

Business Insurance

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Jury rules Delta not negligent in 1985 Dallas jetliner crash

FORT LAUDERDALE, Fla.—A federal jury's verdict that Delta Air Lines was not negligent in the 1985 crash of Flight 191 is not expected to influence the decision of the Fort Worth judge who will determine whether the Federal Aviation Administration should be held liable for the crash, Delta says.

A U.S. District Court jury declined to award damages to the family of Fort Lauderdale lawyer Sidney T. Bernstein, which had sued Delta claiming it was

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Prop. 103 survives

California court upholds 20% rollback, offers insurers relief

By GLENN HUNTLEY and DONNA DIBLASE

SAN FRANCISCO—Property/casualty insurance rates in California will be judged by the historic standard that rates cannot be "excessive, inadequate or unfairly discriminatory" under the California Supreme Court ruling last week upholding most provisions of Proposition 103.

While upholding the one-year 20% rollback in most property/casualty "insurance charges" from November 1987 levels—as called for by Proposition 103—the Supreme Court struck down as unconstitutional the provision that would have required insurers to be "substantially threatened with insolvency" before they could receive relief from the rollback.

Instead, the California court "essentially rewrote Proposition 103 to allow rates above the rollback level whenever insurers justify them as not being excessive," said the American Insurance Assn. in Washington.

"We are largely where we were before the initiative fight," said the AIA, adding "there are still no meaningful curbs on the costs that increased the price of insurance in the first place."

Insurance company executives willing to

comment late last week after the court issued its 60-page opinion Thursday morning appeared confident that their current rates would not be considered excessive and therefore not forced down by the rollback provision.

While appealing for relief from the rollback, insurers can continue to charge their current higher rates, the court said.

It is universally agreed that the rollback provision has little immediate meaning in the commercial insurance market, where competition has driven rates at least 20% below November 1987 levels. In addition, Proposition 103 does not apply to workers compensation insurance.

The rollback provision is most important to personal automobile insurance, where rates continue to climb.

However, the Risk & Insurance Management Society Inc. has warned that inade-



quate rates in the personal auto insurance market could have adverse results in the commercial insurance market in California and elsewhere in the country (BI, March 6).

Despite the court's decision to strike the "insolvency standard" and the creation of a consumer advocacy corporation, proponents of California's Proposition 103 are rejoicing that their attempt to reform the state's regulation of the property/casualty insurance industry stood the constitutional test.

The California Supreme Court last week unanimously upheld all but those two provisions of the controversial voter-approved measure—both of which had been stayed pending the court's decision on the insurance industry's challenge to the law. The 20% rollback also had been stayed, but now is in effect.

And, the court found that since all parts of

Proposition 103 are "reasonably germane to the subject of insurance rates and regulation, the initiative does not violate the single-subject rule" for initiatives in California.

As a result, the property/casualty insurance industry in California is subject to prior approval of rates beginning in November 1989, the insurance commissioner will be elected beginning with the 1990 election, agents can rebate portions of their commissions, the insurance industry is subject to the state's antitrust laws and state-chartered banks can sell insurance in California.

In addition, insurers cannot cancel or fail to renew auto insurance policies, except under certain circumstances including non-payment of premium, fraud or misrepresentation by the policyholder or a substantial increase in the risk insured. And, "good driver" discounts on auto insurance policies will be mandated after November 1989.

The court did not rule on the validity of increasing the premium tax rate to compensate for revenues lost to the state by lower premiums, commenting that the California Constitution prohibits courts from preventing or enjoining the collection of any tax.

"Everything we wanted, everything that is permanent in Proposition 103, is what we

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Walbrook's reserves in 'reasonable' range, actuarial review finds

By CAROLYN ALDRED

LONDON—Loss and unearned premium reserves for the lead underwriter of H.S. Weavers (Underwriting Agencies) Ltd., the largest U.S. liability insurance market in London, are within a range considered "reasonable," according to a leading actuarial firm.

The endorsement of Walbrook Insurance Co.'s reserves by Tillinghast, a division of Towers, Perrin, Forster & Crosby Inc., was issued by Walbrook's owner, London United Investments P.L.C., after the release of LUI's 1988 results on the London Stock Exchange shortly before noon on Friday.

However, the endorsement—promised by LUI the previous week—came with some qualifications, including that Tillinghast's London-based unit has not yet completed a review of the loss reserves of all of Walbrook's subsidiary companies or a review of the reserve methodology or statistical systems employed by Walbrook.

The actuarial endorsement refers to the insurance funds of Walbrook and its subsidiary LUI Syndicate Inc., a member of the Illinois Insurance Exchange. Their insurance funds—reserves for outstanding claims, incurred-but-not-reported losses and unearned premiums—totaled 279.4 million pounds (\$505.7 million) at year-end 1988, according to Tillinghast.

"While the work for Walbrook has not been completed in reviewing reserve methodology or the statistical systems, Tillinghast cur-

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Administration joins Section 89 reform drive

By JERRY GEISEL

WASHINGTON—The Bush administration is climbing aboard the Section 89 reform bandwagon, a move that greatly increases the chances that the much-assailed law will be overhauled this year.

Two key administration officials last week gave enthusiastic blessings to a total revision of Section 89's non-discrimination rules for welfare benefit plans.

"The cost of compliance with Section 89, as it presently stands, is excessive," Treasury Secretary Nicholas Brady told the annual meeting of the U.S. Chamber of Commerce in Washington, D.C.

"The law needs to be changed, and we stand ready to encourage, support and work with Congress to revise and improve it," he said.

At the same time, Mr. Brady flashed a signal that the administration wants Congress to act quickly on Section 89 reform. He announced that the Treasury Department is delaying the effective date of most Section 89 compliance rules to Oct. 1 from July 1.

This delay, Treasury Department staffers said, is intended to give legislators time to pass a new non-discrimination statute.

While Mr. Brady was delivering welcome news to an appreciative business audience, Dana Trier, the Treasury Department's tax legislative counsel, was on Capitol Hill explaining to legislators at a standing-room-only House Ways and Means Committee hearing that the administration is committed to a fair and simple non-discrimination testing statute.

"We are convinced that Section 89 is not workable in its current form."

"We want to be absolutely sure we have it right this time," he said.

The administration is seeking a much simpler approach in contrast to the current, hopelessly complicated Section 89 non-discrimination tests, Mr. Trier said.

"We are con-

vinced that in order for any legislative response to be effective, the statute must be made comprehensible and simple to administer," Mr. Trier said.

The administration will not support any legislative package that has "35 exceptions to 40 rules," he said.

The Treasury Department official saluted Section 89 reform legislation, H.R. 1864, introduced last month by Ways and Means Committee Chairman Daniel Rostenkowski, D-Ill., though Mr. Trier's words fell short of an endorsement. Rep. Rostenkowski's legislation would

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'The law needs to be changed, and we stand ready to encourage, support and work with Congress to revise and improve it,' says Treasury Secretary Nicholas Brady.



Prosecutor details 'secret empire' formed by ex-Howden executives

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Update

Delta not liable in crash: Jury

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negligent in the August 1985 accident.

The crash of the L-1011 jetliner, which killed 137 people, occurred in a heavy thunderstorm as the plane was landing at Dallas/Fort Worth International Airport. The crash was found to be caused by violent downdrafts called "microbursts," a form of wind shear that can force an airplane to the ground during takeoff or landing.

The Bernstein family had sought \$3 million in punitive and compensatory damages in the first suit related to the crash to seek a punitive award. In previous cases—in which Delta has been found liable for about \$100 million in damages—the airline agreed not to contest liability while plaintiffs sought only compensatory awards.

The family's attorney, Stephen Walker with the Chicago-based law firm J. Stephen Walker & Associates, was not available for comment.

The jury's decision comes after the close of a separate, 14-month trial in Fort Worth to determine whether the government will be responsible for all or part of the \$100 million in damages. Delta sued the FAA in 1985, alleging, among other things, that negligence by air traffic controllers contributed to the crash (BI, Sept. 9, 1985).

However, Delta says the outcome of the Fort Lauderdale case won't influence the decision of Judge David O. Belew, who is expected to issue a ruling in the airline's suit against the FAA this fall.

"Judge Belew spent a year hearing evidence from both sides," said a Delta spokesman. "His ruling will be based on the evidence and testimony that he has heard. I don't expect the jury verdict will have any impact."

Dallas attorney John Martin, who represented Delta in the Fort Worth trial, said: "It's not up to me or the government's lawyers to say" whether the verdict will have an impact on Judge Belew's decision. "That's up to the judge."

At the time of the crash, Delta had \$750 million in aviation liability coverage, and underwriters subsequently reserved \$125 million to pay claims related to the accident (BI, Aug. 12, 1985).

Claims examiner faces 5 years

CAMDEN, N.J.—A former Continental Assurance Co. claims examiner and her husband are scheduled to be sentenced next month for defrauding the insurer of \$123,000 on phony group health claims.

Jamie Petrock, 37, and her husband, Charles Petrock, 49, both of Lake Hiawatha, N.J., pleaded guilty to federal fraud charges April 28. They face a maximum of five years in jail and \$250,000 in fines when they are sentenced June 9 by U.S. District Court Judge John F. Gerry.

Ms. Petrock in 1987 and 1988 was a medical claims examiner for Continental, a CNA Financial Corp. unit, and was responsible for authorizing reimbursement checks under group health insurance policies, according to charges filed by the office of the U.S. Attorney for the District of New Jersey.

From July 1987 to February 1988, Ms. Petrock caused Continental to issue a series of checks totaling \$122,979.39 covering claims purportedly made by employees of the Hillsborough Township Board of Education under the township's group health policy with Continental, federal prosecutors charged.

The checks were issued in the names of fictitious employees—including Charles Petrocco and James Petroci—and Ms. Petrock had the checks sent to a Lake Hiawatha post office box maintained by C.J.A.C. Enterprises, a business operated by Mr. Petrock, the charges state.

The couple then deposited the checks in a C.J.A.C. bank account at Midlantic National Bank, the charges state.

Ms. Petrock and Mr. Petrock were released on personal recognition bonds after pleading guilty to the charges.

U.S. sues for overpayments

NEW HAVEN, Conn.—The U.S. Justice Department is suing Travelers Insurance Co. in federal court seeking to recoup "millions" of dollars in Medicare claims that it says should have been paid by the insurer.

The lawsuit is part of an ongoing effort by the government to force private insurers and companies that administer Medicare payments to reimburse the agency for claims the program mistakenly paid. The litigation charges that, under federal law, group health care plans—not Medicare—should have covered claims incurred by older workers and their spouses (BI, April 17; April 3).

To date, the government has sued Provident Life & Accident Insurance Co., a private insurer, and Blue Cross & Blue Shield of Michigan, a Medicare administrator.

"To the best of our knowledge we have assumed the role (of primary payer of Medicare claims) whenever we were given sufficient information to show that Travelers was the primary insurer," a Travelers spokesman said. The lawsuit lacks any specific allegations of wrongdoing, he added.

Lloyd's agents fight new tax

LONDON—Lloyd's of London underwriting agencies are fighting the British Inland Revenue in London's High Court this week over a tax ruling that could cost them tens of millions of dollars.

In a judicial review hearing that began last Wednesday, five Lloyd's agencies are disputing the taxation of redemption profits from U.S. Student Marketing Assn. investment bonds as revenues rather than capital gains. Between 30 and 40 syndicates are disputing the tax treatment and are watching the test case in the High Court.

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Errors & omissions

General Motors Corp. and the United Auto Workers union do not use the HMO RateCheck software product offered by MEDSTAT Systems Inc. of Ann Arbor, Mich., as reported in the April 17 issue. However, GM and the UAW are working with MEDSTAT to develop an HMO data base and HMO decision support system for health care purchasers.

McCarran doesn't protect reinsurers, brief contends

By JUDY GREENWALD

SAN FRANCISCO—Reinsurance activities are not protected by the insurance antitrust exemption in the McCarran-Ferguson Act, 18 state attorneys general argue in their most recent brief filed in the massive insurance antitrust case.

"Reinsurance is not the business of insurance," declares the brief, filed April 28, in opposition to the insurance industry defendants' December motions seeking dismissal of the antitrust action (BI, Jan. 9).

"First, reinsurance is not related to the transferring or spreading of a policyholder's risk," says the attorneys general brief. Second, "reinsurance is not an integral part of the policy relationship between the insurer and the insured," the brief says.

The attorneys general argue that because the reinsurance defendants are not protected by McCarran-Ferguson, neither are the primary insurance defendants—which normally would be—because they conspired with the reinsurance industry defendants.

"This combination strips all defendants of McCarran exemption," says the brief. "As a result, all activity alleged in the complaint, since undertaken in combination with such defendants, is unprotected by the McCarran Act."

This is the only surprising argument in the attorneys general brief, according to two attorneys representing insurance industry defendants.

Robert N. Schiff of Fisher & Hurst in San Francisco, who represents reinsurance intermediary Thomas A.

Greene & Co. in the litigation, said he was somewhat surprised by this argument.

"It just strikes me as being a silly argument," he said. "They're not in the grocery business," he said of the reinsurers.

The argument also is inconsistent with other arguments the attorneys general made, said Aubin Barthold, an attorney with Hancock, Rothert & Bunshoft in San Francisco, which represents Edwards & Payne (Underwriting Agencies) Ltd.

In fighting a motion to dismiss filed by the reinsurer defendants, the attorneys general discuss reinsurers' involvement in insurance, Mr. Barthold said. "That's the first inconsistency that we spotted immediately," he said.

Apart from the argument that reinsurance is not part of the business of insurance, the attorneys general brief contained what the defendants expected, say the two attorneys for insurance industry defendants.

There were "pretty much no real surprises" in the brief, said Mr. Schiff. "In reading this, I was pretty much struck by how nothing has really changed."

The attorneys general filed the brief April 28 in response to motions to dismiss the case that had been filed by industry defendants in December. The defendants have until June 16 to respond.

A hearing had been scheduled for July 16, but it is expected to be postponed to give Judge William Schwarzer more time to study the briefs (BI, May 1).

The attorneys general charge in their suits, which

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RIMS survey shows market continued to soften in '88

By DOUGLAS McLEOD

NEW YORK—The commercial property/casualty insurance market continued to soften in 1988, with fewer buyers forced to accept claims-made forms and fewer showing interest in alternative risk financing facilities, a new survey shows.

In its fourth annual insurance availability survey, the Risk & Insurance Management Society Inc. questioned 4,126 of its members in December 1988. RIMS received responses from 1,151 companies ranging in size from \$10 million to \$10 billion in annual revenues and representing a cross section of industries.

The survey reviewed market conditions in 10 commercial insurance lines, including:

- Primary general liability, where 70% of the respondents reported coverage "easy to purchase" and 62% reported premium reductions. Limits and deductibles were stable.

- Umbrella/excess liability,

where 80% reported premium reductions and 29% reported increased limits. But the number of companies reporting larger limits actually fell from 37% in 1987.

- Product liability, where respondents reported coverage to be generally available with stable limits and deductibles. Sixty percent reported premium reductions, though 3% reported increases of more than 10%.

- Professional liability, which was found to be generally more available than the previous year with stable limits and deductibles. Premium changes varied widely, though, with 28% of the respondents reporting increases and 40% reporting decreases.

- Directors and officers liability, where some respondents reported persistent availability problems, though most found increasing limits with declining premiums and deductibles. Forty-four percent reported improved coverage conditions and 67% reported declining premiums.

- Environmental impairment li-

ability, where 43% of the respondents reported that coverage was "unavailable." For those able to buy EIL coverage, though, premiums fell somewhat while limits and deductibles remained stable.

Some respondents are still considering alternative facilities for EIL coverage, although the general movement to alternatives has slowed, RIMS discovered.

Only 9% of the respondents joined alternative facilities in 1988, down from 13% in 1987.

The softening market also produced a steady decline in the use of the claims-made general liability form, the survey found. Respondents with claims-made coverage for primary liability programs dropped to 7% last year from 12% in 1987. Respondents with claims-made policies for excess liability programs dropped to 17% last year from 27% in 1987.

Survey copies are available for \$35 each by writing RIMS, Research Department, 205 E. 42nd St., New York, N.Y. 10017.

Inside

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✓ Some simple steps can reduce employers' exposure to carpal tunnel syndrome claims and fines, says attorney Lawrence P. Postol in Perspectives. **PAGE 21**

✓ Many employers will not be able to afford fee-for-service health care programs in the future, says Joseph W. Duva in Ask a Benefit Manager. **PAGE 22**

✓ Emergency legislation passed late last month to prevent the bankruptcy of Maine's workers compensation guaranty fund is drawing praise. **PAGE 23**

✓ Cash flow and asset quality are becoming increas-

ingly critical with respect to both the operation and evaluation of property/casualty insurance companies, points out securities analyst Myron M. Picoult of Oppenheimer & Co. **PAGE 35**

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'Secret empire' detailed in Howden trial

By STACY SHAPIRO

LONDON—Four former executives of Lloyd's of London brokerage Alexander Howden Group Ltd. and a famed former Lloyd's underwriter used a "secret empire" to defraud Howden and Lloyd's syndicates of millions of dollars in the late 1970s and early 1980s, prosecutors charge.

This "private and secret empire" was built wholly with funds misappropriated from Howden and Lloyd's syndicates for the "criminal enrichment" of former Howden Chairman Kenneth V. Grob, former Deputy Chairman Ronald Comery, former Directors Allan Page and Jack Carpenter and former Lloyd's underwriter Ian R. Posgate, Crown Prosecutor Michael Hill said.

Mr. Hill, donned in the wig and black robes of a British barrister, revealed these allegations in his opening statement last week in the criminal trial against Messrs. Grob, Posgate and Carpenter in Southwark

Crown Court.

Mr. Comery died in a car accident in 1987. Charges against Mr. Page were dropped last year during a pretrial hearing because he is terminally ill (BI, June 13, 1988).

The criminal trial, which could last three months, is the climax of 6½ years of investigations since allegations were first made by Alexander & Alexander Services Inc. in a lawsuit filed in High Court in London in September 1982 against the four former Howden officials and Mr. Posgate.

A&A acquired Howden, which managed Mr. Posgate's syndicates, in 1982 for \$299.9 million in cash and stock (BI, Sept. 28,



Mr. Grob

1981).

The Howden scandal later was the subject of Lloyd's disciplinary hearings, which led Lloyd's to expel Mr. Grob and Mr. Carpenter from the market and suspend Mr. Posgate for two six-month periods (BI, July 22, 1985).

The three defendants and Mr. Page were arrested in July 1987 (BI, July 20, 1987).

Lloyd's underwriter Colin Hart, who was arrested at the same time and faces six charges of dishonesty in regard to the Howden affair, will be tried at a later date (BI, May 1).

During his opening arguments, Mr. Hill, the Crown prosecutor, said the four Howden officials and Mr. Posgate used the funds misappropriated from Howden and from Mr. Posgate's syndicates to "secretly" buy 51% of the Banque du Rhone et de la Tamise, a Swiss bank that had been owned by Howden.

The four Howden officials and Mr. Posgate purchased a majority of the shares in the

Swiss bank through a private "syndicate" so their names would not be disclosed to the rest of the Howden board, Mr. Hill alleged.

"Their silence was deliberate," Mr. Hill told the jury.

The four ex-Howden executives and Mr. Posgate might have retired with "their dignity and reputations untouched" in January 1982 when A&A bought Howden, said Mr. Hill.

However, A&A discovered that one of Howden's underwriting subsidiaries was suffering "substantial losses" from reinsurance written for Mr. Posgate's syndicates, said Mr. Hill. The Posgate syndicates showed 50 million pounds (\$85.5 million at appropriate exchange rates) in underwriting losses from computer leasing insurance, some of which had been ceded to Howden subsidiary Sphere Drake Insurance Co. Ltd., Mr. Hill said.

A&A ordered its auditor, Deloitte Haskins

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Merrett lawsuits seek cancellation of runoff policies

By CAROLYN ALDRED

LONDON—Lloyd's of London underwriter Stephen Merrett is seeking court approval of his cancellation of two runoff reinsurance policies and the return of any claims he has paid under the policies.

Merrett Underwriting Agency Management Ltd. recently gave two British insurance companies "notice of avoidance" of two unlimited liability runoff reinsurance policies written almost a decade ago by Merrett marine syndicate 418, one of Lloyd's largest syndicates.

In two separate suits filed in London's High Court, Merrett is seeking a determination that it is not liable for any claims stemming from the two runoff policies: one written in 1978 to reinsure Cumbria, England-based Provincial Insurance P.L.C., and the other written in 1980 to reinsure London-based UIC Insurance Co. Ltd.

Merrett could be liable for as much as \$20 million in claims under the policies, some sources say, though others indicate Merrett's liability may be only \$10 million.

The suits do not specify the amount of liabilities being disputed or the total claims already paid.

Merrett contends in the lawsuits that it "lawfully avoided" the policies and "is discharged from any liability" because of breach of contract, misrepresentation and non-disclosure by the two insurance companies.

The policies in dispute provide coverage for unlimited liabilities arising from certain books of business written by the companies prior to 1969, according to court papers. Merrett wrote 50% of each policy and fellow Lloyd's underwriter Richard Outhwaite wrote the remaining 50%.

So far, only Merrett is disputing the policies.

However, Syndicate 661/317 managed by R.H.M. Outhwaite (Underwriting Agencies) Ltd., is not paying claims arising from the two policies and is awaiting the outcome of the Merrett suit, said an Outhwaite spokesman.

Outhwaite estimates its liabilities from both policies amount to about \$10 million, the spokesman said.

Ken Randall, managing director of Merrett Holdings P.L.C., would not be so specific about Merrett's estimated liability under the policies, but said the amount in dis-

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Tort trouble

Washington cap on damages unconstitutional

By GLENN HUNTLEY

OLYMPIA, Wash.—A portion of a 1986 Washington law that caps non-economic damage awards is unconstitutional, the state Supreme Court has ruled.

The court ruled 6-3 that the cap on non-economic damages violated a plaintiff's right to trial by jury.

Washington's tort reform law—which included the non-economic damage cap and eliminated joint and several liability in many cases—was one of the most sweeping tort reform measures enacted by any state (BI, Aug. 18, 1986).

The Washington ruling indicates "a fair amount of hostility in the courts" to state-imposed limits on damage awards, said Martin F. Connor, president of the American Tort Reform Assn.



Prior to the April 27 Washington decision, courts in 11 states had ruled on the constitutionality of damage caps, with a recent decision by the Kansas Supreme Court tipping the balance in favor of tort reform by a 6-5 margin, Mr. Connor said (BI, April 24; March 20).

"I thought we had a trend going, and then Washington pulled the plug," Mr. Connor said.

Indeed, the tide may be shifting against caps on damage awards, said Bill Wagner, president of the Assn. of Trial Lawyers of America.

"It's beginning to be a trend throughout the country for courts to closely question these artificial limits," Mr. Wagner said, adding that the Washington ruling "will be frequently cited by other courts."

