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Update

Louisiana moves to liquidate physician risk retention group

BATON ROUGE, La.—Louisiana regulators are liquidating Physicians National Risk Retention Group Inc.

The malpractice insurer, which was domiciled in Louisiana and operated from Marietta, Ga., was the subject of cease-and-desist and other actions in about 14 of the 44 states where it wrote coverage, Louisiana regulators said. It was placed in conservatorship in August, apparently out of concern over its discounting of loss reserves (*BI*, Aug. 26).

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Santa brings risks as well as rewards

Mall risk managers protect 'true believers'

By MEG FLETCHER

Like energetic elves, risk managers for malls, stores and other organizations that feature Santa Claus during the holiday season are busily taking steps to prevent losses and cope with the accidents that do occur.

Some retailers regard Santa as "an attractive nuisance" who can be a seasonal liability hazard, especially in today's litigious society.

But most enjoy the challenge of keeping this holiday tradition free of losses.

Historically, most stores hired temporary employees to act as Santas between the Thanksgiving and Christmas holidays. Those workers spent their days seated on thrones near the toy departments of major downtown department stores, like Macy's in the movie "A Miracle on 34th Street," listening to the wish lists of countless children.

Santa-related exposures were generally considered "incidental operations" of the stores and were covered by the stores' comprehensive general liability, workers compensation and property insurance policies, said Ron Russo, underwriting specialist with Western World Insurance Co., a surplus lines insurer in Ramsey, N.J.,

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Photo by Brooke Hummer

Courts OK challenges to claims settlements under retro policies

By STACY ADLER GORDON

CHICAGO—Courts nationwide are giving policyholders the power to challenge how their workers compensation insurers pay claims under retrospectively rated policies.

By imposing an express duty upon insurers to exercise good faith when paying claims under retro policies, in which the final premium is based on loss experience, courts have opened the door for policyholders to sue insurers when they believe insurers have acted negligently.

To date courts in at least five states—Illinois, Delaware, Massachusetts, Minnesota and Kansas—have allowed policyholders to sue workers compensation insurers that wrote retrospectively rated policies for negligently handling claims.

In each case, the insurers claimed to have an absolute right to settle claims under a retrospectively rated policy without being second-guessed by policyholders. They point out that standard workers compensation policies impose no duty of care on insurers when making settlements.

But in each case, the courts held that while insurers normally have an unfettered right to make settlements of claims, policyholders with retrospectively rated policies have a right to question whether settlements are reasonable.

The courts reasoned that when a policy contains a retrospectively rated premium, the insurer is actually using the policyholder's money to settle claims. Therefore, the insurer has a duty of good faith in making such settlements, the courts ruled.

These cases are making policyholders more aware that they have a right to question their workers compensation insurers' claims payment practices and "could lead to more second-guessing," said Norman Burdick, vp-Midwest region of Argonaut Insurance Co. in Chicago, which specializes in workers compensation insurance.

These decisions 'send a message to insurers that they have to pay attention to basic claims handling procedures,' says J&H's John Rico.

"Policyholders might be more apt to file a lawsuit and make the insurer come in and justify what it is doing" as a result of these cases, he explained.

These decisions "send a message to insurers that they have to pay attention to basic claims handling procedures," agreed John Rico, casualty claims administrator for Johnson & Higgins in New York. "They make insurers more accountable through the court system."

While experts say it is impossible to determine exactly how many similar lawsuits are pending, more and more litigation is being filed by policyholders disgruntled with the way their workers compensation insurers

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Health claims handling proposal spurs debate

Insurers, employers at odds over Berman bill

By JERRY GEISEL

WASHINGTON—Legislation that would expose group health insurers to punitive damage awards for improperly handling claims is triggering friction between employers and insurers.

Each side says the lobbying strategy being pursued by the other could lead to the passage of legislation that would hurt both parties.

While some insurers have been discussing alternatives to the legislation, employers have mounted a full-court press to kill the bill.

The legislation, H.R. 1602, introduced by Rep. Howard Berman, D-Calif., and now awaiting a vote before the full Education and Labor Committee, would essentially overturn a 1987 U.S. Supreme Court decision (*BI*, Sept. 30; Sept. 2).

That ruling exempts insurers from state unfair claims practices laws in their handling of group health, life and disability claims. The high court ruled that the preemption provisions in the Employee Retirement Income Security Act of 1974 protect insurers from any state sanctions—including punitive damages—for improperly handling a group plan claim.

The ruling limits recoveries for mishandled claims under group plans to the remedies laid out in ERISA, which limits recoveries to claims costs. The law also gives courts the discretion to award attorneys' fees to people whose claims have been mishandled.

The passage of the legislation by the House Labor-Management Relations Subcommittee in late September and a simultaneous warning by Subcommittee Chairman Pat Williams, D-Mont., that he would seek a vote by the Education and Labor Committee in November resulted in a flurry of contrary activity by employers and insurers.

Some insurers, while opposed to the Berman bill, have been working on alternatives.

For example, the Blue Cross & Blue Shield Assn. earlier this month unveiled an alternative. Its proposal would, among other things, automatically award attorneys' fees to prevailing plaintiffs and require group health plan administrators to act within 10 days after receiving requests for preauthorization of procedures that are costly and potentially life-saving (*BI*, Nov. 18).

Defending their approach, BC/BS officials say the current system of ensuring that health care claims are paid can be improved.

"Our position is that there is room for improvement in ERISA to ensure that plan participants receive the benefits to which they are entitled," said Paul Dennett, the Blues' director of congressional relations in Washington, D.C.

In addition, several individual insurers—including Massachusetts Mutual Life Insurance Co., Metropolitan Life Insurance Co., New York Life Insurance Co. and The

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NEWSPAPER

Update

Physicians National liquidation

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About 1,000 claims are pending against the insurer, said a Louisiana Insurance Department spokesman.

Physicians National assets are expected to cover claims filed before Oct. 1, while claims filed after Oct. 1 will be paid by Builders & Contractors Insurance Ltd., a group captive in the Bahamas that has assumed Physicians National's business. Sphere Drake Insurance P.L.C. of London is reinsuring Builders & Contractors on the business.

A state court order will delay all legal actions against Physicians National for six months, the department spokesman said. The order gives Louisiana regulators time to ask courts in other states to recognize the liquidation order and direct all claims to the liquidators.

Physicians National wrote $10.5 million in direct premiums in the year ended June 30. At that date, it reported surplus of $8 million.

In a separate action, the Insurance Department also placed Presidential Fire & Casualty Co. of Gretna, La., in liquidation.

Presidential wrote automobile, general liability and bail and performance bond coverages. It also offered an employers liability policy as a substitute for workers compensation coverage.

Insurance fraud penalties

WASHINGTON—President Bush is expected to veto a comprehensive crime bill wending its way through Congress that contains new penalties for insurance fraud.

The bill, H.R. 3371, was approved Wednesday by the House, 205-203. The Senate had not yet acted on the bill as of late Wednesday.

Insurance trade groups and the National Assn. of Insurance Commissioners support the bill's anti-fraud provisions. They would establish federal criminal penalties for anyone who knowingly files fraudulent financial statements about an insurer with a state regulator; embezzles insurance company funds; falsifies records with the intent to defraud an insurer or policyholder; or criminally obstructs proceedings before state insurance regulators (*BI*, Oct. 28). In most cases, maximum penalties for insurance fraud would be a $250,000 fine and 10 years in prison. But a 15-year term could be imposed if the fraud endangered the soundness of an insurer.

The insurance provisions were included in a sweeping anti-crime bill that created more than 50 new federal capital crimes.

But, President Bush contends the overall bill is not tough enough and has threatened to veto it. The closeness of the House vote indicates that it would be next to impossible to override a veto.

GAO studies pollution cover

DENVER—The General Accounting Office will survey hazardous waste treatment, storage and disposal facilities this month to determine whether the cost and availability of pollution liability insurance have affected their operations.

The study is being conducted at the request of Rep. Nancy Johnson, D-Conn., a member of the House Ways and Means Committee.

Under the Resource Conservation and Recovery Act of 1976, owners and operators of such facilities must show they are capable of compensating third parties for property damage and bodily injury caused by the facilities. This requirement usually is satisfied by purchasing liability insurance.

