

business insurance

Michigan to consider pool regulation legislation

LANSING, Mich.—A Michigan state representative has introduced legislation that would subject the state's municipal insurance pools to regulation by the Michigan Insurance Bureau.

The bill, sponsored by Rep. Mary C. Brown, D-Kalamazoo, would:

- Subject the pools to regulation under the state insurance code.

- Require the pools to meet the

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Firm restores health coverage for retirees

By DONNA DiBLASE

DETROIT—In the latest battle by retirees over health care benefits terminated or altered by employers, Baltimore-based Maryland Shipbuilding & Drydock Co. is reinstating retiree benefits if terminated nearly two years ago.

Maryland Shipbuilding, a wholly owned subsidiary of Detroit-based Fruehauf Corp., reinstated health care and prescription drug benefits on March 1 for about 1,065 retirees who are members of Local 31 of the Industrial Union of Marine and Shipbuilding Workers of America in Baltimore.

The benefits were reinstated under terms of a settlement between Maryland Shipbuilding and the retirees, which was approved Feb. 25 by U.S. District Court in Detroit.

The company also agreed to make a lump-sum payment of more than \$1.5 million to a "settlement fund" to cover medical, surgical and prescription costs incurred by the retirees during the time they were without coverage. In addition, the company will contribute \$270,000 to cover the retirees' attorneys' fees and the cost of administering disbursements from the settlement fund.

Maryland Shipbuilding, under the settlement, is entitled to negotiate and place the retirees' health insurance coverage with any insurer that has an A or an A-plus rating from A.M. Best Co. The company also can self-insure the coverage.

The retirees' benefits are currently underwritten by Blue Cross & Blue Shield of Maryland, as they were before they were terminated.

Quinn, Ward & Kershaw, the Baltimore-based law firm that represented the IUMSWA retirees in the case, handled a similar case last year in which the salaried retirees of Maryland Shipbuilding were notified that their retiree health care benefits would be canceled.

"We obtained a temporary restraining order requiring the company to continue providing those benefits," explained John T. Ward, a partner with Quinn, Ward & Kershaw.

"When we first took on the salaried retirees' case, there was no real case law regarding terminations of retiree health benefits. But, I think there will be more attention given to protecting retirees in the future," he predicted.

"Each case is going to have to go on its own. One has to look very carefully at the terms of collective bargaining agreements, such as what is promised and what the understanding of the benefits to be provided is on both the employer's and the retirees' side of the equation.

"The law is developing and thus far is developing to the advantage of retirees whose benefits have been terminated. However, we are far from an open-and-shut case," Mr. Ward observed.

The settlement between Maryland Shipbuilding and the IUMSWA retirees is the latest development in the ongoing legal battles involving employers' attempts to terminate or alter retirees' health care benefits.

In a case involving White Farm Equipment Co., a federal appeals court ruled in April 1986 that employers may terminate health care benefits for retirees without

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Car rental cover changes drive up employer risks

By MEG FLETCHER

Car rentals are posing new—and increased—risks for many employers.

Recent changes in short-term car rental agreements used by leading rental companies substantially increase the likelihood that some employers will be responsible for collision damage or liability claims stemming from rental car accidents.

The four leading rental car companies have increased employers' exposure for physical damage if an employee damages a rental car during a business trip. While employers previously could be held liable for only a few thousand dollars of damage, they now face the possibility of having to pay for the full value of a damaged auto—or more than \$20,000 for a luxury car.

Most employers self-insure this exposure and have no coverage to pay for a short-term rented car damaged by an employee, observers say.

In addition, three of the four leading car rental companies have reduced the liability coverage they automatically provide by at least 75% in most states.

These rental companies usually provide only up to \$25,000 per person and \$50,000 per occurrence in liability coverage if an employee injures another motorist or pedestrian, compared with previous limits of \$100,000 per person/\$300,000 per occurrence.

While most employers' business automobile insurance will cover liability exceeding these limits, the cost of this



Photo: Mary Herlehy

The four leading rental car companies have increased employers' exposure for physical damage if an employee damages a rental car.

coverage is expected to rise as more rental car-related claims are filed under these policies.

Also, provisions of the Insurance Services Office's revised business auto and commercial general liability policy forms, which insurers now are beginning to use, contain a gap that can leave employers without coverage for rental

car accidents caused by the negligence of the car rental company.

"It's an insanity," said Bill Eggers, vp at broker Alexander & Alexander Inc. in New York, referring to this coverage gap. The gap increases agents' and brokers' potential for errors and omissions claims if they fail to inform clients

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Beneficial to sell insurers, add \$200 million to reserves

By JUDY GREENWALD

PEAPACK, N.J.—The proposed sale of most of Beneficial Corp.'s insurance operations, including American Centennial Insurance Co., would relieve Beneficial of a long-term headache, observers say, although it comes with a high price tag.

Beneficial Corp. said last week it has signed an agreement in principle for the sale of American Centennial and five other insurance subsidiaries to a management group led by Robert Rothman, chairman and chief executive officer of ACIC and chief financial officer of Beneficial Insurance Group.

However, in response to Delaware Insurance Department concerns, Beneficial has agreed to contribute \$200 million to Delaware-domiciled ACIC's loss reserves once the sale is complete.

Beneficial already had boosted ACIC's reserves by \$165 million on a statutory basis in August (BI, Sept. 1, 1986).

ACIC has been battling with a growing number of its reinsurers over business produced by former managing general agents. Many of the reinsurers are no longer paying claims on the business and have charged ACIC with misrepresentation and negligence in the handling of its MGA business (BI, Jan. 12).

The sale of ACIC and the other units must be approved by the Delaware department. A public hearing on the sale is scheduled for March 23, with a decision expected to be an-

nounced within 30 days.

Under terms of the sale agreement, Beneficial will receive \$10 million in cash from Beneficial International Insurance Co., a Hamilton, Bermuda-based subsidiary that is one of the units being sold. Also included in the purchase price is a package of notes, most of which have a 10-year maturity, with a face value of \$98 million.

The ultimate value of the notes, however, is primarily tied to ACIC's future market value.

In addition, Beneficial will have an option to purchase at a nominal price 9.9% of the equity of Beneficial's two profitable British-based credit insurance subsidiaries, Consolidated Marine & General Insurance Co. P.L.C. and Consolidated Life Assurance Co. Ltd., the two other major companies included in the sale.

Referring to the \$200 million reserve addition, Catherine S. Mulholland, the Delaware department's director of company solvency, said Beneficial was told to boost American Centennial's reserves based on worst-case estimates by three actuarial firms.

Beneficial last year announced it would attempt to sell the entire company, but that attempt failed. Beneficial then announced plans to divest its property/casualty insurance units.

While the sale is intended to end the drain on Beneficial's profits caused by ACIC, Beneficial still will be responsible for some liabilities created by the litigation and arbitration

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Republican senators pushing federal product liability reform

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update

Pool regulation bill introduced

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code's minimum capitalization requirements.

- Require the pools to file financial statements with the insurance commissioner.
- Allow examination of the pools by the Insurance Bureau.
- Require annual independent actuarial certifications of the pools' loss reserves.

The bill would amend Michigan Public Act 138, which exempts municipal pools from Insurance Bureau regulation.

Public Act 138 requires only that the pools file annual audited financial statements with the state Treasury Department and maintain aggregate reinsurance projection in the amount of at least \$5 million.

At least one Insurance Bureau official expressed support for such legislation.

"I think we would not object to that bill," said Deputy Commissioner Jean Carlson. "I thought it was a good draft."

No hearings have yet been scheduled on the bill.

Meanwhile, the Insurance Bureau is assisting the Treasury Department in reviewing the financial statements of several municipal insurance pools in the state.

In addition to reviewing the financial statements themselves, state officials may also ask to see the working papers of the auditors who certified the statements, according to Laura Lasater, deputy state treasurer. Ms. Lasater added that the Treasury Department has not yet decided to ask for the working papers.

She also said that the Treasury Department's recent request for help in reviewing the financial statements was not related to a *Business Insurance* story on the Michigan Municipal Risk Management Assn., in which some consultants and MMRMA competitors criticized the pool as financially shaky (*BI*, Feb. 16).

Executive Life fined \$250,000

JERICHO, N.Y.—Executive Life Insurance Co. has agreed to pay a \$250,000 fine to the New York Insurance Department for violations that include taking credit for \$151.5 million in reinsurance backed by inadequate letters of credit.

An Insurance Department spokesman said the size of Executive Life's fine is matched only by the fine levied against Marsh & McLennan Cos. Inc. in connection with its 1984 bond trading losses (*BI*, June 23, 1986).

Ronald L. Kehrl, Executive Life's president and chief executive officer, said the \$151.5 million in disallowed reinsurance has been replaced with a capital infusion of the same amount from Executive Life's parent company, Los Angeles-based First Executive Corp.

The Insurance Department charged that Executive Life took credit for reinsurance on its annuity business in 1983, 1984 and 1985 that was backed by letters of credit that had unacceptable restrictions as to when they could be drawn down.

The department also charged that Executive Life entered into reinsurance transactions without making the required filings or receiving the Insurance Department's approval.

"These were just technical differences as it relates to our reinsurance treaties," said Mr. Kehrl, who described the law as "unspecific and vague."

He said his company agreed to pay the fine to avoid a court battle. Executive Life collected \$600 million in premiums last year, according to Mr. Kehrl.

Kennedy delays health care bill

WASHINGTON—Senate Labor and Human Resources Committee Chairman Sen. Edward Kennedy, D-Mass., is delaying until next month introduction of legislation that would require most employers to offer a group health insurance plan.

Sen. Kennedy had been expected to propose the health care legislation last month, but he has delayed introduction because of scheduling problems, staff members said.

However, sources are speculating Sen. Kennedy needs more time to line up co-sponsors.

While the proposal continues to be fine-tuned, an outline of the legislation has been widely circulated. The legislation calls for minimum federal standards for employer-provided health plans, including capping an employee's annual out-of-pocket expenses at \$2,000 and limiting an employee's share of the premium to 20%.

Generally, the only employers exempt from the legislation would be those exempt from minimum wage laws, such as certain religious organizations.

The health care mandate would have its greatest effect on firms with less than 25 employees, which are least likely to offer a group health care plan.

Unimar investigation dropped

LONDON—Criminal investigations into Unimar S.A.M., a Monte Carlo-based broker that wrote reinsurance for Lloyd's of London syndicates managed by PCW Underwriting Agencies Ltd., have been dropped by the British director of public prosecutions.

The Unimar inquiry was part of a wider investigation into the alleged misappropriation of millions of dollars of PCW syndicate funds between 1979 and 1981 (*BI*, Dec. 9, 1985).

Lord Hailsham, the British Lord Chancellor, told the House of Lords last week that the DPP has concluded "the prospects of a successful prosecution resulting from the further investigation of the Unimar affair are not such as to justify the diversion of resources from the efforts now being made to bring the main PCW investigations to a conclusion."

The Unimar probe was hampered by "considerable difficulty in obtaining information from sources in Switzerland," he said.

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Senate Republicans resume product liability reform drive

By DEBORAH SHALOWITZ

WASHINGTON—Two Senate Republicans, who have led the drive for federal product liability reform for the past several years, are again proceeding full speed ahead.

Sen. John Danforth, R-Mo., ranking minority member of the Senate Commerce Committee, said he will introduce two federal product liability bills. One is based on a number of tort reforms proposed by the American Bar Assn. (*BI*, Feb. 23; Jan. 19), while the other is a free-standing expedited settlement proposal that was one of the most controversial aspects of a tort reform proposal approved by the Commerce Committee last year (*BI*, June 30, 1985).

Both bills were expected to be introduced late last week.

In addition, Sen. Robert Kasten, R-Wis., said he will introduce a bill that is similar in most respects to compromise legislation that was approved by the Commerce Committee last year. Sen. Kasten's bill, however, does not contain the controversial caps on non-economic damage awards included in last year's legislation.

Sen. Kasten also said that at some point he plans to introduce, with Sen. Richard Lugar, R-Ind., an amendment to his product liability reform package that would establish a fault-based standard of liability for manufacturers.

"There is broad bipartisan support for product liability reform," declared Sen. Kasten, although at this point only Sen. Danforth is co-sponsoring his bill. Sen. Kasten is a co-sponsor of Sen. Danforth's main prod-

uct liability bill.

This Senate action follows the introduction in the House of a bill also similar to the legislation approved by the Senate Commerce Committee last year. The House bill is sponsored by Rep. William Richardson, D-N.M. (*BI*, March 2).

Supporters of federal product liability legislation greeted these new proposals with enthusiasm, but they noted that the road to congressional passage still isn't smooth.

"We very strongly applaud" the two senators' "staying power with the issue," said Dirk Van Dongen, president of the National Assn. of Wholesaler-Distributors in Washington.

"Sen. Danforth's decision to throw the ABA's proposals into play is quite creative and constructive," Mr. Van Dongen added.

But Peter Lefkin, federal affairs counsel of the Washington-based American Insurance Assn., said the senators "still have significant obstacles to overcome in the committees," referring to opposition to federal product liability legislation from Senate Commerce Committee Chairman Ernest Hollings, D-S.C.

Liberty Mahshagian, co-counsel of the Product Liability Alliance in Washington, speculated that if the legislation gains a lot of support from the Democrats on the Commerce Committee, Sen. Hollings might be inclined to allow the bills to go forward.

Sen. Danforth, who noted that he is just beginning to "shop for co-sponsors" for his bills, said that while Sen. Hollings "is not of the same mind that we are, he recognizes that there's a strong sentiment in his com-

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Jury awards ship officer \$10.4 million

By STEPHEN TARNOFF

NEW YORK—Farrell Lines Inc. must pay \$10.4 million to a former ship officer and his wife because the officer was exposed to asbestos and subsequently contracted asbestos-related cancer, a state court jury says.

In a Feb. 24 verdict, a New York Supreme Court jury ordered New York-based Farrell to pay \$8 million to Kenneth C. Torrens and \$2 million to his wife for loss of consortium.

The jury also awarded \$400,000 for Mr. Torrens' past and future lost earnings and \$60,000 for hospital bills.

Mr. Torrens is suffering from mesothelioma, a cancer of the lining of the lung linked to asbestos that is invariably fatal.

Last week, an attorney for Farrell said the company believes liability insurance will cover the award, but he declined to give details.

"It is our strong contention that

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4 more IEA syndicates placed in rehabilitation

By JUDY GREENWALD

MIAMI—Four more syndicates on the Insurance Exchange of the Americas have been placed in court-supervised rehabilitation, while the Florida Insurance Department has obtained show-cause orders as to why another three syndicates should not be rehabilitated as well.

Bill Godwin, assistant director of company regulation at the Florida Insurance Department, said the department has obtained rehabilitation orders for AIB Syndicate Inc. and RAM Syndicate Inc. at the syndicates' request.

In addition, court orders also were obtained for Syndicate Two and Syndicate Four, which earlier had consented to go into rehabilitation, said Dr. Claude Lilly, director of the Center for Insurance Research at Florida State University and a consultant to the syndicates.

A fifth syndicate, Hispano American Syndicate Ltd., previously had been placed in court-supervised rehabilitation.

At least 10 of the exchange's 15 syndicates have said they will seek statutory rehabilitation (*BI*, Feb. 23).

RAM syndicate, the IEA's third-largest in 1985, wrote \$13.4 million in gross premiums and \$9.6 million in net premiums that year, the latest year for which figures are available. It reported a net loss of \$235,000 and a surplus of \$2.1 million.

RAM and another IEA syndicate, Administrative Management Services Syndicate Ltd. Inc., are being sued by Omaha Indemnity over payments on business ceded to the syndicates by Omaha Indemnity. The case is currently being arbitrated (*BI*, Sept. 1, 1986; April 28, 1986).

AIB Syndicate Inc., the seventh-largest on the IEA in 1985, reported gross premiums of \$8.3 million, net premiums of \$8.2 million, a net loss of \$34,000 and a surplus of \$1.1 million in 1985.

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inside

✓ Tort and insurance reform legislation is becoming a top priority for state legislatures around the country, and as these proposals receive widespread attention, newspapers around the country—both large and small—are voicing their support for attempts to reform the civil justice system and change the way property/casualty insurers are regulated. **PAGE 8**

✓ David G. Guyer, president of Insurance Management Services in Anaheim, Calif., cautions that a hardening is now being felt in the market for third-party workers compensation claims administration services. This time, he says, maybe businesses will hear the warnings and prepare for the worst. **PAGE 27**

✓ Fourth-quarter results confirm that insurance brokers face a new environment, reports Leonard M. Wilson, a principal at L.F. Rothschild, Unterberg & Towbin in New York. Total revenues for four brokers that have so far released their 1986 results were up an average 17% in the fourth quarter, he reports, compared with an increase of about 25% for the full year. **PAGE 47**

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Tort reforms

Virginia legislation too weak, some say

By DEBORAH SHALOWITZ

RICHMOND, Va.—Tort and insurance reform legislation awaiting Virginia Gov. Gerald Baliles' signature is too weak to have a significant impact in the state, some observers say.

However, another bill approved by the Legislature that sets up a fund to compensate families of infants with delivery-related neurological disorders is expected to ease the medical malpractice insurance crunch created last year when one of the state's major medical malpractice insurers pulled out of the market.

Some of the tort reforms passed by the Virginia Legislature at the close of its session Feb. 28 include:

- A \$350,000 cap on punitive damage awards.
- A limit on the liability of directors and officers of for-profit corporations, while exempting from liability direc-

tors and officers of not-for-profit organizations.

- A "Good Samaritan" exemption from liability for obstetricians treating women who arrive in an emergency room already in labor.

- A limitation on the amount of time a minor has to file a medical malpractice suit.

Insurance reforms passed by the Legislature increase insurers' reporting requirements and establish standards by which the state Bureau of Insurance is to evaluate rate increase requests.

However, the reform packages, which are expected to be signed by the governor, will have "no measurable effect on the number or size of claims coming through the system, or the cost of adjudicating them," complained Grover Czech, mid-Atlantic regional vp of the American Insurance Assn.

Mr. Czech added the legislation does not address some of the most-needed

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Missouri bill includes insurance reforms

By LINDA J. COLLINS

JEFFERSON CITY, Mo.—Legislation currently winding through the Missouri General Assembly would make major revisions in the state's tort law and property/casualty insurance regulations.

House Bill 700—passed by the House Feb. 19 and then sent to the Senate—represents a cooperative effort developed by a task force of legislators, business owners, insurance industry representatives, trial and defense lawyers and consumers.

The insurance reform provisions contained in the legislation would restrict property/casualty insurers' rate increases and policy cancellations; increase capital and surplus requirements for both admitted and surplus lines insurers; and increase insurers' data reporting requirements.

The bill's tort reform provisions, among other things,

would modify joint and several liability; limit the liability of uncompensated directors and officers of non-profit entities; allow courts to reduce excessive damage awards and increase inadequate awards; allow defendants to introduce evidence of collateral sources of income; and prohibit plaintiffs from seeking specific monetary awards for damages.

The bill in its current form is "very close" to the original recommendations made by the task force, pointed out Rep. Doug Harpool, D-Springfield, a sponsor of the bill, a member of the House Judiciary Committee and a member of the task force.

The legislation "provides a good balance between insurance reforms and tort reforms," stressed Sen. Truman Wilson, D-St. Joseph, a sponsor of the bill and chairman of the Senate Insurance Committee.

"While there are certain areas that we would have made stronger had we had a free hand," the bill is an "artfully

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RIMS to examine health costs

By STACY ADLER

The growth of health care cost-containment and utilization review programs are causing benefit managers to question the impact of these programs on the quality of health care.

In response, the silver anniversary Risk & Insurance Management Society conference will include a seminar entitled "Is Cost Containment Endangering Health?"

In addition, RIMS' 25th annual Risk Management and Employee Benefits Conference, to be held March 29 through April 3 in Las Vegas, Nev., will offer some answers to benefit managers' questions regarding flexible benefits, tax reform, the cost of catastrophic illnesses and mandated benefits.

The seminar on health care quality is designed to help benefit managers achieve the precarious balance between keeping down costs while assuring quality health care, said Samuel Y. Fisher, insurance manager at Hamilton Brothers Oil Co. in Englewood, Colo., and moderator of the seminar.



Using charts and graphs, David Rosenbloom, president of the Health Data Institute in Lexington, Mass., will illustrate how cost-containment measures also can improve the quality of care.

John D. Oswald, senior vp-administration at the Swedish Medical Center in Englewood, Colo., will point out the differences in health care providers' approaches to cost containment and teach benefit managers how to apply this knowledge when negotiating contracts with providers.

Also during the seminar, James D. Motz, vp-group insurance at Great-West Life Assurance Co. in Englewood, will discuss how benefit managers should choose the cost-containment program that is best for their company.

Once an employer chooses the program that best fits its needs, it is necessary to explain the program to employees in a positive light.

Linda G. Hellman, compensation and benefit manager at Liebert Corp. in Columbus, Ohio, will discuss how to communicate a cost-containment program to employees, as well as demonstrate ways to motivate employees to use health care

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Berkshire units concentrating on large risks

By JUDY GREENWALD

OMAHA, Neb.—Despite its small staff, Berkshire Hathaway Insurance Group is becoming a "big" player in the commercial insurance business by targeting accounts generating \$1 million or more in premium, its chairman says.

When it began actively soliciting new commercial insurance business in August 1985, the group simply did not have the personnel to handle the volume of requests from firms seeking lower-premium policies in a capacity-tight market, says Warren Buffett, who has been described as the nation's premier investor and dubbed the "Wizard of Omaha."

But with \$1.5 billion in surplus, Berkshire Hathaway did have the capital to write the business.

In ads that appeared in *Business Insurance*, the company announced: "Berkshire Hathaway wants to see property/casualty risks where the premium is \$1,000,000 or more."

Referring to its surplus, the ads invited large-premium businesses to submit proposals, promising it rarely took more than 48 hours for Berkshire Hathaway to respond.

Results were dramatic, said Mr. Buffett. From August 1985 through December 1986, Berkshire Hathaway wrote \$184.5 million in net premiums for large accounts, compared with virtually none previously.

"This was the beginning of the large-risk business, essentially," said Mr. Buffett.

For the first three quarters of 1986, Berkshire Hathaway's large-account business generated \$50 million in net earned premiums, compared with less than \$1 million earned from similar business for the comparable period in 1985.

Including smaller accounts and personal lines business, Berkshire Hathaway generated \$601.9 million in net earned premiums during the first nine months of 1986, compared with \$176.9 million for the corresponding period in 1985. The group posted a 101.6% combined ratio vs. a 114.6% ratio for the comparable 1985 period.

Mr. Buffett said National Indemnity Co., the largest company in Berkshire Hathaway Insurance Group, had always written some commercial automobile insurance.

"Our bias has been toward the commercial business," he said, though Berkshire Hathaway was not, however, involved in large-premium business.

"It seemed to me there was an opportunity in that business," said Mr. Buffett, explaining the decision to run the ad.

Many large risks, he said, needed financially stable insurers, "and they did not know about Berkshire." An ad, it was decided, would serve the purpose of a "large megaphone."

Once the decision to run the ad was made, he said, the next step was to determine precisely what it would say.

Berkshire Hathaway, he said, simply could not physically handle the number of accounts that would be at-

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"Our bias has been toward the commercial business," says Warren Buffett.

Teams must explain injuries to athletes: Court

By STEPHEN TARNOFF

SAN FRANCISCO—A California appellate court decision could make it easier for injured sports figures to recover damages from their teams if team physicians do not fully inform the athletes about the nature of their injuries.

In addition, the decision may hold physicians to a higher degree of responsibility for informing patients about the nature of their injuries, said the plaintiff's attorney involved in the case.

The 1st Appellate District for the State of California ruled on Feb. 20 that besides providing basic medical information to an injured athlete, a sports team also must fully disclose all medical information concerning the injury to the player, such as how it may affect his or her future health.

In the case, the court ruled that former National Football League player Charles

Krueger could pursue his claim for damages for fraudulent concealment of medical information against his former team, the San Francisco 49ers.

The former defensive lineman says he suffers from traumatic arthritis and a crippling degenerative process in the left knee. Mr. Krueger cannot stand for prolonged periods, walk up stairs or run without severe pain, he claims in court papers.

The decision reverses a ruling by a state trial court that held Mr. Krueger failed to prove the 49ers concealed material medical information from him. The appellate court remanded the case to the trial court for damages, which are to be awarded based on the evidence submitted in a retrial.

Although declining to give an exact amount, Mr. Krueger's attorney said the former player is seeking "several millions" of dollars from the 49ers.

"It's a very important decision," said the

attorney, Clark G. Leslie, with the Law Offices of Clark G. Leslie in San Mateo, Calif. "It's going to make it easier to sue."

Mr. Leslie said that because of the decision, sports teams involved in similar cases will find it tougher to successfully use a defense that an injured player would have continued to play even if the team had fully informed him about the nature of their injuries. That defense is commonly used by sports teams in such cases, he said.

Mr. Leslie says the decision has national implications.

In addition, he said the decision not only applies to the medical information supplied by teams to their players, but it also could extend to the relationship between doctors and their patients.

"It will increase litigation when there is a duty to advise the patient as to what the injuries are—or what the implications of those injuries are—and fails to do so," Mr. Leslie

pointed out.

Last week, an attorney for the 49ers said the team will file a petition for rehearing with the appellate court. If that is unsuccessful, the team will seek review from the state Supreme Court.

"We believe the appellate court is wrong," said 49ers attorney John M. Ottoboni, with the Santa Jose, Calif., firm of Ferrari, Alvarez, Olsen & Ottoboni.

Mr. Krueger played for the 49ers from 1958 to 1973. During that time, he suffered numerous injuries, according to court papers, though the injuries in question in the suit involve his left knee.

At various times during his career, Mr. Krueger suffered injuries to the knee but was not informed of them or their severity by team physicians, he alleged.

Specifically, Mr. Krueger charges that:

- After undergoing an operation for a

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Retiree coverage

Continued from page 1
violating any federal common law if employers have effectively communicated that right to employees and retirees (BI, May 12, 1986).

That ruling followed a federal judge's decision in a case involving Bethlehem Steel Corp. that held the company, because of ambiguous plan language, could not reduce retirees' health care benefits (BI, Oct. 29, 1984; Oct. 1, 1984).

That decision was appealed and, in a later settlement, Bethlehem established a substitute permanent retiree health care program not subject to later modification or termination.

Since these two rulings, the United Steelworkers union has filed a lawsuit in U.S. District Court in Los Angeles seeking reinstatement of health care benefits for about 5,300 retirees of Fontana, Calif.-based Kaiser Steel Corp., which has filed for protection

under Chapter 11 of the Federal Bankruptcy Act (BI, Feb. 9).

In the case recently settled by Maryland Shipbuilding and the IUMSWA retirees, coverage under the retirees' benefits plan were terminated on May 31 and June 15, 1985, because the company was having financial difficulties and needed to reduce expenses, Mr. Ward explained.

Maryland Shipbuilding is no longer in business, according to Richard Darke, general counsel for Fruehauf in Detroit. "We're just winding down that company."

Mr. Darke added that the termination and subsequent reinstatement of retiree health care benefits for the IUMSWA retirees will not have any bearing on future decisions Fruehauf and its subsidiaries may make concerning group health care benefits for any of its other current or future retiree groups.

The IUMSWA retirees, citing their collective bargaining agreement, initially sought to have the

'I think there will be more attention given to protecting retirees in the future,' Mr. Ward says.

case settled through binding arbitration, but the U.S. District Court in Baltimore denied their request, Mr. Ward noted.

The union, on March 24, 1986, then filed suit against Maryland Shipbuilding, Fruehauf, the Maryland Shipbuilding & Drydock Co. Blue Cross & Blue Shield plan and the Maryland Shipbuilding & Drydock Co. Hourly Employees Group Insurance Plan.

In October, a U.S. District Court in Detroit ruled that the suit could proceed as a class action and set the trial to begin in April 1987. However, a settlement proposal

was agreed to in January, Mr. Ward explained.

Under the settlement, Maryland Ship and Fruehauf agree to:

- Provide lifetime group health insurance to IUMSWA retirees who were hourly rate workers, former workers who are on disability leave and awaiting retirement and spouses of eligible retirees.

These benefits must be at least equal to the benefits that were terminated in 1985.

Retirees do not pay any deductibles or co-payments under the group health plan, according to Mr. Ward, the plaintiffs' attorney, and Mr. Darke of Fruehauf.

For retirees who are age 65 or older, the company-provided health insurance will remain a supplement to Medicare, covering any costs not paid for by Medicare.

- Provide prescription drug coverage to eligible retirees who received this coverage in addition to their health coverage before the

benefits were terminated.

However, retirees who were not receiving prescription coverage before termination will not receive the coverage now.

- Pay 100% of the monthly health insurance premium from the time of reinstatement until May 1, the first day of the next quarter of the policy year.

After May 1, the company will pay 90% of the monthly premium, with retirees paying the remaining 10%. However, retirees will be required to pay their share of the monthly premiums in quarterly installments.

- Cover the cost to retirees of annual premium increases up to 15%.

If the cost of the monthly premium charged by the health insurer increases, the company will pay for the entire increase up to 15%.

If the annual premium increase is more than 15%, retirees will be required to pay any increase exceeding 15%.

This provision will be effective until the 1990-1991 policy year, after which the company will pay rate increases up to only 11.6%. Retirees will cover the cost of any premium increase exceeding 11.6%.

If retirees do not pay for the additional cost of the premium increase after due notice, their coverage will be dropped.

- Make a lump-sum payment of \$1.53 million to a settlement fund.

The settlement fund will be used to compensate IUMSWA retirees for the lack of health insurance coverage from May 31, 1985, until March 1.

Retirees will be compensated from the fund for the cost of replacement coverage during the cancellation period, whether or not they bought the coverage. In addition, the retirees will be reimbursed for any medical, surgical, hospital or prescription costs they incurred during that period.

If the benefits had not been reinstated by March 1, the company also would have been required to increase its payment to the fund by \$80,000 for each additional month the retirees would have been without coverage.

"We calculated the total payment by the company to the settlement fund to be more than it would have paid if coverage had been continued, because we did not want the company to profit from its actions," Mr. Ward pointed out.

Shalowitz joins Washington office

CHICAGO—Deborah Shalowitz has joined the *Business Insurance* Washington, D.C., bureau as an associate editor, announced Editor Kathryn J. McIntyre.

Ms. Shalowitz previously was an assistant editor at McGraw-Hill Inc. in Washington.

She covered Congress, the Federal Energy Regulatory Commission, the Securities and Exchange Commission and general business for two newsletters, *Inside F.E.R.C.* and *Inside F.E.R.C.'s Gas Market Report*.