The decision came in a case brought by Austin Sofie, a former pipe fitter who had sued asbestos

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Tort laws hurt Texas business: Study

By MICHAEL BRADFORD

AUSTIN, Texas—Thousands of manufacturers are considering halting operations in Texas because of the state's product liability laws, a controversial study says.

In addition, some 3,000 companies have decided not to introduce new products because they are afraid they will be sued in Texas, the study says.

Furthermore, "liability costs" have contributed to the layoffs of some 30,000 Texas workers, the study says.

The study was commissioned last

year by the Texas Civil Justice League, a tort reform advocacy group, and conducted by M. Ray Perryman, a Baylor University economist and head of a Waco, Texas, consulting firm that bears his name.

Texas Gov. Bill Clements, citing the study, is calling for "decisive change" in the state's product liability laws.

The study proves that the current laws have had a negative impact on the creation of jobs and are negating gains from corporate relocations to Texas, Gov. Clements said last month in a speech before the Texas Assn. of

Business.

Legislation to reform the state's product liability laws, H.B. 15, sponsored by Rep. Curtis Seidlits, D-Sherman, has passed the Texas House and was being debated last week in the Senate.

The bill would establish new standards of proof in product liability lawsuits, allow judges to assess a portion of the responsibility for a product-related accident to the claimant and install a two-part trial system that would require juries to

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States thwart Risk Retention Act: Kasten

By JERRY GEISEL

WASHINGTON—Opponents of the Risk Retention Act "are working at the edges" to impede the law's effectiveness, a U.S. senator says.

Improper interference from state regulators and court decisions that conflict with congressional intent have prevented the Risk Retention Act from achieving its full potential, said Sen. Robert Kasten, R-Wis.

New legislation may be needed to achieve Congress' goal in passing the legislation—to ensure that businesses and professionals have access to affordable liability insurance—Sen. Kasten said last week at a Senate hearing.

"We wanted uniformity" in the regulation of risk retention groups and risk purchasing groups to allow the groups "ease of entry," into states, Sen. Kasten told the Senate Commerce, Transportation and Science Consumer Subcommittee.

A stream of witnesses who appeared before the subcommittee described a number of practices by state regulators that have made it difficult and costly to operate risk retention and risk purchasing groups.

Witnesses pointed out that purchasing group insurers have been ordered by state insurance regulators to obtain rate and

policy form approval for coverage offered through the groups, which some witnesses said violated Congress' intent when it passed the Risk Retention Act.

In other cases, witnesses said, risk retention groups and purchasing group insurers have been slapped with hefty administrative and registration fees and seemingly needless requests for information they already had filed with regulators.

For example, David Bossman, president of the American Feed Industry Insurance Co. Risk Retention Group, said the group was bombarded with various filing forms from various states after it was licensed in Iowa in 1987.

These forms, varying in length and complexity, sought information that the feed industry risk retention group already had provided the states in its business plan.

Other state regulators have demanded that the group appoint an agent or surplus lines broker in their states even though the coverages are marketed through a feed trade association.

And, in several instances, state regulators tried to force the risk retention group to join the state guaranty fund even though such participation would directly violate the Risk Retention Act, he said.

Mr. Bossman said the group has, in most cases, complied with the requests of state regulators, even when the requests seemed outside the requirements of the Risk Retention Act.

But that decision—to make peace with state regulators—has had a costly price tag.

"We have spent a great deal of time, energy and significant legal expense to achieve our desired goal to live peaceably in the existing insurance regulatory environment," he said.

Other witnesses said demands that state regulators review and approve rates and policy forms used by purchasing group insurers have made it difficult for purchasing groups to operate nationwide.

"This has probably caused problems for small insurers wanting to write risk purchasing group business," said Edward Barrett, a Commerce Department official.

While state regulators have defended state-by-state rate and policy form approval as necessary to protect policyholders, these requests, at times, appear to serve little purpose other than to impede purchasing group operations, said one expert.

Michael Mullen, the legislative counsel to the National Risk Retention Assn. in Washington, D.C., and an attorney

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Walbrook

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rently considers the amount of insurance funds, 279.4 million pounds of Walbrook and LUI Insurance Syndicate Inc., to be within a range which they consider reasonable," the Tillinghast statement said.

The amount of insurance funds was determined using a discount rate of 7.5% per annum, Tillinghast pointed out.

The actuary was instructed earlier this year to review the insurance funds of Walbrook and its subsidiary companies—LUI Syndicate, El Paso Insurance Co. Ltd. and Desert Insurance Co. Ltd.—and to review the reserving methodology and statistical systems employed by the companies, according to last week's statement.

London-based El Paso and Bermuda-based Desert both stopped underwriting business Jan. 1, 1989. El Paso previously was a participant on the Weavers underwriting slip.

"Tillinghast's work has not been completed for El Paso or Desert," the Tillinghast statement said.

LUI noted that "Tillinghast was not requested to review the overall capital adequacy of Walbrook as it would be usual for interested parties to refer to Walbrook's annual accounts and make that assessment for themselves."

Walbrook and its subsidiaries reported a pretax 1988 profit of 797,000 pounds (\$1.4 million), compared with a 1987 loss of 3.576 million pounds (\$6.7 million).

However, 1987's loss followed an exceptional claims provision of 8.5 million pounds (\$16 million) and the 1988 "improvement in the Walbrook result is partially attributable to a 3.25 million pound (\$5.9 million) intra-group refund of expenses from Weavers to Walbrook," the statement notes.

Walbrook's subsidiaries include the three insurers, a property investment company and LUI Management Inc., a syndicate manager on the Illi-

nois Insurance Exchange.

Walbrook and its subsidiaries' premiums "increased slightly," according to Mr. Wilson. In 1987, these net premiums totaled 118.25 million pounds (\$222.3 million).

Walbrook's and its insurance subsidiaries' reported capital and surplus increased to 66.36 million pounds (\$120.1 million) at the end of 1988, compared with 63.13 million pounds (\$118.7 million) at the end of 1987.

Peter Wilson, managing director of Weavers, last Friday would not disclose Walbrook's total reserves for the year ended 1988, commenting that Walbrook's full results would be released this week.

According to LUI's financial statement, insurance funds for Walbrook and three subsidiary companies totaled 345.3 million pounds (\$625 million) at Dec. 31, 1988.

This compares with insurance funds of 242.7 million pounds for 1987 (\$456.3 million) reported last year for the same insurers: a 42%

increase based on the British pound.

Insurance funds for the other insurance companies in the LUI group acquired after Dec. 31, 1987, totaled 188.97 million pounds (\$342 million) at year-end 1988, according to LUI.

An actuarial endorsement of Walbrook's reserves had been promised by LUI in an earlier announcement to the London Stock Exchange on April 26, following letters issued by U.S. broker Alexander & Alexander Inc. to clients, in which A&A said it is "unable to determine Walbrook's potential to fully meet its future obligations to policyholders" (BI, May 1; April 24).

Walbrook earlier this year requested Tillinghast to review the insurance funds required by Walbrook at Dec. 31, 1988, and will continue to request annual independent reviews of its reserves, according to Mr. Wilson.

Tillinghast said in its endorsement of Walbrook's and LUI Syndicate's insurance funds that "in accordance with Tillinghast's normal practice, its

full report will contain a number of conditions and limitations."

"These will include reference to the uncertainty of United States excess liability reserving, especially where policy language disputes are involved, and the fact that no margins for adverse deviations have been taken," the Tillinghast statement notes.

"These conditions and limitations are similar to those contained in other reports on excess liability accounts issued by Tillinghast," the statement adds.

Tillinghast will review the insurance funds of 65.88 million pounds (\$119.2 million) "pertaining to El Paso and Desert," according to LUI.

In addition, LUI "has reviewed in detail" the insurance funds of 188.97 million pounds (\$342 million) for the other insurance companies in the group, which include three former underwriters of the Weavers slip that were acquired by LUI in September 1988 and now are in runoff. The three companies in runoff are: Kingscroft Insurance Co. Ltd., formerly Kraft Insurance Co. Ltd.; Lime Street Insurance Co. Ltd., formerly Louisville Insurance Co. Ltd.; and Mutual Reinsurance Co. Ltd.

Also owned by LUI are LUI Insurance Syndicate No. Two Inc., formerly Calfed Insurance Syndicate Inc., which is a member of the Illinois Insurance Exchange; and The First Reinsurance Co. of Hartford.

"In the company's judgment these reserves are also reasonable. Tillinghast was not involved in this review," the LUI statement says.

Walbrook plans to instruct Tillinghast to review the remaining LUI companies' reserves—including those of the companies in runoff—at a later date, said Mr. Wilson, adding that Walbrook has applied "the same reserving practices" for all its subsidiaries.

"I think our group is putting forward extremely strong security and a strong balance sheet, and I see no reason why anyone should be questioning our security," Mr. Wilson commented, referring to the A&A letter.

Mr. Wilson said he had been contacted by several London brokers after the release of the A&A letter and "all have indicated very positive support in the group."

LUI, meanwhile, reported a slump in pretax profits to 5.45 million pounds (\$9.9 million) from 9.15 million pounds (\$17.2 million) on increased revenues of 177.9 million pounds (\$322 million), up 9% from 163.1 million pounds (\$306.6 million) in 1987.

This partly stems from a 5.8 million pound (\$10.5 million) fall in Weavers' results due to a decline in commission revenues because of currency exchange rates and the 3.25 million pound (\$5.9 million) refund to Walbrook.

"The balance of the reduced earnings of the London United Group is largely accounted for by increased interest and overhead costs," according to the company statement.

A substantial part of LUI's 1988 pretax profit was earned by its U.S. insurance company subsidiaries, according to the LUI statement.

"These are recently formed companies and the profits are being retained within them to build up their capital bases," LUI announced, adding that as a result it is "unable to recommend" a dividend to shareholders for 1988.

Meanwhile, LUI also announced that Chairman and Group Chief Executive C.R. Driver "wishes, in view of his health, to relinquish his position as chief executive" while remaining as chairman of LUI.

Mr. Driver "had indicated last year that in view of his age the time would come to step down," said Mr. Wilson. Mr. Driver is 68.

LUI "has engaged a leading firm of executive search consultants to seek a suitably qualified person. Mr. Driver's resignation will be accepted as soon as that person has been selected," the statement noted. ■



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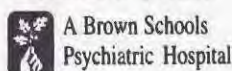
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Managed care enrollment doubles: Study

Employee enrollment in managed health care plans nearly doubled between 1986 and 1988 as private-sector employers continued to investigate and implement health care cost containment measures, preliminary findings from a government study reveal.

However, the vast majority of full-time, private-sector employees are covered by traditional indemnity plans, according to the survey by the Bureau of Labor Statistics.

In addition, an increasing number of private-sector employers are offering flexible benefit plans and reimbursement accounts, the survey showed.

The BLS survey, "Employee Benefits in Medium and Large Firms in 1988," also looked at parental leave benefits for the first time.

The survey, conducted last year, covers 31 million full-time, private-sector employees, up from 21 million workers included in the 1986 study. The increase reflects the BLS' attempt to include smaller employers and service industries not previously studied, such as health and educational services.

Full results from the BLS survey, which contains data on a wide variety of employee benefit topics, will not be available until this summer.

Managed care plans—including health maintenance organizations and preferred provider organizations—were chosen by 26% of employees in 1988, up from 14% recorded in 1986, according to preliminary reports from the BLS. Among those employees enrolled in such plans in 1988, some 19% were in HMOs, while 7% were enrolled in PPOs.

The remaining 74% of plan participants in 1988 were enrolled in indemnity health care plans, down from 86% in 1986, the survey says.

In addition, an increasing number of employers also sought out lower cost alternatives to hospital care in 1988, the survey reports.

For example, more than 75% of employer-sponsored health care plans offered coverage for home health care and extended care facilities in 1988, up from 66% in 1986.

Hospice care for the terminally ill was available to nearly 38% of all private-sector employees in 1988, up from 31% in 1986.

Many of the plans surveyed in 1988 also had other features designed to curb health care costs. For example:

- More than 40% of employees were offered incentives for undergoing diagnostic testing prior to hospitalization. No comparable 1986 figures were available.

- Approximately 60% of employees—the same as in 1986—were in plans that included second surgical opinion incentives, such as increased reimbursement of surgical costs if employees obtained a second opinion.

More employers are offering flexible benefit plans and flexible spending accounts to employees, according to the survey.

In 1988, 13% of the workers—nearly four million—were eligible for either flexible benefits, FSAs or both arrangements, up from the 5% reported in 1986, the first year the BLS provided such estimates.

"These plans were more common among white-collar workers (19%) than among blue-collar workers (6%)," the BLS found in its 1988 survey.

The BLS also studied parental leave plans in medium-sized and large private-sector firms for the first time in 1988.

Unpaid maternity leave was available to 33% of full-time employees, while unpaid paternity

Benefit beat

leave was available to 16% of the workers. Maternity and paternity leaves both averaged four months in duration.

"These plans are provided to new mothers or fathers to care for their children during the early days of infancy and are separate from other leave plans... which also might be used for this purpose," the BLS noted.

However, paid maternity and paternity provisions were rare, the BLS found. Only 2% of employers offered paid maternity leave, while just 1% offered paid paternity leave.

The BLS also examined employer-subsidized child-care bene-

fits for the first time since 1985.

Last year, 4% of employees were eligible for employer-subsidized child care benefits, up from 1% reported in 1985. These benefits included various reimbursement programs for child care expenses, as well as facilities provided by the employer.

—By Christine Woolsey

Legal service benefit

Pepsico Inc. is providing legal service benefits through its cafeteria benefit program to employees of its major U.S. subsidiaries.

Purchase, N.Y.-based Pepsico recently extended Hyatt Legal Ser-

vices' plan to more than 48,000 employees at Pepsico subsidiaries including Frito-Lay, Taco Bell, Kentucky Fried Chicken and Pizza Hut.

Under the program, employees, their spouses and dependents are eligible for unlimited consultation regarding wills, divorces, adoptions, real estate transactions and tenant problems, among other things, according to Joel Hyatt, senior partner with the Cleveland-based firm.

Prior to Jan. 1 of this year, Hyatt's plan was offered to approximately 6,000 corporate employees of Pepsico and 3,000 employees in Pepsico's bottling operations.

Pepsico pays for the entire benefit with an annual premium of \$140 per employee.

"Legal services are an option we offer in our flexible benefits plan because it meets the needs of certain employees," said a Pepsico spokeswoman.

Companies like Pepsico offer this type of benefit because middle-income workers need quick, convenient access to legal services, according to Mr. Hyatt.

—By Michael Schachner

Benefit beat keeps insurance and employee benefit managers informed on what other companies are doing and of current developments in the employee benefit field. We'd like to know if you've made any changes. Write Michael Schachner, Associate Editor, Business Insurance, 220 E. 42nd St., New York, N.Y. 10017-5806; 212-210-0143.



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Utgoff to step down as PBGC director

By JERRY GEISEL

WASHINGTON—The executive director of the Pension Benefit Guaranty Corp. is resigning.



Ms. Utgoff

Kathleen P. Utgoff, who served as PBGC executive director since 1985, will depart from the agency on July 31.

"Now that I have accomplished the objectives I set forth at PBGC, it is time for me to turn to other endeavors," Ms. Utgoff said.

Ms. Utgoff's four-year tenure at the PBGC—the longest of any PBGC executive director—was a tumultuous one: The agency, which guarantees workers' and retirees' basic pension benefits, was hit with some of the largest claims in its 14-year history.

For example, soon after Ms. Utgoff's arrival, the PBGC was hit with a \$500 million claim following the November 1985 termination of seven underfunded pension plans by Wheeling-Pittsburgh Steel Corp. (*BI*, April 29, 1985).

But the Wheeling-Pittsburgh claim, whose size dwarfed previous claims, soon was overshadowed by the pension problems of LTV Corp., another financially troubled steelmaker.

In January 1987, the PBGC terminated three LTV pension plans, which were underfunded by about \$2 billion, after the Dallas-based company said it could no longer afford to fund the plans.

After LTV later established new pension plans, the PBGC attempted to force LTV to take back the terminated plans. That matter now is pending before a federal appeals court (*BI*, July 6, 1987).

Ms. Utgoff, 41, warned that the PBGC, which is financed by premiums paid by employers with defined benefit plans, was headed toward bankruptcy unless changes were made.

She became a tireless champion of legislation to plug loopholes in

federal pension law that she and many others said make it too easy for companies to terminate underfunded pension plans and shift the liabilities to the PBGC.

Ultimately, Ms. Utgoff's crusade was successful.

In December 1987, Congress enacted reform legislation that required companies to accelerate pension funding and made it much more difficult for companies to terminate underfunded pension plans.

In addition, the legislation established a variable rate premium structure under which the termination insurance premiums employers pay to the PBGC are based on the funding levels of their pension plans. The annual variable rate premium now ranges from \$16 to \$50 per plan participant (*BI*, Dec. 28, 1987).

At this point, the legislation appears to have been a success: Since enactment of the legislation, the PBGC has not been hit with any major new claims.

Ms. Utgoff, a political appointee whose resignation had been expected following the change in administrations, has not announced her future plans.

Meanwhile, another top PBGC official is leaving his post.

Royal Dellinger, who served as PBGC deputy executive since February 1984, is resigning, also effective July 31.

Mr. Dellinger, 39, was involved in a number of vital negotiations between the PBGC and employers that terminated underfunded pension plans.

For example, Mr. Dellinger last year helped negotiate a settlement between Wheeling-Pittsburgh and the PBGC in which the steelmaker agreed to pay the PBGC \$85 million—the largest settlement of its kind—in exchange for the PBGC dropping some \$600 million in claims against the company.

Mr. Dellinger said he expects to take a position in private industry but has not yet made a final decision.

Successors to Ms. Utgoff and Mr. Dellinger have not been named yet.

Deduction proposal

Self-employed taxpayers eventually would be allowed to take a full tax deduction for health insurance premium expenditures under legislation introduced last month by Rep. Byron Dorgan, D-N.D.

Under the measure, H.R. 2121, introduced April 26, the current 25% tax deduction for health care expenses for the self-employed—set to expire at the end of the year—would be extended to the end of 1991.

In 1992, the tax deduction would be raised to 50% and in 1994 it would be increased to 100%.

Rep. Dorgan noted that the tax treatment of health insurance premiums paid by the self-employed should be the same as corporations, which currently can deduct 100% of their health insurance costs.

Aside from ensuring greater tax equity, boosting the tax deductibility of health insurance premiums would provide a greater incentive for the self-employed to purchase health insurance, Rep. Dorgan added.

Section 89

While pressure is building in Congress to overhaul Section 89, employers shouldn't wait for the dust to settle before beginning compliance efforts, a benefit consultant warns.

Employers should not "mark time while waiting for legislative relief" from the controversial statute that sets non-discrimination rules for welfare benefit plans, said Richard Ostuw, a vp in the Cleveland office of TPF&C, the employee benefits consulting division of Towers, Perrin, Forster & Crosby Inc.

Mr. Ostuw notes that regardless of the outcome of the legislative debate over the future shape of Section 89, companies still will need time to collect data, apply the appropriate non-discrimination tests and decide what, if any, corrective action to take.

In addition, running the current non-discrimination tests will help employers to determine whether they would be better off or worse off if any of the various Section 89 reform proposals are enacted into law, TPF&C commented in a recent legislative update.

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Opinions

PBGC chief will be missed

EMLOYERS ARE LOSING an effective and fair regulator in Washington.

Kathleen P. Utgoff, who has served as executive director of the Pension Benefit Guaranty Corp. since 1985, is resigning effective July 31.

Her four-year tenure at the PBGC is noteworthy for several reasons. For one, it is the longest of any executive director of the nearly 15-year-old agency.

More importantly, Ms. Utgoff guided the agency through a tumultuous period: The agency, which guarantees workers' and retirees' basic pension benefits, was hit with some of the largest claims in its history in the last four years (see story, page 7).

The PBGC's funds, which are generated by premiums paid by employers with defined benefit plans, were going to run out unless changes in pension law and PBGC funding were made.

Ms. Utgoff became a tireless champion of legislation to plug loopholes in federal pension law that she and many others said made it too easy for companies to terminate underfunded pension plans and shift the liabilities to the PBGC.

And, to cover liabilities of underfunded pension plans already taken over by the PBGC, Ms. Utgoff lobbied for an increased and variable rate PBGC premium, with the amount charged employers based on the adequacy of the funding of their pension plans instead of one flat PBGC premium.

A variable rate premium was one of Ms. Utgoff's goals when she joined the PBGC. Her crusade with Congress was finally successful in December 1987 (BI, Dec. 28, 1987).

As part of that reform legislation, Congress also enacted provisions that require companies to accelerate pension funding and make it much more difficult for companies to terminate underfunded pension plans.

As Senior Editor Jerry Geisel points out, so far



the legislation appears to have been a success: Since enactment of the legislation, the PBGC has not been hit with any major new claims.

And, the agency expects to have sufficient income to meet the obligations it has incurred.

Despite the agency's rough times, Ms. Utgoff was always accessible to lobbyists, business groups and the press to discuss the PBGC's problems and possible solutions. When the issues were hottest, she was accessible—not taking cover from controversy as too many regulators are inclined to do.

Ms. Utgoff isn't saying what she will do next, but we have no doubt that whatever it is, her creativity and management skills so evident during her tenure at the PBGC will bring her success.

We'll miss her.

Letters

Rosenfield offends most risk managers

To the editor: I was offended, as were most risk managers, by Harvey Rosenfield's comments regarding the three reasons why risk managers did not support Proposition 103 (BI, April 3).

As buyers of insurance, we are not intimidated by the industry but rather recognize and utilize its resources in our organizations' best interest. In response to his three reasons, let me say the following:

- We did not support Proposition 103 because we *did* understand it, probably better than many of the other voters.

- Yes, we did indeed know the Proposition 103 applies to our liability insurance and have a good understanding of the far-reaching implications of its passage.

- I, along with many other California risk managers, hoped that individuals such as Mr. Rosenfield would not be able to sway the voting public with their misrepresentations and hype.

I appreciate *Business Insurance* and was sure you would want to know my reaction to that particular article.

Alice Bryan
Director of Risk Management
Adventist Health System West
Roseville, Calif.

Goal of Section 89 needs to be singular

To the editor: Your April 3 editorial, "Safe Harbor Offers Little Calm," certainly hit the mark.

Supporters of Section 89 claim it has two goals, namely expanding the number of people covered by employer-sponsored health plans and increasing federal tax revenues. The fundamental problem with Section 89 is that those goals are mutually exclusive.

If Section 89 motivates employers to shift dollars from taxable payroll into health insurance contributions, federal tax revenues will certainly be negatively affected.

If, on the other hand, Section 89 causes an increase in tax revenues, that will be a sure sign that employers are not expanding health insurance eligibility in large numbers.

Therefore, any attempts to reform Section 89 need to begin with picking a goal, either expanding health insurance or increasing federal tax revenues, but not both.

