

business insurance

update

JAL, Boeing to share liability in plane crash that killed 520

TOKYO—Japan Air Lines and The Boeing Co. have agreed to share liability in the deaths of 520 people and injuries to four others in the Aug. 12 crash of a JAL jet near Osaka, Japan, according to a high-ranking JAL official (*BI*, Aug. 19).

He said the decision to cooperate was reached partly to speed up payments to the victims and their families.

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Reinsurers probe AMC loss reports

By DOUGLAS McLEOD

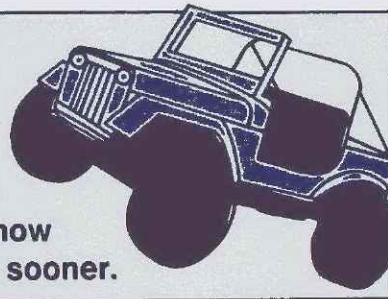
NEW YORK—Facultative reinsurers of an American International Group Inc. unit are investigating the reporting and reserving of millions of dollars of product liability losses under excess liability insurance policies written for American Motors Corp.

The reinsurers, representing about half of the applicable reinsurance, have reserved their rights not to pay claims under the reinsurance programs pending the outcome of their investigation, *Business Insurance* has learned.

The reinsurers began their joint investigation last year, following the discovery by National Union Fire Insurance Co. of Pittsburgh, Pa., the AIG unit, that it was significantly underreserving for AMC losses, related mainly to accidents involving AMC Jeep vehicles.

The reinsurers have hired a law firm to assist them in their investigation. National Union has contracted with another law firm to help respond to the reinsurers' inquiries.

A December 1983 National Union audit of AMC claim files found that losses from AMC Jeeps were far worse than previously thought. Now, several reinsurers are investigating why National Union did not know the extent of the AMC liability losses sooner.



AMC has been hit with more than 1,000 Jeep-related product liability lawsuits since the 1970s. Several U.S. government and private studies conducted since 1980 have found that Jeeps are more prone to rollover accidents than other vehicles (see story, page 42). Compensatory and punitive damages sought in pending lawsuits totaled more than \$1.6 billion at the end of last year.

National Union has provided excess liability insurance, including product liability coverage, excess of AMC's self-insured retentions, since April 1981.

Since April 1981.

National Union reinsured the policies issued from 1981 to 1984 with 18 U.S. reinsurers, syndicates on the New York Insurance Exchange, and several foreign reinsurers (see story, page 43).

Until early 1984, losses reported to National Union's reinsurers did not exceed AMC's \$8 million aggregate retention in any National Union policy year, several reinsurers say.

However, a December 1983 National Union

audit of AMC claim files found that losses were far worse than previously thought.

As a result, National Union's reinsurance broker, Guy Carpenter & Co. Inc., reported to reinsurers in March 1984 that National Union had reserved its full \$25 million policy limit for the 1981-82 policy year and half its \$25 million limit for the 1982-83 year, reinsurers say.

After receiving that report, which preceded the April 1984 reinsurance renewal, many reinsurers did not renew their facultative reinsurance support for the AMC program.

National Union informed AMC's broker, Frank B. Hall & Co. Inc., shortly before the April 1984 renewal that it would be able to write only a \$5 million limit, down from \$50 million during the 1983-84 policy year, reinsurance and other sources say.

National Union subsequently reserved the full \$25 million limit of its 1982-83 policy, according to a November 1984 letter an AIG claims supervisor sent to Guy Carpenter.

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Regulators spell out changes they want in claims-made form

By CAROL CAIN

Insurance regulators want at least four more concessions from the Insurance Services Office before they will approve the use of the controversial commercial general liability claims-made form.

ISO—under pressure from buyers, brokers and regulators—earlier this month announced several significant revisions to the claims-made form (*BI*, Oct. 14).

But, regulators still want:

- A guaranteed reinstatement of a policy's aggregate limits when the policyholder buys the optional tail coverage.

- These limits would not apply to occurrences reported during the policy period but only to incidents that occurred during the policy period but were not known to the policyholder before the end of the policy period.

- Currently, ISO has proposed only an optional endorsement that would allow insurers to reinstate a policy's aggregate limits for unknown occurrences when a policyholder buys optional tail coverage.

- A requirement that policyholders acknowledge in writing their acceptance or rejection of a change in the retroactive date from policy to policy.

- An explanation of the word "recorded" in ISO's policy revision that allows coverage to be triggered when claims are "received and recorded" by the policyholder or insurer, rather than only when written claims are received by the policyholder.

- An explanation of why use of the new claims-



made form cannot be limited to risks that create long-tail or latent injury exposures.

ISO says it will review the regulators' comments, but still plans to file its latest revisions with state insurance departments in all 50 states this week, and wants insurers to be able to start using the new claims-made general liability form Jan. 1.

"It's a good product that can be sold to anyone in any business, especially with the safeguards added," said an ISO spokesman. "It is not an inferior product."

But commissioners disagree.

"We've heard from ISO, and there's no doubt about it, they have moved—and moved significantly—on the new form," said Illinois Insurance Director John Washburn. "But we've got to have further discussions."

Mr. Washburn hosted a meeting in Chicago Oct. 17 between ISO and an estimated 20 state insurance regulators.

A meeting between ISO and another group of regulators was held the day before in Kansas City, Mo., at the headquarters of the National Assn. of Insurance Commissioners (*BI*, Oct. 21).

ISO also met with representatives from the Risk & Insurance Management Society Oct. 21.

That meeting resulted with both sides "agreeing that they disagree," said Jon Harkavy, RIMS general counsel and director of governmental affairs. RIMS and ISO have not scheduled another meeting.

One of the regulators' concerns with the latest policy form centers on the optional endorsement to reinstate a policy's annual aggregate limits when unlimited tail coverage is purchased.

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Tax reform unlikely; stop-gap hikes loom

By JERRY GEISEL

WASHINGTON—Congress apparently will not pass a comprehensive tax reform package this year, but employee benefit and insurance issues still are likely targets of stop-gap tax increase legislation that could be passed next year.

Many of the benefit and insurance tax provisions incorporated in the marooned tax-reform proposals could be incorporated yet in more modest tax legislation that Congress is expected to pass next year to curb the huge federal deficit, observers warn.

"It doesn't matter that tax reform is dead. The benefit proposals in tax reform packages are still alive and will be in other tax legislation," says Mark Ugoretz, executive director of the ERISA Industry Committee, a benefits-lobbying organization.

"You don't need a tax reform bill to change benefits. All you need is a revenue or budget bill. . . . Benefits can be added to it," agrees Frank McArdle, director of communications and education programs for the Employee Benefit Research Institute in Washington.

Eliminating or at least restricting 401(k) plans, reducing defined benefit and defined contribution limits, taxing employees' health care benefits, new non-discrimination rules for benefit plans and new taxes on the property/casualty insurance industry—which now are part of tax reform proposals—could be incorporated in tax increase legislation, lobbyists say.

Many predict that a tax increase bill could be passed next year, because time is running out for action this year.

But, already, budget bills S. 1730 and H.R. 3500, which were expected to be voted on by the full Senate and House last week, contain provisions affecting benefits. These bills would require employers to extend group

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'You don't need a tax reform bill to change benefits. All you need is a revenue or budget bill. . . . Benefits can be added to it,' Mr. McArdle says.

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update

Boeing, JAL share crash liability

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"In cases such as this, where more than two parties are related to the cause of the accident, it follows that those involved should share the responsibility in accordance with each others' liability," Takayuki Hashizume, JAL senior vp, said in a statement issued in Tokyo.

"However, the present circumstances are such that neither the cause of the accident nor the degree of liability could be clarified for some time. Under the circumstances, it was best for JAL and Boeing to cooperate and proceed in a unified manner with the compensation negotiations," he said.

However, the exact division of the liability between JAL and Seattle-based Boeing, which manufactured the 747, has not yet been determined, said a JAL spokesman in New York.

Settlement payments currently are being made with JAL funds; JAL will settle with Boeing after investigations into the crash are complete, the airline spokesman says. He could not estimate what percentage of the total payments each party might pay.

Individual negotiations with the injured and families of the deceased began Oct. 5 throughout Japan and will continue indefinitely, says the JAL spokesman. The airline has assigned about 300 people to negotiate on behalf of it and Boeing, says the spokesman.

"For the convenience of the bereaved families and the injured," Boeing asked JAL to represent the firm "in accordance with customs and methods in Japan," said Mr. Hashizume.

Tradition among Japanese Buddhists dictates that such discussions not take place for 49 days after death, to allow the souls of the deceased some solace.

JAL does not know how many claims have been settled, nor how much money has been disbursed so far, the spokesman says. He could not speculate on when the settlements will be complete or on the ultimate liability.

Major pension bills introduced

WASHINGTON—Comprehensive pension legislation introduced last week by Sen. John Heinz, R-Pa., and Rep. William Clay, D-Mo., would require employers to speed up their pension plan vesting schedules so that workers were 100% vested after five years of service. Multiemployer plans would be exempt from the five-year vesting requirement.

The legislation, called the Retirement Income Policy Act of 1985, also would link the maximum annual pension benefits and contributions to the Social Security taxable wage base. For example, the maximum annual benefit that could be provided through a defined benefit plan would be 200% of the Social Security wage base, while the maximum contribution to a defined contribution plan would be 50% of the wage base. The taxable wage base, now \$39,600, is scheduled to rise to \$42,000 next year.

In addition, the bills would retain current non-discrimination tests for 401(k) salary reduction plans but limit the maximum contribution to 25% of the Social Security wage base.

The legislation, S. 1784, H.R. 3594, also would make it more difficult for employers to offset or reduce retirees' pension benefits with Social Security benefits.

Also, retirement plans no longer could provide lump-sum benefit distributions for workers who retire or leave a company before age 59½. Such distributions only could be paid out in a monthly annuity or rolled over into an Individual Retirement Account.

Fireman's Fund stock a winner

NEW YORK—Fireman's Fund Corp. and its parent company, the American Express Co., raised \$906.4 million last week in the largest initial public stock offering in American history.

A total of 35.2 million shares of Fireman's Fund stock costing \$25.75 a share were sold last Wednesday, a Fireman's Fund spokesman said. The stock was the most heavily traded stock of the day, with 4.5 million shares being resold before the stock closed at \$27.75.

A total of 32 million shares originally were offered, with 8 million of these owned directly by Fireman's Fund and the remainder owned by American Express, says the spokesman. And, stock underwriters exercised an option to purchase an additional 10%, or 3.2 million shares from American Express.

American Express now retains a 41% ownership of the company, with a newly established Fireman's Fund employee stock ownership plan controlling an additional 6%. The rest is now publicly held, except for a small amount that has been set aside for a management stock option program, the spokesman said.

In the prospectus for the stock offering, Fireman's Fund noted it might be required to restate some of its recent financial data if the

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States weigh options to ease commercial insurance crunch

New York Superintendent of Insurance James Corcoran is asking state senators to consider expanding the State Insurance Fund to write property/casualty insurance for municipalities and businesses.

Currently, the State Insurance Fund only writes workers compensation and disability coverages.

And, the New York State Coalition for Municipal Tort Liability & Insurance Reform is asking the state senate to act on proposals to help protect municipalities from large increases in liability insurance rates and make more coverage available.

The current crisis in commercial insurance has prompted several other states also to take steps to help businesses cope with the tightening market:

- The South Carolina Insurance Commission has issued an emergency regulation that makes insurers liable for penalties ranging from a \$500 fine to revocation of their licenses for canceling property/casualty policies midterm or without adequate notice of non-renewal.

- In California, a market assistance plan has been developed to help licensed day-care facilities in the state find liability insurance.

- Colorado Gov. Richard D. Lamm has appointed a 26-member task force to study the state's liability insurance crisis.

- The Tennessee Department of Commerce and Insurance is soliciting information from businesses about coverage problems to gauge the severity of Tennessee's commercial liability capacity crunch.

- The North Dakota Insurance Department is investigating the possibility of municipal self-insurance pools for liability coverage.

investigating the possibility of municipal self-insurance pools for liability coverage.

New York Superintendent Corcoran offered his proposal to expand the Insurance Fund before a recent hearing held by a group of state senators.

The proposal calls for the Insurance Fund to sell property and liability coverage to businesses and municipalities when it is determined by the superintendent to be "in the public interest" to ease a coverage availability problem.

Under the proposal, the Insurance Fund would sell all commercial lines except auto insurance, according to a spokesman for the Insurance Department. The spokesman explained that there is no capacity shortage for commercial auto coverage.

The plan was one of several suggestions offered by Mr. Corcoran.

Other proposals included:

- Allowing municipalities to form self-insurance pools.

- Establishing a joint underwriting association for municipal liability insurance. The association would be funded by current liability insurers.

- Preventing midterm cancellations by applying regulations currently in force for personal lines to commercial lines.

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New Weavers form gains acceptance

By STACY SHAPIRO

LONDON—The first London claims-made excess liability form is slowly winning acceptance.

Not only is the new form—which was introduced by H.S. Weavers (Underwriting) Agencies Ltd. in September—being purchased by U.S. policyholders, but also other London insurers are agreeing to participate in insuring accounts under the Weavers form.

So far, as many as 20 U.S. companies have renewed their lower levels of excess liability coverage on the new Weavers claims-made form, brokers say.

Policyholders can insure almost all of the first \$5 million of excess liability coverage on the Weavers form and then up to 60% of the next \$15 million layer and a small portion of the next \$30 million in coverage on a new Weavers overlying excess form that is identical to Weavers' first excess form, brokers say. The new overlying form was introduced Oct. 17.

"The clients are accepting the Weavers form," said Brian Hibbert, chairman of Bowring Non-Marine Insurance Brokers Ltd. "But, the clients knew that claims-made was coming this year. I don't think there will be any meaningful occurrence coverage available by Jan. 1 anyway."

Bowring now has six firm orders from U.S. com-



Mr. Wilson

panies for excess coverage under the Weavers form, said Bowring Director John Tyndall.

The companies are in the pharmaceutical, high technology, utility and medical equipment fields. They have renewal dates sometime in October, he said.

Other Lloyd's brokers also said they have a few firm orders for coverage on the Weavers form and expect more before year-end renewals begin.

The new Weavers excess liability form is rather restrictive because it will not follow the conditions of any underlying policy—whether it is claims-made or occurrence.

Instead, the Weavers form imposes a new "self-insured deductible" of indemnity payments stemming from exposures covered by the Weavers policy before the excess coverage is available. And, the Weavers form will not recognize underlying defense costs as satisfying this "self-insured deductible."

This will make it difficult to dovetail the Weavers form neatly with primary liability coverage written under the new commercial general liability form devised by the Insurance Services Office for use in the United States beginning Jan. 1 (see story, page 1).

ISO is asking state insurance departments to approve the inclusion of defense costs within policy limits effective July 1, 1986. Therefore, to the extent that primary insurance is exhausted by the defense costs, a Weavers policyholder will have to foot the

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Judge to rule on \$64 million award

By MICHAEL BRADFORD

HOUSTON—A federal judge is expected to decide next week if he will let stand a \$64.2 million jury verdict to a worker disabled in an accident at a natural gas drilling site.

A motion to enter the judgment will be made by the plaintiff's attorneys Nov. 4. At that time, U.S. District Judge James DeAnda will decide how much the plaintiff actually will be awarded.

In September, Moore-McCormack Productions Inc. was found liable in a 1981 accident near Port Aransas, Texas, that left a worker paralyzed from the middle of the back down when a piece of equipment he was trying to move collapsed on top of him.

A jury in U.S. District Court for the Southern District of Texas in Houston awarded Homer Hinojosa and his wife, Guadalupe, \$32.2 million in actual damages and \$32 million in punitive damages as the result of the accident.

With interest, the award is expected to total about \$70 million.

Attorneys for Mr. Hinojosa say they have been told Moore-McCormack, a Dallas-based oil and gas company, has sufficient insurance to cover the award, plus interest.

"I understand it would be totally covered," said William R. Edwards, with the Corpus Christi, Texas, firm

of Edwards, McMains & Constant. "I've been informed that there are several insurers involved."

"I'm told there is coverage in excess of the verdict," added Harold Eisenman, an attorney with Schecter, Eisenman & Solar who also is representing Mr. Hinojosa.

Sources say a unit of American International Underwriters, a division of American International Group, underwrote a \$500,000 primary layer of liability coverage for Moore-McCormack and that CIGNA Corp. underwrote the next \$5 million layer.

And there are additional layers above the \$5 million layer to cover the full award, they say.

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errors & omissions

In an article on the settlement of claims stemming from the 1981 Las Vegas Hilton fire, Neil Galatz of the Las Vegas law firm of Galatz, Earl, Catalano & Smith estimated that on a per-capita basis, the Hilton settlement is 15% to 20% larger than settlements made in the MGM Grand hotel fire litigation (BI, Oct. 21). Due to an editing error, the statement was attributed to another attorney.

Suit seeks to stall asbestos claims facility

By STEPHEN TARNOFF

CLEVELAND—Asbestos producers and insurers that signed the Wellington agreement are violating federal antitrust, racketeering and monopoly laws, charges a recent lawsuit filed by a lawyer who represents asbestos victims.

The suit also charges that the Wellington agreement, which set up an asbestos claims-handling facility, is delaying settlements with asbestos disease victims, reducing payments to those victims, forcing plaintiffs to go to trial and complicating the litigation.

Plaintiffs' attorney Robert E. Sweeney filed the lawsuit Oct. 7 in U.S. District Court for the Northern District of Ohio naming more than 40 asbestos producers and insurers; however, not all the producers and insurers named in the suit signed the Wellington agreement. More than 50 producers and insurers have signed the agreement.

Mr. Sweeney, of the Cleveland law firm of Robert E. Sweeney Co., is the sole plaintiff in the lawsuit.

The 22-page complaint charges that the Wellington agreement is a restraint of trade and an attempt to create a monopoly in settling asbestos cases.

It also contends Wellington members have entered into a conspiracy to discriminate against various asbestos health claimants and have engaged in a pattern of illegal racketeering activity.

The suit seeks an injunction to prevent Wellington from negotiating on behalf of its members and asks unspecified compensatory damages and attorneys' fees.

The suit apparently is the first to be filed by a plaintiff's attorney seeking to block operation of the asbestos claims facility created by the agreement, although other plaintiffs' attorneys oppose elements of the agreement.

In a prepared statement, a spokeswoman for Wellington said the lawsuit hinders the facility's efforts to resolve various issues being discussed with plaintiffs' attorneys.

"The asbestos claims facility has been and continues to be committed to maintaining a dialogue with representatives of the plain-

tiffs' bar and obtaining input from these representatives as we develop the facility," the spokeswoman said.

"We do not believe that litigation of the type recently filed will help this process."

An attorney for one of the defendants in the lawsuit, who asked not to be identified, said the defendants plan a vigorous response to Mr. Sweeney's action.

The attorney also called the complaint "poorly drafted," in part because some companies named as defendants are not members of the facility.

The Wellington agreement, signed by 50 asbestos producers and insurers last June, seeks to establish an out-of-court claims facility for handling asbestos claims more quickly, efficiently and fairly for significantly less money than is being spent in the court system.

It also resolves numerous insurance coverage disputes between producers and insurers (BI, May 28, 1984; July 1).

Although the facility was established by producers and insurers, major plaintiffs' at-

torneys whose support is considered crucial for the facility's success are negotiating with Wellington members on various points of the agreement.

Meanwhile, the Wellington group has hired attorneys across the country who so far have settled some asbestos cases with plaintiffs' attorneys on behalf of the Wellington members.

In his suit, Mr. Sweeney singles out Article IV of the agreement, which requires producers and insurers to designate the facility as their sole agent, with exclusive authority for administering and arranging on their behalf the evaluation, settlement, payment or defense of all asbestos-related claims.

"The Wellington Plan thereby operates to prevent the individual settlement of claims and adversely affects the property rights and remedies of asbestos health claimants represented by plaintiff," the suit says.

The suit adds that before Wellington, asbestos health claimants could settle claims prior to or following the filing of a lawsuit against the defendants.

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Electric utilities, banks creating liability capacity

By STEVE TARAVELLA

Chafing under the reduced limits of insurance coverage available in today's market, buyers continue to forge ahead with their own plans to create casualty capacity.

Representatives from about 10 U.S. electric utilities met in Toronto last week on behalf of 50 utilities to review consultants' proposals for ways to secure excess liability capacity beyond what is available from the commercial market.

Meanwhile, banks continue their search for more capacity for directors and officers coverage and bankers blanket bonds.

Among the exposures to be addressed by the electric utilities are general liability, director and officers liability and pollution liability coverages, explains Darla Tarletz, manager of insurance and loss prevention at Virginia Electric & Power Co. in Richmond.

Ms. Tarletz expects the study to be completed in about six months. The utilities, which began to organize last spring, seek "long-term solutions" and expect to look at "all alternatives," she says.

This might include a captive, but could also include risk-sharing or pooling arrangements, notes Richard Hinds, risk manager at Florida Power & Light Co. in Miami, one of the utilities participating in the project.

He said that although now the group involves only electric utilities, it later may expand to include gas utilities.

The group plans to retain a consultant to study options for finding liability limits above what can be obtained from Associated Electric & Gas Insurance Services Ltd., a Bermuda mutual insurer with about 215 members.

Many, but not all, of the utilities financing the study purchase their primary liability coverage from AEGIS, Mr. Hinds says.

AEGIS now offers liability limits up to \$20 million, but hopes to increase that to \$25 million next year, according to AEGIS Chairman Robert Fortune.

AEGIS now offers an additional \$2.5 million in D&O liability coverage, but will stop writing that at year-end, Mr. Fortune says.

He explains that until this year, AEGIS offered \$10 million in D&O liability coverage, ceding much of it to reinsurers. But a reinsurance shortage this year forced it to cut limits to \$2.5 million, bearing the entire risk itself. It wrote those limits for about 35 utilities, he estimates.

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Lingering illness

CEOs say health care costs are still at crisis level

By ALISON KITTRELL

Despite recent corporate efforts to contain the rising cost of health care, the vast majority of chief executive officers at the largest U.S. corporations still believe the country is facing a health care crisis.

The root problem is the high cost of health care, which they blame on the third-party reimbursement system that insulates employees from the true cost of medical care.

And, they believe that as employers, they have to work harder to help control health costs.

These are among the findings of the ninth annual survey of chief executive officers by William M. Mercer-Meidinger Inc., the New-York based benefit consulting subsidiary of broker Marsh & McLennan Cos. Inc.

The survey, entitled "Employer Attitudes Toward the Cost of Health," was sent to the chief executive officers of the 5,000 largest employers in the United States. Some 885 responded.

Of those responding, 84% said the United States is facing a health care crisis.

"It is somewhat remarkable to learn that 84% of the CEOs still perceive a crisis, even though a great deal has been done in the corporate sector to check health care costs," said Carson E. Beadle, a managing director of Mercer-Meidinger.

"This is likely a recognition that causes of rising costs such as an aging workforce, exotic health care such as transplants, and malpractice liability suits are still with us and their effects not yet fully felt," he said.

However, the CEOs clearly feel that the major problem is the cost of care.

For example, only 12% think the quality of the nation's health care has deteriorated during the last five years. And, 70% think the quality of health care will improve during the next five years.

But, 57% think high health care costs and limited access to high-technology medical care will create a two-tiered system of health care in the United States, with one level of care for the rich and one for the poor.

Asked to name three reasons for the high cost of health care, 67% blamed the third-

party reimbursement system. Other reasons were:

- The high cost of new technology, cited by 48%.
- Society's expectation that everyone should have good health care at any cost, 34%.
- Increased expenses, such as malpractice insurance and labor costs, for health care providers, 31%.
- An aging population, 26%.
- Inefficient hospital management, 23%.
- Inadequately informed health care consumers, 19%.

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Employers' views on state of health care in U.S.

	Strongly agree	Agree	Disagree	Strongly disagree	No opinion
United States is facing health care crisis.	30%	54%	14%	1%	1%
Quality of health care in U.S. has deteriorated over past five years.	2%	10%	63%	23%	2%
Quality of health care in U.S. will improve over next five years.	3%	67%	19%	2%	9%
High costs and limited access to high-tech medical care will create two-tiered system—one for rich and one for poor.	8%	49%	34%	4%	5%
Health promotion programs can help control health care costs.	22%	69%	5%	0%	4%
Preventive health care is underutilized as approach to cost containment.	30%	61%	5%	0%	4%
Government should regulate price of medical treatment.	2%	6%	39%	50%	3%

Source: Mercer-Meidinger survey Chart: Amy Palmer

'Contract' guarantees retiree benefits: Judge

By JERRY GEISEL

NASHVILLE, Tenn.—Retirees have a contractual right to promised post-retirement benefits and employers cannot unilaterally cut those benefits, a federal judge has ruled.

The retirees' rights exist even when the company's plan documents explicitly state that the employer has the right to alter or terminate the benefits, according to a ruling by U.S. District Court Judge Thomas Wiseman Jr.

The promise to provide post-retirement health care benefits is not a "mere gratuity," but a contract that a company cannot break without cause, according to the ruling.

In the third legal defeat in the last year for employers over the issue of retiree benefits, Judge Wiseman rejected arguments by American General Corp., a major Houston-based insurer, that "termination/modification clauses" in plan documents give employers the unilateral right to alter post-retirement health care plans.

"To permit the enforcement of termination/modification clauses without a showing of good cause has the effect of re-

ducing the status of hard-earned welfare plan benefits to mere gratuities," Judge Wiseman said.

Employees of NLT Corp., a Nashville-based holding company that American General acquired in 1982, had been promised by NLT and predecessor companies they would receive free post-retirement health care benefits, Judge Wiseman said.

Judge Wiseman found that promise was extended as part of a "contract" between the employer and employees: If employees stayed with the company until retirement they would have the security of free post-retirement health care benefits.

If the employees completed their part of the contract—working for the company until retirement—then the company has to make good on its promise to provide health care benefits, the judge said.

"Upon retirement, the bilateral bargaining position of the parties ceased. The employee was now entitled to receive those earned benefits deferred until retirement. Deferred retirement benefits earned during active employment are enforceable contract rights," Judge Wiseman said.

He added that it would be contrary to the spirit of the Em-

ployee Retirement Income Security Act, which seeks to protect retirement benefits, if promised benefit plans were "terminable at the will of the employer."

American General is appealing the ruling.

While Judge Wiseman's ruling is only a preliminary injunction that certifies the retirees' suit as a class action and bars American General from making any further cuts in the benefits for NLT retirees, the decision already has sent new shock waves rumbling through the benefit community.

Employers were stunned last year when a federal judge ruled that because of ambiguous plan language, Bethlehem Steel Corp. could not reduce post-retirement health care benefits (BI, Oct. 1, Oct. 29, 1984).

Under a later settlement, the steelmaker agreed to freeze monthly insurance premiums paid by retirees, while non-union retirees accepted a new medical plan that incorporated coinsurance and deductibles for the first time (BI, March 18).

While employers still were twitching from the Bethlehem Steel decision, U.S. District Court Judge Ann Aldrich deli-

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Wellington suit

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But, the suit charges that under Wellington, Mr. Sweeney, as the plaintiff in the suit:

- Is deprived of the ability to enter into individual negotiations with the various defendants to resolve the claim prior to trial.

- Is barred from approaching certain producers even prior to filing the lawsuit to resolve the claim.

"The Plan is not designed to effect the expeditious settlement of cases," the suit says.

"It is, in fact, a defense trial mechanism with the primary function of compounding the plaintiff's already substantial difficulties in the prosecution of an asbestos-related health claim."

The suit also charges that the "sole function" of the plan is to retard the settlement of claims by compelling plaintiffs to try every claim against a signer of the Wellington agreement, rather than set-

ting the claim.

"The Plan is designed to prohibit, bar and stop asbestos health claimants from retiring individual claims against individual defendants based on their liability in a specific case and as such, operates to restrain the retirement of asbestos health claims and further restrains the practice of law between the several states," the suit adds.

This contention is expanded upon by a brief in support of a motion for a preliminary injunction filed with the complaint.

The brief says that, in a typical asbestos case, numerous defendants are named, and in the course of discovery a plaintiff can make various allocations as to liability based on the plaintiff's exposure to any particular defendant's product.

With the Wellington plan, however, the plaintiff cannot negotiate settlements with marginal or peripheral defendants, and instead must proceed to trial against all of the defendants.

"This compounds and complicates the presentation of the case, calls for the expenditure of unwarranted sums of money, and in general, serves to frustrate and impede the administration of justice, not to mention the expenditure of mass quantities of court time which otherwise would not be necessary," the brief says.