According to the GAO, Congress has received reports that owners and operators of these facilities are having difficulty obtaining the necessary coverage. This survey is designed to provide Congress with the information needed to determine whether it should change existing and proposed federal environmental legislation, said Art Gallegos, a GAO project manager in Denver.

Rep. Johnson has been working on this issue since 1983, when she unsuccessfully tried to get a bill passed that would recognize operators' good-faith efforts to find insurance. A similar study was conducted in 1988. "This study needs to be done again," Rep. Johnson said. "We're still in a serious bind. What you will find is a few who can self-insure, and everyone else is either going without or is out of business."

Bad faith claims handling found

WHITE PLAINS, N.Y.—A federal court jury here ordered Nationwide Mutual Fire Insurance Co. to pay $150,000 in punitive damages as well as $200,000 in compensatory damages for engaging in a pattern of unfair and deceptive claims practices.

This marks the first time a homeowners insurer in New York has been found guilty of bad faith claims handling and forced to pay punitive damages, according to attorneys. In an earlier case, a court found bad faith claims handling by a liability insurer.

Because New York law requires policyholders to prove that insurers engaged in a pattern of wrongful behavior, bad faith claims handling verdicts in the state are very rare, they explain.

In this case, homeowners contended that Nationwide routinely forced policyholders to accept less money than they were entitled to on their claims, said plaintiffs' attorney Mark Friedman with Wilkofsky, Friedman, Karel & Cummins in New York.

Marvin Metter, an attorney for Nationwide Fire at its regional office in Syracuse, N.Y., says the company plans to appeal the verdict because the facts do not support the jury's finding.

New deadline set in LUI dispute

LONDON—All issues concerning the schemes of arrangement for four insolvent insurance units of London United Investments P.L.C. must be decided by Dec. 18, or the companies should be liquidated, says the U.K. guaranty fund covering individuals' policies.

In the High Court last week, lawyers for the Policyholders Protection Board agreed to again postpone a petition to wind up the four "KELM" companies, this time until Dec. 18. But, the lawyers said, unless all of the issues surrounding the schemes of arrangement are resolved by then, the policyholder board will refuse to support a continuance. In that case, the companies would be liquidated.

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State tries to shut down largest N.Y. taxi insurer

By DOUGLAS McLEOD

NEW YORK—New York City's largest taxicab insurer is fighting state Insurance Department efforts to shut it down after an examination found it insolvent by at least $39.9 million at the end of 1989.

The New York Insurance Department last month requested a court order to liquidate American Transit Insurance Co., which insures more than 60% of city-licensed—or medallion—taxicabs and wrote $66.4 million in gross premiums last year.

Severe underreserving and several other problems left the insurer insolvent by $39.9 million as of year-end 1989, and the insolvency narrowed only slightly to $35.6 million by year-end 1990, despite a $6.5 million capital contribution from American Transit's parent, the Insurance Department charges.

However, American Transit adamantly denies it is insolvent and went to court to head off a state takeover on Oct. 29, the same day the department filed its liquidation petition.

Several weeks of legal wrangling have followed, and the insurer's status is still undecided: A state judge has prohibited American Transit from "wasting or disposing of" its assets but also ordered the New York department not to take "any actions that interfere with (American Transit's) normal transaction of business."

The Insurance Department has labeled this order "unprecedented."

Meanwhile, New York Supreme Court Judge David B. Saxe has referred the liquidatation petition and an American Transit complaint for an injunction against the Insurance Department to a court-appointed hearing officer. The hearing officer, a retired state judge, will weigh the two sides' arguments and report to Judge Saxe.

No date has been set for a hearing, but Insurance Department and American Transit representatives are scheduled to hold a preliminary meeting with the hearing officer Wednesday.

American Transit, formed in 1972 and licensed only in New York, is a unit of New York-based ATIC Management Corp. The parent company acts as a broker for taxi and other coverages written by American Transit and accepts business through about 50 subbrokers, according to the New York department's exam report.

Gross written premium volume has grown to $66.4 million in 1990 from $14.4 million in 1985, while net premiums expanded to $58.8 million last year from $7.3 million in 1985. Surplus grew to $13.8 million at the end of 1990 from $2.6 million at the end of 1985, the insurer's financial statements say.

American Transit now insures in New York roughly 7,000 medallion cabs—which amounts to at least a 60% market share—and 2,000 livery cabs, according to state regulators. American Transit's lawsuit against the Insurance Department

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Weaker reporting standard a relief to manufacturers

Product safety rules revised

By STACY ADLER GORDON

WASHINGTON—Manufacturers are breathing a sigh of relief over new proposed reporting requirements from the Consumer Product Safety Commission that appear to interpret federal law in a less burdensome manner.

However, consumer advocates claim that proposed reporting requirements do not go far enough to protect consumers from dangerous products.

Under the proposed rules, manufacturers of consumer goods would be required to report to the commission if any single product is the subject of three or more product liability settlements or judgments within a two-year period.

That requirement emerged after the commission rejected an earlier proposal that would have required manufacturers to report every time they settle or lose a product liability lawsuit that alleged serious bodily injury or death.

The CSPC's proposed rules interpreting Sections 15(b) and 37 of the Consumer Product Safety Act of 1990 were published Oct. 28 in the Federal Register (*BI*, Nov. 4).

The new rules are designed to provide guidance to manufacturers on how to comply with the product liability reporting requirements of the act.

"It is important for manufacturers to be aware of these regulations so that they will be able to comply with them," said Paul Brown, director of governmental affairs at the Risk & Insurance Management Society Inc. in New York.

While less onerous than earlier interpretations of the law, the new rules would substantially broaden the circumstances under which manufacturers must report product liability litigation to the commission. The rules also would provide for civil penalties of up to $1.25 million for manufacturers that fail to make required reports.

Under the proposed rules, firms would be required to report:

- Products deemed by the manufacturer to create an "unreasonable risk of serious injury or death."
- If a "particular model" of a product is the subject of three or more civil actions in a prescribed two-year period alleging death or grievous bodily injury and resulting in a final settlement or in a judgment in favor of the plaintiff.

Manufacturers would not be required to disclose the amount of a settlement. And, under the proposed rules, these reports would

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Deadline near for TPA list

The deadline is approaching for companies to return questionnaires to be listed in the *Business Insurance* directory of third-party administrators.

The directory will appear in the Jan. 27 issue, which will focus on trends in self-insurance.

If your company offers claims administration, adjusting or auditing services for self-insured clients, either for property/casualty risks or for employee benefit programs, and you have not yet received a questionnaire, please request one by calling Karen Armaganian at 312-280-3195.

There is no charge to be included in the directory; listings are published as an editorial service.

The deadline for TPAs to return questionnaires is Dec. 16.

Inside

- Liabilities of the nation's 50 largest underfunded pension plans jumped to $21.5 billion last year from $14.2 billion in 1989, the PBGC reports. **PAGE 4**
- An Illinois Supreme Court ruling in a legal malpractice case seeking to create more predictability in damage awards instead may have created more uncertainty, warns this week's editorial. **PAGE 8**
- Norway's UNI Storebrand A/S and Denmark's Hafnia Insurance Co. Ltd. teamed up to acquire major stakes in Sweden's Skandia Insurance Co. Ltd., to the chagrin of Skandia and stock analysts. **PAGE 29**

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Oregon takes aim at comp claims

Efforts by state agencies cut costs by 75%

By LOUISE KERTESZ

SALEM, Ore.—Could a state possibly cut its workers compensation costs by 75% over two years?

Oregon state agencies did, largely by quickly returning injured employees to their jobs or modified duties.

Based on previous experience, state agencies had projected paying $142 million for job-related injuries and illnesses during fiscal years 1989/1990 and 1990/1991. But the state, which self-funds its workers compensation risks through the State Accident Insurance Fund, now estimates its actual cost at $35 million—a $107 million savings.

Each agency individually attacked the roots of its own high workers comp costs. The greatest savings were achieved by reducing time loss claims, as state agencies helped injured employees' return to the payroll as quickly as possible by, among other things, modifying their duties. Lost workdays due to injuries have dropped to 3,000 per month from 10,000 per month since the beginning of 1989.