Thomas G. Emerick
Manager-Insurance Plans
BP America Inc.
Cleveland

Insurance certificates not always needed

To the editor: It seems like a colossal waste of time to me for Fortune 500 companies to be asking each other for certificates of insurance.

Do people really think it likely that these companies have inadequate insurance programs? Even if their certificates

do not evidence a lot of insurance, what about other assets for meeting their financial obligations?

Corporate risk managers could better spend their time focusing on the insurance programs of non-Fortune 500 companies.

General acceptance of this idea would be a step toward reducing unnecessary paperwork.

Peter H. Fleig
Assistant Director,
Corporate Risk Management
Pfizer Inc.
New York

Performance reviews can lead to litigation

To the editor: I read with great interest the article in the April 24 issue: "Job Evaluation Can Trigger Termination Suits."

However, I would like to point out that "job evaluation" and "performance evaluation" are not the same. Job evaluation is a technique used in setting up or maintaining a compensation structure. In Dr. David Belcher's book, "Wage and Salary Administration," job evaluation is defined as a "systematic method of appraising the value of each job in relation to other jobs in the organization. Job evaluation is concerned with jobs, not individuals."

"Performance evaluation" (or appraisal), to which your article referred, is a process of appraising or rating employee performance. Performance evaluations are often the reason behind wrongful discharge suits.

Lin J. Ball
Vp-Group Insurance Consulting
The Epler Co.
San Diego

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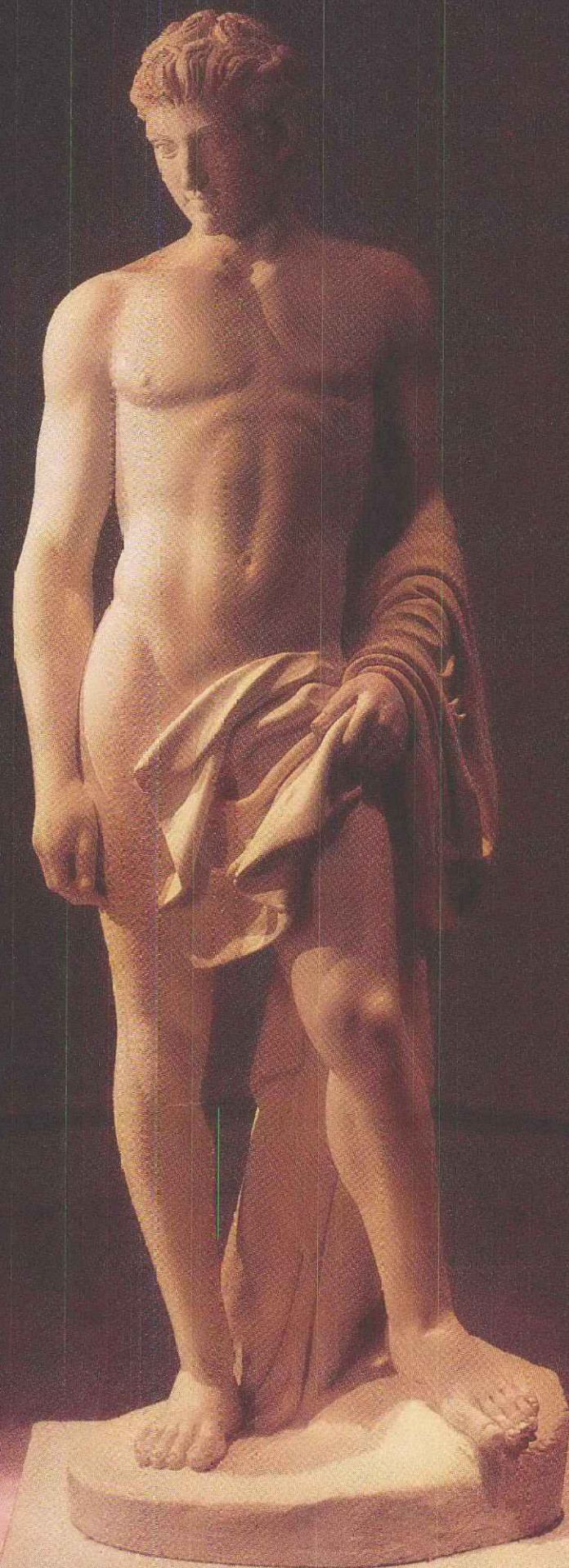
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At issue

Will in-house wellness programs catch on among employers?



Nina Lansky Falci
supervisor-
compensation/
benefits
Engineering
Research
Associates Inc.,
Vienna, Va.

Yes. If employers can be shown, quantifiably, that wellness programs reduce sick leave and medical care expenses, then employers will be willing to spend the money to set up and support wellness programs.



Reezin Swilley
director-benefits
BellSouth
Corp.,
Atlanta

Most probably. In the future, I think industry will have to concentrate more on preventive activities that focus on the root of the problem as a long-term strategy. As an adjunct to wellness programs, I feel screening programs and risk-related premiums will become the norm.



Paul R. Stoffer
vp/manager-
employee
benefits
Goldome,
Buffalo, N.Y.

Wellness, principally exercise rooms, provides a nice, up-beat image for employers—but little else. Statistics of U.S. children show a decline in physical fitness which, unfortunately, will continue into adulthood. Employers can't change the couch potato.



Timothy Pecsénye
manager-
benefits/
compensation
Libbey Owens
Ford Co.,
Toledo, Ohio

As wellness programs mature, employers should begin to see quantifiable correlations between the costs related to the wellness programs, health care claims and workers compensation claims. In any event, the concept of wellness promotion aids employers in helping transfer the notion of responsibility for health and lifestyle to their employees.

Compiled by Christine Woolsey

Cal/OSHA resuming past duties

By GLENN HUNTLEY

SAN FRANCISCO—California workplace safety authorities are beginning to enforce job safety and health rules at private sector workplaces after a nearly two-year hiatus.

The transition from enforcement by the federal Occupational Safety and Health Administration to the California Division of Occupational Safety and Health is expected to be completed by about Sept. 30, according to officials at the agencies.

The state's oversight of private workplaces ended in July 1987 after Gov. George Deukmejian eliminated \$7 million from the

The transition from federal OSHA to Cal/OSHA authority is expected by about Sept. 30.

agency's budget in a line-item veto, in what he called a money-saving move.

Since that time, Cal/OSHA had been responsible for regulating only the workplaces of public employees.

But labor groups and some business leaders contended Cal/OSHA was more effective and responsive than federal OSHA (BI, Aug. 15, 1988; Feb. 23, 1987).

State voters elected to re-establish the state workplace safety program by approving Proposition 97 last November (BI, Nov. 14, 1988).

During the transition period, the federal agency will continue to conduct regularly scheduled inspections in "target" industries such as aerospace, construction, hazardous waste operations and agriculture.

OSHA also will resolve workplace complaints that were received prior to May 1, when Cal/OSHA began responding to all new complaints of unsafe working conditions. The state agency now also will investigate accidents and conduct inspections where previous state inspections found serious violations.

"As soon as Cal/OSHA can mount a fully operational worker safety and health program, federal OSHA will again suspend the exercise of its concurrent authority in the state's private sector," said Frank Strasheim, regional OSHA director in San Francisco.

Cal/OSHA will reopen the same 21 district offices it had operated prior to the federal agency assuming authority for private sector safety issues in 1987.

The state agency has hired about 136 of the projected 214 inspectors it will need to hire by Sept. 30, said Ronald Rinaldi, director of the California Department of Industrial Relations.

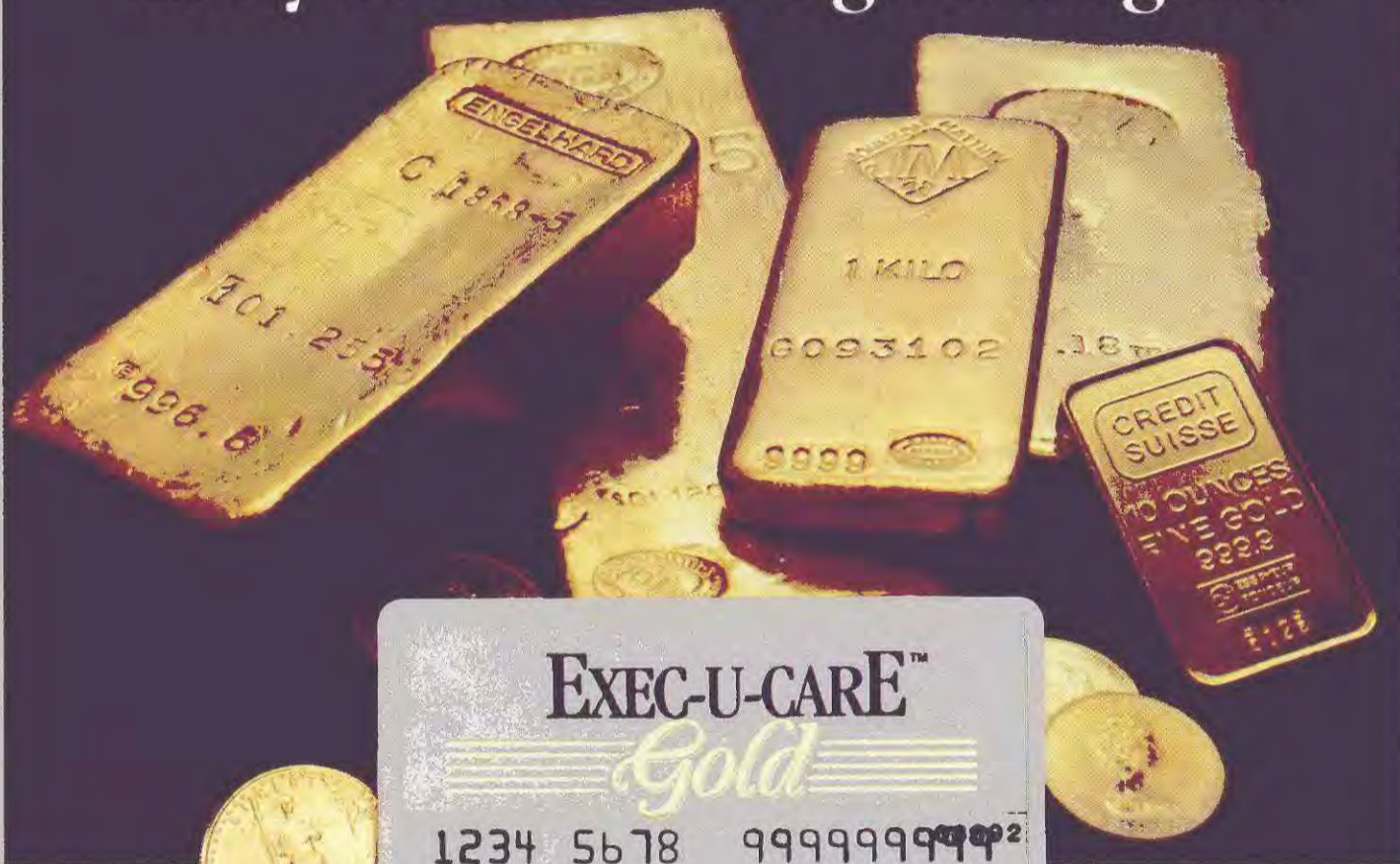
Also under the transition agreement:

- The federal and state workplace safety agencies will coordinate all activities and may conduct joint inspections or take other actions to ensure continuity of safety provisions.

- Cal/OSHA will continue its public sector job safety program for all state and local government workers.

OSHA expects to close four of its seven offices by the end of the transition period.

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United efforts yield work comp reforms

By DONNA DiBLASE

LAGUNA NIGUEL, Calif.—A well-organized legislative lobbying effort by employers is the key to meaningful, long-term workers compensation reform, according to a panel of workers compensation experts.

"I always thought reform involved a number of elements that are intended to bring about changes in the way we do things. But, what I see mostly are short-term skirmishes that often require repeat efforts" to bring about workers compensation reform, said John Lewis, a workers compensation consultant and an attorney based in Coconut Grove, Fla.

"If we don't have better information" on workers compensation costs "and deal more with reality, we'll continue to have some states that have some movement toward reforms and other states that don't have any reform," said Mr. Lewis, who has assisted several employer groups and state legislatures in designing workers comp reform packages.

Representatives from self-insured employer groups that have worked on reforms in six states drew on their experiences during a panel discussion at the annual meeting of the National Council of

Self-Insurers April 23-26 in Laguna Niguel, Calif.

"Organization of legislative lobbying efforts is probably the most important step you can take" when working on workers comp reform, said Ross Dwinnell, workers compensation claims manager for United Grocers Inc. of Portland, Ore.

Employer groups can accomplish this by developing political action committees through which they support both Democrat and Republican candidates for the state legislature who are sympathetic to workers comp reform issues, he said.

In addition, self-insured employers should "develop trust and confidence in key members of the labor committees of the legislature or whoever works on workers comp bills," Mr. Dwinnell said.

Employers also must maintain relationships and contact with other legislators, he said. "Self-insurers need to get involved after hearings and after hours so that they are visible at the state capitol," Mr. Dwinnell said.

Self-insured employers also should coordinate their efforts and make sure they are represented by a good lobbyist "that will zero in on workers comp issues for the self-insurers' association," he added.

The difficulty employers can expect in reforming a state's workers comp system if they do not pull together is illustrated by workers comp reform efforts in Maine, according to Michael Skinner, corporate manager of safety and workers compensation for Atlanta-based Georgia Pacific Corp. The company employs about 700 workers in Maine.

Bringing about workers comp reform in Maine was difficult, in part, because there were "many small, splinter groups that all wanted change but couldn't coordinate" their needs and efforts, Mr. Skinner said.

But, employers eventually organized, and industry groups concerned about workers comp reform issues promoted these concerns to other industry groups that previously were not as interested in

'Organization of legislative lobbying efforts is probably the most important step you can take' when working on workers comp reform, says Ross Dwinnell, workers compensation claims manager for United Grocers Inc. of Portland, Ore.

workers comp reform, he said.

In California, the Sacramento-based California Self-Insurers Assn. last year called on "a group

representing employers, labor, insurers, lawyers and the medical community to negotiate a workers compensation reform package,"

explained Joseph E. Markey, association manager.

Labor representatives then suggested getting Gov. George Deukmejian involved in the negotiation process.

Last month, the group unveiled a workers comp reform package that was negotiated without the assistance of the attorneys' group that represents plaintiffs in workers comp cases. The bill does not yet have a legislative sponsor (BI, May 1).

Employers in Texas have been

working since 1979 for passage of legislation that would enable employers to self-insure their workers comp programs, noted Ed Struck, a workers compensation representative in the pay and benefits administration office of Shell Oil Co. in Houston.

This year, self-insured workers comp programs just may become a reality, he said.

However, after years of working just for the passage of legislation that would allow Texas employers

Continued on next page

National Council of Self Insurers

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Comp claims can trigger bad-faith suits

By DONNA DiBLASE

LAGUNA NIGUEL, Calif.—Litigation charging employers with bad-faith denial of workers compensation claims is growing, but employers can avoid such suits by taking several measures, according to a legal expert.

Although state workers compensation systems are intended to be the exclusive remedy for injured workers—as opposed to allowing workers to sue their employers for damages in civil courts—some states also permit injured workers to sue employers or workers comp claims administrators for bad-faith handling of a workers compensation claim, noted Merton E. Marks, a partner in the Phoenix, Ariz., law firm of Lewis & Roca.

"We are going to continue to see

bad-faith claims filed in states that allow" the suits to be filed, he predicted.

Mr. Marks discussed the current state of workers compensation bad-faith litigation, as well as steps employers can take to avoid such litigation, during the annual meeting of the National Council of Self-Insurers April 23-26 in Laguna Niguel, Calif.

"The most rapidly developing issue of employer and (insurer) liability as an exception to exclusive remedy is whether the employer and (insurer) can be held civilly liable of bad faith for improper processing—including investigation—of a workers compensation claim," Mr. Marks noted.

Bad faith exists when an insurer or self-insured employer unreasonably denies benefits to a claimant

and knows that the denial is unreasonable or shows a reckless disregard of the fact that the denial is unreasonable, he explained.

Courts in more than half of the states—as well as some federal courts—have agreed to hear and have sided with workers in bad-faith workers compensation suits, Mr. Marks pointed out. Most of the cases have been filed within the last 10 years and most have been decided within the last five years.

Mr. Marks noted that courts have allowed workers comp claimants to pursue bad-faith litigation based on several theories of common law. Among those theories are that:

- Bad-faith conduct in claims processing is a separate tort that falls outside the workers comp system.

- The penalties in some states

where workers comp laws contain a penalty provision for improper claim processing are inadequate to compensate for the wrong committed against the claimant and were not intended to apply to intentional or bad-faith conduct.

- In those states where there is no penalty in the state workers comp laws for delay or wrongful denial of claims, there is no redress for the claimant.

- Court rulings that allow bad-faith litigation in general liability cases establish a precedent for allowing bad-faith suits in workers comp cases.

Employers whose workers comp programs operate in states where bad-faith claims can be pursued in the courts can take steps to minimize the likelihood of injured employees filing such claims, Mr.

Marks said.

Employers should ensure that their claims processors understand that workers comp claims are fundamentally different from general liability claims.

Because workers compensation benefits are statutory and courts have ruled that employers must award these benefits liberally, an employer is better off giving the claimant the benefit of the doubt instead of denying compensation when faced with a reasonable claim, he said.

Before denying a claim or limiting benefits, employers should evaluate how the action would look to a judge and a jury if a bad-faith suit were to result.

Employers also should meticulously document workers compensation case files, particularly noting the reasons for a denial of benefits to a claimant. "Remember, bad-faith claims arise when a claimant thinks there has been an unreasonable denial of benefits," Mr. Marks noted.

In addition, employers denying a claim should consult legal counsel early and often, making sure to provide counsel with all information pertinent to the case. This measure would allow the employer to use as a defense in a bad-faith suit the fact that it acted on advice of legal counsel, he said.

However, a court may rule this defense invalid if the employer failed to provide all information about the case to its counsel or if the judge determines that the legal advice was unsound, Mr. Marks cautioned.

When dealing with a claimant who is not represented by an attorney and is merely trying to collect his or her benefits, an employer should show some genuine concern for the claimant's condition, he advised.

"Remember, a little kindness goes a long way" and could encourage greater cooperation from the claimant in settling the claim, he said.

Employers should discuss problem cases with their claims adjusters to make sure the adjuster is not causing the problems, he also advised.

If the adjuster is found to be creating an adversarial relationship with the claimant or the claimant's attorney, action should be taken to either improve the adjuster's conduct or remove the adjuster from the case, Mr. Marks suggested.

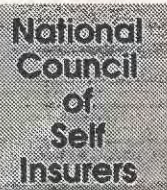
Employers should make sure their claims staffs are kept up to date on claims-handling procedures, industry practices and new developments in workers compensation laws, he said.

Employers also should promptly respond to letters or phone calls from claimants and claimants' attorney, Mr. Marks said.

Many states, however, have rejected bad-faith suits in workers comp cases based on the exclusive remedy provisions of their workers comp laws. Claimants instead are required to pursue bad-faith actions through the workers comp systems in those states, Mr. Marks said.

States that have denied workers the right to file civil bad-faith suits in work comp cases include Arkansas, California, Delaware, Florida, Georgia, Illinois, Kentucky, Louisiana, Minnesota, Missouri, New York, South Carolina, Tennessee and Washington, he said.

Claims and premiums seeking pay-
Continued on next page



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Triam Group L.P. promotes Richard Inserra to new post

Richard M. Inserra, 40, has been named vp-risk management and business development for Triam Group L.P. Inc. in New York. In this expanded position he continues to oversee Triam Group's risk



Mr. Inserra

management programs and now also reviews major capital expenditure requests and conducts financial and operational reviews. He reports to William Pollert, senior vp-operations services. Prior to joining Triam—formerly Triangle Industries Inc.—as vp-risk management in 1986, Mr. Inserra spent five years as director of insurance and risk management with American Can Co. in Greenwich, Conn., until various American Can operations were acquired by Triangle. He also has held risk management positions with Nabisco Inc. and NL Industries Inc. Mr. Inserra received a bachelor of arts degree in history from Fordham University in Bronx, N.Y., and a master of business administration degree from Iona College in New Rochelle, N.Y. Mr. Inserra was named *Business Insurance* Risk Manager of the Year in 1984 (*BI*, April 2, 1984).

Bruce I. Taylor named director-foreign service human resources at GTE Corp. in Stamford, Conn. In this position he is responsible for GTE's foreign service employee policies and services, including employee benefits, tax equalization, payroll and currency corrections. He replaces **Malcolm Kennedy**, who was named director of regional operations at GTE's CODE-TEL subsidiary in the Dominican Republic. Mr. Taylor reports to Jeremiah Reen, vp-human resources planning and international. Mr. Taylor joined GTE in 1979 as manager-employee insurance. Prior to that he worked for Travelers Insurance Co. in Hartford, Conn. He holds a bachelor of business administration degree from the University of Connecticut at Storrs. In addition, he is a member of the Council on Employee Benefits, the Foreign Benefits Study Group and the employee benefits committee of the National Assn. of Manufacturers.



Mr. Taylor

W. Michael Trant, 38, named vp-risk and insurance management at Shawnee Development Inc. in Shawnee-on-Delaware, Pa. In this newly created position, he oversees the administration, coordination and management of Shawnee's risk management and property/casualty insurance programs. He reports to Salvatore L. Manda, senior vp-finance. Before joining Shawnee, a real estate development and resort management company, Mr. Trant served as Pennsylvania's associate deputy attorney general. He holds a bachelor of science degree in business administration and economics from Georgetown University in Washington, D.C., and a doctor of law degree from the Georgetown University



Mr. Trant

from the Georgetown University

Comings & goings: buyers

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Kenneth E. Brockman, 38, named director-risk management and insurance at Western Union Corp. in Upper Saddle River, N.J. In this position he oversees property/casualty insurance, claims administration, risk management information systems and fire protection systems. He replaces **Raymond J. Devine**, who left the company, and reports to S.E. Smiszko, vp and treasurer. Prior to joining the telecommunications giant, Mr. Brockman was a claims

representative for Alexander & Alexander of New York Inc. He holds a bachelor of science degree from Wilkes College in Wilkes Barre, Pa. In addition, Mr. Brockman holds a New York state Independent Adjuster's License in Automobile and Casualty Claims.