Ms. Shalowitz, 29, also has a wide range of experience in broadcasting and business.

Ms. Shalowitz holds a master of science degree in journalism from Northwestern University's Medill School of Journalism in Evanston, Ill., and a bachelor of arts degree from Brandeis University in Waltham, Mass.

Ms. Shalowitz can be reached at 202-662-7200.



Ms. Shalowitz



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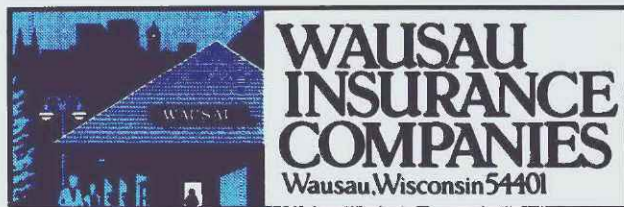
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"The Wausau people are very professional. They've helped us with avoiding back injuries, with air-quality

testing, and with hearing-loss programs.

"We feel Wausau has our interests at heart. They try to keep abreast of changes in our growing company. Our experience with them in workers compensation has led us to place other coverages with them. We think Wausau has the expertise we need."

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RIMS conference

Continued from page 3
services judiciously.

Employers today also face the difficult task of maintaining costs in an era of increasing claims for catastrophic illnesses—a problem intensified by the spread of AIDS—acquired immune deficiency syndrome.

In response, "Catastrophic Medical Costs—The Impact on Benefit Plans," another seminar, will show benefit managers how to implement case management programs that will result in "low costs while maintaining quality care," said Jackie Mazoway, product manager of medical case management at Intracorp, a Wayne, Pa.-based health care cost management firm.

Ms. Mazoway will define what case management is and discuss how it can provide quality care at reduced costs.

Tom Billet, a consultant with Johnson & Higgins in New York,

will discuss the impact of AIDS on benefit plans.

In addition, Marjorie Gross, president of Marjorie Gross & Co., a New York-based consultant specializing in benefit communications, will discuss how to communicate these programs to employees.

Also during the session, Laird Miller, corporate manager for provider relations at Honeywell Corp. of Minneapolis, will describe how his company's catastrophic case management program works.

In addition to implementing cost-containment measures, many benefit managers are considering flexible benefits programs.

While there is a great deal of information available on how to implement these plans, there is little information available on how to decide whether flexible benefits are the best way to meet organizational goals, said Bruce E. Noda, a principal at William M. Mercer-Meidinger-Hansen Inc. in San

For the first time an industry session recap will be held especially for non-RIMS members.

Francisco.

"People are familiar with how to design and administer these plans, but they do not know how to determine if the corporation or employees are ready for flexible benefits," Mr. Noda said.

A seminar coordinated by Mr. Noda, "The Flex Decision—How to Determine if Your Firm is Ready for Flexible Benefits," is designed to help managers judge the corporate climate and employees' attitudes on flexible benefits.

Mr. Noda and Pamela Reeves, a principal with Mercer in Houston, will teach benefit managers how to

judge the corporate climate and employees' attitudes by conducting surveys and focus groups.

"All too often, flexible benefits plans are put together because a chief executive officer reads about them—not because there is a real need," Mr. Noda observed.

Another issue benefit managers are concerned with is tax reform. In the seminar, "Tax Reform: Coping With All the Benefit Changes," experts will attempt to help benefit managers decipher those changes.

Seminar coordinator Gerald Uslander, a principal with Mercer in Louisville, Ky., will discuss changes in individual retirement accounts and 401(k) salary reduction plans.

According to the new legislation, every 401(k) plan must be amended to accommodate new, more complex and restrictive non-discrimination rules.

Mr. Uslander also will discuss the new rules regarding maximum pension benefits and contributions.

The maximum annual benefit that can be provided from a defined benefit plan will remain at \$90,000, and the maximum annual contribution to a defined contribution plan will stay at \$30,000. Both limits will rise with inflation, but the defined contribution limit will be frozen at \$30,000 until the defined benefit limit hits \$120,000. After that, the maximum defined contribution will be set at 25% of the maximum defined benefit (BI, Aug. 25, 1986).

Maureen Gorman, an attorney at Mayer, Brown & Platt in Chicago, will discuss the new non-discrimination rules for retirement and welfare plans.

John E. Stair Jr. of E.I. du Pont de Nemours & Co. of Wilmington, Del., will describe the new rules affecting loan provisions in savings plans. He also will describe tax law changes affecting employee stock ownership plans.

Mr. Uslander will conclude by describing how all the rules will affect public sector and tax-exempt employees.

A panel discussion featured at the RIMS conference, "Mandated Benefits: A Look into the Future," will assess the impact of the Consolidated Omnibus Budget Reconciliation Act of 1986 on businesses.

Galt Grant, director of risk management for Polaroid Corp. in Cambridge, Mass., will moderate commentary by government and labor experts. Scheduled speakers include Phyllis C. Borzi, counsel for pensions at the House Labor-Management Relations Subcommittee, U.S. House of Representatives in Washington; David N. Levinson, the Delaware insurance commissioner; and Mark J. Ugoretz, executive director of the ERISA Industry Committee in Washington.

Other seminars designed for benefit managers will cover new benefit accounting rules; managing doctor charges; health maintenance organization networking; utilization review; and new COBRA rules.

In addition, the conference will feature seminars focusing on general risk management, risk management information systems, international risk management, general insurance, risk financing, loss control/safety, law/legislation, workers compensation, claims management, exposures and personal and professional development.

And besides the 38 industry-specific sessions to be held at the conference, for the first time an industry session recap will be held especially for non-RIMS members. Leaders of the industry sessions dealing with banking, motor vehicle manufacturing and import, construction, public entities, real estate and utilities will highlight issues and ideas expressed by risk managers during closed sessions, explained Barbara Parker, assistant RIMS conference director in New York.

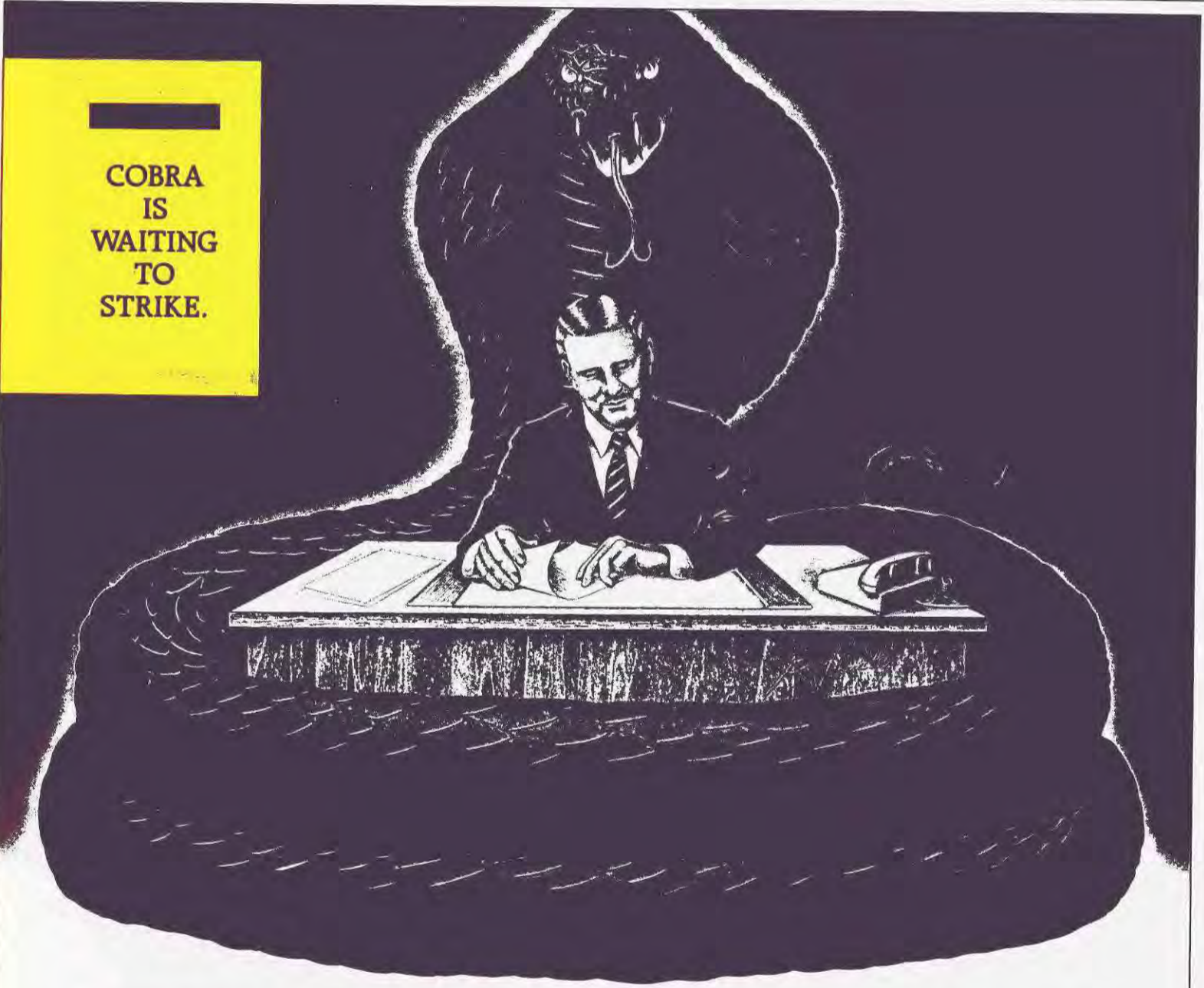
The Hilton Center at the Las Vegas Hilton will house the 1987 RIMS exhibition hall, featuring about 150 exhibitors. It also will be the site of many of the seminars and meetings, as well as registration, a message center and hospitality suite listings.

Other sessions will be held at the Riviera and Sahara hotels.

The registration fee for the full conference is \$595 for members and \$695 for non-members. For a partial week, the fee is \$475 for members and \$575 for non-members. The cost for one day at the conference is \$195.

Because attendance is limited, RIMS' Ms. Parker encourages attendees to register and make seminar selections prior to arriving in Las Vegas.

For more information, contact the RIMS Conference Department, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.



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opinions

Voices are being heard

AS STATE LEGISLATURES around the country finally get down to business, tort reform is heading many of their agendas.

Both Georgia and Virginia lawmakers already have approved legislation containing tort reforms this year, while legislative approval may be drawing near in other states, including Missouri. And, still other state legislatures—including some of the 35 that approved tort reform measures during 1986—are beginning to study new tort reform proposals this year.

We have long been a strong supporter of reasoned, balanced tort reforms, as well as reasoned, balanced insurance industry reforms. And as these issues receive widespread attention, other publications—both large and small—are voicing their support for attempts to reform the civil justice system and change the way property/casualty insurers are regulated.

Here are some views from newspapers around the nation:

The heated issue of tort reform has been building steam for months as public relations efforts on both sides gained ground. Insurance companies, trial lawyers and businesses make good arguments. However, it's obvious that the Legislature needs to make some changes.

The Legislature first should change the law to make sure that the person or company responsible for a certain percentage of damages only pays that amount. Currently, the law operates under a joint and several liability concept. That means, in practice, the richest party in the damage suit often ends up paying the entire damage award.

The Legislature also needs to place a limit on pain and suffering awards. Far too often, sympathetic juries give exceptionally high money awards in this area.

These reforms won't reduce liability insurance rates. Those steep rates were caused by a number of factors, with high jury awards being only one.

However, the changes should help stabilize liability insurance rates and make sure defendants only pay for damage they are responsible for. At the same time, victims will still receive damage awards for their injuries.

—**Beaumont, Texas, Enterprise**

What lawmakers ought to be weighing, instead of wispy claims about insurance costs and availability, is whether the current system is flawed by inherent unfairness—which it is.

No thinking person should be advocating legislation that would deny an injured person the right and opportunity to recover damages from the person or entity responsible for the injury. The problem with the current system is that it often goes beyond that.

... Current law seeks to compensate for the victim's hardship by arbitrarily imposing a different hardship on someone else. And that's not fair.

—**Spokane, Wash., Chronicle**

... The liability insurance problem is not likely to ease, contrary to the contention of opponents of tort reform. That should encourage Virginia General Assembly members to act on the wide array of proposals they face, not the least of which would apply some carefully balanced restraint on pain and suffering awards in personal injury cases.

—**Norfolk, Va., Virginian Pilot**

Both tort reform and greater regulation of insurers... (are) precisely what the legislative committee recommends. That can be expected to produce

bills intended to reform insurance practices as well as bills intended to limit some types of damage awards, to limit the scope of liability and even to reduce the number of lawsuits.

Texans are caught between greedy lawyers and greedy insurance companies—to use their own terms for each other. It sounds as if the legislative committee has zeroed in on a reasonable middle ground as well.

—**Fort Worth, Texas, Evening Star-Telegram**

Business owners are being forced to pass up investment opportunities, abandon plans for new expansions and new products, delay expansions, pass up job-creation opportunities, reduce employment and even move out of state because Mississippi hasn't faced up to the problem of tort reform.

Legislation is needed to penalize those who file frivolous lawsuits, statutes of limitation need revision. . . Tort reform should be a priority item for the 1987 Legislature.

—**Pascagoula, Miss., Press**

Erratic and exorbitant courtroom awards have an across-the-board negative impact on the community. Businesses find it necessary either to curtail products and services available to consumers to avoid potential lawsuits or to hike prices to meet rapidly rising insurance rates. Municipal services are threatened with elimination, as are programs offered by school departments. Hospitals and medical professionals cut back on some regular services and procedures and either halt or delay the introduction of innovative techniques and medicines. The list could be extended and the examples multiplied, but the net effect is always the same: The taxpayer and the consumer end up shouldering the burden.

... People should let their lawmakers know they want action on this issue.

—**Providence, R.I., Bulletin**

The day-care insurance crisis is just another example of how the litigation snowball threatens to cripple elements of our society.

—**Birmingham, Ala., News**

We think joint and several liability should be abolished. No person—not even one with "deep pockets"—should have to pay a larger proportion of a jury award than the extent of his responsibility for the accident.

Once tort reform is approved, we hope the Assembly will give its attention to other elements which we consider essential to solving the liability insurance crisis: better policing of physicians and tougher regulation of insurance companies.

—**Columbus, Ga., Enquirer**

Moreover—in our opinion—more fundamental changes will be required to reduce liability insurance costs for government and business.

Laws are needed to: (1) limit the size of awards, an approach that has slowed the rise of malpractice insurance costs for California physicians; (2) limit contingency fees paid to lawyers; and (3) establish a better system for monitoring pricing policies so that consumers aren't gouged or required to pay the costs of insurance companies' failed investments.

Tort reform will again be debated in the California Legislature this year. As in the past, the danger remains that the competing interests—insurance companies and lawyers—will cancel each other out and the Legislature will do nothing.

—**Santa Rosa, Calif., Press-Democrat**

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RIMS supports variable rate PBGC premium

By **JERRY GEISEL**
and **DEBORAH SHALOWITZ**

WASHINGTON—The pension termination insurance premiums employers pay the Pension Benefit Guaranty Corp. should be based on the financial condition of their pension plans, the Risk & Insurance Management Society says.

A so-called variable rate premium, already backed by the Reagan administration, is fairer and more equitable than the current flat-rate PBGC premium, according to RIMS.

"Under the present system, well-funded plans provide a large subsidy to underfunded plans," Howard Greene, RIMS associate legislative director, said in testimony submitted to the Senate Finance Committee.

Such a system punishes employers with well-funded defined benefit pension plans while providing a windfall for employers with underfunded plans, Mr. Greene added.

"Switching to a variable rate will end or drastically reduce the unfair subsidy-based scheme," he noted.

"Furthermore, insurance is based on paying in relation to risk, and since the PBGC provides insurance, it makes sense to conform PBGC premiums to established practices."

While the administration's variable-rate premium proposal continues to be fine-tuned, it would set an annual per participant PBGC premium of roughly \$10 to \$15 for plans that were fully or overfunded.

For underfunded plans, the premium would rise in tandem with the extent of underfunding, but would be capped at about \$100 per plan participant per year (*BI*, Dec. 29, 1986).

By contrast, all employers with defined benefit plans now pay an annual PBGC premium of \$8.50 per plan participant. Even with a variable-rate premium structure, basic premiums would rise because the PBGC needs to collect more revenue to pay for its massive \$4 billion deficit.

But if the current flat-rate premium structure is retained, PBGC premiums soon could climb to between \$40 and \$50 per plan participant, Mr. Greene warns.

And, as premiums escalate, employers with the best funded plans could flee the defined benefit plan system, Mr. Greene said.

"These are the solid plans which the PBGC is meant to foster, not discourage," he added.

RIMS is believed to be the first business organization to endorse a variable-rate PBGC premium structure.

ing beneficiaries on a portion of the actuarial value of the benefits for which they are eligible.



Rep. Gradison

However, under the proposal, many beneficiaries still would not be taxed, because their taxable income—even by counting the estimated \$1,800 value of the Medicare package as income—would not put them over the thresh-

washington

old that triggers the payment of federal income taxes.

Under the legislation, the maximum annual out-of-pocket cost for hospital-covered services for a beneficiary next year would be \$541, while the maximum out-of-pocket expense for physician services would be \$1,000.

By contrast, Medicare currently imposes a \$520 deductible for the first 60 days of hospitalization. For hospital stays that last between 61

and 90 days, the daily coinsurance charge is \$130.

For any additional days of hospitalization, the coinsurance charge is \$260 per day.

Medicare also now pays 80% of physician bills, with no cap on the beneficiary's out-of-pocket expenses.

In addition, while Medicare currently limits hospice stays for the terminally ill to 210 days, the Stark-Gradison bill provides cov-

erage for an unlimited number of hospice stays.

While an expanded Medicare program could reduce pressure on employer-sponsored supplemental retiree health care plans, taxing Medicare benefits, as Reps. Stark and Gradison propose, could be the first step that could lead to taxing health care programs for employees, experts say.

Pension terminations

The Senate Labor Subcommittee and the House Labor-Management

Continued on next page

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Medicare expansion

Two key congressmen have introduced legislation to expand Medicare coverage to give the elderly greater protection from catastrophic health care bills.

The legislation, H.R. 1280 and H.R. 1281, introduced late last month by Rep. Fortney (Pete) Stark, D-Calif., chairman of the House Ways and Means Health Subcommittee, and ranking minority

member Rep. Willis Gradison, R-Ohio, would limit out-of-pocket expenses for Medicare-covered services to approximately \$1,600 per year.

This cap on out-of-pocket expenses would be financed by tax-



Rep. Stark

Continued from previous page
Relations Subcommittee will hold a joint hearing March 24 on the various problems relating to the terminations of underfunded pension plans and overfunded pension plans.

Experts worry that the terminations of underfunded pension plans threaten to bankrupt the Pension Benefit Guaranty Corp.

On the other hand, pension activists charge that the terminations of overfunded pension plans could mean smaller pension benefits for



Mr. Brock

plan participants—especially if companies establish less generous successor plans or no pension plan at all.

Among the witnesses to testify will be Labor Secretary William Brock III. Mr. Brock will outline the Reagan administration's sweeping new pension reform proposals.

The administration's proposals, among other things, allow companies to shift surplus defined benefit plan assets to special retiree health care plans on a tax-free basis, remove surplus assets from overfunded plans without terminating the plans and beef up minimum funding standards (BI, Feb. 23).

The subcommittee hearing will begin at 9 a.m. in Room 430 of the Dirksen Senate Office Building in Washington.

Benefit hot line

A Washington-based benefits lobbying and research organization has started a telephone hot line service to provide fast help on benefit issues to its members.

The "Technical Assistance Line," operated by the Employers Council on Flexible Compensation, will enable ECFC members to get quick, informed, answers on questions regarding flexible compensation plans and 401(k) plans, said Executive Director Ken Feltman.

The special phone number is: 202-659-6364.

"This new telephone line, reserved for our members, should allow us to do what any trade association should: serve our members first," according to Mr. Felt-

man.

For more information, contact the ECFC at 1660 L St. N.W., Suite 715, Washington, D.C. 20036; 202-659-4300.

HMO Act changes

Employers have until March 16 to comment on a recent Reagan administration proposal to repeal the so-called equal contribution rule contained in the 1973 Health Maintenance Organization Act.

The equal contribution rule requires employers to contribute the same per-employee amount to the federally qualified HMOs they offer as they contribute to the medical indemnity plans they provide.

Reagan administration officials

have said HMOs no longer need the special protection offered by the equal contribution rule (BI, Feb. 16).

Comments on the HMO Act proposal should be sent to the: Health Care Financing Administration, Department of Health and Human Services, Attention: OPH-001-P, P.O. Box 26676, Baltimore, Md. 21207.

Multiemployer plans

The Supreme Court will decide whether the National Labor Relations Board or a federal court has jurisdiction over a suit filed by trustees of a multiemployer pension plan seeking recovery from an employer that withheld funds from the plan while it was involved in a contract dispute with a labor union.

A 1980 amendment to the Employee Retirement Income Security Act of 1974 says that trustees of a multiemployer pension plan can file suit against an employer in a federal court if the employer fails to contribute the negotiated amount due under a labor agreement.

However, the employer involved in the pending case—noting that its contract with the labor union had expired—argues that the case is a labor dispute and should be decided by the National Labor Relations Board, not the courts.

The case stems from a dispute between a construction company, Advanced Lightweight Concrete Co., and the Laborers Health and Welfare Trust Fund for Northern California, a multiemployer plan. Advanced Lightweight stopped contributing to the pension plan when its contract with the union expired.

The 9th Circuit U.S. Court of Appeals in late 1985 ruled in favor of Advanced Lightweight Concrete Co., saying that the federal courts do not have jurisdiction over such disputes.

Pension plan trustees claim that if the Supreme Court agrees with the lower court and upholds the NLRB's jurisdiction over the case, pension plans might not recover the full amount owed to the plan employers in these types of disputes.

Pension plan trustees also noted that the NLRB cannot award punitive damages in these cases.

Debating family leave

Legislation that requires employers to give extended unpaid family leave to workers could "devastate" small employers, according to a business lobbying organization.

The legislation, H.R. 925, which was introduced by Rep. Patricia Schroeder, D-Colo., requires employers with more than 15 workers to provide up to 18 weeks of unpaid leave to male and female employees for the birth, adoption or serious health condition of a child or dependent.

Under the bill, employees would be guaranteed their former positions when they return to work.

The Washington-based National Federation of Independent Businesses says the legislation has the potential to cripple the efficient operation of small companies.

"This legislation will devastate small businesses and destroy the very jobs advocates seek to protect," NFIB President John Sloan said.

Small businesses, Mr. Sloan maintains, cannot operate efficiently if they have to hold open jobs for employees on extended leave programs.

"To enact such an ill-conceived law will almost certainly eliminate jobs, bankrupt companies and, in the long run, ensure the downhill slide of our national competitiveness," the NFIB's Mr. Sloan pointed out. ■

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Hansen board OKs Mercer-Meidinger merger

Shareholders of Deerfield, Ill.-based benefit consultant A.S. Hansen Inc. gave overwhelming approval last month to a merger with New York-based William M. Mercer-Meidinger Inc. (BI, Dec. 15, 1986).

The merged firms will operate in the United States under the name of William M. Mercer-Meidinger-Hansen Inc.

The merger, valued at about \$45 million and earlier approved by the board of directors at Marsh & McLennan Cos. Inc., Mercer-Meidinger's parent, brings together two firms of very different size. Mercer-Meidinger, the world's largest benefit consultant, reported benefit consulting revenues of \$281 million and 4,129 employees in 1986, while Hansen, the ninth-largest U.S. benefit consultant ranked

markets

by *Business Insurance*, reported benefit revenues of \$48.4 million and 703 employees.

Steven W. Fargason, Hansen's former chairman and chief executive officer, has been named a vice chairman at Mercer-Meidinger-Hansen and will serve on the board of directors.

Diljit S. Juneja, who served as president of Mercer-Meidinger, will continue to serve as president of the merged companies.

Including Hansen, the Mercer organization will have more than 4,900 employees with consulting offices in 94 cities around the world.

Under the terms of the merger,

Mercer-Meidinger paid about \$45 million for Hansen, with the payment consisting of M&M stock and a small amount of cash equivalents.

Corporate headquarters for William M. Mercer-Meidinger-Hansen Inc. are at 1211 Ave. of the Americas, New York, N.Y. 10036; 212-997-7171.

Vision care PPO

A national vision-care preferred provider organization, National Vision Services, is now operational in eight states: Arizona, Colorado, Idaho, Illinois, Massachusetts, Mississippi, New Mexico, Ohio and

Utah.

In addition, the National Vision Services now is being marketed in 20 other states.

National Vision Services says it can provide vision care services to employees at a 30% to 60% discount.

Phoenix-based NVS offers selected optometrists a chance to increase their patient load in return for discounted service and eyewear.

Currently, there are more than 270,000 enrollees in the program, including 100,000 subscribers of Blue Cross & Blue Shield of Arizona and 100,000 subscribers of Blue Cross & Blue Shield of Missouri.

This month, 38,000 additional enrollees will be added, subscribers of Blue Cross & Blue Shield of

Colorado.

Employers also can contract directly with the PPO. NVS acts as its own third-party administrator.

In July 1986, Chief Executive Officer Ben Ward took the company public, selling 880,000 shares at \$5 a share.

"We would be very happy to have 5% of the people in the United States," Mr. Ward said. "We're looking to build a national provider network of approximately 2,000 doctors, providing vision care services to approximately 5 million subscribers and their families."

Mr. Ward and his associates also launched a subsidiary, National Hearing Services Inc., a hearing-care PPO, in late 1986. NHS offers enrollees full audiometric exams by licensed audiologists. In addition, enrollees receive hearing aids at a 50% discount.

Currently the NHS serves 60,000 enrollees in Arizona. But it will soon be operational in Missouri and Washington, D.C., where insurer contracts have just been signed.

Mr. Ward said, "A hearing-care PPO has great appeal to insurers that carry Medicare supplements, but many employers are gaining interest," as well.

As in the vision-care PPO, NHS acts as the TPA and employers can contract directly.

For more information on either program contact National Vision Services Inc., 4201 N. 24th St., Suite 300, Phoenix, Ariz. 85016; 602-956-7287.

New consulting firm

James S. Brownlow Jr. has opened Brownlow Associates Inc., a risk management consulting firm specializing in financial institutions.

Services offered include continuous consulting, preparation of specifications for bidding, claims analysis and audits and risk management audits.

Mr. Brownlow formerly was senior vp in the financial institution division of Corroon & Black Corp. in Chicago.

For more information, contact Brownlow Associates Inc., P.O. Box 498, Western Springs, Ill. 60558; 312-246-5225.

Mergers/acquisitions

Charles V. James, former president and chief executive officer of Rollins Burdick Hunter of Wisconsin Inc., has purchased Fitzgerald, Clayton, Noyes & Kasten Inc., a Milwaukee insurance agency.

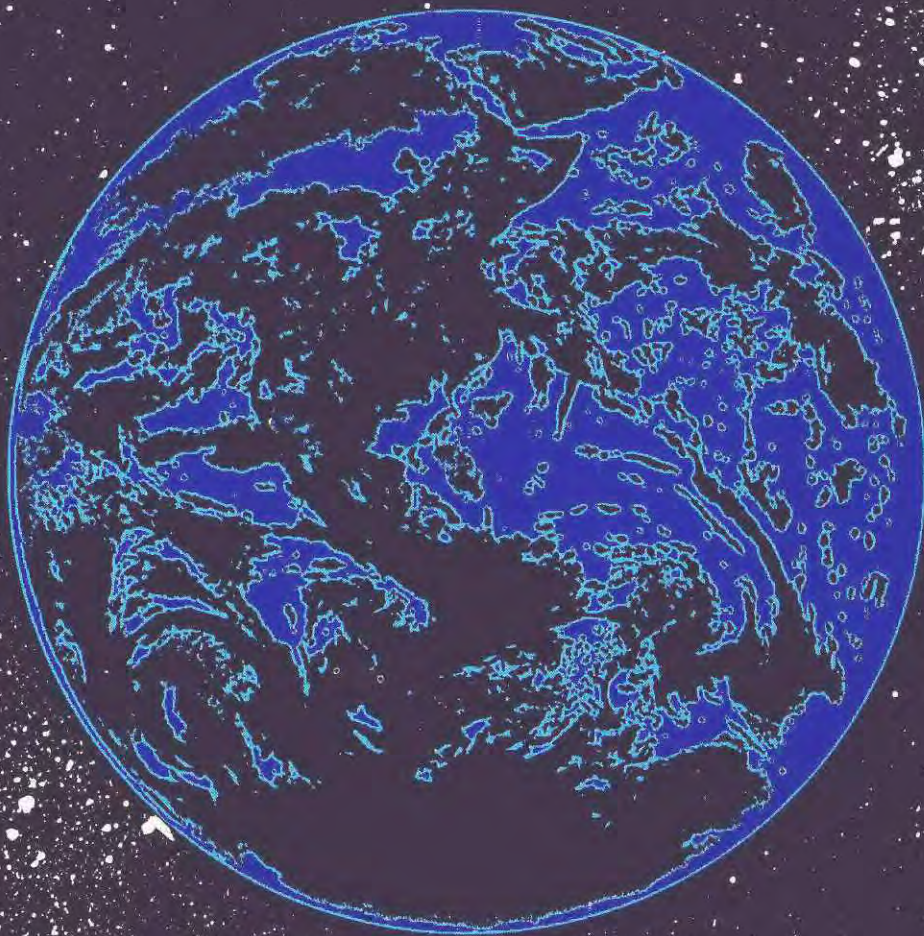
QCC Inc., an affiliate of Blue Cross of Greater Philadelphia, acquired Delaware Valley HMO of Concordville.

Noble Lowndes & Partners Ltd., a major British-based international employee benefit consulting and actuarial firm, has acquired Chicago-based Compensation & Capital Inc., an actuarial and consulting firm.

New offices

Third-party administrator Hewitt, Coleman & Associates Inc. in Greenville, S.C., has opened new branch offices in Birmingham, Ala., and Albuquerque, N.M. The Birmingham office is located at: 25 W. Oxmoor Road, Suite 35, Hager Building, Birmingham, Ala. 35209; 205-942-9510. The Albuquerque office is at: 300 San Mateo N.E., Albuquerque, N.M. 87108; 505-265-2250.

FLX Corp., a manufacturer of flexible benefits software, has moved to 130 S. State Road, Suite 103, Springfield, Pa. 19064; 215-435-0653.