In addition, the lawsuit contends that the Wellington agreement attempts to create a monopoly in the settlement of cases and to artificially reduce the monetary value of personal injury claims of the victims Mr. Sweeney represents.

It also claims that Wellington members have entered into a conspiracy to discriminate against some plaintiffs and their attorneys to prevent settlement of cases in a reasonable, timely, just and expeditious manner. And, it says defendants are engaged in a pattern of racketeering activity and committed at least two acts of racketeering through the mail and interstate

wire communications to perpetrate a fraud.

It cites the sending out of more than 600 letters to federal and state judges by former Yale Law School Dean Harry H. Wellington that announced establishment of the Wellington facility (BI, Sept. 23).

According to the suit, the letter invited the judges to surrender their asbestos health claim caseload to the settlement facility.

"Plaintiff states that the mailing of this letter by Dean Wellington was part of an ongoing conspiracy effectuated through mail fraud to defraud the asbestos health claimants of monies reasonably due them and to suborn the court system in a manner consistent with a pattern of malicious and reckless activity dating back to the 1930s by the various manufacturers and their insurers, now members of the Wellington group," the suit adds.

The suit also charges that the agreement may force plaintiffs to go to three different forums simultane-

ously to resolve a claim.

This is because the Wellington agreement represents only a "substantial minority" of producers and insurers in asbestos litigation.

In addition, another facility is contemplated as part of a reorganization plan for Manville Corp., the largest asbestos defendant, which filed for reorganization under federal bankruptcy laws in 1982.

As a result, Mr. Sweeney says, he may be forced to proceed in three separate areas simultaneously: Wellington, the courts and the Manville settlement facility, if it is enacted.

"Plaintiff states that this approach will compound and further complicate already complex litigation and is designed solely to frustrate the fair, just, equitable and speedy retirement of asbestos health claims," the suit adds.

In an interview, Mr. Sweeney said the Wellington agreement "affects product liability litigation far beyond asbestos."

He said it severely restricts his opportunity to effectively represent clients in an adversarial product liability case and deprives him of a tactical advantage in dealing with defendants.

"It affects my tactical option in prosecuting and litigating claims," he said.

He also said that the fact some plaintiffs have entered into settlements with Wellington counsel did not negate the effect of allegations included in his complaint.

"It is poor logic to leap from the view that because a plaintiff settles with Wellington counsel for an acceptable amount that gives the Wellington subscribers legality," he said.

He would not say whether he has entered into settlements with the Wellington group, citing the confidential nature of asbestos litigation in Ohio.

Mr. Sweeney said other plaintiffs' attorneys support his effort and have volunteered to testify on the inhibiting effects of the Wellington agreement.

Plaintiffs' attorney Aaron Simon said his firm is looking into the possibility of joining Mr. Sweeney's action or proceeding along parallel lines on its own.

"It (the suit) is legitimate," said Mr. Simon of the Los Angeles firm of Green, O'Reilly, Broillet, Paul, Simon, McMillan, Wheeler, Rosenberg. "I wish him well."

Mr. Simon, called the Wellington agreement a "disaster" and "one of the worst things that's happened" to asbestos litigation.

However, other plaintiffs' attorneys were less enthusiastic about the lawsuit.

A Virginia attorney said such action was not necessary from the standpoint of his clients; however, he emphasized he was not passing judgment on Mr. Sweeney, since circumstances in Ohio may differ.

"For my clients, I would not have done it and I don't endorse it," said Bobby Hatten, a plaintiffs' attorney with the Newport News, Va., firm of Patten, Wornom & Watkins.

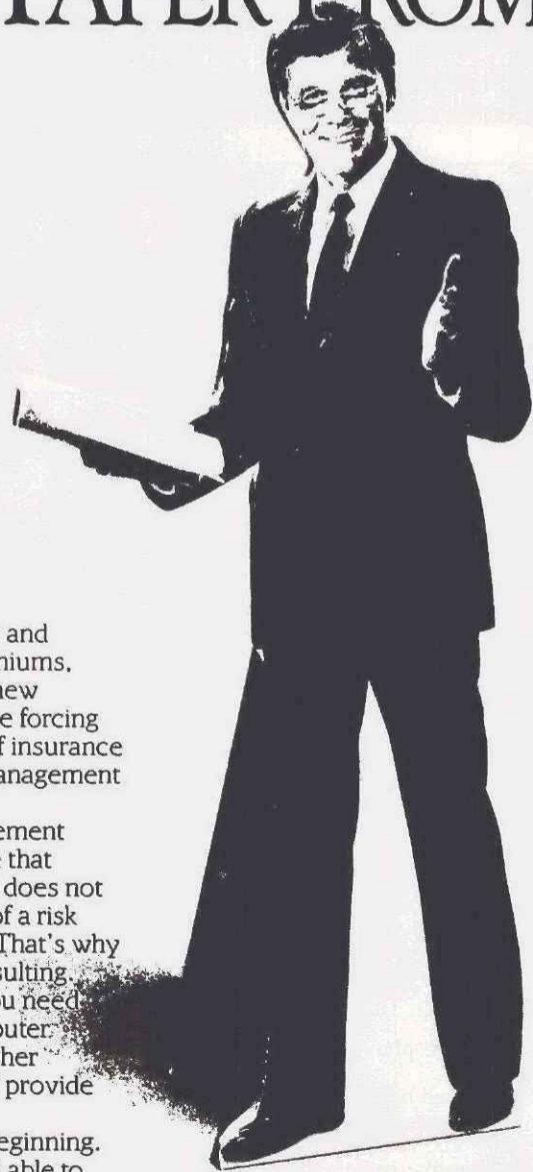
"I certainly hope that no one gets the impression his lawsuit speaks for anybody other than Bob Sweeney," Mr. Hatten said. "He doesn't speak for me, and I don't think he speaks for a majority of plaintiffs' lawyers."

But, Knoxville, Tenn., plaintiffs' attorney Paul Gillenwater said: "I have seen nothing out of Wellington lawyers in Tennessee that causes me to believe that the Wellington group will in any fashion be beneficial to my clients."

"I have an open mind about the Wellington group, but unless I see something productive by Wellington I will probably be disposed to take some affirmative action against Wellington."

Mr. Gillenwater of the firm of Gillenwater, Nichol & Ames, declined to specify what action he might take.

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Tax reform

Continued from page 1

health insurance plans to widowed and divorced spouses of employees as well as make it more expensive and difficult for employers to terminate underfunded pension plans.

Employee benefit and insurance industry lobbyists until last week feared comprehensive tax reform this year.

House Ways and Means Committee Chairman Daniel Rostenkowski, D-Ill., had hoped to send a reform package to the full House by mid-October. But, his committee is nowhere near finished drafting a bill.

Despite close to a month of closed-door drafting sessions, the Ways and Means Committee has discussed only about 10% of the hundreds of individual tax reform provisions prepared by its staff, congressional sources say.

And progress on drafting a bill has slowed markedly. Two weeks

ago, for example, when the drafting sessions were supposed to be in high gear, the committee met for only one half-day.

Last week, drafting sessions were cut short because many committee members were tied up on a conference committee that is in the process of ironing out deficit reduction legislation.

"As each day passes, you have to be more skeptical about Congress passing tax reform legislation," said Gerald Uslander, a principal in the Louisville, Ky., office of benefit consultant William M. Mercer-Meindinger Inc.

"If tax reform isn't dead, it is in a coma," said Andre Maisonneuve, president of the Reinsurance Assn. of America in Washington.

"Ways and Means Committee members lack the stomach to report out a tax reform bill," said Edward J. Davey, vp-technical analysis for Johnson & Higgins in New York.

A benefit expert said last week

that he had heard rumors that Mr. Rostenkowski was prepared to scrap tax reform if he didn't have the needed votes. Instead, he would order his staff to begin drafting a much more modest tax bill for the committee to consider.

In addition to such items as minimum corporate and individual taxes, employee benefit provisions taken from earlier tax reform packages would be included in this new tax increase bill, the lobbyist added.

Most observers say that it is inevitable, in view of the large federal budget deficit, that Congress will begin work on a tax increase bill that targets both employee benefits and the insurance industry.

When Congress fashions a tax bill, "don't think all the old ideas will be discarded," advises Mr. Davey.

Employee benefits always "stick out" as candidates for inclusion in a tax bill because they are perceived as revenue raisers, says Theresa

Stuchiner, a partner at benefit consultant Kwasha Lipton in Fort Lee, N.J.

Property/casualty insurers also say they will become a revenue target when Congress begins to fashion a tax increase bill.

"There is a perception on Capitol Hill... that we are not paying our fair share," says Tom O'Day, assistant vp at the Alliance of American Insurers in Washington.

The last two tax bills passed by Congress, in 1982 and 1984, contained major provisions limiting benefits provided employees and risk-financing techniques.

But, benefit and insurance industry lobbyists are taking advantage of this momentary lull in the tax reform effort to convince congressional staffers to discard the benefit and property/casualty provisions now in the tax reform packages when they consider tax legislation.

At the same time, lobbyists are taking the offensive and suggesting counterproposals to what the ad-

ministration and Ways and Means Committee have suggested.

For example, Mercer-Meindinger's Mr. Uslander has met with Capitol Hill and Treasury Department staffers and discussed a compromise position on 401(k) plans.

While the administration wants to kill the popular plans and Ways and Means Committee staff have suggested slashing the maximum annual salary deferral to \$5,000 from \$30,000, Mr. Uslander has suggested a \$15,000 limit.

In addition, Mr. Uslander has lobbied for a continuation of pre-retirement hardship withdrawals, which congressional staffers and the administration want to kill.

In return, Mr. Uslander says, the benefit community might accept a Ways and Means proposal that would limit salary deferrals by highly compensated employees to 125% of the average salary deferrals of the group of lower compensated employees.

By contrast, under a widely used discrimination test, the average deferral by the higher paid one-third cannot exceed 150% of the average percentage deferral of the lower-paid two-thirds.

In addition, J&H's Mr. Davey has advanced a proposal to congressional staffers that bases future increases in maximum pension benefits and contributions on annual increases in the Social Security wage base.

By contrast, the Ways and Means Committee staff has proposed slashing the maximum annual pension benefit offered by a defined benefit plan to \$75,000 from the current \$90,000, while the maximum contribution made to a defined contribution plan would be lowered to \$25,000 from \$30,000. These new lower limits would remain in effect until at least 1991.

And, property/casualty lobbyists are trooping to Capitol Hill to discuss alternatives to Ways and Means Committee staff proposals to slap the industry with new taxes.

For example, reinsurers have been discussing with Rep. Fortney (Pete) Stark, D-Calif., an influential Ways and Means Committee member, a "minimum tax" proposal.

Under this proposal, property/casualty companies—at a minimum—would be liable to pay a tax equal to 1% of their premiums or 20% of their net income, whichever is less.

By contrast, Ways and Means staffers have proposed, among other things, barring insurers from taking tax deductions on reserves to cover claims paid in the future. A deduction could be taken only at the time a claim is paid.

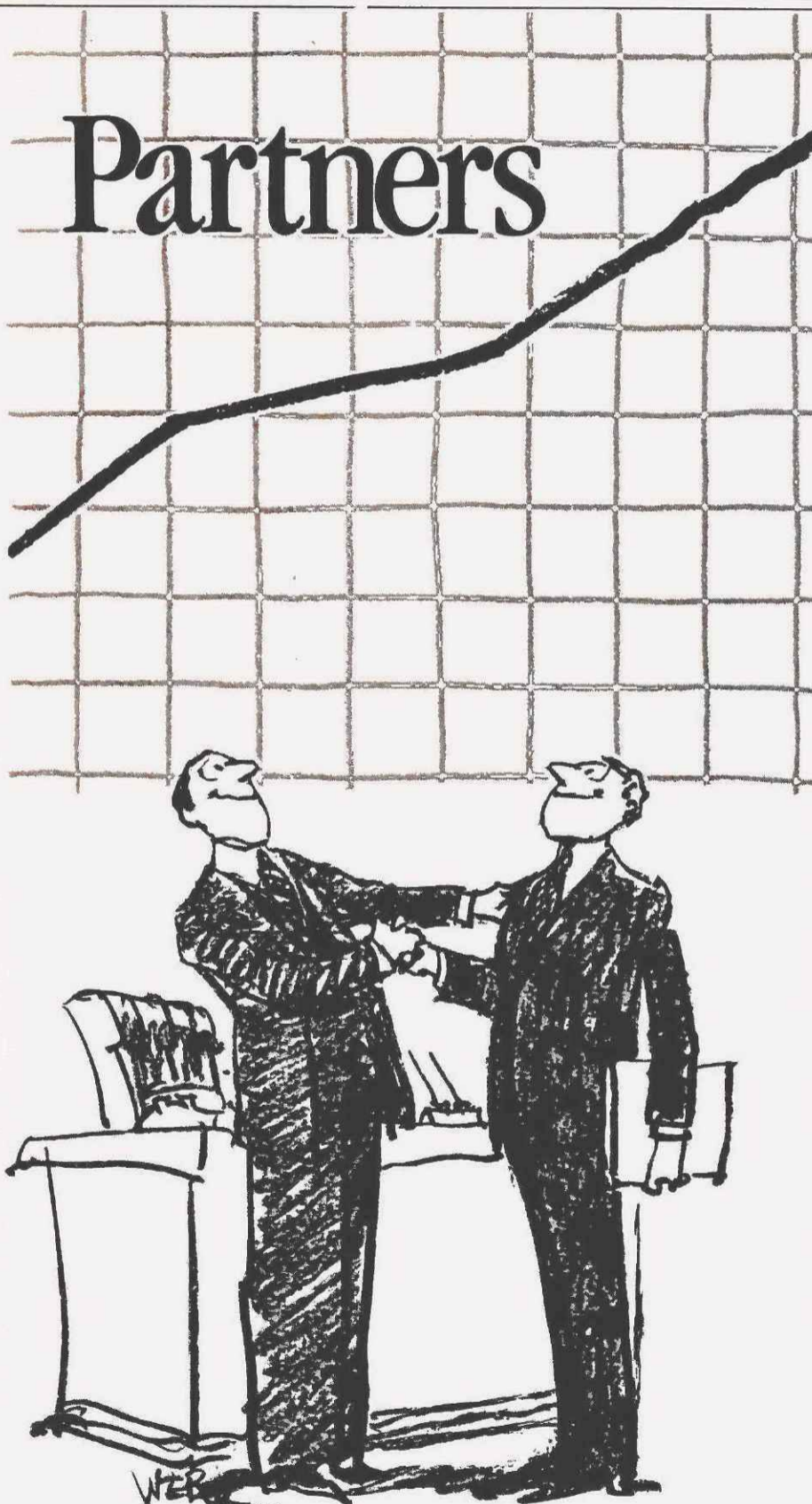
Other Ways and Means staff proposals would tax a portion of insurers' tax-exempt income, such as tax-free municipal bonds, and limit the ability of companies that file consolidated tax returns to offset profits from non-insurance company operations with losses incurred by their property/casualty units (BI, Oct. 7).

Benefit lobbyists also are urging benefit managers to make their positions known now to Congressional staffers, before proposals become part of another tax bill.

Congressional staffers have already altered an administration proposal that would have disqualified benefit plans of companies with different divisions if too many high-paid employees were concentrated in one benefit plan (BI, Aug. 19).

That revision came after companies, such as Mobil Corp., provided detailed examples of how the rule would disqualify benefit plans that have been in operation for decades, a tax committee staffer said.

The latest discrimination rules proposed by Ways and Means Committee staff are an improvement, but still could destroy some benefit programs (BI, Oct. 14).



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opinions

Do you hear the ticking?

EMLOYERS THAT PROVIDE retirees with health care benefits are sitting on time bombs, but they don't hear the ticking.

Most employers believe that they have the right to reduce retirees' health benefits. But, federal district courts are consistently refusing to allow employers to reduce health plan benefits to existing retirees. Once provided to retirees, these health plan benefits appear to be irrevocable no matter how expensive they become.

Just a year ago, based on an early court ruling on this issue, we warned that employers would not be able to waltz on promises to deliver health care benefits to retirees.

While agreeing employers should stand behind promises, we advised employers to carefully word their benefit communications to employees to state that health care benefits provided to retirees could be reduced or withdrawn. We maintained that employers should have the right to control the cost of retiree health care plans, given the rising cost of health care and every employer's uncertain economic future.

But now, based on the latest court ruling involving retiree health benefits, it appears that employers will find it nearly impossible to draft language that will permit them to reduce—let alone eliminate—health care benefits to existing retirees (see story, page 3).

An appellate court considering the issue could find that employers who carefully worded their benefit

plan communications have the right to reduce health benefits to retirees. But, we don't think such a ruling in favor of employers' rights is probable. As has occurred repeatedly in liability cases, we expect future rulings to favor the plaintiffs.

We now suggest that all employers promising to provide retirees with health care benefits assume that, once provided, the benefits can't be cut. As a result, employers should immediately assess what these retiree benefits as now designed will cost in the future.

Believe it or not, surveys show that many companies have not determined their future liability for health benefits promised to retirees.

With projected costs in hand, the employer can then determine if these benefits will be affordable. Employers may find, much to their surprise, that they can't expect to cover the cost of these benefits out of cash flow, which is the norm now.

Employers will then have two options:

One, the employer can begin prefunding now for retiree health care benefits, despite the fact that recent tax legislation has reduced the tax advantages associated with prefunding retiree health benefits.

Two, the employer can reduce to affordable levels health care benefits promised today to future retirees.

Employers should not delay in determining their liability for future retirees' health plan costs. With each new retiree, the company's irreducible liability is growing.

letters

Readers offer views on mandated employee benefits

To the editor: I applaud the "Perspective" contribution by Shirley Bales, president of the Central Indiana Business Group on Health, on the federal proposal to mandate that employers extend health care coverage to divorced spouses, widows and dependents of employees (*BI*, Sept. 23).

The insurance industry might be encouraged to adopt a more aggressive attitude toward government intrusion into insurance contracts if it had more overt support from business and industry such as she has offered.

Like any other business, insurance must generate adequate income from its own customers to continue to exist. Every benefit added by legislation, state or federal, costs insurers more and so businesses pay more when they buy insurance. Nothing is free on account of government decree.

A.E. Lutz
Jacksonville, Fla.

To the editor: The proposed bill that would mandate that employers extend health care coverage to divorced spouses, widows and dependents of employees (H.R. 3128, Section 161) presupposes that employer contributions to welfare plans are government property.

Once upon a time, Congress thought it advisable to encourage employers to provide benefits for employees. It now seems to be the policy in Congress to see how much they can get away with.

It is now so much easier for an employer simply to pay employees cash compensation and let the employee worry about the tax consequences of purchasing various benefits.

Just imagine a world with no 5500

forms, no TEFRA legislation to follow, no DEFRA legislation to follow, no age discrimination problems, and no Bill 3128 to worry about.

The jig is up. Congress better wake up to the realization that employers are fed

up and they are not going to take this anymore.

Mark A. Mitchell
President
U.S. Benefit Consultants
Marietta, Ga.

Accountant remark only supports another stereotype

To the editor: The description of an actuary accompanying William J. Miner's "Ask an Actuary" column (*BI*, Oct. 7) was informative, should increase public awareness of the actuarial profession and will alert potential clients to the specialized skills that actuaries can apply to financial security plans of all types.

But, I was disappointed to see that Mr. Miner could only attempt to dispel one stereotype by reinforcing another: "No, an individual need not be at least as boring as an accountant to become an actuary."

Although the writings of Charles Dickens are entertaining, they are not necessarily authoritative. I would have

expected a more enlightened "perspective" from a trained professional.

John C. McKenna, C.A.
Financial Manager
General International Ltd.
Hamilton, Bermuda

■ *Mr. Miner replies: "The purpose of the article was not only to inform, but also to entertain. I had hoped my readers could distinguish between the two, and not mistake humorous remarks for authoritative discourse. Indeed, I hoped that my readers would have been so entertained by the article that they would realize that professionals—be they actuaries or accountants—are not necessarily boring individuals."*

Pre-admission review available for small groups

To the editor: I am encouraged by your recent attention to pre-admission review, a new approach that promises great cost savings for insurance companies and policyholders alike. You noted John Hancock Mutual Life Insurance Co.'s program for 500 or more lives (*BI*, Sept. 9), and Pacific Mutual Life Insurance Co.'s program for 25 or more lives was mentioned in J. David Adams' letter to the editor (*BI*, Sept. 23).

Let me add that now even groups of just two employees can benefit from pre-admission review through multiple em-

ployer trust group programs.

Dun & Bradstreet Plan Services has helped to develop MET pre-admission review programs for leading insurers. Our own pre-admission review cuts carrier costs an average of 10%, making affordable small-group premiums a reality.

Lower insurance premiums are the No. 1 concern of small business employers.

Carol A. O'Neill Westfall
Vp-Cost Containment
Dun & Bradstreet
Plan Services Inc.
Tampa, Fla.

Scottsdale clarifies terms of day-care coverage

To the editor: The article entitled "Scottsdale Offers Cover to N.J. Day-care Centers" (*BI*, Oct. 7), quotes New Jersey Insurance Commissioner Hazel Gluck as saying "... the company's policy does not exclude coverage for child abuse incidents."

This statement is not correct.

This misinformation has been the source of consternation on our part, as well as the reinsurance market. We can-

not allow this statement to stand uncorrected.

Vickie Kartchner
Director
Casualty Underwriting
Scottsdale Insurance Co.
Scottsdale, Ariz.

■ *Editor's note: Business Insurance had quoted a press release issued by the New Jersey Insurance Department.*

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Lloyd's settles tax dispute out of court

By STACY SHAPIRO

london line

LONDON—Sooner or later, Lloyd's of London members will foot the bill for the 42.5 million pound (\$60.8 million) tax settlement Lloyd's made with the Inland Revenue Department earlier this month, Lloyd's Chief Executive Ian Davison admits.

But, the advantages of settling with Inland Revenue out of court will outweigh the cost to the Lloyd's members, says Mr. Davison and Lloyd's Chairman Peter Miller.

In a letter to members, Mr. Miller said the out-of-court settlement will avoid litigation that would have cost members much more than the lump-sum payment to Inland Revenue, which was made to settle tax disputes over certain re-

insurance arrangements, known as "rollover" policies.

Inland Revenue began investigating Lloyd's underwriting agencies' and members' accounts after allegations of fraud were raised in 1982 regarding the rollover policies.

Lloyd's claimed the rollover policies, in which premiums were paid to offshore companies, were used as catastrophe reinsurance for Lloyd's syndicates.

But, Inland Revenue had questioned whether the premiums were legitimate reinsurance arrangements, and whether the agencies were justified in deducting the funds for tax purposes (BI, April 30,

1984).

In 1984, Inland Revenue began a full-fledged investigation of Lloyd's underwriting agencies' and member's accounts dating back to 1976.

Originally, Inland Revenue estimated that about 100 million pounds (\$143 million) was involved in its investigation.

In 1984, Mr. Miller said Lloyd's would not settle with Inland Revenue, and that instead, Inland Revenue would have to settle with each individual member.

But, Mr. Davison said, Lloyd's decided to settle because it was becoming apparent that by next year, all Lloyd's members would be af-

ected by the Inland Revenue investigation.

Mr. Miller added in his letter: "The problems of litigation would be enormous; it would be costly, lengthy and wholly disruptive of the market and of the tax affairs of the individual names. Likewise, further protective assessments would not only be disruptive, but extremely costly to all members, both by way of continuing restrictions on loss relief and by additional accountant's fees.

"It was clear to the Council in examining the adverse consequences where a monetary quantification can be made, that to make a settlement on the terms referred to was advantageous to the members and completely justifiable in monetary terms alone," Mr. Miller said.

Lloyd's took a loan from National Westminster Bank and Citibank in order to pay the settlement.

As part of the settlement, Lloyd's and Inland Revenue agreed that:

- The settlement covers all members except 23 members who Inland Revenue will notify soon. Mr. Davison could not identify those 23 members, but he said he believed they were members whose actions "leaned toward criminality."

- Rollover policies will be terminated as quickly as possible. Syndicates can in the future keep reserves offshore, but they will be taxable.

- Lloyd's will set up a working party to consider further guidelines on reinsurance matters.

- Lloyd's still believes that most rollover policies were "valid reinsurance for proper commercial reasons" and in the best interest of the syndicates.

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This is an actual case history. In reinstating the Social Security benefits, the Administrative Law Judge cited CNA's involvement.

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Disciplinary results

Lloyd's of London has posted the results of disciplinary proceedings on four individuals involved in extended warranty insurance policies administered by Multi-Guarantee Ltd.

Lloyd's alleged in 1983 that someone altered these policies, which were underwritten by Lloyd's syndicates and administered by Multi-Guarantee (BI, March 21, 1983).

In an unprecedented move, Lloyd's announced the judgments of the Council of Lloyd's but did not distribute booklets describing why the judgments were given, the position of the individuals or how they were involved.

According to Mr. Davison, this was not Lloyd's decision but the decision of the Department of Public Prosecution, Britain's attorney general.

Lloyd's did announce, however, that Ronald Leslie Meddes, chairman of Multi-Guarantee, was found guilty on four charges of misconduct and has been expelled from Lloyd's. He also was ordered by Lloyd's to pay costs of 50,000 pounds (\$71,500).

Stuart John Campbell Ritchie was found guilty of one charge of misconduct. Mr. Ritchie was suspended for four years and ordered to pay 20,000 pounds (\$28,600).

Robin John Kershaw Roberts was reprimanded on one charge of misconduct and ordered to pay 9,000 pounds (\$12,870) to Lloyd's.

And, Peter Geoffrey Smith pleaded guilty to one charge of misconduct and was reprimanded by Lloyd's.

Lloyd's neither would elaborate on these individuals' positions nor comment on their involvement in the matter.

ABA committee studies malpractice

CHICAGO—A special committee of the American Bar Assn. will study proposed legislation that pertains to medical professional liability.

The Special Committee on Medical Professional Liability, appointed by ABA President William Falsgraf amid concern about availability and cost of malpractice insurance, will develop ABA policy in response to bills addressing such issues as contingency fees, structured payments, caps on awards for non-economic damages, pre-trial screening panels and payments from collateral sources.

The proposals will be considered for adoption by the association's House of Delegates at the ABA's midyear meeting in February 1986.

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Jury award

Continued from page 2

Moore-McCormack would not discuss its liability insurance, but an attorney representing Moore-McCormack in the Hinojosa case said last week investigations were still going on to determine the exact amount of Moore-McCormack's liability coverage.

Moore-McCormack's general liability insurance was placed by Johnson & Higgins in New York, according to sources. The brokerage would not comment on Moore-McCormack's coverage.

According to court papers, the jury found that Moore-McCormack was negligent in establishing safety rules and proper supervision at the site of the accident and, therefore, should be held liable for the entire verdict—even though it was not entirely responsible for the accident.

The jury's verdict placed 25% of the responsibility for the accident with Janssen Lease Service Inc. in Ganado, Texas, but assessed no damages against the company. The jury also determined that Janssen Lease was acting as an employee of Moore-McCormack at the drilling site.

The accident occurred at a site owned by Moore-McCormack near Port Aransas. Mr. Hinojosa, an employee of Beach Inc. in Bay City, Texas, was helping dismantle a piece of natural gas drilling equipment at the site when the equipment collapsed and fell on him.

According to Mr. Eisenman, Janssen had been hired by Moore-McCormack to dismantle and remove the equipment.

Janssen in turn hired Beach to complete some of the work, he explained.

Mr. Eisenman said Mr. Hinojosa was lifted in a truck to secure a chain around a tower used for extracting moisture from natural gas. Workers for Beach were unaware that Janssen employees had removed bolts that helped keep the tower aloft, said Mr. Eisenman, and it collapsed as Mr. Hinojosa was attaching the chain.

Since the accident, Mr. Hinojosa has been paralyzed from the middle of his back down and has experienced severe pain, according to Mr. Eisenman.

The jury found that workers for Janssen were "borrowed servants" of Moore-McCormack, Mr. Eisenman explained.

"Under Texas law, that means Moore-McCormack is legally responsible," he added.

"Primarily, Moore-McCormack

was found liable for failing to set up the proper safety rules and failing to provide a supervisor," Mr. Eisenman said. "The Janssen workers were all illegal aliens and there was no one on the job that was truly a supervisor."

He noted that "in its contract with Janssen, Moore-McCormack had reserved the right to make safety rules. They had absolute right of control of the premises and could ask anybody to leave at any time."

But Moore-McCormack's attorney contends his client was not at the site, and, therefore, was not responsible for what happened there.

John Scully, with the Dallas law firm Cowles & Thompson, says

charges against Moore-McCormack of "vicarious liability" arose only after the plaintiff had rested his case, when the court decided to allow a trial amendment requested by the plaintiff's attorneys to be presented before the jury.