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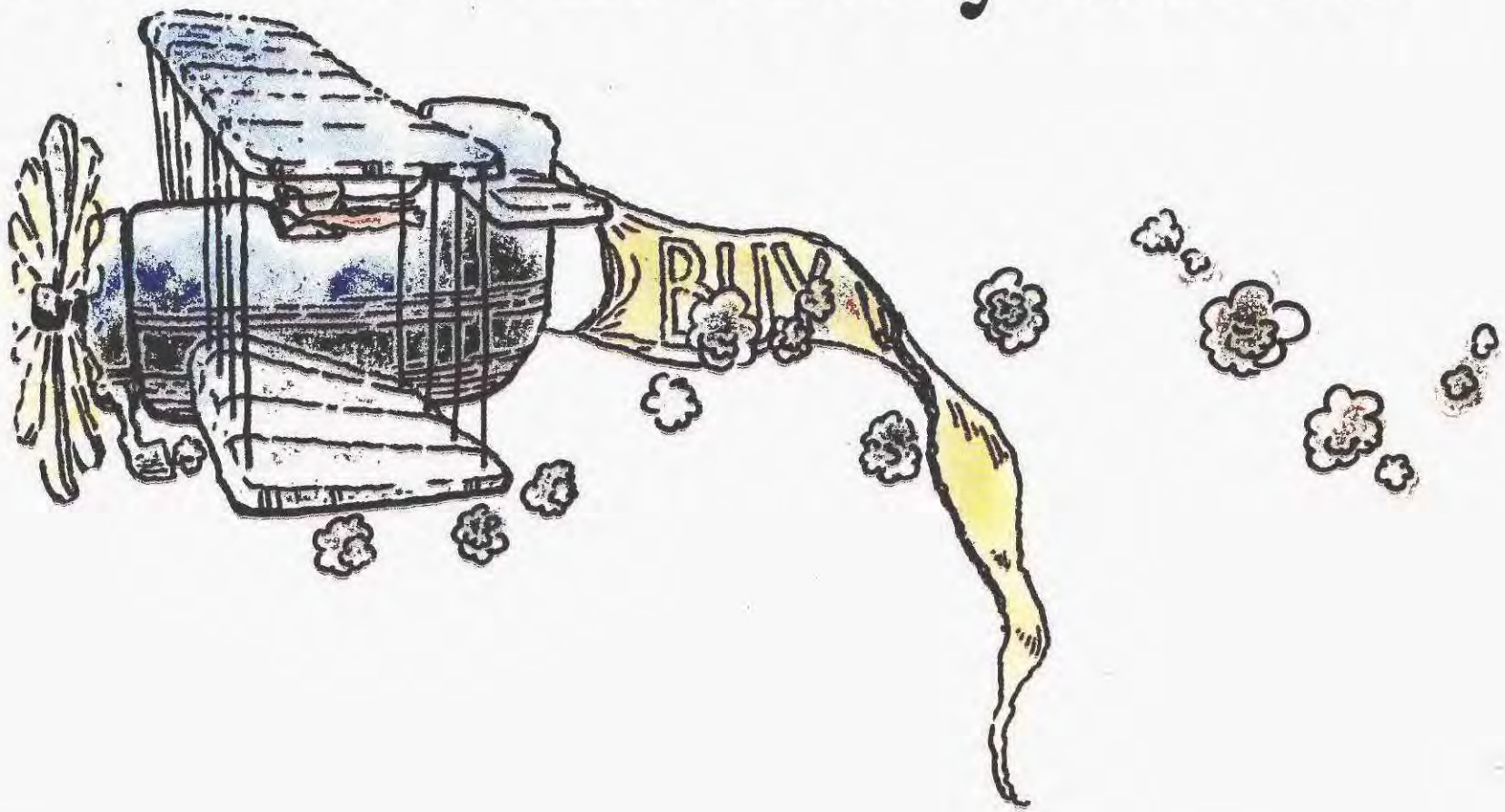
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A treatable illness

Smart employers will control carpal tunnel syndrome cases

By Lawrence P. Postol

CARPAL TUNNEL SYNDROME is a compression injury to the nerve in the wrist, often caused by repetitive flexion-extension of the wrist, particularly by pinching, gripping and grasping motions. Until recently, few persons had heard of this condition except the hand surgeons who perform surgery in an attempt to relieve the compression.

In the last couple of years, however, the Occupational Safety and Health Administration and workers compensation commissions have taken an interest in this potentially disabling condition. In order to meet the OSHA requirement of providing a safe workplace, as well as reducing workers compensation liability, employers are being required to look at the incidence of carpal tunnel syndrome in their employees and consider ergonomic changes in workers' job duties in order to reduce the number of carpal tunnel syndrome injuries.

Carpal tunnel syndrome is hardly a new phenomenon. The medical literature contains references to carpal tunnel syndrome developing in persons whose work involves repetitive use of their hands, including meatpacking workers, retail employees, poultry processing plant workers and supermarket checkers. Indeed, OSHA recordkeeping requirements have always classified repetitive work injuries as "illnesses," thus requiring that they be recorded on the OSHA 200 log, under Column 7(f), irrespective of whether the worker loses any time from work due

to the condition.

In recent years, due to encouragement from unions, more and more employees are filing workers compensation claims for carpal tunnel syndrome and OSHA is fining employers for:

- Not recording carpal tunnel syndrome injuries on the employer's OSHA 200 log.
- Not providing a safer workplace by using ergonomics to reduce the incidence of carpal tunnel syndrome.

The medical and legal communities have, in recent years, focused more and more on incidences where carpal tunnel syndrome is being related to work activities. One manifestation of this was the July 1988 meeting held by the National Institute for Occupational Safety and Health to study the "Surveillance of Cumulative Trauma Disorders of the Upper Extremities, with Emphasis on the Wrist." Similarly, the House Committee on Government Operations, when reporting on OSHA's policy of exempting companies from programmed inspections, commented on the underreporting of carpal tunnel syndrome.

Anyone who reads the newspapers knows that in the past year, OSHA has proposed million-dollar fines against employers that underreport carpal tunnel syndrome injuries and that do not take steps to reduce such injuries. While many of OSHA's charges are totally baseless, it is an expensive proposition to defend against such charges.

Employers can take some simple steps to reduce their workers

compensation liability and minimize the risk of an OSHA citation based on carpal tunnel syndrome.

First, a company should check its OSHA 200 log and make sure that carpal tunnel injuries are being correctly recorded. Carpal tunnel syndrome must be recorded as an illness, and it must be listed in the log, even though it does not result in any disability.

Indeed, many companies have used law firms to audit their records to make sure that all occupational injuries are being recorded correctly. Since OSHA levies fines of \$10,000 for each mistake, such audits can be very cost-effective.

Once the employer is sure that all carpal tunnel syndrome injuries are being properly recorded, the safety director should analyze the injury rate as compared to industry statistics, the medical literature and common sense.

If the incidence of carpal tunnel syndrome is at all elevated, the company should retain an outside consultant to evaluate the ergonomics of the workplace to see what changes can be made that might reduce the injury rate at a reasonable cost.

Often, minor changes in the work station or job duties can greatly reduce the incidence of carpal tunnel syndrome at a minimal cost. Indeed, sometimes productivity may actually increase.

Of course, some ergonomic changes are not economically feasible or must wait until the present equipment wears out and needs replacement. Employers should consider having the ergonomic evaluations performed at the request, and under the supervision,

of their attorneys. In such a manner, the study may be protected as a privileged attorney work product.

As a guide to avoiding trouble, one can look at OSHA's record settlement with IBP Inc. OSHA required that the Dakota City, Neb.-based meat producer, in order to reduce cumulative trauma disorders, implement:

- An education program for employees on the causes and prevention of such injuries.
- A medical program for the early detection and control of such injuries.
- An orientation and training program for new employees to be instructed on injury prevention.
- An ergonomic study to determine how job duties can be modified to reduce injuries.

While OSHA often goes overboard, the basic ideas behind the IBP program provide a good foundation for all employers to consider. If one keeps an open mind, it may be possible to reduce lost time and workers compensation liability due to avoidable injuries at a minimal production cost. Moreover, if OSHA sees that the employer is at least making an effort to study and cure the problem, OSHA is much less likely to fine the employer.

Lawrence P. Postol is a partner in the Washington, D.C., office of Seyfarth, Shaw, Fairweather & Geraldson. Mr. Postol specializes in health and safety litigation.



Non-work-related fall not compensable

A worker's fall is "idiopathic" and non-compensable if it was caused by a condition personal to the worker, rather than work-related or unexplained, said an Oregon appellate court.

Vlassios Damis was working for Cotter & Co. as a loader when he sustained an injury to his head. He originally told his doctors that he could not recall falling or his activities immediately before the injury. He testified at the hearing, however, that he remembered picking up a heavy toolbox and twisting to the left; the next thing he remembered was lying on the floor. No one saw him fall. His co-workers found him unconscious on the floor. His claim for compensation benefits was denied.

On appeal, the court said that a fall is "unexplained" if it occurred during the course of employment and was not caused by idiopathic factors; that is, caused by a condition personal to the claimant. The court said that when idiopathic causes have been eliminated, the inference arises that the fall is traceable to some risk, albeit unidentified, to which the employee was exposed at the worksite.

The court noted that the doctors who saw Mr. Damis immediately after the fall concluded that his fall was the result of a sudden loss of consciousness

Legal briefs

or a fainting spell. Furthermore, the court said that there was no evidence that he did trip or that the fall was otherwise "mechanical." Thus, the court concluded that the most plausible explanation for the fall was that the claimant fainted and, thus, he had not met his burden of proving that the fainting was not idiopathic.

Damis vs. Cotter & Co., Court of Appeals of Oregon, Jan. 13, 1988 (BI/05/Jan.-\$10).

Personal attack not compensable

When an employee is injured from an attack by a co-employee, the attack must be work-related rather than for personal reasons in order for the injury to be compensable, a Georgia appellate court ruled.

Mr. Hamilton, an employee of Walsh Construction Co., was injured in a "change shack," a building where employees gather before they start work.

On the morning of the incident, Mr. Hamilton asked one of the workers for some of his breakfast. Another worker, Mr. Mitchell, admonished Mr. Hamilton for begging every morning. Mr. Hamilton

told Mr. Mitchell it was none of his business. When Mr. Hamilton turned his back, Mr. Mitchell grabbed him and ran him into a wall, fell on top of him and broke his leg. Mr. Hamilton filed for workers comp benefits. His claim was allowed.

The appellate court said that there was no evidence that the incident grew out of anything other than a personal situation.

According to the court, Mr. Hamilton was not performing tasks required by or incidental to his employment at the time he sustained his injuries, so that his injuries did not arise out of the course of his employment.

The court observed that eating breakfast was unrelated to the employment and did not have its origin in the employment. Thus, the court reversed the allowance of the award.

Walsh Construction Co. vs. Hamilton, Court of Appeals of Georgia, Nov. 6, 1987, rehearing denied Nov. 30, 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 to Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590. List the number for each opinion.

ASK A BENEFIT MANAGER

Reviewing why some turn to managed care

Q

Why are major employers turning to managed health care as a way to slow down their rate of health care cost increases? Also, what advice can you provide regarding the implementation of this type of program?

A

For the period 1984 to 1986, health care costs grew for most major companies at a reasonable level, at or below the medical care component of the Consumer Price Index.

Companies were able to control the cost increases during the

period by a series of plan changes and the introduction of various cost management techniques, such as hospital preadmission certification and second surgical opinion programs. Also, they required employees to share more of the costs—in the form of higher contributions and deductibles.

However, by 1987, these changes and techniques had run their course for most employers as the providers of health care adjusted to these cost containment efforts. The cost containment efforts of the early 1980s really involved cost shifting to employees.

These efforts did not work at controlling the medical delivery system—that is, the amount and type of medical services and supplies employees and their dependents were using.

In addition, companies are now reviewing the balance sheet and charge to earnings impact of the accounting changes proposed by the Financial Accounting Standards Board for retiree medical plans. The results of these

studies and the projections of health care cost increases for current active employees is convincing many employers that they need to take immediate action to slow down the rate of health care cost increases and find a more affordable way to provide

quality care for active employees and their dependents and the need to restructure their retiree medical plans for the future.

After studying the factors driving health care costs, it is becoming clear to many employers that they will not be able to afford the fee-for-service system in the future.

Some conditions that are not being managed cost-effectively in fee-for-service plans are mental and nervous disorder claims that include substance abuse and alcoholism. In addition, indemnity plans do not properly manage many medical conditions including outpatient services. Also, there is a significant amount of cost-shifting to indemnity plans from governments, other employers and managed care plans.

The following are some of the reasons employers are deciding that the health care programs and the manner in which they have been provided to employees and their dependents must be changed:

- ✓ Companies cannot afford the kinds of health care cost trend increases they face in the near term.
- ✓ Prior cost containment efforts are no longer working and will not properly address future health care problems and issues.
- ✓ Cost shifting to traditional indemnity plans is increasing at a significant rate, which makes these plans more costly.
- ✓ Health care plans with managed care

features—particularly HMO-type plans with solid financial models that encourage effective health care treatment—are experiencing lower increases; in many cases, half the increase of indemnity plans.

As employers analyze various cost containment and plan redesign approaches, managed care appears to provide the best opportunity to moderate the rate of increase in health care costs for the future.

Regarding advice on implementing a managed care plan, companies should consider the following:

- ✓ Determine your corporate health care objectives and how long it should take to get there. Make sure the plan design, implementation strategy and ongoing plan management support your objectives.
- ✓ Identify the important criteria for evaluating and selecting a health care manager: the financial arrangement; quality of the provider networks; geographical coincidence of where your employees live and the physicians are located; the program support needed from a health care manager.
- ✓ Know what managed care is. It is a way for the private sector to better manage health care through involvement and intervention based on necessity and quality of care.

There is a considerable amount of paper that employees and their doctors must deal with—such as a primary care physician's referral form—that allows the participants to see network specialists. Without the paper, neither the health care manager nor employer could effectively control utilization and cost as well as have the kind of experience data needed in order to manage this type of plan on an ongoing basis.

Good communications are extremely important in this type of program since you are changing a significant number of employees' behavior and

perceptions, as well as developing an understanding of why this type of change is necessary. It is important that employees understand the business reasons for adopting a program of this nature as well as the program itself. Keep in mind, however, that a comprehensive communication effort does not guarantee that employees will accept the program.

Health care coverage is considered by employees as one of their most important employee benefits and is a sensitive and emotional issue. Therefore, it is important that the communication program be ongoing and the employees and their dependents be continually educated on the issues and the realities of the present and future health care system.

Accordingly, you must continue to tell the story to ensure that employees understand the seriousness of the issue.

If you adopt a corporate-sponsored managed care plan, you are a pioneer. Although managed care is attracting a lot of interest and gaining in popularity, the number of plans in operation today is still small. You are breaking new ground. Much can go wrong and you can be sure Murphy's Law will apply to a concept this new.

The program works well when there is a good partnership between the local management and the health care manager. Where this does not exist, it is important that corporate management take the necessary action to breach the gap and fix the problems as quickly as possible.

Basically, the biggest challenge to making this kind of program work is the management

challenge. If all levels of management buy in and support the program, implementation is less difficult.

There are a number of different approaches either being followed or considered by employers implementing managed health care plans and each of them have certain advantages:

- ✓ Nationwide basis. In this type of arrangement you select one health care manager who either uses its own networks throughout the country and/or a combination of its networks and subcontracting with other networks so as to cover all your eligible employees within some established time frame.
- ✓ Regional basis. In this type of arrangement, you select a health care manager by geographical region and use its networks.

Here, again, you may give the manager the authorization to subcontract

with other networks within its geographical area if this makes good business sense to all parties.

Location-by-location. This is an approach that is being followed by some retail operations. They select a health care manager by actual location site. In this type of arrangement, you will have a number of different health care managers.

Build your own networks. There are a number of companies and employer coalitions that are building their own networks and not using any health care or insurance company's networks.

After a complete review of all the facts, each company interested in managed care must decide on its own proper arrangement, based on its business, culture and the speed in which an employer wants to implement the program.

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

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

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

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Mr. Duva

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

Council on Employee Benefits elects Duva as new president

Allied-Signal Inc.'s Joseph W. Duva has recently been elected president of the Council on Employee Benefits.

The CEB was founded in 1946 to provide, among other things, a forum for the exchange of ideas, information and statistics for the design, financing, administration and communication of employee benefit plans.

The CEB is composed of 192 of the largest corporations in the United States.

Many employers are convinced that they need to take immediate action to slow down the rate of health care cost increases.

Although managed care is attracting a lot of interest and gaining in popularity, the number of plans in operation today is still small.

Insurers hail Maine guaranty fund reform

By LINDA J. COLLINS

AUGUSTA, Maine—Insurer representatives and others are praising legislation passed late last month to prevent the bankruptcy of Maine's workers compensation guaranty fund, calling the final law a vast improvement over earlier proposals.

Emergency legislation—L.D. 750—signed April 27 by Gov. John R. McKernan Jr. gave the state's workers comp guaranty fund a badly needed cash infusion, enabling the fund to pay about 1,000 claimants who otherwise would not have received checks (BI, May 1).

The fund had been seriously depleted by the insolvencies of three insurers that wrote workers comp insurance in Maine, explained Joseph A. Edwards, superintendent of insurance for the Maine Bureau of Insurance.

The insolvencies of American Mutual Liability Insurance Co. and American Mutual Insurance Co. of Boston—both units of Boston-based American Mutual Insurance Cos.—earlier this year (BI, Feb. 20; Jan. 23) represented "the final straw" for the workers comp guaranty fund, which had already been depleted by the 1987 insolvency of Mission Insurance Co. (BI, Feb. 9, 1987).

Although the two American Mutual units did not write a lot of business in Maine, "we're a small state" and the loss was enough to drain the rest of the fund's reserves, Mr. Edwards said.

"A mechanism had to be in place to provide funds immediately," he stressed.

The emergency legislation immediately increased the maximum that property/casualty insurers can be assessed for the state's three property/casualty guaranty funds to 2% from 1% of applicable direct net written premiums.

The state's three guaranty funds cover workers compensation, auto liability and all other lines of property/casualty insurance.

However, under a formula contained in the law, small mutual insurers' maximum assessment is set at a lower percentage of premium volume.

Other provisions in the emergency legislation apply to the three property/casualty guaranty funds and the state's three life/health guaranty funds, which cover life insurance, health insurance and annuities.

Life, health and annuity insurers already can be assessed a maximum of 2% of premium volume for each line of business.

Those provisions:

- Add a special assessment clause permitting the Maine Guaranty Assn.—which oversees all of the funds—to tap the remaining two property/casualty or life/health guaranty funds when a third fund is exhausted, subject to the 2% maximum insurer assessment.

This clause will expire 91 days after the end of next year's legislative session, which Superintendent Edwards says will give the Legislature enough time to develop a more satisfactory solution.

- Establish a "preinsolvency" assessment fund—to be prefunded by insurers—for each of the six Maine guaranty funds. These preinsolvency funds would make money immediately available to pay claims for the first 60 days after an insurer is declared insolvent.

Insurers' contributions to these funds could be in the form of cash deposits with the state or letters of credit.

Under the legislation, insurers writing workers compensation

coverage could be assessed a total of \$2 million to finance that preinsolvency fund.

Other maximum preinsolvency fund assessments by line of business are: \$1.7 million for automobile liability; \$1.5 million for health insurance; \$1.4 million for life insurance; \$1.3 million for other property/casualty lines; and \$500,000 for annuities.

Mr. Edwards explained that the preinsolvency fund permits the guaranty fund to pay claims immediately after an insolvency until insurer assessments are received by the fund to pay remaining claims owed by the insolvent insurer.

And in no case would insurers be assessed more than 2% of direct net written premiums—including the preinsolvency fund assessment—in a given year.

- Holds insurers that are operating in Maine on the date an insurer is declared insolvent liable for assessments to fund that insurer's claims paid by a Maine guaranty fund even if an insurer subsequently withdraws from the state.

In addition, employers that self-insure their workers compensation risks can no longer collect from the workers compensation guaranty fund if their excess workers comp insurer becomes insolvent.

And, insurers will no longer be assessed on excess workers compensation insurance written for self-insurers.

Originally, the guaranty fund reform legislation had proposed to

'A mechanism had to be in place to provide funds immediately,' says Superintendent Joseph A. Edwards.

establish two "superfunds"—one for property/casualty and one for life/health—through which insurers could have been tapped for an additional assessment equal to 2% of premium volume if one of the other guaranty funds were exhausted.

The proposal also originally would have established a preinsolvency fund for each of the six already-existing guaranty funds. However, these new preinsolvency funds would have been financed through an assessment of up to 0.5% of an insurer's applicable direct written premium volume—subject to the overall 2% cap—to pay for future claims and expenses.

That 0.5% cap would have resulted in much higher assessments on insurers for the preinsolvency funds than the assessment schedule adopted in the final legislation.

Jeffrey Williams, counsel for the National Assn. of Independent Insurers in Des Plaines, Ill., said: "We are very pleased with the outcome. We opposed the original bill unequivocally."

"We refused to go along with the

superfund proposal and we opposed the original prefunding proposal very strongly," Mr. Williams noted.

"We would have been willing to live with L.D. 750 in its initial form with the exception of the preassessment fund, since they tend to be the subject of raids," said Joseph DiGiovanni, Boston-based vp of the American Insurance Assn. in Washington, D.C. He was referring to the appropriation of \$124 million by the New York Legislature from that state's property/casualty guaranty fund, which is the only such fund in the nation that is prefunded by insurers (BI, Jan. 16).

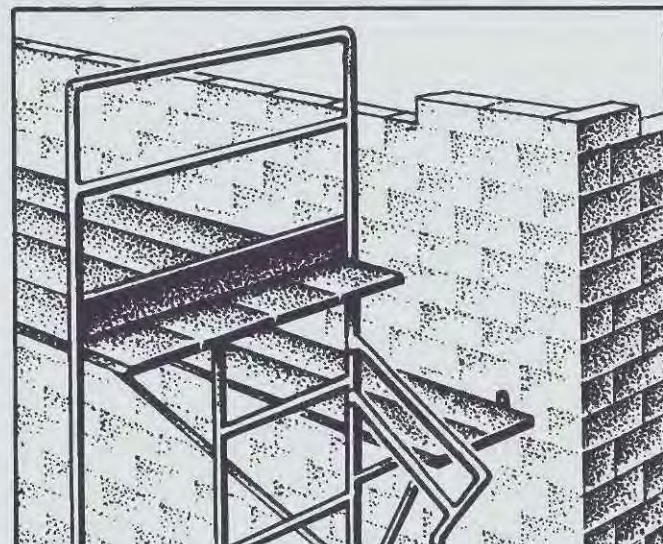
"Superintendent Edwards was faced with an extremely difficult situation, and he spread the burden as wide as it could be spread to

deal with the problem," Mr. DiGiovanni added.

"I'm absolutely delighted that we have averted not being able to pay 1,000 injured workers for their claims under workers comp and extremely pleased that we've arrived at a creative, innovative and responsive solution to a difficult problem," Mr. Edwards agreed.

The plan's administrator was also pleased with the legislation.

"I think it will be a workable solution, and I think a lot of credit is due the superintendent and the Maine Legislature, because we were running out of money and people would not have been paid their workers comp benefits," stressed Paul M. Gulko, president of Guaranty Fund Management Services in Boston, which manages Maine's guaranty funds. ■



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Discounts shouldn't sway PPO choice

By MICHAEL SCHACHNER

BOSTON—Employers in the process of evaluating a preferred provider organization must avoid the temptation to use discounts as the primary measure of the PPO's value, warns an attorney specializing in corporate managed care.