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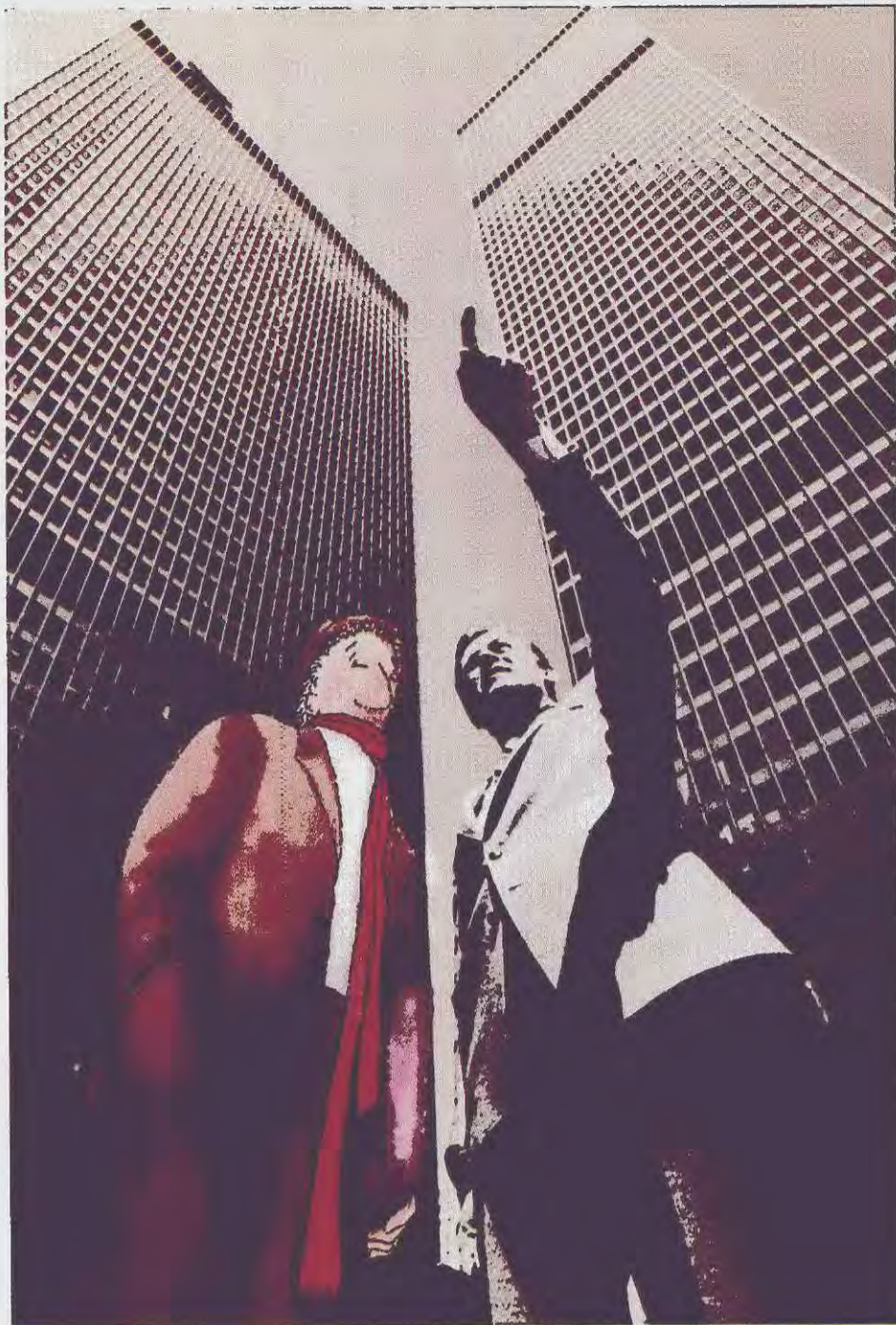
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MBGH conference

Experts study cost-containment efforts

By DONNA DiBLASE

CHICAGO—While employers have made great strides in managing health care costs, they must put even more effort into cost management and quality assurance of health care, some health care experts say.

These efforts are especially important if employers are to keep up with the many trends in the health care delivery system, they add.

And, employers must take a more active role in lobbying efforts, making known their views about proposed health care benefit legislation, they say.

Employers' health care cost-management efforts as viewed

from the perspectives of physicians, hospitals and government were discussed at the seventh annual conference of the Midwest Business Group on Health, held Feb. 26 and 27 in Chicago.

"One of the fundamental changes employers have to adjust to is high-technology medicine," said Dr. Richard Frey, a Minneapolis physician.

Most health care purchasers focus their buying efforts on the price of services, he said.

But, "discount buying is counterproductive to cost control because there is no control on the volume of services used. With discounts, you're buying mismanaged care," he said.

"If employers don't get away from the mentality of discounts and beating up the system—with no volume control—we're going to see health care costs go through the roof," he warned.

And, while employers have reduced utilization of inpatient health care through utilization review programs, "they have done little to effect quality, cost-effective ambulatory care," Dr. Frey said.

An effective health care purchasing process first should ask whether the service is necessary, he explained.

Then, a quality assurance mechanism should be put in place to review the quality of the service

delivered. The process also should include a mechanism for determining the most appropriate setting in which to deliver the care—either inpatient or outpatient.

Finally, the purchasing process should determine whether the price of the service is reasonable, Dr. Frey said.

Cost-sharing with employees also is an important cost-control tool, he said. "The patient has to be involved in his own health care and should share in the costs of the care. We've seen that first-dollar coverage can be a disaster."

And, physicians also should be put at some financial risk to avoid the delivery of unnecessary care. Through risk-sharing, physicians

have an incentive to provide only health care that truly is necessary, because they could be responsible for the cost of care that is determined to be unnecessary, he explained.

"Involving the patient and the physician in health care costs gives you volume control. Don't buy into any system that doesn't give you volume control," Dr. Frey emphasized.

New trends in the health care system also require employers to be informed, active purchasers of health care, the experts noted.

For example, in the near future "we'll see more health care delivery on a regional basis instead of on a national basis," said Joseph A. Wasserman, president of Mercy-Memorial Medical Center Inc. in St. Joseph, Mich.

Other trends he predicted include:

- Regional health care organizations that have relationships with quality physicians will grow and be successful.

- "As a result of this, some hospitals will close or develop alternative delivery systems," Mr. Wasserman said.

- Hospitals will continue to diversify. And, many hospitals will fail because of competition, size, location, payer mix and inadequate reimbursement, he said.

- Employers and health care providers will place more emphasis on the quality of health care.

- "I predict the preoccupation with cost will shift to an obsession with quality," Mr. Wasserman contended.

- There will be significant changes in both the way physicians practice medicine and in the way they are compensated.

- "There will be more salaried physicians and, by 1990, 80% to 90% of physicians will practice in groups. There also will be a continued growth of alternative delivery systems," he said.

- Physicians also will face greater malpractice exposures and a more competitive environment, since there may be more doctors than needed, he added.

- Health care will remain expensive because of increased technology and demand for services.

- The role of government in health care will increase.

- "This will be in the areas of indigent care, nursing home care and AIDS, which is a ticking time bomb," Mr. Wasserman predicted, referring to acquired immune deficiency syndrome.

- Hospitals will become the focal point for health care.

- Hospitals will become high-technology centers and providers of medical information and wellness programs, he predicted.

- Providers will form networks to maintain quality and control costs. These networks will be formed on regional and national bases, and in cooperation with payers of health care, he said.

- And, Mr. Wasserman emphasized that employers have been and can continue to be more active purchasers and payers of health care through their own coalitions.

- "Coalitions are not a transitory phenomenon. This is a real effort by employers to control what, in the past, had been beyond their control," he said.

- In the future, the impact of coalitions will be important in both rural and urban areas and for both large and small businesses, he predicted.

- But, an important change in the work done by employer coalitions is that hospitals will begin to be

Continued on page 18

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Control communication may stem liability

CASE

GO—Communication of objectives in managed care plans could be the best protection against employer liability for the quality of health provided through the plans, one attorney says.

"The key thing is to make sure whatever you're doing, that you clearly communicate it and you'll go a long way," said John D. Blum, director of the Institute for Health Law at the Loyola University of Chicago School of Law.

"And, if you can, build arbitration into any utilization review or managed care contract," so litigation can be avoided, he advised.

However, "I don't foresee the legal implications of health care benefit plans as being major bar-

riers to employers' cost management actions," he predicted.

Mr. Blum discussed the legal issues for employers as purchasers of health care at the seventh annual conference of the Midwest Business Group on Health, held Feb. 26 and 27 in Chicago.

"A corporation must determine its obligations to provide health benefits. There are few statutory requirements, except that once you offer benefits, you are legally bound to provide what you said you would," Mr. Blum said.

One of an employer's major responsibilities in purchasing managed care plans, like health maintenance organizations, preferred provider organizations and utilization review programs, is "you have a duty to investigate and monitor what you are offering," he said.

"Also, you should know the plan's track record of lawsuits filed against it, as well as the performance of health care providers participating in the plan," he explained. However, litigation pending against a plan does not indicate overall poor health care performance of the plan, he added.

Employers also should use any credentialing criteria as a guide in evaluating the plan.

For example, the American Assn. of Preferred Provider Organizations soon will have available a new credentialing function for PPOs, he said (BI, Feb. 16).

This credentialing process can indicate to employers the selection criteria used by the plan to choose participating health care providers, quality assurance procedures, utilization review and financial

solvency of the plan.

"A very clear liability for employers stems from the employer's interaction with its health care plan," Mr. Blum.

For example, administrative errors can occur in which an employee or dependent may think they are covered by the plan and discover the contrary only after they receive health care services.

If clear, current records are not kept by the employer or the underwriter of the health plan, the employer or insurer could be liable for the costs of the uncovered health care services, he said.

Although there is little case law of employers' liability in the utilization review area, one lawsuit over utilization review was filed in California last summer.

In the case, a female Medicaid

patient sued MediCal, the utilization review program for California's Medicaid program.

In the case, the plaintiff and her attorney claimed that she was dismissed from the hospital too early after being treated for blood clots in her leg. MediCal notified the patient and her physicians that she had been in the hospital for the necessary length of time and would not be covered for any additional services, the suit alleges.

The patient later had to have her leg amputated because of complications resulting from an early hospital discharge, Mr. Blum said.

While her doctors did not argue against the hospital dismissal, the plaintiff sued only the MediCal review organization.

A court decision in the case is at least two years away, he said. However, in preliminary rulings, "the court did make very clear that the reviewer could indeed be held liable," he said.

Fourth-party audit organizations—like the employer's utilization review agent—can definitely be held liable for errors in their utilization review process and errors in their professional judgment, Mr. Blum explained.

However, employers can control this liability by working arbitration into the contract to avoid litigation, he said.

Issues that can trigger liability problems in utilization review programs include patient confidentiality and the patient's or employee's understanding of the mechanisms for obtaining approval of care and coverage from the review organization, he said.

A major liability issue for health maintenance organizations falls under a law known as "bad-faith breach of contract," he said.

Under bad-faith breach of contract, a defendant can be charged with conscious wrongdoing and failure to perform a duty stated in a contract.

"In California, we see hundreds of these actions. But, they are not widely reported because in California, HMOs require mandatory binding arbitration. This says something about the benefits of building arbitration into the contract to avoid litigation," he explained.

And, if such a case is litigated, the award can be huge, he said.

For example, in one bad-faith breach of contract action against a health insurer, a plaintiff was awarded \$3.5 million, \$3 million of which was punitive damages, he noted.

This tort has not been aggressively introduced into the area of utilization review, he added.

The main liability concern for employers with regard to PPOs is in the antitrust area, he said.

"For the future, we may see an increase in private litigation over antitrust" concerning an issue called monopsony, he said.

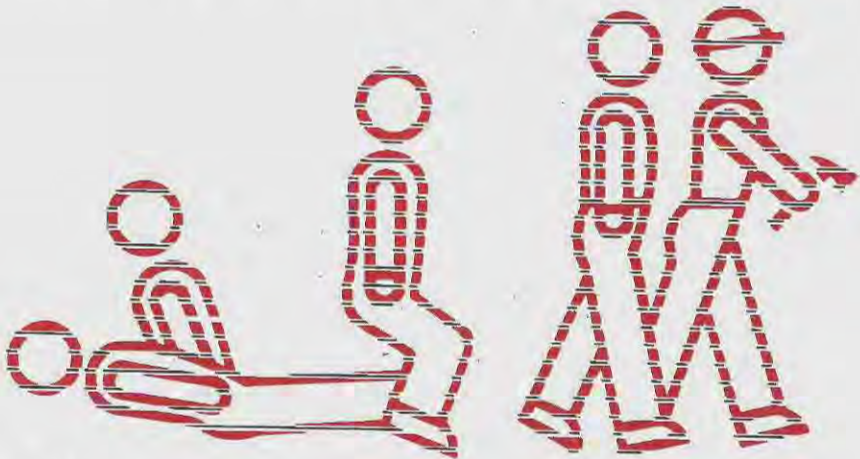
Monopsony—which is the opposite of monopoly—occurs in the health care marketplace when a group of purchasers buy services from providers who are willing to set prices at very low levels in return for a certain marketshare of patients.

Before managed care, providers had a monopoly in which they could set prices at very high levels, he explained.

While employer liability stemming from managed care plans may be limited, employers still should be aware of the potential for liability.

However, implementing preventive measures is the best strategy for employers to limit their exposure while concentrating on health care cost control and quality assurance, he said.

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Continued from previous page
against the risks, he said.

For example, "if you were in a burning building, the benefits of you jumping out the window far outweigh the risks of staying in the burning building. But, if you are dared through a bet to jump out the window of a non-burning building, the risks far outweigh the benefits of a payoff," he illustrated.

Likewise, the risks and benefits of some medical procedures also must be evaluated, he said.

Examples of some risky, and possibly unnecessary, procedures causing today's iatro-epidemic include:

- A recently developed corrective eye surgery known as radial keratotomy (BI, Dec. 17, 1984).

"The benefit of radial keratotomy is that the patient won't have to wear glasses," Dr. Robin said. But, 20% of the patients who undergo this procedure develop some type of complication, he said.

'Safer and more cost-effective medicine that brings better quality outcomes for patients could mean cheaper medicine. But, cheaper medicine does not necessarily mean safer medicine,' says Dr. Eugene Robin of Stanford University.

Dr. Robin further noted: "About one-third of those patients develop progressive far-sightedness in three to five years after the surgery. So, since the vision impairment is progressive, patients need to get new eyeglass prescriptions more often."

And, about 20% of the patients who had the surgery performed by one of its pioneer surgeons eventually went blind, he said. "Given the minor benefit of not having to wear glasses, the risks of the surgery are not worth it."

- Routine chest X-rays.

"Since 1972, a series of excellent

scientific studies say there is no real improvement in health as a result of routine chest X-rays," Dr. Robin noted.

One of the risks of the X-ray is that the patient may receive a false positive result from the radiologist reading the X-ray, he pointed out.

"This can lead to repeat chest X-rays and even more complicated diagnostic tests, such as CAT scans, bronchoscopy or open-lung biopsy," he said.

Another risk is that the X-ray could be read as a false negative and a treatable condition could be overlooked.

"In one test series, about 22% of the patients who received routine chest X-rays during emergency room treatment after accidents had false negative results," he said.

Perhaps the major risk of routine X-rays is the exposure to radiation, according to Dr. Robin.

"Even low-level X-ray does pose some risk of cancer. And, since all the different risks of developing cancer that one is exposed to do add up, the younger you are, the greater your risk of developing cancer. For smokers, the risk is even greater," he contended.

But, along with analyzing the risks and benefits of procedures, it is also important to analyze the costs and benefits of medical procedures, Dr. Robin observed.

"Safer and more cost-effective medicine that brings better quality outcomes for patients could mean cheaper medicine. But, cheaper medicine does not necessarily mean safer medicine," he said.

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is a one in three chance
have an unnecessary hyste
By age 70, the chance increas
two in three. And, three out of
1,000 women die during the sur-
gery," he said.

Another over-used procedure is coronary bypass surgery, he said.

"In 1986, 200,000 of these were performed. About 100,000 of these surgeries were performed on patients that most likely could not benefit from the procedure," he said.

Some unnecessary tests, while posing the risks of providing false negatives or false positives, also could "wound, injure or kill the patient," Dr. Robin said. For example, X-rays and annual physicals pose more risks than benefits, he said.

But, employers and employees can take action to control costs, risks and quality during the iatro-epidemic, he said. These actions include:

- Learn more about the medical system and how it generally works.

"Medical education and leadership is a perfectly legitimate concern of business and industry. There's an enormous hunger for medical information in this country—so, form classes in your company to meet that need," Dr. Robin advised.

- Know and understand your own medical records.

- Obtain an independent second opinion or more than one extra opinion.

- Buy and learn to use the "Physicians' Desk Reference," which lists medical conditions and how they normally are treated.

- Learn to use some doctor as an "ombudsdoctor" who can advise and inform you about your care without actually treating you.

- Develop an active role in your own health care.

Most of all, Dr. Robin recommended, "Patients, get off your knees and take the doctor off of the pedestal."

"We need an organized effort in which educated employees and employers can improve the safety and effectiveness of health care," Dr. Robin said. ■



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benefit beat

NCR offers new program for mental health cover

NCR Corp. is offering its employees an incentive to control the cost and quality of the psychiatric care services they utilize.

Under a new psychiatric benefits program called "The Psychiatric Advisory Service," employees receive increased coverage if they contact the company's employee assistance program before seeking mental health care services, explained Douglas M. Bartlett, director of U.S. employee benefits for the Dayton, Ohio-based electronics manufacturer.

"We have had an employee assistance program for three years and it helped employees to handle problems through company-paid short-term counseling," he said.

Originally, the EAP provided confidential counseling for problems such as family and marital conflicts or stress.

The EAP is administered by St. Louis-based Personal Performance Consultants Inc.

Under the new Psychiatric Advisory Service, which became effective in January, the EAP will refer employees needing further treatment to the appropriate psychiatrist, psychologist or counselor.

After receiving a referral, employees receive a special health claim form that entitles them to increased coverage of their outpatient psychiatric care, he said.

Usually, the plan covers 50% of the cost of office visits, up to a maximum of \$30 per visit and a maximum of 50 visits per year. But if employees use the EAP referral service, coverage is increased to 80%, up to a maximum of \$70 per visit for up to 50 visits per year.

NCR's group indemnity plan—which includes psychiatric benefits—is self-insured, with claims administered by The Prudential Insurance Co. of New York. Some 25,000 employees are covered by the plan.

"Employee reaction to the Psychiatric Advisory Service has been very positive," Mr. Bartlett said.

Wellness program

Travelers Corp. is combatting medical care cost increases with a wellness program for its own employees.

The Hartford, Conn.-based insurer recently opened The Travelers' Taking Care Center, the newest component of its Taking Care Program.

The program is a product of Travelers' subsidiary, The Center for Corporate Health Promotion, which markets wellness programs to employers, according to a spokeswoman.

The new fitness facility houses exercise equipment, a swimming pool, a sauna and a track. There also are meeting rooms for health education courses such as nutrition education, stress management and prenatal classes. Some 5,000 employees are eligible to use the center, at an annual cost of \$100, payable through payroll deductions, the spokeswoman said.

Employees must obtain authorization from their own physicians that they are in good health to participate. Then, Travelers' own medical staff performs a fitness evaluation, which is used to help employees set their own fitness goals. The fitness evaluation includes tests that measure body fat, stress levels, back condition, cardiovascular fitness, strength and cholesterol levels.

Employees' physical conditions and their progress in the fitness

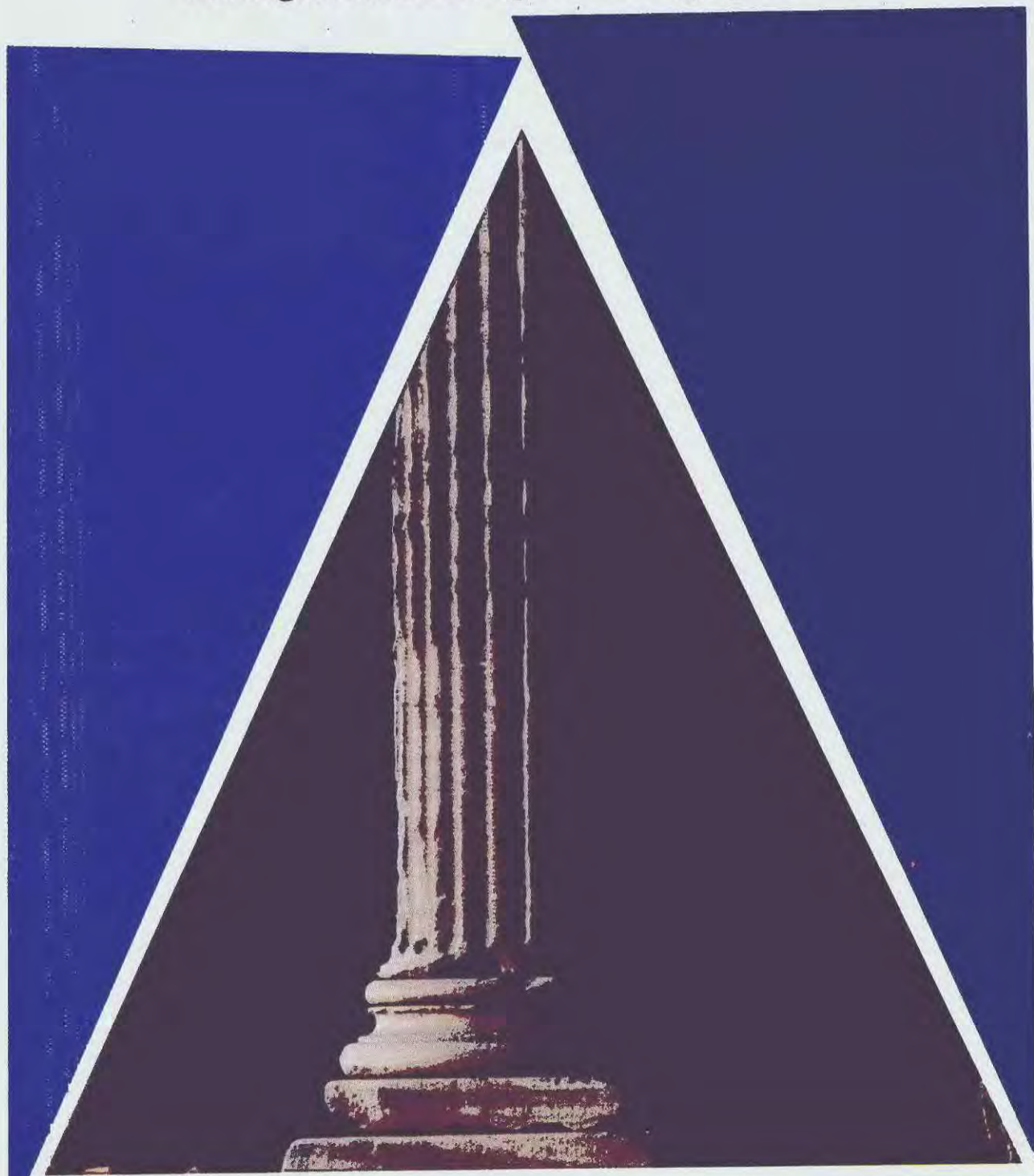
programs will be periodically monitored as part of a Travelers' study on the relationship between modification of health habits and medical care cost savings, said the spokeswoman.

Benefit beat keeps insurance and employee benefit managers informed on what other companies are doing and of current developments in the employee benefit field. We'd like to know if you've made any changes. Write Donna DiBlase, Associate Editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611; 312-649-5393.

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to the report, in 1986, 38% of the companies paid premiums of less than \$25,000 for their primary liability insurance, compared with 16% in 1982. And 36% of the companies paid \$500,000 or more for their primary coverage in 1986, compared with only 17% in 1982.

A similar increase has been seen in the cost of excess liability coverage. In 1986, only 3% of the respondents paid less than \$25,000 for their excess liability coverage, compared with 20% in 1982. And, in 1986, 48% paid \$500,000 or more for their excess coverage, compared with 8% in 1982.

Deductibles also have risen. Approximately 26% of the companies reported a deductible or self-insured retention of less than \$100,000 in 1986, compared with 38% in 1982. And, 19% had a deductible or SIR of \$1 million or more in 1986, compared with only 9% in 1982.

These increases in premiums, deductibles and retentions may force more corporations to use risk financing alternatives, such as captives. The report says, about one-fourth of the respondents are considering making such a move within the next two years. However, 86% of the companies still bought their liability insurance from a commercial insurer in 1986, down from 89% in 1982.

"For most of the companies surveyed, product liability insurance coverage has remained fairly steady, notwithstanding increases in its cost," Mr. Weber said.

He also claims that, although the number of product liability lawsuits filed against the respondent companies has increased in recent years, the effect on the companies also has been minor.

"The current findings leave no doubt that a substantial number of lawsuits are filed against companies on product liability charges. Two-thirds of the corporations surveyed have had suits filed against them within the past five years," he said.

Of those companies sued, 60% face up to 25 suits annually, 20% face 30 to 100 suits an year and 14% face 101 to 500 lawsuits. And, the report notes, the cost of responding to such large numbers of suits can be high—regardless of the outcome.

"But for many major corporations, the task of responding to a large number of lawsuits has become a way of business life," Mr. Weber said.

And, the report shows most companies do not fare badly in the legal arena. In commenting on the disposition of their five most-recent lawsuits, risk managers said that the complaint was dismissed in 14% of the cases, the court ruled in favor of the defendant in 12% of the cases, the ruling went against the defendant in 6% of the cases and they were not sure of the disposition in 4% of the cases. The remaining 64% of the cases resulted in out-of-court settlements.

And, in 57% of those cases settled out of court, the settlement amount was less than \$25,000. The settlement was \$500,000 to \$999,999 in only 2% of the cases, and \$1 million or more in only 3% of the cases.

In response to the liability issue in general and the increased corporate costs associated with it, 43% of the respondents said their company had passed on a small portion of those increased costs in the form of higher prices to consumers. More than two-thirds of the companies said that 1% or less of the final cost of their product can be attributed to the cost of liability insurance, and an additional 11% put the figure at 2% to 3%.

The next-most common management response to the liability issue was to alter product labeling, an action that was taken by more than one-third of the companies surveyed. Less than one-third of the companies improved the safety design of their product. And one-fourth of the firms said that they had discontinued a product or service.

Mr. Weber concluded that, although the responses of the survey participants do not reflect the state of the liability situation among small businesses, the report's findings "refute the general contention of a severe and deepening crisis in tort liability and insurance availability, at least for the nation's large corporations. The impact on the general economy, likewise, is believed to have been minor." ■



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Cost containment

Continued from page 16

included and viewed as part of a solution to health care problems, instead of as the cause of the problems, he added.

However, Mr. Wasserman said, to take an active role in employer coalitions, hospitals must be willing to:

- Provide occupational health services, health education and wellness programs.
- Participate in concurrent claims review.
- Support the development of alternative delivery systems if the employer community desires.
- Provide information on health care issues and local health care concerns.
- Assist in the development of model health benefit plans and data base development for claims review.

In general, he said, hospitals must be willing to work together with employers in a positive, constructive way.

But, employers also must recognize that they are part of the problem of high health care costs, Mr. Wasserman said. For example, if employers offer first-dollar medical coverage to their employees or don't have a utilization review program, costs and utilization are not being controlled.

To move toward solutions to health care problems, he said, employer coalitions should focus their efforts on:

- Inviting provider participation in coalitions.
- Becoming involved in local or regional health care planning projects.
- Determining health care problems before implementing solutions.
- Rewarding cost-efficient, quality providers and punishing those who aren't.
- Trying to understand the hospitals' concerns, problems and goals.
- Clearly communicating employer objectives to health care providers to gain acceptance and support.

This can help avoid a "we/they" mentality, Mr. Wasserman said.

- Playing a stronger role in health care legislative issues, such as indigent care or medical malpractice problems.

"If not, employers may be forced to overpay their share," Mr. Wasserman said.

Employers must exercise their ability to "get in there and tell your ideas for dealing with health care problems," agreed Robert B. Helms, Assistant Secretary of the U.S. Department of Health and Human Services.

The major health care issues currently facing Congress and employers are an increasing elderly population, a large number of people with no form of health insurance and medical costs that are steadily rising at an annual rate of about 8%, Mr. Helms said.

"I'm concerned that we may have oversold the ability of the private sector to take care of all of these problems," he said.

And, while there is "still a very real resistance in the Reagan administration to raise taxes, Congress is still concerned about these problems and costs," Mr. Helms continued.

"But, I think Congress has developed unrealistic expectations about what employers can do. I'm optimistic that business can do something, but Congress wants to push too much to employers," Mr. Helms observed.

"On the state level, there's talk of mandating benefits for catastrophic care," and there could be more action taken to provide health insurance for some 37 million uninsured Americans, he said.

"Mandating insurance would have enormous cost effects. The

mandates in COBRA already make employers responsible for some uncovered individuals," he said, referring to the Consolidated Omnibus Budget Reconciliation Act, which requires employers to extend health benefits to divorced and widowed spouses of employees and to most former employees.

And, in addition to the increased health care costs employers could face as a result of the coverage continuation requirements of COBRA, they also are facing a cost shift from providers, he said.

Health care providers shift costs to employers and insured patients to make up for revenues lost as a result of providing care to uninsured patients and Medicare recipients.

Aside from actively monitoring and participating in legislative movements, employers "must require employees to share in medical costs up front. This gets people to take control of their own costs," Mr. Helms advised. ■

Overutilization of health care creating new risks: Doctor

By DONNA DiBLASE

CHICAGO—An "iatro-epidemic" is spreading throughout the nation's health care system, according to one physician.

The iatro-epidemic is the overutilization of some medically unnecessary services—which also may be unsafe—by doctors or medical practitioners, according to Dr. Eugene Robin of Stanford University in Stanford, Calif.

"In our country, if we're not hemorrhaging from escalating health care costs, we're certainly dropping a trail of blood," he added.

Dr. Robin discussed the risks and costs vs. the benefits of some of these overused services at the seventh annual conference of the Midwest Business Group on Health, held Feb. 26 and 27 in Chicago.

"There has been an increase in the number and nature of risks resulting from medical care services today. This is because rapid advances in medical sci-

ence and technology over the last 20 to 30 years have not been matched by improved safety and efficiency of delivering care," he explained.

