

Business Insurance

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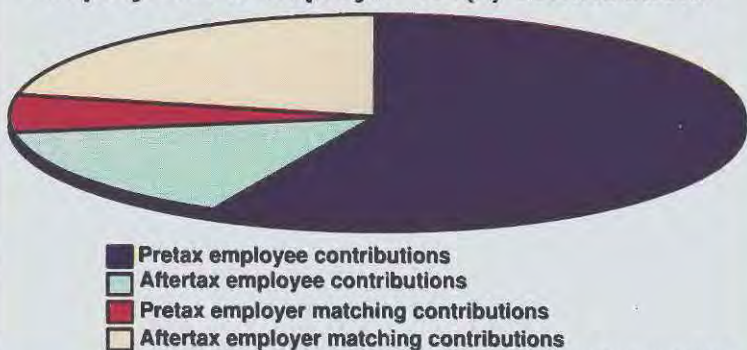
Louisiana regulator arrested, charged with insurer extortion

BATON ROUGE, La.—The Louisiana Insurance Department's chief examiner has been arrested on charges that he defamed Champion Insurance Co. after attempting to extort \$200 from the insurer on an auto claim involving his sons.

Max H. Moseley Jr., 47, chief of the department's financial solvency division, was arrested at his home May 12 and charged with extortion, defamation and malfeasance in office.

According to the arrest warrants, Mr. *Continued on next page*

Employee and employer 401(k) contributions



Source: General Accounting Office

Tallying 401(k) funds

Employees deferred \$5.1 billion on a pretax basis to 401(k) plans in 1986, says a General Accounting Office study (see story, page 3). These deferrals comprised 57.2% of the \$8.9 billion in overall 401(k) plan contributions that year. Employees also deferred \$1.4 billion on an aftertax basis, or 15.2% of all 401(k) contributions. Employer matching contributions on pretax deferrals totaled almost \$2 billion, or 21.9% of all contributions, while aftertax matching contributions totaled \$513 million, or 5.7% of the total.

Court allows state to prosecute exec for safety violations

By MARK A. HOFMANN

MADISON, Wis.—The U.S. Supreme Court probably will review whether the federal workplace safety agency can pre-empt a state's right to prosecute corporate officials for workplace safety violations.

A Wisconsin appellate court last month ruled that the state has the right to bring criminal charges stemming from employer actions regulated by the U.S. Occupational Safety and Health Administration.

However, that ruling contradicts a 1987 Illinois appellate decision that an employer cannot be prosecuted under state criminal law for subjecting employees to dangerous working conditions. Such charges, the court said, are pre-empted by the Occupational Safety and Health Act of 1970 (BI, July 6, 1987; Dec. 30, 1985).

The Illinois case is currently under review by the state Supreme Court.

"There's little doubt in my mind that this issue will eventually go to the Supreme Court of the United States," said Milwaukee County District Attorney E. Michael McCann, who supports the Wisconsin court's interpretation. "The precise issue—'Does OSHA pre-empt state statutes?'—has never been resolved," he said.

"With contradictory rulings, it makes the subject a particularly good candidate for Supreme Court review," agreed Robin Conrad, director of litigation for the National Chamber Litigation Center, the legal affiliate of the U.S. Chamber of Commerce in Washington, D.C.

The Chamber supports OSHA pre-emption of state law because it creates a uniform standard of conduct that works to the benefit of employers. The Chamber has filed briefs expressing this opinion with both the Illinois appellate and supreme courts.

OSHA itself has not taken a position on the question of pre-emption, said a spokesman for the safety agency in Washington.

The Wisconsin case, *Larry Norman Cornellier Sr. vs. Joseph J. Black, sheriff of Rock County, Wis.*, stemmed from a March 23, 1983, explosion at a fireworks factory in Milton, Wis., after an employee plugged a fan into

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Medicare bill may offer COBRA penalty relief

By JERRY GEISEL

WASHINGTON—Legislation that would expand the federal Medicare program also could provide employers with some long-awaited relief from COBRA's massive tax penalties.

In an 11th-hour move that has pleasantly stunned benefit lobbyists, House Democratic tax committee staff members are drafting new COBRA penalty provisions to be added to the Medicare legislation being hammered out by a House-Senate conference committee (BI, Aug. 17, 1987).

The staffers last week, in a hurried series of meetings, discussed some of the COBRA changes with insurers and other lobbyists.

Meanwhile, Washington observers say it is likely that the conferees will approve a proposal, strongly opposed by employers, that would force companies to pass on to retirees any health care savings reaped by the companies because of Medicare's expansion (see story, page 34).

The COBRA provisions now under consideration are based on a proposal stripped last year from a House-passed budget bill that would tie employer tax penalties to the length and severity of COBRA violations (BI, Dec. 14, 1987).

Generally, the revised penalty would be \$100 for each day a company failed to extend COBRA health care continuation coverage to a beneficiary. In some cases, penalties would be waived if a COBRA mistake were inadvertent and quickly corrected.

In certain limited circumstances, though, employers could face a minimum tax of \$3,000 per beneficiary.

Still, even a \$3,000 penalty would be a huge improvement over automatically stripping employers of annual tax deductions for health care expenses for a single COBRA violation—regardless of the severity and length of the violation—that companies face under

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Report rejects proposal that Outhwaite names sue

By CAROLYN ALDRED

LONDON—Members of a Lloyd's of London syndicate underwritten by Richard Outhwaite who face at least \$150 million in losses on runoff reinsurance policies would be unlikely to win a judgment against the syndicate's managers for breach of duty, a new report concludes.

However, the report prepared by the London law firm of Freshfields criticizes Mr. Outhwaite for writing so many runoff policies "without giving sufficient weight to the consequent aggregation of risk."

The report was commissioned by 102 Lloyd's members' agencies to investigate whether "a court or arbitration tribunal is likely to hold" that R.H.M. Outhwaite (Underwriting Agencies) Ltd. was "in breach of duty or in breach of contract" when Mr.

Outhwaite wrote unlimited liability runoff reinsurance policies for more than 30 Lloyd's syndicates and several insurance companies during late 1981 and 1982.

"Freshfields concludes that a substantial case against Outhwaite based on breach of duty could be made out in relation to the writing of (the runoff reinsurance policies), but they state that on the evidence and advice which they have... this cause of action would be unlikely to succeed," John Heynes, chairman of the Outhwaite Members' Agents' Steering Committee, said in a letter sent Thursday to members' agents.

Members of the Outhwaite syndicate have been examining how they can avoid paying the huge losses on the runoff policies (BI, Jan. 25).

Members of other loss-riddled syndicates have

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Louisiana official arrested

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Moseley threatened to cause Champion regulatory problems if it did not pay an additional \$200 for damages to a car occupied by his sons that was involved in a 1984 accident with a Champion-insured driver. Baton Rouge-based Champion had paid \$1,105.25 for damages to the car.

The malfeasance warrant charges that Mr. Moseley wrote to A.M. Best Co. on Aug. 7, 1987, saying that Champion provided false information to Best when he knew the information was correct. Best, which had assigned Champion an A rating, placed it on its watch list later that month, citing a pending regulatory review.

Mr. Moseley also allegedly provided false information about the value of Champion real estate and collateral loans to the chief examiner of the Alabama Insurance Department.

The defamation warrant accuses Mr. Moseley, who was promoted to chief examiner in December 1986, of "systematically and deliberately" injuring Champion.

Mr. Moseley—who was released May 13 in lieu of a \$10,000 bond—could not be reached for comment.

Douglas D. Green, who took over as Louisiana insurance commissioner in March, said in a statement that the department was notified of the charges against Mr. Moseley on April 25 and was investigating at the time of Mr. Moseley's arrest.

Meanwhile, Champion is pressing a \$55 million damage lawsuit against former Insurance Commissioner Sherman A. Bernard and the state of Louisiana in 19th Judicial District Court in East Baton Rouge parish. The suit charges the department with abuse of its regulatory powers.

Insurers fight N.Y. assessment

NEW YORK—Major insurance organizations and property/casualty insurers say they will sue for the return of \$87 million appropriated from the state's guaranty fund by New York State in 1982.

The move is prompted by a New York Insurance Department assessment that insurers now must pay because the fund has fallen below the required \$150 million minimum, in part because of the appropriation (BI, May 9).

August P. Alegi, vp and deputy general counsel for GEICO Corp. in Washington, D.C., said the suit also will seek the interest the \$87 million would have generated over the past six years and a declaration the appropriation was unconstitutional. The suit is expected to be filed in state Supreme Court, perhaps as early as this week.

Mr. Alegi said plaintiffs will include Geico; the Alliance of American Insurers; the National Assn. of Independent Insurers; an Allstate Insurance Group unit; Utica Mutual Insurance Co.; Lumbermens Mutual Casualty Co., which is a Kemper Corp. unit; and a unit of American International Group Inc.

Spokesmen for the NAII, AIG, Allstate, Kemper and Utica Mutual confirmed they were joining the suit. Officials at the Alliance, Allstate and Kemper could not be reached for comment.

In addition, Phillip Schwartz, vp-financial reporting and associate general counsel at the American Insurance Assn., said his organization plans to file its own suit that may be joined by others.

Mr. Schwartz said the AIA advises members to pay the assessments, which total about \$15 million a quarter, under protest.

Employee contribution ruling

WASHINGTON—Employers must transfer benefit contributions from employees into special trusts, the Labor Department says.

Under a final regulation the department published in the Federal Register May 17, employers no longer will be able to commingle funds contributed by employees, like pension plan contributions, with other assets. Employers must segregate those contributions and transfer them to a trust no later than 90 days after the funds are received by an employer.

Employers that fail to make such transfers in the prescribed time could be charged with engaging in a prohibited transaction under the Employee Retirement Income Security Act of 1974.

However, the rule—which is effective Aug. 15—fails to make clear whether pretax contributions, such as salary deferrals made by employees enrolled in flexible spending accounts to pay for uncovered benefit expenses, will have to be transferred to trusts.

The rule, among other things, is designed to keep employee contributions from creditors in the event of a bankruptcy.

OIL responsible for Shell claims

SAN BRUNO, Calif.—Bermuda-based captive Oil Insurance Ltd. is responsible for paying claims stemming from events that started before Shell Oil Co.'s policy began, a San Mateo County Superior Court judge ruled last week.

The decision is a victory for commercial insurers in Shell's \$1 billion coverage battle over pollution cleanup costs. Commercial insurers argue that OIL, which was not named in Shell's original lawsuit, should be held liable for cleanup costs (BI, April 25, 1985).

OIL attorneys had contended that the captive was created only to insure future events. Shell's OIL policy states: "An occurrence means an event or a continuous or repeated exposure to conditions which commence during the term of this policy."

But, in his preliminary ruling, Judge William Lanam said: "There is no requirement that the event (which causes damage) commenced during the term of the insurance."

"The court has just rewritten OIL's policy," OIL attorney Raoul Kennedy told the judge.

Mr. Kennedy, with the Oakland, Calif., firm of Crosby, Heasey, Roach & May, said he plans to appeal the ruling.

Shell's OIL policy provided \$100 million in coverage for each year from 1975 to 1980 for first-party property damage and third-party liability claims with a \$10 million per-occurrence deductible. Since then, limits have been increased to \$150 million per year.

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City to appeal ruling on retiree health costs

By MARK A. HOFMANN

CHICAGO—The city of Chicago will appeal a circuit court judge's dismissal of its suit to force four pension funds to reimburse the city for \$83 million in retiree health care costs the city claims it has illegally paid since 1980.

However, Cook County Circuit Court Judge Albert Green's May 16 ruling leaves unanswered a central question in the dispute between the city and the pension funds: Who should pay for about 30,000 retirees' and dependents' health care coverage?

"The decision didn't say who was responsible for paying the premiums," said a spokesman for City Corporation Counsel Judson D. Miner.

The spokesman added that the appeal has yet to be filed.

"The pension funds could well afford to share the cost with the taxpayers," said Chicago Comptroller Ronald Picur.

But an attorney that represents one of the pension funds called the judge's ruling "sound."

"I don't see any basis for appeal," said Martin J. Burns of the Chicago law firm Jacobs, Burns, Sugarman & Orlov, which represents the Chicago Fireman's Annuity & Benefit Fund.

Mike Cohen, secretary of the firefighter's fund, was more blunt: The city should drop the appeal or risk wasting the taxpayers' money, he said.

The decision stems from an October 1987 lawsuit the city filed against the pension funds after alleging that the city had been making illegal payments for retired city employees' health care claims since 1980.

The payments were illegal because they were made without specific authorization by the City Council, ac-

cording to Mr. Miner.

In addition, state law requires the city's employee pension funds to purchase health insurance for their retirees from commercial insurers, while the city is funding the claims under its self-insurance program.

The pension funds have filed countersuits seeking to have the retiree health care payments declared part of an "implied contract" between the funds and the city, which the funds consider to be acting as an insurer, said Mr. Cohen.

By ruling against the city, Judge Green "kept alive our case," Mr. Burns added.

According to Mr. Miner's office, since at least 1980 the city has subsidized the health care expenses of retirees covered by the Chicago Municipal Employees Annuity & Benefit Fund, the Chicago Policemen's Annuity & Benefit Fund and the Chicago Laborers' & Employees Annuity & Benefit Fund, in addition to the firefighters' pension fund.

Mr. Miner's spokesman added, however, that the City Council authorized appropriations for the retirees' health-care costs in 1984.

The allegedly illegal payments had been folded into the budget appropriation that pays for the cost of providing health care benefits to active employees.

"There were no clear statements that these payments were intended to cover the costs of annuitants' health coverage," said Mr. Picur.

However, the pension funds argue that the payments were neither illegal nor secret and that the city is simply playing politics with the retirees' benefits.

"The issue isn't between the city and pensioners. It's between taxpayers and the pension funds," said Mr. Miner's spokesman.

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Deadline for RMIS listings near

Business Insurance will publish its annual directory of risk management information system vendors in the July 18 issue, which will include a report on trends in risk management automation systems and analysis.

There is no charge to be listed in the directory, but companies wishing to be included must fill out and return a questionnaire provided by *Business Insurance*.

If your company produces and supplies software to corporate risk management personnel and you have not yet received a questionnaire, please request one by writing Christine Woolsey, Editorial Assistant, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611-2590; or by calling 312-649-5460.

The deadline for returning completed questionnaires to *Business Insurance* is June 13.

McLeod honored for MMRMA article

NEW YORK—*Business Insurance* New York Bureau Chief Douglas McLeod last week was awarded first place in the "Reporting on Controversy" category of the New York Business Press Editors' editorial competition.

Mr. McLeod won the award for a report on the finances and management of the Michigan Municipal Risk Management Authority. The article, "Godsend or Gamble? Critics Question Security of Municipal Program," was published in the Feb. 16, 1987, issue of *Business Insurance*.

The article on MMRMA reported concerns about the adequacy of the pool's loss reserves and its reinsurance program, the reliability of its loss statistics and the thoroughness of its underwriting practices. The article also pointed out that the pool operated under an exemption from state Insurance Bureau regulation and was required only to file an annual audited financial statement with the state Treasury Department.

Late last year, the MMRMA board of directors assumed greater control over the management of the pool, including creating a new position of executive director to oversee the service companies under contract with MMRMA.

And, earlier this year Michigan enacted legislation tightening regulation of self-insurance pools for government entities.

Mr. McLeod was one of seven first-place prize winners in the competition, which attracted 200 nominations.



Mr. McLeod

Inside

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✓ The controversial provision in trade legislation passed by Congress that would require employers to give 60 days' notice before a plant closing would not have a significant impact on risk management and benefit programs, most observers agree. **PAGE 13**

✓ In Perspectives, Joseph K. Hegedus, a partner with law firm Knapp, Petersen & Clarke, explains how a recent court ruling that a ceding insurer could not sue a reinsurer for bad faith raises several issues. **PAGE 21**

✓ Although nearly all employers offer mental health benefits, they often fall short of the level required by Sen. Kennedy's mandated health care benefit bill. **PAGE 23**

✓ A Bermuda panel is studying whether to adopt a British trial court ruling that limits the basis on which rein-

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401(k) plans hold \$70 billion in assets

By ALISON KITTRELL

401(k) salary reduction plans are fulfilling their role as retirement savings vehicles, according to a new government survey.

U.S. employees participating in 401(k) plans made average contributions of \$2,005 per employee in 1986, according to the survey conducted by the General Accounting Office for the Senate Special Committee on Aging.

About 79%—or \$1,584—of the average contribution was made on a pretax basis, the survey reports.

In addition, U.S. employers contributed about \$767 to each participating employee's 401(k) account, increasing overall 401(k) contributions to \$2,772 per participating employee in 1986, the survey shows.

Based on the findings of its survey of 4,995 employers, the GAO concluded that 3.2 million employees nationwide at 35,014 companies participated in 401(k) plans in 1986. Total employee contributions totaled \$6.4 billion in 1986, including \$5.1 billion—or 79%—in pretax contributions and \$1.3 billion in aftertax contributions.

Employers contributed about \$2.5 billion in matching contributions, increasing overall 401(k) plan contributions in 1986 to \$8.9 billion.

Assets totaling about \$70.4 billion were held in the 401(k) accounts of all participating U.S. employees at year-end 1986, or an average of \$13,500 per employee eligible to participate in a 401(k) plan and an average of \$21,900 for each employee actually participating in such a plan.

The survey was conducted by the GAO in response to the Senate committee's request for information on the actual use of 401(k) plans as retirement savings vehicles. The information collected was based on the 1986 plan year and does not reflect many of the sweeping 401(k) plan changes called for by the Tax Reform Act of 1986.

However, employers surveyed by the GAO do not expect the Tax Reform Act to have a huge impact on 401(k) plans (see story, page 31).

The GAO concluded that "401(k) plans seem to have succeeded in combining retirement savings incentives with flexibility goals for most participants."

Although the GAO "found some evidence that the benefits of 401(k) plans are somewhat more concentrated among higher-paid

than lower-paid workers, none of the evidence we have examined suggests that 401(k) plans are largely designed to provide tax subsidies for the savings and investment activities of the highly compensated."

The survey found that 4.4% of the nation's employers offered a 401(k) plan to employees.

The survey also showed that nearly all employers with 5,000 or more employees sponsored a 401(k) plan, as did slightly more than half of employers with 500 to 4,999 employees.

However, fewer than 10% of the firms with 50 to 99 workers offered a 401(k) plan, and a minuscule percentage of companies with fewer than 50 workers offered a 401(k) option.

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Rehabilitation plan approved for First New York Syndicate

By DOUGLAS McLEOD

NEW YORK—First New York Syndicate Corp., one of the largest syndicate insolvencies on the New York Insurance Exchange, will be rehabilitated under a plan approved by a state court judge last week.

The plan calls for eight of the syndicate's insurance company owners to contribute a total of \$29.4 million to First New York, which will then commute nearly all of its assumed reinsurance contracts.

Insurers that ceded business to First New York will receive about \$25.9 million through the commutations, which represents payment of roughly 70 cents per dollar of paid and outstanding losses, excluding incurred-but-not-reported losses.

If an estimate of IBNR losses is included, the commutations will represent recovery of about 25 cents on the dollar for First New York policyholders.

Additionally, the plan calls for liabilities from the syndi-

cate's relatively small volume of uncommuted business to be reinsured by six of First New York's shareholders.

The rehabilitation plan, which drew the support of hundreds of First New York policyholders, has required sacrifices by nearly everyone connected with the syndicate, including policyholders, shareholders, retrocessionaires and the exchange itself, said W. Lockwood Burt, executive vp of the syndicate and president of Burt Management Inc., First New York's manager.

"It has been a cooperative effort by everyone involved to come up with an equitable solution to a serious problem," Mr. Burt said. "I firmly believe that it was the right thing to do and everyone is better off."

Meanwhile, a similar commutation plan is being proposed for The Burt Syndicate Inc., another of the exchange's eight insolvent underwriting members.

The plan calls for commutation of roughly \$65 million in losses, including IBNR losses, for a total of \$16.3 million in

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Insurance Woman of the Year: College of Insurance's Lamel

By COLLIN NASH

NEW YORK—In recognition of her efforts to revitalize The College of Insurance, Linda Lamel will receive the Insurance Woman of the Year award from the Assn. of Professional Insurance Women.

When Ms. Lamel assumed her duties as president and chief executive officer of the college in 1983, the college was struggling to repay a \$19.2 million debt incurred for the construction of its new Manhattan facility (BI, June 8, 1987; May 4, 1987).

Now, nearing the end of her tenure, the 44-year-old Ms. Lamel is receiving credit from her colleagues for being "instrumental" in the college's refinancing plan, which included gifts and mortgage-backed financing from insurance industry concerns.

With the college on firmer financial ground, Ms. Lamel will leave the college on Aug. 1, more than two years after she originally intended to leave, to become corporate vp-insurance services at the Teachers Insur-

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Photo: Harvey Wang

Linda Lamel, the APIW's Insurance Woman of the Year, will soon leave The College of Insurance to become a vp at TIAA-CREF.

ELL risks abound in property sales

By MEG FLETCHER

NEW ORLEANS—Not only is "buyer beware" a watchword for risk managers concerned about pollution exposures in newly acquired property, but "seller beware" also can apply, an environmental consultant says.

"Many investors and financial institutions have found that in their rush to close a seemingly attractive real estate deal, they have become unwitting owners of a toxic waste site," said Kenneth P. Bechely, senior environmental consultant with Clayton Environmental Consultants Inc.

However, the sellers of the property also must be aware of any environmental problems because they

can be held liable for the cost of cleaning up toxic wastes long after they sell the property, he said.

Mr. Bechely, who is based in the Marietta, Ga., office of the Marsh & McLennan Inc. unit, spoke at one of the more than 60 sessions presented at last week's Public Risk & Insurance Management Assn. conference.