"There were no allegations of vicarious liability during the trial, then suddenly the trial amendment was granted," said Mr. Scully. "After the plaintiff had rested his case, we found ourselves defending our case and Janssen Lease as well. It was our position all along that, as defined in the contract, Janssen Lease was responsible for what happened at the site."

Mr. Scully said the charges of vicarious liability contributed to the

large settlement, as did the jury's sympathy with Mr. Hinojosa's injuries.

"The jury seemed to run away with the injuries; they let them play too large a part," he remarked. "Our research reveals the award was way out of line with similar awards to paraplegics."

Mr. Scully said Moore-McCormack would decide after the Nov. 4 hearing whether to file a motion for a new trial or appeal the judgment.

Meanwhile, Houston General Insurance Co., Moore-McCormack's workers compensation insurer, will attempt, after the Moore-McCormack judgment is entered, to recover the workers compensation

indemnity and medical payments it made to Mr. Hinojosa, says Robert Bateman, a Houston attorney representing the insurer.

Any award paid to Houston General would come from damages awarded to Mr. Hinojosa.

The insurer is attempting to recoup all its previous payments and those made until the final settlement of the lawsuit.

At the time of the jury's verdict, Houston General had paid Mr. Hinojosa \$28,063 in workers compensation disability payments and \$164,861 for medical care, according to court papers.

Moore-McCormack is a subsidiary of Moore-McCormack Resources Inc. in Stamford, Conn. ■



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Bermuda sets general election

HAMILTON, Bermuda—The ruling United Bermuda Party is expected to increase its 14-seat majority in Bermuda's Parliament when a general election is held Oct. 29.

In announcing the election, Premier John Swan denied he was trying to take advantage of a recent split in the opposition Progressive Labor Party. Four dissident PLP members broke away from the party seven weeks ago to form their own group, the National Liberal Party.

Mr. Swan's UBP has until 1988 before its current mandate expires. But, Mr. Swan said the formation of the new National Liberal Party represented a fundamental change in Bermuda's political climate and that the election was being called to allow voters to reaffirm their support for his administration.

Due to the recent split, the PLP is not fielding a full slate of candidates.

Mr. Swan, whose party won a 14-seat majority in Bermuda's Parliament in the 1983 general election, strongly supports developing Bermuda as an international insurance center.

Retiree benefits

Continued from page 3

vered another blow. She said ERISA gave courts the authority to fashion a common law to protect retirees' health care benefits. (BI, Oct. 29, 1984).

Judge Aldrich then said that under the common law she was fashioning, employers could not invoke termination clauses in their post-retirement plans to eliminate the benefits.

Judge Aldrich's decision, which involved several post-retirement benefit plans that financially troubled White Farm Equipment Co. of Cleveland wanted to cut, was even more disturbing than the Bethlehem Steel case because there was no ambiguity about the benefits promised: White Farm had informed employees explicitly in plan documents that the company had the right to change or terminate benefits.

Judge Aldrich's decision currently is being appealed to the U.S. 6th Circuit Court of Appeals.

Now, with Judge Wiseman's decision, which follows the same principle as the common law fashioned by Judge Aldrich, benefit experts worry that a new body of law is developing that will prevent companies from shedding even a portion of their enormous post-retirement health care liabilities.

"You can have only so many court precedents before you have an iron-clad rule," observed Rick Lee, vp-public policy at the Washington Business Group on Health.

"Employers may be locked into these benefits," Mr. Lee added.

"Courts are saying: 'You (employers) promised these benefits, and we are going to see that you keep those promises,'" said Robert Ballow, a partner with King, Ballow & Little, the Nashville law firm that filed on behalf of the NLT retirees.

The suit, filed in May, seeks to bar American General from cutting benefits. It also seeks \$150 million in compensatory damages and \$100 million in punitive damages.

"Federal judges aren't going to allow employer promises to be abrogated," Mr. Ballow added.

But James Tuerff, executive vp at American General, says employees and retirees will be the real losers if companies can't amend post-retirement health care plans.

"There will be a fear of being locked in... and there will be reluctance by employers to either offer or improve these plans," Mr. Tuerff said.

But, despite court decisions limiting the right of companies to alter post-retirement benefit programs, many benefit managers still aren't getting the message.

For example, 81% of 200 companies the Washington Business Group on Health surveyed this year said they had the right to amend or terminate post-retirement health care plans.

"Eight out of 10 employers think they can change post-retirement benefit plans. They may continue to think this, but courts aren't agreeing with their interpretations," Mr. Lee said.

And, making good on the promise to provide post-retirement benefits will be more expensive than companies probably realized when they set up the plans decades ago, at a time when the number of retirees was small and medical costs were low.

According to 1983 figures, the most recent available, the unfunded liability of post-retirement benefit plans exceeded \$125 billion; and, the liability is growing at the rate of \$5 billion a year, according to U.S. Labor Department estimates.

And, although the Employee Benefit Research Institute estimates that about 57% of medium and large employers offer post-retirement health care plans, just 2%

of employers with these plans are prefunding the benefits, said David Walker, deputy assistant secretary at the Department of Labor.

Employers must realize that their attempts to shift some of the cost burden to retirees are likely to end up in court, experts agree.

"If you are an employer, you better be careful before you make any adjustments. Retirees aren't going to take changes lying down," said Fred Rumack, director of tax and legal services at Buck Consultants Inc. in New York.

And Mr. Rumack advises employers considering acquisitions to research the post-retirement health care promises of a company it wants to buy to make sure it isn't taking on more obligations than it realizes.

"When you buy a company, you buy its history," Mr. Rumack said.

In the American General case, the NLT retirees launched their suit after American General altered the NLT health care plan so it

matched with the benefit program American General was offering its own employees.

For example, effective July 1, 1984, the ceiling on maximum annual out-of-pocket health care expenses for NLT employees who retired before 1984 was boosted to \$1,000 from \$600 per individual. In addition, American General said it would only pay 80% of the first \$3,000 of certain hospital expenses, down from 100% coverage.

For pre-1984 retirees age 65 or over, a monthly health care premium of \$16.10 was charged; previously, coverage was free.

American General also began to charge a \$14.87 monthly premium for retirees under 65, whose coverage also previously had been free. Then on July 1, 1985, that premium was scheduled to rise to \$29.75. However, a temporary injunction stopped the July 1 increase.

Benefits also were adjusted for workers retiring after 1984, although their benefits already dif-

Employers 'better be careful before you make any adjustments,' warns Mr. Rumack.

fered from the pre-1984 retirees.

At the same time, American General made a number of benefit improvements for the NLT retirees including offering a dental plan and raising the maximum lifetime ceiling on medical benefits to \$200,000 from \$100,000.

In his ruling, Judge Wiseman described what he believed was an ambiguity surrounding the post-retirement health care offered to NLT retirees.

Prospective employees were told by NLT that one of the attractions of working for the company was free post-retirement health care

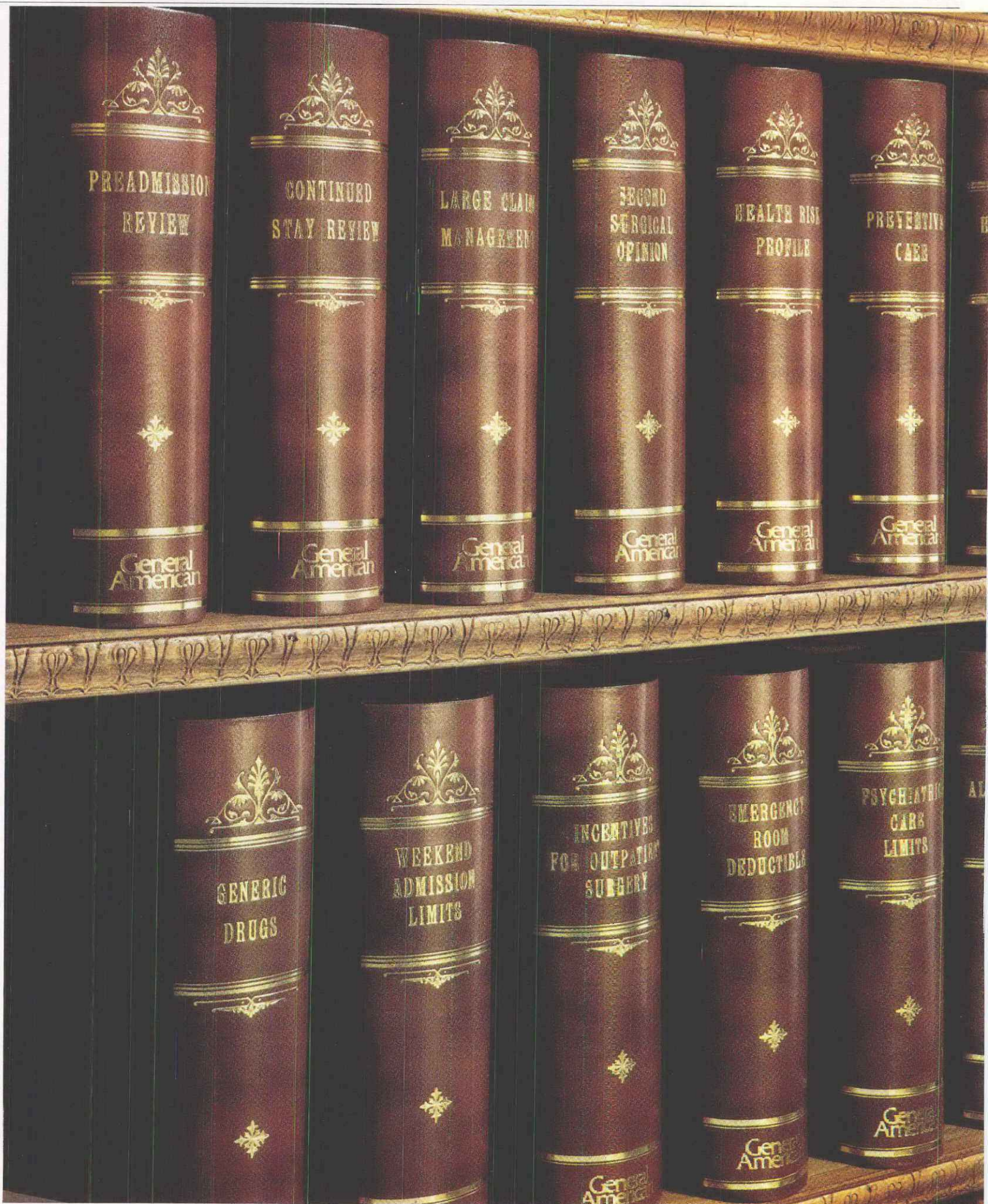
benefits, Judge Wiseman said. And when employees were considering leaving the company, management would remind employees of the company's free post-retirement health care program he said.

However, Mr. Tuerff, the American General executive vp, said American General could find no record of such promises being made.

Aside from such oral promises, Judge Wiseman noted that NLT employees received annual personal benefit statements that said employees would not be required to contribute for medical and life insurance coverage after retirement.

Judge Wiseman said NLT did distribute individual certificates of insurance to active employees that indicated coverage could be terminated. In addition, at retirement, a retiree was issued a new certificate that also reserved to the company the right to amend or terminate promised benefits.

Continued on next page



Continued from previous page

And, summary plan descriptions, required by ERISA and distributed to employees and retirees, warned that the company reserved the right to change or, if necessary, discontinue the post-retirement health care program.

However, the plan descriptions also told employees and retirees that no contributions would be required for post-retirement health care coverage, Judge Wiseman pointed out.

And, he said, the termination/modification clause and the provision promising to provide free post-retirement health care conflicted.

"To read the plan as providing lifetime paid-up medical insurance and, at the same time, reserving the right to terminate the benefits at any time constitutes an illusory promise," Judge Wiseman said.

The NLT summary plan description did say changes could be made if "necessary." And, Judge Wise-

man said that some compelling financial reason could make such changes "necessary."

But, he said, higher health care costs are not a sufficiently compelling reason.

"American General must demonstrate, not that the costs of the medical insurance plan far outweigh the insurance premiums paid by retirees, but rather that the contractual promises previously made are now avoidable because of some unforeseen contingency that threatens the financial base of the entire corporation," Judge Wiseman said.

"In light of American General's earnings during the first half of this year, the court does not view the alleged incremental cost attributable to the retirees' medical insurance plan to constitute sufficient cause to warrant amendment of the plan," he added.

During the first six months of 1985, American General reported after-tax operating income of \$218 million. ■

Health care costs to drop in 1986 for government workers: Survey

WASHINGTON—The federal government and most of its employees will pay less for health care coverage in 1986.

Office of Personnel Management Director Constance Horner says more than three-fourths of the workers in the Federal Employees Health Benefits Program will pay less next year for the same or improved benefits.

"Last year, OPM announced the lowest premium growth in six years," she said (BI, Sept. 10, 1984). "This year there's an actual decline in the premiums."

"The average savings is 6% for our (non-postal) employees and 8% for our retirees," Ms. Horner said.

And, she said, the government's

contribution to premium also will decline—for the first time in the history of the benefits program.

In 1986, the maximum monthly government contribution for non-postal employees' coverage will be \$48.59 for individual coverage and \$108.14 for family coverage, down from \$51.84 and \$115.62 in 1985.

And, several insurers and pre-paid plans offered refunds—first proposed by Blue Cross and Blue Shield—in 1985 to the government and to plan enrollees.

Besides Blue Cross/Blue Shield, the fee-for-service plans and their insurers offering rebates were Aetna Life Insurance Co.; American Federation of Government Employees, whose insurer is Union

Labor Life Insurance Co.; Government Employees Benefit Assn., whose insurer is Metropolitan Life Insurance Co.; the Government Employees Hospital Assn. of Kansas City, which is self-insured; the Foreign Service Benefit Plan, whose insurer is Mutual of Omaha Insurance Co.; and the National Assn. of Letter Carriers, which is self-insured.

Prepaid plans paying refunds were Medical Service Bureau of Idaho, a Blue Shield of Idaho plan; Kitsap Physicians Service in Washington state; SSS Plan in Puerto Rico, a Blue Shield of Puerto Rico plan; and Washington Physicians Service in Washington state.

Monthly premiums are lower in 1986 for almost all the fee-for-service plans. For example, the total monthly premium for standard individual plans sponsored by Blue Cross/Blue Shield declined to \$57.35 in 1986 from \$65.41 last year. The employee pays \$14.34 a month for this coverage in 1986, down \$2.01 from 1985.

In the standard family Blue Cross/Blue Shield plans, the monthly premium dropped to \$138.32 from \$156.07. And, the employee's monthly share dropped \$5.87, to \$34.58.

For high-level individual coverage plans sponsored by Blue Cross/Blue Shield, the total monthly premium dropped to \$114.92 from \$119.69. The employee's monthly share dropped \$1.52, to \$66.33.

For the Blues' high-option family cover, the total monthly premium dropped to \$251.42 from \$261.91. The employee's monthly contribution dropped \$3.01, to \$143.28.

The monthly premium for the standard-coverage individual plan underwritten by Aetna Life Insurance Co. dropped to \$56.42 from \$64.72. The employee's monthly share dropped \$2.08, to \$14.10.

The monthly premium for Aetna's standard family coverage dropped to \$120.73 from \$138.47. The employee's monthly share decreased \$4.44, to \$30.18.

For the higher-level individual coverage underwritten by Aetna, the monthly premium dropped to \$97.54 in 1986 from \$111.87. The employee's monthly contribution dropped \$11.08, to \$48.95.

And, for Aetna's higher-level family coverage, the monthly premium fell to \$181.78 from \$208.46. The employee's monthly share dropped \$19.20, to \$73.64.

The monthly premiums for health maintenance organizations generally did not drop in 1986, but most still were slightly lower than for traditional coverage.

For example, the monthly premium for individual employees in Northern California covered under the Kaiser Foundation Health Plan, an Oakland, Calif.-based HMO, is \$75.23 in 1986, up from \$72.06 in 1985. And, the employee's share rose \$6.42, to \$26.64 a month.

The monthly premium for family coverage under the HMO in Northern California also rose, to \$176.17 in 1986 from \$171.38. And, the employee's monthly share rose \$12.27, to \$68.03.

But, in Washington, D.C., premiums declined at the George Washington University Health Plan, an HMO.

The monthly premium for individual coverage through the HMO dropped to \$88.99 from \$96.98, and the employee's monthly share dropped \$4.74, to \$40.40.

For family coverage, the monthly premium dropped to \$229.23 from \$249.93. And, the employee's monthly contribution dropped \$13.22, to \$121.09. ■

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Pemberton named to vp post at San Antonio medical center

Roger Pemberton has been promoted to vp of the 1,100-bed Santa Rosa Medical Center in San Antonio, Texas. In this newly created position, he will represent Santa Rosa in the Preferred Choice Health Plan, a newly formed preferred provider organization. In addition, he will continue to oversee the medical center's risk management activities, which include supervision of the center's communications, safety and security departments. He reports to Sister Angela Clare Moran, chief executive officer and president. Mr. Pemberton, who joined Santa Rosa Medical Center in 1972 as assistant director of patient business services, most recently served as the center's director of risk management. He received his bachelor of science degree in business administration from Phillips University in Enid, Okla., and the equivalent of a master's degree in insurance principles and management techniques from Hartford Insurance Group in Hartford, Conn.



Mr. Pemberton

comings & goings: buyers

William P. Buttney has joined the insurance and risk management department at International Metals & Machines Inc. in Des Plaines, Ill. Mr. Buttney, who is filling a newly created position, will be responsible for IMM subsidiaries' corporate insurance and risk management programs. He also will administer the insurance program of IMM's sister company, American Machine & Science Inc. He will report to Richard J. Anderson, vp and treasurer. Mr. Buttney previously was a vp in the Chicago office of Frank B. Hall & Co. Inc. He has attended the University of Illinois and DePaul University. He also holds the Chartered Property & Casualty Underwriter and Associate in Risk Management designations.

Tom Fleming, 33, has been named corporate insurance administrator at Safeguard Scientifics Inc. in King of Prussia, Pa. He will administer the company's property and casualty insurance programs and will report to William Gillan, treasurer. Mr. Fleming, who previously was accounting manager at Safeguard Scientifics, replaces **Barbara Garro**, who is now director of risk management at Comcast Corp. in Bala-Cynwyd, Pa. Mr. Fleming has a bachelor's degree in accounting from Villanova University in Villanova, Pa.

Jerry N. Growel, 37, has been promoted to senior vp and corporate risk manager for American Savings & Loan Assn., a subsidiary of Financial Corp. of America. Mr. Growel also will be senior vp of Oak Insurance Agency, a division of FCA. Mr. Growel, previously corporate risk manager at American Savings & Loan, continues his responsibilities for administration of the company's property and casualty insurance programs. Working from FCA's Irvine, Calif., headquarters, he will report to Donald E. Royer, FCA executive vp-general counsel. Mr. Growel has a bachelor of science degree in economics and business administration from Wilmington College in Wilmington, Ohio. He also holds the Accredited Adviser in Insurance designation.

Diane F. Wyzga, 32, has been named corporate director-risk management at Summit Health Ltd. in Los Angeles. Ms. Wyzga will have responsibilities in the areas of risk management, insurance, employee benefits, workers compensation and human resources. She reports to William L. Pierpoint, president and chief operating officer at Summit Health Ltd., and replaces **Dana Easton**, who left the company. Ms. Wyzga previously was director of claims management/loss prevention at National Medical Enterprises in Los Angeles. She received a bachelor's degree in nursing from St. Anselm's College in Manchester, N.H., and a master's degree in nursing and hospital administration from the University of Virginia in Charlottesville. Ms. Wyzga also holds the Associate in Risk Management designation.

•
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PCN means lower rates, limited inpatient utilization, shorter lengths of hospital stays and reduced claims processing costs. In keeping with the needs of employers, PCN has developed a sophisticated data system to provide meaningful reports necessary to making decisions on employee health benefit programs.

Some of the cost effective measures employed by Preferred Care Network to reduce overall healthcare costs include: pre-admission screening, on-site nondelegated utilization review, second surgical opinions, patient surgery, and automated claims management.

PCN is a preferred alternative to traditional healthcare benefits for employers in the Chicagoland area. Through PCN, employers can provide health services at preferred rates via a network of over 20 healthcare institutions. The following hospitals are a few of the medical providers that PCN has chosen because they have demonstrated their ability to deliver excellent care while maintaining costs.

Resurrection Hospital

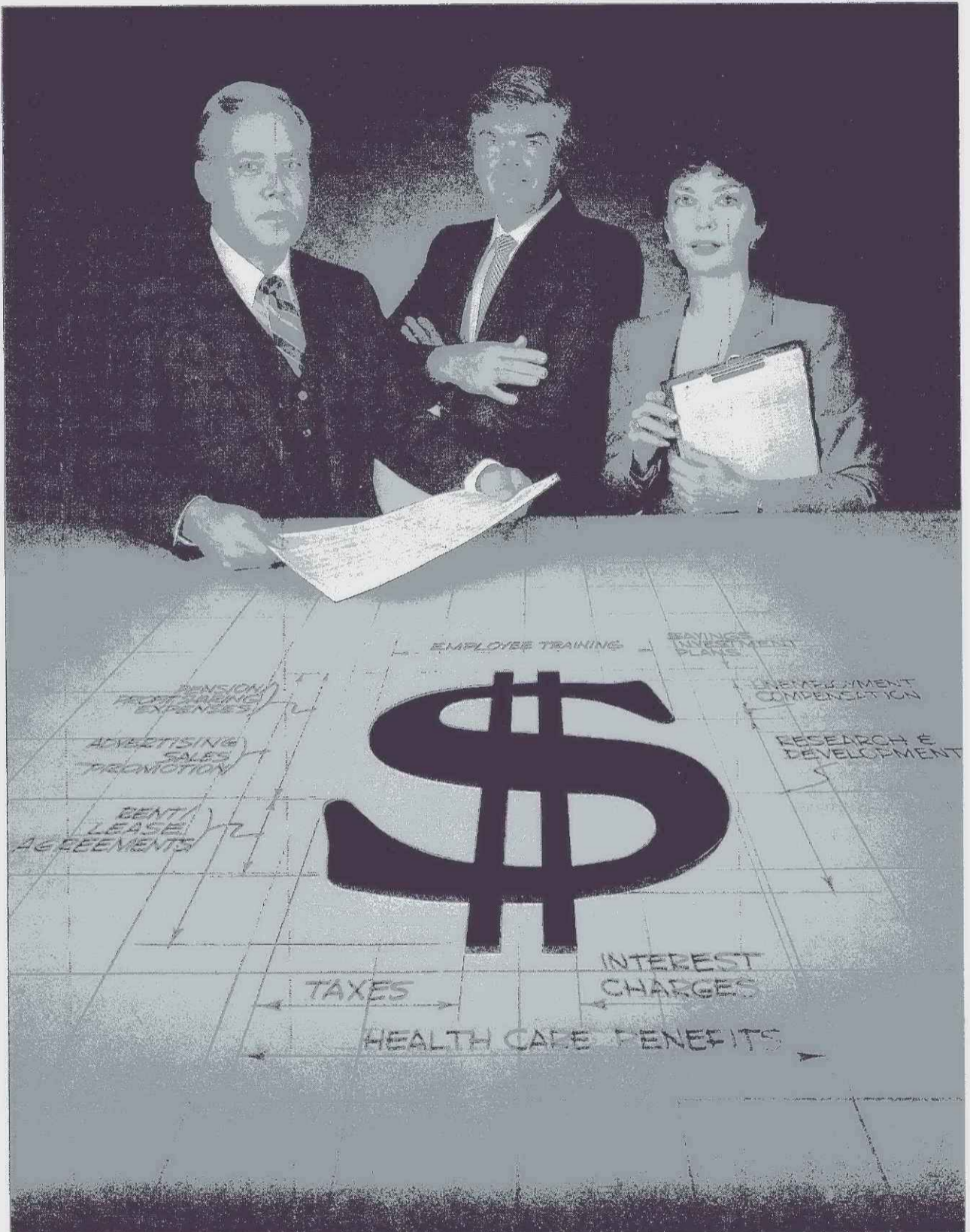
A 454-bed full service acute care medical complex, serving Chicago's northwest side, the nearby O'Hare complex and adjacent suburbs. Known as a major cancer care center, Resurrection also offers same day and laser surgery, endoscopy diagnostic services, and special care nursery and neonatology units. Supportive services include a pain control/behavioral medicine center, home health care, and an acute care alcohol treatment unit.

South Chicago Community Hospital

This 90-year-old teaching hospital serves a half-million residents in the southeast metropolitan Chicago area. A 436-bed facility, South Chicago prides itself on never reducing staff or services. Among its services are a new ambulatory surgery program, state-of-the-art nuclear medicine and radiology departments, a chemical dependency unit, a department of physical medicine and an advanced respiratory therapy program.

Holy Cross Hospital

A full-service, 417-bed hospital serving Chicago's southwest side, Holy Cross offers a complete range of services from one day surgery to home health care, a quick care center, physician referral, a speaker's bureau, and a fully-accredited rehabilitation hospital facility. Clinics for psychological counseling, hand injuries, and ear, nose, and throat treatment are part of Holy Cross Hospital's rehabilitation service.



SwedishAmerican Hospital

Located in Rockford, a 413-bed acute care medical center serving the greater Rockford area, northern Illinois and southern Wisconsin. Specialties include cancer care, pediatric and adult cardiology, a pediatric intensive care unit, ambulatory and outpatient surgery and laser eye surgery. Swedish American offers special services in dentistry, neurology, and physical, pulmonary and occupational medicine.

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U.S. Chamber panel will seek solutions to insurance crisis

By **JERRY GEISEL**

washington

WASHINGTON—The U.S. Chamber of Commerce is establishing a special task force to devise business solutions to soaring liability insurance rates.

Examination of how reforms of the legal system might be able to ease the insurance crisis is expected to be high on the special task force's agenda.

The Chamber, one of the nation's largest employer lobbying organizations, with about 200,000 members, set up a 13-member task force to make short- and long-term recommendations to ease what the Chamber calls an insurance "crisis" and "emergency."

The task force will be headed by Frances Shaine, chairman of SPM Manufacturing Corp. in Holyoke, Mass.

The task force was established in the wake of rate increases—sometimes between 500% and 1,000%—that Chamber members have faced this year, according to Barry Bauman, a Chamber corporate policy attorney.

These increases are cutting into profit margins of Chamber members and will damage members' financial stability, Mr. Bauman explained.

In addition, he said, some companies are having difficulty obtaining insurance coverage at any price.

"That is why we consider this such an important issue," Mr. Bauman added.

Rules rescinded

The Equal Employment Opportunity Commission is rescinding regulations that guide employers in complying with federal laws that require companies to give older workers and their spouses the opportunity to enroll in group health insurance plans.

While the regulations are being withdrawn—due to a squabble be-

tween the EEOC and the Office of Management and Budget—employers still will have to give older workers the option of enrolling in corporate health care plans, rather than Medicare, for their primary health care coverage.

Even though regulatory guidance is being withdrawn, "The law is still the law," an EEOC attorney warned.

"We'll let the act stand on its own," said EEOC Chairman Clarence Thomas following the agency's decision last month to withdraw the regulations.

The EEOC-OMB squabble erupted when the EEOC proposed that disabled spouses who chose Medicare for their primary coverage could then receive employer-provided coverage that would supplement Medicare, the EEOC attorney said.

The OMB opposed this proposal because it believed that disabled spouses would have a financial incentive to opt for Medicare coverage for their primary coverage if they were able to supplement that coverage with employer-provided benefits.

The EEOC regulations applied to provisions in the Tax Equity and Fiscal Responsibility Act of 1982 and the Deficit Reduction Act of 1984 that were intended to shift the burden of providing health care coverage for older workers and their spouses to employer-sponsored programs rather than the federal Medicare program.

TEFRA requires companies with more than 20 employees to offer workers between the ages of 65 and 69 the choice between enrolling in the corporate health plan or sticking with the federal Medicare program for their primary health care coverage.

If these older workers had

Continued on next page

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SOUTHEASTERN AVIATION UNDERWRITERS, INC.

Continued from previous page
spouses who were between the ages of 65 and 69, employers also had to offer health care coverage to those spouses.

Regulations implementing that provision of TEFRA were issued in the spring of 1983 by the Equal Employment Opportunity Commission.

Under DEFRA, employers have to offer health care coverage to spouses of employees who are between 65 and 69—even if the employee is under 65.

The EEOC had not yet issued final regulations on the DEFRA provisions.

PBGC premiums

The head of the Pension Benefit Guaranty Corp. is re-emphasizing her support for so-called "risk-related" termination insurance premiums.