Time loss claims—which include medical costs and lost income benefits—accounted for 95% of the projected $142 million of workers comp costs for fiscal years 1989/1990 and 1990/1991, according to the state's Department of General Services.

Besides returning workers to their jobs more quickly, the agencies cut workers comp costs in other ways, like taking steps to prevent injuries and detecting and managing incidents before injury claims are ever filed. Indeed, state agencies cut serious injuries causing time loss claims by 60% to 652 in the last fiscal year from 1,640 in 1988.

The assault on workers comp costs followed a 1988 executive order from former Gov. Neil Goldschmidt that made managers of state agencies accountable for reducing disability claims costs.

Gov. Goldschmidt issued his Executive Order on Workplace Health and Safety following testimony during legislative hearings in 1987 on workers comp reform. The governor signed two reform bills that year (*BI*, July 20, 1987).

"Throughout the testimony, in the forefront was the fact that the state of Oregon had some of the highest work comp claims, so the governor decided we needed to work diligently to reduce our own costs," said Craig Kuhn, staff development manager at the Department of Insurance and Finance.

Workers comp costs at the state's 140 agencies, which employ 50,000 workers, were "heading upward at 27% a year. We were averaging 17% for almost a decade in the '80s," said David White, administrator of the state's risk manage-

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Benefits viewed as a way to help employees make a company healthy

By CHRISTINE WOOLSEY

Employers' economic success in the next century will largely depend on taking a different approach to employee benefits, says the head of a new non-profit organization that studies how companies can be more productive and profitable.

Employers no longer should view employee benefits in terms of health care coverage or pension plans, maintains Robert H. Rosen, president of Healthy Cos.

Rather, employers should define employee benefits in a much broader context—one that takes into account the relationship between employees and their jobs and how they interact with management to contribute to the overall health—or success—of a company, he says.

In addition to improving bottom-line results, running a "healthy" company can pay dividends in terms of controlling health care costs, Mr. Rosen said. "Sick" jobs make sick people in terms of on-the-job accidents and workplace stress, he explained.

Washington, D.C.-based Healthy Cos. plans to create an international data base of successful business practices to which employers will have access and can use as a blueprint.

Healthy Cos. is funded by a grant from the John D. & Catherine T. MacArthur Foundation in Chicago, a philanthropic organization created in 1978.

"Employees are rejecting jobs and companies that jeopardize their health," Mr. Rosen writes in his book, "The Healthy Company."

"People who once tolerated positions that gave them ulcers or bad backs are leaving those spots."

However, "in today's shrinking labor market, no organization can survive with a reputation as an unhealthy place to work," he noted.

Creating a healthy company—one that focuses on human as well as economic concerns—is imperative in the 1990s, according to Mr. Rosen.

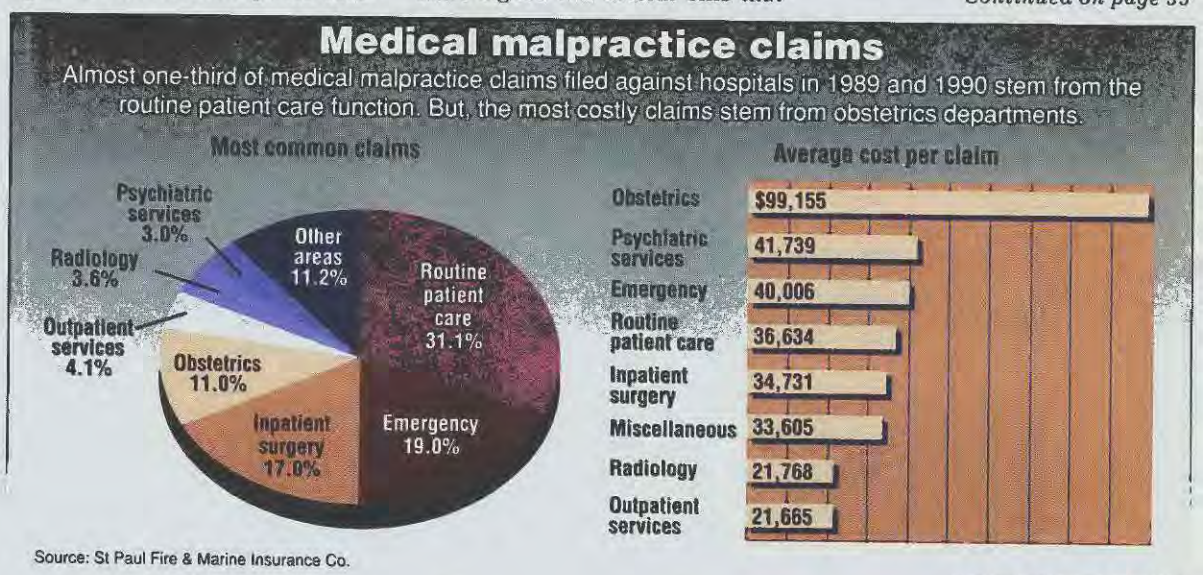
"No longer are these ideas simply the nice ways to conduct business," Mr. Rosen writes in his book.

"They are not just perks, short-term frills or the inventions of a few socially responsible companies in the heartland of America. Now more than ever, they are the requirements of running a successful business."

Healthy Cos. "will focus primarily on the relationship between organizations and employees, exploring the components of a healthy job, a healthy working environment and a healthy employer-employee social contract," Mr. Rosen explained.

Working with scholars, business practitioners and strategic alliances, like employer coalitions, Healthy Cos. will try to develop and help implement new manage-

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Source: St Paul Fire & Marine Insurance Co.

GRAPHIC BY KIMBERLY MART

Medical malpractice

Hospital coverage competitively priced, plentiful

By CHRISTINE WOOLSEY

The hospital medical malpractice insurance market is in stable condition, but hospital risk managers and brokers remain watchful for signs of a relapse of high rates and tight capacity.

Costs for professional liability coverage from commercial insurers are holding steady and even declining for some hospitals with good loss records. Risk retention groups and other alternative markets also are offering competitive rates.

Capacity is plentiful, brokers and medical malpractice insurers say. In fact, some hospitals are increasing their limits because the coverage is so available and affordable.

Furthermore, the coverage has become profitable for insurers, brokers contend. That is in sharp contrast to the medical malpractice crises of the late 1970s and mid-1980s, when some insurers and reinsurers stopped writing the coverage altogether.

Some companies that in the past have pulled out of the market now are looking for market share, while European insurers and reinsurers are showing increased interest in writing coverage for hospitals.

Loss trends, however, are inching upward again after leveling off during the past two years, insurer and risk retention group officials report (see story, page 12). And, both brokers and insurers question whether the current low rates can be sustained for long.

"The market since the mid-1980s has been relatively stable," said Karen Logue, deputy chairman of Johnson & Higgins' HealthGroup in New York. "Many of the issues are still issues," like high medical malpractice awards, but "we are seeing a very competitive market from a pricing standpoint."

"I believe the proper term is stable," agreed Judy Hart, vp and deputy national director of the national health care division of Alexander & Alexander Services Inc. in St. Louis. "We aren't really predicting any change in medical malpractice insurance for hospitals in 1992."

In general, premium increases have tempered and most hospitals have renewed coverage this year at or below their 1990 rates, said Kevin Downs, chairman of J&H's HealthGroup in New York.

"Decreases on average are in the 5% to 10% range," Ms. Logue added.

"Up to now, renewals are flat," Ms. Hart said, noting that most accounts are not seeing more than a 2% or 3% change in either direction.

But other brokers express con-

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Economy affects market cycles: ISO study

By DOUGLAS McLEOD

NEW YORK—Property/casualty insurance cycles are not driven solely by internal competitive dynamics but, rather, are also influenced by larger changes in the economy, including shifts in the gross national product, interest rates and inflation, a new study concludes.

The study, conducted by the New York-based Insurance Services Office Inc., also looks at the connection between the general economy and losses in four property/casualty insurance lines: workers compensation, manufacturers and contractors liability, personal auto liability and homeowners coverages.

For example, the study found that the frequency of workers compensation lost income claims rises during periods of strong economic growth, while manufacturers and contractors liability claims slow in a strong economy.

One surprising finding was the degree to which property/casualty insurer profitability is linked to economic variables, said Mark Whitman, an ISO assistant vp and actuary.