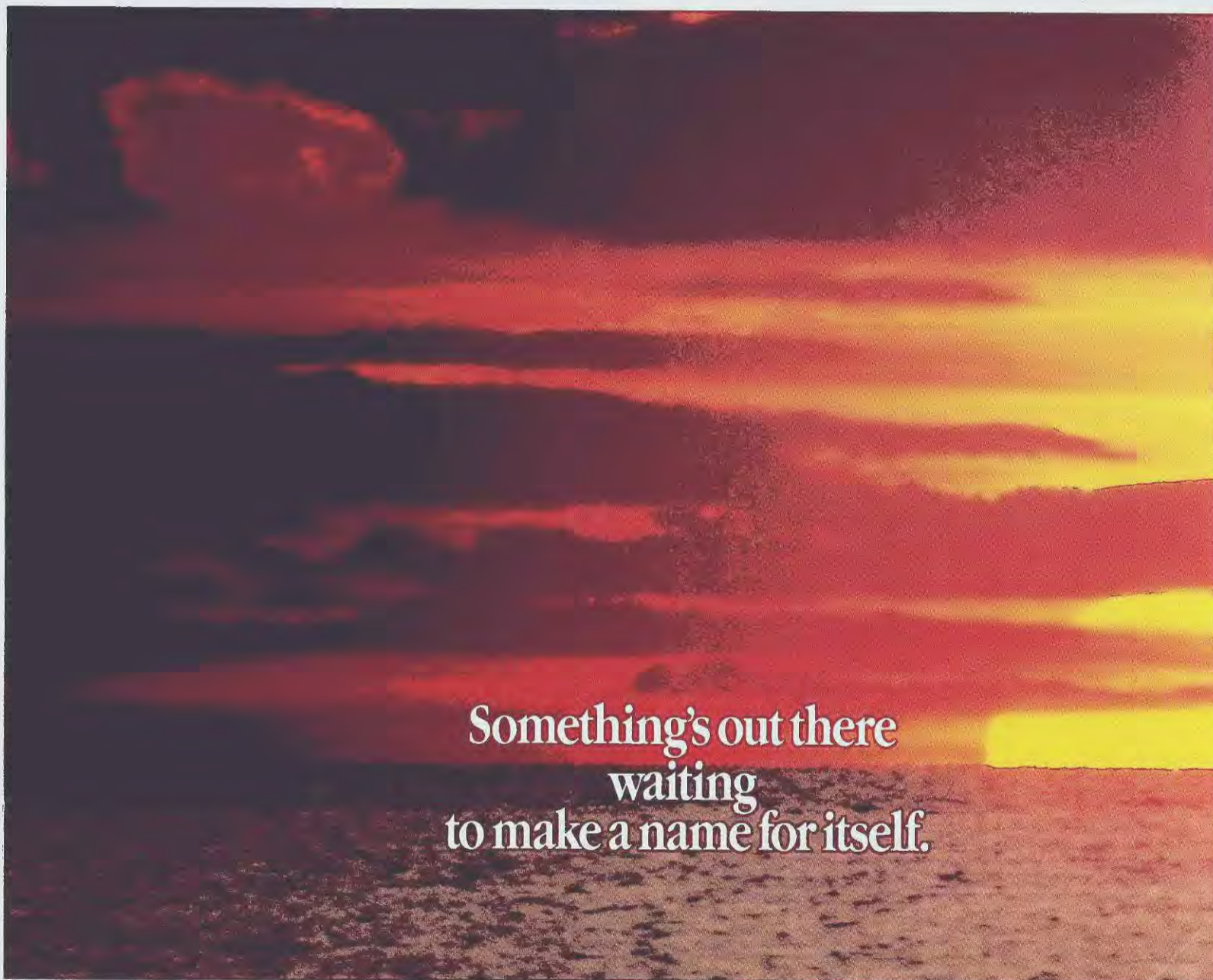
The current iatro-epidemic is different from iatrogenic conditions—unanticipated health complications resulting from surgery or other medical procedures, he said.

One of the causes of the current iatro-epidemic is gross errors in medical judgment, such as ordering unnecessary tests for a dying patient that serve no health benefit, he said.

Another is deliberately performing a procedure without taking all the necessary safety precautions, he explained.

For example, performing surgery on a patient who is in a sitting position after general anesthesia has been administered can cause serious brain damage, Dr. Robin said.

It is important to weigh the benefits of an action
Continued on next page



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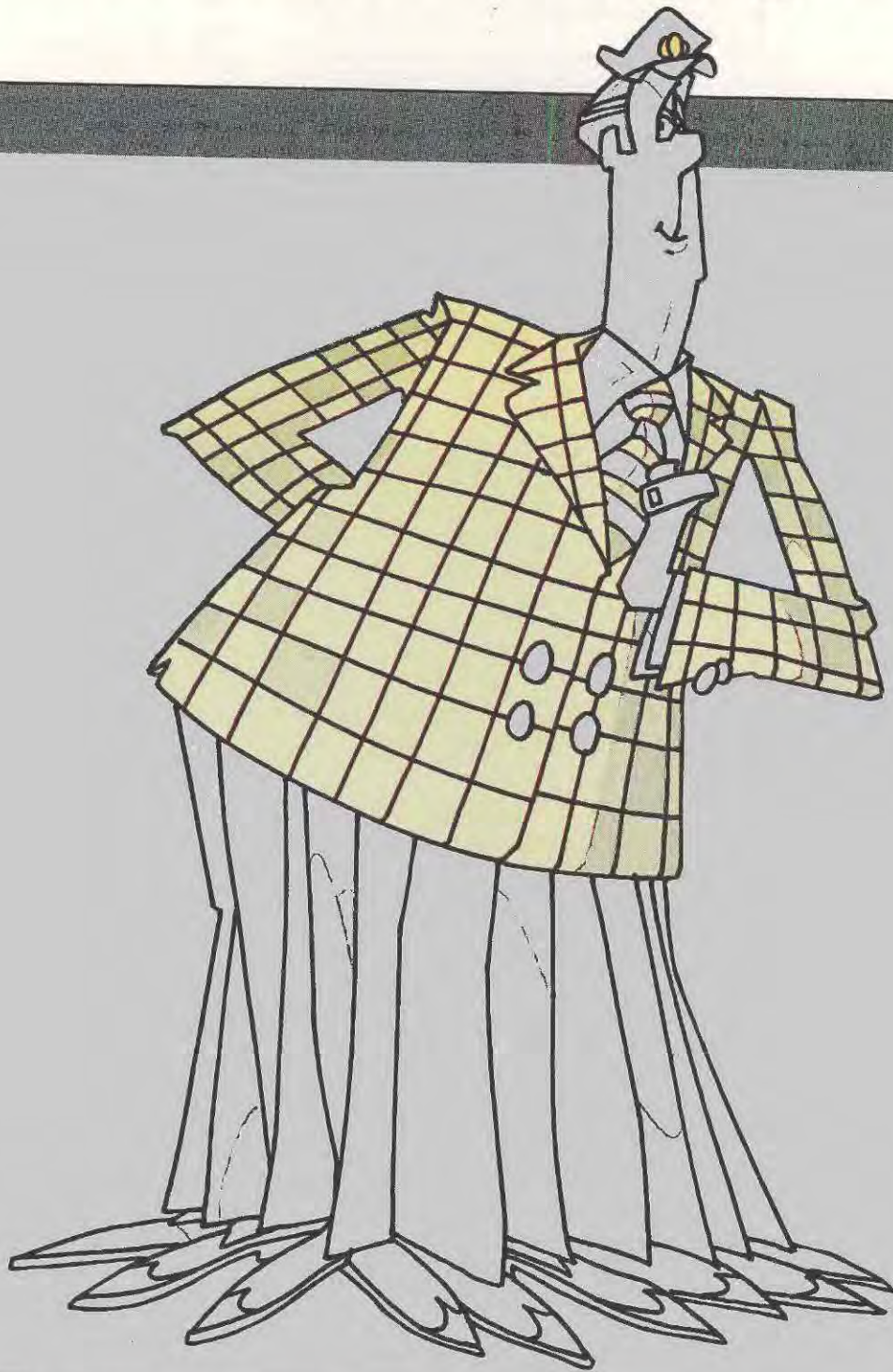
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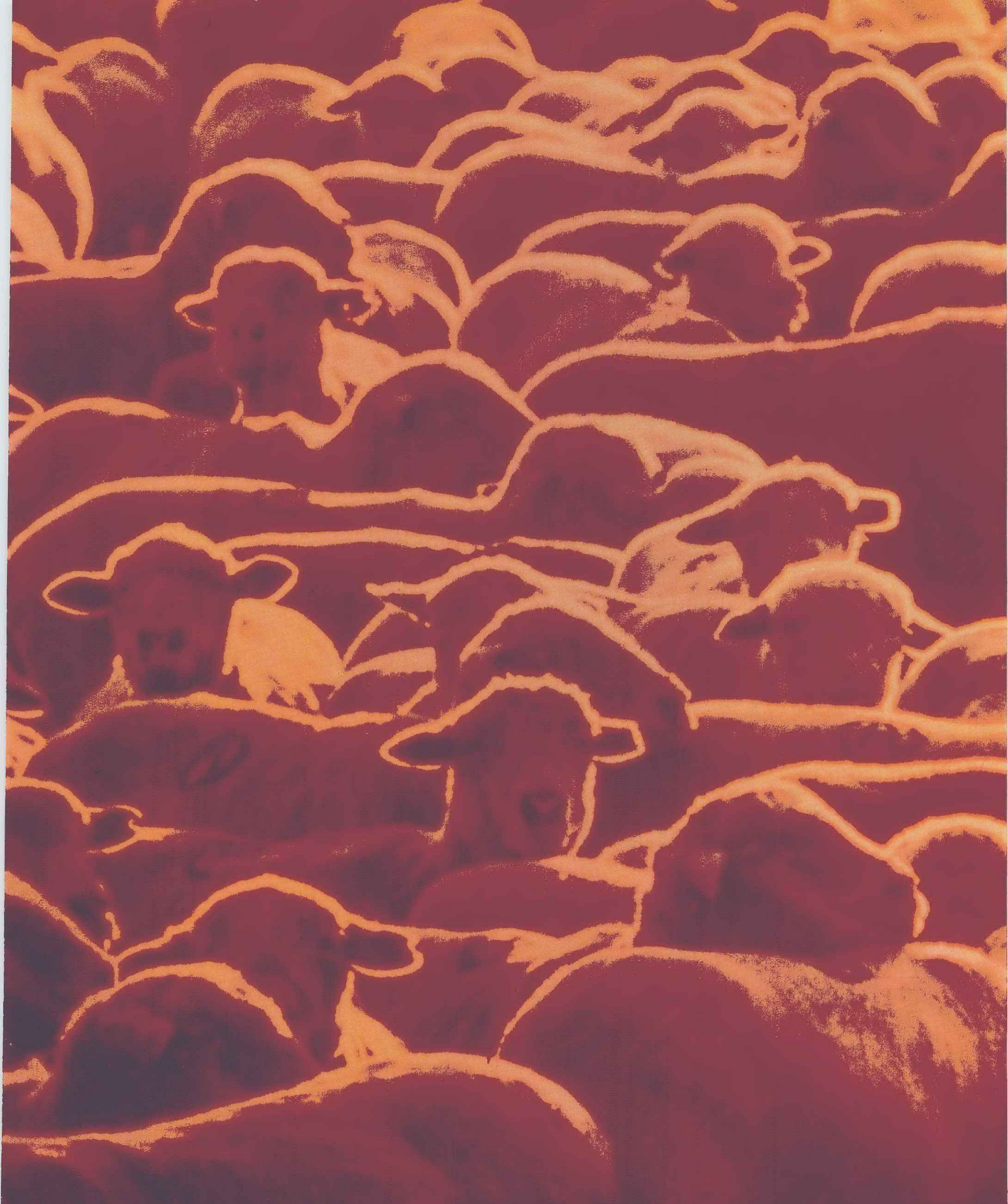
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Survey examines mental health benefits

By ALISON KITTRELL

Virtually all employers offer some sort of mental health coverage for their employees, and almost half also offer an employee assistance program, according to a recent survey. However, the types and amounts of coverage offered vary widely.

The survey by Lincolnshire, Ill.-based Hewitt Associates showed that 292 of 293 companies offer mental health coverage to employees and their dependents, but very few companies kept statistical data on their mental health programs.

Of those companies that kept such data, a slight majority noted at least a small increase in employee utilization of mental health services in the past few years; others note an increase in per-employee costs for mental health care.

The two most common reasons for offering the coverage were a sense of moral obligation, cited by 37% of the companies, and a need to keep up with the competition in benefits, cited by 35%.

Only 15% said they offered mental health coverage as part of a cost management scheme for their overall medical plan. Six percent cited employee demand for the benefit, and a mere 1% said they offered the benefit to improve employee productivity.

In addition, although virtually all employers offer some coverage for mental health care, most of them place restrictions on the kinds of treatment covered.

For example, 91% of the programs surveyed cover the costs of treatment for substance abuse. Psychotherapeutic treatment costs are covered by 85%, and the costs of psychiatric drugs prescribed by a doctor are covered by 84%.

Some 69% of the programs surveyed cover the costs of psychological testing, and 64% cover group psychotherapy.

Only 36% of the programs cover the costs of marital or family counseling, while 24% pay for psychological day care, and 19% cover therapy for developmental or learning disabilities.

In addition, 93% of the surveyed companies provided separate limits for the treatment of mental health problems. Some 71% have specific limits for both inpatient and outpatient costs. But, 19% said their specific limits are for outpatient care only, while inpatient care is covered as any other illness under the medical plan.

About 18% of the companies have combined limits for inpatient and outpatient mental health care. Of these, 91% have a lifetime dollar maximum ranging from \$3,750 to \$500,000, with a median of \$45,000. And, 22% have an annual limit ranging from \$1,000 to \$20,000, with a median of \$3,250.

And, about 22% of the companies have a separate limit for substance abuse treatment. Of these, 71% have an annual length of stay limit, with a median of 30 days per confinement, and 38% have a lifetime limit on number of confinements, with a median of two.

Ten percent have a dollar limit per plan year, with the median limit of \$1,250, and 17% have a lifetime dollar limit, with a median limit of \$10,000. And, 13% cover a limited percentage of costs associated with treatment of substance abuse, with a median of 80%.

Some 58% of the companies include some kind of cost-control measures in their mental health benefit plan, including pre-certification of inpatient admissions, required by 38%; concurrent review of inpatient admissions, required by 34%; data analysis, 26%; mental health case management, required

by 20%; and retrospective review of inpatient admissions, 16%.

Only 10% of the companies surveyed could provide data on per-employee mental health care costs for the years 1984 through 1987. Among those that could provide the data, the average cost in 1984 was \$118. That rose 15% in 1985 to \$136. And, the report estimated another 15% cost increase in 1986, to \$156, and an 8% boost in 1987, to \$169. Further, 33% of the companies could not provide data on employee use of mental health

care.

Finally, the survey showed that 47% of the companies sponsor an employee assistance program, with an additional 10% considering offering such a program. And, 91% of those companies that offer an EAP extend coverage to the dependents of employees.

The most common problem covered by an EAP is substance abuse, covered by 99%. Mental and nervous disorders are covered by 92%, and marital or family problems are covered by 91%.

Most of the EAPs are free to employees, at least up to a certain number of visits. Some 34% offer unlimited visits at no cost to the employee, and 47% are free to employees up to a median of three visits.

Only about half the employers surveyed could estimate the EAP's annual charge per employee. Among those that could, the median was \$18 per employee.

One respondent said that, as a result of the EAP, his company had experienced "reduced turnover by

rehabilitated employees who might otherwise be discharged."

A second said that the EAP "program essentially paid its own costs in the first year." And another said that, through the EAP, "A life was saved."

Copies of the survey, "Company Practices in Mental Health Coverage," are available for \$45 each from Hewitt Associates, 100 Half Day Road, Lincolnshire, Ill. 60015, Attention: Cathy Schmidt; 312-295-5000.



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Will history recur?

Market hardening for administrators of work comp claims

By Dave Guyer

NOT LONG AGO the property/casualty insurance industry sounded a warning to the public: Premium increases are inevitable. Because of substantial losses from previous years, rates for almost all lines of commercial insurance would rise.

Few took the warning seriously. And when the hard market finally hit, there were policy cancellations, astronomical rate increases, reduced availability of needed coverages and a public outcry.

No one likes to believe that history repeats itself, but a similar hardening of the market is now being felt in the market for third-party workers compensation claims administration services. This time, let's hope the marketplace hears the warnings and prepares for the worst.

At the heart of the storm is the increased cost of doing business. Claims examiners currently are demanding—and receiving—higher fees from their clients. General business expenses have increased and profits have dwindled into the red. Third-party claims administration firms are faced with the simple alternatives of either closing their doors or increasing their fees to produce a reasonable profit. The days of absorbing loss, loss-leader departments and continuous downspiraling of profits are a thing of the past.

Conscientious buyers need to get ready for higher fees than they have paid in the past.

As an observer of the industry, I have witnessed many situations that support this forecast. For example, in 1985 it was not uncommon to observe spreads in bid proposals in California as high as 136% for the same account. In 1986, we see those spreads reduced significantly to about 30% to 40%. I have also watched the cost per claim rise from \$150 to a more realistic figure of \$225 and higher.

In a recent bidding for the workers compensation claims administration business for a Southern California public entity, 80% of the companies bid a fee of more than \$200 per claim, and 60% bid \$225 and higher per claim. In this same example, the firms with a low-bid tradition were still 30% above their quoted cost per claim of a year earlier. Even a high bidding firm came in with a quote higher than the previous year, though the difference was only 10%.

While most self-insurers would think that these increases are exorbitant within such a short period, in actuality, they are long overdue. Many changes have taken place within the industry in the past two years that are reflective of the business environment and the need for a more realistic pricing for quality service.

Several companies have left the workers compensation claims administration business entirely

because of economics—big names such as Marsh & McLennan Cos. Inc., Employee Benefits Insurance Co. and Industrial Indemnity Co. Likewise, independent companies have been unable to compete and have closed their doors. Still others have suffered marked reductions in business and substantial crunches within their organizations in their attempts to remain solvent.

Claims administration firms dedicated to providing quality service for their clients face some basic economic factors. One of these elements is the high cost of competent, service-oriented personnel. A certificated examiner in California now commands approximately \$30,000 in annual salary, plus benefits. The recommended case load for such an experienced examiner is approximately 250 open indemnity files. The cost to the company for overhead and support is approximately two times salary. Therefore, the examiner really costs

entirely.

While those firms are busy cutting their fees, a client's claim costs are skyrocketing. Under such a scenario, the self-insured program ultimately costs more in claims expenditures than the increased cost of administrative services.

Another phenomenon earning greater acceptance and popularity is the movement of qualified claims examiners from employee to independent contractor status. More and more certificated examiners are finding they can earn \$20 to \$30 per hour as independents, and earn \$200 per week more than if they were an employee earning \$30,000 per year. At that differential, they need only work 40 weeks per year instead of 52.

This movement could dramatically increase the cost of doing business for a third-party administrator that is forced to employ independent claims examiners as a result of staffing shortages.

Additionally, these independent

Third-party claims administration firms are faced with the simple alternatives of either closing their doors or increasing their fees to produce a reasonable profit. The days of absorbing loss, loss-leader departments and continuous downspiraling of profits are a thing of the past.

the TPA \$60,000 per year.

Divide the average case load of 250 claims into the \$60,000 and you find that the TPA's actual cost per claim is \$240. And, keep in mind that this is a minimum figure.

Some executives of well-known claims administration firms say that salaries must remain around 40% of total costs in order for them to break even. If that's true, the real cost of an examiner is \$75,000, for a cost per claim of \$300.

Other executives say 2.3- to 2.5-times salary is the break-even point, which produces a real administration cost of \$276-\$300 per claim. If you use the theory that each employee must produce \$65,000 income, the cost per claim is \$260.

No matter what formulas or methods are used, the conclusion is the same: To achieve quality performance—the real cost-saver—claims administration companies will be forced to charge their self-insured clients more.

How then can some firms quote fees below the real cost of handling an account? The answer is simple: They cut services.

These administration firms increase examiner caseloads and reduce the level of quality. They utilize defense law firms, rehabilitation firms, investigative firms and other vendors to perform claim functions that are billed against the claim file. They render huge increases in following years; they commingle profit centers and accept clients as loss leaders; or they suddenly leave the business

claims examiners may not have the best long-term interests of the client at heart. They can always move on to another company if the going gets too tough. These factors can easily create increased costs to a self-insured claims administration program.

How then does the self-insured employer know how to choose a quality claims administration firm, or know when they are receiving quality service from their TPA? It's not easy, and self-insurers may need help if they are not familiar with the workers compensation industry.

I have found that it is not so much what a company says it will do but, rather, what it *doesn't* say that creates large differences among administration firms.

First, you cannot assume that every claims administration company will provide the same level of service for the quoted fees. You must know about what services you need and desire, and what it takes to provide these services at your desired level. Then you need to evaluate each proposal and compare them in great detail.

Proposals that promise to "administer your claims in accordance with workers compensation laws" are not sufficient. You need much more specific information and you need it incorporated as part of your formal contract.

Second, have the proposing (or incumbent) firm clearly demonstrate how they arrived at their quoted fee for your program. Justification that the administrator's fee is the "going charge in the industry" is meaningless

and insufficient. You should know the people who will handle your program, how much they make in salary and benefits, overhead costs and profit factors.

With this information you can more easily determine which company can do the best job for you. This exercise may also give you important clues as to the forthright responses and the productive relationship you can expect in the future.

Third, do your homework. Check references and independent sources. I even recommend that you check with former clients to determine why they left and what level of service they received for specific fees. If an equal size client received the same promises, for the same fees, but was not satisfied, you also may experience similar problems.

Fourth, it is advantageous for self-funded employers to consider claims administration firms that have established cost-containment programs, because generally 50% of the claims dollar is spent on medical reimbursement. Historically, employee benefit programs have been more advanced in their use of cost-containment features than have workers compensation programs.

Therefore, it might be wise to consider choosing an administration firm that has a good cost-containment track record in health benefits as well. Claims administration firms with cost-effective cost-containment features will perhaps require higher fees because of additional costs in setting up and maintaining these features. In the long run, however, the higher fees will probably be worth it in terms of lower claims levels.

Fifth, conduct your own annual independent audit of your workers compensation TPA's performance. I have seen employers, which haven't audited their TPAs for several years, react with great surprise when they discover that their self-funded program is not performing the way they expected or wanted. The administration firm is not going to tell you they are not performing, so you need to find out for yourself.

The audit is a double-edged sword and a very beneficial tool for the client. The annual independent audit can reveal problems but can also disclose the high-quality programs and areas producing good results and accomplishments. I frequently find employers that are unaware of the high-quality service they are receiving, or how well their program is being administered.

Continued on next page

David G. Guyer is president of Insurance Management Services in Anaheim, Calif.



ASK A BENEFIT MANAGER

DEFRA made changes to life insurance rules

Q

I understand that income may be imputed to retirees if they are covered by group life insurance, except for those employees that are "grandfathered" under the law. Would you please explain how the law works in this

regard and what classes of retirees are "grandfathered?"

A

Before 1984, an employee who retired and was covered for retiree group life insurance had no income imputed to him or her on account of such insurance, regardless of the amount.

The Deficit Reduction Act of 1984, however, imposed the following change on the more liberal pre-1984 law by extending Internal Revenue Code Section 79 rules for group term life insurance to retirees.

First, income is imputed for amounts of retiree group life insurance provided under non-discriminatory plans in excess of \$50,000 at the Section 79 Table I rates.

Second, key employees in discriminatory plans that favor the key employees over other employees have income imputed to them in the entire amount of their retiree group life insurance and such income is imputed on the greater of the actual cost (age-related) of the insurance or the Section 79 Table I rates.

Key employees include: Officers of the company (not to exceed 50 or, if lesser, the greater of three employees or 10% of all employees); the 10 employees owning the largest interest in the company; employees owning 5% or more of the company; and employees owning 1% or more who are paid more than \$150,000 a year.

All other employees in a discriminatory plan have income ascribed to them on the basis of Section 79.

Third, all employees who were age 55 or older on Jan. 1, 1984, were "grandfathered" by DEFRA. For these employees, the liberal pre-1984 law would apply as long as they continued to be covered by the plan. Employees lose their grandfathered status if the plan is changed to increase benefits.

Furthermore, employees who retired after Jan. 1, 1987, also lose their grandfathered status if the plan is discriminatory.

If the employee is a key employee, income is imputed on the entire amount of insurance or the Section 79 Table I rates. If the employee is not a key employee, income is imputed on the basis of Section 79.

Accordingly, you must have amended your plan

before Dec. 31, 1986, to eliminate any discrimination either in eligibility for coverage, in benefits or in employee cost, to protect the grandfathered status for all of your employees who were age 55 or older on Jan. 1, 1984.

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

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

This month's column, on employee benefits issues is written by Joseph W. Duva, director of employee benefits at Allied-Signal Inc. in Morristown, N.J. Ralph F. Perry Jr., vp and director of risk management at Amfac Inc. in San Francisco answers risk management questions. And, William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions on benefits issues. Richard E. Sherman, a principal with Coopers & Lybrand in San Francisco, answers actuarial questions in the casualty field. Mr. Duva's and Mr. Perry's columns appear alternately on the second Monday of each month. Mr. Miner's and Mr. Sherman's columns appear alternately on the first Monday of each month. Mr. Duva'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.



Mr. Duva

Job stress caused heart attack: Court

A heart attack, suffered by an employee after he left work, was compensable where it was established that he was under severe stress while at work and that job stress was a material contributing cause, according to an Oregon appellate court.

Howard Hurst worked as a union business agent. For six months prior to his heart attack, he had worked long hours under serious stress. Mr. Hurst had frequently lost sleep at night during this time because of worry over his job.

On Oct. 4, 1984, he had a strenuous and long day beginning at 4:30 a.m. with travel for the union and attendance at several emotional union meetings. During the night of Oct. 5, he awoke ill.

His wife drove him to the hospital where it was determined that he had suffered an acute myocardial infarction. A later angiogram confirmed that he also suffered from arteriosclerotic heart disease that pre-existed the infarction.

Mr. Hurst filed for workers compensation benefits, but his claim was denied.

legal briefs

The appellate court said that, although Mr. Hurst suffered the infarction after he left work, he was under severe stress while at work. According to his physician, the court said, the attack followed that stress.

Thus, the court concluded that Mr. Hurst had proven by a preponderance of the evidence that his job stress was a material contributing cause of his infarction.

The court held that his injury was compensable.

Hurst vs. SAIF, Court of Appeals of Oregon, Nov. 20, 1985 (BI/05/D.-\$5).

Race discrimination defense

An insurer was held to have breached its duty to defend its policyholder in a suit claiming employment race discrimination, according to the Court of Appeals of Washington.

In 1976, Castle & Cooke Inc. was sued in federal court in an

employment discrimination class action. Cooke was covered under an insurance policy issued by Great American Insurance Co. that obligated the insurer to pay all sums that Cooke became legally obligated to pay as damages because of personal injury.

Personal injury was defined to include racial discrimination not committed by or at the direction of the policyholder.

The policy excluded coverage for mental anguish or bodily injury to any employee arising out of and in the course of employment.

The federal racial discrimination suit sought lost wages and damages for physical suffering, arbitrary treatment and mental anguish. Cooke notified Great American of the suit. However, Great American denied coverage and refused to defend Cooke. Cooke then brought this suit seeking a declaration that Great American had a duty to defend and damages for breach. The trial court ruled for

Cooke.

The appellate court concluded that the employee exclusion in the policy was clear and unambiguous.

"Although there is no insurance coverage and no duty to defend employee claims for bodily injury or mental anguish, there is a duty to defend non-intentional employment race discrimination claims which allege damages for lost wages and arbitrary termination," the court said.

The court concluded that Great American had a duty to defend Cooke, although the court also held that Great American had not acted in bad faith.

Castle & Cooke Inc. vs. Great American Insurance Co., Court of Appeals of Washington, Jan. 6, 1986 (BI/01/N.—\$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. List the number for each opinion.

Workers compensation TPAs

Continued from previous page

The hardening of the workers compensation claims administration market is a good indicator of the need for higher TPA rates, but caution and research are still appropriate. Some companies that have consistently underpriced their services for years are now utilizing this hardening market to "blend fees."

This is the process of using exorbitant fee increases to correct the substantial losses of the past. This activity is unacceptable.

Fortunately, high-quality workers comp claims administration firms are not participating in "fee

blending."

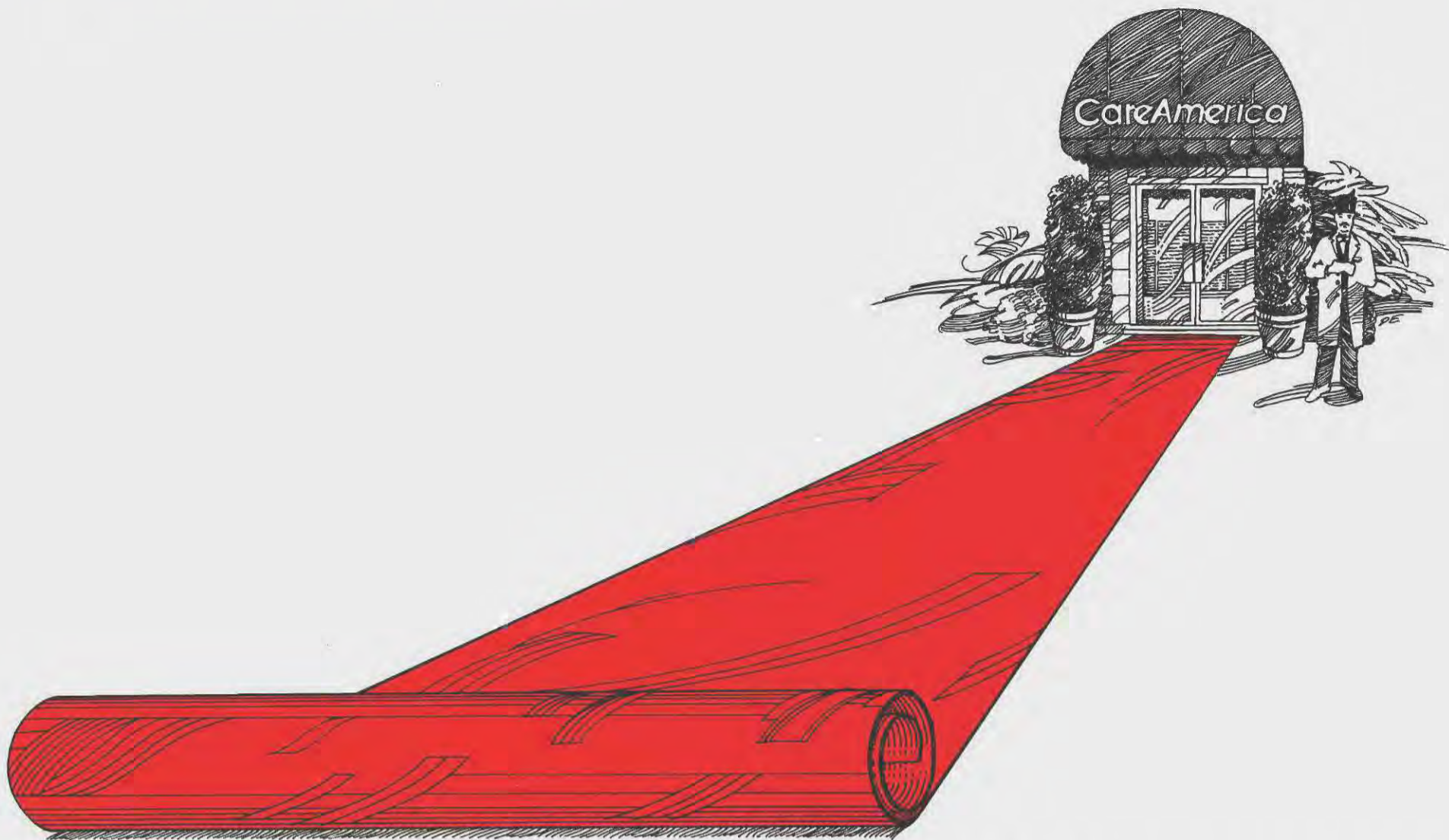
While their costs are also increasing and their fees are reflecting these increases, the percentage of increase is reasonable, justifiable and explainable.