Adoption of risk-related premium, which would require congressional approval, "is a question of how, not when," PBGC Executive Director Kathleen P. Utgoff says.

Speaking before a Washington meeting of the ERISA Industry Committee, a benefits lobbying group, Ms. Utgoff says the current PBGC premium structure—in which all employers with defined benefit pension plans pay a uniform termination insurance premium to the agency—encourages the underfunding of pension plans and penalizes those plans that are well-funded.

The current annual PBGC insurance premium for single-employer pension plans is \$2.60 per plan participant.

However, proposals now working their way through Congress call for increasing the premium—effective next Jan. 1—to between \$8.10 and \$8.50.

Ms. Utgoff also told ERISA members that the Reagan administration fully supports the PBGC program.

"The insuring of basic benefits will always be a goal of this administration," she said.

But she says loopholes that make it easy for some companies to terminate underfunded plans and shift the plans' liabilities to the PBGC need to be closed.

"The system can be made more efficient and financially sound," Ms. Utgoff said in support of proposals that would make it more expensive and more difficult for companies to terminate underfunded pension plans (BI, Oct. 14).

"We want to lighten the burden for the 98% of premium payers" that are paying for abuses of the 2%, she said.

401(k) plans

More than 400 trade associations have signed a letter sent to House Ways and Means Committee Chairman Daniel Rostenkowski, D-Ill., urging that Congress reject proposals to eliminate or restrict the popular 401(k) salary reduction plans.

"There can be no benefit to American workers in removing the attractive 401(k) plan from the range of compensation plans which have been established for their retirement," the trade groups said in the letter.

"The proposal to seek revenue neutrality in the tax-reform proposals by placing the burden of revenue enhancement disproportionately on employees attempting to plan for their futures is both unfair to employees and counterproductive to the general drive for tax reform," the trade groups' letter added.

The Reagan administration has recommended the elimination of 401(k) plans as part of its tax reform package, while staff members of the Joint Committee on Taxation and the House Ways and Means

Committee have proposed slashing the maximum annual salary deferral to \$5,000 per employee from the current \$30,000.

The committee staffers also have recommended more restrictive and complex salary non-discrimination rules (BI, Oct. 7).

Programs extended

President Reagan has signed legislation that extends to Nov. 14 the Federal Crime Insurance Program and the National Flood Insurance Program.

Statutory authority for those programs had expired on Sept. 30.

Approval of the legislation allows the programs to issue new policies while Congress decides their long-term future.

The Reagan administration favors the termination of the crime insurance program. However, the administration has requested a six-year extension of the flood insurance program. ■

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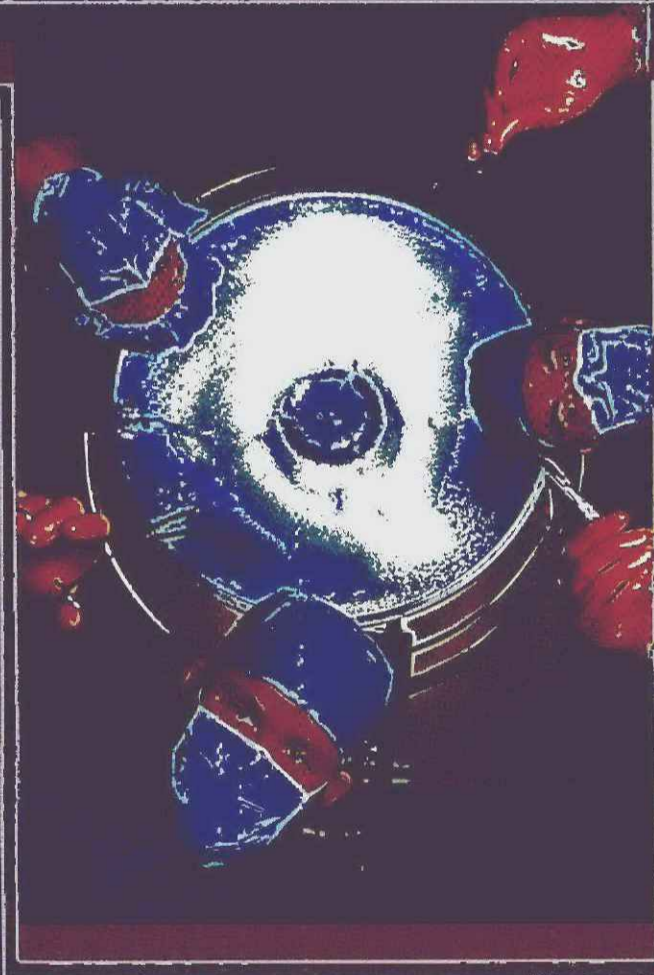
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NATIONAL — INTERNATIONAL

Tillinghast opens an international office

Tillinghast, Nelson & Warren is operating its first international risk management office following the purchase of a 50% interest in United Risk Management Consultants Ltd. in Stockholm, Sweden.

H. Felix Kloman, a principal with Tillinghast, says the new Stockholm office "marks a definite commitment to expand our risk management capabilities around the world."

UNIRISK, which will be re-named UNIRISK/Tillinghast, employs four professionals and two secretaries. It was formed in April 1984 by Ulf Nordblad and Ronald Berg, formerly risk management consultants with Skandia Risk Management.

Atlanta-based Tillinghast, which also consults in the field of life and property/casualty insurance and

markets

employee benefits, has offices throughout the United States and in Bermuda; Toronto; London; and Sydney, Australia.

Tillinghast is the largest risk management consultant in the United States, with 1984 risk management consulting revenues of \$4.2 million.

There is "a lot of growing interest" in captive insurance companies among companies in Europe, and Tillinghast has a "broad knowledge of U.S. and European captives," Mr. Kloman notes.

Investors acquire insurer

A group of investors led by two

former Mission Insurance Group officers has acquired a virtually inactive property/casualty insurer and plans to reopen the company for business Nov. 1.

Coastal Holdings Inc., founded by the two former Mission Insurance Group officers, purchased Superior National Insurance Co. from its owners, the royal family of Kuwait, for \$1.6 million.

Louis F. Marioni, former MIG president and chief executive officer, and Michael Mulholland, former MIG senior vp and chief financial officer, head Coastal Holdings. Both men resigned their positions at MIG in March.

Los Angeles-based Superior National, which was licensed in 1979 but hasn't assumed new business for several years, will reopen with \$11 million in capital and surplus,

Mr. Mulholland said.

The funds were invested by about 65 individuals, most of whom are from California. Mr. Mulholland declined to identify the investors.

With a staff of nine, the insurer initially will write workers compensation coverage in California. But, its owners hope to expand into other states and other commercial property/casualty lines as additional state licenses are granted, Mr. Mulholland says.

Continental merger

The Continental Corp. plans to merge the reinsurance operations of its London-based subsidiaries Continental Reinsurance Corp. Ltd. and Unionamerica Insurance Co. Ltd. sometime next year.

In 1984, the two companies generated premiums of \$120 million, according to Continental.

The reorganization is expected to be completed sometime in 1986; however, the management of the two companies will merge sometime this year.

Continental Re Corp. currently has a portfolio of international treaty business, while Unionamerica specializes in U.S. casualty reinsurance underwriting. Under the reorganization, those portfolios will be continued and additional capital will be added to the combined operations, according to Continental says.

Reciprocal agreement

Corroon & Black Corp. in New York and the Dale-Parizeau Group in Montreal, a unit of Sodarcan Ltd., have finalized a reciprocal agreement whereby the brokerages will provide services to each others' multinational clients.

Dale-Parizeau will handle insurance needs of C&B's U.S.-based clients' Canadian operations. Meanwhile, C&B will provide brokerage services for U.S. subsidiaries or branches of Dale-Parizeau clients.

Allianz closes offices

Allianz Underwriters Insurance Co. and Allianz Intermediaries have closed their New York and Chicago offices and moved most operations to the home office in Los Angeles.

Increased efficiency was cited as the reason for the move.

"With the exception of the property underwriting office in San Francisco, we are moving to centralize operations with all future underwriting being performed in the Los Angeles home office," said Herbert F. Hansmeyer, president and chief executive officer of the companies.

"Greater efficiency will be achieved by this restructuring and will enable AUIC to increase its writings in 1986."

He said AUIC will continue to write surplus lines property/casualty business throughout the United States.

Submissions previously sent to the New York or Chicago offices can now be directed to AUIC headquarters at 6435 Wilshire Blvd., Los Angeles, Calif. 90048; 213-937-5530.

Change of affiliation

First of Georgia Insurance Group, a property/casualty insurer based in Augusta, Ga., will become affiliated with Nationale-Nederlanden U.S. Property & Casualty Holdings Inc. through a corporate realignment of the holding company's parent, Nationale-Nederlanden U.S. Holdings Inc.

Under the arrangement, Nationale-Nederlanden U.S. Property & Casualty Holdings Inc. will assume direction of First of Georgia and all of Nationale-Nederlanden U.S. Holdings Inc.'s other U.S. property/casualty companies. The change in Georgia will become effective Nov. 1, pending approval of the state insurance regulator.

According to officials at NNUSP&C Holdings, the move is aimed at strengthening the product support and marketing posture of its regional companies.

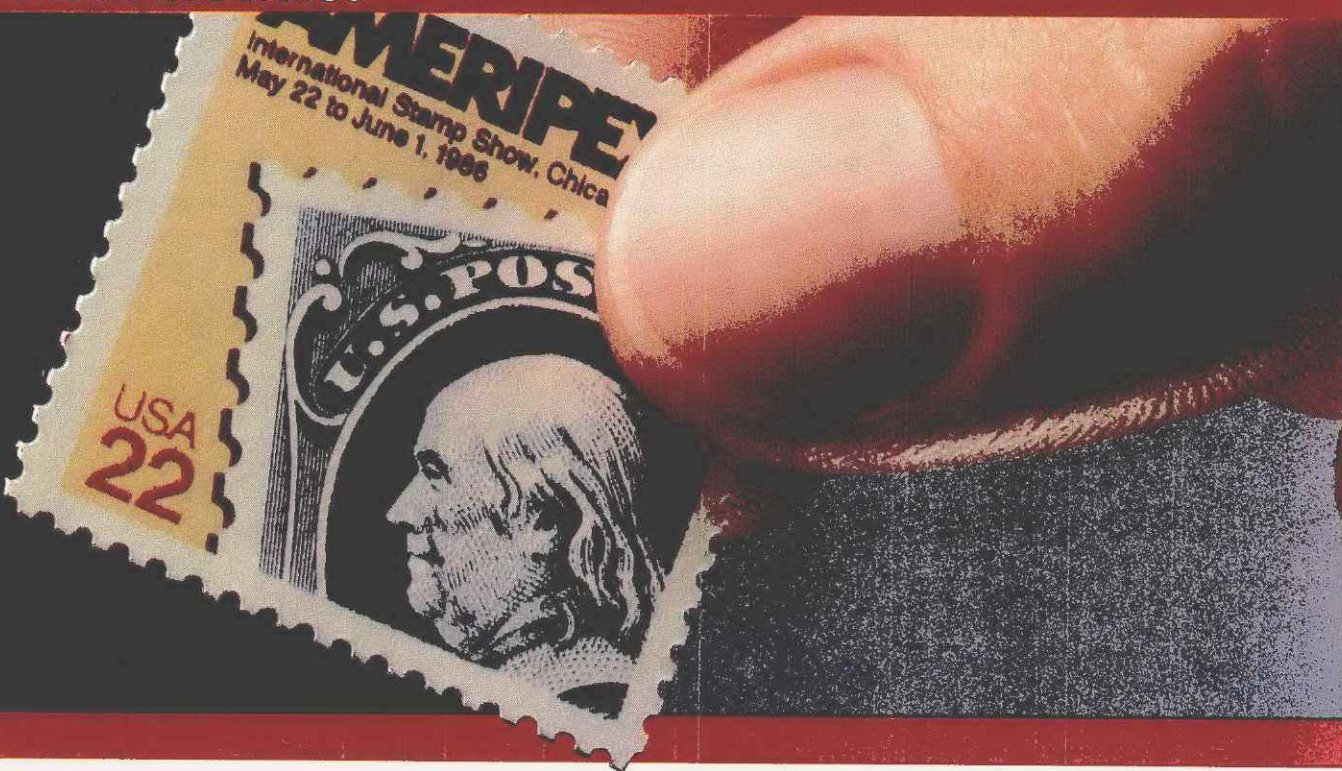
First of Georgia is a subsidiary of GeorgiaUS Corp. of Atlanta, which also owns a life insurer, a computer services company and a financial services company. GeorgiaUS Corp. is a Nationale-Nederlanden unit.

New international office

Arthur J. Gallagher & Co., the insurance brokerage and risk man-

Continued on facing page

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Continued from preceding page
agement services firm based in Rolling Meadows, Ill., has opened an international division in London.

The new division, operating from the offices of Arthur J. Gallagher & Co. (U.K.) Ltd., will coordinate Gallagher's international business operations conducted in London, Bermuda, Brussels and Providence, R.I., according to company President Robert Gallagher.

Colin Formby, former chairman of Sedgwick Risk Management Services Ltd., is deputy chairman of the international division.

Gallagher's international offices are responsible for brokering insurance and reinsurance for worldwide clients and for providing risk management services.

"Each office has its own role to play, but the operations are now coordinated under a common direction and a common strategy," Mr. Gallagher explained.

Rhulen acquisition

The Rhulen Agency Inc. of Monticello, N.Y., has acquired the animal mortality division of New Jersey-based Jay-Mar Group Ltd.

Rhulen, which ranked 22nd in *Business Insurance's* annual survey of the largest U.S. brokers, specializes in livestock-related coverages that last year accounted for a large part of the agency's \$16.2 million in gross revenues (*BI*, June 24).

Jay-Mar, a managing general agency in Mahaw, N.J., is now concentrating its marketing efforts on commercial trucking and property/casualty business.

In addition to livestock coverages already provided through Rhulen, policyholders now can seek race track liability, equine surgery, equine liability, stallion infertility and other animal mortality coverages.

Gloria Garn, special accounts service manager at Rhulen, will provide service for brokers that previously dealt with Jay-Mar.

Ohio plan to expand

Community Mutual Insurance Co., the largest Blue Cross/Blue Shield plan in Ohio, is expanding its operations to the entire state.

The company, marketing coverage through agents and brokers, says it will offer "a complete product line with Blue Cross & Blue Shield coverage, life insurance, health maintenance organizations, third-party administration and dental coverage" in the state's 88 counties.

Previously, Community Mutual had sold Blue Cross coverage in 42 Ohio counties and Blue Shield coverage in 83 counties.

"It is a natural progression for Community Mutual to market statewide since our consolidation," said Lawrence Weier, vp and corporate secretary.

Community Mutual was formed in late 1984 as the result of the consolidation of Hospital Care Corp., a Cincinnati-based Blue Cross plan and Ohio Medical Indemnity Mutual, the Worthington, Ohio-based Blue Shield plan.

Community Mutual currently has 2.5 million policyholders with a projected premium income of more than \$1 billion this year.

Metropolitan purchase

Metropolitan Life Insurance Co. has completed its previously announced purchase of Albany Life Assurance Co. Ltd. in Hertfordshire, England, and other U.K.-based subsidiaries of American General Corp.

Canada had been the base of Metropolitan's international financial services operations before its acquisition of Albany Life.

Albany Life, a life insurance underwriter, had assets of \$520.7 million as of June 30.

John J. Creedon, president and chief executive officer of Metropolitan Life, said the acquisition marks the beginning of a more active role in international operations for Metropolitan in the United Kingdom and continental Europe.

Acquisitions/mergers

Johnson & Higgins, the nation's third-largest broker, has acquired **Durall-Silberer Inc.**, an insurance agency in Anchorage, Alaska, and the **Stephan Agencies** in Columbus, Ohio.

New offices

The law firm **Knapp, Petersen & Clarke** in California has moved to 4000 MacArthur Blvd., Newport Beach, Calif. 92660; 714-851-8600.

The Columbus, Ohio, office of **The Wyatt Co.**, the actuarial and consulting firm, has moved to 65 E. State St., Suite 2100, Columbus, Ohio 43215; 614-469-1241.

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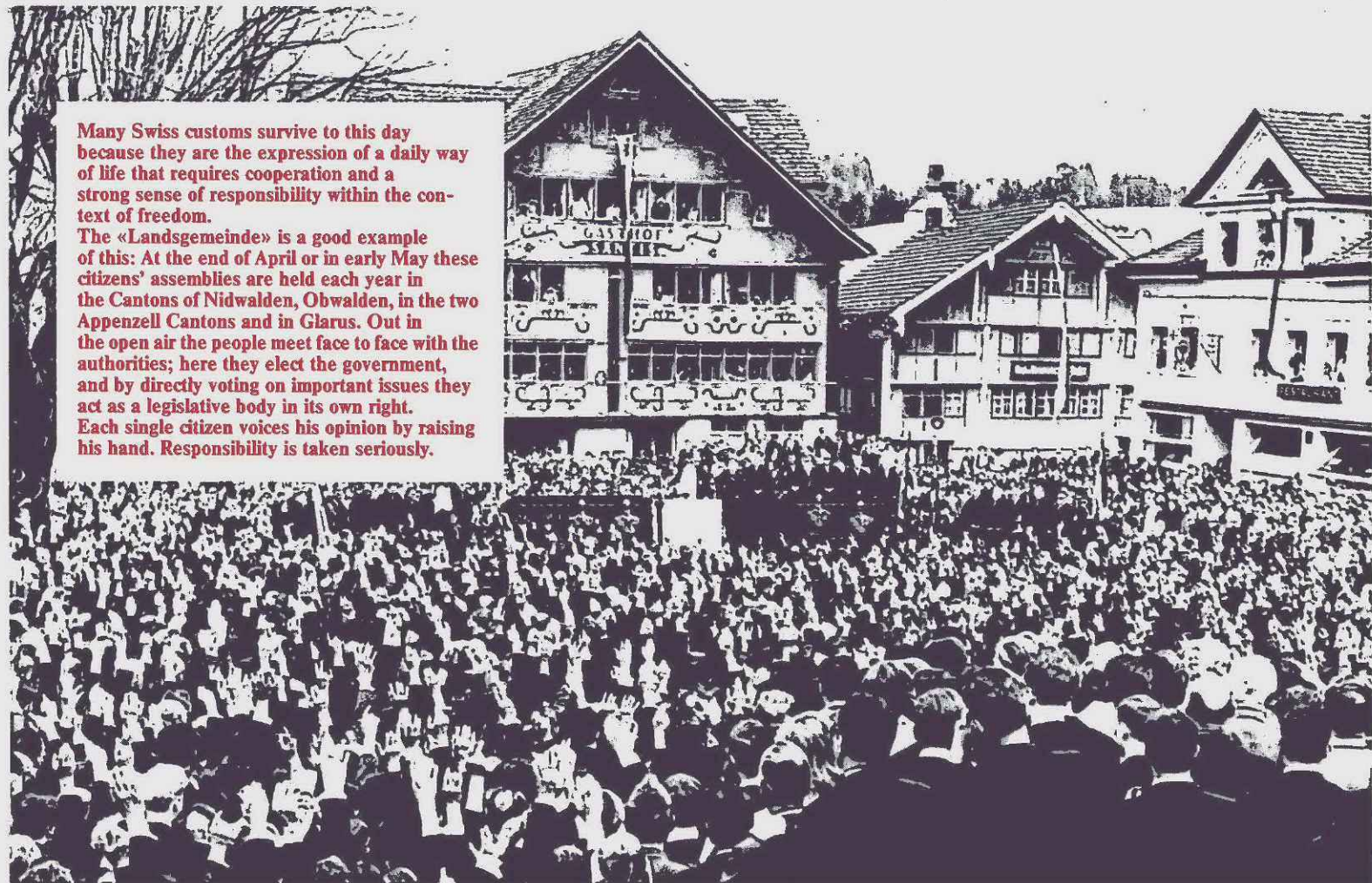
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Many Swiss customs survive to this day because they are the expression of a daily way of life that requires cooperation and a strong sense of responsibility within the context of freedom.

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Stress-related injury ruled compensable in Colorado

around the states

DENVER—An employee's illness or injury stemming from job-related stress is grounds for collecting workers compensation, according to a recent ruling by the Colorado Supreme Court.

In the decision last month, the Colorado high court agreed that a Boulder, Colo., firefighter suffered job stress so severe that it eventually contributed to a fatal heart condition.

The case now will be returned to the Industrial Commission of Colorado for further consideration.

"We are satisfied that job-related mental or emotional stress may cause an injury or occupational disease which will support an award for an ensuing disability or death

resulting from the injury or occupational disease," wrote Chief Justice Joseph Quinn in the high court's unanimous decision in the case, *City of Boulder vs. Barbara E. Streeb*.

This ruling "clarifies" interpretations of on-the-job stress to include emotional strain that is related to a worker's job and not necessarily the result of a job requirement, according to Barre M. Sakol, Mrs. Streeb's attorney. Mr. Sakol is with the Boulder law firm of Thorburn, Sakol & Thorne.

"The decision was well thought

out and well reasoned," Mr. Sakol said.

"And I think that it recognizes that if stress is indeed work-related then there's no reason why it should not be compensable," he added.

The opinion is based on the case of Ronald Streeb, a lieutenant in the Boulder Fire Department. Mr. Streeb had worked at the department for 11 years before his death on Nov. 16, 1979.

According to the opinion, testimony from the Boulder Fire Chief, co-workers of Mr. Streeb and his widow established that Mr. Streeb suffered "a great deal of tension and frustration relating to his work."

For example, in 1978, Mr. Streeb applied for the position of fire chief and was rejected.

Several employees junior in rank to Mr. Streeb had been promoted ahead of him and his proposals for improved department efficiency were ignored, according to the high court.

The court decision broadens the definition of what is incident to employment, said Edwin L. Felter Jr., director of the state's division of hearing officers in the Department of Administration.

According to the ruling, if an activity is sufficiently interrelated to the conditions under which the employee performs his or her job functions, that activity can be characterized as incident to employment, even if it does not benefit the employer.

If the Industrial Commission of Colorado ultimately decides the case in favor of Mrs. Streeb, she will be eligible to receive two-thirds of her husband's weekly wage at the time of his death or the maximum wage of \$173.60, according to a claims supervisor at the State Compensation Insurance Fund, the Denver-based state fund that insures public and private employers and was Boulder's workers compensation insurer.

"It basically boiled down to whether it was or it wasn't job-related stress," said Mary Ann Whiteside, assistant attorney general and counsel for the Industrial Commission of Colorado.

"It was the same type of stress that any (employee) is subjected to," she said.

"You don't always get what you want," she added.

The impact of this ruling on future stress claims is still being assessed by the commission, Ms. Whiteside said.

However, one employer/employee group already predicts that the number of stress-related work comp claims will increase as a result of the decision.

"I think that we'll be seeing a number of increasing cases of stress-related cases, very definitely resulting in higher workers compensation premiums," said Dick Moore, director of Governmental Regulations for the Employers Council. The council is a Denver-based association of 900 employers dealing with employer/employee relations.

And, proving that an employee's stress was self-induced and not job-related will be "enormously more difficult" for employers, Mr. Moore said.

"When you have five different physicians testifying that the job did or did not cause the stress, who do you believe?" he asked.

However, the court's ruling still

Continued on next page

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Continued from previous page requires claimants to prove that the stress does exist, that it is work-related and that it is the cause of the physical problems, according to Mr. Sakol.

"It's difficult to anticipate, but I don't see a floodgate of insurance cases," he said.

While stress claims were relatively rare in Colorado 10 years ago, now they comprise about 5% of all workers compensation claims, said Mr. Felter of the Department of Administration.

"I think employers and the insurance industry are quick to push the panic button and predict disaster when it's not coming," Mr. Felter said.

HMO regulations

TALLAHASSEE, Fla.—A new Florida law requires health maintenance organizations to contribute \$10,000 to an HMO rehabilitation fund to aid financially troubled HMOs.

Some \$240,000 already has been collected from the state's 24 licensed HMOs under the law, which took effect Oct. 1.

The amount in the rehabilitation fund could increase to \$500,000, since the state currently has applications pending for licenses from 31 other HMOs.

In addition to establishing the rehabilitation fund for HMOs, the new law:

- Raises surplus requirements for HMOs to \$100,000 or 5% of an HMO's total liabilities.

- Requires HMOs to fully inform subscribers of their rights and responsibilities under HMO contracts, in clear language that will be subject to approval by the Florida Insurance Department.

- Prevents HMOs from disenrolling subscribers because of their age or the state of their health.

- Requires HMOs to provide their subscribers with a list of their primary care physicians and hospitals.

- Requires HMOs to pay for emergency services rendered outside their service area to subscribers.

- Gives the state Department of Health and Rehabilitative Services access to medical records of HMO subscribers to help it monitor the quality of care being provided by the HMOs.

- Requires HMOs to distribute a buyer's guide listing the advantages and disadvantages of membership in an HMO. The buyer's guide is being prepared by the Insurance Department.

- Makes the operation of unlicensed HMOs a third-degree felony, subject to a maximum sentence of five years in prison and/or a \$5,000 fine.

Previously, such violations were classified as misdemeanors, and they were subject to a maximum sentence of one year in prison and/or a \$1,000 fine.

Work comp reform

SPRINGFIELD, Ill.—What appears to be a minor amendment to the Illinois workers compensation statute is being labeled by a business leader as a major first step toward improving the administration of the state system.

Under the new amendment, Illinois employers will report to the Illinois Industrial Commission only those work-related injuries that result in a loss of more than three working days.

Current law requires those reports be filed for all injuries that result in a loss of more than a single workday.

The new provision will reduce substantially the number of accident reports employers must file, leading to significant cost savings and providing a manageable number of reports filed with the Illinois

Industrial Commission to create an accurate statistical data base on work-related accidents, according to Lester W. Brann Jr., president of the Illinois State Chamber of Commerce.

With adequate funding, the IIC can use these reports to generate statistics on the state's total workers compensation caseload, providing a better basis for setting future workers compensation policies, Mr. Brann said.

The Chamber's next step is to urge the governor and legislators to provide funding so these statistics can be compiled, according to Mr. Brann.

The amendment was part of S.B. 447, which was signed by Gov. James Thompson last month. It took effect immediately.

The amendment was one of the key recommendations urged by the Illinois Alliance for Economic Initiatives, an affiliate of the state Chamber.

The alliance is a coalition of con-

cerned citizens, associations and government representatives dedicated to improving Illinois' business climate and economic growth (BI, May 27).

Maine comp head

AUGUSTA, Maine—Ralph L. Tucker has been appointed as the new chairman of the Worker's Compensation Commission in Maine.

Mr. Tucker is assuming the five-year term as chairman from Charles D. Devoe, who is resigning after 5½ years as chairman (BI, Aug. 5).

Mr. Tucker has served as a work comp commissioner in Maine for the past four years.

Prior to that, he was a union attorney and employee counsel with the law firm of McTeague, Higbee & Tucker in Brunswick, Maine.

Mr. Tucker has an undergraduate degree in political science from Hobart College in Geneva, N.Y.,

and a law degree from the University of Maine School of Law in Portland.

Mr. Tucker said he will continue the current direction of the administration, which is to develop a vocational rehabilitation plan and to emphasize informal dispute resolutions.

He also is committed to keeping the workers compensation system intact, or "keeping the ship together—to see that the underlying agreement struck in 1916 doesn't come unglued." He was referring to the no-fault aspects of state workers compensation systems.

"I want to make sure we keep the system and not throw it out," he said.

Liquidation planned

DES MOINES, Iowa—Representatives from state guaranty funds were scheduled to meet in Chicago late last week to coordinate how they will pay claims against Iowa

National Mutual Insurance Co., which was placed in liquidation Oct. 10.

Iowa National, which writes various property/casualty insurance lines, including auto liability, workers compensation, commercial multiperil and homeowners insurance, has about 330,000 policyholders.

The 76-year-old Cedar Rapids, Iowa, insurer was placed in rehabilitation Sept. 19, while the Iowa Insurance Department searched for a buyer of all or part of the company (BI, Sept. 30).

However, "there was no buyer willing to take on the liability," according to Iowa Insurance Commissioner Bruce Foudree.

Mr. Foudree estimates that the insurer has a deficit of \$40 million to \$60 million.