"I thought (the industry cycle) was internally driven, that it runs on its own steam and that what happens out there in the world was not terribly important to it," Mr. Whitman said.

Insurance cycles have historically "demonstrated unique characteristics," but most over the last 20 years have coincided with changes in overall economic conditions, according to the ISO study, "Changes in the Economic Environment: Insurance Implications." For example:

Most cycles have coincided with changes in overall economic conditions, the study says.

- Growing property/casualty premium volume between 1970 and 1990 corresponded with growth in the GNP, as the expanding economy increased the value of assets and income streams to be protected by insurance. Likewise, inflation boosted premium volume by increasing the dollar value of policyholders' assets and income streams.

However, incurred losses also grew at a faster rate than both the GNP and premium volume, ISO found.

While rising economic activity and inflation could be expected to produce rising losses, ISO also blames increasing litigiousness, liberal court interpretations of insurance policies and increases in the cost of insured items that outpaced the inflation rate.

- Underwriting profitability has deteriorated following increases in interest rates but has improved following periods of inflation. Likewise, insurers' rates of return on net worth generally have fallen with rising interest rates but improved with expanding inflation.

High interest rates have produced "cash-flow underwriting," with insurers cutting rates while assuming—in many cases erroneously—that they can maintain profitability with higher investment yields.

Rising interest rates also depress the value of insurers' bond holdings, ISO notes. This also encourages price competition, since insurers may seek to pay claims with premiums generated by new business rather than liquidate bonds at a loss.

While the six-year soft market that ended in 1984 was partly driven by the industry's own com-

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Biggest pension liabilities

The PBGC's Top 50 underfunded pension plan list is not an indicator that a plan will terminate. It represents the agency's projection of its exposure based on PBGC guaranteed benefits.

Companies with largest unfunded guaranteed liability	Unfunded guaranteed liability ($ millions)	Funding ratio
General Motors	$7,145	83.0%
Chrysler	3,328	60.5
LTV	3,183	6.0
Bethlehem Steel	1,301	71.4
Westinghouse	692	84.0

Companies with lowest funding ratios	Funding ratio	Unfunded guaranteed liability ($ millions)
LTV	6.0%	$3,183
Jesup Group	20.3	106
CF&I Steel	25.0	164
Sharon Steel	29.9	150
Blaw Knox	34.2	70

Source: Pension Benefit Guaranty Corp.

GRAPHIC BY JOHN HALL

Pension underfunding rises

Most of increase attributable to GM defined benefit plans

By JERRY GEISEL

WASHINGTON—Liabilities of the nation's 50 largest underfunded pension plans jumped by more than 50% last year, rising to $21.5 billion from $14.2 billion in 1989, according to the Pension Benefit Guaranty Corp.

Most of that rise, though, is the result of a roughly $6 billion increase in promised but unfunded benefits in pension plans sponsored by General Motors Corp. A GM spokesman cites a recent increase in benefits and a slump in the equities market which hurt pension plan investment performance as among the reasons for the increase—to $7.15 billion in unfunded liabilities in 1990, from about $1 billion in 1989.

Coinciding with the release of the PBGC's annual list of the nation's most underfunded pension plans, a federal judge in New York last week approved the termination of two pension plans sponsored by Pan American World Airways Inc.

As a result, the PBGC is on line to guarantee more than $600 million in benefits to about 35,000 participants, including 11,500 retirees, covered by the plans. The agency doesn't know how much of the loss it will be able to recover from Pan Am, which is operating under Chapter 11 of the bankruptcy code (*BI*, Jan. 14).

The PBGC's annual list of underfunded plans—which are concentrated in the aviation, steel, automobile and tire industries—shows that the 50 plans' liabilities for guaranteed benefits were $86.29 billion in 1990, while plan assets were only $64.78 billion.

Guaranteed benefits are those the agency must pay if an underfunded plan is terminated. But the PBGC does not guarantee all benefits, like recent plan improvements or participants' benefits exceeding about $2,250 a month.

For example, the Pan Am plans, according to the PBGC, have about $860 million in unfunded liabilities, of which the agency will only guarantee about $600 million.

PBGC officials, citing the increase in underfunding, contend that companies are promising more than they can deliver because they are aware that the agency will guarantee most benefits if the plans are terminated.

"Overall, underfunding in pensions has increased because pension contributions and investment income fell short of benefit payments and increases. Companies have continued to treat PBGC's guarantee as a subsidy for pension promises they make but cannot afford to meet," said James Lockhart III, executive director of the pension agency.

Some pension lobbyists and consultants, though, contend that the PBGC list unfairly lumps all underfunded plans in one category.

"It suggests that all underfunded plans pose an equal threat to the PBGC. The list fails to note that there are huge differences in the financial health of the firms on the list," said Howard Weizmann, executive director of the Assn. of Private Pension & Welfare Plans in Washington, D.C.

Being on the list of the nation's most underfunded plans produces a stigma that in many cases is not justified, agreed Dominick Cardace, a partner with Kwasha Lipton in Fort Lee, N.J.

In fact, Northwest Airlines Inc., which is on the list with $78 million in unfunded guaranteed benefits, says the PBGC is creating a "groundless fear in the minds of our people that their pension benefits are at risk. That's unnecessary and just plain wrong," the Minneapolis-based airline said last week.

While the list shows GM with the most unfunded guaranteed benefits—$7.15 billion, the result of $42.03 billion in liabilities and $34.89 billion in assets—its pension plans were relatively well-funded with a "funding ratio" of 83%. A funding ratio refers to the percentage of benefits that are covered by plan assets.

By contrast, the ratio was just 6% for plans sponsored by LTV Corp., by far the lowest on the list.

LTV's pension plans have promised $3.4 billion in benefits, but have just $204 million in assets, resulting in $3.2 billion in unfunded guaranteed benefits. Since filing for Chapter 11 in 1986, the Dallas-based steel and aerospace firm has made only sporadic contributions to its pension plans.

Other employers on the PBGC list, their unfunded pension liabilities and their funding ratios in 1990 include:

- Chrysler Corp., $3.33 billion, $60.5%.
- Bethlehem Steel Corp., $1.3 billion, 71.4%.
- Westinghouse Electric Corp., $692 million, 84%.
- Navistar International Corp., $536 million, 78.4%.
- Uniroyal Goodrich Tire Co., $434 million, 47.5%.
- American National Can Co., $429 million, 47.4%. ■

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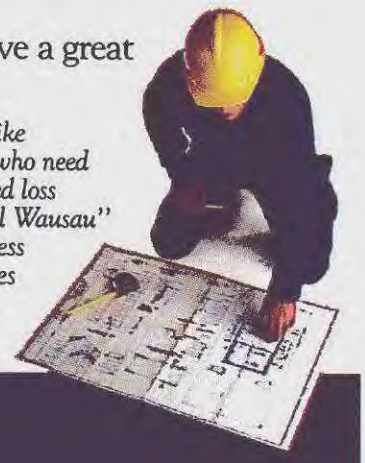
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USAir to require health care contributions

By MICHAEL SCHACHNER

Benefit beat

As part of a $400 million cost-cutting effort, USAir Inc. next year for the first time will require non-union employees to make monthly contributions toward the cost of their health care coverage.

And, American Airlines Inc., in an effort to maintain health care inflation at current levels, is introducing a new indemnity plan with managed care features that will be available to more than 50,000 employees throughout the country.

USAir will begin requiring 24,000 non-union employees to contribute approximately 10% of the monthly cost of their medical and dental indemnity plan, which the airline self-funds, beginning Jan. 6. The move is part of a plan to trim more than $400 million from its budget in 1992. The Arlington, Va.-based airline reported a third-quarter loss of $81.4 million.

Monthly contributions will be about $13.29 for single employees and $38.28 for those with family coverage. The airline could not estimate how much the contributions will total.

USAir's approximately 22,000 unionized employees currently do not contribute toward the cost of their coverage, but the airline is asking them to accept a similar arrangement. However, contract talks with unions representing pilots, flight attendants and mechanics have stalled over this and other issues.

USAir currently finances the entire cost of all employees' basic medical and dental coverage.

For major medical care, non-union employees with individual coverage pay a $100 deductible annually and 20% of costs up to $1,500—excluding deductibles—biennially. The family deductible is $200 annually with an out-of-pocket maximum of $1,500 per person biennially.