"Don't buy the cheapest package at the cheapest price," recommends Douglas L. Elden, an attorney with the Chicago firm of Altheimer & Gray and chairman of the board of the American Assn. of Preferred Provider Organizations.

"You should buy the best package at the best price," he told a group of benefit managers during a session at the 1989 National Managed Health Care Congress conference, held April 25-27 in Boston.

Mr. Elden offered an overview of what employers should do to ensure that they have a quality managed care program instead of a poorly functioning discount PPO.

"You must analyze price vs. cost," he told the benefit managers. "You can equate picking the cheapest providers at the cheapest price, or the best providers at the best cost, to running a baseball team. If you don't pay your players sufficiently, then your team will be pretty bad."

Hence, Mr. Elden insisted that payment methodologies and reimbursement levels must be sufficient to assure quality care, adding that discounts do not save enough dollars to justify the emphasis placed upon them by many employers and PPOs.

"Adequate reimbursement levels are necessary for quality care. You must pay physicians adequately," said Mr. Elden.

He stressed that provider discounts are too often exaggerated and perceived by employers as the primary way to save money through a PPO.

"Employers think discounts save money," Mr. Elden commented. "Not so! I'll take them if they give them to me, but the worth of discounts is exaggerated."

He explained that discounts come with an inherent contradiction that fouls the entire managed care process.

A PPO that offers an employer discounts is established to encourage the employer to channel its sick and injured employees to members of the PPO. However, concurrently, employers are trying desperately to battle skyrocketing health care costs by reducing utilization of health care services, according to Mr. Elden.

"Managed care, in essence, says 'Keep 'em out,'" he noted, "while the PPO (concept) says, 'We'll send 'em your way.'"

In his address Mr. Elden outlined eight basic criteria that employers should use when selecting a PPO:

- The PPO must offer a complete health care network.

"Care is coordinated. It isn't just hospitals and physicians," said Mr. Elden. "It includes home health, drugs and other things as well."

He also said PPOs should possess the ability to coordinate and to place patients in the type of care appropriate for their maladies.

- The PPO must have quality providers.

"Quality, cost-efficient providers are the basis of managing health care," said Mr. Elden.

- The PPOs must require sufficient payment levels.

Mr. Elden insisted that providers be paid sufficiently and that less emphasis be placed on discounted care.

- The PPOs must have a complete utilization management program.

Utilization review programs must not harass providers, said Mr. Elden. "This is of the utmost importance. It may even be good to have physicians govern physicians," he said.

According to Mr. Elden, utilization review programs must: identify quality and cost-efficient providers; monitor quality and effective treatment rendered to patients; assist in the design of benefit plans; and encourage cost-consciousness among patients.

- The PPO must offer quality care.

Mr. Elden quoted Charles M. Jacobs, chairman of MediQual, a health care consulting firm in

Westborough, Mass., who said: "All medical professionals agree that the highest-quality providers are also the most cost-effective. They perform operations skillfully and successfully the first time."

- The PPOs must have sufficient administration and information systems.

Since a PPO is a business and management is a key element of business, the capability of a PPO to manage itself properly is vital, said Mr. Elden.

Good information systems are necessary to operate a business, added Mr. Elden.

"There is a perception that PPOs... save money, but without an adequate information system, nobody will buy it," he said.

- The PPOs must have up-to-date legal structures.

A PPO must be structured to comply with all applicable laws, Mr. Elden noted.

In addition, the contract between the PPO and the employer must contain hold-harmless provisions specifying that the employer cannot be held liable in a malpractice suit.

"As an employer you can avoid the big liability hit despite being named in a lawsuit," he said.

- The PPOs must be in good financial shape.

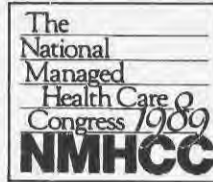
Mr. Elden admonished that failing businesses cut corners, which cannot be permitted in health care. Employers must also be aware of the consequences in case the PPO fails, he said.

"Get (solvency) guarantees from the PPO," advised Mr. Elden. "Without the guarantee, find yourself another PPO."

In addition, Mr. Elden emphasized that employers have leverage over the PPOs with which they contract because employers not only control payment of the health care dollar, but possess the ability to deliver patients to the PPOs.

Also, he advised benefit managers to make sure they are signing the same agreement with all providers in the network so that the employer can better coordinate its managed care program.

"If the plan is not coordinated you may have savings at each place, whereas coordination could save at multiple levels."



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Scrutinizing provider charges can cut health costs: Consultant

By MICHAEL SCHACHNER

BOSTON—Employers attempting to slash health care costs should take aim at the amount charged by providers, suggests a group health care consultant.

"Everything begins at the provider/patient level," said Edwin Freedman, vp and director of the national group practice for Alexander Consulting Group Inc. in Lyndhurst, N.J., a subsidiary of New York-based Alexander & Alexander Services Inc.

Employers have the best chance of controlling their health care expenses by negotiating hospital and physician charges and monitoring care, rather than trying to lower health care plan premiums or reducing workers' benefits, several speakers told a group of benefit managers during a session at the 1989 National Managed Health Care Congress conference April 25-27 in Boston.

Mr. Freedman likened the typical group health care cost breakdown to a three-tier health care iceberg consisting of medical benefit costs at the tip, claims payments in the middle, and provider and patient expenses at the base.

If an employer is trying to pinpoint the causes of health care cost increases, benefit managers should focus on the base before attacking the other parts of the iceberg, he said.

When attempting to cut costs, Mr. Freedman advised benefit managers to examine patient charges, volume multiplied by charges per unit, and incidence of employee illness. He suggested that if patient charges or the incidence of illness declines, then the employer's health care bill will be reduced. And, if both of those factors

can be reduced, the product of the equation will be reduced even further, he said.

Charges, either direct or shifted by the provider to compensate for a patient who didn't pay his or her bill, can be addressed through negotiations with providers and by

assuming further control of the managed care system to which an employer subscribes, he said.

Some controls include outside managed care review, including utilization reviews, and quality-of-care analysis, he added.

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Provider costs

Continued from previous page

But with the popularity of managed care and its inherent discounts, as well as the slack that providers are forced to pick up from inadequate Medicare and Medicaid reimbursements in most states, understanding provider charges is no longer simple, said John J. Mahoney, director of Alexander Consulting Group's health strategies group in Westport, Conn.

"Charges used to be simple. You provided a service and sent out charges," Mr. Mahoney said.

One way an employer can gain control of unpredictable and unsuitable charges from providers is to design its own preferred provider organization, said Edward H. Lipson, a consultant with William M. Mercer Meidinger Hansen Inc. in San Francisco.

Custom-designed PPOs often yield a "win-win" situation in which both the employer and the provider obtain what they are seeking, which promotes network continuity and stability, he said.

When an employer sits down to hash out the details of a PPO, it should keep in mind five objectives, according to Mr. Lipson. Em-

ployers should strive to attain:

- Favorable prices.
- Cooperation with the utilization review process.
- A requirement that treatments be subject to UR in order for payment to be made.
- Satisfactory quality analysis of the managed care system.
- Access to records.

With these objectives met, employers can achieve savings net of development costs of 10%-20%, said Mr. Lipson.

Gerry Martens, benefits manager for Southern New England Telephone in New Haven, Conn., agreed that a custom-designed

PPO can lead to significant savings for an employer. A major problem in the health care arena today is that the marketplace is controlled by suppliers rather than buyers, he said.

Mr. Martens, who appeared with Mr. Lipson at another conference session, said employers who value their employees should step up their control of the benefit pro-

gram and provide generous benefits.

"If employees are your best asset, treat them right," he said.

One thing that employers should not do, said Mr. Mahoney, is to discontinue benefits when costs get too high.

"Companies tend to throw the benefit away. This is not a good idea," he said.

Data analysis useful weapon in fighting rising health costs

By MICHAEL SCHACHNER

BOSTON—Employers can effectively attack their rising health care costs through intense data analysis, according to an employee benefits consultant.

"This is relatively easy to do in-house and will tell you what is wrong, which is more important than what is right," said Thomas R. Friedlander, senior vp with Hay/Huggins Co. in Boston.

Using health care utilization and pricing data, employers can identify health care plan trends, analyze provider costs and examine the diagnoses reached by providers, Mr. Friedlander said during the 1989 National Managed Health Care Congress conference, held April 25-27 in Boston.

"Data analysis can show that what realized savings one year may not do so in another year," Mr. Friedlander noted.

"You want to contain costs, but by how much? Data analysis tells you where the dollars are going and how things are changing. It looks into hospitals and types of claims," he explained.

One method to contain high health care costs is to obtain cost savings guarantees and commitments from utilization review vendors and then negotiate with the group health insurer to lower the premium based on the cost savings promised by the UR firm, Mr. Friedlander said.

"Let's put the risk back in insurance," he said. "Get a discount on your premium if your UR vendor says it will save you 10%."

Also, to successfully contain health care costs, employers should effectively communicate health plan cost containment measures to their workforces, Mr. Friedlander said.

He explained that health benefit changes are difficult for employees to accept even if the changes are for the better. Therefore, benefit managers should make changes in benefits conservatively, Mr. Friedlander advised.

Employers also should consider managed care options to combat the high cost of health care and provide quality care, Mr. Friedlander advised. Those options include health maintenance organizations, preferred provider organizations and utilization review provisions, including preadmission certification, second surgical opinions and concurrent review, he

said.

Catastrophic care case management and psychiatric case review in particular can help employers trim health care costs, he said.

However, such case management programs are not sure-fire methods for controlling costs, Mr. Friedlander warned, noting that savings produced by these programs will disappear after a year or two because the programs will have already reduced excess utilization.

"Benefit management programs are certainly active areas," Mr. Friedlander said. "But, in many situations, big cities for instance, preadmission certification won't save you a lot of money. It's a value when new, but in general, it won't save you money."

He also said that second surgical opinion programs are unlikely to save an employer a substantial amount of money.

"There is a high likelihood of concurrence" among doctors, Mr. Friedlander pointed out. "That's the way they are trained."

When an employer designs any type of employee benefit program, it should be designed to attract and retain quality employees, he noted.

However, benefit managers may find it difficult balancing the financial interests of their employers and providers with the needs of employees, Mr. Friedlander said.

Compounding an employer's difficulty in balancing the interests of all parties in the health care equation is the fact that health care costs are being driven sky-high by inflation, high utilization of services, enhanced medical technology, state benefit mandates and an aging workforce requiring more health care, Mr. Friedlander said.

But regardless of the type of benefit program used, it must be controlled and measurable, Mr. Friedlander said.

From an employer's perspective, a managed care program is easier to control and measure than a traditional indemnity plan, he asserted.

In addition, Mr. Friedlander recommended that employers' managed care programs be simple to avoid administrative complications.

Regarding the keys to efficiently designed managed care benefits packages, Mr. Friedlander said: "Plan ahead, make sure you measure results and always be conservative with changes."

'You want to contain costs, but by how much? Data analysis tells you where the dollars are going and how things are changing,' says Hay/Huggins' Mr. Friedlander.

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Employees need reasons for benefit plan changes

By MICHAEL SCHACHNER

BOSTON—Involving employees in a company's efforts to contain health care costs can help smooth the introduction of any benefit plan changes, advises an employee benefit communication specialist.

"Employee cooperation is vital," stresses Terrance Toth, director of communication consulting services for Buck Consultants Inc. in Secaucus, N.J.

"Without their help, nothing you do will work," he added.

Mr. Toth outlined a four-phase system employers can use to enlist employees in benefit restructuring efforts during the 1989 National Managed Health Care Congress conference, held April 25-27 in Boston.

According to Mr. Toth, the four phases of this program are: awareness; announcement; education; and follow-up.

"The biggest mistake for an employer is to come out with a change without your employees knowing there is a problem," Mr. Toth said, referring to the awareness stage.

He said the three levels of awareness include providing employees with an overview of health care costs, how the company is affected by these costs and explaining what the company is currently doing about the problem.

"With the overview, you tell them medical costs are up 10% a year and you tell them about the hospital bed vacancies," Mr. Toth said, referring to unused hospital beds, which cause hospitals to shift

'The biggest mistake for an employer is to come out with a change' in an employee benefit plan 'without your employees knowing there is a problem,' says Terrance Toth of Buck Consultants Inc. in Secaucus, N.J.

costs to other patients to make up for lost revenues.

Conveying to employees that if the company continues to be subject to the current pace of health care cost inflation there will be no additional money for new benefits or improvements, usually sinks in, Mr. Toth noted.

Employees should know what the company currently is doing to manage health care costs, Mr. Toth said, noting that employers can inform workers about such programs as health maintenance organizations, preferred provider organizations and utilization review that the company is using to curb costs.

"If you don't tell them, employees get the feeling that the problem is their fault," he said. He advised that, at a minimum, employers should say something along the lines of: "We're trying to do something."

"At least it's a good message to get across," he said.

In the second phase—announcing what new benefits will exist or what changes will be made—Mr. Toth recommended face-to-face communication because printed information often is not fully absorbed by workers.

However, employers should not completely abandon printed support material because roughly 66% of those covered by group health programs are dependents—not employees—and they, too, must be made aware of the benefit changes, he said.

During the third phase of the communication process—education—employees must be taught to be wise consumers of health care services, according to Mr. Toth.

"This way they will know they have a stake in it all," he said.

Mr. Toth added that explaining to workers that providers have no incentives to cut costs might encourage employees to utilize services less.

Some other means of educating employees include worksite health fairs and providing personalized annual benefits statements, said Mr. Toth.

After a new benefit program has been put into place comes the fourth and final phase: the follow-up period. Here, the employer must update its benefit communications material so that new employees understand the benefit program, Mr. Toth said.

Also, allowing for feedback and relaying results of the changes throughout the workforce are good ideas, said Mr. Toth.

He suggested implementing "focus groups" that provide employees with a chance to talk about the employee benefits they receive and make suggestions as to what improvements they would like to see.

But, such free-forum groups come with dangers to the employer, warned Mr. Toth.

"You are going to have to get back to them (employees) and tell them what you found out" about their suggestions, he said. Focus groups sometimes initiate studies or turn up areas that need to be researched, he explained.

In addition, employees "may expect changes which you may feel forced to go with," Mr. Toth pointed out.

Also speaking at the session was Joseph Charles, group director-employee benefits for Ryker System Inc. in Miami.

Risk Retention Act hearings

Continued from page 3

ney with the Washington, D.C., law firm of Crowell & Moring, said a state could reject a policy form that used the word "immediately" rather than "promptly" in explaining when policyholders must notify a purchasing group insurer of a claim.

But a state regulator told the subcommittee in written testimony that it is the responsibility of state insurance departments to review rates and policy forms used by insurers for serving purchasing groups.

"The recognition of the states' responsibility and authority is important since rates should be neither excessive, inadequate, unfairly discriminatory, non-competitive or otherwise unreasonable," wrote David Gates, the Nevada insurance commissioner and president of the National Assn. of Insurance Commissioners.

"Citizens need someone who can review rates and policy. You need individual (state) attention," Mr. Gates said in his oral testimony at the hearing.

Insurance regulators are not opposed to alternative financing vehicles like risk retention groups and purchasing groups, Mr. Gates continued.

"I recognize the need for alternatives, but the alternatives need to be responsible," he said.

Mr. Gates recommended that the subcommittee reject several proposals made last year by Commerce Department staffers that would, among other things, make clear that only one state—the state that a risk purchasing group declares as its principal place of business—would have the power to regulate the rates and policy forms used by a purchasing group insurer.

"We feel the changes would be disastrous and counterproductive to the citizens of this state. Trying to get one state to be a (national) policeman is very problematic," he said.

While some subcommittee members, such as Sen. Kasten, are ready to consider changes to the Risk Retention Act, other members clearly have not made up their minds on what steps, if any, Congress should take to amend the law.

For example, Subcommittee Chairman Sen. Richard Bryan, D-Nev., expressed concern about any changes in the federal law that would interfere with the ability of state insurance departments to regulate the solvency of purchasing group insurers and risk retention groups.

On the other hand, Sen. Bryan seemed annoyed at the hefty registration fees states are starting to impose on risk retention groups as well as picayune state requests for information on insurance policy forms.

States are charging or intend to charge risk retention groups filing fees ranging from \$50 up to \$1,000.

Meanwhile, most of the witnesses testifying at the May 3 hearing endorsed changes to the Risk Retention Act that would make clear that primary regulation of risk retention groups and purchasing groups should be with the state in which a particular group is based.

They said this is what Congress intended when it passed the original Risk Retention Act in 1981 and when it expanded the act in 1986 to allow most types of commercial liability risks to be insured through risk retention groups and purchasing groups.

"We understood that Congress intended that as a risk retention group we would only have to notify the other 49 states that we are alive and well in Iowa," Mr. Bossman said.

Other witnesses criticized a federal court decision in Iowa, which is strongly supported by state insurance regulators, that says any state in which a purchasing group has members can require the purchasing group insurer to be licensed or comply with surplus lines laws in the state.

Karl Koch, president of Savers Property & Casualty Co. in Overland Park, Kan., which writes coverage for several purchasing groups, said it would not object to this requirement if states acted in a timely manner.

"A few states, such as Iowa and Illinois, gave us approval within a few weeks. However, after 18 months, we are still exchanging phone calls and correspondence seeking approval in several states," Mr. Koch said.

Mr. Gates in his written statement said that requiring insurers of purchasing groups to meet licensing and surplus lines requirements in each state is needed to protect the public from financially weak insurers.

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Washington ruling

Continued from page 3
producers claiming that their products caused his lung cancer. In a majority decision by Justice Robert Utter, the state Supreme Court found the damage cap violated Article 1, Section 21 of the state constitution, which states: "The right of trial by jury shall remain inviolate."

"For such a right to remain inviolate, it must not diminish over time and must be protected from all assaults to its essential guarantees. In Washington, those guarantees include allowing the jury to determine the amount of damages in a civil case," the court ruled.

However, the justices were "wrong" to conclude in the majority opinion that determination of damage awards was a duty of the jury guaranteed by the state constitution, said Steven T. Johnson, an attorney with Gibson Dunn & Crutcher in Seattle, which represented Fibreboard Corp. and three other defendants in the Sofie case.

"It enshrines the large jury award as a constitutional right for defendants," Mr. Johnson said.

Unlike many other states that capped non-economic damages in medical malpractice cases only, the Washington law imposed a formula

that used life expectancy and average annual wages to set maximum damages for non-economic damages, such as pain and suffering, in any personal injury or wrongful death case.

Under the sliding scale, the average limit would be about \$350,000 per case.

Attorneys noted that few cases affected by the cap have reached trial since passage of the 1986 law. The law applies only to suits filed after August 1986.

As a result, it is not known whether the reform would have accomplished its goal of reducing large jury awards and reducing liability insurance rates.

The availability of some types of insurance, such as municipal liability coverage, improved in Washington state after adoption of the tort reform law, according to a spokesman for Seattle-based SAFECO Insurance Co. of America.

However, he noted that last month's decision comes amid a competitive insurance market in contrast with the hard market that existed in 1986 when the tort reform was approved. Thus, "it's hard to say what impact" the court's decision will have on the cost and availability of liability insurance, the SAFECO spokesman said.

The ruling 'enshrines the large jury award as a constitutional right,' says attorney Steven Johnson.

Plaintiffs' attorneys counter that huge non-economic damage awards were not responsible for increasing insurance rates.

"The large (award) cases are few and are not the cause of higher insurance rates," said Daniel F. Sullivan, an attorney with the Seattle firm Sullivan Golden & Otorowski. He submitted an amicus curiae brief on behalf of the Assn. of Trial Lawyers of America.

"It (the ruling) should have zero effect on insurance rates, but it will have great effect on those people who are seriously injured. People with catastrophic injuries will now continue to be fully compensated," Mr. Sullivan said.

Defense attorneys contend that the high court decision will increase the number of lawsuits filed.

The decision means a return to plaintiffs taking even minor cases to trial in hopes of "hitting the

long ball" or winning a huge jury award, Mr. Johnson said.

"(Under the limit) both sides would have known to the penny what the risk of exposure would be in bringing cases to trial. Now it's the same old ball game," Mr. Johnson said.

In addition, many plaintiffs will now go to trial and strike out instead of accepting a fair settlement offer, predicted William H. Mays, an attorney with Williams, Kastner & Gibbs in Tacoma. He represented defendant Eagle-Picher Industries Inc. in the Sofie case.

"More plaintiffs will wind up with zero," Mr. Mays said.

However, Mr. Sofie's attorney said she believes the decision means more cases will be settled.

The potential of large awards will increase the likelihood of acceptable settlement offers, said Janet L. Rice of the Seattle firm Schroeter, Goldmark & Bender. "It should help with court congestion."

She also noted that state legislators had debated the constitutionality of the damage limit when they approved the law in 1986. "It was perceived from the beginning as suspect," Ms. Rice said.

Defense attorneys are expected to ask the court for a rehearing of the case, but that will be "a fruit-

less act" because the justices have clearly stated their opinion and rarely grant rehearings, she said.

In the underlying litigation, a Kitsap County Superior Court jury in October 1987 awarded Mr. Sofie \$191,240 for compensatory damages and \$1.2 million for non-economic damages.

Applying the cap under the 1986 law, Judge James Maddock reduced the award for non-economic damages to \$125,136. However, he held the defendants jointly and severally liable because the case involved a hazardous substance.

The law eliminated joint and several liability for all types of damages except in cases in which defendants act in concert, the plaintiff was not at fault or hazardous substances are involved.

The lower-court ruling was appealed by both sides, and the appeal was heard directly by the state Supreme Court.

Besides striking down the damage award cap, the high court also affirmed that the defendants could be held jointly and severally liable, citing the fact that the plaintiff was not at fault.

Besides Eagle-Picher and Fibreboard, defendants in the Sofie case included Celotex Corp., Keene Corp., Raymark Industries Inc. and Owens-Illinois Inc.

Texas product liability bill

Continued from page 3
determine first whether a manufacturer was liable for damages and award compensatory damages and then separately decide the amount of any punitive award.

While business leaders support the study's findings and are pushing for changes in the state's product liability laws, Texas trial lawyers say the study is misleading and that there is no need for the legislative changes.

According to the study, 3,300 Texas manufacturers employing 340,000 Texas workers claim to be considering stopping all manufacturing operations in the state and/or moving operations to another state because of concerns regarding product liability laws.

The study based its results on survey responses from 610 Texas manufacturers with at least 10 employees and interviews with 209 economic development recruiters in the state.

The study also points out that costs associated with the state's product liability laws have prompted 1,500 manufacturers to discontinue products and 3,200 manufacturers have decided not to introduce a new product because of these costs.

"Liability costs were an important factor in 30,000 Texas workers being laid off," the study adds.

People responding to surveys for the study included under "liability costs" such factors as liability insurance premiums, the decision not to introduce new products out of fear of being sued and legal fees.