Iowa National, which reported net written premiums of \$129 million in 1984, is licensed in 35 states and active in 15, according to A.M. Best Co. ■



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FOR SOMETHING THAT
STARTED LONG BEFORE
HE WAS HIRED?**



Herman

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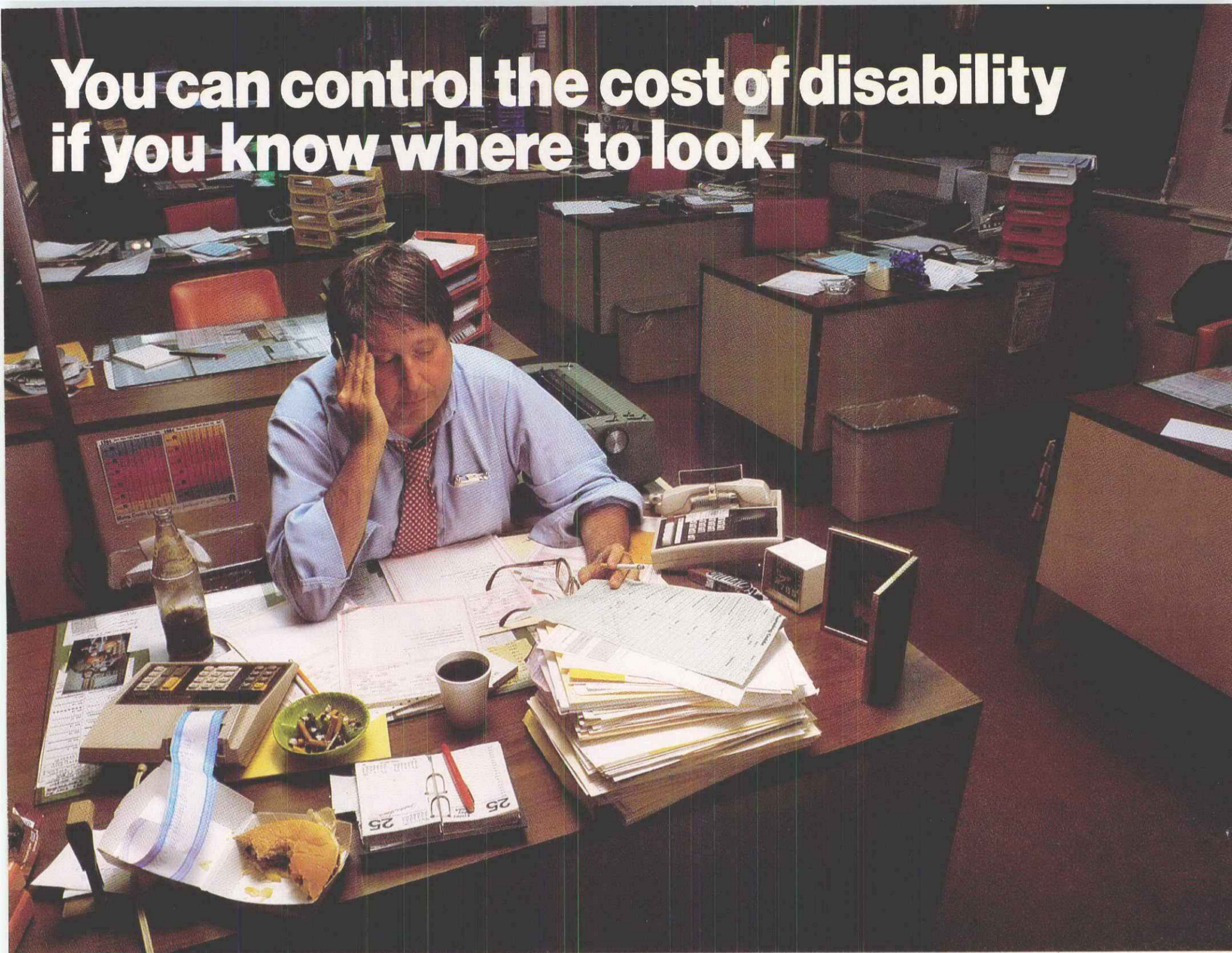
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SURVIVAL STRATEGY

Risk managers must take action to cope with hard market

By Bernard M. Brown

THE DIFFICULT property and liability insurance market in which all of us find ourselves today requires a risk manager to adopt different strategies if his or her organization is to maintain a sound risk-financing and insurance program.

Obviously, some strategies or steps should have been taken a few years ago, before the current crisis. Nevertheless, there are a number of programs and ideas that can be implemented now to help lessen the effects of the current hard market.

Our view is that a risk manager must undertake a number of steps simultaneously, including communicating realistically to management and field personnel; considering restructuring of the organization's insurance and risk-financing program; assessing the appropriateness of other alternatives, such as self-insurance and captive insurers; determining whether it makes sense to switch insurance brokers; and beginning to develop a strategic plan for risk management, which will help position the organization for the next crisis.

Communication

During the last hard market in 1975-79, many risk managers lost their jobs not because they were inept, but because they failed to communicate effectively to their managements. Those who did communicate effectively kept their jobs or managed to move on to even better positions at other organizations.

Putting a risk manager's self-interest aside, effective communication also helps the organization focus on insurance market problems and provides the foundation for a reasoned approach to solving problems.

One risk manager, Steve Scammell of GAF Corp., believes strongly in a number of corporate and divisional communication devices. For example, he circulates appropriate articles regarding insurance to top management. He also prepares an annual report that shows premiums and losses by line of coverage, provides a realistic assessment of the current status of his program and points out what needs to be done during the next year.

All of this serves to condition top management, so they are not surprised should insurance problems begin to develop.

As for communications to divisions, Mr. Scammell believes that division management needs to know how much they are being charged, and why, for various insurance and risk-financing

programs. This requires basic written communication followed up by personal visits or telephone conversations, where appropriate.

As many risk managers know so well, some corporations are managed on a decentralized basis. To avoid communication with decentralized units is tantamount to committing corporate suicide.

Insurance restructuring

In a hard insurance market, the risk manager may be faced with restructuring the organization's risk-financing and insurance program. John Keyser and Norman Barham of Johnson & Higgins believe that restructuring is much easier to accomplish if the risk manager pays attention to certain details, including:

- Recordkeeping. Use a personal computer to maintain and update underwriting data regarding the organization—premiums, losses, exposures, revenue, location of plants and other operations, etc.

'There are various ways an insurance program can be restructured, including the use of self-insurance for certain lines of business previously insured, giving back "throw ins" to reduce premiums, assuming higher retentions and carefully considering policy wording changes.'

- Knowing your markets. Risk managers should keep a file on which insurers provide coverage, particularly for difficult types of risks.

It also is important to meet the underwriters and to educate them about the risk manager's organization.

Mr. Barham recounts the story of a risk manager who was uninformed about his organization's risks when asked a question by a lead London underwriter. This made a bad impression on the underwriter, which hurt the organization in terms of available capacity and reasonable pricing.

- Engineering and other services. In addition to the insurance coverage provided, it is important to obtain commitments regarding engineering and other services.

- Security. Given the chaotic condition of the insurance and reinsurance industry, it is important that risk managers look for quality, in terms of financial stability, when they consider various insurance underwriters. There is great pressure to keep costs down, particularly when premiums are escalating as rapidly as they are today. However, particularly for "long-tail" business, it is critical that the risk manager place his or her organization's coverage with underwriters of top-flight security.

Keeping the above basics in mind, there are various ways in which an organization's insurance program can be restructured. These include the use of self-insurance for certain lines of business previously insured, giving back "throw ins" to reduce premiums, assuming higher retentions, and carefully considering policy wording

changes—that is, are wording changes absolutely necessary, or does it make sense to live with what the underwriter wants in order to maintain capacity and reasonable premium?

Finally, if the organization is restructuring its insurance program, it is important that the risk manager involve others within his or her organization during the decision-making process. Certainly, a risk manager's superiors will want to be involved and to be kept informed.

But, also bring in others from various departments within the organization: Perhaps someone from the legal department, accounting department or even divisional personnel who know operations could be helpful during the restructuring process.

Alternatives

Two alternatives that a risk manager should consider during this hard market are the use of a captive insurer and whether it makes sense to switch

insurance brokers.

Captives have enjoyed cyclical growth that parallels hard markets within the property and liability insurance industry. The last great surge in captive growth came between the mid-1970s and the early 1980s as a direct result of the crisis in certain liability coverages, such as workers compensation, products and medical malpractice.

Subject to some recent developments with respect to income taxation, it is likely that captives again will see a resurgence in growth during the next few years.

There are various types of captive insurers, but the four main categories are:

- Single-parent, owned by one organization.
- Association or group, owned by an association on behalf of its members, or by the members themselves.
- Rent-a-captive, in which the captive of some other organization is used to fund the risks of the organization requiring coverage.
- "Joint venture" captives, a type of association captive wherein the insurance broker or agent takes a position along with the other owners that require insurance coverage.

A captive may work through a fronting company that issues policies and provides services wherever they are needed, or the captive may write "direct" and contract separately for services. The most important services required by captives usually are considered to be policy issuance, claims adjusting, reinsurance and excess insurance to protect the captive, and administration, such as management, accounting and legal services.

A number of domiciles, both onshore and offshore, cater to captive insurers. According to Spencer Traver of American Risk Management Inc., Vermont is the leading onshore captive domicile and Bermuda is the leader offshore. The Cayman Islands provides strong competition for Bermuda offshore, particularly with regard to association, medical malpractice and joint venture captives.

The explosive growth of captives in the middle to late 1970s caught the attention of various tax and regulatory authorities. While hope lingers on, it generally is conceded by tax experts that there are very few tax advantages for single-parent captives.

For associations, tax deductibility exists for premiums paid by members, which makes an attractive alternative. And, of course, if the captive is deemed a "non-controlled foreign corporation," such as an association captive, and is located in a domicile with no income tax, such as Bermuda or the Caymans, then no U.S. income tax is payable on earnings until repatriated.

Regulators also have taken a harsh stand with regard to captives: To the extent possible, they attempt to limit how a captive may operate within a particular state and also require fronting companies to have letters of credit issued to protect the fronting company in case of captive insolvency.

Captives also have been criticized because of their ventures into third-party, "outside" business. A number of captives, particularly those associated with oil companies, have shut down their outside business departments, which has brought criticism from the traditional insurance and reinsurance industry.

However, the criticism should run both ways, since many prominent reinsurers and insurers also have withdrawn from various markets, most notably from syndicate investments on the New York Insurance Exchange.

For the most part, captive business emanating from internal risks tends to be properly rated. As a result, captives have enjoyed success with writing their parents' business.

Looking into the near future, we see a number of developments for captive insurers.

First, middle-market companies—those with sales of \$50 million to \$250 million—may find a single-parent captive, despite the lack of tax advantages, to be less expensive than traditional insurance protection.

As Steve Scammell points out, depending upon the effective tax rate of a corporation, the lack of any particular tax advantage may not detract from the captive alternative.

Second, we see growth in the group and association captive area. This is particularly true for the "joint venture" captives.

Third, there may be some type of tax backlash as a direct result of insurance industry problems. That is, legislation may be submitted that would give back

Continued on next page



Bernard M. Brown is a principal with Risk Strategies Inc. in Darien, Conn.

Violent death not 'accidental,' court rules

The Supreme Court of Virginia ruled, in a suit for death benefits under a group life insurance policy, that an insured's death was not "accidental" where he voluntarily initiated the violent course of conduct that ended in his being shot to death by his son.

Everett M. Tucker was insured under a group life policy naming his wife as the beneficiary. He was fatally shot on Nov. 23, 1979, by his 15-year-old son.

Mr. Tucker was mean, unpredictable and frequently bullied his family when he was drinking. He was drinking on the day of his death, and an altercation took place between Mr. Tucker and members of his family. The son got his 12-gauge shotgun and called to his father to stop. Mr. Tucker approached the son, who fired without aiming, and Mr. Tucker was killed.

Mrs. Tucker filed a claim for accidental death benefits. The insurer refused payment. Mrs. Tucker sued, but lost in the trial court.

The appellate court said that Mr. Tucker voluntarily initiated the violent course of conduct that ended in his death. According to the court, when Mr. Tucker saw for the first time that his son found his actions so dangerous as to require armed intervention, he should have anticipated that failure to cease aggressive movements would cause him serious bodily harm.

Thus, the court concluded that Mr. Tucker's death was not accidental within the meaning of the insurance policy. *Tucker v. Life Insurance Co. of America*, Supreme Court of Virginia, Sept. 7, 1984 (BI/04/S.-\$5).

Employer action criticized

Where an employer "winked" at the practice of its employees cleaning drums while the machine was turning, the misconduct of the employees resulting in injury did not constitute disobedience of a work "rule" and was not "willful misconduct," the Supreme Court of

legal briefs

Tennessee ruled.

In this case, a trial court denied Thomas Bryan workers compensation benefits on the grounds that his injury was due to his own willful misconduct.

Mr. Bryan operated a 100-foot-long laminator. During its operation, he noticed a build-up of lacquer on the drum. He attempted to clean it with a single-edge razor blade, which he held against the drum while it was turning. His arm was caught by a drive gear, and he was seriously injured.

Although the employer had advised against cleaning a machine while it was in operation, the safety rule frequently was ignored, and the employee's supervisors were aware that operators habitually ignored the rule.

On appeal of the denial of benefits, the appellate court said that disobeying a rule was not willful misconduct where the rule was habitually disregarded with the knowledge and acquiescence of the employer.

The court concluded the employer's winking at the disobedience precluded it from asserting willful misconduct as a defense to the compensation claim.

Bryan v. Paramount Packaging Corp., Supreme Court of Tennessee, Oct. 1, 1984 (BI/02/O.-\$5).

Connection between job, injury

The "positional risk doctrine" holds that an accident arises out of employment when the connection between the employment and the accident was such that the circumstances of the employment placed an employee in the particular place at the particular time that he was injured by a force not solely personal to him, a Wisconsin appellate court says.

Henry Klein, president of Applied Plastics,

apparently was murdered by a disgruntled employee who had abducted him at gunpoint and attempted to extort \$15,000 from him. Before the murder, Mr. Klein had been in the habit of picking up the employee on the way to work. The employee also killed himself.

Mr. Klein's minor son, through a guardian, filed for workers compensation death benefits. Benefits first were denied. But, the state commission granted maximum benefits, which a trial court sustained.

Applied Plastics and its insurer, U.S. Fire Insurance Co., appealed. In the appeal, the employer disputed the conclusion that the fatal injuries arose out of Mr. Klein's employment and were sustained while he was performing services incidental to his employment.

But, the appellate court said an injury is compensable if it would not have happened except for the fact that the conditions or obligations of employment placed the employee in the position in which the accident occurred.

"All that is required," the court emphasized, "is that the conditions of employment create the 'zone of special danger' out of which the injury arose."

The court said the fact that Mr. Klein had a practice of picking up the employee on the way to work and had an interest in seeing that the employee arrived at work was sufficient to support the conclusion that Mr. Klein was performing services growing out of and incidental to his employment. The award was affirmed. *Applied Plastics v. Labor and Ind. Rev. Comm.*, Court of Appeals of Wisconsin, Oct. 25, 1984 (BI/01/O.-\$5).

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

Risk managers must act to survive the hard market

Continued from previous page

some of the tax advantages that recently have been eliminated for both captives and self-insurers.

Fourth, we see continued reinsurance and fronting problems. If there is no aggregate or excess reinsurance protection to limit captive losses, then the captive alternative becomes very risky indeed.

Also, fronting companies are more reluctant to deal with captives, since they have their hands full with traditional business. This implies it will be more difficult for a captive to structure a program that meets various state insurance requirements.

The second alternative considered by many risk managers is whether it makes sense to change insurance brokers and to remarket the organization's insurance program. In general, organizations tend to change insurance brokers for two reasons: market conditions or incompetence.

Putting aside the question of incompetence, the current hard market may require special expertise not available within the brokerage firm now handling an organization's insurance program.

Or, alternatively, a broker may have special market clout that gives it an advantage over other brokers now servicing the organization.

Generally speaking, the larger insurance brokers tend to thrive in hard markets, at the expense of their smaller counterparts.

When selecting a new insurance broker or brokers, it is important to prescreen a number of likely candidates. This involves reviewing credentials, the

size and depth of the staff and any special expertise the broker can bring to bear.

For corporations, we usually recommend the interview method of selecting one or more brokers to market an organization's insurance program. The interview method involves the following steps:

- Identifying five or six likely broker/agent candidates.
- Providing the candidates with basic information about the organization and its insurance program.
- Having the candidates present their credentials and suggested ideas to a team for the organization.
- Establishing criteria for the organization's team to assess the various candidates.
- Selecting one, and usually no more than three, brokers to actually remarket or restructure the insurance program.

A second method, which we recommend for government entities or other non-profit institutions, is what we call the questionnaire method of selecting one or more insurance brokers. This involves having the five or six candidates fill out a lengthy questionnaire regarding their services, capabilities and suggestions for insurance program or market restructuring.

This usually is followed by an interview with the candidate. The questionnaire provides a useful reference so that the decision process is understood fully by those who might choose to review the process at a later time.

When the insurance program is remarketed through the one to three candidates selected, it is important that each broker receive specific market assignments with respect to

underwriters. Otherwise, the organization runs the risk that some underwriters may balk at providing coverage, since more than one broker is presenting the risk.

The remarketing should be accompanied by detailed specifications as to what the organization currently has in terms of exposure, revenues and other underwriting detail. An underwriting submission with sketchy information is not well-received.

Very importantly, the specification should state what the organization believes to be the best or most-likely risk financing and insurance program. Creativity should be encouraged from the brokers and underwriters submitting bids.

In most cases, no one bid submitted is best for all the loss exposures of an organization, particularly the large ones. Therefore, it is important that the organization have the power to pick and choose among the various programs that are submitted, so that the combination best fits what is needed.

This should be understood beforehand by all of the bidding brokers, since a losing broker may not release a market if he does not wish to help the winning broker.

All things considered, the selection of a new broker and the remarketing of an insurance program is a tedious process.

Under the best of circumstances, it usually takes at least two to three months. And ideally, the timing should involve four to six months of planning, negotiation and bid review.

Strategic planning

During a hard insurance market, it

often is difficult for a risk manager to look ahead and begin planning for the next crisis.

Nevertheless, those risk managers who now find themselves with unforeseen problems can well appreciate how important it is to institute a risk management strategic planning process.

Ward Ching of Reed Risk Management believes that risk managers should establish goals within the framework of an organization's overall operating and financial goals.

The risk manager should set objectives, establish procedures and, in general, take a positive and proactive approach to planning.

As Mr. Ching states so well, risk managers should be "market makers," not "market takers." He believes, and we concur, that all organizations should create a strategic plan for risk management.

The current market crisis is unpleasant for risk managers. Their jobs were easy during the last few years, when rate decreases and expansions in coverage could be had merely for the asking.

Those risk managers who didn't plan for, or didn't anticipate, the quickness and severity of the market turn now are scrambling to maintain some semblance of a reasonable risk-financing and insurance program.

Those who did anticipate probably also are scrambling, but not to the same extent.

Also contributing to this article were Stephen Scammell of GAF Corp., Norman Barham and John Keyser of Johnson & Higgins, Ward Ching of Reed Risk Management and Spencer Traver of American Risk Management.

Bieber is named president of Ebasco unit

Robert M. Bieber has been promoted to president of Ebasco Risk Management Consultants Inc. in New York, a subsidiary of Ebasco Services Inc. and a wholly owned subsidiary of Ensearch Corp.



Mr. Bieber

He succeeds **Bruce H. Suter**, who retired.

Mr. Bieber, who joined Ebasco in 1982 as manager-client services, was appointed vp in June. He was named to the *Business Insurance* Risk Management Honor Roll in 1981 when he was risk manager of Westchester County, N.Y.

Other supplier changes:

Bruce E. Buchanan Sr. promoted to president of Independent Employee Consultation Services of Ebasco Inc., a subsidiary of New York-based Ebasco Risk Management Consultants Inc. Mr. Buchanan, formerly vp of INDECS, served as claims manager and director of third-party administration operations.

T. Donald Smith joins Huggins Financial Services Inc. in Philadelphia as vp in the merger and acquisition/reinsurance unit. Mr. Smith previously was manager of national accounts at Penn Mutual Life Insurance Co.

James M. Rusine named vp at Dun & Bradstreet Plan Services in Tampa, Fla. Mr. Rusine previously was South Texas marketing manager at Aetna Life & Casualty Co.

Ruth Ann Hadley joins Health Cost Consultants Inc. in Fairfax, Va., as director of review services. Ms. Hadley previously was executive director of the National Capital Medical Foundation.

Insurers

G. Wayne Crawford will become president and chief executive officer of Industrial Risk Insurers in Hartford, Conn., effective Dec. 12. He succeeds **Jack W. Cates**, who is retiring.

Mr. Crawford, who has been with IRI for more than 30 years, most recently served as executive vp. Mr. Cates, who had been president of IRI since 1976, has been with the company for 44 years.

Robert A. Puccinelli named chairman and chief executive officer of San Francisco-based Industrial Indemnity Co., a Crum & Forster Inc. unit. Mr. Puccinelli, formerly president of Industrial Indemnity, succeeds **Robert C. Gowdy**, who has resigned. Mr. Puccinelli also served as manager of the company's Pasadena division and as manager of field operations in the home office. He was elected senior vp in 1973 and executive vp in 1983.

Metropolitan Life Insurance Co. has restructured its corporate management office:

Stewart G. Nagler, executive vp in charge of pensions and other functions, appointed to executive senior vp in charge of multiple business lines. Also promoted and named to the corporate management office was **Ted Athanasiaides**, promoted to executive vp-pensions from senior vp-pensions; **John D. Moynahan Jr.**, promoted to executive vp-group operations from senior vp-group life and health operations; **William G. Poortvliet**, promoted to executive vp in charge of the corporate actuarial, corporate controller's, corporate structures and tax departments from senior vp and chief actuary.

Frederic W. Richter named vp-underwriting at Citizens Insurance Co. of America in Howell, Mich., a unit of Hanover Insurance Cos. Mr.

Richter, who joined Citizens in 1961, previously was manager of commercial casualty underwriting and an underwriter in personal and commercial lines. He replaces **Philip Frakes**, who was elected president of the Beacon Insurance Co. of America and American Select Insurance Co. in Westerville, Ohio, also of the Hanover Group.

Also at Citizens, **Roger H. Gardner** named vp-claims. Mr. Gardner has served as national claims manager for The Hanover Insurance Co. in Worcester, Mass.—another member of the Hanover Group—since 1981.

Agents/brokers

J. Bransford Wallace has been named chairman of Corroon & Black Corp.'s Brokerage Services

comings & goings: industry

Group in New York. Mr. Wallace, who is also the BSG's chief executive officer as well as a senior vp of the parent company, has been the group's president since 1980. Mr. Wallace joined a predecessor firm of Corroon & Black in 1954.

In addition, **Richard A. Maxwell** has been named president of the Brokerage Services Group, succeeding Mr. Wallace. Mr. Maxwell, who is also the BSG's chief operating officer, had been executive vp.

Also, **James M. Corroon** and **John R. Lamberson** have been named executive vps of the group. Mr. Corroon, who is director of the BSG's Eastern Region, will now also be responsible for growth and

development of the group's employee benefits business. Mr. Lamberson, who is director of the group's Pacific Central region, will be responsible for the BSG's growth and development in the construction industry.

Reinsurance

John T. Webb joins NWNL Reinsurance Co. in Minneapolis as senior vp. Mr. Webb, who will be responsible for the company's direct facultative and treaty underwriting operations, most recently served as senior vp and senior underwriting officer at Mead Reinsurance Co.

George A. Edwards named se-

nior vp and treasurer of Intere Intermediaries Inc. in New York. Mr. Edwards, who joined the company in 1983, most recently was vp and head of the market security department. Also at Intere, **Kenneth R. Fewell** named senior vp of the Atlanta branch. Mr. Fewell, who joined the company in 1971 and most recently was vp, continues as manager of Intere Atlanta.

Excess/surplus

David W. Sanders named vp-property/brokerage at Atwater McMillian Inc. in St. Paul, Minn., the surplus lines unit of The St. Paul Cos. Mr. Sanders, who joined St. Paul Fire & Marine Insurance Co. in 1969, most recently served as regional underwriting director-general commercial insurance. ■

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Survey of CEOs

Continued from page 3

- Greater use of medical facilities because more diseases are treatable and curable, 15%.
- Expansion of Medicare, 12%.
- Private health care coverage that is too generous, 10%.
- Collectively bargained health benefit programs, 10%.

The chief executive officers also said companies could do more to contain rising health care costs. Only 33% said their company has done all it reasonably can do to manage those costs.

But, 89% said health care cost containment will become a more important issue for their company's top management during the next few years. And, 75% said their company plans to exert much more influence on health care providers over the next five years.

They also expect to exert more influence on their employees to control health care costs. Seventy-three percent said their employees probably would be paying a higher share of their health benefit costs by 1990.

"Signs point to more employee involvement, both financially and personally, and to providers receiving more pressure to reduce costs," Mr. Beadle said.

The high cost of health care also is affecting the price employer charge for products and services, the survey shows. Sixty-four percent of the chief executive officers said high health care costs have resulted in higher prices for their company's products and/or services.

If health care costs are to be contained, it will be due mostly to the efforts of employers, not the federal government, survey respondents say.

Some 59% of the CEOs said that either employers or coalitions of employers and providers will have the greatest effect on health care cost containment by 1990.

Only 16% said the federal government would be the major player in the health care cost-containment game.

"The CEOs express little faith in the government as the primary solution to the health care cost problem," the survey's authors say. "Rather, they tend to believe that the private and public sectors need to work together."

Some 87% of the respondents agreed that "the private sector must work actively with the government to control the country's health expenditures and assure its citizens of quality medical care."

However, 89% oppose government-regulated pricing of medical treatment.

Sixty percent of the respondents believe that the advent of large, diversified multihospital systems will have a positive effect on the quality and cost of health care in the future. And, 87% said increased competition among hospitals would have either a significant or a moderate effect on containment of health care costs during the next five years.

While 91% said health promotion programs can help control health care costs, an equal number said preventive health care is being underutilized as an approach to cost-containment.

"(The CEOs) believe that employers need to work on two fronts to control medical costs: one, the use of health promotion, wellness and preventive programs, which they believe will cut costs; the other, a partnership between government and the private sector to assure affordable medical care for all citizens," the survey's authors say.

Some 46% of the CEOs said their companies sponsor a wellness or disease-prevention program, and 38% said they are planning or considering such a move.

Only 4% said they have decided

against instituting a wellness or disease-prevention program. Twelve percent said they have not considered such a move.

Although the majority of the CEOs support wellness programs in theory and almost half already have implemented such programs, the survey found that many of the CEOs are unaware of whether these programs are saving their company money.

For example, although 46% said their company sponsors a wellness program, 62% of those CEOs said they were not sure how the program has affected their costs.

A smaller percentage—32%—said they were not sure how it has affected employee relations. Most said it has improved relations with employees.

Similarly, 58% of those that offer an alternative delivery system said they were not sure how it has affected their health care costs.

Some 68% of the CEOs said their company offers its employees the

option of joining a health maintenance organization, and 21% offer the option of joining a preferred provider organization.

In addition to wellness programs and alternative health care delivery systems, the chief executive officers reported a number of other cost-containment initiatives either in place or under consideration at their companies. These included:

- Encouraging the use of ambulatory surgery facilities: 71% said they have done so, and 18% said they are planning or considering such a move.

- Shifting some costs to employees: 67% said they have done so, and 23% said they are planning or considering such a move.

- Encouraging the use of health maintenance organizations or other alternative delivery options: 49% said they have done so, and 27% said they are planning or considering such a move.

- Implementing a utilization re-

Continued on next page

Employers' views on cost containment

	Strongly agree	Agree	Disagree	Strongly disagree	No opinion
Company has done all it reasonably can do to manage benefit costs.	4%	29%	58%	8%	1%
By 1990, employees probably will pay substantially higher share of benefit costs.	12%	61%	23%	1%	3%
Health care cost containment will become more of a top management issue.	21%	68%	9%	0%	2%
Company plans to exert much more influence on health care providers.	19%	56%	14%	1%	10%
Rising cost of health care is reflected in higher prices for products and/or services.	15%	49%	25%	4%	7%

Source: Mercer-Meindinger Survey

Chart: Amy Palmer

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Continued from previous page
view program: 47% said they have done so, and 39% said they are planning or considering such a move.

- Establishing a hospital pre-admission program: 46% said they have done so, and 35% said they are planning or considering such a move.

- Joining coalitions of other employers to work together on cost management: 45% said they have done so, and 21% said they are planning or considering such a move.

- Negotiating rates with providers: 44% said they have done so, and 32% said they are planning or considering such a move.

- Reducing health benefit coverage: 42% said they have done so, and 15% said they are planning or considering such a move.

- Offering employees several price options for health care benefits: 25% said they have done so, and 33% said they are planning or

Almost three-fourths of the CEOs said their company offers medical coverage to its retirees.

considering such a move.