The conference, titled "The Next Decade... Risk Management Goes Marching On," drew a record 950 people to New Orleans to celebrate PRIMA's 10th anniversary.

To illustrate the risk of purchasing property, Mr. Bechely explained that an individual unknowingly purchased a golf course in Fullerton, Calif., in 1980 that was contaminated

with 200,000 tons of hazardous waste and soil. The site had been used for the disposal of acid sludge and drilling mud from nearby oil fields.

The new owner is now involved in massive litigation after federal officials ordered a cleanup at the site.

In other cases, the presence of hazardous material like polychlorinated biphenyls or asbestos has lowered property values, Mr. Bechely said.

For example, the Exxon Building located in New York's Rockefeller Center was recently purchased for \$610 million, about \$100 million less than predicted, at least partially because of the presence of asbestos in the building, he said.

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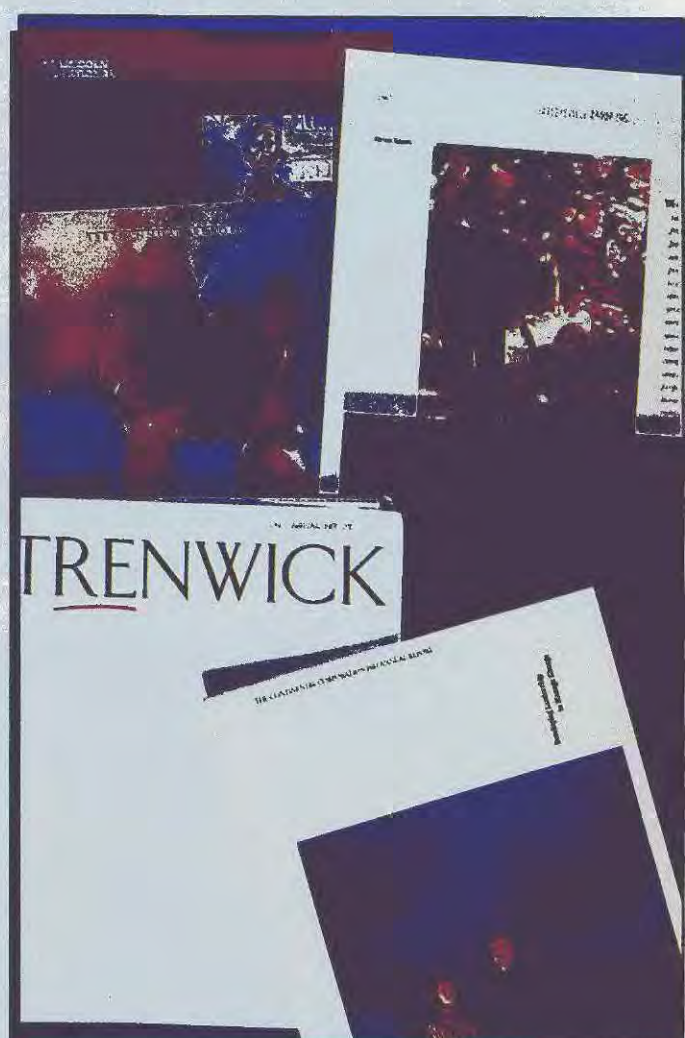


Photo: Mary Herlehy

Annual reports paint optimistic profit picture

By JAMES M. BURCKE

Increased competition in the commercial property/casualty insurance market should not drain insurers' earnings in 1988, most insurance company executives are telling shareholders.

Even though they concede that property/casualty rate cutting is intensifying, insurers are telling shareholders in recently released 1987 annual reports that there is not yet cause for alarm, especially if the industry acts responsibly during the soft market.

The insurers point out that the conditions that triggered the underwriting cataclysm of the early 1980s—including high interest rates, excess reinsurance capacity and little tax liability—are not factors in the current cycle.

"We are pleased with our 1987 property and casualty results. We are also mindful that we have entered a period of increased competition and uncertainty," said Saul P. Steinberg, chairman and chief executive officer of New York-based Reliance Group Holdings Inc., and Robert M. Steinberg, Reliance's president and chief operating officer, in their letter to Reliance shareholders.

"We are confident that we have the operating strategies and management team in place to build on our recent success and continue to outperform our competitors," they commented.

"Overall, we anticipate a robust general insurance market in 1988, although prices for some classes of risks will

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Marine insurers consider suing Iran, Iraq

By CAROLYN ALDRED

LONDON—Marine underwriters are considering whether to sue Iran and Iraq to recover massive shipping losses sustained during the seven-year war between the two Middle East nations, a London marine lawyer contends.

Donald O'May, a partner with the London law firm Ince & Co., has advised Lloyd's of London underwriter Richard Outhwaite that underwriters may be able to sue Iran and Iraq in U.S. courts for damages caused by attacks on ships in the Persian Gulf based on a recent ruling by the New York Court of Appeals.

A spokesman for R.H.M. Outhwaite (Underwriting Agencies) Ltd. said that Mr. Outhwaite is "seriously considering" such legal

'The total number of casualties and the quantum of losses suffered by neutral shipowners and their war risk underwriters is very substantial. This has prompted consideration of legal remedies for recovery of the large losses,' Mr. O'May says.

action if sufficient support is shown by other underwriters in the London marine insurance market.

"The total number of casualties and the quantum of losses suffered by neutral shipowners and their war risk underwriters is very substantial. This has prompted consideration of legal remedies for recovery of the large losses involved," Mr. O'May said at a London marine seminar this

month, which was co-sponsored by Tulane University in New Orleans and the University of Southampton in the United Kingdom.

The Iran-Iraq War has cost marine insurers more than \$1 billion in hull and cargo losses (BI, Oct. 5, 1987).

The New York appellate decision that prompted Mr. O'May to consider filing litigation against Iran and Iraq dealt with a neutral ship

that was destroyed during the Falklands War between Argentina and the United Kingdom.

The Liberian-registered ship, the Hercules, was chartered to a U.S. oil company when it was hit on June 8, 1982, by Argentinian bombs while sailing outside the exclusion zones declared by Argentina and the United Kingdom, said Mr. O'May.

The Hercules' owner and the U.S. company that chartered it sued the Argentinian government in a New York state court after the Argentinians refused to pay damages of about \$12 million for the hull and fuel on board, he noted.

"The (New York) Court of Appeals held that an action could be brought against a foreign state where there was a violation of international law. The court also held that there were sufficient contracts

with the U.S. to establish jurisdiction against Argentina," Mr. O'May told seminar attendees.

The lawsuit was filed under the U.S. Alien Tort Act, a statute enacted in 1789 that provides jurisdiction in any civil action by an alien for a tort "committed in violation of the law of nations or a treaty of the United States," said Mr. O'May.

That decision is currently being appealed to the U.S. Supreme Court and is due to be heard later this year, said Mr. O'May.

Mr. Outhwaite currently is "mulling the idea of the London marine market getting together" to file suit against Iran and Iraq, said a spokesman for the Outhwaite agency. However, he added the chance of recovering any money from either nation is remote.

Other marine underwriters noted that it would be very difficult to obtain any compensation even with successful litigation.

"Even if you won a case, there would be little chance of ever getting the money," said a spokesman for the Hellenic Mutual War Risks Assn. (Bermuda) Ltd., which writes war risk insurance for most Greek-owned vessels.

The association has already received separate legal advice on the possibility of suing both countries.

"There is a degree of optimism regarding possible litigation in the U.S. It all depends on the Supreme Court decision," said the Hellenic Mutual spokesman.

Other marine underwriters dismiss the idea as fanciful.

"I think Mr. Outhwaite's got a touch of the sun. Filing such litigation in the U.S. would cost a fortune," said one leading war risk underwriter who asked not to be named.

At least 524 vessels have been destroyed or damaged in the Persian Gulf since May 1981, and another 93 currently are trapped in various areas of the gulf because of fighting in the area, according to Lloyd's of London Casualty Reporting Officer Roger Lowes.

Furthermore, attacks on commercial shipping in the Persian Gulf have escalated in the past 10 days, resulting in losses totaling tens of millions of dollars.

On May 14, four tankers were struck by Iraqi gunfire aimed at Iran's Larak Island Oil terminal, including the Seawise Giant, reportedly the world's largest tanker.

At least two, the Barcelona and the Seawise Giant, are total losses, according to Lloyd's Mr. Lowes. In addition, a third ship, the Argosy, is feared to be a total loss after extensive damage, he said.

The loss of the Seawise Giant and the Barcelona will cost Lloyd's of London underwriters at least \$55 million, sources said.

However, the recent spate of attacks is unlikely to have any effect on marine hull rates for vessels sailing in the Persian Gulf, underwriters and brokers note.

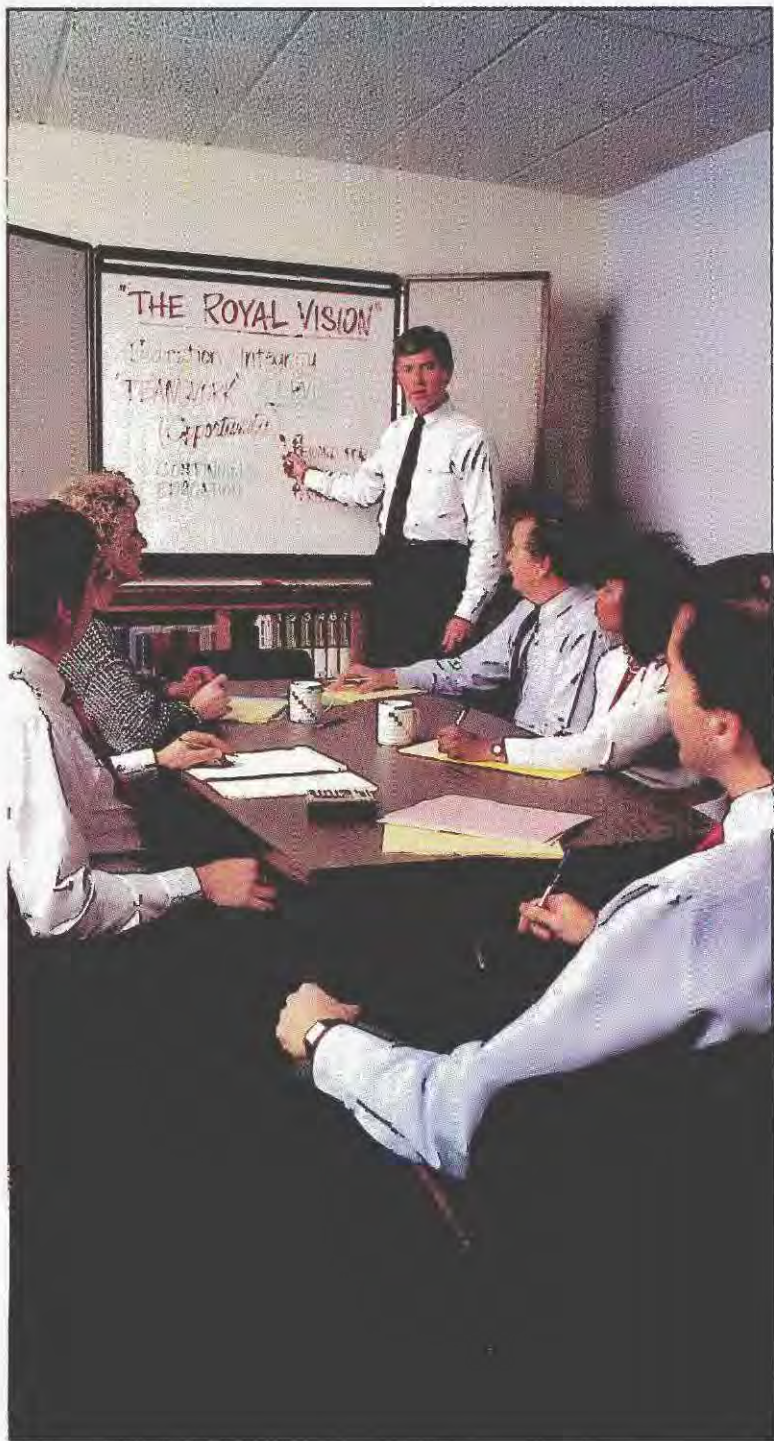
"Nothing would have any effect on rates at the moment, the market is so competitive," said one leading Lloyd's underwriter.

"There is tremendous capacity at Lloyd's at the moment. For every major player that moves out of the market, several minor players step in," said the spokesman for Hellenic Mutual.

"No underwriter will raise rates for fear of losing his market share. Underwriters are relying on their reinsurance and not until that is burnt out do they feel the loss," said a leading marine underwriter in the London company market.

"There is no will to do anything even with uneconomic rates. There is no leadership in the market and underwriters just need to fill capacity," he added.

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Flex plan unveiled following acquisitions

More than 9,000 employees of Quantum Chemical Corp. are participating in a new flexible benefits plan implemented April 1.

New York-based Quantum, formerly known as National Distillers & Chemical Corp., established the flex program in an effort to consolidate recently acquired operations.

Quantum had divested its wine and liquor production operations and made acquisitions in the chemical industry. Quantum also is involved in the manufacture of plastics and liquid petroleum

Benefit beat

gases.

The plan was introduced after a yearlong effort to design a benefit package comparable to or better than previous programs, said Wes Clarke, Quantum's vp of human resources.

Under the new flexible benefits program, Quantum provides each employee with a monthly credit of \$180, plus 0.75% of annual pay, to

be applied toward the premium of three major medical plan options.

Each medical option pays 80% of health care costs after an annual deductible is met:

- Option 1 has an annual deductible of 1% of annual pay with a minimum of \$200 and a maximum of \$900.

Copayments under this option are capped on a sliding scale de-

pending on salary, with the maximum annual copayment ranging from \$400 to \$1,800. The employee pays no premium for single coverage and \$198 for family coverage.

- Option 2 has an annual deductible of 0.5% of pay with a minimum of \$100 and a maximum of \$450. Copayments are capped at \$200. The employee pays \$120 for single coverage and \$574 for family.

- Option 3 has the same deductible and copayment as Option 2 for certain services, like doctor visits.

However, unlike the first two options, Option 3 provides full coverage of many services—including hospitalization, surgical procedures and lab fees—with no deductible.

The premium is \$464 for single coverage and \$1,650 for family.

All three plans are underwritten by Aetna Life & Casualty Co. of Hartford, Conn.

Employees can use excess credits not spent on major medical premiums to purchase life, dental and prescription drug coverage, all of which are underwritten by Aetna.

After an employee uses the credit allotment, he may purchase additional coverage with his or her own money, Mr. Clarke said.

The change from standard deductibles to pay-related deductibles was not a controversial issue with employees because the amounts generally compared favorably with the previous deductibles, Mr. Clarke said.

The flex program was designed last year after Hewitt Associates of Lincolnshire, Ill., conducted a study of benefit programs in comparable companies, Mr. Clarke said.

Psych cost control

A cost control program introduced last year for GTE Corp.'s Los Angeles operations has dramatically cut the amount paid for employee psychiatric care claims.

Although utilization of mental health services increased during 1987, inpatient mental health costs declined. For example, GTE's Los Angeles workforce of 15,000 had 15% more hospital admissions and the number of total claimants increased by 44% in 1987.

However, the number of hospital bed days declined 25%, costs per inpatient case fell 30% and average length of stay dropped 41%.

PsychCare, a cost control product offered by Preferred Health Care Ltd. of Wilton, Conn., was credited with saving \$3.6 million, or about 26% of the \$13.8 million the company had projected to pay for mental health care in 1987.

Bruce Taylor, GTE's manager of employee insurance in Stamford, Conn., reported the results during a recent conference of the Business Coalition on Health in Cromwell, Conn., but declined telephone requests for further comment.

GTE's mental health care costs had increased 25% to 30% annually prior to cost containment efforts, said Rick Lee, senior vp of marketing for Preferred Health Care. If unchecked, the costs of mental health care at the phone company's Los Angeles operations could have exceeded its medical costs by the year 2000, he said.

The PsychCare program consists of several components:

- Pre-admission review by telephone. A 24-hour telephone service provides the screening process.

- Directing employees to preferred providers after the initial assessment.

- Negotiating all-inclusive institutional costs on a per-diem basis with providers.

However, negotiated discounts were only a small factor in the savings recorded by GTE because the contracts were not signed until late last year, Mr. Lee said. That means GTE should save even more in the future, he said.

The PsychCare program will be introduced next month for about 10,000 employees in GTE's Tampa, Fla., operations. Other GTE divisions may be added later, he said.

Made any benefit changes? Write Glenn Huntley, Business Insurance, 6404 Wilshire Blvd., Los Angeles, Calif. 90048; 213-651-3710.



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Opinions

Guaranty fund was robbed

PROPERTY/CASUALTY insurers licensed in New York—and their policyholders and shareholders—have every right to be fighting mad over the state's intention to begin assessing these insurers to replenish the state's guaranty fund.

The Property/Casualty Insurance Security Fund is short of cash not only because of the rash of insolvencies in recent years but also because the state in 1982 appropriated \$87 million from the then-flush coffers of the country's only pre-assessment guaranty fund.

The state, strapped for cash, couldn't resist dipping into the \$217 million sitting in the guaranty fund.

Insurers fought the 1982 appropriation, but they lost in court. The state Court of Appeals, New York's highest court, ruled that the state did not have to return the money because at the time insurers could only speculate that they would be called upon to contribute additional funds in the future due to this appropriation.

It's no longer mere speculation, with the state announcing that a quarterly assessment of about \$15 million was due May 15. And, the state expects to make additional quarterly assessments through the end of the year to replenish the fund, which had fallen to only \$41 million in cash plus a worthless IOU for \$87 million (BI, May 9).

The IOU is worthless because the state is not required to pay it back under its law permitting the appropriation. And, Gov. Mario Cuomo is not interested in volunteering to pay back money appropriated by the prior administration of Gov. Hugh Carey.

Furthermore, the fund has been denied the investment income that would have been earned on that \$87 million if it had not been appropriated. Conservatively estimating the potential investment income based on the return on three-month Treasury bills, the fund would have generated an additional \$48 million.

Therefore, without the appropriation and the loss of investment income, the fund would not be forced to make assessments now. It would have about \$176 million on hand.

The issue has been dormant for six years because the guaranty fund was permitted to count the worthless \$87 million IOU toward the minimum \$150 million it is required to maintain. Now, after paying tens of millions of dollars in claims to poli-



cyholders of insolvent insurers, assets in the fund—even when the \$87 million IOU is included—have dropped below the minimum required by the state. So, the fund must assess insurers.

Policyholders of mutual insurers will have to pay these assessments through higher premiums. Policyholders and shareholders of stock companies both will have to pay.

We encourage insurance companies and their trade associations to fight these assessments in court again, which they say they will do. Since the insurers no longer can be accused of only speculating, maybe they can win back the \$87 million, the interest those funds would have accrued and maybe even a declaration that such appropriations are unconstitutional.

While pre-assessment guaranty funds are advocated by some insurers as the best means of smoothing the cost of guaranty funds over the years, New York's 1982 appropriation—and the resulting assessments—now stand as strong arguments against guaranty funds building up cash reserves.

It makes no sense for insurers to pay today for tomorrow's guaranty fund losses when some of their payments can be siphoned off by a cash-hungry state to pay other bills, leaving the insurers subject to additional assessments and, thus, larger guaranty fund costs.

Letters

Cost containment savings are still possible

To the editor: As a health care executive as well as medical plan administrator, I believe that cost containment programs have worked, despite what several speakers said during the recent Risk & Insurance Management Society conference (BI, April 25).

Since 1983, there has been a drastic change in the attitude of health care executives, managers and employees. Every hospital that I have come in contact with has worked diligently to hold the line on costs and I believe most have succeeded. Cost containment measures are responsible for this change in attitude. There is a long way to go in reducing cost, but I believe it can and will be accomplished. If this is true, why is the cost of health care continuing to rise? The reason is very complex but can be stated in simple terms.

Since 1983, the government, through diagnostic related groups and Medicaid, has embarked on a program of massive cost shifting of this nation's elderly and indigent health care bill. The health care and insurance industry have, in effect, been used as the intermediary in passing these costs to

American businesses. Every corporation has been taxed to provide a promise that the government has been unable to keep. This is why cost containment measures appear not to be working.

If you subtract Medicare and Medicaid pass-throughs, I would suspect that overall medical costs for businesses have actually declined. As in any business, someone has to pay the bill. When some of your customers refuse to pay those that do pay, pay more. In the case of health care, it has been American businesses.

Robert A. Rotar
Vp-Human Resources
Southern Medical Health Systems Inc.
Mobile, Ala.

To the editor: I agree with David L. Rosenbaum's statement that "we were given outrageous promises as to what so-called cost containment programs could do for us" in regard to potential savings (BI, April 25).

But, I strongly disagree with his comment that utilization management is the last-ditch effort of the private sector to control

health care costs.

Also, he states that most of us are going to throw up our hands and tell the government to control the cost. I do not think that there are many employers that are prepared to do this, as they know full well that costs will really go out of control when the government takes over.

Utilization review, pre-certification and length-of-stay review, combined with employers and insurance companies auditing providers' charges, are integral parts of the total cost containment program. However, if you want real cost containment, I think it is imperative that employers increase deductibles and coinsurance limits to the point that employees are directly involved. Once the employees feel the money coming out of their pocket, I assure you there will be point-of-service audits.

Management has to change its way of thinking. Current deductibles of \$200 or \$250 are about double what we had 30 years ago, and these levels are simply too low.