Deductibles and copayments will not change when the non-union employees begin making monthly contributions toward the cost of their health care coverage.

Beginning in April, USAir also plans to introduce a new indemnity plan with a preferred provider option for non-union workers. Coverage details have not been made available.

The company also will not make any more contributions toward the fully-funded defined benefit pension plan it sponsors after Dec. 31. Employees hired after Jan. 1 will not be offered a defined pension benefit.

Instead, new hires—as well as current employees—will be eligible for a defined contribution pension plan that the airline will implement in April 1993.

Meanwhile, Fort Worth, Texas-based American Airlines believes that a new self-insured indemnity plan with a managed care option can maintain its health care inflation level at its current level of 8.1%.

"We don't expect the preferred provider option to save us money. We only want managed care to help us control costs," said an American spokeswoman.

Under the new plan, which will be available to about 51,000 employees nationwide, workers who seek care from network doctors pay only small office visit copayments, while those treated at network hospitals pay minimal hospital deductibles. Employees who receive care from non-network providers face significantly higher out-of-pocket costs.

For example, basic office visits, including wellness-related visits like well baby care and mammography, will cost only $10, though visits to certain specialists in the network cost $20. Employees and their dependents are subject to $50 daily deductibles for hospitalization up to a maximum of $250 per person.

The cost of all provider services obtained from non-network providers will be subject to an annual $300 individual deductible or a $900 family deductible. In addition, employees with individual or family coverage will be responsible for 30% of charges up to $1,500 per person annually, excluding deductibles.

Metropolitan Life Insurance Co. will administer the plan in the San Francisco Bay area, Southern California, Chicago, Detroit and Cincinnati. Prudential Insurance Co. of America is the administrator in New York, Tulsa, and Dallas. CIGNA Corp. is the administrator in Miami, Nashville and Raleigh-Durham, N.C.

"Our employee surveys and general feedback indicated that many of our employees would be receptive to managed care if they could get wellness care at affordable prices," the spokeswoman said.

American will continue to offer a traditional indemnity plan that does not include coverage for wellness care and helth maintenance organization options.

Corning family benefits

Corning Inc. plans to expand an already progressive work and family benefits program by, among other things, building an on-site child care center, training backup child care providers and coordinating an after-school and holiday program for school-age children of employees.

The programs are designed to help employees balance work and family responsibilities and help the Corning, N.Y.-based manufacturer recruit and retain top-level employees, said Sonia Werner, an in-house work/family consultant.

Corning plans to build a 7,500 square-foot near-site child care center next year that will serve up to 150 children between the ages of 6 months and 6 years free of charge. The center, which will cost about $1.2 million, will have a classroom, library and conference room.

Corning also plans to begin next year a one-year pilot program designed to train backup child care providers. Under the plan, Corning will contract with the Steuben Child Care Project, a local community agency, to train local people to provide care on an emergency basis to children of Corning employees.

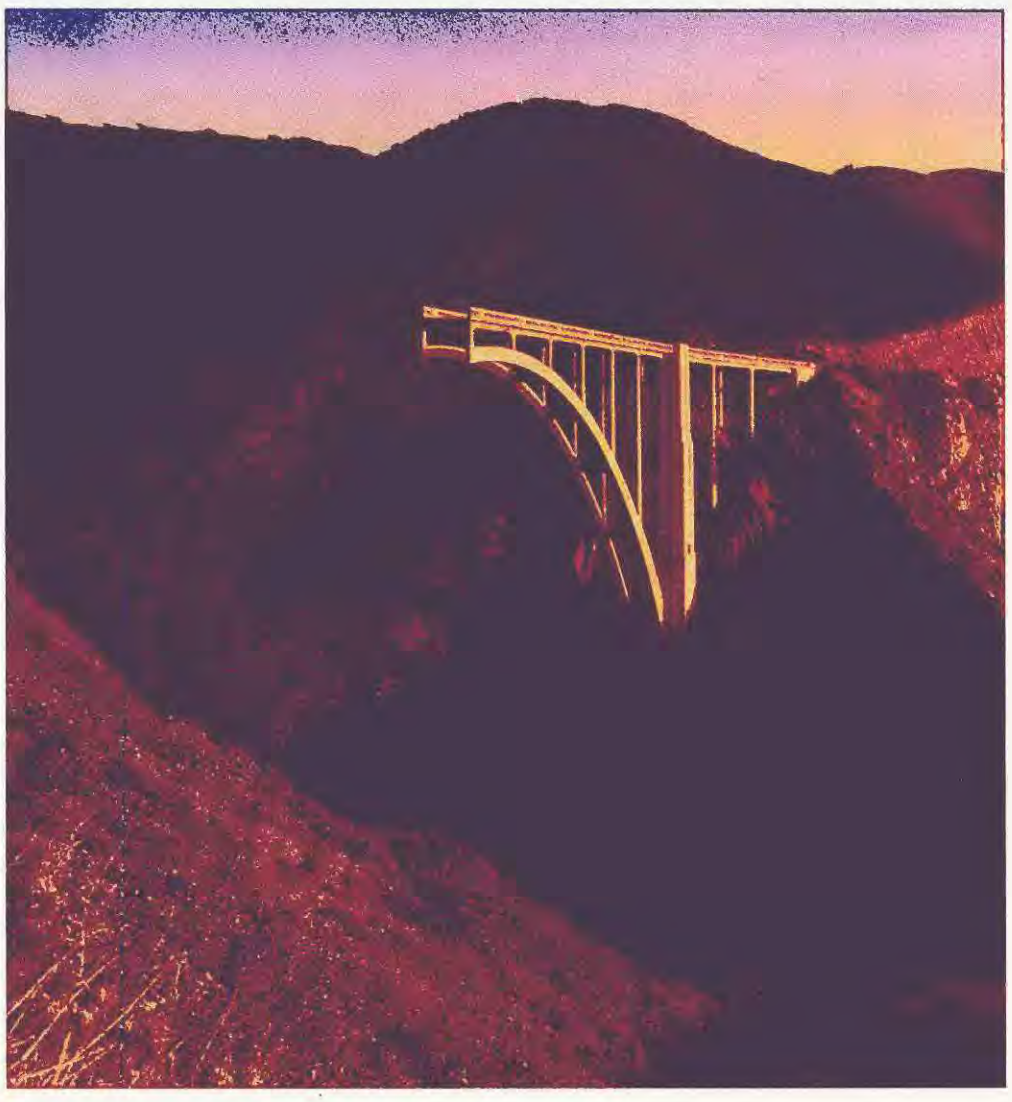
Parents who use the backup providers will pay about $5 per hour if their child is cared for in the provider's home. Hourly costs will run about $9 if the provider comes to the family's home.

"All the providers will be trained in CPR and first-aid. We hope that they'll be responsible people that parents feel comfortable placing their kids with on snow days or when their normal provider is sick," Ms. Werner said.

Corning also plans to begin a pilot project with the Corning-Painted Post School District, in which area schools will provide free space after school to a non-profit organization that will run child care programs for children of Corning employees between the ages of six and 12 years.

Corning also has hired Work-Family Directions Inc. of Boston to provide continuing education to managers on work and family subjects.

Corning, which already offers employees a wide range of work and family benefits, was identified as being one of the four most "family friendly" companies in America by the New York-based Families and Work Institute (*BI*, Nov. 25). ■



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Opinions

A shield for lawyers?

AN ILLINOIS Supreme Court ruling in a legal malpractice case seeking to create more predictability in damage awards instead may have created more uncertainty.

The court ruled last month that when a client has suffered only economic damages—not related to fraud, personal injury or property damage—from an attorney's malpractice, the client can sue the lawyer only under contract law, not under tort law (*BI*, Nov. 25).

The court reasoned: "Contract law provides a superior basis to tort law for the resolution of issues concerning the failed expectations of clients of professionals where only economic loss is sought to be recovered. Contract damages provide recompense for failed commercial expectations and do not expose professionals to unlimited and unforeseen damage for economic loss."

The "unlimited and unforeseen damage" can result when suits are brought under tort law, which allows unlimited recoveries for damages like pain and suffering, and injury to reputation—as doctors, manufacturers and even journalists know all too well.