Texas' product liability laws have reduced spending in Texas by more than \$8.2 billion, the study states, while workers have been deprived of \$53.8 million in income.

However, the study points out that the losses are partially offset by corporate relocations to Texas last year that will generate spending of \$4.3 billion per year.

Plaintiffs' attorneys assail the study's conclusions.

John Howie, a member of the Texas Trial Lawyers Assn. and an attorney with the Dallas firm of Misko & Howie, criticized the study's methodology. He said the survey authors "planted a seed by asking employers what they think of the product liability laws."

"Nobody can point to one example of where product liability laws have run any companies off," or influenced corporations not to relocate in Texas, he said.

Mr. Howie called the product liability reform bill now before the state Senate "a tremendous setback for product safety in Texas. It shifts the burden from the expert—the manufacturer—to the uninformed consumer. That isn't the way to make a product safer."

Norman J. Glickman, an urban policy professor at the University of Texas in Austin and a pioneer in the field of urban and regional economics, told the House State Affairs Committee in March that the manufacturers and industrial recruiters interviewed had a lot to gain from changes in the laws.

Mr. Glickman said other factors—like the cost and quality of labor, access to suppliers, cost of living, taxes and quality of life—are more important to corporations selecting a home than a state's product liability laws.

Both the Texas Civil Justice League and the Texas Assn. of Business are backing the product liability reform bill.

Proponents of H.B. 15 believe that if the legislation is signed in its present form it will encourage product manufacturers and sellers to remain in Texas and encourage companies in other states to relocate to Texas.

The Texas Civil Justice League noted in a follow-up to Mr. Perryman's study that: "Certain aspects of products liability laws are wholly counterproductive, doing nothing but breeding a stifling fear of potential liability. These excesses in the law have a negative effect on the Texas business climate."

Ralph Wayne, the league's executive vp, said the biggest fear spawned by current product liability law is that "manufacturers don't know what their options are when they are manufacturing something. . . . We're trying to codify the game rules. There just aren't any statutory product liability laws in Texas."

For example, he said a manufac-

turer that makes a product for 10 years according to industry guidelines is afraid to upgrade it to state-of-the-art specifications because to do so would give the impression that the old product was not as good as it could have been.

The bill would narrow the liability of manufacturers and sellers in a number of ways.

The legislation states that the absence of a warning or instruc-

tions would not necessarily allow a product liability action if the danger or safe use associated with a product is obvious, known by the person using the product, generally available to users or not known to the manufacturer or seller at the time the product was supplied.

The bill also limits the liability of manufacturers and sellers in cases of injuries or damages caused

Continued on page 28

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Runoff dispute

pute is "substantial."

Merrett also is suing for the return of all claims that syndicate 418 already has paid out under the runoff policies.

Merrett would reimburse the companies the premiums paid for the policies.

Runoff reinsurance policies provide, often on an unlimited basis, coverage for claims arising from ceding companies' or syndicates' past underwriting years.

However, many of the runoff policies written in the late 1970s and early 1980s now are being disputed by underwriters, who claim the ceding insurers did not provide adequate information to assess the underlying liabilities, particularly in regard to asbestos liabilities.

For example, Mr. Outhwaite, one of the leading runoff reinsurance underwriters in the early 1980s, has disputed at least 13 such policies. Outhwaite marine syndicate 317/661 faces hundreds of millions of dollars of losses on its 1982 underwriting account, primarily be-

cause of the runoff policies (*BI*, Aug. 29, 1988).

Merrett, too, is disputing several other runoff policies. Besides the two policies involved in the suits, its syndicates wrote unlimited runoff policies for nine Lloyd's syndicates (*BI*, May 2, 1988).

Most runoff reinsurance disputes have been settled through negotiation or private arbitration, resulting in no legal precedents to resolve similar disputes in the courts.

According to Merrett's lawsuits, filed in London's High Court March 21, former Merrett underwriter John Emney agreed in June 1978 to underwrite 50% of a runoff policy to reinsure the business written by Provincial's marine department in "various risks" for years prior to 1969.

Provincial paid Merrett a premium of almost \$700,000 for its 50% share of the policy, which provided unlimited coverage.

Mr. Emney agreed in July 1980 to write a 50% share of a similar policy reinsuring UIC for all business written by "the marine department

of the London & Overseas Insurance Co. Ltd. . . in conjunction with the Provincial Insurance Co., and accepted in their 1968 or earlier underwriting years."

UIC, which agreed to assume the liabilities of London & Overseas' runoff business in 1972 following the sale of L&O by UIC's parent company, paid Merrett total premiums of about \$850,000 for Merrett's 50% share of the policy, according to the court papers.

Prior to the signing of the contracts, the companies provided Mr. Emney with information concerning the "nature and quality" of the risks via broker C.T. Bowring & Co. Ltd. and various Bowring subsidiaries, the court papers say.

However, the insurance companies and Bowring "failed to disclose matters which were known (or ought to have been known)" by them and which "were not known" to Merrett, the suit charges.

The companies and brokers "failed to disclose the true extent of the (companies') actual and anticipated liabilities in respect of the risk. . . . Insufficient material was made available to Mr. Emney for him to make a fair assessment of the risk," the lawsuits claim.

For example, Provincial or UIC failed to disclose that Provincial's "reserves in respect of outstanding claims had not been updated. . . since the fourth quarter of 1972 with the necessary consequence that the information given (Merrett) was inaccurate," court papers say.

As a result, Provincial "was not in a position to make any adequate assessment of its prospective liabilities," Merrett charges.

According to Merrett, Provincial or UIC also did not disclose that:

- Provincial's reserves "had been periodically reduced since the end of 1972 by the amount of ever-increasing claims settled each quarter and for most underwriting years had been completely extinguished."

- Provincial's board of directors "had been very concerned at the incidence of claims affecting its old years of account."

- Provincial's marine department "had become deeply concerned with the growing problems of asbestosis claims."

Meanwhile, neither company disclosed that Provincial's reserves for outstanding claims were inadequate in relation to the risk, Merrett says.

According to Merrett, in about October 1979, Provincial's claims adjuster "carried out a reappraisal of Provincial's outstanding claims and found that in most cases the reserves were inadequate."

Provincial "believed that its total involvement in losses since 1955 was approximately \$12 million," Merrett says.

"Provincial also knew of its involvement in Agent Orange claims but provided for no reserves in this regard. Provincial also knew that it had never advised any updated claims estimate in these respects," the lawsuit claims.

Furthermore, an exposure to asbestos claims via the companies' reinsurance of Travelers Corp. of Hartford, Conn., was not disclosed by the companies, the suit says.

"At no time prior to consideration of the risk by Mr. Emney" were the companies' liabilities to reinsure asbestos claims paid by Travelers "disclosed sufficiently or at all," the lawsuits claim.

Unknown to Merrett "the risk reinsured included (the companies') exposure to asbestosis claims by the Travelers. A prudent underwriter would have regarded the prospective reinsurance of the Travelers as highly material," the suit says.

Also unknown to Merrett, the companies "together with other London underwriters" had received a copy of a report by the New York law firm of Mendes & Mount that "made detailed reference to the exposure of the Travelers to asbestosis claims," according to the lawsuit.

However, the companies failed to disclose to Merrett the fact that they had received the report or were aware of its contents, the lawsuit says.

Furthermore, the suit charges that neither the companies nor Bowring told Merrett that in September 1978 they had received a letter sent by Travelers to all of its reinsurers from 1941 onward regarding possible asbestos claims. The 1978 letter indicated that Travelers at that time had identified 27 policyholders with some degree of asbestos exposure, with approximately 5,000 bodily injury claims already reported, Merrett says.

Merrett also alleges that the companies breached their contract by failing to:

- Maintain proper and accurate books and records relevant to the policies reinsured by Merrett.

- Conduct their insurance business in relation to "matters relevant to the (policies) in a proper and competent manner."

- Employ sufficiently competent underwriting and accounting staff to handle the business falling within the runoff policies.

As a result of the allegations, Merrett gave the companies "notice of avoidance of the contract" on March 20, 1989, and offered to return the premiums paid for Merrett's 50% share of the runoff policies, the lawsuit states.

David Potts, Provincial's general manager of finance, said Provincial is "strenuously resisting" Merrett's lawsuit. He would not comment on the size of the liabilities or the number of claims in dispute with Merrett.

UIC's former parent company, TSB Hill Samuel Bank Holding Company P.L.C.—which has assumed all liabilities for UIC prior to April 1982, including the business written by London & Overseas in conjunction with Provincial—also will defend the lawsuit, said a Hill Samuel spokesman.

Bowring officials could not be reached for comment.

Meanwhile, Provincial has "not received any communication from the Outhwaite agency at the present time," though claims have been submitted to Outhwaite "in the normal way," Mr. Potts said.

The Hill Samuels spokesman said that although Mr. Outhwaite has "not taken any steps yet" to cancel the runoff policy, he is not paying claims. ■

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Texas product liability bill

Continued from page 27
by an alleged design defect in a product.

Under the bill, a defendant could not be found liable in cases concerning alleged design defects unless it is proved that a "practical and technically feasible safer alternative design existed" when the product was made or sold.

In addition, the plaintiff would have to prove the design rendered the product "unreasonably dangerous for its intended or reasonably foreseeable use."

In addition to those limitations, a defendant who is a retailer but did not manufacture the product would have added protection against product liability lawsuits.

The claimant filing a suit against a retailer would have to prove that the retailer either:

- Was responsible for the testing, labeling and warnings related to the aspect of the product that caused injury, property damage or death.
- Altered or modified the product and the change caused damages.
- Had knowledge of the product defect.

The legislation also would allow a judge in a product liability case to hold the plaintiff partially liable for an accident if the claimant is determined to have altered or misused a product or failed to discover a defect or avoid harm from a product in a manner that would be expected of a "reasonably prudent person."

The judge could also assess some liability to a product user that was intoxicated or impaired by illegal drugs when using a product.

The new law also would set up a system whereby a jury would determine first whether a manufacturer or seller was liable for an injury or damage related to a product and, if so, award compensatory damages. In a separate proceeding, the jury would determine if punitive damages should be awarded.

Mr. Wayne said the burden of proof called for in the bill and the two-part jury trial will help solve some of the problems illustrated in Mr. Perryman's study.

Requiring a jury to decide if punitive damages should be awarded after deciding there was liability could lead to lower awards because the emotional aspects of the first part of the trial will be over, he said.

However, Mr. Howie said, "I don't understand why all of a sudden in product liability cases we need a bifurcated trial."

He pointed out that other types of civil cases are not split into two proceedings and noted that product liability suits are a "token percentage of overall cases tried" in Texas. ■

Antitrust suit

Continued from page 2

have been consolidated in the U.S. District Court in San Francisco, that the 31 defendants conspired to eliminate coverage for pollution-related losses and for prior acts under the claims-made commercial general liability insurance policy form issued by defendant Insurance Services Office Inc. (BI, March 28, 1988; June 20, 1988).

At this stage of the proceedings, motions and responding briefs are focusing on the overall legal issues and not on any issues of fact, which would be preceded by discovery.

Consequently, the brief filed by the state attorneys general calls upon legal precedent to bolster their case, while also charging the defendants with misinterpreting case law.

This was to be expected, say defense attorneys.

"We have substantial confidence in the positions that we sponsored before Judge Schwarzer, and nothing that's in the briefs filed by the attorneys general alter our view about the merits of our motions," said Barry Ostrager of New York-based Simpson Thacher & Bartlett, who represents K.F. Alder & Others (Underwriting Agency) Ltd. in the litigation.

"I would think we anticipated the arguments they made and will reply in June," said John G. Harkins Jr. of Pepper, Hamilton & Scheetz in Philadelphia, who represents Aetna Casualty & Surety Co. in the litigation. "There were no surprises."

"I don't think there's anything particularly surprising in the briefs, from what I have seen in them," said Robert N. Mitchell of San Francisco-based Adams, Duque & Hazeltine, who represents the Reinsurance Assn. of America in the litigation.

"Their briefs are basically a rehash of their allegations," said Mr. Barthold.

The brief responds to five motions by the defendants to dismiss the action:

- The McCarran-Ferguson motion, filed on behalf of all the defendants, which seeks dismissal of the suit on the grounds that, contrary to claims in the consolidated antitrust suits, the industry defendants did not engage in a boycott and therefore are entitled to immunity from antitrust laws under McCarran.

- The "state action" motion, also filed on behalf of all the defendants, which seeks dismissal on the basis of the state action doctrine. The doctrine provides immunity from antitrust laws if the anticompetitive restraint reflects a state policy and if the state activity supervises any private anticompetitive conduct.

- A motion filed by the reinsurer defendants arguing that there are no grounds for the antitrust suit against the reinsurance defendants because there is no direct relationship between them and the plaintiffs.

- A motion filed by foreign reinsurer defendants and one broker calling for dismissal of two claims alleging conspiracies to eliminate pollution coverage because of their foreign base.

- A motion filed by eight foreign reinsurer defendants in the case that states the complaints against them should be dismissed because a "global conspiracy" has not been established.

Based in part on comments that have been made by Judge Schwarzer, attorneys consider the McCarran-Ferguson motion the most significant in the case.

"I think the battleground in these motions is going to be McCarran-Ferguson," commented Mr. Schiff. "That issue is likely to be decisive."

In discussing the McCarran-Ferguson motion and arguing against the suit's dismissal, the attorneys general brief states that the act specifically excludes boycotts from immunity from antitrust action.

"First and foremost, the challenged conduct falls squarely within the Act's 'boycott exception' and so is excluded from McCarran protection,"

says the brief.

The boycott exemption to McCarran-Ferguson includes all trade restraints "involving force or compulsion designed to pressure another into submission," says the brief. And the charges against the industry defendants represent a "classic" case of "boycott, coercion and intimidation," it says.

The brief charges that "numerous non-conspiring primary insurers" were compelled "to act in accordance with the conspirators' wishes by not offering the consumer-demanded coverages."

As a result, government entities had to buy the restricted coverage "that the conspirators sought to force upon them."

Discussing the attorneys general's McCarran-Ferguson arguments overall, one attorney commented that "they're basically, without saying, agreeing with us that there's a purely legal issue here" insofar as the boycott exemption is concerned.

Generally, the plaintiffs are tak-

ing a view of the McCarran-Ferguson Act that is unprecedented, as well as unsupported by case law, said the attorney who spoke only on the condition that his name not be used.

The plaintiffs' interpretation, he said, would "essentially nullify the whole exemption" in the McCarran-Ferguson Act.

Almost all the major arguments in the brief, he said, are based on an interpretation of McCarran-Ferguson that "the courts simply haven't made," he said. "They're really asking Judge Schwarzer to really change that law, not apply it," he said.

(Many of the attorneys representing insurance industry defendants said they were reluctant to comment or needed additional time to study the brief.)

The industry's alleged anticompetitive activity was also the focus of the attorneys general's arguments against the state action doctrine.

"Such conduct is not clearly articulated and affirmatively expressed as state policy in any of the States,"

says the brief. "Indeed, the statutory mandates of all the States are exactly to the contrary, expressly prohibiting the type of conduct in question."

The attorneys general's view is "equally unsupported by the cases," said the attorney who asked not to be named, adding that their interpretation is contrary to the view of a majority of Supreme Court cases.

Another attorney commented that he believes there are not enough facts now before the judge for him to resolve this particular issue without going through the discovery process.

The attorneys general also argued against the other motions that were made by insurance industry defendants.

For instance, the brief argues that the states have the right to sue reinsurers despite the industry's argument that their role as direct-purchasing consumers bars them from doing so.

"First, the States purchased directly from primary insurers that conspired with the reinsurers," says

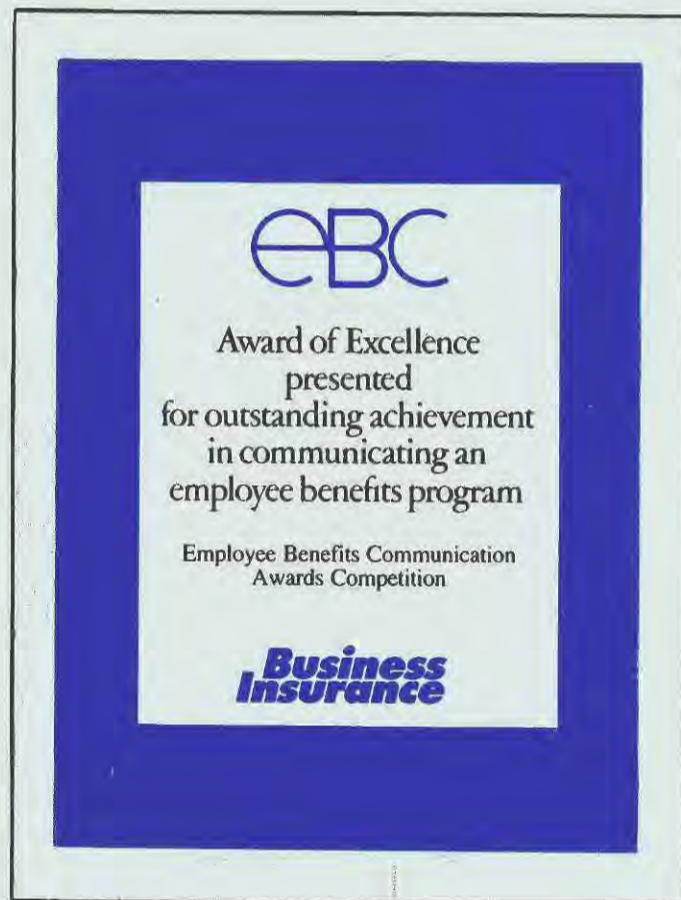
the brief. "Second, even when the States did not purchase directly from conspirators, they still purchased primary insurance in the markets restrained by the conspiracy."

The attorneys general also contend in their brief that the states have the right to sue foreign reinsurers, which the industry defendants had disputed. U.S. courts have jurisdiction over prohibited restraints of trade that affect U.S. commerce, says the brief.

"The mere fact that restraints of trade are carried out by foreign nationals on foreign soil does not alter this principle," states the brief.

The brief also contends that the antitrust suit allegations "are more than adequate to support the conclusion that a 'global conspiracy' existed, and that the foreign defendants were parties to it."

The state attorneys general also argue that the insurance industry defendants failed to meet the proper criteria for calling for the suit's dismissal in their motions.



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NOTICES

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NOTICES

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Vice Presidents, General Managers and Other Administrative Personnel	3,650
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Secretaries, Treasurers, controllers and other Financial Personnel	4,446
Risk/Employee Benefits:	
Vice-presidents, directors, managers, and other related department personnel of insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations	10,687
Sub-total	23,959
Associations:	
Government, Unions and Educational Institutions	1,299
Commercial Consumers	
Sub-total	25,806
Insurance Agents and Brokers	10,745
Insurance Companies	7,557
Actuaries, Consultants, Attorneys, Adjusters, Appraisers and Third Party Administrators	3,580
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Howden trial

Continued from page 3

& Sells, to examine the Howden books. The auditor's investigation, led by Anthony Shearer, uncovered the "secret empire," said Mr. Hill. "But for the assiduity of (Mr. Shearer's team), the four Howden executives and Mr. Posgate might have gotten away with (the fraud)," said Mr. Hill.

The courtroom for the May 4 opening arguments was filled with red, green, white, blue and black legal folders, electronic equipment to show charts to the jury and rows of barristers in wigs and black robes representing Mr. Grob, Mr. Carpenter, Mr. Posgate and the Crown Prosecution.

Before the jury was picked, the three defendants—all sitting in a glass-encased "dock"—stood up and pleaded not guilty to a total of 29 charges against them.

Mr. Carpenter faces a charge that he conspired with Mr. Grob, Mr. Comery and Mr. Page to defraud Alexander Howden Group, its subsidiary and associated companies and the members of Lloyd's syndicates by dishonestly transferring sums of money belonging to Howden and the syndicates to offshore companies that the four men controlled.

In addition, Mr. Carpenter and Mr. Posgate both face a charge that they conspired with Mr. Grob and Mr. Comery to defraud the members of Mr. Posgate's Lloyd's syndicates 126-129 and syndicate 700/701 by "dishonestly effecting reinsurance transactions and by otherwise dishonestly enabling premium monies paid by the said syndicates by way of quota-share and other insurances to be used to acquire the Bank du Rhone," which benefitted themselves and others.

Mr. Grob is charged with 16 counts of theft of a total of around 7 million pounds (\$12 million at current exchange rates), four counts of receipt of stolen goods, four counts of false accounting and three counts for issuing false statements.

Mr. Grob faces these charges, rather than conspiracy charges faced by Mr. Carpenter and Mr. Posgate, because Mr. Grob was arrested and extradited from France in July 1987 when the others were arrested, said Mr. Hill. Mr. Grob could not have been extradited from France on a conspiracy charge, Mr. Hill said.

Following the reading of the charges, red-robed Justice MacNeill selected the jury from a cafeteria full of citizens who said they could serve on the jury until July 31 and who said they were not connected with and did not have relatives connected with Lloyd's and the British insurance market.

The jury has been given three files of documents to help them understand the prosecution's case against the defendants, and jurors already have viewed several color-coded charts outlining the alleged "secret empire" on a huge television screen in the courtroom.

Mr. Hill also told the jury that during the trial he will deliver at least one lecture on how the insurance and reinsurance markets work and how Lloyd's of London operates.

The jury also has been given a glossary of terms that "will cover all the technical words you will need," said Mr. Hill.

In his opening statement, Mr. Hill outlined a history of events that started in 1966, when Mr. Grob—as chairman of London broker Swann & Everett Ltd.—arranged a merger with Alexander Howden Holdings Ltd.

He noted that Mr. Grob had become chairman of Howden by 1970, while Messrs. Comery, Carpenter and Page all became officers or directors of Howden in the early 1970s.

Meanwhile, Mr. Posgate, a senior underwriter at Lloyd's, became a director of Alexander Howden Underwriting Ltd. in 1978 and served as chairman of AHUL from 1979 until 1982.

"By 1975 there were in position four people in the group who were the driving force of the company and who, together with Mr. Posgate, were involved in the criminal activity which the Crown alleges," said Mr. Hill, referring to Messrs. Grob, Carpenter, Page and Comery.

Meanwhile, in 1972, Howden—along with a U.S. insurer referred to as "Century Wisconsin"—bought the Banque du Rhone through a Bermuda corporation known as Manor Insurance Co. Ltd., said Mr. Hill.

Former Lloyd's member Mario Benbassat had formed a company in Geneva, Switzerland, that by 1965 was known as the Banque du Rhone, Mr. Hill said.

Late in 1974, Howden and the

U.S. insurer terminated their agreement and Howden took sole control of the Swiss bank, which became the Banque du Rhone et de la Tamise, the prosecutor said, adding that the official owner of the bank was Alexander Howden Group (Bermuda) Ltd. Mr. Page was appointed the executive chairman of the bank and became the main contact between Howden and the bank, Mr. Hill alleged.