Howard A. Holman Jr.
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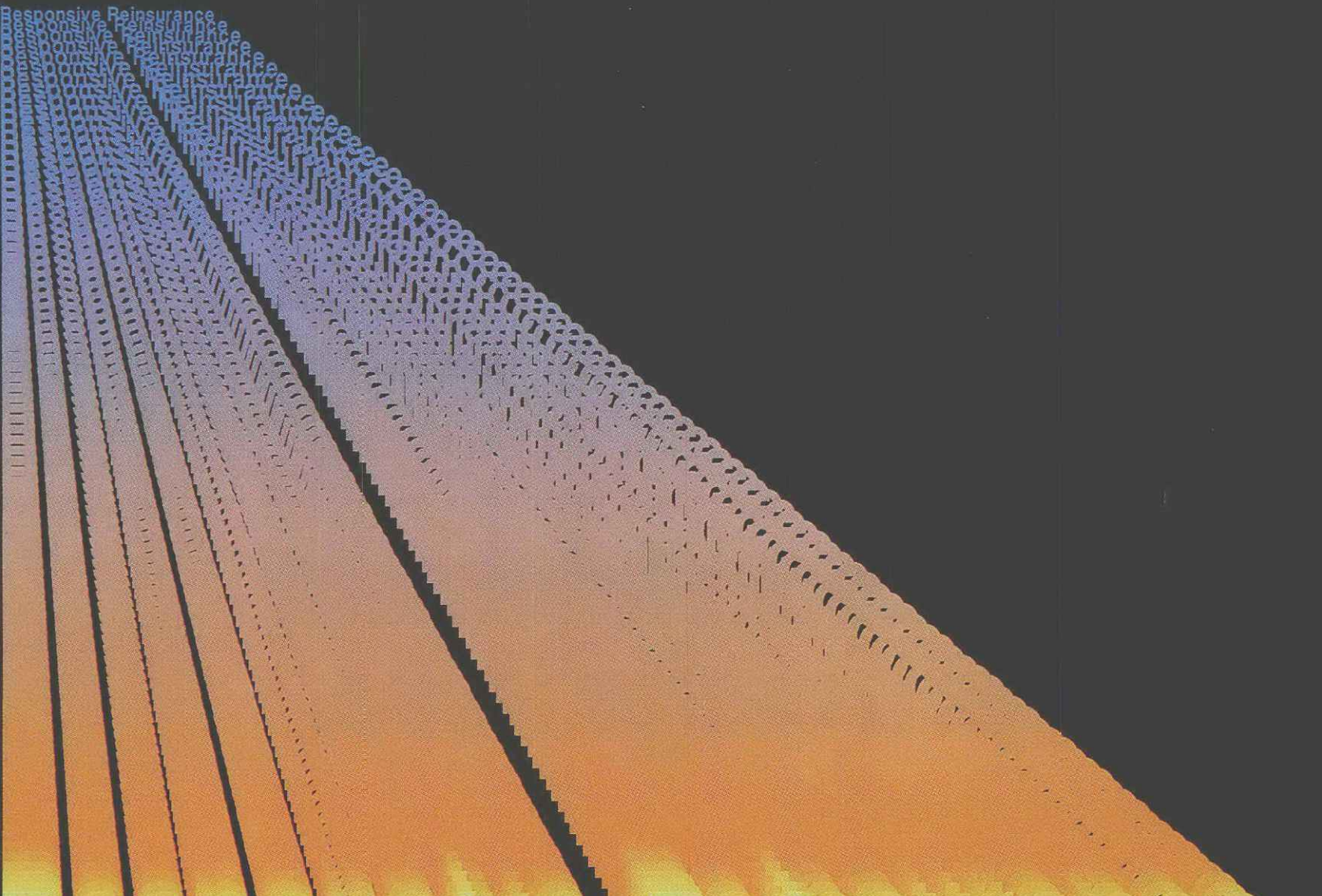
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Annual reports

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be less than desirable," said Maurice R. Greenberg, president and chief executive officer of American International Group Inc. in New York in his letter to AIG shareholders.

"Our policy is clear: We will remain a market in those classes where prices can be maintained at adequate levels and we will withdraw where they cannot," Mr. Greenberg said.

Like AIG, Sentry Insurance Co. in Stevens Point, Wis., vows that it will hold the line in the face of increasing competition.

"Sentry will not compete with unrealistic prices or inadequate underwriting," commented Chairman and Chief Executive Officer Larry C. Ballard in his message to the mutual insurer's policyholders.

Insurer executives generally predict in their companies' annual reports that competition will not be-

"We are managing our operations as if the present cycle will be as severe as the industry downturn of the early 1980s. However, there are signs it won't be," Dean W. Case and David C. Woodward say in Reliance Group Holdings' report.

come as heated in 1988 as it did during the soft property/casualty market of the early 1980s.

"The fear of many in our industry is that companies will return to the same level of cutthroat competition that existed during the last soft market. We do not think that will happen," commented Jack Mosely, chairman and president of USF&G Corp. in Baltimore, and Paul J. Scheel, president and chief operating officer of United States Fidelity & Guaranty Corp., USF&G's main operating unit.

"Some of the factors that existed the last time the market softened,

such as record high interest rates, excess capacity and cheap reinsurance, are not around this time as the market continues to change. We believe that the cycle will become closer to the historical norm in the future," Messrs. Mosely and Scheel said.

"We are managing our operations as if the present cycle will be as severe as the industry downturn of the early 1980s. However, there are signs it won't be," explained Dean W. Case, president of General Casualty Cos., and David C. Woodward, president of Reliance Insurance Co. and United Pacific

Insurance Co., in Reliance Group Holdings' annual report.

"Interest rates are not at the high levels that once encouraged insurers to write business below cost on the expectation of earning high returns on the invested premiums," they explained. "In addition, primary insurers are retaining more risk because reinsurance has been in shorter supply."

"Changes in the tax laws should also temper price competition because the industry's tax flow and surplus will be adversely affected in 1988 and beyond," Messrs. Case and Woodward said. "And, of course, the October 1987 stock market crash is a vivid reminder that industry surplus can swiftly be depleted by falling stock prices."

Marshall Manley, president and chief operating officer of The Home Group Inc. in New York, doesn't see a return to the cutthroat competition of the early 1980s "because the factors relating

to that scenario don't exist today and are unlikely to appear anytime soon. Low interest rates discourage cash-flow underwriting, higher net retentions mean primary companies have a lot more at stake, the Tax Reform Act of 1986 will increase pressure on cash flow and a limited amount of quality reinsurance will be available at reasonable prices."

However, some insurance company executives are warning that their companies face challenges in 1988, both from property/casualty and from group health insurance operations.

"Earnings will be constrained by increasingly competitive P&C pricing; accelerating medical care cost inflation; losses in our prepaid health care network, including our expansion costs; and lower 'fresh start' tax benefits," pointed out Robert D. Kilpatrick, chairman and chief executive officer of CIGNA Corp. in Philadelphia.

"There also are a number of legislative and regulatory issues at both the federal and the state levels about which we need to be concerned," he continued. "Examples include increased taxation in response to an unacceptably high federal budget deficit, mandated health benefits and limitations regarding AIDS testing."

And, while Lincoln National Corp. President and Chief Executive Officer Ian M. Rolland commented that "property/casualty will continue to produce favorable earnings, the other key determinant of our earnings growth—group health—is more difficult to predict."

However Mr. Rolland added that he believes "pricing and underwriting" actions taken by the Fort Wayne, Ind.-based insurer will "improve results in our traditional indemnity business in 1988."

Many executives used corporate annual reports to specifically point out the impact the new tax law will have on property/casualty insurers.

"The Tax Reform Act of 1986, as we also commented last year (BI, April 27, 1987), has significantly increased the tax liability of the insurance industry," AIG's Mr. Greenberg noted. "It is clear that the industry will be a bigger taxpayer in 1988 than was originally thought. The outcome will adversely affect the industry's statutory surplus and its ability to underwrite new risks. It appears that few insurers have adjusted prices to compensate for this burden."

"When the Tax Reform Act of 1986 was enacted, it was estimated that the property/casualty insurance industry would pay an additional \$7.5 billion in taxes over the succeeding five-year period," said USF&G's Messrs. Mosely and Scheel.

"Revised estimates indicate that the industry's additional tax burden over that same time frame will be in the \$12 billion to \$15 billion range—twice what was thought to be our fair share," they said.

"Insurers, faced with a larger tax burden, should become more conservative in their pricing strategies. While the new tax law is very complex, it is clear the industry cannot afford to reduce rates and continue to maintain its current level of profitability," pointed out Bradford W. Mitchell, chairman and president of Harleysville Group Inc. in Harleysville, Pa.

And, other companies are telling shareholders they have embarked on cost control efforts in an attempt to buoy profits in an increasingly competitive environment.

"Our biggest and most important challenge is to drive expenses down to the industry average or better by 1990. Sentry will continue to consolidate all functions except sales, field claims and new business underwriting, where we

Continued on page 12

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1987 annual reports

Continued from page 10

need to be close to our customers," said Mr. Ballard.

In commenting on CIGNA's cost management activities, Mr. Kilpatrick noted: "Our initial step was to complete an exhaustive review of the cost structure of all operations, which identified opportunities to significantly reduce expense growth. We acted on many of these opportunities during the year and will be pursuing others during 1988 and beyond as a critical management priority."

Meanwhile, publicly owned reinsurers generally predict that reinsurance market conditions also will become more competitive in 1988.

However, like primary insurers, the reinsurers are assuring shareholders that earnings should not dip substantially this year.

"Looking ahead, 1988 promises to be a more difficult year for the reinsurance industry, with a softer insurance market developing earlier than expected," points out the annual report of Greenwich, Conn.-based NAC Re Corp. However, the report continues, "we believe that NAC Re is well-prepared to weather the more difficult times ahead."

Gerald L. Radke, president and chief executive officer of New York-based Phoenix Re Corp., said that despite "disturbing trends, we believe present rate

'1988 promises to be a more difficult year for the reinsurance industry, with a softer insurance market developing earlier than expected,' says NAC Re Corp.'s annual report.

levels allow a reasonable return in 1988."

Among the "disturbing trends" noted by Mr. Radke were competition in the primary market, which reduced earnings from Phoenix Re's pro rata account, and losses from the windstorm that ripped through Western Europe in October, which underwriters have labeled the largest insured loss on record (*BI*, May 9).

"Commercial insurance rates have been declining since their all-time highs in 1986," warned James F. Billett Jr., chairman and chief executive officer of Trenwick Group Inc. in Westport, Conn.

"Reinsurance rates appear to be holding up, but, as these rates are generally a function of the underlying insurance rates, there is at least an implicit decline occurring in reinsurance rates. We believe reinsurance rates will continue to decline, both implicitly and explicitly, in the foreseeable future." ■

Chicago retirees

Continued from page 2

Meanwhile, the city and the funds are still negotiating who should pay how much of the retirees' health care expenses.

Because the city did not budget for retiree health care claims during fiscal 1988, the City Council's Budget Committee appropriated \$3 million from its active employees' benefit fund to cover retiree health care costs. However, the special funding runs out May 31.

Roughly 16,000 retirees, as well as 14,000-15,000 dependents, are covered under the pension funds' health programs, said Mr. Picur. If its appeal fails, the city may have to increase property taxes by about \$22 million to pay retiree health care expenses, based on projected 1988 claims of \$32 million to \$35 million and a \$10 million contribution from the pension funds, said Mr. Picur.

In comparison, the city paid \$19

million for retiree health care claims last year and just \$2 million in 1980—the year in which the subsidies started.

Individual retired police officers and firefighters currently make no contributions to their health care coverage, while those with dependents pay varying amounts, said Mr. Picur.

For example, a retired firefighter under age 65 would pay \$55 a month to cover himself and one dependent, or \$95 per month for family coverage. A retiree over age 65 who is eligible for Medicare and opts for family coverage pays a maximum of \$129 per month.

There was nothing unusual about retired public employees not having to pay premiums, said Mr. Cohen. Most of the larger private firms in the Chicago area pay retiree health care costs, he said.

Mr. Cohen also said that the city could have sought to increase the health care premiums paid by retirees over a period of time, but did not do so. However, Mr. Picur said the city tried to increase retiree contributions in 1984, but the plan died after the administration and

Chicago tried to increase retiree contributions in 1984, but the plan died after a deluge of protests.

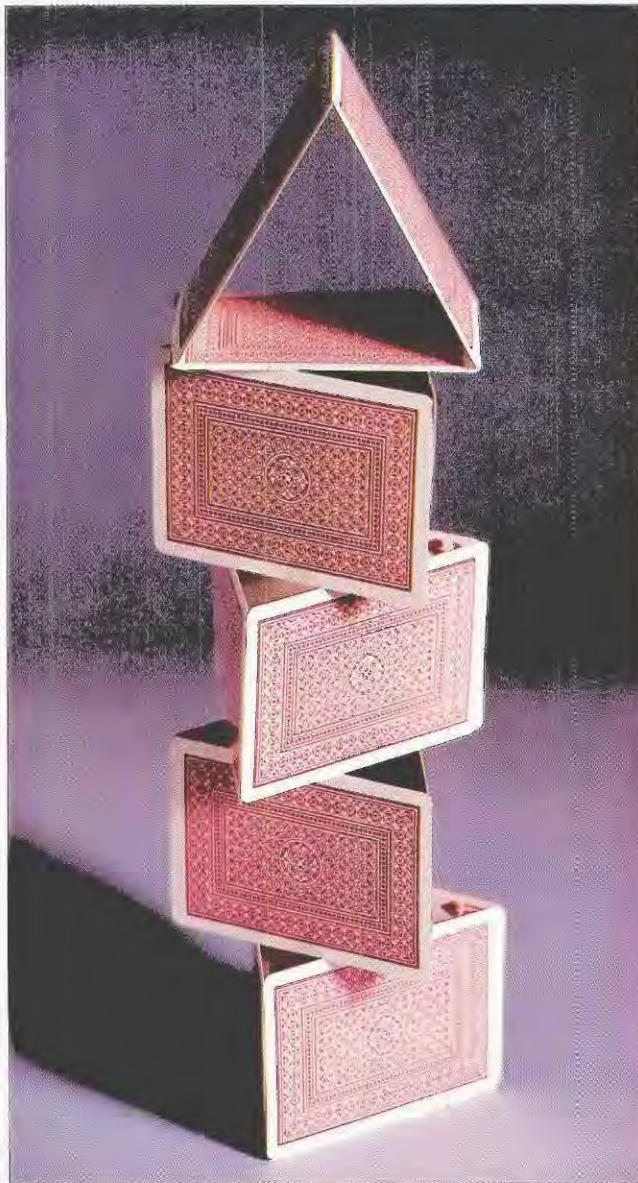
aldermen were "deluged" with protest letters from retirees.

Still, the city "believes there are substantial savings" possible and is examining ways to hold down health care costs for its active employees, including setting up a preferred provider organization, Mr. Picur said.

"We are proposing that once a PPO program is approved by all the unions, we'd move annuitants into that program," he said.

But that will be difficult, he added, because only about 6,000 of the 16,000 retired city employees covered by the pension funds still live in Chicago, with another 2,000 or so in the Chicago metropolitan area.

This is not the first time the city and its retirees' pension funds have been at loggerheads. Earlier in the decade, the pension funds sued the city, charging that Chicago had earned millions of dollars in interest by making late payments into the pension funds. The city was told to pay approximately \$25 million to the pension funds to make up for interest lost by the funds during the delays. ■



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Trade bill provision not worrying employers

By JUDY GREENWALD

The controversial provision in trade legislation passed by Congress that would require employers to give 60 days' notice before a plant closing would not have a significant impact on corporate risk management and employee benefit programs, most observers agree.

"My initial reaction is that I can't get very, very excited about it," said Donald J. Sullivan, director of risk management at Baxter Travenol Laboratories Inc. in Deerfield, Ill. "We don't think it would be a major change for us."

"I don't see it as being a major issue," agreed Tom Dimmick, manager of human resources and personnel at Samsung International Inc. in Ledgewood, N.J.

But, some observers point out that if Congress overrides an anticipated presidential veto and the 60-day notice provision becomes law, it could increase workers compensation and health care claims frequency.

And while most observers say it is not inconceivable the 60-day notice could cause disgruntled workers to damage company property and tamper with the company's products, few cite it as a serious cause of concern.

President Reagan has vowed to veto the trade legislation, which was on his desk last week, because he objects to the 60-day notice provision. The provision, which applies to employers with 100 or more employees, generally states that personnel must be informed in writing at least 60 days in advance of a plant closing or a layoff lasting 30 days or more.

Employers that violate the law would be required to give employees back pay for the length of the violation.

However, companies usually give that much advance notice of a plant closing, pointed out Joseph H. Albert, president of J.H. Albert International Insurance Advisors Inc., a risk management consultant in Needham, Mass.

"To me, it's kind of a moot point," he said. "To my view, I don't see it doing anything that's not been done before."

"I'm not so sure in our case the law doesn't accomplish what we're already doing," said William L. Mather, administrator of risk management for The Gillette Co. in Boston, expressing his personal opinion.

In many cases, General Motors Corp. will give "significant" advance notice, said Al Strohmaier, director of unemployment and workers compensation for the Detroit-based automaker.

"From my viewpoint, it's also academic," said Norman B. Chanzis, director of risk management at American Standard Inc. in New York, in discussing the provision.

"We have not simply said, 'This is your last shift and we're closing down,'" Mr. Chanzis explained.

"We would certainly give 60 days' notice, and we have personnel policies in place where we have reasonably generous severance programs for anybody who had any length of service, so it's a non-issue for us," said a risk manager for a major corporation.

"It's kind of tacky; it's irresponsible for a business not to give employees some kind of minimal notice," said a spokeswoman for the Business Council of New York State, an association of 3,600 businesses.

The Business Council, the state AFL-CIO and Gov. Mario Cuomo signed a voluntary agreement in 1983 that businesses would give at least 60 days' notice before a plant closing. The agreement, she said, was an alternative to a state law

'It's kind of tacky; it's irresponsible for a business not to give employees some kind of minimal notice,' said a spokeswoman for the Business Council of New York State, an association of 3,600 businesses.

mandating the notice. "We always prefer to have a choice."

"Although we have probably complied with the 60-day requirement, we would really not be happy with having it imposed on us," agreed a benefits manager for a major corporation. "We can't predict the business environment in which we're going to be operating in the future."

A Massachusetts law provides

incentives to employers that give employees advance notice on plant closings, but "I'm not aware of any problems" caused by the law, pointed out Brian Gilmore, director of legislative affairs for the Greater Boston Chamber of Commerce.

Observers point out a rash of workers compensation claims often are filed prior to a plant closing, regardless of how much notice is

given. When a plant closes, workers who had been only marginally disabled but were willing to work as long as they had jobs often file workers compensation disability claims or long-term disability claims.

While the 60-day notice "tends to exacerbate the problem," Argonaut Insurance Co. in Menlo Park, Calif., does not "consider that particular piece of legislation to be a serious threat to the comp business," said President Michael Crall.

However, "It might enable people (employees) to better document their claims as they're exiting," said David A. Lewsley, manager of workers compensation for Chrysler Corp. in Detroit.

"I think there's an increased opportunity for workers to file claims

that might be associated with closings," said David Appell, vp for research at the National Council on Compensation Insurance in New York.

The 60-day notice gives the worker much greater opportunity "to create a plausible incident" for a work-related accident, commented Douglas H. Hartman, principal of Coopers & Lybrand-Casualty Actuarial and Risk Management Consulting in New York. The notice also provides extra time for employees to discuss among themselves how to go about filing claims, he added.

And, when people know they are about to lose their jobs, they "tend to do careless things," said Samsung's Mr. Dimmick.

Arthur Cohen, vp and consulting

Continued on next page

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Continued from previous page
actuary at Huggins Financial Services in Philadelphia and a workers compensation specialist, does not believe the 60-day notice will significantly increase these types of claims, though he commented that such claims may be filed earlier because workers may have advance knowledge of the plant closing.

Risk managers stress the key to minimizing workers compensation claims before a plant closing always has been good employee relations, and that won't change even if advance notice of the closing is mandated.

For instance, Mr. Strohmaier noted that when GM closed two comparably sized assembly plants in California, 1,800 workers compensation claims were filed by workers at one plant and only 100 were filed by employees at the other.

The only discernable difference between the two plants, he said, is

Treating people decently and helping them overcome the shock of losing their jobs is a 'cost of doing business that will pay off,' says Coopers & Lybrand's Douglas Hartman, who suggests employers hold classes to help workers find jobs.

that the company had much better relations with the unions and employees at the plant with fewer claims.

The frequency of workers compensation claims has not increased when Baxter Travenol has closed plants because of the company's good communications with both its workers and the general community, explained Mr. Sullivan.

While Baxter Travenol gives its workers more than 60 days' notice of the plant closings, Mr. Sullivan said the timing of the notice is not material if a company has a good relationship with its employees. On

the other hand, "If you have problems, certainly it can be really emphasized when you do have a shut-down."

Treating people decently and helping them overcome the shock of losing their jobs is a "cost of doing business that will pay off," said Mr. Hartman.

He suggests employers hold classes to help train displaced workers to find new jobs.

Observers also point out that the 60-day notice provision would probably not have a large impact on health care benefits.

For instance, observers note that

the Consolidated Omnibus Budget Reconciliation Act of 1985 already permits employees to continue to receive health care benefits for 18 months after a plant closing, though they must pay a premium of up to 102% of their former employers' cost.

In addition, others point out that it's not feasible for employees to file some types of health care claims before a layoff.

"Someone's not going to go in for a heart transplant unless they have a heart problem," explained Bill Danish, a benefits consultant at Fort Lee, N.J.-based Kwasha Lip-ton.

At the other end of the scale, he said, if a dental plan only covers teeth cleaning every six months, "you can't simply go out and get your teeth cleaned. It's not going to be paid for anyway."

And use of elective "high-ticket" dental and medical procedures would be limited because of co-insurance provisions, he commented.

While health care claim frequency may increase during the 60-day period, "you're certainly not going to see a year's worth of claims in two months," he said.

But, Leon Smith, a partner in the employee benefits consulting division of Touche Ross & Co. in Dallas, said he believes the 60-day notification period could lead to more employee stress and, thus, increase the number of health care claims filed.