- Sponsoring a flexible benefit program: 14% said they have done so, and 45% said they are planning or considering such a move.

On the issue of who should pay for medical care for the poor and the aged, the chief executives were divided. Some 35% of the respondents said that state governments should pay for medical care for the poor, and 28% said the federal government should pay for the cost of this care.

Some 24% said individuals should pay higher provider fees to subsidize care for the poor, and 13% said

the hospitals should absorb these costs.

However, regarding medical care for the aged, only 10% said the state government should pick up this tab. Thirty percent said the federal government should pay, 24% said the costs should be borne by the individuals or their families, 15% said employer-sponsored retirement plans should pay the bill, and 21% suggested some other source of funding.

Medical care for the aged is becoming a significant issue for many U.S. companies, and some of the CEOs are looking at the options open to their companies in this area.

"The aging U.S. workforce, increasing longevity, the unwillingness of courts to allow reductions in post-retirement medical benefits and the shifting of costs from Medicare to the private sector are creating significant liabilities for employers offering health care benefits to retirees," say the survey's au-

thors.

Almost three-fourths of the chief executive officers said their company offers medical coverage to its retirees.

However, only 40% of those executives said their company has analyzed the future cost of this benefit to determine if they should pre-fund for their eventual liabilities, as they do with their pension liabilities.

However, the survey's authors point out, "In many cases, respondents indicated in marginal comments that their retiree medical coverage is entirely employee-paid, and therefore (they) do not expect any company obligation to pay the future cost of these benefits."

At the companies that have considered the future cost and financing of retirement health care programs, most of the CEOs say they expect to make retirees pay more for their coverage or reduce benefits, rather than eliminating retiree coverage or requiring active em-

ployees to prepay for their retirement coverage.

Some 72% of the respondents said they would require retirees to pay more for their coverage, and 43% said they would reduce post-retirement benefits.

Only 8% said they would restrict coverage to existing retirees and end the program for future retirees. And, 28% said they would expect active employees to prepay for their retiree coverage.

Nearly three-fourths of the respondents said that their company's concern about increased private-sector responsibility for retirees' health coverage would prompt them to complain to Congress about the shifting of costs from Medicare to private employers.

Copies of the survey, "Employer Attitudes Toward the Cost of Health," are available free from William M. Mercer-Meidinger Inc., Marketing Department, 2600 Meidinger Tower, Louisville, Ky. 40202.

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Michigan regulator backs tort reform

LANSING, Mich.—A former science teacher, recently appointed to the post of Michigan insurance commissioner, will support legislative solutions to the current liability insurance capacity crisis.

Liability coverage for hospitals, physicians, restaurants and tavern owners in Michigan is at a critical point, said Herman W. Coleman, who was appointed insurance commissioner Oct. 9 by Gov. James J. Blanchard. That appointment is waiting Senate confirmation, which could come as early as next month.

"There has to be a legislative solution this session...and I will be involved," Mr. Coleman said.

Currently, the Michigan Legislature is considering caps on tort awards, formulas to set limits on attorneys' fees and a state fund for liability insurance, he said.

Mr. Coleman said the philosophy of letting the market take care of itself will not prevail in this crisis, and that is why he is supporting legislative action.

Besides dealing with the liability insurance crisis, Mr. Coleman says he plans to boost the image of the Michigan Insurance Bureau.

He said he will work to restore the insurance industry's confidence in the bureau's ability to regulate the industry objectively and to make the bureau a positive resource for all aspects of the industry.

Mr. Coleman, 46, replaces Nancy A. Baerwaldt who resigned as insurance commissioner in September (BI, Sept. 2).

He most recently served as a management consultant to the National Education Assn. in Washington. He also held the posts of executive director for the Rhode Island Education Assn., where he developed a self-funded insurance trust; assistant to the Secretary of the U.S. Department of Education, an appointment made by former President Jimmy Carter; executive director of the Michigan Education Assn., a position he held for seven years, after serving three years at the MEA as associate executive director for minority affairs; and a school administrator of several urban affairs projects in Rochester, N.Y.

The Michigan native also taught science at the junior high and high school level, was a coach, community school director and counselor-coordinator of neighborhood projects in Muskegon, Mich. He has an undergraduate degree from Alcorn State University in Lorman, Miss., where he majored in biology, chemistry and mathematics. He also has a graduate degree in school administration from Eastern Michigan University in Ypsilanti.

Software program screens medical claims

products & services

A new software program designed for screening corporate medical claims before payments are made to hospitals is available from Health Systems International, a New Haven, Conn.-based corporation specializing in software for the health care industry.

The Clinical Claims Editor allows self-insured employers to verify that hospital payments are based on accurate clinical data by evaluating the accuracy of hospital medical claims, identifying inconsistent information, assigning the correct diagnosis-related group and supporting quality data analysis, the company says.

The software simultaneously examines a hospital claim's principal diagnosis, any secondary diagnoses, surgical procedures, age, sex and discharge status of a patient to as-

sure clinical consistency, according to the company.

Clinical Claims Editor software can evaluate all 12,000 diagnoses and 4,000 procedures from the ICD-9-CM (International Classification of Diseases-9th Revision-Clinical Modification) code books.

The software can be purchased for an IBM Personal Computer or other compatible computers. Clinical Claims Editor software also can be used with IBM mainframe computers and can be integrated into an existing claims-processing system.

Prices range from \$16,000 for personal computer software to \$125,000 for mainframe software.

The software also can be leased on an annual basis for half the purchase price.

For more information on Clinical Claims Editor, contact Walter Wieners, Director of Corporate Cost Containment, Health Systems International, 100 Broadway, New Haven, Conn. 06511; 203-562-2101.

Policy for retailers

A tailor-made insurance policy specifically geared to retail merchants' property/casualty exposures is available from The Atlantic Cos. in New York.

The Atlantic Cos.' Merchants Insurance package provides special-

ized coverage under a single policy for hardware stores, nurseries, food stores, clothing stores, household appliance stores, drug stores, stationery stores, luggage and leather goods stores, florists or any merchant that sells goods for personal or household consumption and renders services incidental to the sale of these goods.

The package policy can provide property, liability, crime, automobile and umbrella coverages.

The package's features include:

- Coverage for loss of business income, with limits up to \$100,000 for combined earnings and extra expense losses.
- Contingent loss of business income extension.
- Personal property extension, including theft of jewelry, watches and furs up to a \$15,000 limit.

- Broadened building coverage, including coverage for attached additions and extensions, exterior glass, fences and outdoor signs.

- Consequential loss to personal property caused by changes in temperature or humidity.

- Broad water damage coverage, including surface water, seepage and sewer and drain backups.

- Inflation-guard adjustment for buildings and personal property.

- Broadened personal property coverage (including interior glass and window displays), and personal property of others (including customers' goods) in the merchant's care, custody or control.

- Broad-form comprehensive general liability coverage including contractual liability, broad-form property damage, employees as insureds, extended bodily injury liability, host liquor liability, incidental malpractice coverage and non-owned watercraft liability coverage. The liability coverage, which requires no deductibles and is written on an occurrence basis, can be written with limits of \$300,000, \$500,000 or \$1 million.

- All-risk legal liability coverage for damaged real property covered up to \$100,000.

- Personal injury and advertising injury liability coverage.

- Loading and unloading coverage.

- Optional hired and non-owned automobile liability coverage.

Additional options include umbrella liability and workers compensation coverage.

For more information on the package, contact an independent agent or broker that represents Atlantic.

Insurance newsletter

A newsletter service that reports on new insurance-related legislation is now published by NILS Publishing Co. in Chatsworth, Calif., a unit of ABC Publishing Cos.

The monthly INSight Service features synopses of insurance legislation introduced in all 50 states, dealing with all insurance lines and all facets of the insurance business, including reinsurance, policy provisions, filing requirements, agency business, and trade practices.

In addition, INSight features articles pertaining to legislative trends, industry-related controversies and landmark legal interpretations of insurance laws.

The publication also reports regularly on proposed regulations and newly issued bulletins, circular letters and attorneys general's opinions.

Included with every issue is IN-Status, a chart that reports the current status of each bill summarized in INSight.

All subscribers to INSight Service also receive the NILS NAIC Report, published twice a year following the National Assn. of Insurance Commissioners' winter and summer meetings.

Included in the report is coverage of all open sessions at the meetings.

The cost of INSight Service is \$240 per year. For sample copies or more information, contact the NILS Publishing Co., 20675 Bahama St., Chatsworth, Calif. 91311; 800-423-5910; 818-998-8830 in California.

Cost-containment plan

A comprehensive group cost-containment program for employers seeking to control health care costs is available from Mutual of Omaha Cos. in Omaha, Neb.

The Take Charge program is a *Continued on facing page*

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business insurance

Continued from facing page series of cost-reduction packages that can be purchased by small and large employers and can be combined with existing Mutual of Omaha plans.

Through incentives that encourage cost-effective treatment alternatives, Take Charge provides a direct method of reducing the cost of group insurance by up to 10%, according to Richard J. Sampson, executive vp-group division.

"We feel the Take Charge plan will be effective, not only because of the benefit package, but also because of the emphasis we have placed on employee communication, which is usually the key to effective cost-containment programs," Mr. Sampson said.

Mutual of Omaha has developed support materials designed to stress to employees the importance of choosing health care options that will result in quality care and reduced costs. These materials include an outline of the program in employees' certificate booklets, pamphlets describing program benefits and plans for payroll stuffers and posters.

The cost-containment package includes:

- Take Charge I, which is a package of cost-containment incentives already included in Mutual of

Omaha's group plans for up to 200 employees. Higher reimbursement levels are paid if employees choose health care alternatives such as pre-admission testing, second surgical opinions, outpatient surgery, home private duty nursing and home health care.

- Take Charge II, which features incentives that reward certain health care choices but in some instances provides deterrents for not making those choices. Cost reductions are achieved through directing the location and timing of services. Mandatory second surgical opinions and outpatient surgery, weekend admission disincentives, a birthing center benefit and an emergency room treatment deductible are among its features.

- Take Charge III, which is an option that offers plan benefit modifications for additional rate credits. Among its provisions is one that requires employees to meet a deductible for each hospital admission.

- Take Charge IV, which will be available soon to groups of 36 or more employees, seeks to control unnecessary hospitalization. Employees must receive advance approval for elective hospital admissions, and their treatment will be monitored for cost effectiveness throughout the hospital stay.

Take Charge is being marketed through all of Mutual of Omaha's 23 regional group offices and its agencies. For information, contact any Mutual of Omaha regional office or agency.

Ergonomics services

Ergonomics, the science that seeks to adapt working conditions to the employee, is now among technical services offered by NATLSCO, National Loss Control Service Corp., a Kemper Group subsidiary in Long Grove, Ill.

Through ergonomic studies, improper employee work habits and harmful working conditions that may result in occupational injuries can be reduced.

Two ergonomic services to be offered by NATLSCO include:

- Ergonomic survey, which involves a plant or office walk-through to identify potential injury exposures due to improper work methods and work station designs that could result in body stress. General recommendations are formulated to reduce those exposures.

- Ergonomic study, in which a NATLSCO consultant videotapes worker habits that indicate repetitive motion and improper body positioning, as well as working conditions of each pre-selected job. A written report with still photographs, also produced as part of the service, sequences the job steps and identifies injury-prone positions.

Ergonomic recommendations are subsequently formulated to reduce or minimize the injury exposure. The videotape is also edited to correspond with the written report and can be used for future training of safety personnel and employees.

For information on NATLSCO's ergonomic services, contact Sharon Falkenburg at NATLSCO, 800-323-9585, extension 2231.

benefit beat

Bath Iron Works contracts combine health care plans

New contracts negotiated by Bath Iron Works Corp. with two unions combine major medical and hospitalization coverage into one comprehensive insurance plan and incorporate several health care cost-containment provisions.

Previously, health care coverage for Local 6 and Local 7 of the Industrial Union of Marine & Shipbuilding Workers of America and The Bath Marine Draftsmen's Assn. included separate major medical and hospitalization benefit plans, said Lillian Thomas, employee benefits administrator for Bath Iron Works, a shipbuilder in Bath, Maine.

The previous hospitalization coverage was underwritten by Prudential Insurance Co. of America; the major medical plans were underwritten by Blue Cross and Blue Shield of Maine.

The hospitalization policy provided first-dollar coverage; the major medical plan required workers to pay a \$100 deductible for individual coverage a \$200 deductible for family coverage and 20% of expenses exceeding the deductible, with no maximum out-of-pocket limit.

The new plans, underwritten by Blue Cross and Blue Shield of Maine, also require workers to pay deductibles of \$100 for individual coverage and \$200 for family coverage, plus 20% of expenses exceeding the deductible.

However, the new health care plans cap out-of-pocket expenses for the employees at \$300 for individual coverage and \$600 for family coverage.

Under the new contracts, covering 5,000 workers, lifetime maximum medical benefits also are raised to \$250,000 per person from \$150,000 under the previous plans.

Bath Iron Works will continue to pay the entire medical premium for employees and their families.

In addition, the new contracts also incorporate health care cost-containment provisions and wellness incentives.

For example, employees now are required to obtain second surgical opinions for 10 selected common surgical procedures, such as cyst re-

moval and knee surgery. Employees who ignore this requirement will receive only 50% of the benefits for which they otherwise would be eligible, according to Ms. Thomas.

Employees who have pre-admission or post-discharge tests performed on an outpatient basis will be reimbursed for 100% of the costs of those tests, regardless of whether the employees have met their deductible.

Similarly, surgery performed on an outpatient basis will be reimbursed at 100%, with no deductible applied, Ms. Thomas said.

Generic drugs also will be reimbursed at 100%, but only after employees meet their deductibles, she said.

In addition, employees who are injured in an automobile accident while wearing their seat belts will be reimbursed at 100% for all ensuing medical expenses, with neither a deductible nor copayment required.

In addition, the new contracts also establish a bill audit program that rewards employees who find overcharges in their medical bills with a cash payment equal to 50% of the error, up to a maximum reward of \$500.

To encourage wellness, employees will receive 100% reimbursement for expenses related to wellness, up to a maximum reimbursement of \$100.

Eligible expenses will include physical examinations, smoking cessation and weight control workshops and health club memberships.

Previously, the unions' contracts had no such cost-containment or wellness measures, Ms. Thomas said.

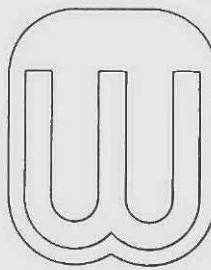
The new three-year contracts will be effective Jan. 1.

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 Diane Kastiel, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611; 312-649-5393.

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52008-0069; 414-786-6700.

● A free brochure from Alexander & Alexander Inc. explains how self-insured employers can purchase **coverage for major organ transplants** through a fully insured, supplemental policy. Write to Peter Kautz, Alexander & Alexander, Three Embarcadero Center, San Francisco, Calif. 94111; 415-434-1500.

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covering such topics as questions for doctors, dentists and surgeons; and other health and wellness tips. For a free brochure and business reply card, contact Larry Chapman, President, Corporate Health Designs, P.O. Box 55056, Seattle, Wash. 98155; 206-364-3448.

● A sourcebook summarizing more than 100 articles, books and studies on **vocational rehabilitation** is now available from the Workers Compensation Research Institute. "Vocational Rehabilitation in Workers' Compensation: Issues and Evidence" covers the success of rehabilitation, the importance of early intervention and the interaction of rehabilitation and litigation. The book is free to institute members, \$15 for non-members. To order, write to Workers Compensation Research Institute, 245 First St., Suite 402, Cambridge, Mass. 02141; 617-494-1240.

● The **pros and cons of self-insurance** are among the topics discussed in "Practical Self-Insurance, An Executive Guide to Self-Insurance for Business." The book outlines methods for conducting feasibility studies, provides advice on structuring a self-insurance program and tells how to implement an effective loss-prevention program. Copies are \$24.95 from Risk Management Press, P.O. Box 670, Inverness, Calif. 94937.

● **Wellness awareness** and how it has helped companies cut their health care costs is explained in a brochure from C.A.B. Consultants, an occupational health and wellness consulting firm. The brochure also describes a wellness program for employees that was prepared by the firm. The program includes courses on cancer prevention, cardiopulmonary resuscitation, nutrition, stress management and other health issues, and it incorporates a monthly employee health newsletter. Free copies of the brochure are available from C.A.B. Consultants, 503 N. Clayton, Hillside, Ill. 60162; 312-544-2087.

● "**Safety Program Assistance for Subcontractors**" is a how-to manual published jointly by Alexander & Alexander Services Inc., St. Paul Fire & Marine Insurance Co. and the American Subcontractors Assn. The manual provides accident charts, checklists and reports to maintain accurate safety records. Copies can be obtained for \$14 each from the American Subcontractors Assn./Colorado, 2150 W. 29th Ave., Suite 310, Denver, Colo. 80211; 303-455-7827

● Designing and administering **association-sponsored benefit plans** is discussed in "Topics in Employee Benefits for Association Executives—1985," a book offered by the International Foundation of Employee Benefit Plans. The proceedings of the organization's 1985 Employee Benefits Institute for Association Executives are discussed in the 74-page book, including economic problems and their causes, political problems and "extras" the plans can offer employees. The cost is \$15 for IFEBP members and \$25 for non-members. Copies can be obtained by writing to the Publications Department, International Foundation of Employee Benefit Plans, 18700 W. Bluemound Road, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

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Court reinterprets British insurance law

By MELISSA GRIGGS
ZOCOLILLO

LONDON—An unauthorized insurance company in Great Britain must honor the claims of its policyholders but cannot enforce contracts against them or its own reinsurers.

That ruling is the latest in a string of contradictory interpretations in the British High Court on Great Britain's 1974 Insurance Companies Act.

In his July ruling in *Phoenix General Insurance Co. of Greece SA vs. Halvanon Insurance Ltd.*, Justice J.P. Hobhouse of the Queen's Bench, High Court, held that contracts made by unauthorized insurers are not void in themselves but are enforceable only by innocent policyholders seeking claims payment.

For example, an unauthorized insurer cannot enforce its contract with a policyholder in order to collect unpaid premiums, under the ruling.

Also, an unauthorized insurer may not recover from its reinsurers, the justice ruled.

Phoenix General sought \$8 million in claims under reinsurance contracts made in London.

The insurer was engaging in aviation contingency business, which the court found it was unauthorized to do.

The Phoenix ruling was the third interpretation of the 1974 Insurance Companies Act and its 1977 amendments since late 1983. The act prohibits insurers, reinsurers and underwriting agencies not licensed by the Department of Trade and Industry from engaging in insurance business.

The solicitor for Phoenix says he is considering appealing the decision, which incorporates portions of both of the previous two interpretations of the insurance act in addition to adding new interpretations.

In October 1983, Justice Roger J. Parker ruled that all of the insurance contracts made by an insurer conducting business in Great Britain without authorization are illegal and void.

The decision, *Bedford Insurance Co. Ltd. vs. Instituto de Resseguros do Brasil*, rocked the London market.

While the decision prohibited the payment of claims to policyholders that had purchased coverage from unauthorized insurers or reinsurers through London underwriting agencies, it allowed offending insurers to keep premiums.

But, in April 1984, Justice Andrew P. Leggatt recognized "the amount of consternation and concern felt in consequence of the Bedford case in insurance and reinsurance markets in London and around the world."

He ruled in *Stewart vs. Oriental Fire & Marine Insurance Co.* that contracts of unauthorized insurers and reinsurers are not void and that those insurers must pay claims to their policyholders.

However, Justice Leggatt left open whether an unauthorized insurer or reinsurer could in turn enforce its contracts with other parties.

The High Court considered the Stewart case so important that it appointed the British attorney general as amicus curiae, or friend of the court.

"What we had were two conflicting opinions. Phoenix is following Bedford," said David Hooper, a solicitor with Pete Carter-Ruck and Partners. Pete Carter-Ruck and Partners represented Halvanon Insurance, the successful defendants, in the Phoenix case.

"In Bedford, the judge said, 'If

someone has broken the law, is that purely a matter between the state and the company, or does it mean there is an illegal contract?' The judge held there is an illegal contract," Mr. Hooper said.

Following that, Justice Hobhouse ruled that Phoenix could not rely on its own illegal conduct in making contracts to recover against its reinsurers. No unauthorized insurance company should be surprised that it cannot resort to the courts for assistance, Justice Hobhouse stated.

But Justice Hobhouse did not agree totally with the Bedford decision. He held that the illegality of an unauthorized insurer's contracts does not affect the whole transaction, only the insurer's part of it.

The effect, allowing an innocent policyholder to recover on claims, is the same as that in the Stewart case.

"In Stewart, the judge found the fact a company infringed the act does not mean its contracts are unenforceable," Mr. Hooper said. "Stewart took the attitude a crimi-

nal offense is a matter between the company and the states."

A decision by the Court of Appeal may be necessary to resolve the conflicting High Court rulings, according to solicitors involved in the cases.

"It is obvious an appeal would be desirable to resolve these issues. We now have a chain of cases in which the judges don't agree," said Phillip Sanders, a solicitor with Reaumont and Sons, which represented the successful policyholder in the Stewart case.

"What is the current state of the law? I would say it is in a tremendous state of flux," said Nick Stone, a solicitor with Elborne Mitchel and Co., which represented Phoenix.

Mr. Stone is contemplating appealing the case.

"It is my understanding that Mr. Justice Hobhouse held Mr. Justice Parker is more right than Mr. Justice Leggatt, but neither is entirely right," Mr. Stone said.

Mr. Stone also represented one of the parties in the Bedford case. ■

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Skandia's international unit will go public in Sweden

By JOHN PARRY

STOCKHOLM—Shares in Skandia International Holding A.B. will begin trading in Sweden Dec. 20.

Skandia Insurance Co. Ltd., Sweden's largest insurance company and one of the 10 largest reinsurers in the world, is selling 55% of its international division to the public.

Current shareholders of Skandia Insurance Co. are being offered a discounted price for shares in the newly formed Skandia International Holding. For every two shares of their Skandia Insurance Co. stock, they can buy one share of Skandia International at a cost of 90 Swedish kronor (\$11.33) per share.

The offer is valued at 540 million

Swedish kronor (\$68 million).

The sale price to the general public per share in Skandia International is set at 120 Swedish kronor (\$15.11).

Trading in the rights of current Skandia Insurance Co. shareholders began Oct. 23.

The largest single unit of Skandia's international business is its U.S. operation, Skandia America Group, which provides almost half of the total international premium income.

In 1984, Skandia America ranked as the seventh-largest reinsurer in the United States, reporting \$239 million in net premiums written.

Skandia Insurance Co.'s international business is mainly in reinsurance. International premiums, both health and life, are expected to total \$1.1 billion in 1985. Skandia International's shareholder's equity in 1984 was approximately \$500 million.

The international business this year is expected to produce a small profit compared with last year, when the business produced a loss of \$28 million.

Skandia Insurance Co. decided to spin off its international operations because "the international operations have reached such a size that efficiency and predictability are served by an independent situation vis-a-vis the Swedish direct operations and by a market quotation," the company said.

"Separation of the Swedish and international operations also gives the international operations increased possibilities of competing on equal terms with other international insurance companies. A more independent situation facilitates the establishment of complementary activities, which in turn can contribute to increasing effectiveness in the international marketplace."

The company also pointed out that the separation of domestic and international business will enable the Swedish operation to function unaffected by events in the international marketplace.

Skandia International Holding has filed for a listing on the Stockholm stock exchange's A1 list.

All 16 million shares in Skandia International have voting rights.

Responding to reports that some individual shareholders opposed the sale of Skandia International stock, a Skandia spokesman in Sweden said the objecting shareholders cannot muster enough opposition to block it.

A majority of Skandia Insurance Co.'s shareholders agreed to the sale, according to the company spokesman.

Skandia Insurance Co. has 11,000 shareholders, but one-third of its 12 million shares are held by three investors: Investment A.B. Beijer, A.B. Investor and Foervalnings A.B. Providentia.

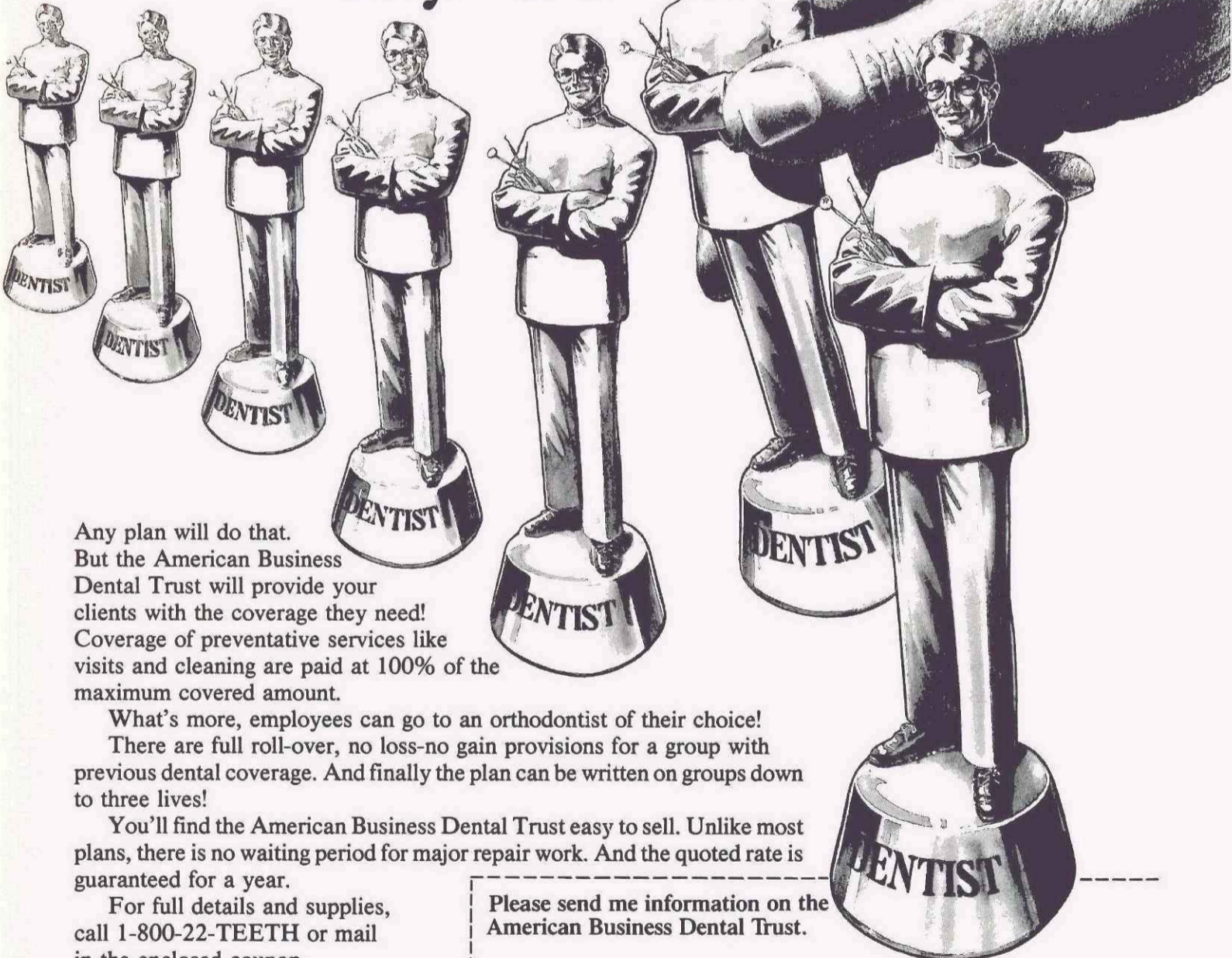
Meanwhile, shares of parent group Skandia Insurance Co. have dropped sharply in recent months. They now are quoted at between 235 and 240 Swedish kronor (\$29.59 and \$30.22), 30% below their Jan. 1 price.

But, the company spokesman said factors other than the international division deal have contributed to this drop.

"Our domestic results have been unsuccessful in 1985," he said. "Under the rules of disclosure in this country, we must make all figures available to the public, and this has pushed the share price down."

"I would say this rather than the debate over the international company is responsible for the weakening of the shares on the exchange."

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State actions

Continued from page 2

● Extending recent regulations limiting medical malpractice awards to other industries. The malpractice changes call for damage awards of more than \$250,000 to be paid in installments and impose penalties for lawsuits deemed frivolous.

The New York Coalition for Municipal Tort Liability & Insurance Reform also presented several legislative proposals to state senators earlier this month in an attempt to harness rising liability prices.

G. Jeffery Haber, executive secretary of the Assn. of Towns of the State of New York, a member of the coalition, said one proposal calls for municipalities to be rated separately from businesses to determine liability insurance prices.