New legislation, other recent state requirements and the multitude of new, innovative and competitive administration programs are forcing the quality firms to increase fees in order to provide quality service and cost-effective administration. The savings produced by high-quality programs far outweigh the increased fees.

The hardening of the market is a clear indication

that those companies that have traditionally been "low balling" their fees have recognized they cannot continue to exist at past fee levels and provide the quality of service now demanded by the educated employer.

Employers can expect to see much greater competition among TPAs than ever before, with the emphasis upon individual programs and techniques that will produce greater savings to the self-insured employer, rather than large fee differences. Quality programs will produce savings in self-insured workers compensation programs that far exceed the administration fee.



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British timber industry forms broker

By CAROLYN ALDRED

london

LONDON—The British timber industry is hoping to improve insurance terms and availability through the formation of its own insurance broker.

T.T.F. Insurance Services Ltd. was formed jointly by the Timber Trade Federation, representing 530 timber firms in the United Kingdom and Ireland, and Lloyd's of London broker Bain Dawes P.L.C. to provide insurance services exclusively for TTF members.

T.T.F. Insurance Services, which began operations on March 1, plans to offer premium reductions on marine, credit, property/casualty, life and pension insurance for TTF members, said the company's chairman, John Wright, who also acts as honorary treasurer of the federation.

So far, 27 members of the federation have said they plan to place their insurance through the new broker, said Mr. Wright.

"We hope to offer significantly better terms than those available for non-members by using the bulk buying power of our members together with improved risk management methods designed to minimize claims," said Mr. Wright.

The broker already has placed policies for TTF members with several underwriters, including Royal Insurance Group P.L.C., Lloyd's underwriter A.L.S. Motor Policies P.L.C., said John Loosemore, managing director of the new brokerage and director of Bain Dawes' U.K. new business division.

Bain Dawes also helped form a

brokerage for the Road Haulage Assn. in Britain several years ago.

Duty of care

A decision by a London High Court overturns the British insurance industry's 200-year-old principles of duty of care, according to an insurance lawyer.

The high court decision last year that awarded a group of banks as much as \$33 million because an employee of the insurers failed to disclose information about credit insurance policies written for the banks sets a very worrying precedent, said David Higgins, the insurers' lawyer and a partner of the London law firm Herbert Smith.

"If the judgment is upheld... all insurers will have to review their understanding of duty of care. After 200 years, the underlying principles by which the insurance industry is governed will have to be changed," Mr. Higgins told a meeting of the Insurance Institute of London.

The two insurers, Skandia (U.K.) Insurance Co. Ltd. and Westgate Insurance Co. Ltd., formerly Hodge Mercantile & General Insurance Co. Ltd., are appealing the decision in favor of the banks. The banks involved are: Chemical Bank of New York; America Fletcher National Bank of Indianapolis; Banque Keyser Ullman of Switzerland; Credit Lyonnais Bank Nederland N.V. in Switzerland; Arbutnot Lathan & Co. Ltd.; and

Banque Arabe et Internationale d'Investissements in Paris (BI, Oct. 13, 1986).

The insurers were held liable because an underwriter, who worked at different times for both insurers, failed to tell the banks that cover notes were inaccurately prepared by the broker.

The credit insurance policies at issue in the case were written to guarantee loans worth up to 53.8 million Swiss francs (\$32.8 million), on which the borrower later defaulted.

"In principle, an insured can claim damages from an insurer arising from loss suffered by the insured as a result of a breach of the obligation of the utmost good (faith) by the insurer," said High Court Justice Johan Steyn during the case.

However, this decision implies that "every insurer and insured owes a duty of care quite separate from his liability in contract," according to Mr. Higgins.

"The judge's finding is quite without precedent and devastating in its implications... if the judgment is upheld in appeal, I can see the economic activities of our country becoming inhibited by the threat of endless litigation," he said.

Football stadium fire

More than 200 people are expected to file claims against Bradford City Football Club, which has

been found partially liable for a 1985 stadium fire in which 56 people died and 200 were injured (BI, May 20, 1985).

Claims are expected to total between 5 million and 10 million pounds (\$7.74 million and \$15.5 million), sources say.

In a test case brought jointly by a woman who lost four members of her family in the blaze and a policeman who suffered injuries, a High Court judge in Leeds apportioned two-thirds of the blame to the football club and the remainder to the local county council.

American International Underwriters (U.K.) Ltd., insurer for the now-disbanded council, has been given 14 days to file an appeal, said Claims Supervisor Steven Eckhardt. However, no decision to appeal has been taken yet, he added.

No appeal is being planned by Sun Alliance P.L.C., the football club's insurer, sources say.

Some 110 claims, including 40 by policemen who were injured at the scene of the blaze, have been filed so far, but more are expected, said Mr. Eckhardt.

The council, whose affairs are now managed by a residuary body to handle any outstanding matters faced by the council, is covered under a general liability policy written by AIU, said Stuart Hoare, the body's lawyer.

Neither Mr. Eckhardt nor Mr. Hoare would comment on the policy limits, although they are believed to be "more than adequate."

Bradford City Football Club, which is a member of the British Football League, is "fully covered" under a policy held with Sun Alliance, said Brian Cook, a director of Lloyd's of London broker S.W. Taylor & Co. Ltd., which acts as broker for all 92 clubs in the league. However, he would not comment on policy limits.

A spokesman from Sun Alliance confirmed the company was the sole liability insurer for Bradford City Football Club, but refused to comment on the policy "while the case is still subject to appeal by the council."

The fire, which took place during a football match at the grounds in 1985, was watched by millions on television as it spread through a grandstand in less than five minutes. The football club had been warned in 1980 by the government's Health and Safety Executive that years of trash accumulated underneath the stadium seats

presented a fire risk, according to evidence presented to the court.

Sedgwick plans

Lloyd's of London broker Sedgwick Group P.L.C. plans to continue its growth in the United States with the help of its three recently acquired U.S. brokers, according to Chairman Carel Mosselmans.

Mr. Mosselmans predicts that profits from the United States will exceed the broker's home-grown profits next year, and he pinpoints employee benefits as a major growth area for Sedgwick in the United States.

Meanwhile, Sedgwick's worldwide pretax profits in 1986 rose 9% to 135.5 million pounds (\$209.6 million) from 124.3 million pounds (\$192.3 million) in 1985. Revenues increased 10.1% to 640.4 million pounds (\$990.7 million) compared with 581.5 million (\$900 million) pounds the previous year.

About 245 million pounds (\$379 million) of revenues came from Fred S. James & Co. Inc., Sedgwick's major U.S. subsidiary.

Sedgwick acquired three U.S. brokers last year—The Crump Cos. Inc., ranked as the eighth-largest U.S. broker in 1985; Armistead Group Inc., the 37th-largest U.S. broker in 1985; and Arthur L. Owen & Co. Inc., the 69th-largest broker—giving it a good base from which to expand in the United States, said Mr. Mosselmans. The retail brokerage operations at all three companies are being merged with James.

"The strategy of establishing a major presence in the United States, initially by acquisition and subsequently by organic growth, is of fundamental importance to the future... of Sedgwick," he said.

In the past year Sedgwick "has achieved an important strategic goal in the U.S. in direct retail broking, wholesale broking and re-insurance broking from which to expand organically," said Mr. Mosselmans. Business is now beginning to flow in both directions across the Atlantic, he added.

Overall, the company's expenses rose to 504 million (\$780 million) in 1986 from 450 million pounds (\$696.2 million), part of which was due to a doubling in Sedgwick's errors and omissions insurance premiums to nearly 20 million pounds (\$31 million) in 1986 from less than 10 million pounds (\$15.5 million) in 1985.

Continued on next page

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Continued from previous page million) the previous year, said Mr. Mosselmans.

Increased E&O premiums is a problem being faced by all British brokers, he said, admitting that the 1987 premium had remained static at around 20 million pounds but for "substantially less cover."

Also, Mr. Mosselmans said that Sedgwick did not face any "material financial loss" as a result of litigation involving a \$62.2 million claim for a damaged oil rig in the Beaufort Sea.

The rig's insurers, led by Commonwealth Insurance Co. of Vancouver, are refusing to pay the claim, contending the risk was misrepresented either by the rig's owners or by two Sedgwick subsidiaries that brokered the coverage (BI, Feb. 23).

Royal's results

Royal Insurance P.L.C. is predicting a "substantial improvement" in its U.S. workers compensation business over the next two years—the only line of business in its North American portfolio that didn't improve in 1986.

A turnaround in Royal's North American underwriting experience in 1986 helped boost the group's total pretax profit more than 600% to 304.8 million pounds (\$471.5 million) from only 41.4 million pounds (\$64 million) in 1985.

Royal pretax profits from U.S. operations jumped to 141.7 million pounds (\$219.2 million) from a 1985 loss of 22.7 million pounds (\$35.1 million) on written premiums of 1.4 billion pounds (\$2.2 billion), up from 1.3 billion pounds (\$2 billion) in 1985.

Royal's U.S. combined ratio improved by more than 12 percentage points in 1986 to 102% from 114.3% in 1985, mainly due to higher prices in commercial business, said Chairman Alan Horsford.

Comings and goings

Michael Eve appointed chairman of the non-marine and special risks division of Lloyd's of London

broker Seacope Insurance Holdings Ltd. Mr. Eve was previously managing director of BankAmerica Insurance Services Ltd. and has held senior non-marine directorships with Jardine Insurance Brokers and Sedgwick/Bland Payne. Mr. Eve has been appointed to develop Seacope's development of its non-marine activities.

Peter Syfret appointed a director of Lloyd's broker Jardine Glanvill Ltd., the London and international insurance markets operation of Jardine Insurance Brokers Group. Mr. Syfret, formerly a director of Price Forbes Federale Volksas (Pty) Ltd. in South Africa, will be responsible for running the company's cargo department.

Alexander Stenhouse Europe Ltd. appointed Michael J. Barrett as chief executive officer, succeeding Malcolm J. Grint who retires in April. Mr. Barrett, was previously chief operating officer of Alexander Stenhouse Ltd.'s London operations.

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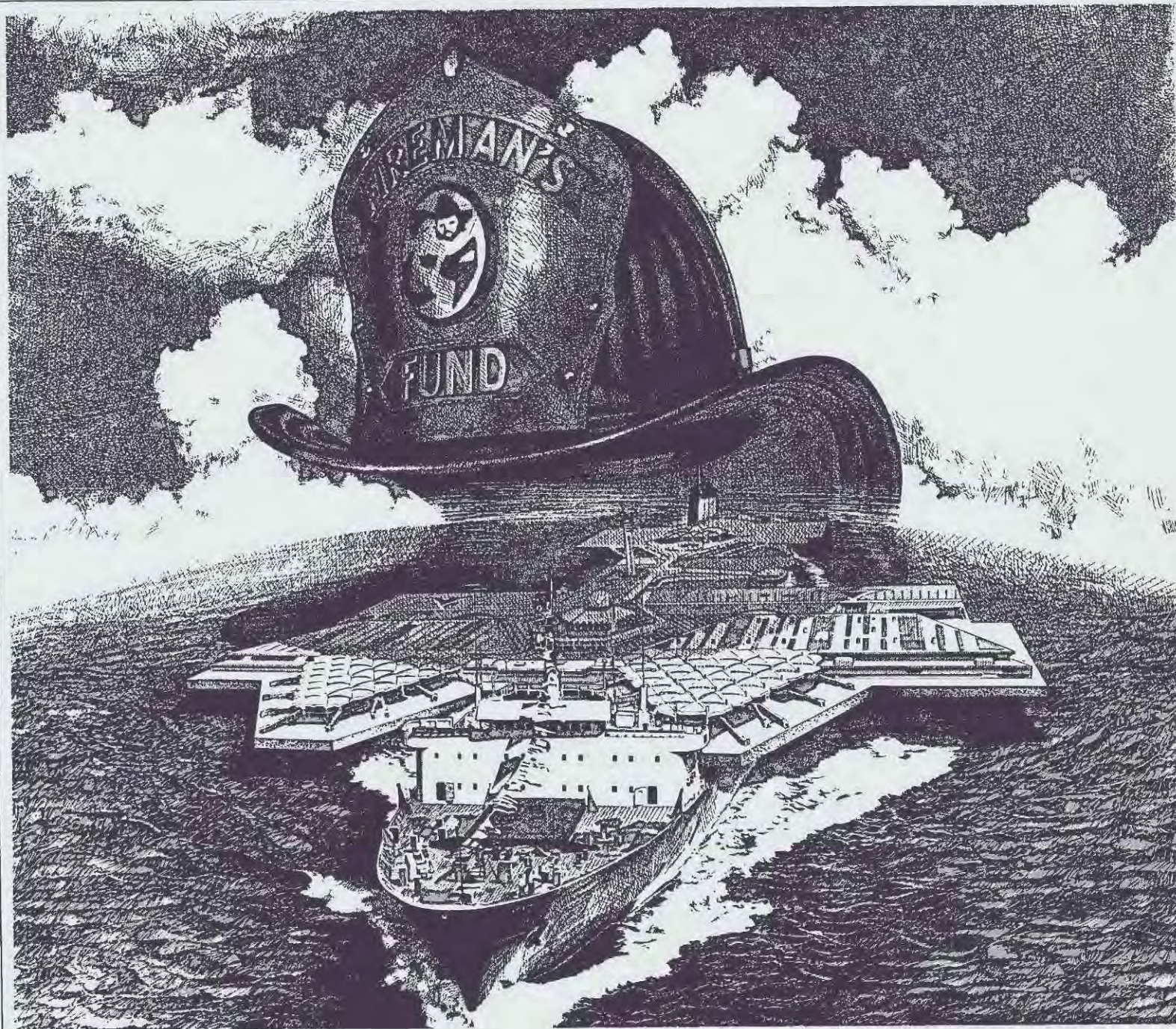
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Mutual of Omaha names top executives

John D. Minton has been promoted to deputy chief executive officer of Mutual of Omaha and United of Omaha in Omaha, Neb., in a realignment of top management at both companies.

Mr. Minton has served as president and chief operating officer for Mutual of Omaha since 1970 and as senior executive vp at United of Omaha since 1984.

John W. Weekly will succeed Mr. Minton as president and chief operating officer of Mutual of Omaha. Mr. Weekly has served as senior executive vp in charge of group insurance and computer data services for Mutual and United of Omaha since 1981.

In addition, **William J. Hetzler** will take over as president and chief operating officer of United of Omaha on April 1, succeeding **Conrad S. Young**, who is retiring from those positions and also from the post of senior executive vp for Mutual of Omaha.

Mr. Young has been with the companies since 1948. Mr. Hetzler has served as senior executive vp-operations for United of Omaha since 1983.

Other insurer changes:

Charles T. Gerry named senior vp-operations planning at Crum & Foster Corp. in Morristown, N.J. Mr. Gerry, who joined Crum & Forster in 1960 as an inland marine underwriter in Los Angeles, most recently served as senior vp-human resources and planning for a Crum & Forster unit.

Eldon A. Ziegler elected vp-claims for Nationwide Insurance Group in Columbus, Ohio, succeeding **Carl MacDonald**, who retired. Previously, Mr. Ziegler was vp-claims for Employers Insurance of Wausau, a Nationwide affiliate. He joined the company 24 years ago.

At Celtic Life Insurance Co. in Chicago: **James Daly** promoted to senior vp-special health products division, **Lindsay Resnick** pro-

comings & goings: industry

moted to senior vp-product management and **Barbara P. Neihus** promoted to executive vp in Celtic's small group division. Mr. Daly joined the company in 1986 after working at Humana Insurance Co. in Louisville, Ky. Ms. Resnick came to Celtic in 1985 from the Blue Cross & Blue Shield Assn. Ms. Neihus, formerly senior vp-actuary, has been with Celtic for two years.

Richard R. Savage appointed vp-government and industry relations at The Home Insurance Co. in New York. Mr. Savage formerly was executive vp at the Insurance Services Office in New York.

At San Francisco-based Industrial Indemnity Co., 10 field managers were promoted to the position of resident vp: **Steve Albers** of Seattle; **Jim Bily** of Portland, Ore.; **Don Blackwell** of Walnut Creek, Calif.; **Maury Costa** of Sacramento, Calif.; **Nancy Dungan** of Stockton, Calif.; **Bob Giarraputo** of Fresno, Calif.; **Larry Jones** of Orange, Calif.; **Dean Middour** of San Jose, Calif.; **Roger Newman** of Phoenix, Ariz.; and **Gary Purdom** of Anchorage, Alaska.

Wade W. Hersperger Jr. promoted to vp-national accounts at Penn Mutual Life Insurance Co. in Philadelphia. Mr. Hersperger formerly was second vp-sales.

Ivan O. Ace named president of the Kemper Group's Northeast division headquartered in Syracuse, N.Y., and elected vp of Kemper's national property/casualty companies. Mr. Ace formerly was Kemper's Quincy, Mass., branch manager.

Robert J. O'Brien elected vp-group special plans and **Philip E. Soule** elected vp-group benefit plans at State Mutual Life Assurance Co. of America in Worcester,

Mass. Mr. O'Brien, who has been with the company since 1958, was elected second vp-group insurance underwriting in 1978. Mr. Soule has been with the company since 1972, most recently serving as regional sales vp for the Midwest region.

James M. Cooper Jr. elected senior vp of Selective Insurance Group Inc., an insurance holding company based in Branchville, N.J. Mr. Cooper has been with the company for 25 years, most recently serving as director of underwriting.

In a move to create a new field structure for Novato, Calif.-based Fireman's Fund Insurance Cos. in Texas, **Jack Cannon** has been appointed vp, Texas regional manager and manager of the Dallas branch, which will serve as a hub for operations throughout the state. Mr. Cannon formerly was branch manager in Greensboro, N.C. Also, **L.A. Smith**, who has been resident vp in Dallas for 25 years, moves up to vp-regional affairs for the Texas region. He remains in Dallas. Fireman's Fund previously established similar regional "hub" operations in Cincinnati for three Midwest states and in Atlanta for six southeastern states.

Also at Fireman's Fund, **Charles M. Wenger** named senior vp and managing director of California commercial insurance. He is based in Novato, Calif. Mr. Wenger most recently was senior vp in CIGNA Corp.'s Property/Casualty Group.

Other suppliers

Robert W. Hessel joined Becher & Carlson Risk Management Inc. in Woodland Hills, Calif., as senior vp in charge of business development. Most recently, Mr. Hessel was ex-

ecutive vp of Equity Reinsurance Managers in Dallas, where he was responsible for property/casualty facultative underwriting.

Philip C. Roller named senior vp of Midwest Benefits Corp., a third-party administration firm with offices in Southfield and Grand Rapids, Mich. Prior to joining Midwest, Mr. Roller was executive director of the QicClaim Client Assn. Inc., an affiliate of Resource Information Management Systems Inc. of Oak Brook, Ill.

Jerry Cronin appointed general manager of Risk Management Inc., a wholly owned subsidiary of the Louisiana Municipal Assn. in Baton Rouge. Previously, Mr. Cronin was a corporate vp at Blue Cross of Louisiana in Baton Rouge.

Agents/brokers

James E. Mahon promoted to senior vp at Jardine Emmett & Chandler Inc. in New York.

Also at Jardine Emmett & Chandler in New York, **Roland Land**, **Samuel G. Pal** and **Sue Utsunomiya-Nuding** promoted to vps. In the Los Angeles office, **John A. Higashi** promoted to vp.

George M. Kearon joined Braishfield Associates Inc. in New York as senior vp. He previously was a vp at Corroon & Black of New York Inc.

Steven C. Deal elected vp at Hilb, Rogal & Hamilton Co. of Richmond, Va. Previously, Mr. Deal was agency and development superintendent for the state of Virginia.

George J. Griffin joined International Insurance Group Ltd. in Boston as vp. Prior to his appointment, Mr. Griffin spent 17 years with Fred S. James & Co. in Boston and at its New York corporate headquarters.

At Frank B. Hall & Co. of Michigan, the following changes were made: **William J. McCaffrey** named president and chief operat-

ing officer; **Robert C. Ball** named executive vp; **Joseph H. Dimond**, **Timothy E. Teagan**, **George J. Walleman** and **James W. Webb** named senior vps; and **Thomas W. Roberts**, **William J. Colgan**, **James L. Glynn**, **Edwin W. McGuire** and **Edgar B. Therasse** named vps.

Howard Herzog joined Alexander & Alexander Inc. in Los Angeles as a vp specializing in jewelers block and fine arts markets. Prior to joining A&A, Mr. Herzog was president and chief executive officer of Lazare Kaplan International Inc., a New York-based diamond firm.

HMOs/PPOs

David B. Snow Jr., formerly vp of operations for Blue Bell, Pa.-based U.S. Healthcare Inc., named president of HMO of New Jersey. While Mr. Snow will concentrate on administration and marketing of the HMO in New Jersey, he also will continue to direct operations in the metropolitan New York and Connecticut region for U.S. Healthcare.

Excess/surplus

Edward Cooke elected president and **Michale Garin** elected executive vp of Global Special Risks Inc., a New Orleans-based specialty insurance broker. Mr. Cooke joined Global as executive vp and partner in 1980. Mr. Garin joined the company in 1980 as one of the original partners and vp.

Reinsurance

John Cashin named vp in the New York office of Sullivan Payne Co., a U.S.-based reinsurance brokerage unit of Sedgwick Group P.L.C. Mr. Cashin formerly was vp and producer for domestic treaty business at Guy Carpenter & Co. in New York. ■



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Japanese shy away from overseas risks

LONDON—Japanese underwriters probably will not form a reinsurance market for overseas risks, predicts a Japanese reinsurer.

A profitable domestic insurance market and the lack of underwriting expertise to write international risks in Japan will prevent the development of an international reinsurance market, said T. Kimishima, deputy chairman of Tokio Reinsurance Co. Ltd. in London.

"Japan is one of the very few developed big countries where insurance is still profitable overall and need not necessarily seek overseas business, particularly when the business is not profitable," Mr. Kimishima told members of the Insurance Institute of London last month.

"It follows from the above that there are in Japan very few underwriters of international business and this is a point of crucial importance."

Even at Tokio Marine & Fire Insurance Co., which has the largest overseas network among Japanese insurers, overseas risks only comprised 15% of total premium volume last year and are predicted to drop to less than 10% in 1987, said Mr. Kimishima.

On the other hand, the Japanese market is dependent on the London reinsurance market through London brokers, he noted.

"The ties between the two markets will be further strengthened, but will never be weakened," he said.

Japan and the London market have worked together for more than 100 years to develop their reinsurance relationship, according to Mr. Kimishima.

The Japanese insurance industry began in 1879 with the formation of Tokio Marine, 20 years after Japan's 230-year-old foreign trade seclusion policy was abolished.

Tokio Marine specialized in marine cargo insurance, first for its parent, Mitsubishi, and for other companies, and within five years was also writing marine hull risks, he explained.

At that time, "Lloyd's had been in existence for 180 years," Mr. Kimishima noted.

In 1890, 11 years after its was founded, Tokio Marine appointed three British agents to write non-Japanese risks on behalf of the company, said Mr. Kimishima. "But this venture soon turned out to be disastrous to the Tokio Marine." The premiums written by these agents in only two years accounted for as much as 60% of Tokio Marine's entire volume.

"This was brought about by the agents' reckless writings of highly hazardous sailing vessels, which accounted for 90% of their writings for the Tokio Marine," he said.

Claims quickly began to roll in. As a result, Tokio Marine dispatched to London Kenkichi Kagami, 26, who only had three years of insurance experience, Mr. Kimishima said.

After one year, Mr. Kagami canceled the three agency agreements and became the company's underwriter. He will "perhaps have been the only Japanese who may well have been ranked amongst the top London marine underwriters," Mr. Kimishima said.

In 1899, Mr. Kagami was called back to the head office and hired Lloyd's of London broker Willis Faber P.L.C. to act as Tokio Marine's underwriting agent in London. He also placed Tokio Marine's cargo reinsurance in the London market, the first time Japanese reinsurance was placed outside the Japan market.

To this day, Willis Faber represents Tokio Marine and places re-

insurance for the insurer in the London market.

London is "an indispensable reinsurance market" for reinsurance ceded from Japan, Mr. Kimishima.

In 1985, Japanese companies ceded 192.8 billion yen (\$1.1 billion) to overseas markets, of which 42% was ceded through Willis Faber, he said.

In contrast, in 1985, the Japanese companies wrote 313 billion yen (\$2.5 billion) in reinsurance premiums, nearly 70% more than they ceded abroad, he added.

Although Japanese companies are still dependent on London for their reinsurance, Japanese companies are shying away from writing international business through subsidiaries in London, said Mr. Kagami.

"As a result of the miserable ex-

worldwide

perience which almost all the Japanese companies have had in London recently in contrast to their profitable domestic business in Japan, London writings appear to have greatly lost their attraction," he said.

—By Stacy Shapiro

Greek pensions

ATHENS, Greece—Shipping magnate John S. Latsis has offered as much as \$10 million to rescue Greek seamen from their financially troubled pension fund.

Mr. Latsis wants to use the money to set up a new non-profit mutual insurer. The mutual would

offer pension programs and other insurance coverages for Greek seamen.

The new mutual would rival Greece's largest seamen's insurance fund, the Greek Seamen's Pension Fund, known as N.A.T., which is in financial trouble, say observers in the main Greek port of Piraeus.

In the past, Mr. Latsis has contributed hefty sums to the N.A.T., including \$10 million to boost pensions benefits for retired seamen.

Now, however, he wants to form the new mutual because "I want the seamen to live in harmony and I also want them to remember me," he said.

The shipping tycoon has offered \$5 million to start the fund with another \$5 million in the future if it is necessary. Only Greek seamen

will be shareholders of the new mutual, which will be a non-profit organization.

Mr. Latsis has already met with representatives of the seamen's unions, including the powerful Greek Seamen's Federation, known as P.N.O., to discuss the proposal.

His proposal has hit a roadblock, however, because several seamen's unions are opposed to shipowners making contributions to their members' pension funds. Nevertheless, P.N.O. has set up a committee to study Mr. Latsis' proposal.

If his proposal is rejected, friends of Mr. Latsis say that he will then consider buying an unnamed insurance company in Greece to offer pensions.

—By Louis Economopoulos

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	47	0	3,885.55	PAID: 50
	49	0	2,545.20	INCURRED: 30
TOTAL FOR GRV: T0002001	197	5,230,000	0.00	PAID: 48
	101	0	0.00	INCURRED: 44
OVERALL TOTALS	27,415	148,325,000	699,352.48	PAID: 10,350
	7,240	1,170,000	359,651.20	INCURRED: 7,428
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Missouri reform

Continued from page 3
crafted compromise that provides a delicate balance" between insurance and tort reforms, stressed Richard C. Heydinger, vp of government affairs for the Risk & Insurance Management Society and director of risk management for Hallmark Cards Inc. in Kansas City, Mo.

"Our position is that the bill at this time is a good, well-balanced piece of legislation," agreed Randy Scherr, coordinator of Missourians for Civil Justice Reform in Jefferson City. "We think it will bring a little more predictability and fairness to the court system."

"I'd put it a little over halfway up on a scale of reforms nationwide," said Dee Ann Bernhard, regional manager of the Alliance of American Insurers in Schaumburg, Ill.

But, "it's certainly not as strong as some of the other reforms that

have been made throughout the country. While we see it as a step in the right direction, we hope it's just a start, because if it's an end-all, it certainly stopped short" of the tort reforms RIMS feels are necessary, Mr. Heydinger observed.

The 15-member task force "really got active in late August and early September," Rep. Harpool explained. "We worked solidly until the first week of January, and then an informal subcommittee spent three weeks drafting the legislation," he said.

During the fall, the task force held meetings in various cities throughout Missouri "to talk to the people about reforms they felt were necessary. Many of us spoke before the task force and discussed our problems," said Jim Pohtos, president of the St. Louis Chapter of RIMS and risk manager for St. Louis County.

The bill was hotly debated on the Senate floor last week after sailing

smoothly through the House with only minor technical changes in the language drafted by the task force, those involved in the legislative effort explained.

"I'm confident there are adequate votes in the Senate to pass the bill. It's just a matter of any amendments that might still be adopted," Rep. Harpool said.

One major amendment has already been approved by the Senate. A provision in H.B. 700 that would have based punitive damage awards against a newspaper on a scale related to the paper's paid circulation was dropped from the Senate version last week.

"That is the one substantive change that could have taken place that will not destroy the delicate balance of the bill," Mr. Scherr pointed out. "If the bill went back to the House in its present form, we would recommend that the House accept it without taking it to a joint committee," he said.

The Senate rejected an amend-

ment that would have placed a three-year sunset clause on the bill. "I was strongly opposed to that," Sen. Wilson stressed.

Other amendments are still being debated.

The insurance reforms spelled out in the bill are:

- A requirement that insurers provide 60-day notice to policyholders prior to cancellation or non-renewal of liability coverage—except in cases of non-payment of premium, fraud or misrepresentation, changes in condition, involuntary loss of reinsurance or insolvency of the insurer.