"The longer it goes on, the bigger the chance of medical complications because of an increased anxiety level over a longer period of time," said Mr. Smith.

However, American Standard's Mr. Chanis disagreed. Stress can be reduced "depending on how much effort the employer puts into" helping employees cope with impending layoffs, he said.

Most observers also discount the notion that employees will sabotage corporate property or products if they are given advance notice of plant closings.

"I know of no instances myself where a plant closing had something like that," said Huggins' Mr. Cohen. Although he is aware of allegations of sabotage, "I've never heard of anything that was substantiated."

The likelihood of product tampering or property damage is "overestimated," said Wyatt's Mr. Dion. "Most of the people look at their own pocket."

However, the U.S. Chamber of Commerce, which opposes the 60-day notice provision, says it is concerned that disgruntled employees could damage property or products, said Mark A. de Bernardo, special counsel for domestic policy at the Chamber. "Unfortunately, labor violence is still with us today. It's a major problem in certain environments."

And damage to products during the manufacturing process at soon-to-be-shuttered plants is "definitely a concern," said Pamela Rainey, corporate risk manager at AMDAHL Corp. in Sunnyvale, Calif.

Aside from maintaining good employee relations, employers should monitor employees more carefully after notice of a plant closing is given to prevent damage to property and products, said Charles T. Tagman, vp and principal with Tillinghast, a division of Towers, Perrin, Forster & Crosby.

Companies also could ship unfinished goods to another plant for completion at some point after notice of layoffs is given, said Coopers & Lybrand's Mr. Hartman. Once at the other plant, the goods could be examined for sabotage-related defects, he said.

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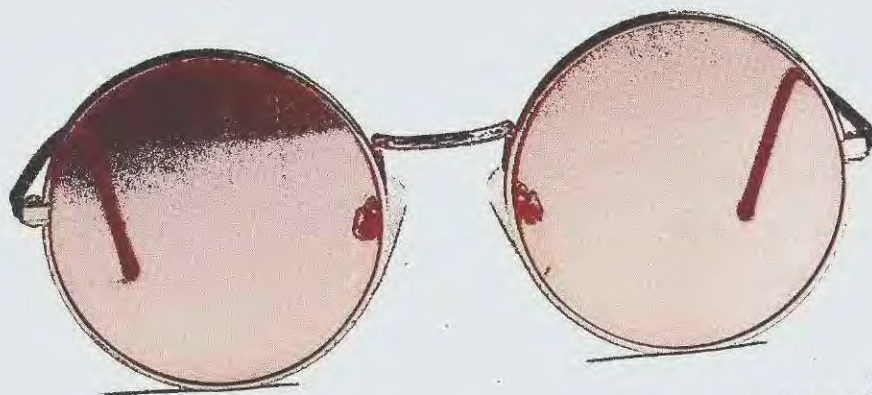
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Illinois exchange emphasizes its record

By MEG FLETCHER

CHICAGO—The Illinois Insurance Exchange is polishing its image and expanding operations with the help of a new casualty line slip and new financial data.

The exchange says its recently released financial analysis shows the IIE "ranks among the nation's top surplus lines insurers and meets or beats nearly every industry norm for performance, underwriting ratios and financial soundness."

The IIE says it reached that conclusion after applying A.M. Best Co. rating methods.

Best gives the IIE a "non-assigned" listing because it contends the normal rating procedures do not apply. But the IIE disagrees, contending that exchange syndi-

cates actually are stock insurance companies.

In addition, the IIE announced May 12 that four of its 13 active syndicates will share both capacity and underwriting capabilities to create the exchange's first line slip. The slip offers \$1 million in casualty insurance limits.

The IIE hopes communicating these developments, using a public relations firm, will help remove the tarnish caused last year by the rejection of three IIE syndicates by California regulators and by the financial woes of insurance exchanges in Miami and New York.

However, the IIE received a boost last month when the three syndicates were allowed to resume writing California business.

Late last year, the California Insurance Department prohibited

surplus lines brokers from using three IIE syndicates: LUI Insurance Syndicate Inc., Britamco Underwriters Inc. and First Oak Brook Corp. (BI, Nov. 30, 1987; Nov. 23, 1987).

The concerns were raised because the syndicates could not meet California's tougher new requirements for U.S.-domiciled non-admitted insurers. The objections included that:

- All three were too new to submit the required three annual statements

- All three were unable to submit the required individual reports of examinations by the Illinois Insurance Department because the examinations had never been conducted.

In addition, LUI Syndicate was singled out because of an auditor's

comment about its inability to evaluate the reasonableness of estimated liabilities for losses and loss expenses because of limited historical experience.

First Oak Brook also was singled out for having only \$2.3 million in surplus at the end of 1986.

After five months of negotiations, the California department last month gave the syndicates until the year-end to submit completed examination reports and the three annual reports (BI, April 25).

Establishing the grace period will "provide equitable treatment and a reasonable transition period for the non-admitted markets," said John J. Faber, the department's chief counsel, in a letter to The Surplus Lines Assn. of California, which represents wholesale brokers in California.

California department officials declined to elaborate.

LUI Syndicate President Richard Foss said regulators have "now backed down" regarding the auditor's comment.

And, First Oak Brook already has increased its capitalization to more than the \$2.8 million the department now requires.

"I think we have established a working relationship with the surplus lines association and the department," said IIE President James M. Skelton.

California regulators tightened surplus lines insurer requirements in "a knee-jerk reaction" to the problems of exchanges in New York and Florida that are no longer operational, said Alison J. Renner, president of the IIE's brokers' association. She heads a Chicago-based wholesale brokerage that bears her name.

However, Peter O'Shaughnessy, president of the IIE's Transco Syndicate 1, said the impetus for the tighter regulation "didn't come from the regulators but from the state." He declined to elaborate.

A.D. Freeman Jr., manager of the association, denied that allegation before asking not to be quoted.

During the five months of negotiations with California regulators, the IIE lost "millions" of dollars in business and spent "tens of thousands of dollars" in expenses, including legal fees and travel costs, Mr. Skelton said.

"The repercussions went much beyond California," Mr. Skelton said, noting he faced questions about the California regulators' actions nearly everywhere he went.

Mr. Foss said, "I think it cost me risks that would have been shown to me."

LUI's direct written premium in California in 1987 was \$629,074, or about half of the \$1.3 million in premiums it wrote in California in 1986, said an IIE spokesman.

Of the three IIE syndicates labeled ineligible by the California department, only LUI recorded less premium from California risks in 1987 compared with 1986.

The IIE announced that it wrote \$42.1 million in gross premiums in the first quarter of 1988, down 40% from \$70.2 million in the first quarter of 1987.

"Declining premium volume will actually have a positive impact on the results of member syndicates," Mr. Skelton said. "We anticipate significant improvement in operating earnings as a result of the tax benefits arising from a substantial reduction in unearned premium balances and outstanding loss reserves," he added.

"The IIE writes more premium, has more admitted assets, a larger policyholder surplus and has developed a better combined ratio than many of the top-rated surplus lines companies in America," according to the financial report commissioned by the exchange.

"At the same time, IIE syndicates are subject to more stringent regulation and review than most competing insurers. All capitalization is carefully monitored, premium ratios and retention percentages are regularly reviewed and reinsurance is tightly controlled," the report emphasizes.

The exchange can stand up to regulatory examination, Ms. Renner said. Most regulators will view the exchange as a whole because of a common guaranty fund rather than take a syndicate-by-syndicate approach like regulators did in California, Nevada and Florida, she said.

"I think any regulator that was going to decide to get up in arms or get out the microscope has done so," she added. ■

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FAIR DEALING

Appeals court overturns bad-faith award against reinsurer

By Joseph K. Hegedus

THE CALIFORNIA COURT of Appeal recently held that a ceding company could not sue a reinsurer for bad faith based on the implied covenant of good faith and fair dealing.

In the case of *Central National Insurance Co. of Omaha vs. Prudential Reinsurance Co.* (Cal. App.3d—241 Cal.Reptr. 773 (1987)), the court reached an important decision that will affect how reinsurance arrangements are drafted and implemented, what the respective obligations of ceding companies and reinsurers are and how courts are likely to interpret provisions common in many reinsurance agreements.

The case raises many issues:

- The law of bad faith as applied to reinsurance.
- The reinsurer's obligations under the follow-the-fortunes clause.
- The reinsurer's reliance on an exclusion clause.
- The reinsurer's obligation where part of a claim is reinsured and part is not.
- The reinsurer's right to challenge the ceding company's handling of a claim.
- The ceding company's duty to give notice of a claim to the reinsurer.

The court's most important holding was that the ceding company could not recover tort damages for breach of the covenant of good faith and fair dealing, implied by law into the reinsurance contract. The court limited the ceding company to contract damages—damages that flow from any breach of the reinsurance agreement—clearly distinguishing insurance from reinsurance.

The court viewed the insurer and reinsurer as having equal bargaining power and gave effect to the literal terms of the reinsurance agreement. In this way, the court freed reinsurance arrangements from much of the law-imposed interpretations applicable to insurance policies.

"Reinsurance contracts serve the essentially commercial purpose of reducing the reinsured's company reserve requirement by spreading the risks assumed and therefore allowing it to undertake more business and increase its profitability. . . . Reinsurance contracts lack the characteristics inherent in ordinary insurance contracts that justify imposing tort liability for breach of the implied covenant of good faith and fair dealing," the court said.

Because of the unique characteristics of reinsurance transactions, the court was clearly inclined to let the parties to such agreements define their own rights and obligations without imposing judicial interpretations and limitations so common to insurance policies. Acknowledging that reinsurance agreements serve a valuable purpose in the marketplace, the court noted that the policyholder is better protected by securing the solvency of the ceding insurer.

Reinsurance, observed the court, is an arm's length commercial transaction between two negotiating equals and is not like an insurance policy transaction "between a small consumer and a large insurance company." Moreover, reinsurance is purchased only by insurance companies that have financial clout in the marketplace, knowledge of the reinsurance product and expertise to negotiate purchase of that product.

The claim underlying the lawsuit arose from a well-publicized skirmish during a Dec. 9, 1977, National Basketball Assn. game. Former Los Angeles Lakers forward Kermit Washington punched and severely injured Rudy Tomjanovich, star forward and captain of the Houston Rockets. At the time, news reports doubted that Mr. Tomjanovich would ever return to basketball.

As a result, he and his wife sued the Lakers and the jury awarded almost \$2 million in compensatory



Photo: Wide World

The reinsurance litigation stemmed from a brawl in which basketball star Rudy Tomjanovich was injured.

damages, plus \$1.5 million in punitive damages. In addition to the Tomjanovich suit, the Houston Rockets also sued the Lakers.

That suit was eventually settled by the ceding company's managing general agent, Cravens, Dargan & Co., for \$2.13 million (*BI*, Oct. 31, 1983).

Fireman's Fund Insurance Co. wrote \$50,000 in primary liability insurance for the Lakers. Central National Insurance Co. of Omaha, Neb., the plaintiff in the reinsurance lawsuit, was the excess insurer, writing an excess liability policy with limits of \$950,000 excess of the underlying \$50,000 and an umbrella policy with limits of \$4 million excess of \$1 million.

The reinsurer named in the litigation, Prudential Reinsurance Co., was one of three facultative reinsurers on the Central National umbrella policy. Pru Re had 50% of the risk on a straight quota-share basis.

Central National did not give notice of the two lawsuits to Pru Re until after the jury returned its \$3.5 million verdict for the Tomjanoviches in the underlying lawsuit. Pru Re then denied any liability on the facultative agreement on the grounds that the ceding company had given late notice and that Cravens, Dargan had mishandled the claims by not reserving rights properly and by not raising an applicable policy exclusion.

After rescinding the facultative reinsurance certificates and tendering refund of reinsurance premiums, Pru Re sued Central National for declaratory relief, asking the court to determine Pru Re's rights and obligations. Central National then countersued Pru Re, seeking payment under the facultative certificates and additional damages for Pru Re's alleged bad faith denial of the reinsurance claim.

Interestingly, the jury found in favor of the ceding company and awarded damages under the reinsurance agreement of \$605,312, plus an additional \$206,280 solely for bad faith. The court of appeal reversed, however, and rendered several decisions of general importance to reinsurers and ceding companies alike.

Consistent with this practical view of reinsurance, the appellate court refused to permit the ceding company to recover punitive damages or attorneys'

fees from the reinsurer. A policyholder may recover such amounts in a bad-faith case against an insurance company.

The appellate court also analyzed the follow-the-fortunes clause of the reinsurance agreement and held that "the reinsurer can refuse a reinsured's claim if the reinsured paid for excluded claims."

Thus, if the ceding company pays a claim to its policyholder that it should not have paid under the terms of the insurance policy, the follow-the-fortunes clause does not automatically obligate the reinsurer to reimburse the ceding company for an amount paid in mistake. Moreover, the reinsurer has the right to challenge that mistaken payment in later litigation, even if the reinsurer, like Pru Re in this case, denies coverage before the ceding company pays on a claim.

In addition, the court held that the reinsurer has the burden of proving that an exclusion in the reinsurance agreement applies. This point follows general insurance law that an insurer must prove clearly that coverage under an insurance policy is defeated by an exclusion.

The reinsurer in this case was permitted to prove that an exclusion in the insurance policy precluded coverage under the reinsurance agreement. Again, the reinsurer was able to make this showing even after it denied the claim in the first instance.

The ceding company argued that where the jury's award was in part covered by reinsurance and in part not covered, the reinsurer should be liable for the entire award. The court, however, disagreed:

"A settlement of excluded claims does not necessarily bind the reinsurer. . . . The burden of separating the covered claims from the excluded claims rests with the reinsured under the terms of this reinsurance contract and not with the reinsurer."

Thus, the ceding company has the burden of proving that specific amounts of a claim or award are covered by reinsurance, unless the agreement states otherwise. This is most instructive on drafting reinsurance agreements, on the ceding company's careful control of liability litigation and on the reinsurer's response to claims.

As for the reinsurer's challenge of claims handling, the court held that Pru Re, as reinsurer of the umbrella policy, had no standing to challenge the alleged mishandling of claims under the separate excess policy that Pru Re did not reinsure. Pru Re argued that the underlying claims should have been settled within the limits of the excess policy, and Central National's failure to do so violated the implied covenant of good faith in the reinsurance agreement.

However, the court rejected this argument, stating that just because the reinsurer reinsured the umbrella policy, it could not assert mishandling under the lower-layer excess policy.

Concerning the reinsurer's claim of late notice of the two underlying liability claims, the court imposed the burden on the ceding company to give the reinsurer proper notice.

In an ordinary policyholder-insurer relationship, an insurer can deny a claim based on late notice only if it can show prejudice by that late notice.

In its view of reinsurance, however, the court refused to establish such a standard. Rather, the court carefully balanced the interests of reinsurer and ceding company by shifting the burden of proof: It held that the ceding company has the burden to show that it gave notice in accordance with the terms of the reinsurance agreement. If the ceding company cannot show that it gave such timely notice, a rebuttable presumption arises that the reinsurer was prejudiced by such late notice. The

Continued on next page

The cost of limited fire safety

By The Insurance Institute of America

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

This month's exercise, drawn from a recent ARM 54 examination, calls for an explanation of how one organization's risk management decision to raise or lower its cost of risk affects the cost of risk for the economy as a whole.

Q: A major national retailer that operates several hundred department and variety stores throughout the United States spends too little money on fire detection/suppression equipment for its stores, thus raising the retailer's overall cost of risk.

• With specific reference to each of the four elements of any organization's cost of risk, explain why this retailer's decision would tend to raise its overall cost of risk.

• Briefly explain why this retailer's underinvestment in fire detection/suppression equipment may

be due to inadequacies in: the applicable fire insurance premium rating system; local building codes; and senior management support of the retailer's existing fire safety program.

• Describe three specific ways in which this retailer's underinvestment in fire detection/suppression equipment for its stores could have adverse economic effects throughout the economy, raising other organizations' cost of risk.

A: • Failing to purchase and install adequate fire detection/suppression equipment is likely to affect each of the four elements of this retailer's cost of risk by:

✓ Reducing its risk control costs as it spends less on fire protection.

✓ Increasing its retained losses as more small fires become large ones.

✓ Increasing its insurance premiums because the retailer fails to qualify for fire safety premium credits.

✓ Perhaps increasing its administrative costs as the expenses associated with adjusting more and larger fires increase.

Alternatively, administrative costs may be left unchanged—or even

fall—as the retailer's outlays for monitoring equipment fall.

Overall, however, it seems likely that this retailer's aggregate cost of risk will increase as a result of its unwise safety decision.

• Inadequacies that may influence the retailer's underinvestment in fire detection/suppression devices include:

✓ The retailer may have decided to cut back on fire detection/suppression equipment because its fire insurer's rating system granted actuarially inadequate credits for appropriate equipment.

✓ The building codes that the retailer is subject to may specify no—or only minimal—fire detection/suppression equipment for these types of structures. Not facing any penalties for underinvestment in fire safety, senior management of these stores understandably could have sought to reduce the company's short-term costs.

✓ A general climate leading to this unwise decision could have been created by senior management's failure to appreciate the importance of risk management—generally by giving inadequate attention to risk control as opposed to risk financing and by not

allocating fire-related risk management costs to its stores in a way that would make more apparent each store's cost of risk for fire.

• Because this retail chain's stores are inadequately protected from fire damage, the entire economy is likely to suffer to the extent that:

✓ More property and lives associated with the chain's operations are destroyed by fires that could have been controlled.

✓ Other retailers' fire insurance premium rates are raised as a result of this major chain's heavier fire losses.

✓ Entrepreneurs considering opening competing retail outlets are deterred from doing so by the chain's heavy fire losses.

✓ Public fire departments increase their outlays to combat fires that could have been contained by this retailer's more prudent investments in appropriate fire protection equipment.

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

Excess insurer drops down in insolvency

A New Jersey appellate court ruled that the language in an umbrella policy that made an insurer responsible for damages "in excess of the amount recoverable under the underlying insurance" was ambiguous.

Thus, the court held that the excess insurer had to drop down and assume claims payable by the insolvent primary insurer.

Werner Industries Inc. obtained primary general liability insurance and umbrella liability coverage. The underlying coverage was placed with Ambassador Insurance Co. and the umbrella coverage with First State Insurance Co.

First State's policy provided that it would pay sums in excess of the "amounts recoverable" under the underlying insurance.

Legal briefs

During the policy period, Werner was sued in two personal injury actions and submitted the defense to Ambassador. One case was settled for an amount less than the underlying policy, but the other case remained pending.

In 1984, Ambassador was declared insolvent. Thus, Werner brought this action seeking a declaration that First State was obligated to provide coverage and indemnify it from all claims and losses arising during the policy period.

The trial court ruled for First State.

The appellate court said that it was convinced that the policy language here could reasonably be

interpreted to expose First State to liability amounts that Werner was not able to recover from Ambassador.

Thus, the court said that First State was compelled to drop down and assume claims payable by the insolvent Ambassador.

Werner Industries vs. First State Insurance Co., Superior Court of New Jersey, Appellate Division, May 6, 1987 (BI/03/Jan.-\$10)

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

Reinsurance ruling

Continued from previous page
ceding company must then show that the reinsurer was not prejudiced by late notice.

Although these burden-of-proof requirements are somewhat technical, they demonstrate that the court is balancing the interest of the reinsurer in receiving reasonably prompt notice, especially in a case in which the reinsurer had a greater percentage of the risk, against the interest of the ceding company in not losing reinsurance protection merely because it may give notice a few days late.

This significant decision is instructive for both ceding companies and reinsurers. For both parties, it removes the punitive damage potential inherent in lawsuits based on claims under insurance policies. The court clearly recognized the different character and value of reinsurance.

Secondly, the opinion indicates the

court's willingness to enforce the literal terms of reinsurance agreements. This suggests that careful attention should be given to both drafting the reinsurance agreement in the first place and complying with its terms—especially concerning notice to reinsurers—while the reinsurance agreement is in effect. Note that by analogy, a reinsurer also may insist on literal compliance with premium reporting provisions.

For the ceding company, the opinion contains lessons on managing liability litigation, such as by requesting special jury verdicts so that the ceding company can satisfy its burden under the reinsurance agreement to show that specific portions of a jury award are covered by reinsurance. A ceding company also should report significant changes in liability litigation to the reinsurer, especially if the ceding company has adopted a usual practice of early or frequent

reporting.

More importantly, the reinsurer is not necessarily obligated to reimburse the ceding company merely because the ceding company pays a claimant.

The reinsurer has the right and opportunity to second-guess the ceding company's payment of a claim and may, in fact, litigate the propriety of a claim payment by the ceding company even after the reinsurer denies coverage under the reinsurance agreement.

Finally, the case is also interesting for what it did not discuss. Conspicuously absent is any mention of arbitration, provisions that are almost invariably included in reinsurance agreements. Also, the court did not discuss any extra-contractual damage provision. Such a provision, or a cut-through endorsement, may cause a court to reconsider some of the above holdings. Also, note that the laws of a state other than California may govern a particular

agreement, depending on how it is drafted or implemented.

From a broader perspective, the case is one more example of the unfortunate trend toward litigating reinsurance disputes, rather than resolving them by discussion or, at most, arbitration. Prudent planning, therefore, suggests that both ceding companies and reinsurers evaluate their reinsurance portfolios in this light.

Joseph K. Hegedus is a partner with the law firm of Knapp, Petersen & Clarke in Universal City, Calif. Mr. Hegedus previously served as general counsel of Allianz Insurance Co., and prior to that was deputy attorney general with the Pennsylvania Department of Justice in its major civil litigation division.



95% of plans provide mental health benefits

By JACQUELINE LaSOTA

Although nearly all employers already offer mental health benefits, the benefits offered by many employers fall short of the level required by Sen. Edward Kennedy's mandated health care benefit bill.