To those who believe that the U.S. tort system too often allows awards that are far larger than reason would dictate, the Illinois Supreme Court's ruling appears to provide some desirable limits on awards against attorneys in Illinois involving only economic loss.

However, lawyers do not agree on what limits the court's decision has imposed, creating uncertainty in Illinois over the rights of a client to recover economic damages from lawyers.

Some lawyers interpret the decision to mean that a client who suffers an economic loss after an attorney botches a case could recover only the legal fees. Even the most ardent of tort reform advocates would have to say that this is indeed too much protection from liability for lawyers who fail to deliver professional services to the detriment of their clients.

Others, however, suggest that Illinois courts could find implied contracts between lawyers and their clients and award economic damages when they find that



the implied contract to meet professional standards is broken. That sounds like common sense, but unfortunately, courts too often fail to exercise common sense.

As a result, clients in Illinois may well want to follow the advice of dissenting Justice Benjamin K. Miller, who wrote: "Prospective clients would be well-advised after today's decision to obtain counsel before they retain counsel: to seek out independent legal advice to vet the expressed or implied contract terms that will now exclusively govern, if not all malpractice actions against attorneys, at least those in which the underlying representation relates to what is deemed an economic loss."

As a footnote, this case does not stem from a group of lawyers seeking to protect their own from "unlimited and unforeseen damage." The Illinois Supreme Court previously has applied this doctrine to product liability cases and a professional liability suit against an architect in which no personal injury or property damage was at issue.

Oregon delivers workers comp cost cuts

ALL EMPLOYERS ARE complaining about rising workers compensation costs; the Oregon state government is doing something about it.

And, that something has saved Oregon taxpayers more than $100 million (see story, page 31).

Oregon's workers comp achievement stands out even further since state bureaucracies are not usually associated with enlightened cost cutting.

The impetus behind Oregon's cost control program was simple: Former Gov. Neil Goldschmidt in 1988 simply ordered the heads of state agencies to do something to contain workers comp costs. That "something" was up to the individual managers, though the state's risk management division had the power to review the programs.

By taking a variety of steps, the agencies cut their comp costs by 75% over two years.

For once, the private sector can learn something about management from government: Ask and you might receive.

At issue

Have employees expressed concern about 401(k) guaranteed investment contracts?



Roxanne Kainz
Benefits Coordinator
Doherty Rumble & Butler,
St. Paul, Minn.

After the Executive Life failure, a number of plan participants expressed concern about the stability of the life insurance company we contract with for our GICs. Our investment committee carefully investigated the company's financial status and is confident our plan assets are secure. We relayed this confidence to participants with numerous statements and financial reports.



Leslie A. Wittmann
Manager-Employee Benefits
Caterair International Corp.,
Potomac, Md.

Our plan participants have not expressed concern over the security of their funds invested in GICs. As a plan administrator, we try to analyze solvency during the bidding process by collecting data on each carrier's investment portfolio and ratings history. We continually collect data on our existing carriers, and our auditors conduct annual reviews.



Rosalie N. Barbera
Manager of Employee Benefits
Banta Corp.,
Menasha, Wis.

No. Our funds have been performing well and our employees know this because of our communications efforts. An in-house newsletter accompanies the employees' quarterly statements. Any questions the employees do have can be directed to the benefits staff, but we have not heard a lot of concerns.

Compiled by Sara Harty

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Hospitals

Continued from page 3

cern over the low rates.

"In my opinion, professional liability rates have gotten too low," said Corbette Doyle, co-chairman of the health care industry division of Willis Corroon P.L.C. in Nashville, Tenn. "I tell my clients, 'Take advantage of the break in price, but don't plan on maintaining these prices.' "

However, competition and abundant capacity now are the order of the day for hospitals looking for medical malpractice coverage.

Insurers "are aggressively looking to write new business" and every insurer is trying to maintain renewal business at current premium levels, Ms. Hart said. Some insurers are resorting to "price cutting" to gain market share, while others are practicing "prudent underwriting," she said, though she added that insurers have been less willing to compete in recent weeks.

Despite the heated competition, few hospitals are changing insurers, Ms. Hart noted. Hospitals typically only change insurers if there is a problem with the scope of coverage or the services the insurers provide, she said.

"There is plenty of market capacity," noted Rich Pfeiffer, vp of medical facilities underwriting in the medical services division of St. Paul Fire & Marine Insurance Co. in St. Paul, Minn.

St. Paul is the nation's leading underwriter of medical malpractice insurance, reporting more than $610.8 million in direct premiums in 1990, according to A.M. Best Co. St. Paul wrote 12.4% of the nation's overall medical malpractice market—including coverage for both hospitals and individual physicians—last year, Best reports.

"There are probably more insurers available to quote on a facility today than in the last 10 years," Mr. Pfeiffer said, summing up the competitive atmosphere. The medical malpractice market for individual physicians is equally stable, he said (see story, page 13).

St. Paul's medical malpractice rates for hospitals increased an average of 3.9% nationwide in 1991, Mr. Pfeiffer noted. The modest increase follows average nationwide decreases of 9.9% in 1990 and 2% in 1989.

St. Paul requested increases ranging from 5% to 15% in 20 states where the company writes professional liability coverage for hospitals. Rates remain unchanged in 24 states and decreases were filed in Kentucky, Oklahoma and Oregon, he said.

"At the beginning of the year, we might have seen 5%, 10% and as high as 15% decreases in premiums," said Joan Wilson, president of Continental Insurance HealthCare, a division of Continental Corp. in New York. Now those decreases, if there are any, are averaging about 5%, she said.

Premiums for hospital professional liability insurance increased just 5.5% nationwide in 1991, said Pete Henning, senior vp at PHICO Insurance Co. of Mechanicsburg, Pa.

'Since prices have stabilized or decreased, hospital administrators have allocated more budgeted premium dollars to buy more insurance,' Mr. Pfeiffer says. 'Our facilities are renewing with higher limits, in general.'

And, he pointed out, more hospitals are enjoying premium credits —upfront premium decreases off manually filed rates—than ever before. PHICO gives credits to hospitals with good loss records and quality risk management programs, he said.

"We had about a 5% decrease in premium," reported Sandra K.C. Johnson, director of risk management and insurance coordination for Delaware County Memorial Hospital in Drexel Hill, Pa. The 310-bed facility, which is insured by PHICO, purchased limits of $200,000 per claim/$1 million aggregate.

"The rates in Idaho stayed exactly the same," said John O'Hagan, director of insurance services for the Idaho Hospital Assn. in Boise. The association includes 44 hospitals ranging in size from four to 350 beds.

"Without blinking an eye," Idaho hospitals got the coverage they asked for, Mr. O'Hagan noted. In fact, he said, many hospitals increased limits this year.

"Budgets in health care institutions are extremely tight, but insurance is one of the few areas where they have discretion" to spend more money, explained Greg Daniels, director and chairman of Sedgwick James North America's national health care group in Nashville. "Price is driving a lot more buying decisions than two years ago."

"Since prices have stabilized or decreased, hospital administrators have allocated more budgeted premium dollars to buy more insurance," said Mr. Pfeiffer of St. Paul. "Our facilities are renewing with higher limits, in general, but I think it's an affordability issue. If rates went up 20%, we'd probably see the limits purchased come back down."

Medium-sized hospitals—those with about 250 beds—are purchasing the same limits as a year earlier, said J&H's Ms. Logue. In general, these types of hospitals purchase primary limits of $1 million or $2 million per occurrence or claim and $3 million or $4 million in aggregate coverage. These hospitals also typically purchase $10 million to $15 million in excess coverage, she said.

Larger hospitals—those with more than 350 beds—typically purchase primary limits of $2 million to $3 million per occurrence or claim and $6 million to $10 million or more aggregate. Excess coverage limits of $25 million to $40 million are not uncommon for larger hospitals, Ms. Logue said.

"We are now seeing a movement toward buying higher limits," since coverage has become more affordable, said A&A's Ms. Hart. But, she explained, there also "is a perceived need for more protection" as hospital directors see medical malpractice claims frequency and severity trends creeping up again.

"You could put together, on a claims-made basis, up to $200 million (in limits) if you wanted to. We can put $50 million together with ease," said A&A's Ms. Hart.