Between October 1974 and November 1975, on instructions from London, the bank formed four corporate entities in Liechtenstein for the four Howden executives, Mr. Hill told the jury: Skyair Registered Trust for Mr. Carpenter; Bloomer Registered Trust for Mr. Grob; Karoli Anstalt for Mr. Page; and Blissful Establishment for Mr. Comery.

Later, in the spring of 1975, Mr. Page instructed Mr. Benbassat—who will appear as a witness during the trial—to set up two Liechtenstein corporations to be owned

equally by the four, according to Mr. Hill. They were an insurance company, known as Southern Reinsurance A.G., and a broker, Zephyr Reinsurance Brokers Co. Ltd. S.A., the prosecutor said.

In December 1978, Mr. Page also instructed the Banque du Rhone to set up a legitimate account for an insurance company known as SNA Re (Bermuda) Ltd., which was 20% owned by Mr. Grob, the prosecutor said. Another bank account was also set up called SNA Re Captive, which was a "strikingly similar name" to SNA Re, remarked Mr. Hill.

The prosecution alleges that this parallel bank account was a "clear determination by the four" Howden executives to misappropriate money for their own purposes while leading auditors to believe that the transactions were legitimate.

"It is the Crown's case that either the (SNAC) accounts were opened deliberately as a temporary

haven for Howden money and the profit of the four or opened for other reasons, but used by the four for their own personal profit," Mr. Hill told the jury. "And if we are right, then the name was deliberately chosen" to fool auditors, he said.

Meanwhile, in 1978, Mr. Grob and Mr. Comery discussed selling the Banque du Rhone, Mr. Hill said. After an attempt to sell the bank to another party fell through, a plan to form a syndicate among the four Howden executives and Mr. Benbassat to buy the bank was agreed upon at a meeting in 1979 in Mr. Grob's Villa Olivula in Villefranche in the south of France, Mr. Hill said.

About October 1979, the idea was explained to Mr. Posgate in London and he agreed to join the "syndicate," Mr. Hill alleged.

The four Howden executives and Mr. Posgate were the five "principal directors" of that syndicate,

Continued on page 32

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Howden trial

Continued from page 31
each owning about 10% of the bank, Mr. Hill told the jury. The prosecutor did not say who owned the remainder of the shares.

"Names of the members (of the syndicate) were not to be disclosed" to other members of the Howden board or others at Howden, the prosecutor said.

The jury will decide how much Mr. Posgate knew about the Panamanian firms, says Mr. Hill.

Then, in 1979 the four Howden executives came to the conclusion that the Liechtenstein trusts should be reorganized because, under Liechtenstein law, dividends paid by the companies were subject to a 4% tax, Mr. Hill said. And, he added, "they needed to find a method of funding the purchase of (the bank) without revealing who was buying the company."

So, five "settlements" were established in Panama to which the money from the Liechtenstein companies could be siphoned, Mr. Hill alleged: Gambit Holdings S.A. for Mr. Grob; Holagio Holdings S.A. for Mr. Comery; Armida Holdings S.A. for Mr. Carpenter; Pirana Holdings S.A. for Mr. Page; and Moliere Co. S.A., which changed its name to Distince Holdings S.A., for Mr. Posgate.

Also, in October 1979, a new company, New Southern Reinsurance S.A., was established in Panama to replace Southern Re in Liechtenstein, Mr. Hill said, ad-

ding that 14% of the new company was owned by the four Howden executives, Mr. Posgate and two others.

In March 1980, another company, Southern International Reinsurance, was set up in Panama to replace Southern Re in Liechtenstein, Mr. Hill said. SIR was owned by the four Howden executives through their Liechtenstein trusts, he said. "Neither" New Southern nor SIR were reinsurance companies under Panamanian law, but in reality were real estate companies, said Mr. Hill.

"Ask yourself, if SIR was supposed to be a reinsurance company, why wasn't it applied for as a reinsurance company under Panamanian law?" Mr. Hill questioned.

The jury will have to decide how much Mr. Posgate knew about the Panamanian companies, Mr. Hill added.

It wasn't until A&A insisted that Deloitte Haskins & Sells conduct its audit on Howden in 1982 that any of this "secret empire" came to light, Mr. Hill told the jury.

The audit "led ultimately to this prosecution," he said.

"For whatever the purpose was for forming the (trusts), the fact is the four created entities to be used for their own control and for their own purposes. None of the four made disclosure of the ownerships. . . They used the offshore entities as vehicles for the creation of (New Southern Reinsurance). They then funded their Panamanian companies by moneys received by the Howden group and Mr. Posgate's syndicates for the purchase of 51% of the Banque du Rhone," Mr. Hill alleged.

"It is the Crown's case that these are a fraud on the group," he said.

The court proceedings will continue this week. ■

RBH of Illinois appoints Pacholick as chairman

John R. Pacholick was appointed chairman of Rollins Burdick Hunter Co. of Illinois Inc. in Chicago, a subsidiary of Rollins Burdick Hunter Co.

Mr. Pacholick, who also remains chief executive officer and central region manager of the brokerage, also previously was president of RBH of Illinois.

Also, **Thomas F. O'Connell** named president and chief operating officer of RBH of Illinois. He previously was executive vp and head of risk management. And, **Rick Voss** joined the brokerage as executive vp and head of risk management.

Douglas B. Brown joined Rollins Burdick Hunter of New York Inc. as executive vp.

In other agent/broker changes:

William J. McGreevy named vp of Frank B. Hall & Co. of Fairfeld/Westchester in Briarcliff Manor, N.Y. Most recently, Mr. McGreevy was a vp with Alexander & Alexander Inc. in Greenwich, Conn.

Bill D. Hines promoted to senior vp and **Barry V. Zalane** and **Terry Flynn** promoted to vps of Near North Insurance Agency Inc. of Chicago.

Douglas J. Dingwall promoted to vp at Corroon & Black of Michigan Inc. in Livonia.

Insurers

Jeffrey K. Amsbaugh joined Nobel Insurance Ltd. of Hamilton, Bermuda, as president and chief

Comings & goings: industry

executive officer. Most recently, Mr. Amsbaugh was vp-corporate development and partnership investing with Progressive Insurance Co.

Dr. Paul W. Frankel named national director-medical management for group health plans of Metropolitan Life Insurance Co. of New York.

Charles M. Angell joined Amerisure Cos. of Detroit as vp-reinsurance and actuarial. Mr. Angell previously was assistant vp of Great American Insurance Co. of Cincinnati.

Also at Amerisure, **Thomas W. Masecar** promoted to vp in the field underwriting division and **James T. Wallace** promoted to vp-products division.

Gregory J. Suffield named vp of Health Providers Insurance Co. of Chicago.

Rebecca J. Cerny promoted to vp of North East Insurance Co. of Portland, Maine.

John Ritchie appointed senior vp of Chubb Life Insurance Co. of America in Concord, N.H.

Also, **Douglas H. Blampied** and **Shannon M. Smith** promoted to vps at Chubb Life.

Engineering Insurance Group in Farmington, Conn., a partnership of The Hartford Steam Boiler Inspection & Insurance Co. and General Reinsurance Corp., announced the following appointments: **Gordon Kreh** to senior vp; **Patrick C.**

Mitchell, John A. Sproha and **A.D. Thomas Jr.** to vps.

Paul V. Brennan Jr. joined Worcester Insurance Co. in Worcester, Mass., as vp-claims. Most recently, Mr. Brennan was district claims manager for American Mutual Insurance Co.

Michael J. Conroy joined Home Insurance Co. in New York as executive vp-claims and loss control, a newly created position. Previously, Mr. Conroy was senior vp and managing director-worldwide claims operations for Chubb & Son Inc.

Bob Demma promoted to vp-claims at Pacific States Casualty Co. of Los Angeles.

Barry E. Scammell named vp of Long Grove, Ill.-based Kemper Group's national property/casualty insurance companies. Mr. Scammell also was named division president of Kemper Corp.'s New York office, where he is based.

Liberty Mutual Insurance Co. of Boston announced the following appointments: **Carl Kruse** and **Joseph G. Tangney** to senior vps; and **Robert L. Barrese**, **Scott R. Goodby** and **Phillip J. Guymont** to vps.

Ian Kilpatrick joined First Security Casualty Co. in Detroit as president. In his previous position, Mr. Kilpatrick was director of Johnson & Higgins (Cayman) Ltd. on Grand Cayman, British West Indies. ■

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Section 89

Continued from page 1
reduce employers' data collection burdens and simplify non-discrimination testing procedures (BI, April 24).

"The administration applauds the efforts of the chairman and the other sponsors of the bill to resolve problems posed by Section 89 and believes the bill sets the stage for legislative debate," Mr. Trier said.

"We look forward to working with Congress during the course of the effort to develop a prompt legislative solution," he said.

The decision of the Bush administration to ally itself with Congress in crafting a Section 89 reform package gives an enormous boost to the reform movement, benefit experts and business lobbyists say.

"This demonstrates that the executive and congressional branches have a united front," said Edward J. Davey, a principal with A. Foster Higgins & Co. Inc. in New York.

"This is very encouraging news. Everyone is singing from the same hymn book," added James Klein, deputy executive director of the Assn. of Private Pension & Welfare Plans in Washington, D.C.

Aside from pledging prompt action, both congressional leaders and administration officials promised this time to consider the views of employers when drafting Section 89 tests.

"I'm interested if there are major problems with the (Rostenkowski) bill," said Rep. J.J. Pickle, D-Texas.

And, Mr. Trier vowed that once an acceptable reform package is agreed upon, employers could rest comfortably knowing that the law won't be continually changing.

"We want to be sure that this is our last crack" at Section 89, Mr. Trier said.

The willingness of the administration and congressional leaders to make the Section 89 debate an open one is in sharp contrast to the aura of secrecy that permeated the crafting of Section 89 almost three years ago when it was added to the Tax Reform Act of 1986.

No hearings ever were held on the proposal, and congressmen lacked a good grasp of the administrative demands mandated by Section 89 when they approved the non-discrimination statute as part of the tax reform law.

Even last year, when employer complaints about Section 89 first escalated, administration and congressional staffers refused to consider any but the most technical changes to the law, which is designed to ensure that the bulk of a company's employees receive health care benefits that are comparable to those provided to highly compensated workers.

But an explosion of employer anger over Section 89 abruptly changed the mood on Capitol Hill. Suddenly, congressmen engaged in a race to introduce legislation to delay, modify or repeal Section 89.

One of those repeal bills, introduced by House Small Business Committee Chairman John LaFalce, D-N.Y., attracted 300 co-sponsors and served as a barometer measuring the widespread discontent with Section 89.

Prop. 103 ruling

Continued from page 1
got," said J. Robert Hunter, president of the National Insurance Consumer Organization in Alexandria, Va.

Voter Revolt, the Los Angeles-based consumer group that sponsored Proposition 103, declared nearly total victory after the court decision.

"Proposition 103 is now the law of the land here in California. Its short-term rollback provisions will provide consumers with immediate relief; its long-term industry reforms will keep rates low," said Harvey Rosenfield, Voter Revolt chairman and the initiative's chief author.

While disappointed with the decision as a whole, the property/casualty insurance industry is relieved that the court struck down the "insolvency clause."

"When legislators feel the heat, they see the light," said Henry Saveth, a principal with Foster Higgins in New York.

Still, there are limits to what Congress will do as the Section 89 debate begins in earnest.

For example, despite the support for Rep. LaFalce's bill, key legislators and administration officials vow that repeal of Section 89 is not an option.

"Section 89 will not be repealed. It is a principle of law," said Rep. Pickle.

"We do not think repeal is a viable option," said the Treasury's Mr. Trier.

Those who think repeal is likely "are not keeping up with politics," said Rep. Beryl Anthony, D-Ark., a somewhat oblique recognition that repeal is virtually impossible without the support of Rep. Rostenkowski who, as Ways and Means Committee chairman, controls the fate of Section 89 legislation. Rep. Rostenkowski is a staunch opponent of Section 89 repeal.

It also is clear that Congress and the administration will have little stomach for considering a slew of safe harbors, special exceptions and tests when rewriting Section 89.

"Chairman Rostenkowski is not interested in more safe harbors. They add only more complexity," said Rep. Pickle.

"We don't want to go down the road of having four or five tests," said Mr. Trier.

In addition, while the administration is willing to consider more lenient non-discrimination rules for small employers, it would oppose a flat Section 89 exemption for small businesses, as will likely be proposed by several congressmen.

If such an exemption were created, small employers could provide benefits to "fat cats" and little or nothing to the bulk of their employees, Mr. Trier said.

In addition, the administration will oppose taxing employees on a portion of their health care benefits exceeding a certain value in exchange for scrapping Section 89, an idea that has surfaced before.

A health care benefit tax cap would not assure that benefits are available on a non-discriminatory basis, Mr. Trier said.

While the final shape of a new Section 89 statute is unclear, the Rostenkowski bill currently is the center of congressional debate.

The Rostenkowski bill is described by Rep. LaFalce as de facto Section 89 repeal because it scraps the need for employers to identify exactly who is participating in as many as dozens of health care plans. In addition, health care plans will not flunk Section 89 simply because a large percentage of highly compensated employees choose a particular benefit option.

Instead, the Rostenkowski bill bases compliance with the non-discrimination tests, in part, on whether a high percentage of employees are eligible for "affordable" health care coverage.

To pass this affordability or eligibility test, an employer would have to offer health care coverage consisting primarily of "core"—or medical and hospital benefits—to at least 90% of non-highly compensated employees. Employee

contributions, either pretax or after-tax, could not exceed \$10 a week for individual coverage and \$25 a week for family coverage. These maximum contribution levels would be indexed to annual increases in wages.

The penalty for flunking the 90% test would be severe: The value or cost of all health care coverage provided to highly compensated employees would be added to their taxable income.

Under the second test, known as the benefits test, a plan that is only available to a limited class of employees would be considered non-discriminatory if the cost of coverage is no greater than 133% of the cost of coverage for a core health plan available to at least 90% of non-highly compensated employees.

The cost of coverage that exceeds this 133% threshold would be included as taxable income to highly compensated employees.

Other provisions in the Rostenkowski bill would:

- Eliminate group term life insurance from non-discrimination testing requirements.

- Require employers to include part-time employees working at least 25 hours a week when running the non-discrimination tests. The current Section 89 statute requires employers to count employees working as few as 17½ hours a week for non-discrimination testing purposes.

- Impose special excise taxes on employers whose benefit plans fail Section 89(k) qualification rules, which detail, among other things, how employers must document and communicate their welfare plans.

- Give employers a choice—this year only—of applying the tests in the current Section 89 statute or complying with the rules in the Rostenkowski legislation.

Most of the witnesses who testified before the Ways and Means Committee last week praised the Rostenkowski bill as a good first step toward Section 89 reform.

Rep. Rostenkowski has "gone 100 miles in giving us something that we can work with," said Victor Gilla, corporate manager of employee benefits at Ball Corp. in Muncie, Ind.

"The bill is straightforward and comprehensible to the layman," said David Marshall, vp-employee benefits at RJR Nabisco Inc. in Atlanta.

But employers and other witnesses criticized specific provisions in the Rostenkowski bill, most notably the provision linking increases in the employee contribution limits contained in the affordability test to increases in the national average wage.

Employers noted that this provision would force them to absorb a much greater share of health insurance costs in the future to remain in compliance with Section 89 because health care inflation is increasing at a much faster rate than wages.

"If the maximum premiums are indexed to wages, increases in the cost of medical care could drastically reduce the employees' share of the cost of an affordable health plan," said H. Richard Klotz, corporate vp and director of taxes at Motorola Inc. in Schaumburg, Ill.

Mr. Klotz, who testified on be-

Commenting that "insolvency has various meanings," the court said none of them would allow it to interpret requiring insurers to be "substantially threatened with insolvency" to "conform to the constitutional standard of a fair and reasonable return."

Instead, insurers appealing to the Department of Insurance for relief from the 20% rollback below November 1987 levels, as called for in Proposition 103, will be subject to the historic standard that rates cannot be "excessive, inadequate or unfairly discriminatory," the court said.

Furthermore, the court commented in its opinion that "over the long term, the state must permit insurers a fair return."

And, in another section of the opinion, the court says that

Update

Lloyd's agents fight new tax

Continued from page 2

The change in the tax treatment of Sallie Maes would cost Lloyd's syndicates at least 15 million pounds (\$28.2 million) for the 1985 underwriting year, which closed in 1988 under Lloyd's three-year accounting system, and tens of millions of pounds for later years, observers estimate (BI, Feb. 13).

2 firms contest OSHA fines

CHICAGO—Two contractors cited for "willful violations" of safety rules that played a role in the deaths of three tunnel workers in Milwaukee last year are contesting \$1.2 million in fines assessed by the federal Occupational Safety and Health Administration.

S.A. Healy Co., the McCook, Ill.-based chief contractor for the Milwaukee deep tunnel sewer project, was cited for 68 willful violations of federal safety regulations—the most serious violations under the OSHA rules—and fined \$10,000 for each violation, or \$680,000, said John Phillips, deputy regional OSHA administrator in Chicago.

CH2M Hill Central Inc., a Corvallis, Ore.-based contractor responsible for supervising construction, was fined \$470,000.

OSHA accused the two contractors of failing to train workers in the proper response to methane in a tunnel, using inappropriate wiring techniques and electrical equipment and having inadequate ventilation.

Healy filed a contest to the fine four days after it was proposed, said a lawyer representing Healy. A spokesman for CH2M said the contractor will meet with OSHA officials later this week and plans to "vigorously contest" the fines.

NYIE President Fahys resigns

NEW YORK—New York Insurance Exchange President Joseph Fahys has resigned to join London reinsurer R.K. Carvill & Co. Ltd.

At an April 28 meeting, the exchange's board of governors elected Robert M. Lowd, retired president and chief executive officer of Associated Aviation Underwriters, to replace Mr. Fahys. Mr. Lowd was elected an exchange governor last November.

"This transition has been planned over the last six months," said Mr. Fahys, who had announced his intention to stay with the exchange during an orderly shutdown of its operations. "Essentially, I think things are in good order, and I think it's a good time for a change." The exchange closed its doors in late 1987 and has since been shutting down its back office facilities as syndicates run off their business (BI, Nov. 30, 1987).

Mr. Fahys, who will be based in the United States, will be involved in product development and other corporate functions for Carvill.

Briefly noted

A U.S. Bankruptcy Court judge in Philadelphia last week denied **Raymark Industries Inc.**'s motion to dismiss an involuntary bankruptcy filing made against it by a group of asbestos injury plaintiffs who hold unstayed judgments against the company (BI, March 20, March 6). While Raymark sought the dismissal on the grounds that the plaintiffs held disputed judgments against Raymark and had no standing to force it into bankruptcy, the judge held that some plaintiffs did have standing. A hearing is scheduled for May 22. . . . The Washington Insurance Department has issued a cease-and-desist order against **Professional Risk Insurers Management Exclusive Co. Ltd.** of St. Vincent, British West Indies, after finding that PRIME had been soliciting medical malpractice business in the state. PRIME, which is not licensed anywhere in the United States, has been hit with cease-and-desist orders by several state regulators (BI, Aug. 15, 1988).

half of the ERISA Industry Committee and the Section 89 Coalition, suggested an indexing method in which maximum employee contributions would be allowed to rise in tandem with the increase in the medical care component of the Consumer Price Index.

Rep. Anthony, the Arkansas Democrat, warned that if the indexing formula is not changed, employee benefits would be reduced as employers hiked deductibles and coinsurance levels to keep maximum employee premium contributions under the ceilings.

Mr. Klotz also said the legislation's 90% availability test was too high and ought to be lowered to 80%.

In addition, Mr. Klotz complained of the "cliff" effect of the 90% test. If core health care bene-

fits were offered, for example, to only 89% of non-highly compensated employees, all highly compensated employees would be taxed on the value of their health care coverage.

Rep. Pickle expressed concern about the cliff effect, but worried that too many exceptions would make the bill too complicated.

Frederick Rumack, director of taxes and legal services at Buck Consultants Inc. in New York, recommended that employers be given a choice of complying with the current Section 89 statute or H.R. 1864.

Employers, Mr. Rumack noted, already have invested considerable time and money in developing administrative systems, gathering data and running tests to meet the current Section 89 tests. ■

when an insurer renews an auto policy as required under Prop. 103, the insurer "is guaranteed fair and reasonable rates."

The Department of Insurance was working quickly last week to develop a procedure to review insurer applications for rollback relief, according to John H. Sullivan, undersecretary for the state Business, Transportation and Housing Agency, parent agency for the Department of Insurance.

Details on the relief procedure may be ready by late this week, he said.

The Insurance Department will "continue to move ahead rapidly" to implement Proposition 103, Mr. Sullivan said.

The state Legislature has authorized \$1.8 million to hire 66

Continued on next page

Prop. 103 ruling

Continued from previous page
additional employees before June 30, and the department is negotiating for money to hire more employees starting July 1.

Among the insurers that have already announced they will file for relief from the 20% rollback are Los Angeles-based Farmers Insurance Cos.

"We don't believe our current rates will be found to be excessive," said a Farmers' spokesman.

State Farm Insurance Cos. also "will be filing an application for rate relief. We believe our rates to be in line with our costs and we don't expect there to be any change in the premiums our customers currently are paying. We don't expect to refund any premiums," said a State Farm spokesman.

In addition, Standard & Poor's Corp. announced last week that because the court struck the insolvency provision, it was removing from its CreditWatch list the claims-paying ability ratings of Farmers Insurance Exchange, Allstate Insurance Co., SAFECO Insurance Co. of America and PMI Mortgage Insurance.

"This action recognizes that the companies will be able to charge adequate rates for their policies while they deal with the primary causes of this insurance crisis—excessive loss costs," S&P said.

The insurers' ratings had been put on the CreditWatch list after voters approved Proposition 103.

However, a Voter Revolt statement issued Thursday referred to the stricken insolvency standard as "a minor technical portion" of the rollback provision.

Declaring that current insurance

rates are "excessive," Mr. Rosenfield predicted few insurers would be able to prove they meet the standard for relief during the law's first year. Many insurers may not even apply for relief, he said.

"I believe some (insurance) companies will give rebates" without appealing for relief, he said.

And, California Attorney General John K. Van de Kamp, who argued the consumers' case before the state Supreme Court, said in a statement: "We now have the tools to make the insurance industry accountable for the rates they charge. I intend to use these tools to make sure that the insurance companies are put to the tough test that Proposition 103 demands."

Echoing the attorney general's position that Proposition 103 will be strictly enforced, Gov. George Deukmejian issued a statement that: "I have consistently maintained that we would faithfully implement the will of the people as interpreted by the court, and that applies to Proposition 103."

Industry associations reported disappointment that most of Proposition 103 was upheld, but—citing antitrust considerations—avoided making sweeping statements about how insurers might react.

"Clearly, individual companies are going to have to evaluate the rollbacks and the need for rate relief based on their own" situations, said Franklin W. Nutter, president of the Alliance of American Insurers in Schaumburg, Ill.