He said loss statistics for municipalities and businesses are currently lumped together when liability rates are calculated for commercial and municipal coverages.

"We feel that if the municipalities are rated separately, the statistics would be more pertinent to the classification of business," noted Mr. Haber.

He said the coalition is also asking the Legislature to consider repeal of the joint and several liability doctrine for municipalities.

And, the coalition asked the Legislature to cap at \$150,000 per claimant and \$450,000 per occurrence the amount that could be recovered from public entities in personal injury cases.

The coalition also wants regulation of medical malpractice suits against municipalities. Like Mr. Corcoran, the coalition urges allowing settlements of more than \$250,000 to be paid in installments and penalizing frivolous suits.

The South Carolina regulation, effective Oct. 17, precludes insurers from canceling policies midterm unless:

- The policyholder fails to pay the premium.
- The policyholder misrepresents certain facts that would have caused the insurer to deny coverage in the first place.
- There is a substantial change in the risk that the insurer could not have foreseen or could not have been expected to contemplate when writing the policy.
- The policyholder breaches the insurance contract.

In addition, the regulation mandates that insurers give policyholders at least 30 days' written notice of non-renewal.

The regulation applies to all 600 admitted property/casualty insurers in the state.

"We had hoped we wouldn't have to take as strident an action as we did," said Insurance Commissioner John G. Richards.

But, he said, the new regulation was proposed after Lumbermen's Mutual Insurance Co. in Mansfield, Ohio, announced it was canceling the property and liability policies of 321 South Carolina-based entities Dec. 15. Policyholders include 193 churches, Mr. Richards said.

When the Legislature reconvenes in January, it may be asked to make the regulation law.

In a related matter, the South Carolina Commercial Property and Casualty Insurance Market Assistance Program is offering to help businesses find property and liability insurance.

The assistance program, which consists of 49 insurers that have volunteered to provide various liability coverages, has been in place since the beginning of September. It is being coordinated by the Independent Insurance Agents of South Carolina.

"There's no assigned risk," said an Insurance Commission spokesman. "It's a voluntary program with which we have attempted to help insureds get insurance."

In California, 26 insurers have

agreed to participate in the California day-care coverage plan, which is called CAL-CARE.

Any of the state's 40,000 licensed day-care providers that cannot find child-care liability insurance in the commercial market can apply for coverage to CAL-CARE. But, before applying, the day-care provider must have been rejected for coverage by two insurers.

Only child-care facilities are eligible for participation in the plan. Providers of day-care services for the elderly, physically or mentally disabled adults and foster home programs are not eligible.

Any licensed insurance agent or broker can help day-care operators apply to CAL-CARE. The plan has established a toll-free telephone number to answer questions and provide applications. The number is 800-428-8181.

The Independent Insurance Agents & Brokers of California will administer the program. Applications will be referred to a CAL-

CARE committee to place the risk with a participating insurer.

Applications must be accompanied by a non-refundable fee of \$25 for facilities with up to 12 children and \$50 for facilities with more than 12 children. This fee will pay the administrative costs involved in processing the application, because CAL-CARE is a non-profit organization.

Under the program, each participating insurer can develop its own policy form, rates, rating plans and underwriting guidelines.

In Colorado, the 26-member task force will examine Colorado's tort system, governmental immunity and liability, said Mark Grueskin, legal counsel to the governor.

The task force includes eight state legislators and 18 representatives from business, medicine, local government and insurance.

In May, Colonial Penn Insurance Co. of Philadelphia, which insures the state's general liability and automobile risks, declined to renew

the state's coverage. The state then moved to self-insure its risks (BI, Sept. 23).

After a series of public hearings, the results of the study will be forwarded to the general assembly "to develop a solid course of legislative action," Mr. Grueskin said. The general assembly reconvenes in January.

In Tennessee, Insurance Commissioner John C. Neff has asked that employers having difficulty retaining affordable commercial coverage call the department and provide information about the type of insurance they need, their insurer and agent, policy number and premiums.

"We will investigate their particular situations and see if we can help them find coverage or resolve some other problem," he said.

"We do not intend to become a price-shopping service, but we do want to know about any extraordinary price increases so that we can make certain consumers are being

treated fairly," Mr. Neff said.

For information or assistance, contact Allan Castle in the department's policyholders service section in Nashville at 615-741-2218.

And, in North Dakota, the Insurance Department will weigh information on municipal self-insurance pools for liability coverage.

Information being gathered by the Insurance Department, the North Dakota Assn. of Counties and the North Dakota Municipal League on creating a self-insurance pool is expected to be analyzed within the next few weeks, according to O.J. Olson, deputy insurance commissioner.

"The premiums that are being charged are outrageous and astronomical," Mr. Olson said, adding that in many cases, counties that go out to bid on coverage are not even receiving quotes from insurers.

This article is based on reports by Business Insurance reporters in New York, Chicago and Colorado.

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datebook

NOV. 1. "Risk Management of PCBs in Electrical Systems" course in Sacramento, Calif., sponsored by Electro-Test Inc.; \$95. Also **Nov. 4** in San Francisco; **Nov. 6** in Las Vegas, Nev.; **Nov. 18** in Salt Lake City; **Nov. 20** in Denver; **Nov. 22** in Albuquerque, N.M.; **Dec. 4** in San Diego; **Dec. 5** in Newport Beach, Calif.; **Dec. 6** in Los Angeles; **Dec. 10** in Phoenix, Ariz. Electro-Test Learning Center, P.O. Box 159, 3470 Fostoria Way, San Ramon, Calif. 94583; 415-866-8566.

NOV. 1. Current Trends in the Legal Environment of Workers Compensation seminar in New York, sponsored by the National Council on Compensation Insurance; \$110 for members; \$145 for non-members. Michelle Lajzer, NCCI Public Affairs Department, One Penn Plaza, New York, N.Y. 10119; 212-560-1026.

NOV. 3-6. "Avoiding and Managing Environmental Damage from Major Industrial Accidents" conference in Vancouver, B.C., sponsored by the National Safety Council, The Air Pollution Control Assn. and other co-sponsors; \$225 (\$300 Canadian) in advance; \$265 (\$350 Canadian) on-site. For information, contact Air Pollution Control Assn., Terry Ames, P.O. Box 2861, Pittsburgh, Pa. 15230; 412-232-3444.

NOV. 4. Controlling Workers Compensation Costs Seminar in Chicago, sponsored by the Illi-

nois State Chamber of Commerce; \$90 for members; \$135 for non-members. Also **Nov. 12** in Springfield, Ill. Carol Jensen, ISCC, 20 N. Wacker Drive, Chicago, Ill. 60606; 312-372-7373.

NOV. 4. Product Liability Avoidance for the Boat Manufacturing Industry seminar in Nashville, Tenn., sponsored by Corroon & Black Corp.; free registration limited to members of boat manufacturing industry. Also, **Dec. 6** in Orlando, Fla. Mary Jo Butts, Seminar Coordinator, Corroon & Black Corp., P.O. Box 1020, Nashville, Tenn. 37202; 615-367-9702.

NOV. 4-5. The 1985 London Insurance Conference in London, sponsored by Oyez International Business Communications Ltd.; 375 pounds (\$525). Mavis Gold, Oyez International Business Communications Ltd., Bath House (2nd Floor), 56 Holborn Viaduct, London EC1A 2EX 01-441-235-4080.

NOV. 4-6. Techniques of Finance and Accounting course in Montreal, sponsored by the Risk & Insurance Management Society's Continuing Education Program; \$445 for members; \$545 for non-members. Fran Jordan, Administrator-Continuing Education Program, R.M.S. 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

NOV. 4-6. Twelfth Annual Computer Security Conference in Rosemont, Ill., sponsored by the

Computer Security Institute; \$680 for members; \$730 for non-members; \$700 for additional non-members from same organization. Computer Security Institute, 43 Boston Post Road, Northborough, Mass. 01532; 617-845-5050.

NOV. 4-6. Advanced Risk Management Techniques seminar in Washington, sponsored by the Public Risk & Insurance Management Assn.; \$350 for members; \$400 for non-members. Dean Phelus, PRIMA, 1120 G St. N.W., Suite 400, Washington, D.C. 20005; 202-626-4650.

NOV. 4-8. Accredited Safety Auditor course in Atlanta, sponsored by the International Loss Control Institute; \$775.50. International Loss Control Institute, P.O. Box 345, Loganville, Ga. 30249; 800-554-6001; 404-266-2208 in Georgia.

NOV. 4-8. Advanced Reinsurance Practice course in London, sponsored by Risk Research Group Ltd.; 718.75 pounds (\$1,006.25). Judith Hobday, Risk Research Group Ltd., Bridge House, 181 Queen Victoria St., London, EC4V 4DD; 01-441-236-275.

NOV. 5-7. Basic Safety Management seminar in Boston, sponsored by the International Safety Academy; \$445; \$415 for three or more registrants from the same organization. Also **Dec. 2-4** in Houston. International Safety Academy, P.O. Box 8527, 1600 Arch St., 12 Tower, Philadelphia, Pa. 19101; 800-231-3147, 215-241-5800 in Pennsylvania.

NOV. 6. "Capacity: A New Dimension"—Atlanta Insurance Day '85 in Atlanta, sponsored by

the Alliance of American Insurers, the American Insurance Assn. and other Atlanta-area insurance organizations; \$30. Richard Welty, Aetna Life & Casualty, 4 Piedmont Center, 3565 Piedmont Road, N.E., Atlanta, Ga. 30305; 404-231-6752.

NOV. 6. Health Improvement/Prevention Workshop in New York, sponsored by the Health Research Institute; \$195. Also **Dec. 11** in Chicago. Workshop Coordinator, Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

NOV. 6. Advanced "Post-Graduate" Cost Containment workshop in New York, sponsored by the Health Research Institute; \$195. Also **Dec. 11** in Chicago. Workshop Coordinator, Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

NOV. 6. Medical Directors workshop in New York, sponsored by the Health Research Institute; \$195. Also **Dec. 11** in Chicago. Workshop Coordinator, Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

NOV. 6-7. Principles of Petroleum Insurance workshop in New Orleans, La., sponsored by the Professional Development Institute and Self-Insurance Resource Inc.; \$450. Also **Nov. 20-21** in Fort Worth, Texas. Jonathan Jeffrey, Professional Development Institute, P.O. Box 13288, NTSU, Denton, Texas 76203-3288; 817-565-2483.

NOV. 6-8. Successful Retirement Planning

Programs workshop in New York, sponsored by Retirement Advisors Inc.; \$450. Registrar, 919 Third Ave., New York, N.Y.; 212-421-2400.

NOV. 6-8. Marine Cargo Insurance seminar in New York, sponsored by The World Trade Institute; \$775; \$730 for each additional registrant from same organization. Registrar, The World Trade Institute, One World Trade Center, 55W, New York, N.Y. 10048; 212-466-4044.

NOV. 7. 37th Annual All Industry Day seminar in San Francisco, sponsored by the Northern California Chapter of the Society of Chartered Property & Casualty Underwriters; fees to be announced. Allen Leggett, Schroeter, White & Johnson, P.O. Box 1439, Oakland, Calif. 94604; 415-832-8300.

NOV. 7-8. Labor/Management workshop in New York, sponsored by the Health Research Institute; \$195. Also **Dec. 12-13** in Chicago. Workshop Coordinator, Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

NOV. 7-8. Chemicals in the Environment: Responsibility and Liability program in Washington, sponsored by The Environment and Safety Services Division, The Bureau of National Affairs and The Washington College of Law-American University; \$300 for BNA subscribers; \$325 for non-subscribers. Chemicals in the Environment Conference Registrar, BNA Conferences, The Bureau of National Affairs Inc., 2550 M St., N.W., Suite 699, Washington, D.C. 20037; 800-420-9890 or in Washington, 202-452-4200.

NOV. 7-8. Airport Safety and Liability conference in Columbus, Ohio, sponsored jointly by the Aviation Safety Institute, the law firm of Vorys, Sater, Seymour & Pease and the Ohio Department of Transportation; \$175 before Oct. 31; \$200 after Oct. 31. Ann Aylwin, The Aviation Safety Institute, Box 304, Worthington, Ohio 43085; 614-885-4242.

NOV. 7 and NOV. 13. The New Commercial Property and Liability Coverage and Rating Workshops two-day series in Hinsdale, Ill., sponsored by the Society of Chartered Property & Casualty Underwriters and the Insurance School of Chicago; \$125 for one day only; \$200 for both days. Insurance School of Chicago, 330 S. Wells St., Suite 202, Chicago, Ill. 60606; 312-427-2520.

NOV. 8. Fundamentals of Environmental Health seminar in Boston, sponsored by the International Safety Academy; \$185. Also **Dec. 5** in Houston. International Safety Academy, P.O. Box 8527, 1600 Arch St., 12 Tower, Philadelphia, Pa. 19101; 800-231-3147, 215-241-5800 in Pennsylvania.

NOV. 10-12. Casualty Actuarial Society 1985 Annual Meeting in Kansas City, Mo.; \$165 for members; \$190 for non-members. Albert Beer, Casualty Actuarial Society, One Penn Plaza, New York, N.Y. 10001; 212-490-3460.

NOV. 10-13. Annual Meeting of the National Assn. of Independent Insurers in Chicago; \$250 for members; \$350 for non-members; \$100 for spouses. For information, contact Registrar, NAII Convention Office, 333 N. Michigan Ave., Chicago, Ill. 60601; 312-782-2958.

NOV. 11. Loss Trends and Loss Control for Off-Road Contractors' Equipment seminar in Sturbridge, Mass., sponsored by the Inland Marine Underwriters Assn.; \$25. Also **Nov. 13** in New York; free. Dora Rothman, Inland Marine Underwriters Assn., 14 Wall St., New York, N.Y. 10005; 212-233-7959.

NOV. 11-13. 1985 Annual Meeting of the American Council of Life Insurance in Washington; \$200 for general session; \$125 for legal session; \$125 for investment session. American Council of Life Insurance, P.O. Box 37016, Washington, D.C. 20013; 202-862-4000.

NOV. 11-15. Fundamentals of Industrial Hygiene Monitoring course in Long Grove, Ill., sponsored by the National Loss Control Service Corp.; \$500; 10% discount for two or more registrants from the same company. For information, contact John Garis, NATLSCO, Long Grove, Ill. 60049; 312-540-2026.

NOV. 11-15. Modern Safety Management in Atlanta, sponsored by the International Loss Control Institute; \$695. Also **Jan. 13-17** in Atlanta. International Loss Control Institute, P.O. Box 345, Loganville, Ga. 30249; 800-554-6001; 404-466-2208 in Georgia.

NOV. 12. 1985 Insurance Conference in Chicago, sponsored by the Illinois CPA Foundation; \$150. For information, contact Illinois CPA Foundation, 1985 Insurance Conference, 135 S. LaSalle St., Suite 400, Chicago, Ill. 60603-4197; 312-346-7957 or 800-572-9850.

NOV. 12-14. Risk/Loss Control Management seminar in Philadelphia, sponsored by the International Safety Academy; \$475. Diane Donnelly, International Safety Academy, P.O. Box 8527, 1600 Arch St., Philadelphia, Pa. 19101; 800-231-3147, 215-241-5800 in Pennsylvania.

NOV. 14. Health and Safety Aspects of VDT Use conference in Chicago, sponsored by the Illinois State Chamber of Commerce; \$45 for members; \$70 for non-members. Carol Jensen, Illinois State Chamber of Commerce, 20 N. Wacker Drive, Chicago, Ill. 60606; 312-372-7373.

NOV. 14-15. A Brief Course in Fraud Prevention in New York, sponsored by The College of Insurance; \$225 for college sponsors; \$260 for others. Russel Fershleiser, The College of Insurance, One Insurance Plaza, 101 Murray St., New York, N.Y. 10007; 212-962-4111.

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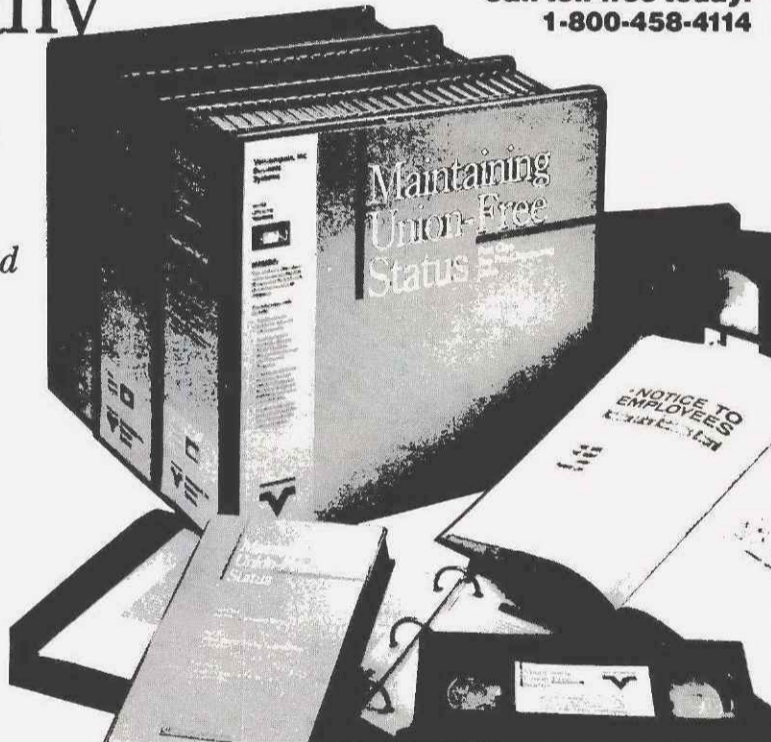
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Weavers form

Continued from page 2

bill for an equal amount of indemnity payments for risks covered by the Weavers form before filing a claim against the Weavers form.

Furthermore, all associated defense costs incurred after the primary policy is exhausted and before the Weavers policy is triggered will be borne by the policyholder.

In contrast, the Weavers overlying excess form will recognize the defense costs included within the limits of the Weavers first excess form as exhausting the underlying limits.

While the Weavers form will not follow the terms of the ISO form, both impose a retroactive date on coverage for claims, introduce separate aggregate limits for specific exposures and exclude, to varying degrees, coverage for pollution liability.

Mr. Tyndall pointed out that large U.S. policyholders would not be concerned that the Weavers form does not dovetail neatly with the ISO form because these companies typically self-insure their primary coverage.

Meanwhile, Weavers is slowly finding a following insurance market for the new form, despite the absence of leading Lloyd's of London underwriters. The Lloyd's underwriters plan to issue their own claims-made form in time for Jan. 1 renewals (BI, Sept. 23).

"There is not a big following insurance market," said Bowring's Mr. Tyndall. "But, there are signs in the last few weeks that underwriters are starting to follow the form. It is not a substantial following that we hoped for when the

form came out, but there are some signs of a formation."

Some non-leading Lloyd's of London underwriters are interested in following the Weavers form, sources say. In addition, other insurers showing interest include the British branch of Italian insurer Assicurazioni Generali SpA., Sovereign Marine & General Insurance Co. Ltd., a subsidiary of London broker Willis Faber P.L.C. and St. Katherine Insurance Co. P.L.C. in London.

Under the lead system, the lead underwriter sets the terms and usually the rates of a policy, and other insurers then agree to take a share of the risk, based on the conditions set by the lead.

"The form looks interesting, and we are interested in it," said a spokesman for St. Katherine. "If it meets our criteria for underwriting, then we would consider the risk on the Weavers form."

"I think it is a good move," said Bernard Sparke, underwriter for Generali in London. "There is no question that by January we want a claims-made form, so by and large I would support it."

But, Mr. Sparke added that using the Weavers form depends on the risk. A claims-made form is ideal, for example, for insuring the liability of a pharmaceutical manufacturer because the underwriter can manage the long tail.

But for the liability of a railroad, "it wouldn't make a row of beans," Mr. Sparke said. If there is a loss, the underwriter becomes aware quickly that there are going to be claims arising from it. All the railroads Mr. Sparke insures are on occurrence forms, he said.

"We have a saying in England:

It's horses for courses," Mr. Sparke said.

Although the current support for the Weavers form among following insurers is greater than the London market originally expected, it does not include leading Lloyd's underwriters.

These underwriters, including those at Merrett Syndicates Ltd., Janson Green Ltd. and Three Quays Underwriting Management Ltd., are creating their own claims-made excess liability form, but it has not been introduced yet (BI, Sept. 23).

These underwriters, along with Weavers' managing director Peter Wilson, are among the leading underwriters of North American casualty risks.

Mr. Wilson explained that on the first \$5 million excess layer, Weavers has basically the same following market it had under the old London umbrella form, which was written on an occurrence basis.

"There are a number of people following the form," he said.

While the companies coming to London for excess liability coverage are looking for limits of \$50 million, they probably will not find more than \$25 million.

"Today, you cannot complete more than \$25 million in liability coverage in London and the U.S. put together," Mr. Tyndall said.

Some argue that if Lloyd's would follow the Weavers form, there would be substantial capacity.

However, even without Lloyd's support, some brokers believe they can find the extra capacity they need on the Weavers form.

"The London companies market is beginning to move in the right direction," said one broker.

Added another London broker: "I am a broker. Whether or not I like the move to claims-made or the policies is irrelevant. I will sell the product. . . . But I admire Weavers. At least Weavers did something."



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update

Fireman's Fund stock a winner

Continued from page 2

Securities & Exchange Commission takes action against it on several reinsurance transactions now under investigation (BI, March 5, Nov. 19, 1984).

But the insurer said that if that happens, it intends to defend its method of accounting.

M&M revenues top \$1 billion

NEW YORK—Marsh & McLennan Cos. Inc., the world's largest insurance broker, recorded more than \$1 billion in gross revenues in the first nine months of 1985.

For the first nine months of 1985, M&M's gross revenues increased 21%, to \$1.005 billion from \$829.5 million for the same period in 1984. In all of 1984, New York-based M&M's total gross revenues were \$1.12 billion.

M&M's third-quarter gross revenues increased 28% to nearly \$351 million from \$274.7 million in third-quarter 1984.

For the first nine months of 1985, M&M's net income rose 293%, to \$126.2 million from \$32.1 million in the first nine months of 1984. The 1984 figure, however, reflects extraordinary charges stemming from unauthorized investment activities in the first quarter of 1984.

The brokerage's net income for third-quarter 1985 climbed 35%, to \$42.3 million from \$31.4 million in third-quarter 1984.

Gallagher reports rise in results

ROLLING MEADOWS, Ill.—Arthur J. Gallagher & Co. in Rolling Meadows, Ill., the 10th-largest U.S. brokerage, reported sizable jumps in income and revenues.

Gallagher reported that net income for the first nine months of 1985 rose 57% over last year, to \$8 million from \$5.1 million.

The brokerage's net income for the third quarter of 1985 rose 50%, to \$3.9 million in 1985 from \$2.6 million in 1984.

Revenues for the first nine months of 1985 increased 27%, to \$59.7 million from \$47.1 million in 1984. And, revenues for the third quarter rose 30%, to \$23.1 million from \$17.8 million in 1984.

OSHA may tap 3M health official

WASHINGTON—The Reagan administration may nominate John Pendergrass, an industrial hygienist at Minnesota Mining & Manufacturing Co., to be the new chief of the Occupational Safety and Health Administration, sources said.

Mr. Pendergrass would fill the top OSHA position, which has been vacant since Robert Rowland resigned earlier this year. Patrick Tyson, a veteran OSHA official, has been serving as acting OSHA administrator while the administration searches for a replacement for Mr. Rowland.

An OSHA spokesman said he believed reports about Mr. Pendergrass' possible nomination are accurate, but said the agency could not officially comment.

The appointment would be subject to Senate confirmation.



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New capacity

Continued from page 3

But a new D&O market, also a mutual company, is being formed for electric and gas utilities, as well as telephone companies.

Argus International Management Ltd., AEGIS's principal Bermuda manager, is in the process of establishing the company, which will be called Directors & Officers Liability Insurance Ltd., or DOLI.

DOLI, which expects to begin underwriting Jan. 1 in Bermuda, plans to offer \$10 million in D&O insurance to these three industries. Many of AEGIS' expiring D&O policyholders are expected to find replacement coverage with DOLI, Mr. Fortune says.

The coverage will be on a claims-made basis, and its terms and conditions will be similar to those of AEGIS. Policyholders will be individually rated, Mr. Fortune says.

The minimum retention for coverage when the corporation reimburses the director or officer will be \$200,000 while the retention for personal coverage to the directors and officers when the corporation may be unable to reimburse them will be \$5,000. The banking industry also is continuing its search for more capacity (BI, July 22).

Among these efforts is a soon-to-be completed study on how the nation's leading financial institutions

can use their own funds to obtain higher limits of D&O insurance and bankers blanket bonds at reasonable prices.

The project, which initially attracted the participation of 23 commercial banks, now has grown to include more than 40 institutions, according to Edith F. Lichota, chairman of the study committee and senior vp-risk management at Irving Trust Co. in New York.

The group paid \$175,000 to retain consultants at The Wyatt Co. in Chicago and attorneys at LeBoeuf, Lamb, Leiby & MacRae in New York to conduct the study.

Ms. Lichota expects to receive Wyatt's portion of the study shortly, and has scheduled a Nov. 8 meeting in Atlanta to discuss the findings with participating risk managers.

LeBoeuf, Lamb presented Ms. Lichota with its portion of the study, which addressed various antitrust, tax and incorporation issues, about two weeks ago in London.

A similar project for midsized banks is proceeding well, according to New York broker Johnson & Higgins, whose risk management services division is conducting the study. A J&H spokesman declined to discuss specifics at this point.

The American Bankers Assn. announced last week that it is looking into forming a captive insurer. The

study has been under way for about three weeks and is looking principally at D&O insurance and bankers blanket bonds. It should be completed in about 45 days, estimates Ronald Summerville, consultant at Wyatt in Washington, D.C., the firm conducting the study for the ABA.

"We expect even more severe problems at next renewal. If a captive is feasible, we'd like to see it up and running as quickly as possible," he says.

Bank associations in five Mid-west states are beyond the planning stage for finding new coverage.

BankInsure, an Oklahoma City insurer recently founded by the bank associations, is in the midst of negotiating reinsurance for D&O and, separately, for bankers blanket bonds coverages. Oklahoma City broker C.L. Frates & Co., which is organizing the insurer that was capitalized at \$3 million, is working with both domestic and non-U.S. reinsurers, but the brokerage is having a tougher time than anticipated. However, it expects the insurer to be operating in January in five states, according to Timothy O'Toole, a Frates account executive.

BankInsure is licensed in Oklahoma and North Dakota, two of the five states whose bank associations financed the company. License applications are pending in the other

three: South Dakota, Minnesota and Wisconsin, Mr. O'Toole says.

And, BankInsure may issue coverage to banks in other states in the future, Mr. O'Toole says. More than 790 banks have already expressed interest in the facility, he reports.

And, one group of banks is working to keep the capacity it has—by increasing communication with reinsurers.

The Independent Bankers Assn. of America, a group of 7,400 small to midsized community banks, wants to educate reinsurers about the differences between the exposures of community banks and the

large money-center banks.

The average IBAA-member bank has assets of \$29 million.

The group wants reinsurers to recognize that difficulties with D&O insurance and bankers blanket bonds do not have their roots in banks of this size, says Gary Teagno, IBAA's services representative in Washington. Historically, banks of this size have represented a good risk, he says. IBAA is "exploring different ways to make our case" to the reinsurance markets, says Mr. Teagno. A delegation of bank representatives traveling to London is one possibility, he says. ■

Builders group offers comp plan

WILKES-BARRE, Pa.—The Pennsylvania Builders' Assn. has announced that it is offering a new program for workers compensation coverage to its members.

The builders group reached an agreement with InterGUARD Ltd., insurance program managers, and the Geeset, Glatfelter & Zarfoss agency to provide the tailored workers compensation coverage to members of the association.

The GUARD Pennsylvania Builders' Assn. Program is a group workers compensation insurance product written through the AmGUARD Insurance Co. that includes a 20% rate deviation.