Mr. Daniels said there is additional capacity, but it is "redundant capacity—all in the primary layers—and we don't necessarily need it there."

He characterized competition in the domestic market as "tough," noting that many insurers that pulled out of the troubled hospital professional liability and medical malpractice market during the mid-1980s crisis are coming back.

Several brokers and insurers cited Travelers Corp. as an insurer that is pursuing hospitals' business more aggressively.

While Travelers has been writing hospital liability coverage since 1983, it is "building awareness for its medical malpractice and hospital liability product line," said Dave MacLeod, managing director at Hartford, Conn.-based Travelers. The insurer can offer hospitals at least $10 million in claims-made coverage limits, he pointed out.

Continental Insurance HealthCare also is in a "growth mode," said Ms. Wilson. The insurer has been writing medical malpractice risks since 1986 and currently writes about $80 million in physician and hospital liability premiums annually, she said. Any growth will be through "cautious expansion," she added.

"At the same time, doctor-owned and medical society-sponsored insurance companies are aggressively" pursuing hospital professional liability risks, Mr. Daniels said. And, he noted, "since the first quarter of 1991, even the London market"—which traditionally has insured only hard-to-place North American medical liability risks—"has had a hard time competing with the domestic market."

To illustrate the market's competitive atmosphere, Mr. Daniels described a recent renewal of a Sedgwick James' policyholder: a large, urban hospital with bad loss experience. "Two years ago, it was difficult to find anyone to touch it, but this year three domestic insurers were willing to offer very competitive quotes, all better than quotes from the London market," he said.

Not all of this competition is coming from the United States.

Ms. Hart pointed out that on a recent trip to Europe, "European underwriters said they were interested in the North American medical malpractice business." However, she noted, those underwriters expressed concern over the low pricing in the United States. "This may be the first sign that things are beginning to tighten up a bit," she said.

"A lot of European reinsurers that would not touch malpractice before now are open to the 'right'

Continued on page 12

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Hospitals

Continued from page 10

medical professional liability," said Ms. Doyle of Willis Corroon.

"With the kind of premium levels we are looking at now, most insurers would say malpractice and hospital professional liability is a profitable line," ventured Ms. Hart.

While medical liability underwriters will continue to scramble for market share, Mr. Daniels asserts that the "biggest competitive threat is self-insurance." Despite falling rates, many of J&H's hospital clients are increasing their self-insured retentions, he said.

"If there is a trend, it is a heightened interest in self-assumed risk motivated by the need for cost containment," agreed Ms. Logue of J&H. "The trend in American health care to assume some other arrangement other than full insurance is deeply entrenched."

Hospitals also remain interested in alternative risk financing arrangements like captives and risk retention groups.

Willis Corroon is conducting a "tremendous" number of captive feasibility studies for hospitals, Ms. Doyle said. A soft market is the best time for clients to examine risk financing alternatives, she explained.

"Many of our accounts are buying both commercial insurance" and coverage from risk retention groups, said Bob Sinclair, president and chief executive officer of Consolidated Catholic Casualty Risk Retention Group Inc. of Nashville, Tenn. The group, which is domiciled in Vermont, was organized in 1987 and is owned by 11 Catholic multihospital systems with a total of about 115 hospitals nationwide.

Consolidated Catholic Casualty offers $20 million in excess limits, attaching at $2 million per occurrence or per claim and $8 million aggregate. About 70% of its business is underwritten on an occurrence basis and the remaining 30% is claims made, Mr. Sinclair explained.

Renewals in the last 24 months have been characterized by premium decreases, he said, adding that a 10% drop from 1990 rates is not uncommon. "Either our rating base was totally excessive in the past or we're giving coverage away," Mr. Sinclair said, referring to why premiums continue to fall.

"I'm convinced the risk itself is continually improving" and that is what is keeping rates stable, said Gene Marsh, president and chief executive officer of California Hospital Affiliated Insurance Services Inc. CHAIS manages California Hospital Insurance Co. Inc., a Hawaii-domiciled risk retention group based in Sacramento, Calif.

"Underwriting results look darn good and we are doing exceptionally well. We are in our third year of operation and we are reducing rates by an average of 7% this year," Mr. Marsh said.

The group currently has 14 members in California, he said.

The increases in frequency and severity in the past year are not affecting AMHS Insurance Co. Risk Retention Group in Burlington, Vt., because it provides excess coverage, said Jim Baldyga, its director of underwriting. As a result, members' premiums still are not increasing.

"The only time premiums change is when a hospital changes its insurance program," he explained.

The group writes excess professional liability coverage for 26 hospital systems that represent more than 200 facilities and 44,000 licensed beds. The group can provide up to $45 million in claims-made coverage excess of a minimum of $1 million, Mr. Baldyga said, noting that most members self-insure that layer rather than purchase primary insurance. ■

Claims frequency, severity again rising

By CHRISTINE WOOLSEY

Medical malpractice claims frequency and severity are again on the rise, causing some to question how long the competitive market for hospital malpractice coverage will last.

"After two years of relatively positive trends, we are seeing the first signals of change" in claims frequency and severity, said Joseph B. Nardi, president of St. Paul Fire & Marine Insurance Co.'s medical services division, in the insurer's 1991 annual report to policyholders.

The update reported an increase in the frequency of claims reported by the company's insured hospitals and a sharp increase in the severity of those claims.

Hospitals insured by St. Paul reported 3.5 claims per 100 occupied beds in 1990, after years of steady decreases. Frequency reached a low of 3.3 claims per 100 occupied beds in 1989, down from 3.6 in both 1987 and 1988 and a high of 3.9 in 1985, St. Paul reported.

"At the same time, the increase in severity or average cost per reported claim is the largest in six years," the report noted. "The current average cost per reported claim, capped at $200,000 and including defense costs, is $20,865 a 20% increase from the $17,430 for 1989."

The average cost per claim was only $16,366 in 1988, the report said.

"This jump (in severity) has given us cause for concern," Mr. Nardi said.

Other insurers also are watching claims trends closely.

"Through the end of 1990, we are seeing a rise in the frequency of claims reported on the hospital side," noted Craig Rowland, assistant vp and actuary at PHICO Insurance Co. in Mechanicsburg, Pa. The increase is less pronounced in inpatient than in outpatient care, but it's "nothing I'm excited about," he said.

More frequent and more severe claims are taking their toll on medical malpractice insurers' loss ratios, A.M. Best Co. reports.

U.S. medical malpractice insurers' aggregate loss ratio—for both hospital and physician risks—rose last year for the first time since 1986, when the ratio topped 100%. U.S. insurers reported an aggregate loss ratio of 59.4% in 1990, up from 49.8% in 1989 but still much lower than the 77.4% reported in 1988.

But some insurers still reported declining loss ratios in 1990. For instance, St. Paul's loss ratio fell to 41.3% last year from 47.7% in 1989 and 63.7% in 1988, according to Best.

The most costly claims continue to occur in hospital obstetrics departments, according to St. Paul's data. Hospitals insured by St. Paul reported 706 such claims between 1989 and 1990, with the average claim costing $99,155.

Psychiatric services comprise the next most costly type at an average of $41,739 per claim.

But, by far, the most frequent claims arise in the patient care area and include bed-related falls, treatment complications, ambulation-related falls, bathroom-related falls and patient monitoring problems, according to St. Paul (see chart, page 3). ■



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Soft market: Just what the doctor ordered

By CHRISTINE WOOLSEY

Physician medical malpractice rates are stable, capacity is plentiful and no one expects that to change for at least another year or two.

"We are in a soft market, and it appears that will continue for another two years at least," said Dr. Brad Cohn, chairman of Medical Insurance Exchange of California, a policyholder-owned physician insurer based in Oakland.

"Essentially, rates were the same for our last renewals and have been the same for the last three years," he said. And, some physicians insured through the exchange for four or more years are receiving dividends based on MIE's experience and profits over that time, Dr. Cohn explained.

Formed in 1975, the exchange writes about $50 million in medical malpractice premiums per year. Its 5,000 policyholders include individual physicians of all classes, some surgical centers and blood banks and one hospital. The insurer operates in California, Nevada, Idaho, Alaska and Hawaii.