A whopping 95% of the respondents surveyed by the International Foundation of Employee Benefit Plans report that mental health care benefits are included in health care plans with which they are associated. And, 68% consider mental health benefits an important component of health plans.

The Kennedy bill, which would require employers to provide all employees working more than 17.5 hours per week with a minimum level of benefits, was recently expanded to include mental health care coverage (BI, Feb. 22).

The survey found that 46% of the respondents' current health care plans already exceed the bill's requirement for plan coverage of 45 days of inpatient treatment of mental illness. In addition, about half—51%—of the respondents exceed the bill's requirement of coverage for 20 sessions of outpatient psychotherapy or counseling, with a maximum 50% employee copayment for outpatient benefits.

Furthermore, 57% indicate that the bill's requirement for coverage of alcohol and drug abuse treatment is already met by their plans.

The IFEBP study, "Growing Uncertainties—Mandated Benefits and Long-term Care," surveyed 193 members of the International Society of Certified Employee Benefit Specialists on mandated mental health benefits and long-term care issues.

The mental health care provision in the Kennedy bill not only would mandate coverage for services provided by physicians and psychiatrists, but also by "duly licensed or certified clinical psychologists, social workers or equivalent mental health professionals," the study's authors report.

Of the employer respondents who currently offer mental health benefits, 84% already classify clinical psychologists as covered providers and 45% cover services provided by social workers.

The survey also found that employee assistance programs have begun to play a greater role in the delivery of mental health care.

Forty-five percent of the respondents said their companies offer some type of EAP, and an additional 23% are considering establishing one.

Without exception, every EAP offered by respondents provides drug and alcohol abuse counseling—one of the two most frequently used EAP services—along with marital and family counseling.

Counseling for mental/nervous disorders is available through 97% of the EAPs, while 90% offer stress management services. And, nearly one-third—31%—offer AIDS support services.

About 8% to 9% of employees use EAPs, which resulted in an average annual per-employee cost of \$21.50, the survey found.

Although the advantages of EAPs are often difficult to measure, 57% of the respondents say the programs result in increased productivity and morale.

However, 43% of the respondents are undecided whether EAPs have reduced the rate of medical cost increases in associated health care plans. Twenty-eight percent of respondents feel they have cut costs, while 29% do not.

The survey also found that the various long-term care proposals moving through Congress have prompted 69% of the respondents to expect long-term care to be in-

cluded under Medicare within the next five years.

And, according to more than half of the respondents—54%—the push for mandated benefits also has sparked concern that wider employer sponsorship of long-term care benefits may open the doors to government mandates.

However, 68% of the respondents have little or no interest in offering a group long-term care program.

"Before employers actively support (group long-term care), there must be strong interest demon-

strated by employees, practical products available and clearly defined favorable tax treatment," one respondent noted.

Of those respondents with some interest in offering long-term care benefits, 52% expect to offer a program within three to five years.

Half of those interested in offering group long-term care say employees will pay all costs; 48% say their companies will make some contribution; and 2% say their companies are interested in fully "footing the bill."

Eighty-four percent of respondents would support tax incentives to allow individuals to save for long-term care expenses and 83% support no-penalty withdrawals from Individual Retirement Accounts for long-term care.

Another 75% support tax incentives for voluntary employer pre-funding of long-term care benefits. However, only 44% support using excess assets from overfunded pension plans to finance the coverage, and 38% support including long-term care coverage under

Medicare.

"Federal tax incentives that simultaneously benefit both employers and employees will encourage employer sponsorship irrespective of what form they take," commented another respondent.

For a free copy of "Growing Uncertainties—Mandated Benefits and Long-term Care," write the International Foundation of Employee Benefit Plans, Public Relations Department, 18700 W. Bluemound Road, Brookfield, Wis. 53005.

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Bermuda panel studies reinsurance law changes

By ROGER SCOTTON

HAMILTON, Bermuda—Reinsurance contracts drawn up in Bermuda could become more enforceable if the Bermuda government accepts recommendations under review by an ad hoc committee on reinsurance law reforms.

The committee is considering how to adopt a standard outlined in 1982 by a British trial court that held that reinsurers should not be allowed to reject a claim on the basis of misrepresentation and non-disclosure by the ceding company when the reinsurer's bad underwriting is found to be a prime cause of litigation with the ceding company, said attorney John Milligan-Whyte, the committee's chairman.

The decision, involving Oceanus Mutual Underwriting Assn., enhanced the enforceability of reinsurance agreements, Mr. Milligan-Whyte said in a paper delivered this month at the spring meeting of the American Bar Assn.'s Tort & Insurance Practice Section.

The judgment relied on a test of the "materiality of disclosure" to Oceanus, whereby the reinsurer had to satisfy the court that fuller disclosure would have led to "some difference of action" by Oceanus' underwriter.

Although this decision was later overturned on appeal, Mr. Milligan-Whyte argued that the appellate court ruling is not binding on Bermuda.

The appellate court test for materiality was set at a low level favoring the reinsurer, the paper explains. "The Court of Appeal's test was simply whether a prudent insurer should have been told of the non-disclosed facts before being asked to form a judgment about the risk. This is an inappropriate legal standard which imprudent reinsurers preoccupied with cash-flow underwriting could meet."

The appellate ruling encourages the disruption of reinsurance relationships by facilitating the rescission of agreements, said Mr. Milligan-Whyte, who is a consultant to the Bermuda law firm of O.A. Smith's Attorneys.

He noted that the appellate decision sets a "dangerously ambiguous precedent."

"Imprudent reinsureds and reinsurers who indulge in the morality of caveat emptor because they wish to take the money and have deceitfully low combined ratios should be loudly marked to be of ill repute, whatever their wealth and breeding," the paper states.

And, in an eloquent caution aimed at reinsurance intermediaries, who Mr. Milligan-Whyte says whisper sweet nothings of endearment in courting reinsurers and ceding companies, he said that such industry "cupids" run the risk of being "pauperized" by disenchanted suitors.

Mr. Milligan-Whyte's 116-page paper predicts chaos in reinsurance markets and courts on both sides of the Atlantic unless reinsurance law enforces the morality of utmost good faith.

But, the paper says that the laws of various jurisdictions are full of gaps and ambiguities—legal pitfalls that could pose problems for Bermudian courts when applying Bermudian and British case law to disputes involving Bermuda-based companies reinsuring U.S. risks.

Aside from decisions of the British Privy Council, which are binding on Bermuda, the island's courts traditionally regard English court judgments as "highly persuasive" and U.S. judgments as, at worst, "abhorrent," he said.

But Mr. Milligan-Whyte believes that this scenario should be changed. Bermuda soon will be challenged by disputes that raise the question of whether U.S. reinsurance case law should be applied, rather than British precedents, his paper says.

Bermuda will be increasingly faced with litigation filed by companies to avoid liability, the paper explains, adding that Bermuda courts should decline to apply "unsound or inappropriate" British case law.

"The Bermuda courts should, in appropriate instances, look to American reinsurance case law to fill lacunae in English or Bermuda case law," the paper says. "American reinsurance case law should not be uncritically rejected. It is very useful in filling the many startling gaps in English reinsurance case law."

Bermuda currently is considering legal reforms that

Continued on next page

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Continued from previous page
could give it the most advanced insurance and reinsurance regulatory system in the world, Mr. Milligan-Whyte said. But, he urged, the reforms must be in harmony with U.S. law.

"Legal experts and the courts must strive to develop solutions to problems brought about by changing economic circumstances when there is an absence of detailed and legislative solutions," said Mr. Milligan-Whyte, who is vice chairman of the ABA Tort and Insurance Practice Section's committee on public regulation of insurance law and a member of the National Assn. of Insurance Commissioners' rehabilitators' and liquidators' task force advisory group.

"Bermuda's courts, in tailoring Bermuda reinsurance law to Bermuda's circumstances on a case-by-case basis, will face difficult choices which will directly affect the reputation of Bermuda as a responsible international reinsur-

U.S. 'reinsurance case law should not be uncritically rejected,' Mr. Milligan-Whyte says.

ance jurisdiction caught between the case law of England and America. The correct or inappropriate determination of Bermuda reinsurance legal issues can affect the economic stability of Bermuda and of other international reinsurance markets," he said.

Bermuda is in a position to shape laws that will enforce market morality, Mr. Milligan-Whyte suggested.

"Courts should also prevent those who negotiate reinsurance contracts from perpetuating fraud or intentional misrepresentations," states the paper. ■

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Reinsurance suits to rise, expert says

HAMILTON, Bermuda—Non-U.S. reinsurers are increasingly willing to litigate coverage issues with ceding companies, a U.S. reinsurer says.

Faced with huge losses as a result of U.S. court rulings favoring policyholders, international reinsurers are litigating more aggressively than ever before, said Robert Mangino, general counsel and secretary of New York-based North American Reinsurance Corp.

"Years ago, it was unheard of for a reinsurer to even consider arguing seriously with its ceding company," he said at the spring meeting of the American Bar Assn.'s Tort & Insurance Practice Section earlier this month.

"A dispute over a small claim or even a large one was subsumed in the overall, usually profitable, relationship. The thinking then was that if the reinsurer had to pay a little extra one year for a claim that was mishandled, it could get even and recoup its losses the next time the treaty rates were negotiated," he said.

But this theory no longer holds true, Mr. Mangino said. Ceding companies now look for the best rates, regardless of long-standing relationships with reinsurers. As a result, reinsurers are allowing their claims department "to do what they wanted to do all along and contest a treaty dispute that should be contested and not refer resolution of the problem to the underwriting or marketing departments, which typically avoid disputes with ceding companies at all costs."

Reinsurers and ceding companies "seem to be drifting into an arm's-length relationship," Mr. Mangino added.

"For the present and for the next decade, we can look forward to increased arbitration and litigation among and between international and U.S. insurers caused by the inability or refusal of the international reinsurance community to absorb the punishment exerted upon them by the U.S. court system," said Mr. Mangino.

International reinsurers are hiring U.S.-trained attorneys to advise the companies on the mechanics of the U.S. legal system, he said. These lawyers usually work in claims departments rather than the corporate legal office because "the real coverage problems arise from novel interpretations of primary or direct excess policies, rather than from coverage questions involving reinsurance treaties."

—By Roger Scotton

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OSHA ruling

Continued from page 1
an electrical outlet.

According to court papers, sparks from the outlet caused the fire and explosion, which killed another employee and injured several others at the south-central Wisconsin plant owned by Pyro Science Development Corp. of Columbus, Wis.

Following an investigation of the accident, Rock County authorities issued a complaint charging Larry Norman Cornellier Sr., who supervised the facility, with homicide by reckless conduct. However, because of the legal squabble over OSHA pre-emption, Mr. Cornellier's case has never gone to trial.

Under Wisconsin law, negligent homicide is defined as "an act which creates a situation of unreasonable risk and high probability of death...and which demonstrates a conscious disregard for the safety of another and a willingness to take known chances of perpetrating an injury."

The complaint against Mr. Cornellier alleged that:

- He was aware that fireworks were being manufactured without a permit in a structure that did not comply with local and state safety requirements.

- He had been advised by another company official that there were safety questions about the

plant.

- After the explosion, the U.S. Labor Department reported nine separate safety violations at the facility, including what the court called "generally hazardous and unsafe equipment and wiring throughout the building."

Mr. Cornellier, in turn, argued that the OSHA Act of 1970 pre-empted the state's right to file criminal charges for workplace safety violations.

A trial court denied the motion, and the appellate court sent the case directly to the state Supreme Court without acting on it. But the Supreme Court refused to consider the matter, remanding the case to the appellate court.

Mr. Cornellier's attorneys argued that the Wisconsin court should follow the lead of the Illinois appellate court in holding that OSHA supercedes state criminal law in cases involving OSHA-regulated conduct.

However, the Wisconsin court held that despite OSHA's provision of civil and criminal penalties for safety violations and despite the fact that "the (OSHA) act evinces an intent to pre-empt states from enacting and enforcing their own occupational safety and health standards in the absence of prior federal approval," Congress did not intend to totally pre-empt state criminal law when it created OSHA.

But even if such intent existed, "congressional intent to pre-empt state regulation in a particular field must fail where the activity sought to be regulated touches matters which are deeply rooted in local feeling and responsibility," the court said. Nothing in OSHA says that any state is prohibited from enforcing its homicide laws in the workplace, said the decision.

"Wisconsin is not attempting to impose a penalty for violation of any safety regulations. It is only attempting to impose the sanctions of the criminal code upon one who allegedly caused the death of another person by reckless conduct. And the fact that that conduct may in some respects violate OSHA safety regulations does not abridge the state's historic power to prosecute crime," the court ruled.

Rock County District Attorney James Daley praised the decision.

"We think it's important because it's an area of the application of criminal law in the workplace that hasn't been used," Mr. Daley said. "We frankly believe that workers should merit the same protection that the criminal law provides victims of criminal conduct outside the workplace," he said.

"If Cornellier had gone the other way, we'd have to fold our tents," said Mr. McCann, the Milwaukee County district attorney.

Although OSHA does provide criminal penalties for violations, no one has ever been imprisoned for breaking OSHA safety rules, Mr. McCann said and an OSHA spokesman confirmed.

Dividing employers into three groups—those that conscientiously follow safety rules; those that cut corners out of carelessness; and those that do not allow safety to

get in the way of making money—Mr. McCann said that the Wisconsin appellate court ruling will be particularly useful in prosecuting members of that third group.

The Wisconsin court's decision gave short shrift to the ruling of the Illinois Court of Appeals for the 1st District in *People vs. Chicago Magnet Wire Corp.*—the only other reported case on the subject of OSHA pre-emption of state criminal prosecution for alleged safety infractions.

That case stems from June 1985 Cook County grand jury indictments of five executives of Elk Grove Village, Ill.-based Chicago Magnet Wire on counts of aggravated battery and reckless conduct linked to job-related illnesses and injuries suffered by workers.

However, those criminal charges were dismissed by a Cook County Circuit Court judge, who held that OSHA pre-empted state law and, as a result, prosecutors could not apply state criminal law to charges covered by OSHA.

The appellate court upheld that decision, and Cook County State's Attorney Richard M. Daley appealed the case to the state Supreme Court on March 23.

Calling the Illinois appellate court's reasoning "flawed," the Wisconsin court wrote, "the Illinois court never acknowledged or discussed the rule that an act of Congress is presumed not to pre-empt state law, or that the burden of showing pre-emption is upon the person claiming it. Indeed, the court appears to have proceeded on the assumption that the state had the burden to show lack of evidence."

"Most importantly, the court failed to recognize the 'local inter-

est' exception to the pre-emption doctrine, which requires a finding of a 'compelling congressional direction' as a prerequisite to pre-emption of state action that is deeply rooted in local feeling and responsibility. For these reasons, we decline to follow the Illinois Court of Appeals," the Wisconsin court said.

The Cook County State's Attorney's Office praised the Wisconsin ruling.

"We consider it very important because it ratifies our reasoning that local prosecutors have the right to bring this type of charge. We're fighting the same Illinois appellate court decision that was criticized in the Wisconsin decision," said a spokesman.

Rock County District Attorney Daley noted, however, that the Wisconsin case is far from completion since it has yet to be tried. He said that he expected the ruling to be appealed.

Mr. Cornellier's attorney did not return telephone calls.

Stephen Bokart, vp and general counsel for the U.S. Chamber of Commerce, said the major advantage of following OSHA pre-emption is uniformity.

Without OSHA pre-emption, "it turns into a nightmare for compliance purposes," Mr. Bokart pointed out.

But Milan Racic, director of health and safety for the Allied Industrial Workers of America, an AFL-CIO affiliate based in Milwaukee, applauded the Wisconsin decision and called for more action by district attorneys.

"I believe there's an absolute need for the district attorneys to look over OSHA's shoulder," Mr. Racic said.

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Hospital system names Neiburg manager of insurance programs

Lorrie J. Neiburg has been named manager of insurance programs at Franciscan Health System in Chadds Ford, Pa. In this newly created position, she is responsible for property/casualty insurance programs and the FHS Workers Compensation and Employers Liability Trust Fund. She also oversees underwriting activities for FHS' Colorado-based professional and general liability captive, Neumann Insurance Co. She reports to Ellen Barton, director of risk management. Before joining FHS—a multihospital system sponsored by the Sisters of St. Francis of Philadelphia—Ms. Neiburg was assistant director of the risk management office at the University of Pennsylvania in Philadelphia. She received a bachelor of arts degree in Russian from Edin-

boro State College in Edinboro, Pa., and holds the Associate in Risk Management designation.

John S. Nigrelli, 38, has been named risk and insurance manager for NV Ryan Homes L.P. in Pittsburgh. In this newly created position, he is responsible for property/casualty insurance and oversees a company-owned insurance agency that brokers homeowners and life coverages for the residential construction and sales company's clients. Mr. Nigrelli reports to Treasurer Richard Conte. Previously, Mr. Nigrelli served as insurance manager of Ryan Financial Services Inc., the mortgage subsidiary of NV Ryan. He holds a bachelor's degree from the University of Pittsburgh and is working toward his Chartered Property & Casualty Underwriter designation. Mr. Nigrelli serves on the insurance subcommittee of the Mortgage Bankers Assn. and is a deputy member of the Risk & Insurance Management Society.

Michael G. Whelan, 40, was promoted to risk management officer at Enserch Corp. in Dallas. In this newly created position, Mr. Whelan oversees all risk management functions for the multinational energy and engineering company. He reports to Robert E. Wilber, vp and chief accounting officer. Previously, Mr. Whelan served as director of Enserch's insurance department. He received a bachelor's degree in business from Abilene Christian University in Abilene, Texas. Mr. Whelan holds the Chartered Property & Casualty Underwriter designation and is past president of the Dallas/Fort

Comings & goings: buyers

Worth Chapter of the Risk & Insurance Management Society.

Patti E. Carroll, 39, has been named risk manager for TOTAL Energy Resources Inc. in Dallas. In this newly created position, she oversees the domestic property/casualty insurance program for TOTAL, a unit of Paris-based TOTAL Compagnie Francaise des Petroles that operates subsidiaries involved in oil and gas exploration and production, and the mining of coal, uranium and precious metals. In addition, Ms. Carroll coordinates certain coverages with the risk management team in Paris. She reports to Controller J.C. Tusa. Previously, Ms. Carroll was risk manager for LivingWell Inc., a multistate chain of health clubs. Prior to that, she was chief risk manager for King-Wilkinson Inc., an engineering, design and project management firm in Houston. Ms. Carroll holds the Associate in Risk Management designation and has served vp, secretary and assistant secretary of the Houston Chapter of the Risk & Insurance Management Society.



Ms. Carroll

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William Hjorth named CEO at EQUICOR

William T. Hjorth has been named chief executive officer of EQUICOR Inc. in Nashville, Tenn. He will continue as president of the company.

He succeeds Leo M. Walsh Jr., who resigned early this month (BI, May 9).

Mr. Hjorth, 50, joined EQUICOR, a joint venture between Hospital Corp. of America and Equitable Life Insurance Society of the United States, in January 1987 as chief financial officer. Six months later he became chief operating officer, and in September 1987 he was named president and chief operating officer.

Prior to joining EQUICOR, Mr. Hjorth was a senior vp and chief financial officer at Clark Equipment Co. based in South Bend, Ind.

In other insurer changes:

Kelly D. Clevenger and **William J. Cooper** named vps of Lincoln National Pension Insurance Co. in Fort Wayne, Ind. Prior, both were second vps.

IMT Insurance Co. in Des Moines, Iowa, has announced the following promotions: **James A. Vickery** to president and chief executive officer from executive vp and secretary, **George R. Frink** to chairman of the board from president and chief executive officer, **Ervin T. Fuson** to executive vp from vp and assistant secretary, **Newell K. Hart** to vp and secretary from assistant vp and controller and **Wilbert M. Treimer** to

Comings & goings: industry

chairman emeritus from chairman of the board.

Timothy P. Makowski joined Interstate Insurance Group in Chicago as senior vp of underwriting. Most recently, Mr. Makowski was senior vp of the treaty department for Scor Reinsurance Co. in New York.

Glen D. Thompson promoted to vp and manager of field sales operations at Amerisure Cos. in Detroit. Previously, he was assistant vp.

Charles S. Hazen promoted to vp of underwriting at Connecticut National Life Insurance Co. in Simsbury, Conn.

Joel V. Kamer appointed senior vp and group insurance actuary of group benefit services at John Hancock Mutual Life Insurance Co. in Boston. Most recently, he was vp and group insurance actuary.

Nicholas R. Nelson named vp-general manager of St. Paul Fire & Marine Insurance Co.'s service center in Little Rock, Ark. Previously, Mr. Nelson was a regional operations officer.

Richard F. Yeazel appointed vp of Fidelity & Deposit Co. of Maryland's Los Angeles branch office. Most recently, he was resident vp.

Alice F. Rosenblatt named to head the

Blue Cross of California's group service division in Woodland Hills, Calif. She had been a senior vp.

Other suppliers

Richard A. Simon appointed chairman and chief executive officer of GAB Business Services Inc. in Parsippany, N.J. Mr. Simon had been chief operating officer since joining the claims administration and adjusting firm in November.

At Booke & Co., a benefits consulting and actuarial firm, **Philip A. Peterson** and **Laura R. Philip** promoted to vps. Mr. Peterson is in the defined benefit consulting area in Winston-Salem, N.C. Ms. Philip is a defined contribution consultant in Columbus, Ohio.

Kenneth M. Dixon appointed manager of the newly formed flexible benefits department at J.W. Terrill Inc. in Creve Coeur, Mo. Dixon was vp of group benefits at Small/Parker/Ackerman/Blossom Inc.

Harold A. Sandberg named national accounts manager for American Claims Evaluation Inc., a Jericho, N.Y.-based health care cost containment specialist. Most recently, Mr. Sandberg was national marketing man-

ager for the National Electronic Information Corp.