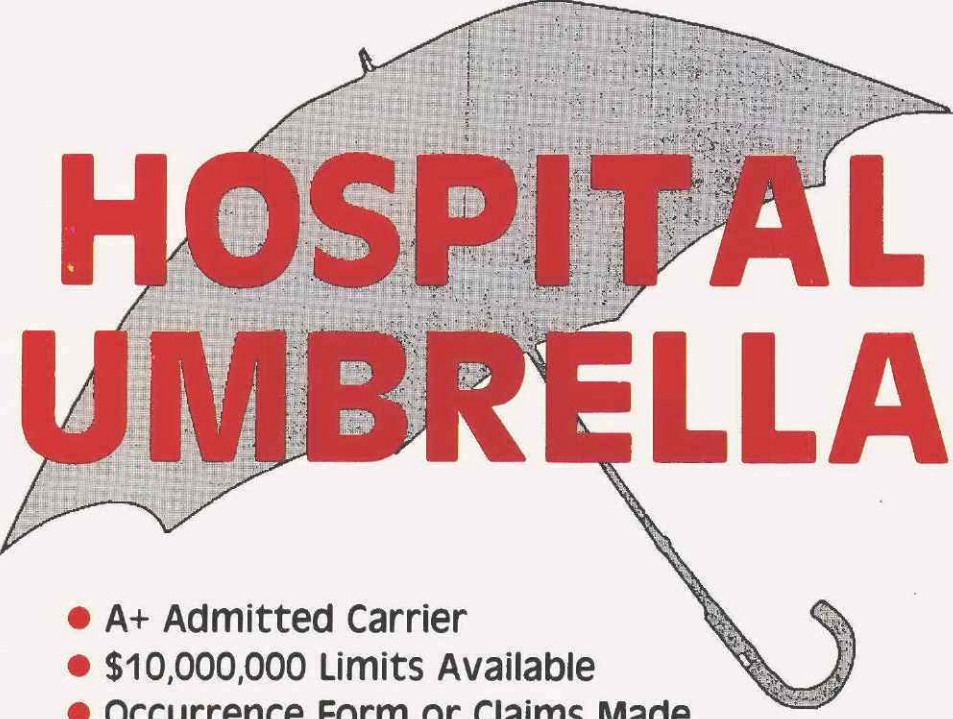
The program also offers a split dividend plan based on the combined performance of the individual employer and the group. Typically, workers compensation dividends are based exclusively on either the individual's loss experience or the group's experience.

These financial arrangements and a wide range of marketing, underwriting, claims, accounting and engineering services are included in the program, which was developed over several months by the builders group, InterGUARD and Geesey, Glatfelter & Zarfoss.

The contract establishing the coverage was signed earlier this month by representatives of all three participating parties in State College, Pa. Present at the signing were Ronald L. Carns, president of the builders group; James R. Zarfoss Jr., president of the agency, and Robert F. Cardamone, vp-marketing for InterGUARD.

InterGUARD and AmGuard are members of the GUARD Network, a family of insurance and insurance services companies headquartered in Wilkes-Barre. The network markets insurance products and services through independent agents and brokers throughout the state of Pennsylvania.

During the coming months, representatives of the GUARD Network will contact members of the builders association to explain the new workers compensation program. ■



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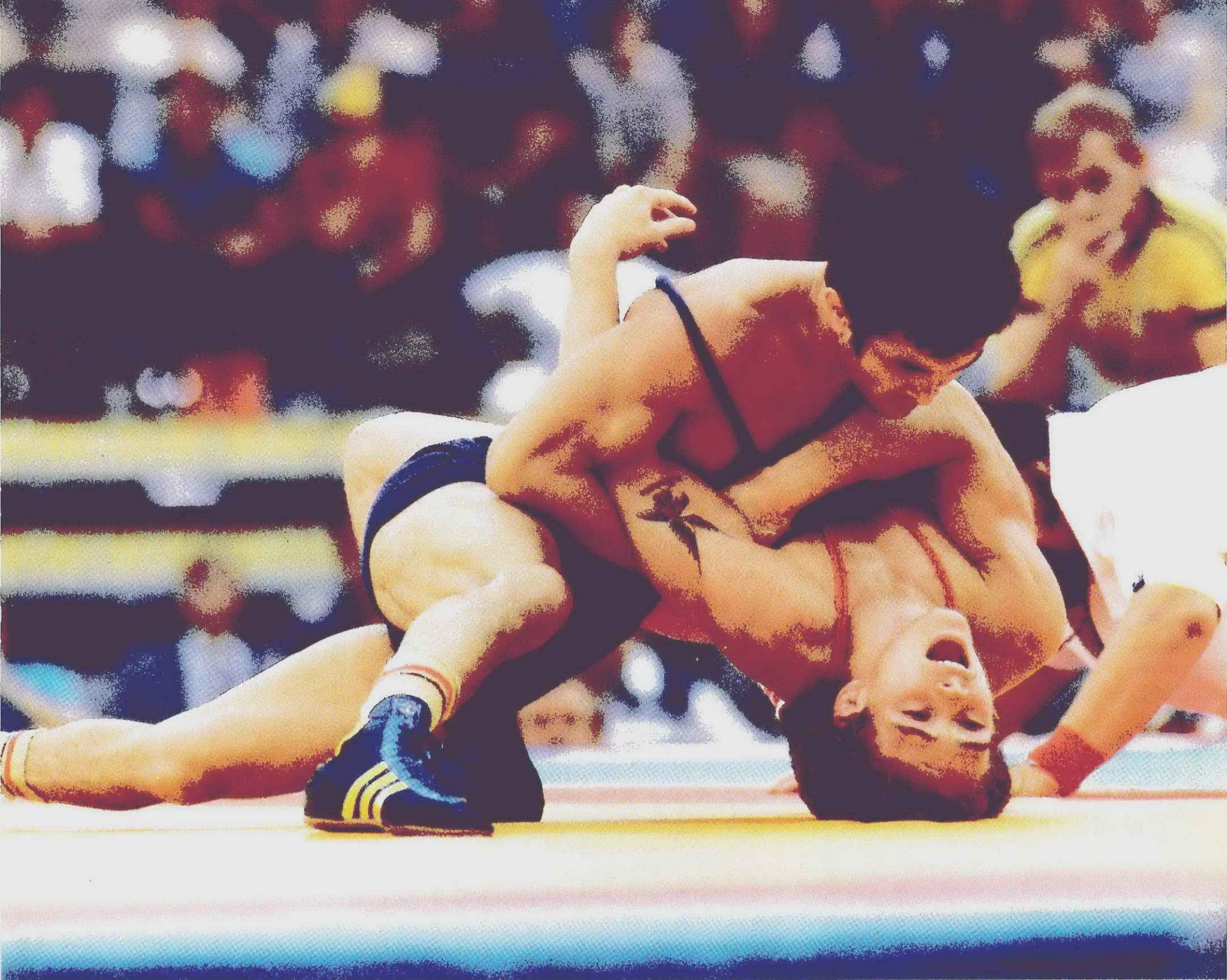


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Financial:
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Secretaries, treasurers, controllers and other financial personnel... 6,886

Risk/employee benefits:
Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations... 8,048

Sub-total 22,087

Associations 804
Government, unions and educational systems 1,030

Commercial Consumers

Sub-total 23,921

Insurance agents and brokers 9,548
Insurance companies 6,089
Financial institutions 536
Actuaries, attorneys, adjusters, appraisers and consultants 3,464
Others allied to the field 1,320

TOTAL 44,878

* Source: Business/Occupational breakdown of qualified circulation, May 6, 1985 issue, as submitted to BPA for June 1985. BPA Publisher's Statement.

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The new Risk and Employee Benefit Management Division is bringing workers' compensation, tort liability, employee benefits, occupational health, insurance purchasing, contact liability, and loss control together. A full-time staff of 14 will perform these functions including a Claims Manager, Loss Control Coordinator, and Occupational Health Nurse Practitioner. The City is accepting applications for three other professional positions in this Division: A Division Director titled Risk and Employee Benefit Manager, an Employee Benefits Manager, and a Risk Analyst.

Risk and Employee Benefit Manager—Division Director
Salary Range: \$44,294-\$61,830
Qualifications: College graduation and seven years experience in insurance or in a risk management field, including 5 years in management, 3 years of which have been as a Risk Manager. An Associate in Risk Management Certificate may be substituted for two years of the risk management experience.

Employee Benefits Manager
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Qualifications: College graduation and four years' professional experience in the field of health and welfare insurance.

Risk Analyst
Salary Range: \$23,673-\$32,980
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Filing deadline for these positions is Friday, January 3, 1986. Appointments will be made between February and July of 1986. Resumes may be sent to; applications and additional information from:
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Claims-made form

Continued from page 1

If the insurer chooses not to reinstate the aggregate limits for unknown occurrences, a buyer that needs tail coverage could be forced to pay a hefty premium for almost no limits if it had used the bulk of its aggregate coverage on claims filed during the regular policy period.

"We're saying when you buy the tail, it's like a new policy year. And if it's a new policy year, there should be a new aggregate," said Richard Rogers, deputy director of the consumer market division with the Illinois Insurance Department.

If the aggregate in its entirety is not reinstated, then policyholders that purchase the tail really don't know how much tail they're buying, Mr. Rogers said.

"There's no way they can tell now," he added.

If claims come in at higher levels than anticipated by the buyer or insurer, a buyer that thought it had a certain amount of coverage remaining under its aggregate when it purchased tail coverage suddenly could have very minimal coverage remaining even though it had paid a hefty premium for the tail coverage.

Connecticut Insurance Commissioner Peter Gillies, who attended the Chicago meeting with ISO officials, agrees that a guaranteed reinstatement of the aggregate is necessary, "or, if not that, some percentage of it. What I'm really looking for is something of a definition, that when an insured walks away it will know what it's buying," Mr. Gillies said.

"When an insurer cancels a product and forces the policyholder to buy the tail and changes the form from claims-made to occurrence, the policyholder may not have enough aggregate," Mr. Washburn said.

But ISO disagrees. "We believe that to guarantee a reinstatement of the aggregate is a form of retroactive insurance," an ISO spokesman said. "This would lead to adverse selection."

Regulators also want policyholders to express in writing their acceptance or rejection of an insurer's change in a policy's retroactive date, reasoning that this will force insurers to explain the move to policyholders in detail if they hope to obtain a written acceptance.

Similarly, regulators are asking ISO for an explanation of the word "recorded" in the revision to the claims-made form concerning when coverage is triggered so it will be as clear as possible to policyholders when the policy will respond to a claim.

The new revision says coverage will be

'Widespread application would result in confusion on the part of consumers, create potential for gaps in coverage and possible bankruptcy of a business caught by large exposures with inadequate coverage or no insurance at all,' said New York Superintendent of Insurance James P. Corcoran.

triggered when claims are "received and recorded" by a policyholder or the insurer, but regulators say they do not know what ISO means by "recorded."

Opponents of the claims-made form do not want notice to the policyholder of claims—written or verbal—to trigger coverage.

Rather, opponents want policyholders to be able to trigger coverage by notifying the insurer of an incident that could result in claims.

Concerning regulators' objection to the unilateral use of the claims-made form, regardless of the exposure involved, the ISO spokesman admits "we have a basic fundamental disagreement with regulators."

"Who is so clairvoyant to know those classes that seem innocuous today won't be tomorrow's latent injury problem?" the ISO spokesman asked.

But Connecticut's Mr. Gillies believes insurers are not doing their homework if they say claims-made policies must be used for all risks.

"It would be useful for insurers to analyze the real risks they're underwriting and say: 'These are the ones that really cause us concern.' And I don't think they've done that," Mr. Gillies said.

New York Superintendent of Insurance James P. Corcoran says across-the-board application of a claims-made form is "an unnecessary and inappropriate change in the traditional insurance system."

"Universal usage of the claims-made approach would unduly shift the burden of risk assumption from the insurer, where it belongs, to the insured," he said.

"Widespread application would result in confusion on the part of consumers, create potential for gaps in coverage and possible bankruptcy of a business caught by large exposures with inadequate coverage or no insurance at all," Mr. Corcoran added.

Mr. Corcoran's position on the claims-made form was included in a 17-page decision he issued earlier this month when he disapproved ISO's earlier version of its new claims-made form.

Several other state regulators, including Mr. Washburn, have praised New York's "eloquent" disapproval of ISO's filing.

Superintendent Corcoran explained that all claims-made policy forms in the future will be required to meet specific minimum standards for use in the New York department.

These minimum standards include:

- An extended claim reporting period of unlimited duration must be offered for 60 days subsequent to the cancellation of the policy at a premium not to exceed 200% of the current mature claims-made liability policy annual premium.

This provision shall also apply to cancellations for non-payment of premium, if a claims-made policy has been in effect for one year or longer.

- A free 60-day extended reporting period shall be provided upon cancellation of the policy by either the insured or insurer at no additional charge at that time. (ISO has already extended this to five years under its latest revisions, providing no other insurance is applicable.)

- If a claims-made policy has been in effect for more than two years, tail coverage must be made available at limits equal to at least 100% of the highest aggregate annual limit previously purchased during any claims-made policy period.

Thus, the tail coverage may not be limited to the remaining coverage available during an insured's last policy year.

- Endorsements restricting the risks to be covered by tail coverage are prohibited.

- Upon termination of a claims-made policy, the insurer must advise the insured of the availability of, and premium for, tail coverage, and the importance of purchasing tail coverage.

To make certain that this notice has been received, the terminating insurer should be required to obtain a written rejection of tail coverage from the insured when such coverage is not purchased.

If such rejection is not received, the insurer should issue a tail policy to the policyholder.

Non-payment of the premium for such tail policy, resulting in cancellation by the insurer, will be presumptive proof of the insured's rejection of the tail.

An alternative to this procedure would be

to place the obligation for obtaining proof of either purchase or rejection of tail coverage on the new insurer.

If such proof is not received, the new insurer would be responsible to provide coverage back to the original claims-made policy effective date.

- A policyholder must receive at least 60-days notice from the insurer of the cancellation or non-renewal of a claims-made policy other than for non-payment of premium.

- The annual premium during the first few years of a claims-made policy should not exceed the applicable occurrence rate for such risk.

- An insurer should not be permitted to unilaterally move up a policyholder's retroactive date as a condition of policy renewal. A policyholder may consent to move up the retroactive date in consideration of an appropriate premium saving.

- A claim shall be deemed made under the policy if written notice of the claim is received by the policyholder or insurer from a claimant, or the policyholder submits written notice to an insurer of an incident that might be expected to be the basis of a claim within the policy period.

- The policy application and the initial page of each claims-made policy must include a boldfaced notice that the policy is written on a claims-made basis.

- An insurer must obtain a signed statement from each new claims-made policyholder in which the insured acknowledges having been informed of the limited scope of coverage provided by the claims-made form.

While establishing these minimum standards for claims-made forms, Mr. Corcoran did approve the use of annual aggregate policy limits for all CGL forms and the exclusion of pollution coverage in commercial general liability policies.

An ISO spokesman previously predicted that when the final language of its latest revisions is filed, many of the concerns expressed by New York's superintendent and other regulators will be allayed.

Although ISO is still targeting a Jan. 1 implementation date for the claims-made form, its spokesman admitted individual insurers may have logistical problems in using the claims-made form on a broad basis beginning Jan. 1.

However, ISO wants state approval by then in order for insurers to be able to use the claims-made form on certain risks, rather than deny coverage, according to the ISO spokesman.

"I think we will see a phased-in introduction of the claims-made policy after Jan. 1. But the key is to have it in place by then," the ISO spokesman said.

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Jeep losses

Continued from page 1

The reinsurers are investigating the loss reporting under the AMC/National Union program to find out why National Union didn't know the extent of the losses sooner.

One aim of the reinsurers' investigation is to determine who was responsible for setting reserves and the extent to which reserve-setting was monitored by National Union, reinsurers say.

"It's a process of discovery we're going through right now," one reinsurer said, adding that there was "poor handling" of claims information "on the part of various parties—it's hard to tell who at this point."

"What happened is that we were not told of the total loss picture," the reinsurer said. "Not only were we not told about it, but it also is possible that no one knew what was going on from AMC down to us."

This reinsurer added, "We may be partially culpable ourselves," for not asking the right questions when the reinsurance was bound.

National Union was given information on claims and lawsuits by AMC directly and by ESIS Inc., a

CIGNA Corp. unit that handled claims for AMC, says AMC risk manager Frederick G. Beattie Jr.

National Union did not conduct a formal audit of AMC claim files until December 1983, reinsurers say.

Mr. Beattie says National Union claims officials had visited AMC to discuss claims reporting.

"I know National Union claims people were in here before the end of 1983, but I don't think they looked at any files," Mr. Beattie said.

Before the December 1983 audit, Mr. Beattie added, National Union received ESIS loss runs showing paid and unpaid losses, and also received information on individual claims directly from AMC.

"National Union was notified of every case that came in," Mr. Beattie said.

Reserve-setting was ESIS' contractual responsibility, Mr. Beattie said. "That's part of what they were supposed to do."

ESIS President Edward P. Holleran declined comment on the AMC account.

Several reinsurers say they have posted reserves for their full participations on the AMC business, but that they have not yet paid any claims to National Union.

National Union is paying claims to AMC, according to several sources.

The reinsurers investigating the claims reporting and reserving on the AMC account have retained the New York firm of Wilson, Elser, Moskowitz, Edelman & Dicker.

National Union has retained the New York law firm of Rein, Mound & Cotton.

Acknowledging that his firm has been retained by National Union, Stuart Cotton said, "We refuse to become involved in debating fact-by-fact or contention-by-contention in the newspaper."

Three AIG officials familiar with the AMC account contacted by *Business Insurance* either refused to comment or did not return telephone calls.

Several of National Union's reinsurers also refused to comment, but other reinsurers agreed to discuss the AMC investigation only on the condition that information not be attributed to them.

When National Union became first excess insurer on the AMC account in April 1981, it took over the business from Northbrook Excess & Surplus Insurance Co., which had been on the risk since 1975.

For the first two years it was on the program, National Union wrote limits of \$25 million over a \$2 million per occurrence/\$8 million annual aggregate self-insured retention. AMC's aggregate SIRs were in excess of an underlying \$100,000 per-claim retention.

In the third year of coverage, National Union's policy limit in-

Reports cite high number of Jeep rollovers

NEW YORK—The propensity of American Motors Corp. Jeeps, particularly the Jeep CJ-5, to roll over in accidents injuring and killing passengers was first widely reported in a 1980 segment of the CBS News program "60 Minutes."

In February 1982, following the CBS broadcast, the National Highway Traffic Safety Administration, a U.S. government agency, released a report finding that in single-vehicle on-road fatal accidents, the Jeep CJ-5 was more likely to have rolled over than any other utility vehicle studied.

The CJ-5 rolled over in 385—or about 80%—of the 479 fatal accidents involving CJ-5s recorded between 1978 and 1980, according to the study. Next on the list were the Toyota Land Cruiser, which rolled over in 78% of 116 fatal accidents and the Jeep CJ-7, which rolled over in 69% of 151 fatal accidents.

The study also found that the Jeep CJ-5 had the highest rate of occupant fatalities in rollover accidents over the same period. A total of 412 people were killed in CJ-5 rollovers, or 56 per 100,000 registered vehicles each year, compared with 49 per 100,000 registered vehicles for the Land Cruiser and 37 per 100,000 registered vehicles for the Jeep CJ-7.

Other studies—including a 1981 report by the Washington-based Highway Loss Data Institute and another by the Highway Safety Research Institute at the University of Michigan—found that Jeeps had among the highest on-road and off-road injury and death rates per accident for utility vehicles and among the highest insurance claim frequencies.

Lawyers representing those injured or killed in

Jeep accidents have contended that the vehicle's relatively narrow wheelbase, high center of gravity and stiff suspension system caused the accidents.

Lawsuits filed against AMC also have claimed that Jeep passenger protection features were inadequately designed and that AMC failed to warn buyers of the danger.

For example, in a 1976 injury case that resulted in a \$2.2 million award against AMC, the plaintiff's lawyer presented testimony that while a CJ-7's roll-bar could withstand 26,000 pounds of pressure, it was attached to sheet metal in the car's body that could only take 4,000 pounds of pressure.

An AMC spokesman refused to comment on the number of Jeep-related lawsuits and claims now pending against the company or the total amount of damages sought.

However, AMC's 1984 10-K, filed with the Securities and Exchange Commission, states that lawsuits pending as of Dec. 31, 1984, sought \$558 million in compensatory and \$1.1 billion in punitive damages. Excluded from these figures are "a substantial number" of claims filed with AMC that have not yet resulted in lawsuits, according to the filing.

AMC stopped producing Jeep CJ-5s in 1983 and will discontinue production of the CJ-7 this year. A new product, the Jeep YJ, is expected to be unveiled next year and is reported to be lower and wider than the Jeep CJs.

An AMC spokesman said that the design of the YJ is not related to the CJ litigation.

—By Douglas McLeod

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creased to \$50 million over the same AMC retentions.

National Union picked up the AMC program over the same \$2 million per occurrence/\$8 million aggregate self-insured retention that had been in force in the last year of the Northbrook coverage, sources familiar with the program said.

Northbrook officials referred inquiries from *Business Insurance* to an Allstate Insurance Group spokeswoman, who would only confirm that the company insured the AMC program between 1975 and 1981.

In the years before it stopped writing the account, Northbrook had audited AMC's claims files at least once a year to set its own reserves and to check the adequacy of retention levels, according to an underwriter who was involved with the account. At the same time, Northbrook had offered AMC—which was already using ESIS claims services—advice on reserves within the self-insured retention, the underwriter said.

Northbrook also continued to audit AMC files after it was off the risk for claims relating to its policy periods, reinsurance sources say.

In its own 1983 audit, Northbrook found that losses under its policies were worse than expected, and the insurer subsequently boosted its reserves.

National Union's 1983 audit and later audits by the AIG unit and other excess insurers also found

significantly worse loss experience than had previously been reported.

Based on information that losses reported to National Union did not exceed AMC's \$8 million aggregate retention in any policy year, one reinsurer said he had expected that AMC losses ultimately would pierce the first \$1 million layer of the National Union program and might enter the \$4 million excess of \$1 million layer.

The timing of National Union's loss reports to reinsurers is confirmed by an internal AIG memorandum and a letter from AIG to Guy Carpenter.

The internal AIG memorandum, dated June 25, 1984, confirms that the total 1981-82 limit of \$25 million had been reserved and that a National Union audit conducted between May 23 and 25 found an additional net liability of about \$3 million. However, the memo recommended against increasing reserves by that amount until a subsequent audit could be conducted. The memo also said that losses on the 1983-84 policy were still within AMC's aggregate retention and that no adjustment to National Union's reserves was required.

In a Nov. 20, 1984, letter to Guy Carpenter, a National Union excess claims supervisor reported that the insurer had then reserved its full policy limit for the 1982-83 policy year. The letter also said that while AMC's aggregate retention for the 1983-84 policy year remained intact, claims would eventually ex-

ceed the retention and that National Union had put up a "precautionary reserve" of \$2 million for that year.

When National Union lost most of the facultative support for the AMC program in 1984 after releasing the results of its 1983 audit to reinsurers, McAlear Associates Inc., a surplus lines broker in Grand Rapids, Mich., was able to line up additional excess insurers. These new excess insurers included Allianz Underwriters Insurance Co., which took \$5 million excess of National Union's \$5 million, and Transit Casualty Co.

On renewal, AMC's aggregate retention was raised to \$12 million, and Allianz and Transit Casualty accepted the risk pending a further audit, sources say.

Transit Casualty conducted the audit in the summer of 1984, and after finding further underreserving, negotiated an increase in AMC's aggregate retention to \$20 million retroactive to the renewal date. Allianz also negotiated a retroactive premium increase, sources say.

National Union, which still writes the first \$5 million excess layer on the AMC account, did not participate in negotiating the increase in AMC's retention, sources say.

Gallagher Bassett Insurance Service, a unit of broker Arthur J. Gallagher & Co. in Rolling Meadows, Ill., is now handling AMC's claims.

Oregon transit workers to share health costs

PORTLAND, Ore.—A new three-year contract between the Amalgamated Transit Union Local 757 and the Tri County Metropolitan Transportation District of Oregon shifts some medical costs to workers.

Under the previous contract, the 1,400 union drivers and mechanics had first-dollar comprehensive medical coverage. The workers could select a traditional indemnity plan or a health maintenance organization, both employer paid.

The new contract offers workers the same choice of plans but both plans require the worker to pay a share of health care costs.

Workers who pick the traditional plan, which is insured by Blue Cross and Blue Shield of Oregon, will have to pay a \$100 individual or a \$300 family deductible, according to Virgil Wellborn, manager of insurance and claims for Tri-Met.

In addition, workers will pay 20% of expenses exceeding the deductible, up to a maximum out-of-pocket contribution of \$5,000 per covered person, Mr. Wellborn said.

Employees who choose the HMO option will pay a \$3 deductible for each visit to a doctor's office and each prescription drug order.

Workers who have surgery performed on an out-patient basis will be reimbursed at 100% for the cost of the surgery, after meeting the deductible. Otherwise, surgery costs are reimbursed at 80%.

Workers are reimbursed for the full cost of surgery, after they meet their deductible, if they obtain a second surgical opinion. If not, they will be reimbursed for between 50% and 80% of the cost.

In addition, workers will be reimbursed at 100%, after they meet their deductible, for pre-admission testing, rather than 80%.

The contract also amends the employer-paid dental plan, which is underwritten by Oregon Dental Service.

The transit district now pays:

100% of expenses for preventative care; 80% for routine work, and 50% for restorative work. The dental benefit maximum is \$1,000 per plan member.

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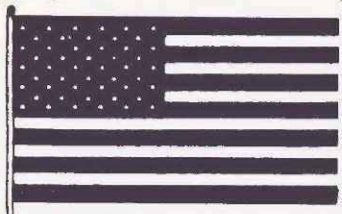
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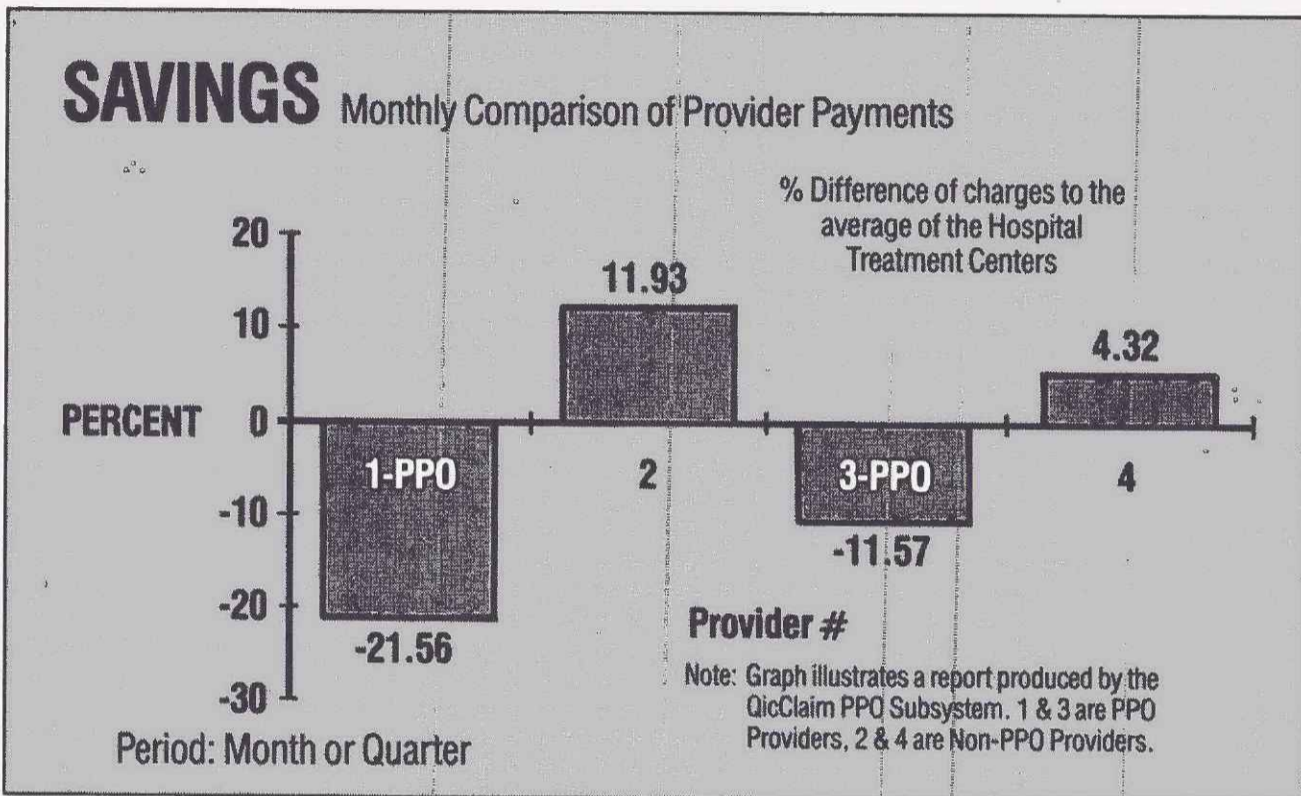
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