- Insurers also would have to specify the reason for the action. Upon request, the insurer within 30 days must provide a policyholder with its claims history for the three years prior to the cancellation or the non-renewal.

- A requirement that insurers provide the Division of Insurance with 90-day notice prior to cancelling an entire book of commercial

casualty business.

- A requirement that insurers seek approval by the director of the Division of Insurance 60 days prior to implementing any rate increases or decreases exceeding 25% annually. The insurer would have to justify the increase.

This provision would not apply to changes in hazard or in magnitude of the exposure base or to individually rated risks for which no class rating is available.

Sen. Wilson said this provision is important because substantial rate variations created "the trouble that insurers are in now."

But Ms. Bernhard predicted that while "these provisions were aimed at controlling insurance prices," they will instead "slow down processing time and add costs to the insurance department."

- An increase in insurer capitalization and surplus requirements to a minimum of \$800,000 in capital and \$800,000 in surplus for single-line property/casualty companies and \$1.2 million in capital and \$1.2 million in surplus for multiline companies.

- An increase in commercial property/casualty insurer reporting requirements. The additional reports, which must be made to the Division of Insurance, include information on closed claims, the amount reserved for those claims and the actual loss payouts. In addition, insurer would have to submit information on the number of claims in which the insurer paid between \$300,000 and \$500,000 in non-economic damages and punitive damages to one person or entity and more than \$500,000 to one person or entity.

But, the problem with reporting non-economic damages is that "Missouri does not have itemized verdicts," Ms. Bernhard of the Alliance explained. "Oftentimes, awards include actual damages and pain and suffering" without distinguishing the amount awarded for each, she noted.

The requirement will create "an added burden to the insurance industry," she predicted.

- A requirement that surplus lines insurers register with the Division of Insurance; provide the division with the same annual reports required of domestic insurers; and increase their capital and surplus on a scheduled basis to a total of \$5 million within six years of the law's effective date. This provision also would require that surplus lines insurers pay premium taxes.

RIMS' Mr. Heydinger stressed: "We were pleased to see that a lot of the more drastic insurance reforms" that have been enacted in other states—such as rate freezes and rollbacks—"didn't make their way into the bill." He said those types of reforms can decrease insurance availability.

And Mr. Scherr of Missourians for Civil Justice Reform noted that the fact that "buyers will be warned of any rate increases, cancellations or non-renewals will make the whole arena more predictable for businesses."

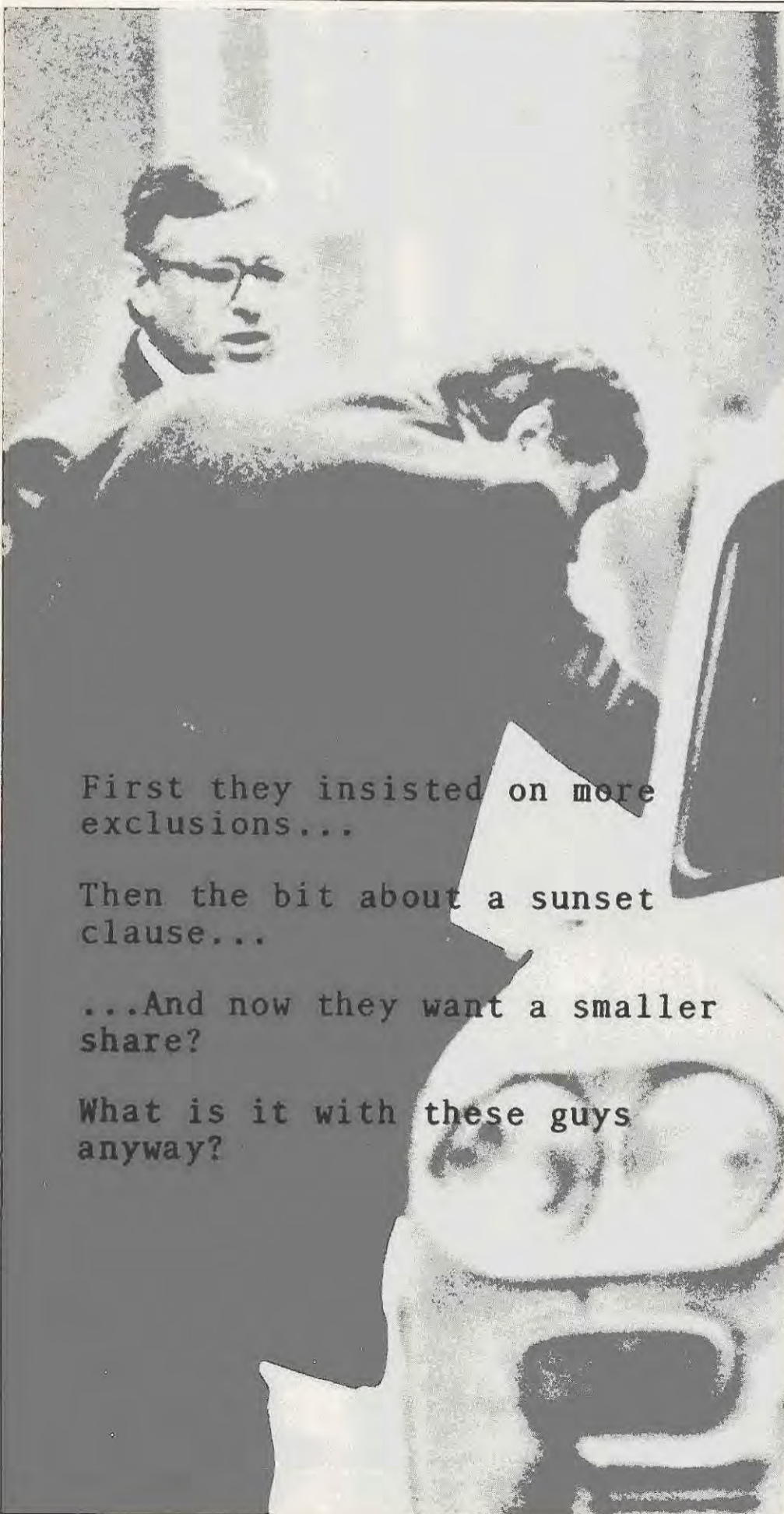
The tort reform provisions would:

- Modify the doctrine of joint and several liability so that if one defendant's share of the damages is uncollectible, that amount is reapportioned among all other parties—including the plaintiff, if the plaintiff is found to have contributed to the loss.

Also under this provision, a party less at fault than the plaintiff would not be responsible for more than two times its equitable share of damages.

- Limit the liability of uncompensated directors and officers of non-profit or tax-exempt organizations to cases of intentional tortious conduct, willful or wanton conduct or gross negligence.

Continued on next page



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Continued from page 34
 bers. Also April 7 in Schiller Park, Ill., April 15 in Tampa, Fla., May 5 in Pittsburgh. Mari Jennings, Society of CPCU, Kahler Hall, 720 Providence Road, CB#9, Malvern, Pa. 19355; 215-251-2741.

MARCH 25. Health Improvement/Wellness workshop in Stamford, Conn., sponsored by the Health Research Institute; \$250. Also May 13 in Houston; June 3 in Chicago; July 29 in Honolulu; Aug. 19 in San Diego; Oct. 7 in Boston; Oct. 28 in San Francisco; Nov. 11 in New York; and Dec. 9 in Chicago. Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

MARCH 25. Workers Compensation for Insurance and Non-Insurance Professionals workshop in New York, sponsored by the College of Insurance; \$195 for sponsors of the college; \$215 for non-sponsors. The College of Insurance, Professional Development Programs, 101 Murray St., New York, N.Y. 10007; 212-962-4111, ext. 301 or 302.

MARCH 25. Advanced "Post Graduate" Cost Management workshop in Stamford, Conn., sponsored by the Health Research Institute; \$250. Also April 15 in Orlando, Fla.; May 13 in Houston; June 3 in Chicago; June 24 in Philadelphia; July 29 in Honolulu; Aug. 19 in San Diego; Sept. 16 in Cleveland; Oct. 7 in Boston; Oct. 28 in San Francisco; Nov. 11 in New York; and Dec. 9 in Chicago. Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

MARCH 26. ISO Commercial General Liability Rating workshop in Georgetown, Del., sponsored by the Insurance Society of Philadelphia and Delaware Tech; \$65 for members; \$75 for non-members. Also April 2 in Philadelphia. Insurance Society of Philadelphia, 737 Public Ledger Building, Philadelphia, Pa. 19106; 215-627-5306.

MARCH 26. Surety Claims '87 Conference in New Orleans, sponsored by the CMA Consulting Group; \$195. Also April 28 in Chicago, May 1 in San Francisco, May 5 in Philadelphia. Beverly Loughlin, CMA Consulting Group, Box 2287, Morristown, N.J. 07960; 201-267-7171.

MARCH 26-27. The Fundamentals of Reinsurance Agreements and Functions conference in New York, sponsored by Executive Enterprises Inc.; \$875 for first registrant; \$775 for second registrant from same organization; \$650 for third or more registrant from same organization. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 212-645-7880; 800-223-0787 within New York; 800-831-8333 outside New York.

MARCH 27-28. Going Bare: A Survival Course for Self-Insureds in Las Vegas, Nev., sponsored by the American Bar Assn.'s Section of Tort and Insurance Practice and the Division for Professional Education; \$400 for non-members; \$375 for ABA members; \$350 for TIPS members; \$325 for young lawyers; \$75 for law

students. American Bar Assn., Division for Professional Education, Department NI 452, 750 N. Lake Shore Drive, Chicago, Ill. 60611; 312-988-6200.

MARCH 29-31. Health Promotion Programs: Taking Charge of Wellness seminar in Charleston, S.C., sponsored by the Group Health Foundation affiliate of the Group Health Assn. of America; before March 9: \$290 for GHAA member, \$360 for non-member; after March 9: \$350 for GHAA member, \$420 for non-member. Health Promotions Programs, Group Health Foundation, 1129 20th St. N.W., Suite 600, Washington, D.C. 20036.

MARCH 29-APRIL 1. Corporate Benefits Management Conference in Buena Vista, Calif., sponsored by the International Foundation of Employee Benefit Plans; if received 60 days prior to meeting date: \$560 for IFEBP members, \$635 for non-members; regular rate: \$605 for IFEBP members, \$680 for non-members. Also May 3-6 in Dallas and June 22-25 in Lake Tahoe, Nev. International Foundation of Employee Benefit Plans, Registration Department, 18700 Bluemound Road, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

MARCH 29-APRIL 1. Health Promotion Management and Evaluation conference in Indianapolis, co-sponsored by the Institute of Wellness, Ball State University and Blue Cross and Blue Shield of Indiana; \$350; \$150 for students; \$350 for exhibitor. Institute for Wellness, Ball State University, Practical Arts Complex 223, Muncie, Ind. 47306.

MARCH 29-APRIL 3. 25th Annual Risk and Employee Benefits Conference in Las Vegas, Nev., sponsored by the Risk & Insurance Management Society; \$595 for RIMS members, \$645 for non-members for full week; \$525 for RIMS members, \$575 for non-members for partial week. RIMS Conference Department, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

MARCH 30-APRIL 3. Recognition of Accident Potential in the Workplace Due to Human Factors course in Los Angeles, sponsored by the University of Southern California, Institute of Safety and Systems Management; \$425. University of Southern California, Institute of Safety and Systems Management, Office of Extension and In-service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 213-743-6523.

MARCH 31. Questions on the New CGL and CP Policies? Ask the Claims Department workshop in Bryn Mawr, Pa., sponsored by the Society of Chartered Property & Casualty Underwriters; \$110 for CPCUs; \$150 for non-members. Mari Jennings, Society of CPCU, Kahler Hall, 720 Providence Road, CB#9, Malvern, Pa. 19355; 215-251-2741.

MARCH 31-APRIL 3. The Association of Insurance and Risk Managers in Industry and Commerce 1987 Conference: Symbiosis or Self-Reliance? in Cambridge, England; £320 (approx. \$468) for AIRMIC, Assn. Europeene des Assures L'Industrie and Risk & Insurance Management Society members, plus 15% VAT; £425 (approx. \$622) for non-members, plus 15% VAT. AIRMIC Secretariat, Plantation House, 31/35 Fenchurch St., London, EC3M 7DX.

APRIL 5-11. 14th International Assn. of Industrial Accident Boards and Commissions Workers' Compensation College in Tempe, Ariz.; \$350 for IAABC members; \$450 for non-member. International Assn. of Industrial Accident Boards and Commissions, P.O. Box 13449, Jackson, Miss. 39236.

APRIL 6-8. Property Loss Managers Conference in San Diego, Calif., sponsored by the Property Loss Research Bureau; \$75 for PLRB member company personnel; \$200 for others. Judith Bollman, Property Loss Research Bureau, 1501 Woodfield Road, Suite 400W, Schaumburg, Ill. 60173-4978.

APRIL 6-10. Safety in Chemical Operations course in Chicago, sponsored by the Chemical Section of the National Safety Council, Industrial Division; \$655 for NSC member; \$815 for non-member. National Safety Council, 444 N. Michigan, Chicago, Ill. 60611; 312-527-4800.

APRIL 7-10. Joint Meeting of the Independent Reinsurance Underwriters Assn. Inc. and Reinsurance Brokers in Wesley Chapel, Fla.; \$250 plus room deposit. Robert L. Sias, Convention Manager, Independent Reinsurance Underwriters Assn., 210 Canterbury Circle, New Smyrna Beach, Fla. 32069; 904-427-2231.

APRIL 8-9. Latest Developments In: Arbitrating and Litigating Disputed Insurance and Reinsurance Agreements conference in New York, sponsored by Executive Enterprises Inc.; \$875 for first registrant; \$775 for second registrant from same organization; \$650 for third or more registrant from same organization. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 212-645-7880; 800-223-0787 within New York; 800-831-8333 outside New York.

APRIL 9. ISO Commercial Property Rating workshop in Blue Bell, Pa., sponsored by the Insurance Society of Philadelphia and Delaware Tech; \$105 for members; \$120 for non-members. Also April 21 in Philadelphia. Insurance Society of Philadelphia, 737 Public Ledger Building, Philadelphia, Pa. 19106; 215-627-5306.

APRIL 9. How to Use the Risk Retention Act of 1986 symposium in San Francisco, sponsored by the Society of Chartered Property & Casualty Underwriters; \$20 for CPCUs; \$250 for non-members. Also April 21-22 in New York, May 13-14 in Chicago. Julie Ann Juliana, Society of CPCU, Kahler Hall, 720 Providence Road CB#9,

Malvern, Pa. 19355; 215-251-2735.

APRIL 13-14. Health Policy Conference in Washington, sponsored by the American Medical Care & Review Assn.; before March 23: \$375 AMCR members, \$475 for non-members; after March 23: \$425 for AMCR members, \$550 for non-members. American Medical Care & Review Assn., 5410 Grosvenor Lane, Suite 210, Bethesda, Md. 20814.

APRIL 15. ISO Commercial General Liability Policy workshop in Blue Bell, Pa., sponsored by the Insurance Society of Philadelphia and Delaware Tech; \$105 for members; \$120 for non-members. Also May 14 in Philadelphia. Insurance Society of Philadelphia, 737 Public Ledger Building, Philadelphia, Pa. 19106; 215-627-5306.

APRIL 21-22. Advanced Safety Management seminar in Phoenix, Ariz., \$295. Dr. Rick Summers, Waite Hill Services Inc., P.O. Box 5816, Kingwood, Texas 77325; 713-358-0949.

APRIL 21-22. Insurance Claims for Environmental Damages: Technical and Legal Considerations conference in Washington, sponsored by Executive Enterprises Inc.; \$875 for first registrant; \$775 for second registrant from same organization; \$650 for third or more registrant from same organization. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 212-645-7880; 800-223-0787 within New York; 800-831-8333 outside New York.

APRIL 21-23. Laboratory Safety course in Chicago, sponsored by the Research & Development Section of the National Safety Council, Industrial Division; \$415 for NSC member; \$520 for non-member. National Safety Council, 444 N. Michigan Ave., Chicago, Ill. 60611; 312-527-4800.

APRIL 21-24. Reinsurance Accounting and Finance for Ceders and Assurers seminar in Tarrytown, N.Y., sponsored by Robert W. Strain Seminars Inc.; \$1,295 (includes lodging and meals). Also Sept. 8-11. Robert W. Strain Seminars Inc., P.O. Box 1000, Wingdale, N.Y. 12594; 914-832-9384 or 212-677-5974.

APRIL 23-24. New Issues in Public Sector Employee Benefits conference in Washington, co-sponsored by Pension Commission Clearinghouse and Johnson & Higgins Edward H. Friend & Co. division; \$250. Laura S. Horvath, J&H/Edward H. Friend & Co. Division, 1800 K St. N.W., Suite 500, Washington, D.C. 20006; 202-785-9080.

APRIL 26-29. Sixth Annual Conference on Employee Benefits in Scottsdale, Ariz., sponsored by the State and Local Government Benefits Assn.; \$120 for SLGBA members; \$140 for non-members. George L. Morawski, State of Arizona, 1831 W. Jefferson, Phoenix, Ariz. 85007; 602-255-5482, ext. 263.

APRIL 30-MAY 1. Workers Compensation: The Changing Character of State Systems conference in Storrs, Conn., co-sponsored by the University of Connecticut, Cornell University, Rutgers University and Syracuse University; \$150. The University of Connecticut, Non-credit Programs, U-56, 1 Bishop Place, Storrs, Conn. 06268.

APRIL 30-MAY 1. SEC Accounting & Financial Reporting for Property/Casualty Insurance Companies conference in New York, sponsored by Executive Enterprises Inc.; \$875 for first registrant; \$775 for second registrant from same organization. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 212-645-7880; 800-223-0787 within New York; 800-831-8333 outside New York.

MAY 5-8. 50th Anniversary Annual Meeting of the National Assn. of Independent Insurance Adjusters: Golden Year-Investment in Excellence convention in Orlando, Fla.; \$200 for NAIA members/guests; \$100 for spouse. National Assn. of Independent Insurance Adjusters, 222 W. Adams St., Chicago, Ill. 60606; 312-853-0808.

MAY 6-8. Insurance Coverage, Practice & Risk Management seminar in Chicago, sponsored by the Defense Research Institute Inc.; \$395 for DRI members; \$420 for non-members. Defense Research Institute Inc., 750 N. Lake Shore Drive, Suite 500, Chicago, Ill. 60611; 312-944-0575.

MAY 14-15. Health Management Conference: Case Management in San Diego, Calif., sponsored by the National Assn. of Employers on Health Care Alternatives; \$395 for NAEHCA members; \$300 for additional registrant from same NAEHCA organization; \$495 for non-members; \$400 for additional registrant from same non-member organization. National Assn. of Employers on Health Care Alternatives, 304 Executive Building, 104 Crandon Blvd., Key Biscayne, Fla. 33149.

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Continued from previous page

"This should help availability of non-profit D&O insurance and put a lot of minds at rest, because the personal assets of these people were at stake," Ms. Bernhard said.

"There was fairly broad support for this provision in both camps, because both sides have people who serve as non-profit directors and officers, and they know the problems" in finding coverage, Mr. Heydinger noted.

- Limit the liability exposure of entities that clean up environmental hazards to \$1 million per individual per accident or occurrence and \$3 million for all claims arising out of a single occurrence, except in cases of intentional, willful or wanton failure to comply with state and federal standards. The entities' liability would be limited for damages resulting from such operations as investigation, evaluation, planning, designing, engineering, removal, construction and ancillary services carried out to abate or clean up a pollutant.

However, Mr. Heydinger pointed out: "We have to be careful that the legislation does not encourage fly-by-nights to come out of the woodwork. But the incentive makes sense because of the social need" for such entities.

- Permit use of comparative fault in product liability cases if the plaintiff: failed to use the product as reasonably anticipated by the manufacturer; used the product for a purpose not intended by the manufacturer; used the product knowing the danger involved in such use; unreasonably failed to appreciate the danger; failed to undertake reasonable precautions in using the product; or failed to mitigate damages.

- Permits use of the state-of-the-art defense in strict product liability "failure to warn" cases.

"We would have preferred a reinstatement of state-of-the-art across the board. There are three areas upon which product liability suits can be based—design, manufacture and failure to warn. We only got part of what we wanted there," Mr. Scherr stressed.

- Readopts the concept of "re-mittitur and additur," which was abolished in Missouri in 1985. This permits courts to increase or decrease a jury award if they deem the award to represent excessive or inadequate compensation.

- Limit the product liability exposure of "sellers" that have shown no other liability for damages, as long as the plaintiff can recover damages from other defendants, including the product manufacturer.

- Modify the collateral source rule. This provision would allow a defendant to introduce evidence that it or its representative already has reimbursed a plaintiff for damages, but without identifying itself as the payer.

- Require a bifurcated trial for punitive damage awards, if such a trial is requested by any party. In the second trial, the same jury would determine the amount of punitive damages. Evidence regarding the defendant's net worth would be admissible only in the second trial to determine the amount of damages. Remittitur and additur rights apply to punitive damage awards.

However, the Senate amended H.B. 700 to omit a provision permitting a defendant to be given credit for previous punitive awards arising from the same incident.

The punitive damage reforms would have been more effective if the second trial in which damages are set was not before the same jury, Ms. Bernhard said. Because the amount of punitive damages are decided by the same jury, you have "the same emotional issue."

- Require that 50% of a punitive damage award, minus court and attorney costs, go into a state fund for victims to be established by the

General Assembly.

"This creates a disincentive for the plaintiff to go after the mother lode," RIMS' Mr. Heydinger said.

- Require that if an award exceeds a settlement offer by the plaintiff, the defendant must pay pre-judgment interest on the entire award. The interest would begin to accrue 60 days after presentation of a written settlement offer or upon rejection of the offer without a counteroffer, whichever date is earlier.

"While pre-judgment interest was listed as a tort reform, in our opinion it was a backward step rather than a step forward. It increases costs rather than reduces them, and we viewed with dismay the fact that it is being touted as a tort reform," Ms. Bernhard said.

However, both she and Mr. Heydinger pointed out that pre-judgment interest has been a pet concern of plaintiffs' attorneys in the state for several years.

"The defense side needed to give

on this point, because it was tied in with the entire package," Mr. Heydinger explained.

- Abolish use of the "ad damnum" clause generally contained in lawsuits. Under this provision, the plaintiff must request only unspecified reasonable compensation rather than a specific dollar amount for damages. In addition, plaintiffs would be required to make a separate request for punitive damages.

Overall, Rep. Harpool predicts that if the legislation is enacted, the Missouri public will "see greater stabilization in insurance availability and insurance rates, and fairer treatment in the courtroom."

"Eventually, the legislation will result in a fairer civil justice system and hopefully a less costly one. The need was not only for greater insurance availability, but also to create a good environment in Missouri in which to work and live," Mr. Heydinger said. ■

Virginia tort reform measure

Continued from page 3

tort reforms, including a cap on non-economic damages, reducing awards by the amounts received from collateral sources and abolishing joint and several liability.

One of the reforms passed by the Legislature, S.B. 402, would cap punitive damages at \$350,000 in personal injury suits. The bill, as originally proposed in the Senate, had placed a \$250,000 cap on non-economic damages, but the House Courts of Justice Committee eliminated that cap and replaced it with the higher cap on punitive damages only.

"This is a fig leaf to cover the legislative retreat," declared Marc Rosenberg, vp of federal affairs for the Insurance Information Institute in Washington.

Paul Shuford, legal counsel of the Virginia Trial Lawyers Assn. in Richmond, noted that awards for punitive damages are "few and far between."

But Katharine Webb, vp of the Virginia Hospital Assn., commented that the cap on punitive damages at least "sends a message to judges in the state" that the tort system is "getting out of whack."

Meanwhile, insurers strongly opposed the two bills passed by the Legislature that address insurance reform.

"There appears to be no benefit to this legislation," declared the AIA's Mr. Czech.

The insurance reform package, composed of H.B. 1234 and H.B. 1235, requires broader closed claim reports for all commercial lines of insurance. Currently, property/casualty insurers are required to submit an an-

Continued on next page

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Virginia reform

Continued from previous page
 nual report and an annual medical malpractice closed claim report.

However, the reports would not have to be filed on individual claims; they could be aggregated into types of coverage or claims.

Among the additional requirements included in the package are 45-day notices to policyholders of rate increases greater than 25% and of any changes in coverage.

Under the package hammered out in the Legislature, the Insurance Services Office could file many of the reports on behalf of the individual companies.

Also, the Bureau of Insurance would be required annually to evaluate competition in 1,100 different classes of insurance. Troubled lines identified by the bureau would be subject to a prior approval system, which would require insurers to file rate changes 60 days prior to their effective

dates.

The bills effectively give greater oversight power of the insurance industry to the state Corporation Commission—of which the Bureau of Insurance is one division.

"The thrust of the whole bill could be to undermine the workings of the competitive rating system, which allows competition to regulate rates as opposed to bureaucratic process," Mr. Czech said.

The insurance reform package is considered by many to be a political victory for Virginia Attorney General Mary Sue Terry, who pushed for the two bills.

However, Mr. Czech said that Attorney General Terry was "misguided" in proposing these changes. He explained that these requirements probably will make insurance in Virginia harder to obtain and more expensive—the opposite of its intent.

Mr. Czech claimed that it will cost insurance companies "millions

of dollars" to comply with the additional reporting regulations. He added that the state Bureau of Insurance already has this type of information on file, or doesn't need it for regulation.

Several of the tort reforms passed by the Legislature were less controversial.

One bill, S.B. 404, would limit the liability of directors and officers of for-profit corporations in suits filed by stockholders to \$100,000 or their annual compensation, whichever is greater.

An exception to this rule is in cases of willful or knowing violation of the law. The bill also expands the right of corporations to indemnify directors and officers if they are sued.

Under this bill, directors and officers of not-for-profit corporations would be totally exempt from any liability.

Another bill, S.B. 409, would grant immunity from liability to members of local government enti-

ties while they are performing the duties of their positions.

Pesticide applicators and solid waste permit holders would be able to certify and pledge their financial net worth in lieu of purchasing insurance coverage under S.B. 406, modeled after similar federal action.

Also passed was S.B. 407, based on Federal Rule 11, which allows a court to impose sanctions against a plaintiff or defense attorney for frivolous motions or suits.

A few of the tort reforms addressed medical malpractice.

One bill, S.B. 405, would give a minor until age 8 to file a medical malpractice suit for injuries that occur during his or her lifetime, after which a two-year statute of limitations would apply.

Under current law, a minor has until age 21 to file a medical malpractice suit for any injury occurring during his or her lifetime. Adults, however, are subject to a two-year statute of limitations.

Another bill, S.B. 408, would grant immunity from liability to emergency room doctors and others who care for women in active labor if the health care practitioner has not been involved in the woman's prenatal care and if her medical records are not available, except in cases of gross negligence or willful misconduct.

A related bill, H.B. 1216, would establish a fund to compensate families for the care of infants born with birth-related neurological injuries to the brain or spinal column because of deprivation of oxygen or mechanical injury occurring during the course of labor, delivery or post-delivery.

Ms. Webb of the Virginia Hospital Assn., which, along with the Medical Society of Virginia, supported the legislation, said the bill "does a lot to solve a societal problem."

Participation in the plan is optional for both doctors and hospitals. If an eligible infant is born in a participating hospital under the care of a participating physician, the family may not sue the doctor or hospital for damages of any kind.

To be covered under this bill, called the Birth-Related Neurological Injury Compensation Act, an infant must be permanently non-ambulatory, aphasic (unable to speak), incontinent and in need of assistance in all phases of daily

living. An estimated 40 infants per year born in Virginia fall into this category.

Obstetricians who want to participate in the program would pay an annual fee of \$5,000. Hospitals belonging to the program would pay annual fees of \$50 per birth, up to a maximum of \$150,000 per hospital. Deadline for paying these fees would be Jan. 1, 1988.

Physicians licensed to practice in the state that decide not to participate in the program would be required under the act to pay an annual fee of \$250 by Sept. 30 of this year.

State-employed physicians would have to pay their fees by July 30, 1988. This allows the state enough time to figure these costs into its annual budget.

The fund also would be financed by insurance companies, if contributions from doctors and hospitals do not cover all costs. If necessary, the state Corporation Commission could annually assess insurers an amount no more than 0.25% of net direct premiums written in the state, beginning Jan. 1, 1989.

If signed, the compensation act would become effective Jan. 1, 1988, and be administered by the Virginia Industrial Commission, the same state regulatory agency that administers workers compensation in the state.

The program is expected to cost \$20 million annually. Of that amount, \$12 million would come from doctors' and hospitals' fees, and the remainder would come from insurance companies' assessments.

The impetus for this legislation, according to many sources, was the insurance crisis that hit Virginia obstetricians last year when one of their major insurers, PHICO Insurance Co. of Mechanicsburg, Pa., stopped writing coverage for all but groups of 10 or more obstetricians.

That left about 160 obstetricians and numerous other physicians without medical malpractice coverage. Furthermore, two other insurers, The St. Paul Cos. Inc. and Virginia Insurance Reciprocal, have severely curtailed writing new and renewal medical malpractice business.

The Virginia reciprocal has said that it would resume writing obstetrics' medical malpractice coverage again if this bill, or a similar proposal, is enacted. ■

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Asbestos award

Continued from page 2

there is insurance," said R.A. Hul-ten, with the New York firm of Kirlin, Campbell & Keating. "But there may be problems areas. "There is a whole bunch of grey area involved. The waters are far from clear."

Mr. Hul-ten noted, however, that Farrell and its liability insurers are currently not involved in litigation over coverage for asbestos injury claims.

Ted Friedman, the attorney for Mr. Torrens with the New York firm of Friedman & Eisenstein, said "there clearly is insurance coverage for at least one-half and probably for all" of the award.

British and U.S. insurers have written coverage for the shipping line for many years, but there is some dispute over which policies will apply to the Torrens case, Mr. Friedman said.

Many companies sued in asbestos litigation and their insurers are involved in disputes over which liability insurers should pay for damage awards and settlements.

Following the verdict, Farrell filed motions with the trial court to reduce the verdict. The company is also seeking a judgment in its favor despite the verdict, said Mr. Hul-ten.

"We think (the verdict) is excessive," Mr. Hul-ten said, noting that virtually all of the award was for pain and suffering.

Mr. Torrens was a chief officer on various Farrell ships, which carried asbestos from South Africa to the East Coast of the United States, and monitored stowage of the cargo, including asbestos. He was exposed to asbestos from 1948 until 1959.