James D. Blinn named to lead the Chicago area risk management consulting practice of Tillinghast, a division of Towers, Perrin, Forster & Crosby Inc.

Dr. William J. Kane appointed senior vp of Jurgovan & Blair Inc., a Potomac, Md.-based managed health care firm. Previously, Dr. Kane was president of TK Associates of Morris Plains, N.J.

Daryl S. Stern promoted to vp at North American Pharmaceutical Services Inc. in Phoenix, Ariz., which provides managed pharmaceutical services. Previously, Mr. Stern was director of sales.

Stuart L. Perry promoted to vp of the Southeast regional office of Penn General Services, a subsidiary of Republic Hogg Robinson of Georgia.

Peter H. Sorensen joined Buck Consultants Inc. in San Francisco. Most recently, Mr. Sorensen was a consultant with The Wyatt Co. in San Francisco.

Agents/brokers

Michael G. Essman joined Poe & Associates Inc. as managing vp in charge of the company's new subsidiary in Norcross, Ga. Most recently, Mr. Essman was president of Molton, Allen & Williams in Birmingham, Ala.

College chief receives honor

Continued from page 3

ance & Annuity Assn.-College Retirement Equities Fund.

Ms. Lamel will be responsible for market research and product development for TIAA-CREF's group and individual coverages as well as for group insurance marketing.

Refinancing The College of Insurance's \$19.2 million debt was clearly a highlight of her career at the college, Ms. Lamel said. But, "maintaining the academic curriculum throughout that difficult time" also ranks as a major achievement, she added.

To this end, "we've moved into the computer age, both in terms of our administrative operations and our curriculum," Ms. Lamel said.

The college is installing more microcomputers, which it plans to network, to handle admissions and student tracking. In addition, minicomputers are being used for accounting.

In terms of curriculum, in addition to basic computer programming, the college emphasizes application of computer skills, such as generating spreadsheets and case studies.

Also, as a result of the college's efforts to make its programs more widely known, enrollment has increased more than 3% to 2,407 students in the 1987-88 school year from approximately 2,335 during the previous school year, she said.

In addition, Ms. Lamel has reorganized the college "as a business, to be an ongoing concern."

For example, while the college formerly allowed continuing education students employed by some of the city's largest corporations to take courses without paying upfront, it now requires payment at registration, she explained.

However, Ms. Lamel concedes that not all of her colleagues agreed with her philosophy. Some segments of the academic community object to the idea that an institute of higher education should operate like a business, Ms. Lamel observes.

But, "you have to pay the bills, so you have to have money, and that means you have to operate like a business in some ways," she said.

The college has expanded its courses of study under Ms. Lamel's direction.

"Where we used to have only one major—the bachelor's in business administration/insurance—we've now added majors in finance and insurance," she said. "The only

difference between our program and others (at major universities) is that we give a core program of insurance courses."

Despite these and other significant accomplishments, the college faces further challenges, Ms. Lamel said.

For example, because the college is "pre-eminent in the field of insurance education as an institution," she said, it must bear the burden of answering such questions as: What is the best academic preparation for a career in insurance and financial services, the best mix of liberal arts, business and insurance subjects and which subjects within these categories are the best ones to emphasize?

"We should also be doing research into areas of insurance and financial services related to issues, be they public policy or industry concerns," Ms. Lamel said.

Conceding that new faculty and personnel would be needed to implement these programs, Ms. Lamel said she envisions the college as a center that identifies new issues concerning the insurance industry and provides a forum for commentary on these issues.

"We should have the research and faculty capacity to be the first to comment on a tax reform issue and how it will affect the industry, or the first to examine the implications of the antitrust suit, for example, and what it means to the industry," Ms. Lamel said.

Furthermore, she thinks the college faculty should publish papers on such issues as federal vs. state regulation of insurance.

"I see an enormous potential for this institution because it does have a clear focus in terms of an industry concentration that we were deterred from pursuing while we dealt with financial and organizational issues. Now that's behind us, we can focus on these issues."

If her vision for the future of the institution is to be realized, Ms. Lamel admits, much needs to be done to improve the industry's image and to encourage young people to pursue insurance careers.

"There has to be more information (disseminated) to students at a younger age," Ms. Lamel said, noting that secondary schools also have a responsibility in this area.

teacher she thinks such knowledge is critical, "most of them don't understand the basics of operating in this economy. We're looking at a generation of young people who don't understand the nature of our economic system and how to play a role in it."

To help secondary schools teach students about insurance, The College of Insurance plans to launch a program next year that would train teachers in the basics of insurance, she said.

The program is modeled after a similar training course developed for secondary school teachers by the National Assn. of Mutual Insurance Companies at the Insurance Center at Drake University. The Drake center has been directed by Ellen Thrower, who will succeed Ms. Lamel as president of The College of Insurance.

Both the college and the industry "need to inform guidance counselors, business teachers and the people who influence the availability of information to students about what careers are out there," Ms. Lamel stressed.

Insurance industry officials must put some of their marketing know-how into finding ways to communicate effectively to different people just what insurance is and its role in the economic system, Ms. Lamel said.

"They have to be more forthcoming about explaining what they do

and how they do it," she added.

Prior to joining The College of Insurance in 1983, Ms. Lamel served as deputy superintendent of the New York Insurance Department. Before that, she was a program secretary to the then-New York Lt. Gov. Mary Anne Krupsak.

Ms. Lamel is a magna cum laude graduate of Queens College, where she was elected to Phi Beta Kappa, and received a master's degree from New York University. She also received a law degree from Brooklyn Law School.

In addition to her membership in APIW, Ms. Lamel is a member of the American Bar Assn., the New York City Bar Assn., the American Arbitration Assn., the Financial Women's Assn. and the Insurance Negligence and Compensation Law Committee of the New York State Bar Assn. She also has written extensively on insurance litigation issues.

Ms. Lamel will receive the APIW's 1988 Merit Award at a June 9 reception at The Wall Street Club in Manhattan.



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401(k) survey

Continued from page 3

"Despite hopes that these plans would prove attractive to small companies; in fact, few such firms sponsored 401(k) plans in 1986," the survey says.

"The low rate of 401(k) sponsorship among small companies may reflect the fact that master and prototype plan provisions approved by the (Internal Revenue Service) were not available until 1987. Small firms often adopt such pre-approved types of plans."

The 401(k) plans also are more prevalent in certain industries, according to the survey. Two-thirds of the 401(k) plans were sponsored by three industry groups: manufacturers, which sponsored 26% of the plans; service companies, which sponsored 24%; and finance, insurance and real estate firms, which sponsored 18%.

Some 53% of the employees of all the firms surveyed were eligible to participate in 401(k) plans in 1986. And, 62% of those eligible actually did participate.

Most of the 401(k) plans were open to salaried employees and to hourly employees not covered by a collective bargaining contract. But, very few hourly employees covered by collective bargaining were eligible to participate.

"This may reflect a decision on the part of union negotiators to forgo the possible benefits of 401(k) plans for other benefits, such as defined benefit pension plans," the survey authors say.

The survey also found that three-fourths of the 401(k) plans offered by the respondents included some kind of employer contribution; only 25% allowed only employee pretax salary reductions as contributions to the plans.

"Smaller firms are more likely to have plans dependent solely on salary reduction, while the largest firms generally include some form of employer contribution."

The most common form of employer contribution, reported by 38% of the 401(k) plans, was an employer match on a specified amount of the employee contribution.

In addition, 24% of plans offered discretionary employer contributions that were not tied to the amount contributed by employees. And, 13% of the plans offered both matching and discretionary contributions

from employers.

Slightly more than half of the employers that matched employee contributions to 401(k) plans did so on a dollar-for-dollar basis. "However," the survey authors note, "the results...largely reflect the influence of the smallest firms."

Among employers with fewer than 50 workers, 69% of those that matched employee contributions did so on a dollar-for-dollar basis. But only 24% of employers with 50 or more employees that matched employee contributions did so at that level; the majority of these larger employers—64%—matched employee contributions at a rate of 50 cents or less for each dollar contributed by employees.

And, virtually all the employers that matched employee contributions did so only up to a certain percentage of salary: About 74% matched only the first 4% to 6% of employee salary deferred to a 401(k) plan.

Most of the 401(k) plans included some limit on the amount an employee could contribute on a pretax basis, usually a percentage of salary.

About 35% of the plans limited employee pretax contributions to between 9% and 12% of salary, including 30% that set the limit at 10% of salary. Twenty-eight percent set the limit at 13% to 16% of salary, including 27% that had a 15% limit. And, 19% set the limit for employee pretax contributions at 20% of salary.

In addition, 46% of the 401(k) plans permitted employees to make aftertax contributions to the funds.

Larger employers were more likely than smaller employers to allow aftertax contributions to 401(k) plans: Sixty-nine percent of the plans offered by companies with 5,000 or more employees allowed such contributions.

About 90% of the plans that allowed aftertax contributions set the maximum for such contributions at 10% of salary, while 5% set the limit at less than 10% and 5% set the limit at more than 10%.

And, about 34% of the plans that allowed aftertax contributions required employees to

first make a pretax contribution to the 401(k) plan.

In other survey findings:

- About 42% of the 401(k) plans allowed employees to change the level of their contribution to the plan only once each year, while an additional 25% permitted such changes only twice a year. Fewer than 19% of the plans allowed employees to change the amount they contribute to the plans as often as they like.

- "This would tend to emphasize the longer-term aspects of 401(k) plan savings, because it would reduce the opportunities for participants to make short-term adjustments in their investment portfolios," the survey said.

- Only 43% of the 401(k) plans surveyed allowed employees to choose among investment options for their contributions; however, these plans represented 95% of the total 401(k) assets.

The most-common investment options were equity funds, offered by 72% of the plans offering investment options; money market funds, offered by 63%; and guaranteed interest contracts, offered by 56%.

Thirty percent of 401(k) plan assets were invested in the stock of the sponsoring company. "Such a relatively high concentration of assets in company stock is potentially risky for plan beneficiaries because, absent more diversified holdings, fluctuations in the value of the firm's stock (for whatever reasons) could have a large effect on the value of the plan's holdings," the survey authors said.

About 50% of the plans allowed employees to change their investment choices only once a year, and an additional 17% allowed only semiannual changes. Only 20% of the plans that allowed investment options set no limit on the number of investment changes that employees could make.

- About 83% of the 401(k) plans surveyed allowed employees to borrow money from their plan balances in 1986. Since smaller employers were more likely than big companies to allow 401(k) loans, only 44% of the participating employees actually could borrow from their 401(k) accounts.

And, 168,000 plan participants—5% of the participants in all plans and 12% of the participants in the plans that allowed loans—had outstanding loans in 1986. The value of the loans totaled \$761 million—about \$4,500 per borrower—and accounted for only 1% of total plan assets.

The survey authors note that the Tax Reform Act of 1986 will tighten restrictions on 401(k) plan loans, mainly by phasing out the deductibility of interest payments. But the authors say, "On balance, loan provisions do not seem to pose a major obstacle to accomplishing the policy objective of encouraging private savings for retirement."

- Almost all—93%—of the 401(k) plans surveyed allowed employees to make early withdrawals of pretax contributions in cases of hardship, and more than half—55%—also allowed withdrawal of employer matching contributions.

Almost 90% permitted hardship withdrawals to pay major medical expenses, about 75% permitted withdrawals to purchase a primary residence and about 70% permitted withdrawals to pay educational expenses.

But, 27% of the plans allowed withdrawal for any "hardship" certified by the participant, 25% allowed withdrawal for any immediate, unplanned financial need, and 24% permitted withdrawals for other reasons.

"Presumably the vagueness of these categories raises concerns among critics of 401(k) plans about possible abuses," the survey notes, adding that the Tax Reform Act also tightened the restrictions on early withdrawals.

Still, the authors say, "As with loans, hardship withdrawals do not appear to pose an immediate threat to the viability of 401(k) plans as retirement savings plans."

- While all 401(k) plan participants deferred an average of 4.7% of salary to the plans in 1986, the average deferral was 5.4% for the higher-paid one-third of workers and 3.8% for the lower-paid two-thirds.

Copies of the study, "401(k) Plans: Incidence, Provisions and Benefits," are available from the U.S. General Accounting Office, P.O. Box 6015, Gaithersburg, Md. 20877; 202-275-6241. The first five copies are free, and additional copies are \$2 each. There is a 25% discount on orders for 100 or more copies mailed to a single address. Orders must be prepaid.

Three industries sponsored two-thirds of the plans: manufacturers; service companies; and finance, insurance and real estate.

Tax law may reduce 401(k) participation

By ALISON KITTRELL

Employers expect 401(k) plans to survive the changes created by the Tax Reform Act of 1986, says a new government survey.

"It appears that the Tax Reform Act will result in some changes in the participation patterns and contribution levels of employees at some firms that sponsor 401(k) plans. But the plans will remain in place," sums up the survey by the General Accounting Office.

In general, employers expect tax reform to have little impact on their own contributions to the plans. But, they say the law will reduce the participation and contribution levels of employees, especially higher-paid workers.

Among other things, the Tax Reform Act reduced the maximum pretax 401(k) deferral to \$7,000 per year from \$30,000. That maximum will be adjusted annually to match increases in the Consumer Price Index; in 1988, the maximum pretax deferral is set at \$7,313.

Predictably, employers say this change would have the greatest impact on higher-paid workers: Some 34% of the employers said that participation in 401(k) plans by higher-paid workers would decrease because of this change, and 50% predicted that contributions by these workers would decrease.

Only 1% said participation rates among higher-paid employees would increase, 62% said there would be no change and 3% said they had no basis to judge. And, no employers predicted contributions from higher-paid employees would increase, while 46% said there would be no change and 4% said they were not able to judge.

In contrast, 88% of the employers said there would be no change in participation levels among lower-paid employees, and 82% said contributions among these employees would not change. Eight percent said they expected greater participation among lower-paid employees as a result of the lower contribution limits, and 7% said they expected higher contribution rates among these employees.

The Tax Reform Act also imposes a 10% excise tax on most pre-retirement withdrawals from 401(k) plans, which will hurt plan participation and decrease contributions, respondents say.

Some 48% of the employers said the excise tax on early withdrawals probably would decrease participation among lower-paid employees, and 42% also said it would decrease the participation of higher-paid employees.

And, 46% predicted the tax would decrease contributions among lower-paid employees, while 35% said higher-paid workers would reduce their contributions because of the excise tax.

Changes in 401(k) plan non-discrimination tests also are expected to affect participation and contribution levels.

For instance, tax reform sets new and tighter standards to compare the contributions of the higher-paid employees with those of the lower-paid.

Under the new law, the deferrals of the highly compensated group of employees now cannot exceed the greater of:

- 125% of the average deferral percentage (ADP) of the lower-paid group.
- The lesser of either 200% of the ADP of the lower-paid group or the ADP for the lower-paid group plus 2 percent-

The Tax Reform Act imposes a 10% excise tax on most pre-retirement 401(k) plan withdrawals, which will hurt plan participation and decrease contributions, respondents say.

age points.

The GAO survey found that in 1986 the average difference between the ADP for the higher-paid and lower-paid employees on a firm-by-firm basis was about 1.6 percentage points. However, at some companies, the ADP of the higher-paid workers was as much as 8 percentage points above the lower-paid group's ADP.

The survey found the average deferral rate for highly compensated employees was 5.4% of salary, which was about 140% of the average of 3.8% for lower-paid employees.

Many employers predict that the more-restrictive ADP test will have an impact on higher-paid employees.

Forty percent said the new rules would decrease participation among higher-paid workers, and 28% said it would decrease higher-paid workers' contributions.

However, 72% predicted these new rules would not change the participation levels of the lower-paid employ-

ees, and 74% said they would not affect their contribution levels.

Besides this change, the Tax Reform Act also amended the definition of "higher-paid" employees to mean:

- Employees owning more than 5% of the company.
- Employees earning more than \$75,000 per year.
- Employees earning more than \$50,000 per year and also being among the highest-paid 20% of the company's workers.
- Corporate officers who earned at least \$45,000 in 1987.

Under provisions of the old tax law, higher paid employees were simply the highest-paid one-third of a company's employees.

Thirty-eight percent of the respondents expect participation levels among higher-paid employees to decrease because of the change in the definition, and 35% expect these employees' contributions to decrease.

However, the survey authors note, "This may simply reflect a reduction of the size of this group in many firms as a result of the new definition."

And, 87% of the employers surveyed expect this change to have no effect on the participation of the lower-paid employees, and 88% expect it to have no impact on the contributions of these employees.

"The participation and contribution behavior of lower-paid workers was generally expected to be unaffected by reform, except for the restrictions and excise taxes placed on hardship withdrawals," the survey authors say.

But, the authors add, "Each provision (of tax reform) was expected to lower the participation or contributions of higher-paid employees by one-fourth to one-half of the firms responding."

Employers also feel that tax reform will have little impact on their own contributions to the 401(k) plans of their employees. But, the survey authors note, "Many of these changes are likely to create additional administrative burdens for plan administrators."

In fact, 68% of the employers expect such an increase in administrative burdens, while only 6% expected no change in their administrative responsibilities as a result of tax reform. The remaining 26% said they were unsure of the impact on plan administration.

"Despite these negatives, overall, virtually no respondents reported that they would discontinue sponsoring their 401(k) plans," the survey says.

First New York

Continued from page 3

payments, according to Peter H. Bickford, a lawyer with the New York firm of Calinoff & Katz, which represents Burt.

Burt policyholders representing more than 96% of the syndicate's paid and outstanding losses have agreed to the commutations, Mr. Bickford said.

Together, First New York and Burt Syndicate accounted for slightly less than half of the total \$170 million surplus deficit projected for six of the eight insolvent syndicates by the Tillinghast division of Towers, Perrin, Forster & Crosby Inc.

A court hearing on the Burt plan is scheduled for Thursday.

First New York, the exchange's second-largest syndicate based on 1984 gross premium volume, stopped underwriting in 1984 and was declared insolvent by the exchange's board of governors in 1986.

The New York Insurance Department filed a petition to liquidate First New York in October 1986 (BI, Nov. 10, 1986).

Until late last year, exchange officials and others were working on plans to consolidate the assets and liabilities of the eight insolvent syndicates into a single runoff syndicate.

However, New York State Su-

preme Court Judge Irving Kirschenbaum signed liquidation orders against two of the syndicates—U.S. Risk Inc. and Realex Group N.V.—on Dec. 29, signaling the death of attempts to consolidate the syndicates' runoff (BI, Jan. 11).

First New York sent out its commutation offers Feb. 23, and by May 4 was able to submit its rehabilitation plan to the Insurance Department, Mr. Burt said.

Under the plan, eight First New York shareholders will make cash contributions to the syndicate totaling \$29.4 million. The shareholders include:

- Arkwright Mutual Insurance Co. of Waltham, Mass., \$5 million.
- Capital Assurance Co. of Miami, a unit of Ryder System Inc., \$4.9 million.
- Gjensidige Norsk Skadeforsikring of Norway, \$5.1 million.
- General Star National Insurance Co., formerly Monarch Insurance Co. of Ohio and now a unit of General Reinsurance Corp., \$4.1 million.
- Nouvelle Compagnie de Reassurances of France, \$2.1 million.
- Ormond Reinsurance Co. of Ormond Beach, Fla.—also the parent company of Burt Management and Burt Syndicate—\$418,750.
- Pearl Assurance P.L.C. of Great Britain, \$2.2 million.
- Pohjola Group of Finland, \$5.7 million.

One First New York shareholder is not participating in the rehabilitation plan: Mutual Fire, Marine & Inland Insurance Co., which currently is under the voluntary supervision of the Pennsylvania Insurance Department.

First New York's shareholders also are quota-share retrocessionaires of the syndicate, and the shareholders will make the cash contributions in exchange for commutation of their retrocessional agreements with the syndicate.

Meanwhile, more than 200 First New York policyholders representing 92.7% of the syndicate's past due balances and known outstanding losses have agreed to commute their contracts for a total of \$25.9 million.

The commutation payments represent a recovery of about 70 cents on the dollar for past due balances and known losses of roughly \$37 million.

However, if the Tillinghast report's estimate of IBNR losses is included, First New York's total liabilities could amount to roughly \$100 million, making policyholders' recovery on the commutations about 25 cents on the dollar.

One First New York policyholder—Safety Mutual Casualty Corp. of St. Louis—has separately settled arbitration proceedings against the syndicate, though First New York representatives refused to disclose the amount of the settlement.

The syndicate's rehabilitation plan called for it to reinsure all liabilities arising from the uncommuted portion of its book, and First New York officials contacted two Bermuda-based financial reinsurers—Forum Reinsurance Co. Ltd. and Centre Reinsurance (Bermuda) Ltd.—for quotes.

However, six of First New York's shareholders ultimately decided to assume this reinsurance obligation themselves. They will provide coverage with a maximum limit of \$14 million—which is expected to be

more than enough to cover losses on the uncommuted business—for a premium of \$10.5 million.

The six First New York shareholders and their participation on the reinsurance program are:

- Arkwright Mutual, 15.72%.
- Capital Assurance, 12.73%.
- Gjensidige Norsk, 20.95%.
- Nouvelle Compagnie de Reassurances, 6.57%.
- Pearl Assurance, 20.95%.
- Pohjola Group, 23.08%.

The plan also calls for the exchange's security fund to contribute \$500,000—an amount equal to the syndicate's initial deposit with the fund—to cover a portion of the \$10.5 million reinsurance premium.

In a court hearing last week, Steven S. Honigman, a lawyer with the New York firm of Miller, Singer, Raives & Brandes who represents First New York, described this payment as a "bargain" for the security fund, which would be relieved of millions of dollars of claims through a successful rehabilitation.

However, the security fund's board of directors has not yet had an opportunity to review the plan, and Judge Kirschenbaum gave the fund's board until May 26 to voice any objections it may have to the plan.