But, "we're encouraged by the court's feeling that companies can charge enough to cover their costs and make a fair profit. I guess that's the silver lining. But, it's a silver lining in a very dark cloud," Mr. Nutter said.

Thomas F. Conneely, president

of the Assn. of California Insurance Companies, said last week that "one of the principal reasons we asked the Supreme Court to review Proposition 103 was because the rate reductions and rollback provisions denied insurance companies the opportunity to earn a fair profit. Today, the Supreme Court agreed with our position on that point."

Lowell Beck, president of the Des Plaines, Ill.-based National Assn. of Independent Insurers, said: "We had hoped that the court would recognize the inequities of Proposition 103 and strike down provisions such as the 20% rate rollback."

The New York-based Insurance Services Office Inc. said "after a preliminary reading, there seems to be no question that we are still in business in California."

ISO will continue to provide products that comply with the new law, a spokesman said, including statistical plans and underwriting tools but not rating information.

However, ISO "is exploring all of our further options for further relief, including administrative and judicial," said the spokesman.

Attorneys for insurers will meet this week to discuss whether to ask the U.S. Supreme Court to review the California ruling, said Allen Katz, attorney for the Assn. of California Insurance Cos.

However, he added, it will be difficult to find grounds for a review.

In seeking to overturn Proposition 103, insurers had argued that the provision ordering insurers to roll back "charges" for most types of property/casualty insurance to 20% below November 1987 levels for one year was arbitrary, discriminatory and confiscatory.

In addition, insurers argued that the provision in Proposition 103 that said an insurer could be granted relief from the rate rollbacks only if the insurer "is substantially threatened with insolvency" did not permit relief from confiscatory rates.

While the California Supreme Court ruled that the mandated rate rollback is constitutional, it said forcing insurers to prove that they were faced with insolvency before they could win relief from the rollback is unconstitutional.

"We conclude that except for the insolvency standard the provisions of Proposition 103 relating to the setting of insurance rates and procedures for the adjustment of rates do not, on their face, deprive insurers of due process under the state or federal constitutions," the court said.

The court first addressed the so-called insolvency standard.

The court rejected the argument by Proposition 103 proponents that requiring an insurer to prove that the rollbacks would threaten its solvency is necessary to combat an

emergency created by a lack of available and affordable insurance.

"Our concern is not with the magnitude of the problem, but with its character," the court stated. "The asserted rise in insurance rates, rendering insurance unavailable or unaffordable to many, is not a temporary problem; it is a long-term, chronic situation which will not be solved by compelling insurers to sell at less than a fair return for a year."

"Over the long term the state must permit insurers a fair return; we do not perceive any short-term conditions that would require depriving them of a fair return."

To assure insurers a fair rate of return while the mandated rate rollback is in effect, the court directed the Insurance Department to approve rate relief when rates are found to be "inadequate."

Insurers that believe rates required under the rollback provision are confiscatory may seek approval of higher rates.

If the insurer seeks approval for higher rates before Nov. 8, 1989—when the one-year rate rollback is scheduled to end—the insurer may charge those rates pending a ruling from the department.

After Nov. 8, 1989, rate changes are subject to the prior approval system.

"If the commissioner finds the initiative's rate, or some other rate less than the insurer charged, is fair and reasonable, the insurer must refund excess premiums collected with interest," the court noted.

"No insurer, however, will be compelled to charge the rates set by the initiative unless it either acquiesces in that rate or is unable to prove that a higher rate is constitutionally required," according to the court decision.

The justices also noted that the insurance commissioner has broad powers to grant interim relief "from plainly invalid rates."

Because insurers have "safeguards" that allow them to charge adequate rates in the face of the mandated rate rollback, "we conclude that the initiative provision requiring a reduction in rates to at least 20% below 1987 rates does not, on its face, violate the due process rights of insurers," the court concluded.

The Supreme Court also ruled that the provision in Proposition 103 that restricts insurers' rights to cancel or not renew auto insurance policies applies to policies in effect when the initiative was enacted.

The provision prohibits cancellation or non-renewal of auto insurance policies except in cases of non-payment of premium, fraud or material misrepresentation affecting the policy or insured, or a substantial increase in the risk.

Insurers had argued that the provision, if applied to policies in

effect before Proposition 103 was approved by voters, would violate a state law prohibiting impairment of contracts.

In ruling on the provision, the justices noted that any contract impairment created by the provision "is relatively moderate and restrained," adding that insurers are guaranteed "fair and reasonable rates" when they renew policies.

Also, the court points out that an insurer, if it chooses, would still be allowed to withdraw from the entire California insurance market "by surrendering its certificate of authority."

In addition, the court pointed out that "if many insurers refused to renew, the state could face a crisis in which many of its residents would be unable to obtain (auto) insurance and thus could not legally drive, and others would be forced to accept inadequate protection."

"We conclude that the public interest in averting this danger, when measured against the relatively low degree of impairment of contract rights involved, is sufficient to justify Proposition 103's non-renewal provision," the court said.

In another section of the decision, the court ruled that the provision of Proposition 103 calling for the formation of a non-profit insurance consumer protection organization clearly violates the state constitution.

The constitutional prohibition against naming or identifying a private corporation in a ballot initiative to conduct any function was intended to prevent special interest groups from gaining privileges not granted to other organizations by sponsoring self-serving initiatives, the court said.

"One might even perceive this danger in the present case," the justices said. Proposition 103 grants the envisioned consumer group exclusive benefit of a low-cost or free statewide mailing to solicit memberships.

The court left unresolved whether the California Board of Equalization can adjust premium tax rates for insurers to compensate for an expected decrease in premium tax revenues caused by the Proposition 103 rate rollbacks.

The initiative permits the board to raise the tax rates for premiums collected between Nov. 8, 1988, and Jan. 1, 1991, to cover revenue shortfalls caused by rate rollbacks.

Insurers argued that the state constitution granted the authority to set the tax rate to only the Legislature.

The court, though, found that state law "bars prepayment review of tax measures" by the courts. It said that insurers will have to pay any increased taxes and then seek a court decision on the provision's validity. ■

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Court refers to 'rates,' not 'charges'

The California Supreme Court apparently has interpreted the 20% reduction in "insurance charges" mandated by Proposition 103 to mean insurance rates.

The proponents of Proposition 103 intended the rollbacks to apply to premiums charged on individual risks, according to Proposition 103 author Harvey Rosenfield.

But, throughout the court's May 4 opinion on Proposition 103 and the 20% rollback provision, the word "rates" is used.

There is a difference between insurance "rates" and insurance "premiums." Insurance "rates" are factors taken into consideration to reach a final premium, but factors other than rates also are considered. For example, to arrive at an auto insurance premium, the insurer takes into account the driver's record, the driver's age and marital status, and the insurance industry's assessment of the safety of a particular vehicle.

The difference between rates and premiums is especially significant in calculating commercial insurance premiums. A commercial property insurance premium, for example, is a function of the property insurance rate times the value insured, as well as other factors. A

commercial liability insurance premium is a function of the liability insurance rate times the limits purchased, as well as other factors.

"I think the court's ruling at least implies and gives the department a basis for saying that the rollback applies to rates and not to just 'premiums,'" said David Hauge, an attorney with Knapp, Petersen & Clarke in Los Angeles.

"How the department comes out with the regs is another issue," he added.

Attorney John Morrissey with McCutchen, Doyle, Brown & Enersen in San Francisco said the court's decision leaves uncertainty about whether rollbacks are tied to rates or directly to specific premiums charged.

"It's probably something that the insurance commissioner can fiddle with," Mr. Morrissey said.

The Proposition 103 rollback provision reads: "For any coverage for a policy for automobile and any other form of insurance subject to this chapter issued or renewed on or after November 8, 1988, every insurer shall reduce its charges to levels which are at least 20% less than the charges for the same coverage which were in effect on November 8, 1987." ■

Cash flow, asset quality critical to comparisons

By MYRON M. PICOULT

Special to Business Insurance

CASH FLOW (actual cash flow) has always been important to the property/casualty insurance industry, because it is the reservoir from which cash expenses are paid. Changes in the industry's ability to accrete statutory capital and prospective confusion about the quality of reported earnings (due to the Financial Accounting Standards Board's accounting changes) should raise the level of investors' interest in cash-flow data.

We recently undertook a study to gather a five- to 10-year data base that was relatively comparable for all companies.

We compared growth rates of cash flow, the standard deviations for each company and the magnitude of the historical multiples accorded the figures. The available public data was not as specific as it should be and many management provided assistance.

Although the final data base probably has some kinks in it, we believe that it is a workable tool providing comparative parameters.

The impetus for the study stemmed from two factors: the 1986 Tax Reform Act and current FASB accounting changes affecting insurance companies. For some time, it has been our belief that the 1986 tax law would inhibit the property/casualty insurance industry's ability to accrete statutory capital and resulting in a material increase in cash tax payments.

We estimate that, over a five-year period, the property/casualty insurance industry

will pay about \$14 billion in taxes. This is in stark contrast to virtually no payments over the past 20 years.

While the cash outflow and squeeze on statutory capital will ultimately help to develop a more disciplined underwriting environment, the near-term disruptions to cash flow could be very unsettling to some insurers given its implications for growth in net investment income, overall earnings and dividends.

Hence we believe it would be useful to look back at cash-flow trends for the major insurers in terms of absolute dollar amounts and volatility to put forthcoming cash-flow figures and trends into some perspective.

FASB has two proposals that are or will be implemented shortly. FASB No. 97 is being implemented by all insurers as they report their 1989 first-quarter earnings. This accounting rule forces companies to include capital gains "above the line" and adjust accounting for interest-sensitive life insurance products.

The implementation of FASB No. 96, which pertains to the accounting treatment of deferred taxes, has been delayed until 1990 and only a few companies are likely to adopt the rule changes sooner. In essence, the resulting earnings figures will not be truly comparable to historical earnings, which could limit the use of past absolute and relative multiple relationships as a guide to future stock valuations. Hence, there is a need for some additional valuation method to back up the traditional price/earnings relationship.

Enter a closer look at cash flow trends and at some point, price/book relationships.

We stress that we treated all companies equally unfairly. Where possible, we used statutory statistics because we believe that they more closely approximate real cash flow.

For property/casualty operations, we used the figures from the statutory consolidated convention blanks.

For life insurance operations, we used statutory net operating income instead of cash-flow data because of the distortions

caused by the influx of interest-sensitive funds.

For other operations, we basically used reported figures based on generally accepted accounting principles that were reported in various public documents.

In general, we found that the compound growth rate over the past four years (up to 1987) for property/casualty insurer cash flows exceeded the nine-year compound growth rates. The same holds true for cash flows related to all—not just property/casualty—operations.

The property/casualty cash flow of The St. Paul Cos. Inc., for example, had a four-year (1984-87) growth rate of 33.8% per share, compared to a nine-year (1979-87) growth rate of 10.7%.

Similarly, Aetna Life & Casualty Co.'s property/casualty cash flow experienced a four-year growth rate of 23.2%, while the insurer's nine-year growth rate was 2.7%.

The top five insurers—ranked by the four-year compound growth rate of their property/casualty cash flow—are: NAC Re Corp., 158.5%; American International Group Inc., 103.6%; Continental Corp., 49.0%; Chubb Corp., 46.0%; and General Reinsurance Corp., 41.9%.

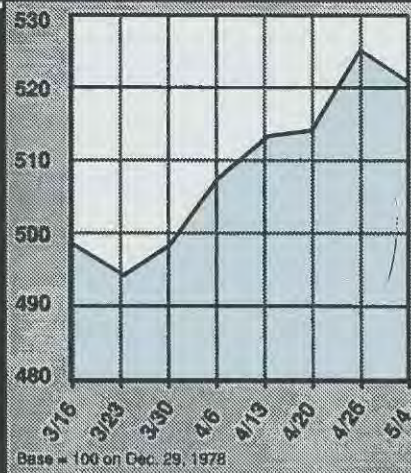
(NAC Re's compound growth rates are based on aggregate data that relates to the nine-year period only.)

And, ranked by their nine-year compound growth rate of property/casualty cash flows, the top five companies are: Chubb, 16.6%; GEICO Corp., 13.4%; Gen Re, 13.3%; SAFECO Corp., 12.0%; and St. Paul, 10.7%.

As shown in the rankings, wide variations exist in terms of cash-flow growth rates. For instance, while NAC Re reported a four-year growth rate of 158.5%, CIGNA Corp. reported a -13.2% growth rate for the same period.

There are clearly nuances about the trends when "comparable" insurers are compared. The bottom line is that cash flow and asset quality are becoming increasingly critical with respect to both the operation and evaluation of property/casualty insurance companies.

BI Insurance Index



Source: Communications Research Group

Insurance industry stocks retreated last week, as the *Business Insurance Index* fell 4.2 points to 521.3 on May 4 after climbing to 525.5 on April 27 from 514.7 on April 20. Declining issues were led by Nobel Insurance Ltd., down 19.0%; Western Health Plans Inc., down 13.8%; RLI Corp., down 10.5%; and Forum Re (Bermuda), down 9.6%. Advancing issues were led by HMO America Inc., up 40%; Sierra Health Services, up 24%; Pacificare Health Systems, up 8.9%; and United Health Services, up 6.8%. The *BI Index* fell 0.8% for the period, while the Standard & Poor's 500 fell 0.8%; the Dow Jones 30 Industrials slid 1.4%; and the New York Stock Exchange Composite tumbled 0.5%.

British Issues

May 4 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High-Low pence
Comml Union	388	13.4	25.3	6.5	388-384
Genl Accident	948	8.8	58.7	6.2	948-937
Gdn Royal Exch	209	10.8	13.3	6.4	209-204
Royal	419	13.0	30.0	7.1	419-405
Sun Alliance	1181	9.2	54.7	4.6	1181-1144

Brokers	Price pence	P/E	Div. pence	Yield %	1 Week High-Low pence
Bradstock	225	12.7	9.0	4.0	225-225
CE Heath	465	14.8	34.5	7.4	465-461
Hogg Robinson	140	10.9	8.7	6.2	140-138
Lloyd Thompson	225	17.2	8.0	3.6	225-224
PWS Holdings	63	17.0	4.6	7.4	63-63
Sedgwick Grp	246	20.2	16.0	6.5	246-244
Steel Brl Jones	221	18.9	13.3	6.0	221-221
Willis Faber	223	16.4	15.3	6.9	223-219

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

BI Industry Stock Report

MAY 4, 1989

4/28/89 THRU 5/4/89

	Price	Weekly % change	Year to Date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value	Price	Weekly % change	Year to Date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value	
				High	Low										High	Low							
BROKERS																							
Alexander & Alexander Svcs	24.75	-1.0	5.3	26.50	22.63	1210	1.00	4.0	15.8	3.71	6.67	Lawrence Ins. Group	6.88	0.0	-12.7	8.50	6.63	3	0.24	3.5	15.0	3.19	2.16
Corroon & Black Corp	33.63	-0.4	8.0	35.00	30.75	178	1.24	3.7	13.1	12.40	2.71	Liberty Corp. SC	34.00	-6.8	-5.6	38.00	34.25	37	0.80	2.4	19.3	21.17	1.61
Gallagher Arthur J. & Co	19.38	-2.5	15.7	19.88	16.13	47	0.52	2.7	13.7	5.33	3.64	Lincoln Nat'l Corp.	47.75	-4.0	8.5	50.63	42.75	205	2.48	5.2	11.8	39.12	1.22
Hall Frank B. & Co.	3.63	-3.2	26.0	4.63	2.50	152	0.00	0.0	-2.1	0.00	N/A	NAC Re Corp.	37.00	-3.3	16.5	38.75	31.00	391	0.00	0.0	13.3	22.81	1.62
Hilb, Rogal & Hamilton	14.25	-3.4	-6.6	15.75	13.75	68	0.20	1.4	12.8	4.60	3.10	Navigators Group	23.00	1.1	15.0	23.00	20.50	13	0.00	0.0	10.5	15.22	1.51
Marsh & McLennan Cos. Inc.	61.50	1.2	9.3	64.50	55.13	964	2.50	4.1	15.2	6.48	9.49	Nobel Ins Ltd	2.13	-19.0	-55.2	2.50	0.75	0	0.42	9.7	-8.2	7.76	0.27
Poe & Assoc. Inc.	8.75	0.0	6.1	8.75	8.25	11	0.40	4.6	9.5	0.27	32.41	Northwestern Nat'l Life	31.75	-3.4	2.0	34.25	26.88	453	1.20	3.8	10.5	37.50	0.85
BROKERS AVERAGE																							
-1.3																							
9.1																							
2.9																							
11.1																							

CONGLOMERATES & HOLDING COMPANIES

Berkley WR Corp.	31.25	-6.7	5.9	34.00	29.25	209	0.40	1.3	6.6	20.24	1.54	Old Rep Int'l Corp.	24.63	-1.5	2.6	28.88	23.75	412	0.74	3.0	12.3	26.50	0.93
Berkshire Hathaway Inc. DEL	5975.00	-5.9	27.1	6175.00	4625.00	254	0.00	0.0	21.9	2492.68	2.40	Orion Cap Corp	21.75	-1.1	41.4	22.25	15.38	127	0.76	3.5	7.3	12.93	1.68
ITT (Hartford Group)	59.00	1.1	17.7	59.50	49.75	2831	1.48	2.5	10.1	56.33	1.05	Phoenix Re Corp	9.25	0.0	-2.6	11.00	9.00	26	0.00	0.0	4.8	12.49	0.74
Sears Roebuck & Co. (Allstate)	45.63	-0.3	11.6	46.88	40.13	7869	2.00	4.4	17.1	36.09	1.26	Protective Life Corp.	13.75	-1.8	3.8	14.50	12.88	223	0.70	5.1	68.8	14.54	0.95
CONGLOMERATES AVERAGE																							
-3.0																							
15.6																							

INSURERS/REINSURERS

Aetna Life & Cas Co.	52.25	-0.2	10.6	54.88	46.75	1356	2.76	5.3	8.1	58.11	0.90	Re Capital Corp	10.88	1.2	19.2	11.13	9.13	49	0.00	0.0	10.9	12.60	0.86
American General Corp	33.50	-3.6	12.1	35.75	29.50	972	1.50	4.5	10.1	28.04	1.19	RLI Corp.	7.50	-10.5	-1.7	9.25	7.50	39	0.36	4.8	7.4	10.71	0.70
Amer Heritage Life Invnt	26.50	1.0	2.9	27.88	25.00	1	1.08	4.1	10.5	22.47	1.18	Providence Life & Acc Ins Co.	23.38	0.0	21.5	24.75	19.13	684	0.68	2.9	9.9	21.96	1.06
Amer Indty Fin'l Corp.	11.00	-2.2	4.8	11.75	9.50	18	0.56	5.1	7.1	17.06	0.64	St. Paul Cos. Inc.	48.88	-3.2	12.4	51.00	43.00	1299	2.20	4.5	6.7	32.00	1.53
American Int'l Group	79.38	-2.9	17.2	84.25	66.25	2331	0.40	0.5	11.1	33.55	2.37	SAFECO Corp.	26.50	-7.4	12.1	29.13	23.13	2259	1.08	4.1	6.6	24.88	1.07
Aon Corp	31.50	-2.0	12.5	33.38	27.00	336	1.40	4.4	9.9	16.67	1.89	SCOR U.S. Corp.	8.75	0.0	-4.2	9.50	7.50	30	0.20	2.3	6.4	10.35	0.85
Argonaut Group	54.25	0.9	24.0	56.00	43.50	332	0.00	0.0	7.5	36.83	1.47	Seibels Bruce Group Inc.	11.88	-1.0	4.4	13.00	11.25	117	0.80	6.7	7.6	13.42	0.89
AVEMCO Corp.	22.75	-1.6	-12.1	26.13	22.88	119	0.40	1.8	12.0	9.20	2.47	Selective Ins Group Inc.	25.00	4.2	8.7	24.75	21.75	588	1.24	5.0	5.6	22.33	1.12
Harleysville Group Inc.	16.50	1.5	10.9	16.63	14.50	15	0.20	1.2	6.4	17.57	0.94	Statesman Group Inc.	2.75	-2.1	-12.1	4.00	2.75	56	0.05	1.8	68.8	3.48	0.79
Belvedere Corp.	5.75	2.1	27.8	6.50	4.50	4	0.04	0.7	8.3	8.43	0.68	Tokio Marine & Fire Ins	78.00	4.0	-14.6	95.50	74.50	25	0.22	0.3	47.3	0.00	N/A
Chandler Insurance	12.00	-2.0	29.7	12.75	8.75	422	0.00	0.0	5.6	6.65	1.80	Torchmark Corp.	35.75	-0.4	17.2	36.50	30.00	1051	1.20	3.4	11.0	12.24	2.92
Chubb Corp	64.63	-4.3	11.4	69.00	57.63	759	2.32	3.6	7.5	53.50	1.21	Transamerica Corp	33.25	-4.3	-1.9	36.00	32.75	1194	1.88	5.7	7.5	30.70	1.08
CIGNA Corp.	52.50	-2.8	11.4	56.13	45.88	695	2.96	5.6	9.4	53.08	0.99	Travelers Corp.	38.75	-3.1	11.5	40.88	34.50	1329	2.40	6.2	30.3	44.85	0.86
CNA Fin'l Corp.	65.25	0.4	7.9	65.50	57.63	217	0.00	0.0	10.3	46.40	1.41	Trenwick Group Inc.	16.25	-8.5	12.1	17.75	13.75	146	0.24	1.5	9.2	16.91	0.96
Continental Corp.	33.88	0.0	4.6	36.00	31.50	1239	2.60	7.7	16.2	42.10	0.80	United Fire & Cas Co.	29.50	-1.7	-3.3	30.75	29.00	14	1.08	3.7	5.2	22.56	1.31
Durham Corp	32.50	0.0	-1.5	33.75	30.00	39	0.92	2.8	19.2	26.32	1.23	United States Fid & Gty	30.63	-3.5	7.5	32.88	28.50	3431	2.80	9.1	11.4	22.57	1.36
Fireman's Fund Corp	33.63	-2.9	15.0	34.88	29.00	733	0.60	1.8	8.3	32.74	1.03	UNUM Corp.	32.25	1.2	19.4	32.88	26.63	431	0.60	1.9	10.7	30.64	1.05
Forum Re (Bermuda)	1.13	-9.6	-30.7	1.75	1.13	11	0.00	0.0	-8.7	2.53	0.45	USLIFE Corp.	40.63	-2.7	16.5	44.88	34.13	511	1.40	3.4	9.9	54.27	0.75
Fremont Gen Corp	16.38	-3.6	22.4	18.25	12.13	368	0.60	3.7	10.4	16.06	1.02	Washington Nat'l Corp.	25.00	-2.0	-7.4	27.63	24.25	68	1.08	4.3	-17.9	32.33	0.77
Frontier Insurance Group	15.75	3.3	26.0	16.75	12.25	48	0.00	0.0	7.8	7.53	2.09												

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