He alleged in his lawsuit that part of his exposure came from the torn and broken bags of asbestos that allowed asbestos dust to enter the atmosphere.

Mr. Torrens also alleged that he also was exposed to asbestos in his duty as a repairer of insulation on the ships.

According to Mr. Friedman, Mr. Torrens was able to sue Farrell, his employer, because maritime workers, who are not covered by state workers compensation statutes, are permitted to sue their employers

Company may appeal jury verdict

NEW HAVEN Conn.—New England Telecommunications Corp. is considering appealing a \$7.5 million federal jury award to a man who claimed the improper placement of a pay phone caused an accident that left him permanently paralyzed from the shoulders down.

While using the pay telephone at the Mohawk Mountain Ski Area in Cornwall, Conn., in 1984, Damon Sable, 23, stepped back, toppled over a railing and fell down a set of stairs, a spokeswoman for Southern New England Telecommunications said.

A U.S. District Court jury in New Haven originally awarded Mr. Sable \$10.7 million from the telephone company, the spokeswoman noted.

However, the jury reduced the award to \$7.8 million after deciding Mr. Sable was 30% responsible because he was intoxicated at the time of the accident, the spokeswoman said.

The spokeswoman noted that the Mohawk Mountain Ski Area Inc. also was sued but was not held liable.

"We're totally insured for it," said the spokeswoman, who would not provide further details of the telephone company's coverage. ■

'This is the first time a maritime worker has recovered for asbestos exposure under this theory' of breach of warranty, said plaintiffs' attorney Ted Friedman of the New York firm of Friedman & Eisenstein.

for damages for breach of a warranty that they will provide a safe place to work.

He also sued Farrell for negligence under the Jones Act.

Mr. Torrens alleged his physical suffering included shortness of breath, fatigue, nausea and loss of motor capacity. He had to undergo eight hours of surgery for removal of a lung and also chemotherapy and radiation therapy, according to Mr. Friedman.

"The prognosis is poor," Mr. Friedman added, noting Mr. Torrens' doctor said he had lived an unusually long period of time since

the February 1985 diagnosis of mesothelioma and predicted Mr. Torrens would not live another two years.

Mr. Friedman asserted the 64-year-old Mr. Torrens had been in excellent health prior to contracting mesothelioma, and had a reasonable life expectancy of 20 to 25 years.

He said the jury was charged to give adequate compensation for the years he would have lived, the earnings capacity he would have had, the loss for enjoyment of life and his physical pain.

While the jury found Farrell was

not negligent and was not liable for punitive damages, it did find that there was a breach of warranty of the ship's seaworthiness.

"This is the first time a maritime worker has recovered for asbestos exposure under this theory (breach of warranty)," Mr. Friedman said. But he added this was "no great feat. He clearly should have won what he won."

Mr. Friedman also said that the award was unique because it was uncommon for individuals to be compensated for a reduction in their life expectancy. "That is not a traditional item of compensable damages," he said.

Mr. Hul-ten, Farrell's attorney, said the award is a good example of the need for tort reform.

Virtually all of the damages were for pain and suffering, he pointed out.

He also noted that a more stringent standard for a judge's review of pain and suffering awards, enacted along with other tort reforms

in New York last year and applying to cases filed after July, would have eliminated a large part of the verdict (BI, June 30, 1986).

"If the new law affected it, the result could have been different," he said.

Still pending is a third-party action filed by Farrell against various asbestos manufacturers, Mr. Hul-ten added.

This action was severed from Mr. Torrens' claim because of his physical condition and the judge's belief that a trial should be conducted as soon as possible.

Mr. Hul-ten said that to his knowledge it is the only case involving a seaman suing on the basis of his exposure to asbestos as cargo, although at least one other similar case has been brought involving a longshoreman.

"It is unique in that it involves a deck officer," added Mr. Hul-ten, noting that claims by ship personnel brought so far have usually involved engine room workers. ■

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Product liability

Continued from page 2

mittee" for some action on federal product liability reform.

Sen. Kasten said that, if necessary, supporters of product liability reform might have to examine other legislative vehicles to accomplish their goals. He mentioned that legislation to amend the McCarran-Ferguson Act, which gives insurers a limited immunity from federal antitrust law, would be a logical place to attach a product liability reform proposal.

The Kasten product liability reform package would:

- Establish a uniform fault-based standard for product sellers. Product sellers other than manufacturers would be liable only if the plaintiff's harm was caused by either the seller's lack of reasonable care or a breach of the seller's own warranty.
- Limit the application of joint and several liability to economic damages only.
- Set the standard of proof for punitive damages at "clear and convincing evidence" and set the standard of liability for punitive damages at "conscious, flagrant indifference to the safety of persons."
- Require product liability lawsuits to be filed within two years from the time a plaintiff discovered—or should have discovered—the harm posed by a product and its cause.
- Give manufacturers protection from product liability lawsuits if their products complied with federal safety rules.
- End workers compensation subrogation liens.

• Fine anyone found willfully destroying or concealing relevant materials or evidence no less than \$1,000 and require that party to pay the other party's legal costs.

• Encourage both sides to settle in a liability damage suit before the case is tried.

If a settlement offer is made by one side but rejected by the other, and if the final judgment is equal to or less favorable to that party than the offer, then the party who rejected the offer would be liable for the other party's legal costs.

If the defendant rejects the offer, these costs would be added to the judgment; if the plaintiff rejects the offer, the costs would be subtracted from the judgment.

Meanwhile, the bill based on the ABA tort reform recommendation that Sen. Danforth said he would sponsor would:

- Allow punitive damages only in cases where the defendant's conduct indicates that the injury was the result of intentional and conscious disregard for the safety of others, as opposed to mere negligence.
- Elevate the standard of proof used for punitive damage awards to "clear and convincing evidence," which is higher than the standard used in awarding compensatory damages.
- Allow evidence relevant only to the question of punitive damages to be introduced only after the defendant's liability for compensatory damages and the amount of those damages has been determined.
- Abolish joint and several liability for non-economic damages for defendants whose responsibility for the injury is one-third or less of the liability of the defendant most re-

sponsible for the accident. For example, if the defendant with the greatest responsibility for the accident is deemed 60% liable, then joint and several liability would be abolished for defendants whose responsibility for the accident was 20% or less.

• Require trial judges to review the amount of compensatory and punitive damages awarded in each case and allow them to seek modification of the amount awarded or set the award aside.

• Establish a national commission to review the current system of awarding product liability damages. The commission would disseminate its findings and make recommendations on product liability jury instructions and awards.

Under Sen. Danforth's expedited settlement bill, both manufacturers and plaintiffs would have incentives to settle a suit before going to trial.

For example, if a plaintiff rejected a defendant's offer to pay all economic damages and at least \$100,000 for a "dignitary" loss (death of a parent, spouse, child, serious and permanent disfigurement, loss of a limb or organ, or serious and permanent impairment of a bodily function), then the manufacturers' maximum liability for non-economic losses—excluding punitive damages—would be \$250,000 in dignitary cases and \$50,000 in all other cases.

On the other hand, if the plaintiff made a settlement offer and the defendant rejected it, the defendant would be liable for up to \$100,000 in plaintiffs' legal fees, assuming the plaintiff won.

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May 4	Apr 22
May 11	Apr 28
May 18	May 6
May 25	May 13
Jun 1	May 19
Jun 8	May 27
Jun 15	Jun 3
Jun 22	Jun 9
Jun 29	Jun 17
Jul 6	Jun 24
Jul 13	Jun 30
Jul 20	Jul 8
Jul 27	Jul 15
Aug 3	Jul 22
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Sep 21	Sep 9
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Berkshire Hathaway

Continued from page 3

tracted if it targeted potential policyholders generating \$10,000, \$20,000 or even \$100,000 in annual premium. Nor was the group particularly interested in hiring the additional 200 people that would have been required to handle those accounts, said Mr. Buffett.

Thus, it was decided "sort of arbitrarily" to set a \$1 million limit with the idea it would be a "manageable number," he explained.

In fact, because of the large volume of responses Berkshire Hathaway received, the \$1 million threshold "wasn't quite manageable," although it was still more practical than a lower minimum premium would have been, he said.

"The key to efficiency is really people with a common interest," said Mr. Buffett, explaining the company's strategy. He said about 40 to 50 large companies became Berkshire Hathaway policyholders as a result of the ad.

Berkshire Hathaway primarily writes general liability, directors and officers liability, product liability and some errors and omissions coverages for the new clients, "the kind you would expect to come in," he said.

The ad may be repeated, said Mr. Buffett. But not until "our phone lines are ready to handle it."

One indication of Berkshire Hathaway's new commitment to large commercial risks is the recent hiring of Dennis Busti, former president of American Home Assurance Co., an American International Group Inc. subsidiary.

Mr. Busti joined Columbia Insurance Co., a Berkshire Hathaway subsidiary, as president and chief operating officer earlier this year (BI, Feb. 2).

Joining Mr. Busti were American Home Executive Vp Dinos Iordanau and Senior Vp Michael Russo.

Columbia, with policyholder surplus of about \$500 million, will concentrate on writing commercial casualty insurance, mostly excess and umbrella liability coverage.

With Mr. Busti's hiring, Mr. Buffett enthusiastically said, "The world sort of opened up for us" in terms of opportunities to expand.

"When you get talented guys you should make the move," Mr. Buffett added. "We're always willing to take people with talent," he said, even if the company is not necessarily "spending a lot of time beating the bushes" for them or even needs them immediately.

However, he adds, "We've got plenty of money. It's brains we need."

Insurance is only one part of the Berkshire Hathaway operation. In fact, to the general public, Berkshire Hathaway is best known as an investment firm. Mr. Buffett, 56, estimates Berkshire Hathaway, of which he and his wife own slightly less than 45%, holds between \$3 billion and \$3.5 billion in marketable securities.

Berkshire Hathaway's interests include 18% of Capital Cities/ABC Inc., plus holdings in furni-

ture, candy and newspaper companies, including The Washington Post Co.

Also, Berkshire Hathaway maintains a 41% share in GEICO Corp. and Mr. Buffett readily admits insurance remains his first love.

That relationship that began when he took a class at Columbia University Business School in New York taught by Ben Graham and became a disciple. Mr. Graham had co-authored "Security Analysis," a landmark book that promoted the "value approach," which calls for buying undervalued companies and holding onto them until the market recognizes their value.

"Anything Ben was interested in, I was interested in," Mr. Buffett explained.

When he learned that Mr. Graham was also GEICO's chairman, he visited GEICO's Washington offices one Saturday. After banging on the door, he finally attracted the attention of a janitor, who said there was a "fellow working on the sixth floor."

That fellow turned out to be Lorimer Davidson, a GEICO official who later became chairman of the company. "Davey spent about four hours educating me on the insurance business" that Saturday, Mr. Buffett recalled.

Upon his return to Omaha at the age of 21, Mr. Buffett continued his ties to insurance by selling insurance company securities for his father's stockbrokerage firm. He even wrote an article on insurance stocks later that year, called "The Security I Like Best," an article he still points to with pride.

At the same time, he studied insurance regulations in the state house at Lincoln, Neb., so his insurance knowledge was "self-taught to a degree."

In 1965, Mr. Buffett acquired Berkshire Hathaway, at the time a textile operation. Berkshire Hathaway's entry into the insurance business occurred in 1967 with the purchase of National Indemnity Insurance Co. and National Fire & Marine Co.

Both Omaha-based companies had been controlled by John D. Ringwalt.

"For about 15 minutes once a year," Mr. Ringwalt would get into the mood to sell the insurance operation, Mr. Buffett said.

In 1967, Mr. Buffett happened to be on hand while Mr. Ringwalt was in the mood, and offered Mr. Ringwalt \$7 million for National Indemnity and another \$1.7 million for National Fire.

Mr. Ringwalt accepted, but immediately regretted his decision, said Mr. Buffett. However, "Jack was a great guy" who stood by his word and besides, Mr. Buffett added, "I never really gave him a chance to back out of it."

"He worked for a number of years for me thereafter," said Mr. Buffett.

Besides the direct insurance business written by Berkshire Hathaway units, they also reinsure 7% of all business written by Fireman's Fund Insurance Co. The quota-share agreement extends through Aug. 31, 1989.

Berkshire Hathaway's link with Fireman's Fund stems from Mr. Buffett's admiration for

former GEICO Chairman John J. Byrne. When Mr. Byrne left GEICO to become chairman and chief executive officer of Fireman's Fund, Berkshire Hathaway "followed" him, and negotiated the quota-share agreement, Mr. Buffett said.

Referring to Fireman's Fund and Mr. Byrne, Mr. Buffett observes in Berkshire Hathaway's somewhat folksy annual report—which includes quotes from sources as diverse as Patrick Henry, Pogo and Woody Allen—that he was "never one to let go of a meal ticket."

Mr. Buffett says he has no plans now for additional investments in the insurance industry, although he adds, "I wouldn't be surprised" if those plans change 10 to 15 years from now. "You never can tell in this business."

This is not to say that Mr. Buffett is necessarily sanguine about the insurance industry's future. Although property/casualty insurers' earnings are booming, Mr. Buffett noted "the period of prosperity will not last long."

"I think it's changing very fast right now," he added.

The hard market will turn by this year's third quarter, Mr. Buffett predicts, though insurers' bottom lines won't be affected "for another nine months or thereafter" because of the time lag between price changes and their appearance on financial statements.

Mr. Buffett also admits he is somewhat frustrated by the fact that only in insurance can a business put out false profit and loss statements for a while "and get away with it."

In other businesses, whether automakers or dressmakers, "the expenses are clear-cut."

An analogy, he said, would be if General Motors made a car to sell for \$10,000, to be delivered in 10 years' time. It could tell people the car cost \$6,000 to make, when in fact it cost \$12,000. "They could kid people for 10 years."

Mr. Buffett also noted that he is in the insurance business to stay, despite the philosophy of Mr. Graham, one of his mentors. One of Mr. Graham's tenets, according to summaries of his work, is that stock should be sold after a company reaches a profit objective of between 50% and 100%, which he assumed would be three years or less from the time of purchase.

But Mr. Buffett said turning over companies quickly is not part of his investment strategy.

"I call that gin-rummy corporate management," he said. "We don't do that."

Mr. Buffett said he prefers to become involved with people and businesses he likes "and just sit there." Referring specifically to GEICO, for instance, Mr. Buffett said, "We'll own that forever."

Mr. Buffett said he has no plans to leave the insurance business. "We love it. It's other people that come and go. Our involvement will last as long as I live—and longer."

"It's an interesting business," Mr. Buffett said. "It's also more fun than making horse-shoes."

He added, thoughtfully, "it's not as profitable sometimes."

Sports injuries

Continued from page 3

rupture in his left knee, he was not informed that his knee lacked the "anterior cruciate ligament," which can result in instability in the knee, particularly if combined with other injuries.

- After experiencing pain and swelling in his left knee in 1964, he was injected with steroids but was never informed by the team medical staff of the dangers associated with such injections.

- He was not informed by the team medical staff that he suffered from a thinning and loss of cartilage on the undersurface of the kneecap, a condition known to be an adverse reaction to prolonged steroid use.

- He was not informed of "degenerative post-traumatic changes" in his left knee joint that were indicated by X-rays taken between 1964 and 1971.

- He was not advised that he risked permanent injury by playing the remainder of the 1970 season without surgery after "a substance" was dislodged from his left knee joint following a hit during a game.

It was not until 1978, five years after Mr. Krueger retired, that a team physician showed him X-rays of his knees and advised him for the first time that he suffered from chronic and permanent disability of the knee, he alleged.

In 1980, Mr. Krueger sued the 49ers for fraud or deceit under two sections of the California Civil Code. Those sections allow an injured party to recover damages from another that has willfully deceived the injured party or has suppressed facts to mislead him.

Another defendant named in that lawsuit, the Bert Bell NFL Player Retirement Plan, had previously settled.

In 1985, a state Superior Court judge in San Francisco ruled that Mr. Krueger failed to prove all of the elements of fraudulent concealment necessary to hold the team liable.

The judge also ruled that Mr. Krueger would have continued to play football even if he had been advised of the nature and extent of his injuries. This finding negated a crucial element in Mr. Krueger's case—that the team's actions were the "proximate cause" of his injuries.

However, the appellate court disagreed. "This finding seems to us mere conjecture," the court said, referring to the proximate cause element of Mr. Krueger's fraud or deceit charges. "Appellant demonstrated throughout his football career a courageous—some might say foolhardy—willingness to endure pain and injuries for the sake of his team and employer, but no credible evidence suggests that he ever assessed and accepted the prospect of permanent disability."

In addition, the appellate court found that Mr. Krueger had proven

the other necessary elements of fraud or deceit, including:

- There was a misrepresentation or suppression of a material fact by the 49ers.

- The 49ers knew that it was misrepresenting or suppressing facts from Mr. Krueger.

- The 49ers intended for Mr. Krueger to rely on its misrepresentations, and that based on that information, Mr. Krueger did base his decision to continue playing.

The court also ruled that the team's evidence never directly contradicted Mr. Krueger's testimony that the team's physicians never disclosed the true nature and extent of his injuries or the adverse effects of steroid injections, the court said.

"As to the crucial issue of full disclosure . . . we find the evidence uncontradicted . . . the requisite disclosure was never made," the court ruled.

"That the team physicians withheld no material information from Krueger is not, in our view, the proper focus of inquiry," the court added. "The critical question is whether full disclosure of his medical condition was ever made to Krueger."

The court noted that in a doctor-patient relationship under the California Civil Code, failure to make full disclosure constitutes not only negligence, but also fraud or concealment, when the requisite intent is shown.

"A physician cannot avoid responsibility for failure to make full disclosure by simply claiming that information was not withheld," the court said.

The court also found that Mr. Krueger established that at the time the team concealed medical information from him, the 49ers intended to induce him to continue playing football despite his injuries. Mr. Krueger relied on the medical advice of the team's physicians and was not required to consult outside sources or undertake independent investigation of the nature of his injuries, the court further ruled.

"We think the record unequivocally demonstrates that, in its desire to keep appellant on the playing field, respondent consciously failed to make full, meaningful disclosure to him respecting the magnitude of the risk he took in continuing to play a violent contact sport with a profoundly damaged left knee," the court said.

"It is in this palpable failure to disclose, viewed in the light of the 49ers' compelling obvious interest in prolonging appellant's career, that we find the intent requisite for a finding of fraudulent concealment," the court said.

Car rental exposures

Continued from page 1

about their new car rental exposures, he added.

ISO representatives promised a few weeks ago to give a high priority to resolving this coverage dilemma, said C. Courtney Wood, a principal with Moore-Lofgren-Wood Agency Ltd. in Edmond, Okla. He is also chairman of the Technical Insurance Committee of the Independent Insurance Agents of America, which meets periodically with ISO.

Until then, business auto policies written on the new ISO form must be modified through an endorsement to prevent the gap, though some insurers say they are reluctant to add the endorsement.

Combined, the recent changes in employers' rental car exposures are causing confusion in the commercial insurance marketplace. Risk management consultants, brokers, risk managers and insurers differ on how employers should manage these risks.

Only the country's largest corporations—such as the Fortune 1,000—generally are free of these worries because they have negotiated overriding agreements with car rental companies that provide both coverage for damage to rented cars and increased liability insurance limits.

However, at least one of the major rental companies is withdrawing from some overriding agreements and is reducing the coverage it will provide under other agreements (see related story).

"Auto contracts are becoming more onerous from the standpoint of the renter," said Robert Dauer, senior consulting editor with The John Liner Letter, a Boston-area risk management advisory publication. "Large auto renting firms are placing more responsibility on the renter of cars."

For instance, in recent weeks both Avis Inc. and National Car Rental System Inc. have joined Hertz Corp. and Budget Rent a Car Corp. in making a renter liable for the full value of a rental car if it is damaged.

Car rental companies' own insurance woes are part of the reason behind the change.

"The losses and premiums have both risen dramatically over a period of years," explained Stan Roth, vp of insurance for second-ranked Avis.

"In the past two years, there has been a sharp erosion of coverage availability," noted Peter J. Piacentino, president of Rental Industry Services Inc. in King of Prussia, Pa., a brokerage that specializes in coverage for car rental agencies. Coverage for these high-risk businesses has been "hard to get," and it also has been "hard to get high limits," he said.

While an employer's liability for damage to a rental car has increased significantly, "at least 90% of all employers do not have any physical damage coverage for leased or rented cars," Mr. Wood pointed out.

Companies that self-insure their rental car collision exposure face "a big problem" now that they are responsible for the full value of the car, said the vp of finance for a Chicago-based publishing company.

Some companies, like Skokie, Ill.-based Bell & Howell Co., are continuing to self-insure their collision damage exposure, (BI, Oct. 18, 1982). However, Bell & Howell's exposure has been capped at about \$3,000 by an overriding agreement with a car rental company, said Bruce Wilson, director of risk management.

Employers can reduce their exposure for rental car physical damage by having employees pay the rental car company an additional fee—usually about \$9 a day—for a "collision damage waiver," which eliminates the renter's liability for damage to the rental car. However, most companies in the past have told employees not to purchase CDWs because of the high cost.

The rates charged for CDWs "are just terrible," noted Tony Schrader, Iowa's deputy insurance commissioner. "What rental car companies are doing is increasing the threat level so the individual consumer will be pushed into buying" CDWs, he said.

But, Rolland L. Krefall, National's director of insurance, said increasing the amount of damage for which a renter is liable is "not a move to develop profit but a move to pay our expenses." He points out that the more than 75,000 cars in National's fleet often come back "battered and dinged."

Some employers have avoided CDWs not only because of their cost, but also because the wording of the waiver may vary, especially in locations operated by franchises. The lack of consistency among car rental agreements makes it diffi-

cult to know what employees are getting for the fee, some sources explained.

However, the four leading rental car companies say most or all of their franchises use standard company wording for the collision sections of a rental agreement and that there is even more consistency in the wording concerning rental liability.

Standardization of collision damage waivers is one of the aims of a model act adopted last summer by the National Assn. of Insurance Commissioners. It requires car rental companies offering CDWs to follow specified terms and conditions, be licensed and file rate information. Legislators in Iowa now are considering adopting the act as law, according to Mr. Schrader.

Employers can reduce their exposure for rental car damage by obtaining coverage under either the old or the new version of the business auto policy, sources say. That coverage would be excess of any coverage obtained through the auto rental agreement. The coverage is obtained by checking the applicable box on the declarations page of the policy, entering limits and deductible amounts and specifying that hired autos be covered by the policy, experts suggest.

In addition, ISO offers insurers a blanket endorsement (CA 99 33) to the new business auto policy that includes collision coverage for all authorized employees, according to an ISO spokeswoman.

Another option is to amend the business auto policy by endorsement to provide physical damage coverage on hired autos.

For instance, broker Bayly, Martin & Fay International Inc. obtains physical damage coverage for its own rental automobile exposures through a manuscripted endorsement to its auto physical damage policy, said Sam Alcorn, senior vp at Fort Worth, Texas-based BMF.

Mr. Wood suggests employers add an endorsement to their business auto policies that emphasize a company's employees are covered by the policy. Such an endorsement reflects an employer's moral responsibility to his employees, prevents an employee from suing an employer if there is no coverage and protects the broker from errors and omissions claims, he said. He believes an endorsement is needed because a typical business auto policy names the company as the insured, while rental agreements name the individual employee as the person responsible for the car.

Ideally, cars should be rented in the name of the company itself and not an individual, observers say, though many rental car companies require the use of an individual's name.

Most employers consider employees traveling on business as their agents and will provide insurance protection for them. However, an employer could decline to do so in cases where an employee has an accident during a vacation day tacked onto the end of a business trip.

As a result, employees also should check their personal auto policies to see whether they will respond if a car is damaged, experts advise.

Whatever the form, rental car physical damage coverage has become more important as the loss potential has increased, but many companies do not seem to realize it, one broker notes.

Yet, despite the new exposures for rental car collision damage, "it's the liability exposure that can kill you," pointed out Joseph H. Albert, president of J.H. Albert International Insurance Advisors Inc. in Needham Heights, Mass.

Rental agreements previously used by the four leading car rental companies automatically included liability coverage limits of \$100,000 per person and \$300,000 per occurrence to pay for claims stemming from bodily injury to anyone other than the driver of the rented car.

However, Avis and National have dropped those limits to \$25,000 per person/\$50,000 per occurrence except where state laws require car rental companies to provide higher limits.

Meanwhile, Budget dropped the liability coverage limits it offers to state minimums, which can vary from \$10,000 per person or \$20,000 per accident to unlimited coverage in a state like Hawaii, sources say.

"The \$25,000/\$50,000 limit is not enough," Mr. Albert said. "I'm surprised they are dropping liability limits. That will cause a hue and cry and get the politicians involved."

Hertz adopted \$25,000/\$50,000 limits for a few months last year but then re-established the \$100,000/\$300,000 limits, Hertz's Mr. Russo said.

And, employees renting cars from Hertz in most states can pay an additional fee to increase the limits automatically

available to \$1 million per person and per accident.

The supplemental coverage is underwritten by Fireman's Fund Insurance Cos. and brokered by Alexander & Alexander, A&A's Mr. Eggers said. A&A now is marketing the program to other rental car companies, he added.

Meanwhile, liability coverage limits for damage to third-party property at Hertz, Avis and National continue at \$25,000 in most states. However, Budget is now offering only the minimum required coverage in each state, which ranges from \$5,000 to \$30,000, said Henry Peterson, Budget's assistant vp for risk management.

Employers typically can purchase liability insurance for third-party bodily injury and property damage claims that exceed the amount of the coverage that is automatically furnished by the car rental company by filling in the declarations page of both the old and the new business auto policy with notations that say cars rented by employees are covered, sources say.

Employers' business auto coverage costs will increase after "losses go through the system," noted Ted Melinosky, assistant director of the commercial lines product management division at Travelers Corp.

In addition, employees who rent cars for business use create a contractual liability exposure that is creating a new coverage dilemma for many businesses.

Rental agreement contracts typically include indemnification or hold-harmless clauses that could create contractual liability for an employer, sources say. Under such an agreement, a company renting a car agrees to hold the rental car company harmless for the rental company's own negligence if an accident arises out of that negligence.

For example, an employer could be held liable for an accident, even if the accident was caused by a rental car's faulty brakes that the car rental company knew or should have known about, Mr. Dauer explained.

Previously, most employers were covered for contractual liability exposures under comprehensive general liability policies, either automatically or through an endorsement.

However, the new commercial general liability policy specifically excludes contractual liabilities.

ISO intended that the new business auto policy provide contractual liability coverage for rental cars, but ISO's commercial Automobile Committee "plain overlooked it," said Philip Brown, a Travelers' assistant director who represents Travelers on the ISO committee, which helped develop the revised business auto form.

The ISO committee is expected to consider the issue when it meets next month and may draft preliminary wording of a new endorsement to cover the exposure by May 1, he said.

The wording should be formally adopted no later than Sept. 1, Mr. Brown said.

An ISO spokeswoman would only say ISO has agreed that the committee will review the topic.

As a stopgap measure, an endorsement (CA 99 16), which covers non-owned autos as if the employer owns them, should be added to an employer's business auto policy and a note should be written on the policy to emphasize that the coverage is for daily rentals, Mr. Brown said.

The ISO spokeswoman said another endorsement (CA 20 01) also could be used, but that endorsement is primarily designed for long-term leases.

"A broker is going to be in trouble if he doesn't get the required endorsements on the new policies," Mr. Eggers noted.

However, some insurers say they are reluctant to add these endorsements to the business auto policy.

"We are definitely not very willing to adopt the endorsement," said Mark Kinder, a commercial casualty underwriter specialist with Kemper. He explained that too many variables exist to properly underwrite the coverage, including the companies from which cars can be rented, frequency of rentals and the nature of the rental agreement wording, he said.

It would be hard to rate and therefore hard to determine a fair price for such blanket coverage, said an underwriting manager for a commercial auto insurer who asked that his name not be used.

Another approach would be for a broker or agent to convince an insurer to delete language in the new business auto policy that excludes contractual liability coverage for rental cars, the underwriting manager said.

But, an insurer will want payment for deleting the exclusion, said Richard N. White, a senior vp with Fred S. James & Co. in New York City.

Companies told to review car rental procedures

By MEG FLETCHER

Risk managers who want to be in the driver's seat need to re-evaluate their companies' approach to managing risk created by car rentals, experts say.

"I think this is an excellent time for a company to re-evaluate its policy about short-term rental of automobiles," said Robert Dauer, senior consulting editor with The John Liner Letter, a Boston-area risk management advisory publication.

"Risk managers should set a threshold on the amount they will sustain a loss for and temper that with the amount the rental car companies are charging for the protection and the number of times a year cars are rented and adjust accordingly," said Lanny L. Hair, executive vp of the Independent Insurance Agents of Arizona.

Risk managers also should review rental car company contracts, observers suggest.

They need to consider whether the rental car agreement contains exclusions that void coverage furnished by the rental company if the driver uses any drugs, including moderate use of alcohol, drives unsafely, drives off paved roads or if someone else drives the car other than the person whose name appears on the form, said William Foran, president of T.E. Brennan Co., a Milwaukee-based risk management consulting firm.

Some "exclusionary language is worded so broadly that anyone leasing a car is exposing himself to some severe penalties," Mr. Brennan said.

After reviewing the contracts, risk managers may want to mandate that employees rent from a company that offers acceptable terms and conditions.

If possible, risk managers may want to try to negotiate overriding agreements with rental car companies to obtain higher limits and more favorable terms and conditions.

One of the most favorable overriding agreements calls for a company's employees to pay no fee for a collision damage waiver and to receive \$1 million in liability insurance from the car rental agency, said Ralph Pound, vp in the Chicago office of broker Rollins Burdick Hunter Co.

A special advantage of an overriding agreement or having proof of collision insurance is that it gets employees off the hook if a rental car company seeks immediate payment for damage to a car, said Sam Alcorn, senior vp at Bayly, Martin & Fay International Inc. in Fort Worth, Texas.

Some franchisees can get "awful rough" if there is no way to immediately satisfy them for damage to a rented vehicle, regardless of fault, he said.

Mr. Alcorn cited one incident in Hawaii in which police were called to prevent a person who returned a damaged rental car from boarding a plane.

However, at least one major car rental agency began de-emphasizing overriding agreements during the hard market.

National Car Rental System Inc. is withdrawing from some of its overriding agreements and, in other cases, is reducing the liability coverage it offers under the agreements to \$100,000 per person/\$300,000 aggregate from \$1 million total, said Rolland L. Krefall, National's director of insurance.