In addition to First New York's shareholder/retrocessionaires, the syndicate ceded facultative and catastrophe excess reinsurance to nearly 100 other underwriters, including numerous Lloyd's of London syndicates, according to Mr. Burt.

Many of these reinsurers also have agreed to commute their contracts with First New York as part of the rehabilitation plan, Mr. Burt said, adding that the commutations with facultative reinsurers will be limited and that these reinsurers will remain liable for losses on the uncommuted portion of First New York's underlying book.

A timetable established for the rehabilitation plan sets a July 25 deadline for receipt of cash infusions by First New York's shareholders, funds due under commutations with the syndicate's other retrocessionaires and payment of the reinsurance premium to the six syndicate owners.

Commutation payments to First New York's policyholders are to be completed by Aug. 2.

In addition, the syndicate will pay \$365,000 to the exchange, representing about 25% of the amounts claimed by the exchange for past due fees, assessments, fiduciary funds advanced on the syndicate's behalf and other items. The settlement also relieves First New York of liability for any future fees or assessments, including any "second call" for a \$500,000 contribution to the security fund's deposit fund.

First New York is expected to emerge from the completed rehabilitation with capital and surplus of about \$1.1 million.

As part of the plan, Miami-based Ryder System Inc. has agreed to buy the rehabilitated syndicate, though the acquisition is subject to several conditions, including approval by Ryder's chief executive and board of directors, along with the chief executive of the Ryder subsidiary that may actually make the acquisition.

A New York law that prohibits voluntary self-liquidations requires that the syndicate emerge from its rehabilitation as a going concern.

In signing an order last Tuesday putting the rehabilitation plan into effect, Judge Kirschenbaum adjourned any further action on the Insurance Department's liquidation petition until Dec. 15.

If the rehabilitation plan is successfully completed, Judge Kirschenbaum's order requires the Insurance Department to withdraw the liquidation petition. ■

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Stress claims outnumber previous estimates: Report

By MEG FLETCHER

SAN FRANCISCO—Stress claims in the California workers compensation system may be as much as 10 times more prevalent than previously reported, the California Workers Compensation Institute says.

During 1986, the state Division of Labor Statistics & Research recorded 3,812 work injuries involving "anxiety reactions and other mental disorders," according to the report.

That total, which is less than 2% of loss-time injuries that year, is

based on reports submitted by employers.

However, only every 10th mental stress claim originates with notice from the employer, according to the report. Instead, nearly 85% begin with the worker's attorney filing an application for adjudication.

Consequently, "the number of mental stress claims may be as much as 10 times greater than employers reported in 1986, approaching 70,000 cases, or 17% of all lost-time injuries," the institute reported.

The institute represents most of the insurers selling commercial workers compensation coverage in California.

"Job pressures" and "harassment" are the most frequent causes of mental stress claims in California, the institute said. Four in 10 workers filing claims allege both causes acting in concert.

The study includes all three types of stress claims:

- "Mental-mental" cases, in which a disability results from emotional distress without an accompanying physical injury.

- "Mental-physical" cases, in which a physical condition like a heart attack is caused by a mental distress.

- "Physical-mental" cases, in which a worker's mental anguish can be caused by a physical injury or event, like a scaffolding accident.

In addition, nine of 10 stress claims are cumulative in nature and do not involve a specific incident. Thus, the combination of subjective causes and cumulative

injury make stress claims hard to disprove, the institute said.

Compensable claims are characterized by absence of physical injury, little time off work, low medical treatment costs, insignificant retraining costs and litigation, the report found.

Permanent disability indemnity costs comprise three-quarters of the cost of stress claims. In cases where payment is made, the claim is settled with the parties agreeing to lump-sum payment in exchange for releasing the employer from any future liability, according to the institute.

Employees claiming disability compensation because of job-related stress generally are older and more likely to be females working in white-collar occupations, the report said.

The institute's estimates of claims in California is considerably higher than national figures reported by the New York-based National Council on Compensation Insurance, which also represents workers compensation insurers.

"NCCI estimates that less than 1% of all workers compensation losses are directly due to stress," according to the NCCI's 1988 Issues Report.

Differences in estimates are due in part to the definition of stress. The NCCI tallies only "mental-mental" claims as workers compensation stress claims.

In addition, some differences in estimates may stem from the way in which costs are assigned to stress-related claims, the NCCI said. ■

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COBRA penalties

Continued from page 1
the current COBRA statute.

"My first reaction is the faster the better," said Howard Greene, associate legislative director for the New York-based Risk & Insurance Management Society, referring to the push to enact the COBRA changes. "Employers shouldn't have to live a single more day with a potential loss of tax deduction for health care expenses for an inadvertent COBRA violation."

But lobbyists, while excited that revision of COBRA penalties could again be on the congressional front burner after more than a solid year of lobbying, warn that the new COBRA penalties still face an uncertain future.

The COBRA changes could be rejected by conferees who don't want to include non-Medicare issues in the legislation, lobbyists point out.

Last week's events are just the latest development in the brouhaha over the COBRA penalties.

Under the health care continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, a single COBRA violation carries with it a penalty that has outraged employers: the loss of the employer's annual tax deduction for health care expenses.

And, the highly compensated employees of a company violating COBRA would have the cost of employer provided health care coverage added to their taxable income.

Some 1,300 employers and trade groups wrote letters last year to the Internal Revenue Service protesting IRS proposed rules reaffirming COBRA's strict penalties.

Those letters helped convince the

IRS to send signals to Congress that perhaps the penalties were unfair and needed overhaul.

Ultimately, legislators read those signals. The House last year, in approving a budget reconciliation bill, included new COBRA provisions under which an employer generally would have paid an excise tax of \$100 for each day it failed to extend coverage to a COBRA beneficiary.

However, due to complex legislative maneuverings, those COBRA penalty changes were deleted by a conference committee.

Initially, benefit lobbying groups were not too concerned by this deletion. Congressional staffers had informally assured the lobbyists that the COBRA penalty changes would resurface in a so-called technical corrections bill that the chairmen of the House and Senate tax committees said they would introduce early this year.

But concern grew when the technical corrections bill—designed to correct drafting glitches in the Tax Reform Act of 1986—was introduced last month without the COBRA penalty changes.

In fact, the only COBRA change in the technical corrections bill has been blasted by business groups. Under that proposal, employers would be required to allow beneficiaries to keep COBRA coverage even if they became covered under another employer's health care plan (BI, April 11).

Some lobbyists, while disturbed about the omission of the COBRA penalties from the technical corrections bill, said it was possible that the penalty provisions would be added when the tax committees began to mark up and vote on the bill. That has not yet occurred.

While the COBRA changes that now may be included in the Medicare bill are based on the revised COBRA penalty provisions approved by the House last year, there are some differences. And, in at least one case, congressional staffers appear to be responding to employer complaints about some of the changes that were approved by the House.

For example, employers and consultants blasted a provision in the House-passed legislation that set a special minimum penalty of \$18,000 to be levied when the IRS uncovered during a plan audit a COBRA violation that was not corrected before the employer received notice that the IRS would be auditing the plan.

In that situation, the IRS would automatically assume the employer was not in compliance with COBRA for at least 180 days, making an employer liable for a minimum tax of \$18,000 per affected beneficiary.

But, under the series of amendments now being drafted, the minimum tax would be lowered to \$3,000, sources said.

While that change would be supported by employers, another COBRA provision under staff consideration is strongly opposed by insurers and third-party plan administrators. Under that provision, insurers and third-party administrators could be held jointly and severally liable for COBRA violations.

Under the current COBRA statute, an employer could lose its tax deduction for health care expenses for a COBRA violation even if the violation was the fault of another party. There would be nothing to

Continued on next page

EIL risks

Continued from page 3

"The recent environmental laws and the courts' broader interpretation of tort liability have not only given new meaning to the old phrase 'let the buyer beware,' but have created the 'let the seller beware' principle as well," Mr. Bechely explained.

"Sale of contaminated property to an irresponsible buyer may result in liabilities that will come back to haunt the seller," he said. "The trail of responsibility can extend all the way back to the first party that may have caused the contamination."

He pointed out that environmental laws pertaining to real estate transactions are new and complex, and many have not been tested in the courts.

"While legal experts differ in their opinions, many feel that the liabilities stemming from common law theories may also be joint and several, so that an injured plaintiff could take action against all potential parties or defendants in an environmental lawsuit," he said.

In most cases, "deep pockets" will ultimately be tapped, which can strain the resources of financially sound corporations.

Environmental risks at most commercial sites include hazardous chemical storage, buried wastes, leaking underground storage tanks, airborne chemicals, asbestos in building materials and PCBs in electrical transformers and capacitors, Mr. Bechely said.

To address these problems, environmental regulations have proliferated at a "tremendous" rate, he said. These include U.S. Environmental Protection Agency regulations written under the aegis of the Resource Conservation and Recovery Act, the Comprehensive Environmental Responsibility Compensation and Liability Act (better known as the Superfund Act), the Substances Control Act and the Occupational Safety and Health Administration's hazard communication standard.

RCRA regulates hazardous wastes from "cradle to grave," or from their production to transport to disposal, Mr. Bechely noted.

The law also has been broadened to regulate underground storage tanks, and final rules for tanks are expected to be released at the end of this year (BI, April 27, 1987).

In addition, "several state environmental laws pertaining to property transactions are on the books and several others are being discussed," Mr. Bechely said.

For instance, under New Jersey's Environmental Cleanup and Responsibility Act, a company selling certain types of industrial property must formally declare there is no on-site contamination. If contamination is found or suspected, state law requires that a cleanup plan be submitted.

New York, Washington, Maryland and California are among the states that enforce or are considering similar laws.

In contrast, Connecticut's approach seeks to assign

legal responsibility rather than use regulatory involvement to force specific remedial action. Under its law, "the seller has strict liability for any past contamination which might be discovered after the sale," he said.

Other states that have or are proposing environmental laws applying to the transfer of property include Pennsylvania, West Virginia, Illinois and Minnesota, he said.

Mr. Bechely advised that risk managers involved in property transactions should be aware of the following "red flags":

- Presence of hazardous materials, storage tanks, electrical equipment, pits, ponds or lagoons.
- Stained soil, fouled surface water.
- Proximity of flood plains, wetlands, coastal zones or surface water.
- Evidence of excavation, filling or other earth-moving activities.
- Proximity to drinking water supplies.
- Proximity to known contaminated sites.
- Unfavorable press reports and neighborhood complaints.
- Regulatory actions against the owner and compliance status.
- Spray-on insulation.
- Electrical transformers.
- Unusual odors.

Any of those conditions may be a strong indication of potential problems and signal the need for a more comprehensive environmental assessment, Mr. Bechely said.

An environmental risk assessment may help both the buyer and seller because it can provide information crucial to decision-making. The information generated in a pre-purchase survey also can be used to negotiate price and incorporate any special insurance or financial provisions, like the creation of an escrow account, he said.

A risk assessment usually begins with a walk-through survey of the property followed by a review of documents including reports, test data, citizen complaints and regulatory citations.

A comprehensive assessment may include evaluation of the population potentially exposed; proximity to drinking water supplies; site history; surrounding terrain, geology and hydrogeology; management awareness and control programs; toxic spill control and containment programs; quantity and nature of chemicals and wastes on-site; integrity of chemical and waste storage both above and below the surface; regulatory compliance; and waste disposal practices both on-site and off-site.

Laboratory analysis of site samples also may be necessary, he added.

Some clients have asked that assessment findings be reported to their legal counsel in an effort to protect the information through the doctrine of attorney-client privilege, Mr. Bechely noted. ■

Update

OIL responsible for Shell claims

Continued from page 2
with the same deductible.

If the ruling is upheld, it would dramatically alter the coverage available to all OIL members involved in hazardous waste litigation, according to several attorneys close to the case.

"This is the single most important ruling to come out of this trial," said Barry Ostrager, an attorney with Simpson, Thatcher & Bartlett in New York, who represents Travelers Insurance Co. "The court's construction of the OIL policy opens the door for a jury verdict in Phase II of the trial that any coverage Shell may have for pollution damage at the Rocky Mountain Arsenal is provided by OIL."

Punitive award review denied

WASHINGTON—The U.S. Supreme Court last week again declined to rule on the constitutionality of punitive damages.

The Mississippi Supreme Court had ruled in *Bankers Life & Casualty Co. vs. Crenshaw* that a \$1.6 million punitive damage award assessed against Bankers Life for bad-faith refusal to pay an injured man's claim for accidental loss of a limb was appropriate. Furthermore, a state law allowed the high court to fine the insurer an additional 15% of the punitive damage, or \$243,000, which then became part of the damage award, because the state Supreme Court did not alter the original award.

However, the U.S. Supreme Court, in a 6-1 vote, declined to hear the case because Chicago-based Bankers Life had not questioned the constitutionality of the punitive damage award before the state court, said Justice Thurgood Marshall in the majority opinion. Justice Harry Blackmun filed the lone dissent.

This is the second time the court has declined to rule on the constitutionality of punitive damages (BI, April 28, 1986).

Aon to underwrite in Bermuda

HAMILTON, Bermuda—Aon Corp.'s Rollins Burdick Hunter (Bermuda) Ltd. plans to open an underwriting management unit in June to underwrite a general treaty reinsurance account on behalf of another Aon unit, Virginia Surety Co. Inc.

Robin Spencer-Arscott, who as expected has been named chairman and chief executive officer of RBH (Bermuda), would not comment on whether the new underwriting unit also will take over underwriting for Paumanock Insurance Co. from his former employer, Frank B. Hall (Bermuda) Ltd. (BI, May 2).

John Williams, who underwrote for Paumanock at Hall, is expected to join Aon's Bermuda operation.

Paumanock, a wholly owned subsidiary of Grumman Corp., is the third-largest treaty reinsurance underwriter in Bermuda with 1987 gross written premiums totaling \$38.8 million.

Paumanock's annual general meeting is scheduled for June 1.

N.Y. firm convicted of dumping

GLEN COVE, N.Y.—A chemical distribution company and three officers were convicted of criminal charges stemming from the dumping and storage of hazardous wastes.

The company, Mattiace Industries Inc., was convicted of six felony and misdemeanor counts carrying maximum fines of \$205,000 after a three-week jury trial, said a spokesman for the New York Attorney General's office.

Mattiace president Louis J. Mattiace also was convicted of forging shipping logs used to track toxic wastes and faces a penalty of up to seven years' imprisonment and a \$5,000 fine. His brothers, William and Otto, pleaded guilty to criminal violations of the state's hazardous waste laws.

The Long Island plant has been shut since September, when the attorney general blocked the company's bankruptcy petition, the spokesman said. The company's attorney could not be reached.

Insurer invests in AIDS study

NEW YORK—On the heels of its AIDS awareness campaigns, New York Life Insurance Co. will invest \$8.5 million in a venture to develop a treatment for the fatal disease.

The \$8.5 million, to be allocated over four years, will fund work by IDEC Pharmaceuticals Corp. of LaJolla, Calif. IDEC is the reported leader in applying anti-idiotypic technology—the use of man-made antibodies to diagnose and treat diseases—to regulate the nature, strength and duration of the body's immune responses.

New York Life's investment "is a combination of ongoing venture opportunities; we're always looking at investments in the health care area," said Jeff Waltcher, senior investment analyst for the New York-based insurer. New York Life also is involved in a \$1.5 million public service ad campaign in New York City about acquired immune deficiency syndrome (BI, Sept. 7, 1987).

Briefly noted

The House Judiciary Subcommittee last week indefinitely postponed consideration of legislation, H.R. 2727, to narrow the insurance industry's antitrust exemptions under the *McCarran-Ferguson Act*. Some subcommittee members complained they were not given sufficient time to study the issue. . . . The U.S. Supreme Court last week ruled unanimously that **medical peer-review committee** activities prior to 1986 are subject to federal antitrust laws. Congress in 1986 passed a law shielding medical peer-review committee activities from federal antitrust laws if the action was taken in good faith. . . . **Tinsley H. Irvin**, president and CEO of Alexander & Alexander Services Inc., was elected chairman, succeeding John A. Bogardus Jr. . . . The House Energy and Commerce Committee will continue marking up a **federal product liability reform** bill Tuesday. . . . An Indian judge has ordered **former Union Carbide Corp. Chairman Warren Anderson** to face homicide charges in connection with the 1984 poisonous gas disaster.

Medicare

Continued from previous page
stop an employer, though, from suing an insurer or administrator to recover damages.

However, under the current statute, COBRA penalties cannot be directly assessed against an insurer or third-party administrator.

While insurer and TPA groups don't object to being held liable for their own mistakes, they say they shouldn't be held liable for an employer's COBRA violations.

"We don't think anyone should be held jointly and severally liable. That would allow the IRS to go after the party with the deepest pocket," said Alan Richards, Washington representative and counsel for the Blue Cross/Blue Shield Assn.

"We don't believe that TPAs should be brought into a joint and several liability situation when they are not at fault. We can understand imposing liability where a TPA is responsible, but not in situations where a COBRA mistake was another party's fault," said Tracy Gilliland, director of government affairs for the Society of Professional Benefit Administrators in Washington.

While business groups are encouraged that congressional staffers appear open to COBRA changes, several lobbyists warn that the staff-led effort could quickly fail. Conferees could decide that COBRA changes are not germane to the Medicare legislation because neither the House nor the Senate-passed Medicare bills

Until COBRA changes are made, business groups vow to keep up the pressure.

contain any COBRA provisions.

Already, there have been rumblings from Republicans on the House Ways and Means Committee that the vehicle for COBRA changes should be the technical corrections bill, observers said.

Until changes are made, business groups vow to keep up the pressure on Congress to make the COBRA penalties more reasonable.

Last week, for example, eight business groups sent a letter to Senate Finance Committee Chairman Lloyd Bensten, D-Texas, and House Ways and Means Committee Chairman Dan Rostenkowski, D-Ill., urging, among other things, that Congress impose a reasonable cap on COBRA penalties.

In addition, the amount of the penalty should be based on the employer's or administrator's track record in complying with COBRA, according to the letter signed by RIMS, the Assn. of Private Pension & Welfare Plans, the ERISA Industry Committee, the Employers Council on Flexible Compensation, the National Assn. of Manufacturers, the Self-Insurance Institute of America, the U.S. Chamber of Commerce and the Washington Business Group on Health.

Retirees likely will receive employer Medicare savings

By JERRY GEISEL

WASHINGTON—House-Senate conferees likely will approve a proposal that bars employers with retiree health care plans from reaping any immediate cost savings when the Medicare program is expanded.

The provision in the Senate Medicare expansion bill, proposed by Sen. Donald Riegle Jr., D-Mich., would require employers that eliminate the portions of their retiree health care plans that duplicate benefits provided by the expanded Medicare program to pass those savings on to retirees (BI, Nov. 16, 1987).

Employers will cut back their retiree health care plans to prevent duplication of coverage when Medicare begins to pay more expenses.

Under the Riegle amendment, retirees would be entitled to additional cash or new benefits from their former employer that equals the "actuarial value" of any company-provided health care benefits eliminated because they duplicate Medicare benefits.

Under the Riegle amendment, which is known as the "maintenance of effort" provision, these savings generally would have to be distributed to retirees for one year.

While this provision—added last year to the Senate Medicare expansion bill—does not appear in the Medicare bill passed by the House, the only objection to the provision by House conferees is that it does not go far enough, business lobbyists say.

"The House's only regret probably is that it didn't think of the maintenance of effort idea first," said Jim Klein, manager-health care and pension policy for the

U.S. Chamber of Commerce in Washington.

In fact, House conferees have been pushing for a revision of the Riegle amendment so that employers would have to pass on cost savings to retirees for at least two years.

Because House and Senate conferees agree that cost savings should be passed on to retirees for some undetermined period, there is little doubt that some version of the Riegle amendment will be in the final Medicare legislation.

"I expect a final bill to include a maintenance of effort provision. Employers should be prepared for such a provision," said Howard Greene, associate legislative director for the Risk & Insurance Management Society in New York.

"It is almost certain that a maintenance of effort amendment will be in the legislation," added Cathy Amkraut, director of public policy for the Washington Business Group on Health.

Business lobbyists are opposed to any maintenance of effort provision, noting that administrative costs would outweigh the few benefits retirees would receive.

However, lobbyists are relieved that conferees don't seem to be buying a proposal, outlined in a letter written earlier this year by Sen. Riegle, that would require cost savings should be distributed to retirees for several years.

That proposal would require employers with retiree health plans to pass along cost savings to retirees as the different portions of the Medicare expansion are phased in (BI, March 21).

Liberal think tank endorses federal long-term care plan

By JERRY GEISEL

WASHINGTON—Congress should consider hiking Social Security payroll taxes to pay for a new federal long-term health program, a liberal think tank says.

The Washington-based Brookings Institution in a new book published last week says it is time to create a new federal social insurance program to cover long-term health care.

"This approach would provide near-universal coverage for the elderly and would explicitly recognize that using long-term care is a normal, insurable risk of growing old," says the book, titled "Caring for the Disabled Elderly."

"Everyone should contribute to public long-term care insurance and earn the right to needed benefits without having to prove impoverishment," the book adds.

To pay for a program providing major new nursing home care and home health care benefits, there would have to be a "substantial but not unmanageable" increase in Social Security taxes, according to the book's authors, Alice Rivlin, a former director of the Congressional Budget Office, and Joshua Weiner, a Brookings fellow.

The book says a federal long-term health care program would

require removing the current \$45,000 ceiling on wages subject to FICA taxes and raising the FICA tax—now 15.02%, with employers and employees each paying half—by between 2.2 and 2.9 percentage points.

The Brookings proposal is similar to a bill currently pending in Congress.

Sen. George Mitchell, D-Maine, last month introduced legislation, S. 2305, that would increase Medicare payments for home health care and nursing home expenses (BI, May 2).

To finance the program, Sen. Mitchell proposes extending the Medicare portion of the FICA tax—which is currently 1.45%—to all wages earned. The legislation also calls for increased Medicare Part B premiums and an estate and gift surtax.

