Annual High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk value			Price	% change	Year to Date % change	Annual High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk value													
BROKERS													CONGLOMERATES & HOLDING COMPANIES													INSURERS/REINSURERS													HEALTH MAINTENANCE ORGANIZATIONS												
Alexander & Alexander	NYS	27.00	4.35	-14.29	34.00	23.63	209	1.00	3.70	19	9.18	2.94	Lawrence Insurance Group	ASE	7.00	3.70	-1.75	8.13	6.50	3	0.28	4.00	15	3.29	2.13	FHP International	OTC	18.13	-11.59	-14.71	26.38	10.25	3714	0.00	0.00	6	3.54	5.12													
Corroon & Black	NYS	32.88	0.38	-14.05	41.00	31.00	150	1.24	3.77	16	12.73	2.58	Liberty Corp.	NYS	46.00	0.55	8.24	46.63	32.50	26	0.92	2.00	17	31.82	1.45	HMO America Inc.	OTC	6.50	-7.14	-16.13	10.83	1.31	325	0.00	0.00	-91	1.12	5.80													
Gallagher Arthur J. & Co.	NYS	23.00	-0.54	-7.07	26.50	17.63	25	0.52	2.26	16	5.33	4.32	Lincoln National	NYS	53.88	2.86	-11.68	62.88	46.75	248	2.60	4.83	9	49.19	1.10	Pacificare Health Sys.	OTC	21.00	-7.69	-19.23	30.38	9.13	1083	0.00	0.00	6	6.35	3.31													
Frank B. Hall	NYS	3.00	9.09	0.00	4.63	2.50	198	0.00	0.00	-2	-2.80	-1.07	NAC Re Corp.	OTC	35.00	3.70	-13.45	41.00	23.75	214	0.20	0.57	14	22.81	1.53	Safeguard Health Enter.	OTC	6.63	-3.64	-22.06	12.50	4.88	157	0.00	0.00	11	2.99	2.22													
Hilt, Rogal & Hamilton	OTC	15.00	-1.64	-19.46	20.63	11.00	150	0.28	1.87	18	4.60	3.26	Navigators Group	OTC	31.25	2.46	13.64	31.50	21.25	48	0.00	0.00	11	15.22	2.05	Sierra Health Services	ASE	7.13	-3.39	-19.72	9.83	2.13	273	0.00	0.00	19	0.62	11.49													
Marsh & McLennan	NYS	79.00	3.95	1.28	89.75	57.63	465	2.48	3.14	19	10.56	7.48	Nobel Insurance LTD.	OTC	2.00	0.00	0.00	5.00	1.50	33	0.00	0.00	0	7.76	0.26	United Healthcare Corp.	OTC	9.25	-11.90	-24.49	12.63	6.25	4470	0.00	0.00	12	0.34	27.21													
Poe & Associates	OTC	12.25	0.00	-7.55	12.75	8.00	8	0.40	3.27	15	1.89	6.48	NWNL Companies	OTC	30.63	4.00	-22.47	44.13	26.50	712	1.20	3.92	6	37.50	0.82	United Medical Corp.	ASE	7.75	0.00	29.17	8.25	5.38	10	0.00	0.00	22	5.70	1.36													
BROKERS	AVERAGE		2.2	-8.7					2.6	15			Ohio Casualty Corp.	OTC	47.50	14.11	-0.52	52.50	34.75	393	2.32	4.88	10	33.30	1.43	U.S. Healthcare	OTC	11.00	-5.38	-22.81	15.50	8.50	0	0.00	0.00	0	3.07	3.58													
													Old Republic Int'l	OTC	24.75	2.59	-3.41	30.38	22.50	107	0.72	2.91	6	30.70	0.81		AVERAGE		-6.3	-13.7				0.0	-2																
													Orion Capital Corp.	NYS	19.88	1.92	-14.52	28.50	18.50	45	0.84	4.23	5	19.72	1.01			1.0	-8.3		2.9	9.7																			
													Phoenix RE Corp.	OTC	12.00	3.23	-7.69	15.50	8.75	23	0.20	1.67	92	12.99	0.92																										
													Protective Life Corp.	OTC	13.00	5.05	-8.77	16.25	10.88	68	0.68	5.23	8	14.54	0.89																										
													Provident Life	OTC	23.75	7.34	-8.21	30.13	20.25	259	0.80	3.37	7	23.24	1.02																										
													Re Capital Corp.	ASE	12.50	-0.99	-13.79	15.25	9.75	7	0.00	0.00	11	12.80	0.99																										
													RLI Insurance Corp.	NYS	10.00	1.27	12.68	10.38	6.88	18	0.40	4.00	7	10.71	0.93																										
													St. Paul Companies	OTC	61.50	4.68	2.50	63.50	46.00	1117	2.40	3.90	8	43.47	1.41																										
													SAFECO Corp.	OTC	37.25	6.05	-6.29	42.38	25.63	823	1.20	3.22	9	24.87	1.50																										
													SCOR U.S. Corp.	NYS	12.25	3.16	-14.04	14.50	8.25	45	0.40	3.27	16	10.61	1.15																										
													Seibels Bruce Group	OTC	10.50	5.00	-3.45	13.63	8.75	31	0.80	7.62	-2	13.75	0.76																										
													Selective Ins. Group	OTC	19.00	8.57	-0.65	20.25	15.25	119	0.96	5.05	6	15.72	1.21																										
													Statesman Group Inc.	OTC	2.50	2.54	-9.09	3.63	1.88	67	0.16	6.40	7	4.19	0.60																										
													Tokio Marine & Fire	OTC	58.63	-5.06	-22.22	90.75	58.50	50	0.92	1.57	25	70.93	0.83																										
													Torchmark Corp.	NYS	49.88	6.97	-12.88	58.75	31.75	232	1.40	2.81	13	13.23	3.77																										
													Transamerica	NYS	38.13	4.45	-14.57	48.00	33.00	541	1.92	5.04	9	34.63	1.10																										
													Traveler's Corp.	NYS	33.25	0.38	-9.83	45.00	32.00	1146	2.40	7.22	5																												
													Trenwick Group Inc.	OTC	20.75	0.00	-14.87	26.88	13.75	232	0.36	1.73	15	16.91	1.23																										
													United Fire & Casualty	OTC	30.50	-1.61	-7.58	34.50	29.00	1	1.20	3.93	8	22.56	1.35																										
													USF&G Corp.	NYS	28.25	1.80	-4.64	34.00	26.88	873	2.80	9.91	-38	22.87	1.24																										
													UNUM Corp.	NYS	45.75	5.78	-4.19	51.38	28.75	364	0.60	1.31	10	31.20	1.47																										
													USLIFE Corp.	NYS	38.50	-1.91	-14.92	48.13	37.63	192	1.48	3.84	5	54.34	0.71																										
													Washington National	NYS	24.63	-2.48	-12.83	29.13	24.00	18	1.08	4.39	-	32.90	0.75																										
													USLICO Corp.	NYS	22.25	-0.56	-6.32	25.38	21.00	72	1.00	4.49	6	27.73	0.80																										
													Zenith National Ins.	NYS	16.00	1.59	-14.67	21.50	14.00	71	0.84	5.25	0	13.81	1.16																										
													INSURERS/REINSURERS	AVERAGE		1.6	-7.7					3.5	11.6																												
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