To clarify the question of employee responsibility for rental car damage and liability, employers should write a corporate statement advising who is covered under different circumstances and give copies of that statement to employees as well as include it in the company's risk management manual, said Dean Brooks, executive vp with Brooks-Lussem Insurance in Des Moines, Iowa, and chairman of the Independent Insurance Agents of America's commercial lines committee.

Beneficial insurer sale

Continued from page 1
against ACIC.

"American Centennial is going to, in general, be liable for all the lawsuits," said Andrew Kerstein, ACIC senior vp and president of First Delaware Holdings Inc., the holding company created to acquire ACIC and the other insurance units.

However, Beneficial has agreed to indemnify ACIC if it is ordered to pay in some of the disputes, including those over business produced by The Underwriters Inc. of Parsippany, N.J., a former MGA for ACIC. Ms. Mulholland said Beneficial's agreement to assume liability in the TUI case was at the department's instigation.

About 15 reinsurers, who together may account for more than \$40 million in reinsurance recoverable by ACIC, have disclaimed liability for and demanded arbitration on business produced by TUI, according to court papers.

The \$40 million estimate is disputed by Mr. Kerstein, who described it as "grossly overstated," and said the total could be as little as 10% of that amount.

ACIC Senior Vp Scott Goodell noted the TUI business has generated lawsuits in both state and federal courts, and that arbitration involving ACIC reinsurers is still pending.

ACIC filed a lawsuit in 1984 in federal court in Newark, N.J., charging that TUI and others defrauded ACIC on a portion of the business that the reinsurers are now contesting (BI, Oct. 29, 1984).

Liability for some other disputes will be shared by Beneficial and ACIC, said Mr. Kerstein. Mr. Goodell stressed ACIC will be sufficiently reserved to cover any eventual loss development.

Besides the disputes stemming from the TUI business, Bermuda-based Walton Insurance Ltd.—a captive owned by

Phillips Petroleum Co. that no longer is writing commercial reinsurance business—has demanded arbitration on its participation in treaties reinsuring business produced by another of ACIC's former MGAs, Dar Allen Reinsurance Agency Inc. of Freeport, Ill.

Walton also has sued ACIC and another reinsurer to block the companies from drawing down on letters of credit and custodial funds maintained by Walton. In addition, a group of ACIC's ceding companies, including Employers Insurance of Wausau, is suing ACIC and demanding arbitration on treaty and facultative reinsurance ceded to ACIC.

Meanwhile, Mr. Kerstein said ACIC has negotiated a five-year production contract with Beneficial for credit property insurance business generated through Beneficial's loan office system. This represents an "ongoing and immediate source of premium income," he said, estimating it will generate \$75 million in premium over the next five years. This business, he said, will be used as the foundation to write additional lines, such as credit property and personal lines.

Mr. Kerstein said ACIC had a policyholder surplus of \$61 million as of Dec. 31, 1986, and he expects that to change "by no more than 10% in either direction" after the change in ownership. Ms. Mulholland noted the company was told to have a minimum of \$60 million in capital and surplus.

"We think there's an excellent opportunity in the future for the companies," said Mr. Kerstein, explaining why the management team decided to buy American Centennial. He said he expects 15 to 25 people to have equity in ACIC following the sale.

The transaction "will put ACIC on a very sound financial basis" and allow it to meet its obligations, he said, stressing that ACIC has no plans to seek rehabilitation.

If anyone does expect American Centennial to be put into rehabilitation, Beneficial "has paid a helluva lot of money for

nothing," said Ms. Mulholland.

"They have been most anxious to satisfy the demand that the company is solvent and can continue to do business, even with all the vagaries" of the reinsurance disputes and other problems, she said.

Analysts last week said they generally support the sale, noting Beneficial's fortunes should improve once it withdraws from the insurance business.

"American Centennial was a disaster" for Beneficial, noted Joanne Morrissey, president of Firemark, an investment banking and insurance research firm in Morristown, N.J. While she said many of ACIC's problems were caused by overzealous underwriting during the soft market, she added the company was an illustration of Murphy's law: "Everything that could go wrong did go wrong."

The result, she said, was a "black hole" in ACIC's loss reserves. The fact that Beneficial found no one that was willing to buy American Centennial suggests there were still "grave concerns" about loss reserve adequacy. And, the fact that the value of the \$98 million in notes will be determined over time "still suggests reserves are difficult," she added.

"I would think Beneficial's main purpose is to get the reinsurance (liabilities) out from under them," said Claire M. Percarpio, an analyst with Duff & Phelps in Chicago. "It's just a black hole. No one knows what the future liabilities are likely to be."

"Beneficial was motivated by the fact that management was in a business that they knew nothing about," said another analyst who asked not to be named.

"They didn't get very much for it, but on the other hand, they had just put in a lot of money to reserves in 1986," said Tanya Azarch, an analyst with Standard & Poor's Corp. in New York. "You might say they paid to get rid of it, depending on how you look at the timing of these things." ■

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IEA syndicates

Continued from page 2

Meanwhile, show-cause orders answerable March 19 were issued last week for the American Management Service Syndicate, American Royal Syndicate and Usher Syndicate, Mr. Godwin noted.

"We have not seen sufficient data to see that they're insolvent," said Mr. Godwin. He noted, however, that based on statements filed with the Florida department, it is clear the syndicates have less than the required \$1 million in capital and surplus. Mr. Godwin said he could not be more specific about the syndicates' surplus at this time. "They're between zero and \$1 million," he said.

Mr. Godwin said American Royal wrote \$7 million in gross direct premiums in 1986 and reported a \$100,000 profit. He said that AMS wrote \$3 million in gross direct premiums and reported a \$10,000 profit.

In both cases, the amount of reinsurance written cannot be determined, he noted. Because both syndicates had canceled assumed reinsurance contracts, the amount of reinsurance reported assumed by both syndicates was a negative number, he explained.

Usher reported \$8.5 million in assets, \$1 million in direct premiums and \$6 million in reinsurance written during 1986. It posted a loss of \$50,000, said Mr. Godwin.

Show-cause orders answerable March 19 already had been issued for Syndicates One and Three by Leon County Circuit Judge William L. Gary (BI, Feb. 16).

Syndicates One, Two, Three and Four are managed by Daum Management Inc.

Sources say Syndicate One—whose owner, RLI Corp., produced financial reports that initially led to concerns about financial stability of syndicates One, Two and Three—may be having second thoughts about rehabilitation.

"We really haven't heard from the people with respect to Syndicate One," said Mr. Godwin.

An RLI official could not be reached for comment.

Last month, the IEA board voted to indefinitely cease underwriting following mounting treaty reinsurance losses.

Exchange officials and the Insurance Department are investigating the participation of most of the 15 IEA Syndicates on as many as a dozen reinsurance treaties that have produced heavy losses. The IEA has questioned whether managing general agents properly handled business connected with the treaties. ■

update

Unimar investigation dropped

Continued from page 2

However, police inquiries are continuing into the activities of Peter Cameron-Webb, former PCW chairman, and Peter Dixon, an ex-PCW underwriter, he added. The police allege that Mr. Cameron-Webb and others concealed PCW's payments to Unimar, failed to report to the Bank of England movements on money outside the United Kingdom and did not properly record any of the arrangements.

PBGC terminates Kaiser plan

WASHINGTON, D.C.—The Pension Benefit Guaranty Corp. says it has terminated one of the four pension plans offered by Kaiser Steel Corp., which recently filed for reorganization under Chapter 11 of the Federal Bankruptcy Act (BI, Feb. 16).

The Kaiser Steel Retirement Plan, which was established in April 1950 and covered approximately 1,000 plan participants, had an unfunded liability of about \$27 million, according to a PBGC spokeswoman.

The spokeswoman said the plan, which covered salaried workers, had a monthly pension obligation to 176 retirees of about \$175,000, with no assets available to pay these benefits.

The PBGC spokeswoman also noted that three other Kaiser pension plans are also underfunded, but these plans have enough assets to provide for continued benefit payments. The agency is now reviewing the status of these plans.

Drexel forms Bermuda captive

NEW YORK—Drexel Burnham Lambert Inc.'s newly formed Bermuda captive, Capital Securities Assurance Ltd., is providing the firm with part of its excess Securities Industry Protection Corp. coverage.

Government-sponsored SIPC coverage indemnifies investors up to \$500,000 per account in the event that a securities firm goes bankrupt.

Drexel previously had \$9.5 million in excess SIPC coverage written by Aetna Life & Casualty Co., but Aetna did not renew the coverage when it expired last week.

An Aetna spokesman would not comment on the Drexel coverage beyond stating policy renewals are determined on a "case-by-case basis."

American International Group Inc. and a London insurer are writing \$2 million of excess SIPC coverage for Drexel, said a Drexel spokesman, who would not identify the London underwriter.

An AIG spokesman could not be reached for comment.

The remaining \$7.5 million in excess insurance coverage will be written by Capital Securities, which was incorporated in Bermuda Feb. 27.

The Drexel spokesman would not provide any details on the captive's capital.

Drexel recently has been in the news because of its ties with arbitrageur Ivan Boesky, a key figure in the Wall Street insider trading scandal.

Briefly noted

Public transit districts serving Miami, Atlanta, Philadelphia and Boston are working to establish a Bermuda-based captive insurer, **TRANSCAP Insurance Ltd.**, which is expected to provide participants with \$25 million in liability insurance excess of \$25 million. . . . A total of 31 **public housing authorities** nationwide are seeking Vermont regulators' approval to establish a captive insurer to provide property coverages and a risk retention group to write liability insurance. Each facility is expected to provide \$5 million in per-occurrence limits, beginning about June 1.

4th-quarter broker results indicate stabilizing market

By **LEONARD M. WILSON**
Special to Business Insurance

THE CURTAIN has rung down on 1986 for the publicly owned insurance brokers. It also has rung down on the hard market for commercial insurance. Fourth-quarter results confirm that insurance brokers face a new environment.

Total revenues for four brokers that have so far released their 1986 results were up an average 17% in the fourth quarter, compared with an increase of about 25% for the full year.

New York-based Marsh & McLennan Cos. Inc. once again topped the list with revenue gains of 23% for the final quarter and 32% for the year. Although no one can quarrel with the fourth-quarter result, it does represent a slowdown.

This deceleration in revenue growth clearly indicates that premium rates for commercial property/casualty insurance lines are no longer the driving force for commission expansion. We calculate that price increases contributed only 2% to 5% to the advance in revenues in the fourth quarter. The figure for the full year was in the area of 10%, we believe.

Industry contacts agree fairly consistently that premium rates are soft in the property insurance market and have leveled out in the liability insurance market. It appears insurance companies are not ready for across-the-board price competition, but we do hear of selective instances where insurers quote aggressively on attractive risks.

Expenses in the fourth quarter rose less than revenues and, as a consequence, profit margins widened. On the average, expenses increased 14% in the fourth quarter against a 17% rise in revenues. The fourth quarter is often used by brokers to make up for underaccrual of expenses in earlier periods. Therefore, one must be careful about drawing too many conclusions about costs on

the basis of the fourth quarter.

It is encouraging, however, that expense growth decelerated along with revenues.

So much for the broader yardsticks. More specifically, domestic retail insurance brokerage commissions expanded between 17% and 19% in the fourth quarter. Since premium rates have petered out as a significant source of growth, new businesses assumed pride of place as the engine of commission growth.

New business is traditionally strong in tight markets. The professional broker has a chance to prove his mettle under conditions of adverse supply. However, the slight easing in insurance markets has not affected the flow of new business. Soft markets challenge public brokers, but in the last cycle they proved they were able to sustain the flow of new business through concerted salesmanship.

International insurance brokerage has not benefited from rate increases to the same degree as domestic brokerage. In the fourth quarter, international commissions revealed no consistent pattern. It appears that international wholesale brokerage was restrained by the reluctance of leading reinsurers to assume U.S. risks. Retail commissions displayed rather solid improvement, perhaps in part due to translation into a depreciating dollar.

Domestic reinsurance brokerage remains relatively strong, but not unaffected by the change occurring in markets. Marsh & McLennan is the bellwether here through its subsidiary, Guy Carpenter & Co. Inc. Commission growth also slowed, a likely indication that tightness in reinsurance has not precluded a slackening in rate escalation.

Employee benefit consulting performed well during the year. This segment varies considerably from one broker to another based on which services are involved. Nonetheless, without the lift from higher prices, the segment posted gains in the range of 15% to 20%. The Tax Reform Act of 1986 and a greater share within this fragmented market likely account for the solid growth.

Self-insurance activity also seems to roll on. The escalation in premium cost and the shortage of capacity enhances the appeal of the self-insurance solution. Arthur J. Gallagher & Co. of Rolling Meadows, Ill., a leader in self-insurance services, affords insight into this category's growth. In the fourth quarter, Gallagher's fees for self-in-

surance rose 22%.

Investment income growth, with only one exception, was either flat or down in the quarter. The drop reflects lower short-term interest rates year after year. Growth in funds available for investment continues to be strong.

Profitability for public brokers received a shot in the arm during 1986. All of the reporting brokers but Alexander & Alexander Services Inc. of New York, achieved pretax margins of better than 20%. Profit margins are almost back to the levels of the late 1970s, before the competitive market exacted its toll.

Clearly, new business will be the prime source of growth in 1987. Premium rates will contribute almost nothing to top-line growth. Moreover, by the end of the year, it is distinctly possible that prices may be, on balance, slightly negative.

Investors are a little nervous about the earnings visibility of insurance brokers. This uncertainty accounts for the low price-to-earnings ratios now prevailing. Greater investor enthusiasm will depend upon earnings progress in upcoming quarters.

UNUM Corp.

UNUM Corp., the holding company of UNUM Life Insurance Co., reported weak results for 1986 as a result of poor performance in its group medical division.

Operating income in 1986 fell 14% to \$101.2 million from \$117.4 in 1985. Likewise, net income for 1986 dropped 4% to \$115.1 from \$120.4 million in the year earlier.

The company said that approximately three-quarters of the decline in its 1986 pretax operating income resulted from the loss in the group medical business. Chairman and Chief Executive Officer Colin C. Hampton cited the higher costs of providing medical care and an increase in claims as the cause of the group medical division's performance.

Premiums written in 1986 totaled \$1.6 billion, up 23% from \$1.3 billion in 1985.

The Home Group Inc.

The Home Group Inc. of New York has approved a leveraged employee stock ownership plan. The company will make open market purchases of approximately 1 million shares during 1987 for the ESOP.

Pan Atlantic Re Inc.

Pan Atlantic Re Inc. of White Plains, N.Y. is offering 1.75 million shares of common stock at \$16 a share. The offering is being managed by Dillon, Read & Co. Inc.

The proceeds from the offering will be used to increase capital and surplus of MultiPlus Insurance Co., a New York-domiciled subsidiary, to more than \$20 million and to increase the capital of Pan Atlantic Re's London insurance subsidiary, Pan Atlantic Insurance Co., to more than 15 million pounds (\$23.4 million).

CIGNA Corp.

CIGNA Corp. of Philadelphia increased its quarterly dividend to 70 cents a share from 65 cents a share. The dividend is payable to stockholders of record as of March 13, 1987.

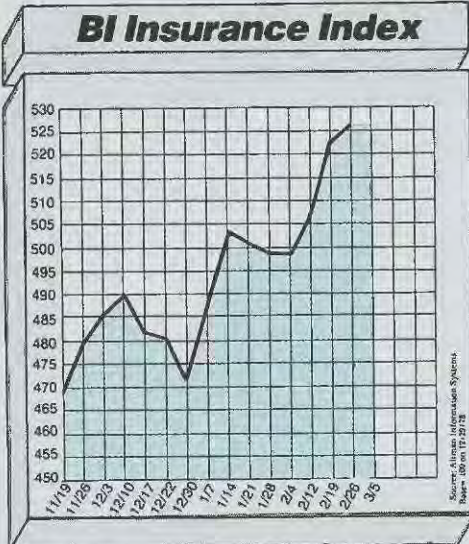
Combined International

Combined International Corp. reported 1986 operating income of \$184.2 million, up 14.4% from \$161.0 million in 1985.

Likewise, net income increased to \$247.2 up 35.9% from \$182.0 in 1985.

Net premiums written totaled \$1.3 billion up 26.8% from \$1.02 billion in 1985.

Combined International's insurance brokerage division, which includes Rollins Burdick Hunter Co., the nation's seventh-largest broker, reported revenues of \$170 million, up 20.1% from 1985. This division had an operating income in 1986 of \$25.8 million up 16.2% from 1985. Commission and fees at Rollins Burdick Hunter increased 20.3% for the year.



The Business Insurance stock index closed at 525.8 on March 5, up a slight one-tenth of a point from 525.7 on Feb. 26. Of the 63 insurance industry stocks included in the index, 28 posted gains, 30 declined and 5 remained unchanged. The largest advances were posted by: Business Men's Assurance Co. of America, up 7.8%; Tokio Marine & Fire Insurance Co., up 7.4%; W.R. Berkely Corp., up 7.0%; AVEMCO Corp., up 6.5%; American General Group, up 5.6%; General Reinsurance Corp., also up 5.6%; and Baldwin & Lyons, up 5.0%. Declining stocks for the period were led by: United Fire & Casualty Co., down 8.6%; Fremont General Corp., down 7.2%; Arthur J. Gallagher & Co., down 4.3%; Old Republic Insurance Co., down 4.1%; Frank B. Hall & Co. Inc., down 3.7%; NAC Re Corp., down 3.2%; and Zenith National Insurance Corp., also down 3.2%. The Business Insurance index climbed only 0.2% for the period, trailing the leading stock market indicators: The Dow Jones industrial average grew 2.7% for the week; the Standard & Poor's 500 average kept pace at 2.7%; and the New York Stock Exchange composite posted a 2.5% gain.



Mr. Wilson

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

British Issues

		1 Week				
March 3	Price	P/E	Div.	Yield	High-Low	
Companies	pence	pence	%	pence/pence	pence/pence	
Comml Union	340	19.4	18.3	5.4	349-340	
Genl Accident	1037	17.3	37.7	3.6	1037-977	
Gdn Royal Exch	957	15.7	46.5	4.9	957-927	
Royal	1050	11.1	42.2	4.0	1062-1012	
Sun Alliance	796	17.7	29.5	3.7	802-764	
Brokers						
CE Heath	438	12.5	34.5	7.8	443-438	
Hogg Robinson	375	13.9	16.2	4.3	383-375	
JH Minet	266	11.8	12.0	4.5	268-266	
Sedg Grp	325	14.8	16.9	5.2	336-318	
Stew Wrightson	498	12.6	19.0	3.8	502-498	
Willis Faber	440	16.9	15.5	3.5	445-439	

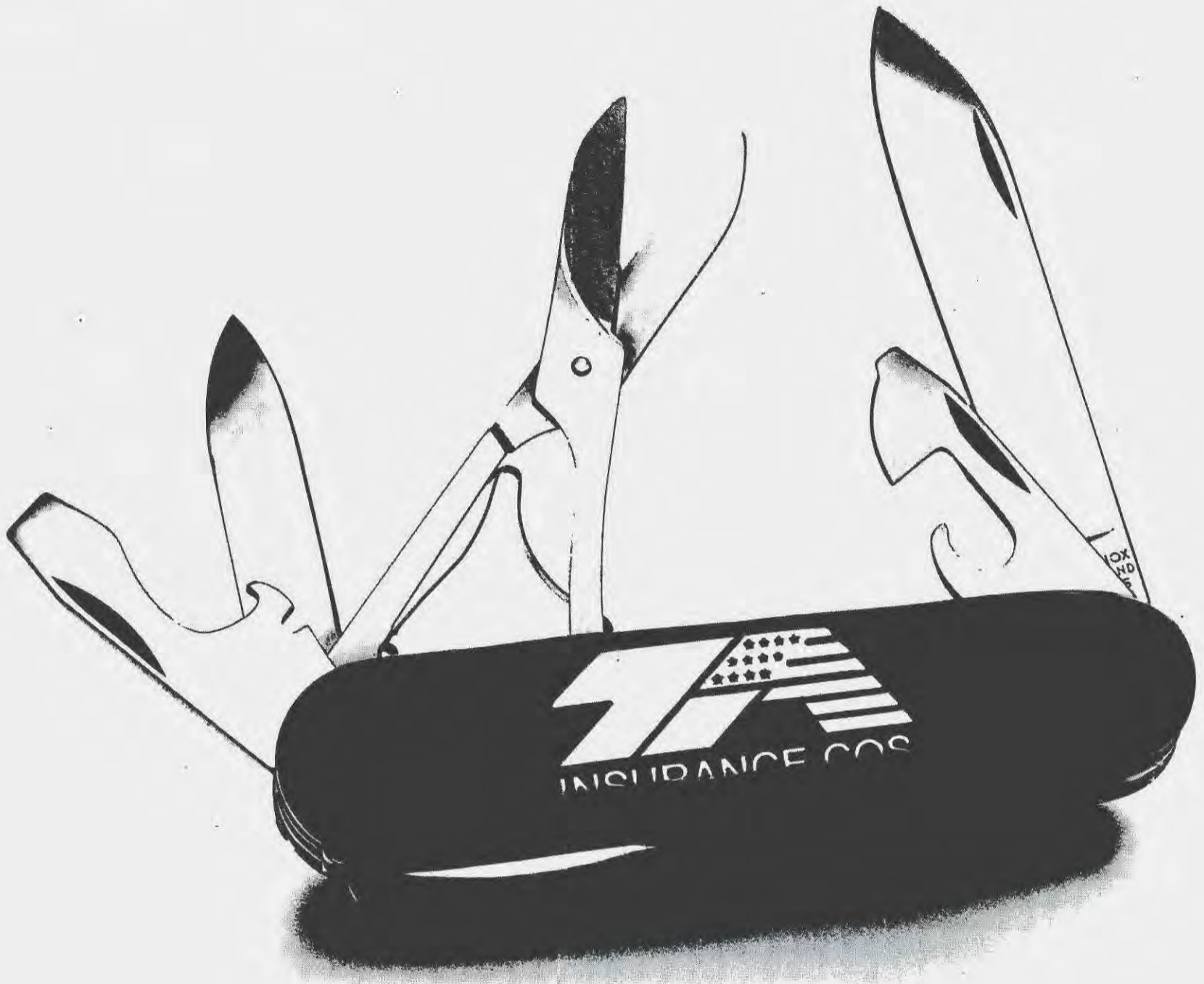
Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

BI Industry Stock Report

March 5, 1987 2/27/87 thru 3/5/87

Brokers	Price	% Chg.	P/E	\$ Div.	% Yld.	High	Low	Vol.(000)	
Alexander & Alexander Svcs	NYSE	27.50	-0.9	26.4	1.00	3.6	28.13	27.50	1,855.1
Baldwin & Lyons Inc	OTC	21.00	5.0	9.1	0.20	1.0	23.00	21.00	1.3
Corroon & Black Corp	NYSE	34.75	3.7	15.4	0.84	2.4	34.75	33.38	393.8
Gallagher Arthur J & Co	OTC	27.75	-4.3	19.8	0.40	1.4	28.00	27.75	343.8
Hall Frank B & Co Inc	NYSE	16.38	-3.7	0.0	0.00	0.0	17.00	16.38	109.0
Marsh & McLennan Cos Inc	NYSE	67.00	-2.7	20.3	1.90	2.8	69.00	66.75	823.1
Poe & Assoc Inc	OTC	13.25	1.9	16.8	0.40	3.0	13.25	13.00	5.8
AGENTS/BROKERS AVERAGE 17.2 2.5									
Conglomerates & Holding Cos.									
Anderson Clayton(Ranger/PanAm)	NYSE	65.63	0.0	18.8	0.00	0.0	0.00	0.00	0.0
Armco Inc	NYSE	8.13	-3.0	0.0	0.00	0.0	8.38	8.13	714.3
Berkley W R Corp	OTC	34.50	7.0	14.4	0.24	0.7	34.88	32.00	928.9
Berkshire Hathaway Inc Del	OTC	3340.00	0.1	193.7	0.00	0.0	3360.00	3060.00	2.0
CIGNA Corp	NYSE	66.50	1.1	10.5	2.80	4.2	66.50	65.75	1,138.1
CNA Finl Corp (CNA)	NYSE	60.88	-0.6	15.1	0.00	0.0	61.50	60.75	302.3
General Re Corp	NYSE	68.38	5.6	25.0	1.00	1.5	68.38	65.50	980.3
ITT (Hartford Group)	NYSE	65.25	5.7	18.5	1.00	1.5	65.25*	62.13	3,338.4
Sears Roebuck & Co, (Allstate)	NYSE	52.88	3.7	14.6	2.00	3.8	53.00	51.25	4,832.5
Transamerica Corp (Occidental)	NYSE	34.88	-0.7	9.8	1.76	5.0	35.38	34.88	893.2
CONGLOMERATES/HOLDING COS. AVERAGE 80.7 0.2									
Insurers									
Aetna Life & Cas Co	NYSE	67.50	0.2	10.9	2.76	4.1	67.75*	66.00	3,018.3
American General Corp	NYSE	44.75	5.6	12.4	1.25	2.8	44.75	43.00	1,654.3
Ameri Heritage Life Invnt Co	NYSE	43.00	0.6	14.9	1.32	3.1	43.13	42.75	1.9
American Indty Finl Corp	OTC	17.75	-1.4	0.0	1.12	6.3	18.00	17.50	15.6
American Intl Group Inc	NYSE	77.75	3.5	22.2	0.25	0.3	77.75	74.75	1,627.5
Aneco Reins Ltd	OTC	3.00	4.3	0.0	0.00	0.0	3.00	2.88	46.1
Avemco Corp	NYSE	40.88	6.5	18.1	0.50	1.2	40.88*	38.00	19.0
Business Mans Assurn Co Amer	OTC	31.25	7.8	0.0	1.10	3.5	32.00*	31.25	93.3
Chubb Corp	NYSE	72.13	3.8	12.8	1.68	2.3	72.50	70.13	869.0
Combined Intl Corp	NYSE	57.00	-1.5	10.3	2.24	3.9	58.38	57.00	373.7
Continental Corp	NYSE	52.75	1.4	14.6	2.60	4.9	53.63	52.13	740.2
Crown Life Ins Co	OTC	340.00	-1.4	11.7	6.40	1.9	345.00	340.00	0.0
Durham Corp	OTC	43.25	-0.6	14.5	1.36	3.1	43.50	43.00	16.0
Farmers Group Inc	OTC	49.00	-0.5	15.9	1.20	2.4	49.00	47.00	1,091.3
Fairmont Finl Inc	AMEX	18.50	-0.7	12.8	0.00	0.0	18.88	18.50	164.4
Fireman Fd Corp	NYSE	40.50	-0.6	17.2	0.40	1.0	40.50	40.00	539.8
Fremont Gen Corp	OTC	17.75	-7.2	0.0	0.48	2.7	18.75	17.50	492.4
Great West Life Assurn Co	OTC	700.00	0.0	14.4	18.00	2.6	700.00	700.00	0.0
Home Group Inc	AMEX	24.38	2.6	6.6	0.20	0.8	24.38	23.50	466.2
Hanover Ins Co	OTC	74.25	2.1	15.8	0.56	0.8	74.25*	72.75	8.3
Harleysville Group Inc	OTC	18.50	0.0	6.0	0.40	2.2	18.63	18.38	97.2
Hartford Steam Boiler Insptn	OTC	62.50	-1.2	14.6	1.50	2.6	62.75	61.00	99.4
Kans City Life Ins	OTC	28.50	-0.9	11.0	0.96	3.4	28.75	28.50	25.3
Kemper Corp	OTC	37.00	2.8	14.7	0.60	1.6	37.00*	34.75	611.9
Liberty Corp S C	NYSE	40.00	2.6	14.1	0.72	1.8	40.00	39.25	144.4
Lincoln Natl Corp Ind	NYSE	50.63	0.7	11.1	2.16	4.3	51.88	50.50	535.9
Mission Ins Group Inc	PAC	0.94	0.0	0.0	0.00	0.0	4.38	0.69	29.4
Monumental Corp	OTC	55.63	0.0	18.8	0.00	0.0	55.63	55.63	1.1
Nac Re Corp	OTC	30.00	-3.2	46.2	0.00	0.0	31.00	30.00	23.0
Nobel Ins Ltd	OTC	14.25	-17.4	10.7	0.37	2.6	14.50	13.88	738.0
Northwestern Natl Life Ins	OTC	29.25	-1.3	8.8	0.86	2.9	29.50	29.25	510.1
Old Rep Intl Corp	OTC	45.00	0.6	14.9	1.68	3.7	45.00	44.25	111.5
Orion Cap Corp	OTC	29.50	-4.1	12.3	0.78	2.6	30.88	29.50	178.9
Protective Corp	NYSE	28.00	1.4	0.0	0.76	2.7	28.13	27.63	185.5
Protective Corp	OTC	18.75	1.4	12.1	0.70	3.7	18.75	18.25	73.4
Provident Life & Acc Ins Co	OTC	28.13	-1.3	13.1	0.84	3.0	28.63	28.13	155.2
St Paul Cos Inc	OTC	53.50	0.5	15.5	1.76	3.3	53.50	52.50	1,419.1
SAFECO Corp	OTC	59.00	-2.1	12.2	1.70	2.9	60.50	58.75	367.1
Scor U S Corp	OTC	14.50	1.8	29.0	0.00	0.0	14.50*	14.25	298.0
Seibels Bruce Group Inc	OTC	17.50	1.4	0.0	0.80	4.6	17.50	17.00	15.0
Selective Ins Group Inc	OTC	24.00	-1.0	11.1	0.92	3.8	24.25	24.00	265.6
Statesman Group Inc	OTC	5.00	0.0	0.0	0.05	1.0	5.13	5.00	119.7
Tokio Marine & Fire Ins Co	OTC	73.00	0.0	82.0	0.17	0.2	73.00	73.00	25.1
Torchmark Corp	NYSE	32.63	-1.1	12.0	1.20	3.7	32.75	31.75	1,147.1
Travelers Corp	NYSE	51.38	-1.2	11.5	2.28	4.4	52.38	51.38	1,066.7
Trenwick Group Inc	OTC	17.00	-2.9	130.8	0.00	0.0	17.63	17.00	103.8
United Fire & Cas Co	OTC	29.25	-8.6	13.7	0.80	2.7	31.50	29.25	56.5
United States Fid & Gty Co	NYSE	46.25	-2.6	12.8	2.48	5.4	47.00	46.00	2,066.6
Unum Corp	NYSE	27.50	-0.9	11.0	0.40	1.5	27.75	27.50	1,540.3
USLife Corp	NYSE	41.75	-2.6	10.7	1.20	2.9	42.75	41.75	

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