In addition, Sen. Edward Kennedy, D-Mass., has unveiled a much broader proposal to create a federal long-term care insurance program. Sen. Kennedy's proposal would be funded by increasing the wage base for all FICA taxes to \$75,000. However, the current FICA tax rate of 7.51% would not be changed (BI, March 28).

The Brookings report points out there still would be room for the private sector to provide long-term

care coverage after a federal program is established.

For example, a federal program should require substantial cost sharing, the book says. Beneficiaries then could purchase supplemental long-term care policies, as is now the case with Medicare, to cover deductibles and coinsurance requirements.

"The role of private sector financing would be substantial but supplementary to provide greater financial protection and services for those who desire them," according to the book.

The Brookings book, though, is highly critical of proposals periodically discussed in Congress to allow employees to take tax deductions for contributions to so-called Individual Medical Accounts to prefund long-term care benefits.

IMAs are an inefficient and ineffective way to subsidize long-term care because the accounts would result in hefty revenue losses while being utilized by few middle- and lower-income workers, the book says.

The survey also notes that some employers have begun to offer long-term coverage to employees, but it questions whether coverage will be offered by more than just large private employers and state governments.

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Study confirms UR programs cut cost

BOSTON—A recently published study that shows utilization review programs can cut employers' health care costs an average of 8.3% annually is the first solid proof of the cost-effectiveness of those programs, asserts one of the report's authors.

The study, published in the New England Journal of Medicine last week, is the first "statistically balanced" look at this facet of managed health care, says Paul J. Feldstein, co-author of the report and a professor at the Graduate School of Management at the University of California at Irvine.

"There have been other studies," said Mr. Feldstein, "but they are mostly anecdotal. There have been no widespread statistical studies" to determine whether UR programs actually save money.

Overall, the study reported that UR reduced hospital admissions an average of 12.3% and cut those expenditures an average of 11.9%.

Companies with high hospital admission rates can save as much as 24% a year if a UR program is implemented, the study showed.

For example, a company with 1,000 employees and about 100 hospital admissions per year can save about \$150,000 in health care costs by offering utilization review, while a company with an older workforce and approximately 150 admissions could save about \$500,000, according to the study.

The study involved three UR programs offered by CNA Insurance Cos. in Chicago in 1984 and 1985. Researchers studied 222 groups of employees and dependents. They assumed the UR program cost \$1.58 per month per employee.

Mr. Feldstein said researchers are completing the final phase of the study that looks at the same data during 1986 and, so far, "it confirms what we have found for the other two years."

Outhwaite report

Continued from page 1

been able to recover some of their losses from other parties by charging mismanagement. For instance, members of syndicates managed by PCW Underwriting Agencies Ltd. received a 103 million pound (\$192.1 million) settlement from Lloyd's, members' and brokers to partially cover a 235 million pound (\$438.3 million) underwriting loss (BI, April 13, 1987).

Meanwhile, the Outhwaite agency last week asked the 1,614 members of marine syndicate 317 and "mirror" non-marine syndicate 661 during the 1982 underwriting year to pay 20.5 million pounds (\$38.2 million) by July 29 toward an underwriting loss of 85 million pounds (\$158.5 million) on the 1982 accounts.

The 1982 underwriting year will be kept open and the balance of the loss will be carried forward, the agency announced.

"This loss is far greater than anticipated a year ago," according to a statement issued by the Outhwaite agency.

Outstanding losses for the 1982 account total 262 million pounds compared with 248 million at the end of 1986, the statement says. "However, since these liabilities arise in U.S. dollars, the exchange rate movement between December 1986 and December 1987 masks a far more serious deterioration," Outhwaite noted.

In terms of dollars, the losses have risen to \$488.6 million (at current exchange rates) from \$367 million (at year-end 1986 exchange rates).

The runoff reinsurance policies written by the Outhwaite syndicate cover all of a syndicate's or insurer's ultimate liabilities above a pre-agreed amount for a specified number of policy years, some dating back to the 1950s.

The runoff policies "have been subject to substantial losses mainly arising from latent disease and environmental pollution in the USA, and claims reported during 1987 have

increased significantly over previous years," said the Outhwaite statement.

Mr. Outhwaite currently is disputing 185 million pounds (\$345 million) of claims against the runoff policies on the grounds that the ceding syndicates and insurers did not fully disclose information about the risks to be reinsured, including asbestos risks.

The refusal to pay claims has set off a round of finger-pointing in which Mr. Outhwaite blames ceding insurers and syndicate members blame the underwriting agency for the large losses.

According to Mr. Heynes, Freshfields concludes in the report that "Mr. Outhwaite may fairly be criticized for failing to identify... precisely the basis of the figures presented to him at the time of the placing of the policies in question, for not investigating more thoroughly the nature of the asbestosis problem and its potential magnitude and for writing a substantial number of these policies without giving sufficient weight to the consequent aggregation of risk."

In addition, Freshfields "expresses concern that the amount of business written into non-marine syndicate 661 exceeded the appropriate 20% limit, though no criticism is made as regards the combined premium limit of the syndicate," the letter said.

Marine syndicates usually can write no more than 10% non-marine business through an incidental syndicate. However, Mr. Outhwaite obtained permission from members of 317/661 and Lloyd's to change incidental non-marine syndicate 661 into a mirror syndicate of 317 that would write 20% of the total syndicate's combined premium limit.

Mirror syndicates share the same members and are treated as one syndicate for accounting purposes.

The Outhwaite members' steering committee "is now considering with some care the consequences which are likely to flow from this report," Mr. Heynes said in the letter sent Thursday.

Another lawyer probably will be asked to

study the report on the members' behalf because of the possible conflict of interest between members and their members' agencies because the agencies placed the names on the Outhwaite syndicate, Mr. Heynes said at a press conference last week.

"Lloyd's has agreed to consider paying for this," he stated, adding that the analysis of the Freshfields report likely will be available before the July 29 cash call deadline.

Lloyd's will nominate several attorneys for the review and the members' agencies will select one, a Lloyd's spokesman said.

Meanwhile, "the steering committee is of the opinion that there is nothing contained within the Freshfields report that would justify (members) withholding payment of the cash call," said Mr. Heynes.

The members' agencies refused to make the full report public last week "on legal advice," though copies of the report will be sent to Outhwaite members soon, he said.

However, in a letter published Friday in Lloyd's List, a shipping and insurance newspaper published by Lloyd's of London Press, Mr. Outhwaite states that "the report's conclusion is clearly that my practices were broadly in line with those prevalent in Lloyd's at the time."

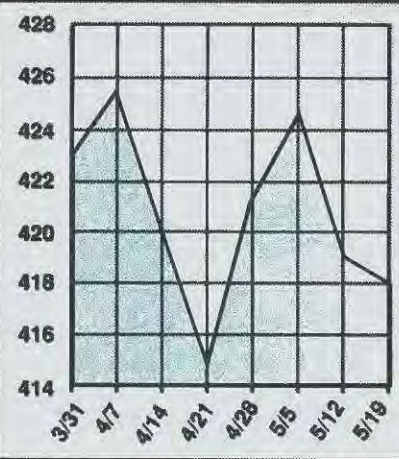
According to Mr. Outhwaite's letter, the Freshfields report pointed out that:

• "It has been confirmed to us that the general standards of enquiry and requests for information made by Mr. Outhwaite were compatible with, and certainly of no lower standard than, other underwriters in the market."

• "The underwriter's choice of methods is a matter for his own discretion and we do not consider that Mr. Outhwaite's methods demonstrate any lack of due skill and care judged by contemporary standards."

• Mr. Outhwaite did not "have any formal system for monitoring aggregation of risk between various contracts... (however) it was highly unusual in 1981-82 for Lloyd's syndicates to have such systems."

BI Insurance Index



Insurance industry stocks faltered for the second consecutive week as the *Business Insurance* stock index dropped 1.3 points to 417.9 on May 19 from 419.2 on May 12. The largest gains were reported by Phoenix Re. Corp., up 10.3%; Fremont General Corp., up 5.3%; Nobel Insurance Ltd., up 5.1%; Argonaut Group Inc., up 3.9%; and SCOR U.S. Corp., up 2.8%. The biggest declines were posted by Zenith National Insurance Corp., down 5.7%; Orion Capital Corp., down 3.8%; CNA Financial Corp., down 3.6%; Liberty Corp. of South Carolina, down 3.5%; and Fireman's Fund Corp., down 3.3%. The most active stocks tracked by *Business Insurance* were Farmers Group Inc., 2.7 million shares traded; Sears Roebuck & Co. (Allstate Insurance Group), 2.5 million shares traded; Aetna Life & Casualty Co., 1.9 million shares traded. The BI index lost 0.3% last week, which was slightly better than the performance of the major market averages. The Dow Jones 30 Industrials and the New York Stock Exchange Composite each fell 0.5%, while the Standard & Poor's 500 index declined 0.4%.

Merrett syndicate faces runoff woes

LONDON—Another of Lloyd's of London's largest syndicates is being forced to keep its 1985 underwriting year open because of problems stemming from runoff reinsurance policies it wrote during 1982.

Syndicate 418/417, managed by Merrett Underwriting Agency Management Ltd. and underwritten by Stephen Merrett, will keep its 1985 accounts open pending "discussions with cedants" over several runoff policies, said Ken Randall, managing director of MUAM (BI, May 9).

Although the syndicate's audit is not yet complete, Mr. Randall planned to send a letter to members last Friday informing them that the syndicates' accounts will remain open.

However, there will be no cash call because the syndicate is not expected to post a loss, Mr. Randall said. The syndicate is adequately reserved for estimated losses from the 11 runoff policies it wrote, despite a substantial increase in claims last year, he added.

The syndicate has reserves "well in excess of \$100 million" to pay for losses on the runoff policies and because of "our very cau-

tious reserving in the past, there has been no material deterioration since last year," Mr. Randall said.

However, the 1985 account is being kept open in case the current situation changes, possibly to the members' benefit, he said.

"We are undertaking a major investigation (into the runoff policies) and entering negotiations with some of the cedants with a view to renegotiation on the grounds of non-disclosure," he said.

One of the contracts questioned by syndicate 418/417 was ceded by another Merrett-affiliated syndicate, Mr. Randall confirmed.

An unlimited runoff reinsurance policy for underwriting years prior to 1975 for losses exceeding \$12 million was ceded to syndicate 418/417 by syndicate 334, managed by Pulbrook Underwriting Management Ltd., which has been acquired by Merrett.

"Questions are currently being asked in regard to the policy," Mr. Randall confirmed, adding that any dispute concerning the policies would be decided through independent arbitration.

Possible claims surrounding the contract total "several million dollars," Mr. Randall said.

British Issues

May 19 Companies	Price	P/E	Div.	Yield	High-Low
Comet Union	362	13.7	21.9	5.9	362-348
Genl Accident	898	10.4	47.9	5.2	918-898
Gdn Royal Exch	872	13.0	55.2	6.3	899-872
Royal	387	10.2	26.4	6.6	395-387
Sun Alliance	925	15.1	43.1	4.5	933-925
Brokers					
Bradstock	230	12.9	6.8	2.9	230-230
CE Heath	400	14.8	34.5	8.3	402-400
Hogg Robinson	153	12.2	9.6	6.1	153-146
Lloyd Thompson	155	13.5	6.8	4.3	158-155
PWS Holdings	188	7.9	14.4	7.4	188-188
Sedgwick Grp	223	13.9	16.4	7.2	225-223
Steel Brl Jones	204	12.6	13.7	6.5	207-204
Willis Faber	240	12.6	15.4	6.4	240-230

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

BI Industry Stock Report

MAY 19, 1988

5/13/88 THRU 5/19/88

BROKERS

		Price	Weekly % change	Year to Date % change	Annual High Low		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander Svcs	NYSE	21.63	0.0	21.9	24.50	17.75	273	1.00	4.6	13.7	3.40	6.36
Baldwin & Lyons Inc.	OTC	15.00	0.0	25.0	15.50	12.00	1	0.20	1.3	5.8	18.66	0.80
Corroon & Black Corp.	NYSE	31.25	-0.8	10.6	34.75	28.00	381	1.08	3.5	4.8	5.43	5.76
Gallagher Arthur J. & Co.	NYSE	16.38	0.0	2.4	18.00	13.88	47	0.48	2.9	10.8	5.16	3.17
Hall Frank B. & Co.	NYSE	4.00	-3.1	38.9	5.50	2.88	105	0.00	0.0	10.8	0.00	N/A
Hill, Rogal & Hamilton	OTC	11.75	0.0	20.5	12.75	9.75	19	0.00	0.0	10.8	0.00	N/A
Lawrence Ins. Group	AMEX	13.88	-0.9	105.6	15.88	6.88	2	0.32	2.3	14.3	4.10	3.39
Marsh & McLennan Cos. Inc.	NYSE	49.75	-0.5	0.5	55.63	45.25	338	2.40	4.8	12.2	6.74	7.38
Poe & Assoc. Inc.	OTC	9.25	0.0	32.1	9.25	6.75	0	0.40	4.3	9.0	0.57	16.23
BROKERS AVERAGE			-0.6	28.6					2.6	10.0		

CONGLOMERATES & HOLDING COMPANIES

Berkley W.R. Corp.	OTC	25.00	0.0	4.2	29.00	23.50	90	0.35	1.4	6.1	17.63	1.42
Berkshire Hathaway Inc. DEL	OTC	3675.00	-0.7	24.6	3825.00	2755.00	167	0.00	0.0	17.9	69.38	9.95
CIGNA Corp.	NYSE	43.13	-0.6	-1.7	51.88	42.88	494	2.96	6.9	5.9	49.19	0.88
CNA Fin'l Corp.	NYSE	53.25	-3.6	-4.3	64.25	51.00	331	0.00	0.0	7.7	46.40	1.15
General Re Corp.	NYSE	49.38	-0.7	-11.6	56.38	45.50	880	1.20	2.4	9.8	26.60	1.86
ITT (Hartford Group)	NYSE	45.25	-2.4	0.6	49.25	43.25	1392	1.25	2.8	5.8	52.23	0.87
Sears Roebuck & Co. (Allstate)	NYSE	33.88	-2.5	0.7	39.88	32.25	2481	2.00	5.9	8.3	34.74	0.98
Transamerica Corp.	NYSE	30.88	-1.6	3.8	36.75	29.75	311	1.84	6.0	6.2	24.94	1.24
CONGLOMERATES	AVERAGE		-1.5	2.0					3.2	8.4		

INSURERS

Aetna Life & Cas Co.	NYSE	40.38	0.6	-10.8	49.88	39.50	1940	2.76	6.8	5.7	53.56	0.75
American General Corp.	NYSE	27.88	-3.0	-12.2	36.38	27.88	596	1.40	5.0	7.6	27.99	1.00
Amer Heritage Life Inv	NYSE	25.00	0.0	3.1	26.00	24.00	2	1.08	4.3	11.3	21.70	1.15
Amer Indty Fin'l Corp.	OTC	11.50	-1.1	27.8	11.75	8.25	9	0.56	4.9	11.3	20.30	0.57
American Int'l Group	NYSE	51.13	-2.6	-14.8	65.38	49.00	1363	0.40	0.8	8.4	33.56	1.52
Aneco Reins Ltd.	OTC	3.13	0.0	-7.4	4.00	3.13	3	0.00	0.0	4.3	2.51	1.25
Aon Corp.	NYSE	23.75	1.6	3.8	27.00	21.88	383	1.28	5.4	8.3	15.13	1.57
Argonaut Group	OTC	46.75	3.9	57.1	49.00	29.50	616	0.00	0.0	7.6	29.19	1.60
AVEMCO Corp.	NYSE	24.63	0.5	25.5	25.25	17.88	20	0.34	1.4	12.0	7.74	3.18
Belvedere Corp.	AMEX	4.88	2.7	11.4	5.00	4.38	6	0.04	0.8	7.1	7.87	0.62
Business Mems Assurn Co.	OTC	34.50	-1.4	29.0	36.00	25.50	163	1.20	3.5	62.7	27.39	1.26
Chubb Corp.	NYSE	53.25	1.7	-4.7	63.38	51.25	192	2.16	4.1	6.1	46.13	1.15

		Price	Weekly % change	Year to Date % change	Annual High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk value
Continental Corp.	NYSE	37.00	2.1	-4.5	41.63	34.75	1046	2.60	7.0	7.0	42.10	0.88
Durham Corp.	OTC	26.25	0.0	22.1	28.00	21.50	12	0.92	3.5	27.1	26.00	1.01
Farmers Group Inc.	OTC	60.25	0.6	49.7	65.75	40.50	2671	1.44	2.4	14.7	22.15	2.72
Fireman's Fund Corp.	NYSE	26.00	-3.3	0.0	31.00	25.75	465	0.50	1.9	433.3	26.17	0.99
Fremont Gen Corp.	OTC	9.88	5.3	2.6	13.50	8.75	63	0.60	6.1	433.3	16.75	0.59
Home Group Inc.	NYSE	11.75	1.0	-1.1	14.38	11.50	230	0.20	1.7	2.5	17.65	0.67
Hanover Ins Co.	OTC	21.25	-1.2	-8.6	26.25	20.50	86	0.36	1.7	4.7	25.10	0.85
Harleysville Group Inc.	OTC	15.38	0.0	17.2	16.38	13.38	23	0.40	2.6	6.8	16.18	0.95
Hartford Steam Boiler Insp	OTC	25.50	-1.9	10.9	29.25	22.50	189	1.20	4.7	9.5	10.65	2.39
Kans City Life Ins	OTC	30.25	-1.6	15.2	30.75	25.25	0	0.00	0.0	9.5	0.00	N/A
Kemper Corp.	OTC	23.25	1.1	13.4	25.25	20.75	329	0.72	3.1	7.3	27.11	0.86
Liberty Corp. S.C.	NYSE	41.75	-3.5	17.6	47.25	34.50	13	0.80	1.9	15.4	17.40	2.40
Lincoln Nat'l Corp.	NYSE	41.75	-1.5	4.0	48.75	40.25	181	2.36	5.7	8.0	36.62	1.14
NAC Re Corp.	OTC	22.00	0.0	23.9	24.50	18.50	4	0.00	0.0	12.8	19.92	1.10
Nobel Ins Ltd.	OTC	5.13	5.1	-41.4	9.50	4.50	135	0.40	7.8	24.4	9.37	0.55
Northwestern Nat'l Life	OTC	26.25	-0.9	14.7	29.25	22.63	54	1.12	4.3	6.7	35.05	0.75
Ohio Gas Corp.	OTC	32.75	-1.5	-9.7	38.25	32.25	972	1.88	5.7	7.7	27.86	1.18
Old Rep Int'l Corp.	OTC	22.00	0.5	10.0	24.63	19.13	200	0.74	3.4	5.1	27.82	0.79
Orion Cap Corp.	NYSE	15.75	-3.8	16.7	17.25	13.13	15	0.76	4.8	5.5	9.34	1.69
Phoenix Re Corp.	OTC	8.00	10.3	23.1	8.75	6.75	61	0.00	0.0	5.8	11.08	0.72
Protective Life Corp.	OTC	12.63	-1.9	3.1	15.13	12.25	45	0.70	5.5	12.0	17.25	0.73
Provident Life & Acc Ins Co.	OTC	19.25	-1.9	23.2	21.88	15.63	196	0.84	4.4	148.1	27.45	0.70
St. Paul Cos. Inc.	OTC	40.00	-1.8	-13.0	51.00	38.25	1101	2.00	5.0	5.7	36.34	1.10
SAFECO Corp.	OTC	23.25	-1.1	-16.2	30.00	22.75	533	1.08	4.6	7.4	21.39	1.09
SCOR US Corp.	OTC	9.25	2.8	0.0	9.50	7.25	139	0.00	0.0	6.7	9.20	1.01
Seibels Bruce Group Inc.	OTC	12.50	0.0	11.1	14.25	11.00	63	0.80	6.4	8.1	12.51	1.00
Selective Ins Group Inc.	OTC	22.63	-2.7	19.1	23.75	19.25	54	1.24	5.5	5.2	19.52	1.16
Statesman Group Inc.	OTC	4.06	-1.7	-13.4	5.56	3.81	30	0.06	1.5	5.2	3.83	1.06
Tokio Marine & Fire Ins	OTC	82.50	0.0	25.2	85.88	63.25	55	0.19	0.2	73.7	0.00	N/A
Torchmark Corp.	NYSE	30.25	0.4	23.5	31.25	24.50	105	1.00	3.3	9.7	12.24	2.47
Travelers Corp.	NYSE	33.38	-0.4	5.0	40.00	33.25	571	2.40	7.2	8.6	45.28	0.74
Trenwick Group Inc.	OTC	12.00	2.1	17.1	12.50	9.75	11	0.16	1.3	10.3	15.41	0.78
United Fire & Cas Co.	OTC	25.50	1.5	-1.9	27.00	24.00	32	0.96	3.8	4.8	21.64	1.18
United States Fid & Gty	NYSE	30.50	0.0	7.0	34.38	28.88	1092	2.64	8.7	6.8	19.53	1.56
UNUM Corp.	NYSE	20.75	-1.2	12.2	22.75	17.88	173	0.48	2.3	10.3	28.53	0.73
USLIFE Corp.	NYSE	32.50	-2.6	14.0	39.00	28.00	141	1.28	3.9	8.4	46.77	0.69
Washington Nat'l Corp.	NYSE	27.75	-2.6	16.2	28.63	24.00	90	1.08	3.9	21.9	32.33	0.86
Zenith Nat'l Ins Corp.	NYSE	20.75	-5.7	38.3	23.88	15.00	99	0.80	3.9	9.3	12.26	1.69
INSURERS	AVERAGE		-0.2	8.9								
ALL COMPANIES	AVERAGE		0.4	10.3					3.5	23.9		



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