"There will be no rate adjustments filed for physicians and surgeons professional liability insurance on those policies renewing on or after July 1, 1991," according to St. Paul Fire & Marine Insurance Co.'s annual update to policyholders.

"We haven't had a rate increase in two years," said Fred Phelps, senior vp at Michigan Physicians Mutual Liability Co. in East Lansing. The doctor-owned insurer wrote approximately $55 million in medical malpractice premiums in 1990 for its 4,800 policyholders in Michigan.

"The market is very soft, very competitive," noted Phil Young, assistant vp of agency business at The Medical Protective Co. of Fort Wayne, Ind., a commercial insurer. "There is ample competition in each and every state (in which) we write." Medical Protective wrote $193.1 million in direct medical malpractice premiums in 1990, according to A.M. Best Co.

Even in states with particularly bad loss experience, rates are stable for anesthesiologists insured by Preferred Physicians Mutual Risk Retention Group, said Dr. David Schoenstadt, chairman of the Kansas City, Mo.-based group. "In states where experience is good or where past premiums were unnaturally higher, we'll give decreases of as much as 25%," he said.

Preferred Physicians writes coverage only for anesthesiologists.

Insurers say it is difficult to come up with an average premium increase or decrease for individual physicians nationwide because premiums vary significantly among states and specialties.

For example, MIE's Dr. Cohn said a California obstetrician insured by his company would pay about $40,000 for a $1 million per claim/$3 million aggregate policy. "If that doctor moves to Manhattan, the premium goes up to $97,000 and if he (or she) moves to Broward County near Miami, the premium shoots up to $175,000."

An obstetrician in Indiana would pay approximately $10,676 in premiums for an occurrence policy providing limits of $100,000 per incident/$300,000 aggregate, said Robert J. Miller, vp of risk management and consumer affairs for The Medical Protective Co. That same physician would pay $71,577 if he or she practiced in nearby Detroit.

Premiums for coverage with limits of $1 million per claim/$3 million aggregate ranged from $1,839 for internists in Oklahoma to $30,050 for internists in Michigan as of June 30—a spread of $28,211, according to a recent study by the Medical Liability Monitor, a newsletter published by Malpractice Lifeline Inc. in Winnetka, Ill.

Based on a survey of 35 leading writers of medical professional liability insurance, the newsletter re-

Continued on next page



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Do reforms really help hospitals?

The jury is still out on whether tort reform is helping to stabilize the hospital professional liability insurance market.

"It appears that in those jurisdictions with caps" on pain and suffering awards, "there has been an improvement—not in frequency, but in the dollar value of the claims," said Karen Logue, deputy chairman of Johnson & Higgins' HealthGroup in New York.

"A lot of tort reforms in various states have mechanisms" to assess the "merits of a medical malpractice claim," explained Judy Hart, vp and deputy director of the national health care division of Alexander & Alexander Services Inc. in St. Louis. As a result, fewer frivolous lawsuits are being filed against hospitals, she said.

But, while "there are certain tort reforms that people believe have been successful, in other states caps (on damages) and immunities won't stand up to court tests," said Corbette Doyle, co-chairman of the health care industry division of Willis Corroon P.L.C. in Nashville, Tenn. Some hospitals and physicians "are buying coverage in excess of state caps because they feel the caps won't stand up in court."

In certain states, "insurers are not as comfortable underwriting medical malpractice because of the loss frequency and the litigious atmosphere and the size of judgments," Ms. Logue pointed out.

Texas is one example. Frequent malpractice awards and high punitive damage awards leave insurers "almost afraid to take anything to court there," said Ms. Hart.

Other problem states include Florida, Michigan and New York, as well as Cook County in Illinois.

"There certainly are states that are less attractive than others," said Joan Wilson, president of Continental Insurance HealthCare, a division of Continental Corp. in New York.

"As an insurer, we are more attracted to states with certain types of tort reforms," like caps on punitive damages, she said. States with "patient compensation funds, which generally pay a portion of the total claim awarded to an injured party, also provide some protection."

Others, though, think tort reform has largely been a bust for medical malpractice insurers.

"At this point, it's just wishful thinking that tort reform is having an effect," said Jim Baldyga, director of underwriting for AMHS Insurance Co. Risk Retention Group in Burlington, Vt.

—By Christine Woolsey

Physicians

Continued from previous page

ported that the median premium for internists around the country was $5,478.

Current premiums for general surgeons ranged from $9,137 in Oklahoma to $114,063 in Michigan, the study found. The median was $21,490.

The study concluded that a large number of insurers cut rates in 1989, 1990 and 1991, though a smaller number increased premiums in 1990 and 1991, especially for internists.

"The rate reductions may reflect a combination of an improved claims climate which the line has enjoyed over the past five years and the fact that competition has intensified as the picture has improved," MLM reported.

But, the report noted, "early signs of rate increases may mean some insurers are beginning to see more claims filings and more expensive settlements and awards."

In fact, insurers are expressing concern that claims trends are moving up again.

According to St. Paul's annual report on physicians and surgeons medical liability insurance, the average number of claims reported by doctors insured by St. Paul increased during 1990, the first increase since 1985. Nationwide, St. Paul reported 13.6 claims per 100 doctors for 1990, up from 12.4 in 1989.

"Frequency was up 17% last year and this year it's up 8% to 9% more," said Mr. Phelps of Michigan Physicians Mutual. St. Paul does not write physicians medical malpractice in Michigan.

Claim severity—or average cost—is also increasing. The average cost per claim in 1990, based on a maximum claim of $200,000, was $36,416, up 11.3% from $32,716 in 1989 and 17.4% from $31,021 in 1988, St. Paul reported.

Despite these trends, capacity remains plentiful for physicians medical malpractice coverage.

"We don't see any crunch as far as limits are concerned, and there are no restrictions on reinsurance," said Bob Jones, assistant vp of medical professional liability at CNA Financial Corp. in Chicago. CNA wrote $262.3 million in direct medical malpractice premiums in 1990, according to A.M. Best.

Despite adequate capacity, insurers say physicians are not clamoring for higher limits.

"Physicians are looking for relief (from insurance costs), so they may not buy the higher limits even though premiums have decreased," said Dr. Schoenstadt.

"Where possible, our agents try to explain the advantage of higher limits, but there is no trend toward" purchasing more coverage, Mr. Jones said. Most physicians select limits of $1 million per claim/$3 million aggregate, he said, noting that CNA can offer $10 million of coverage or more if necessary.

However, other insurers say doctors are purchasing higher limits.

Some physicians "realize that because of the longevity of some medical malpractice cases, it may be as long as 10 years before a claim is made," Dr. Cohn said. "In subsequent years, when the trial occurs, the level of judgment may be much higher. Even if you are covered today for today's standard of award, you may not be covered for future awards," he warned.

Dr. Cohn explained that different types of specialists purchase different limits. At the high end are obstetricians, neurosurgeons and orthopedic surgeons, he said. "Juries usually offer larger amounts for damage to the reproductive system or neurological system," he explained.

The number of million-dollar medical malpractice verdicts increased in 1988 and 1989 following two years of decreases, according to recent research published by Jury Verdict Research Inc. Million-dollar verdicts also appear to have increased in 1990, though complete data is not available.

The average estimated medical malpractice award in cases in which only doctors were defendants rose to $815,906 in 1989, up from $730,575 in 1988, but down from $835,752 in 1987, according to Jury Verdict Research.

Diagnostic issues accounted for the greatest percentage—34.8%—of medical liability costs and for the highest number of claims reported by physicians and surgeons insured by St. Paul in 1989 and 1990. Claims alleging improper treatment account for 30.4% and claims citing surgical issues account for 21.5% of total incurred costs, according to the report.

"Failure to diagnose cancer is the most frequent allegation among diagnostic issues and accounts for 31% of the cost of these claims," St. Paul reported. Most of these claims—more than 70%—allege the misdiagnosis occurred in the physician's office or clinic.

"Statistics indicate that more and more screening and diagnosis of patients' symptoms takes place in these locations," the report added.

Birth-related treatment issues are the most frequently cited among claims involving improper treatment and account for nearly 40% of the costs of such claims, St. Paul reported. And, claims alleging postoperative complications continue to account for 50% of the costs of claims involving surgical issues. ■

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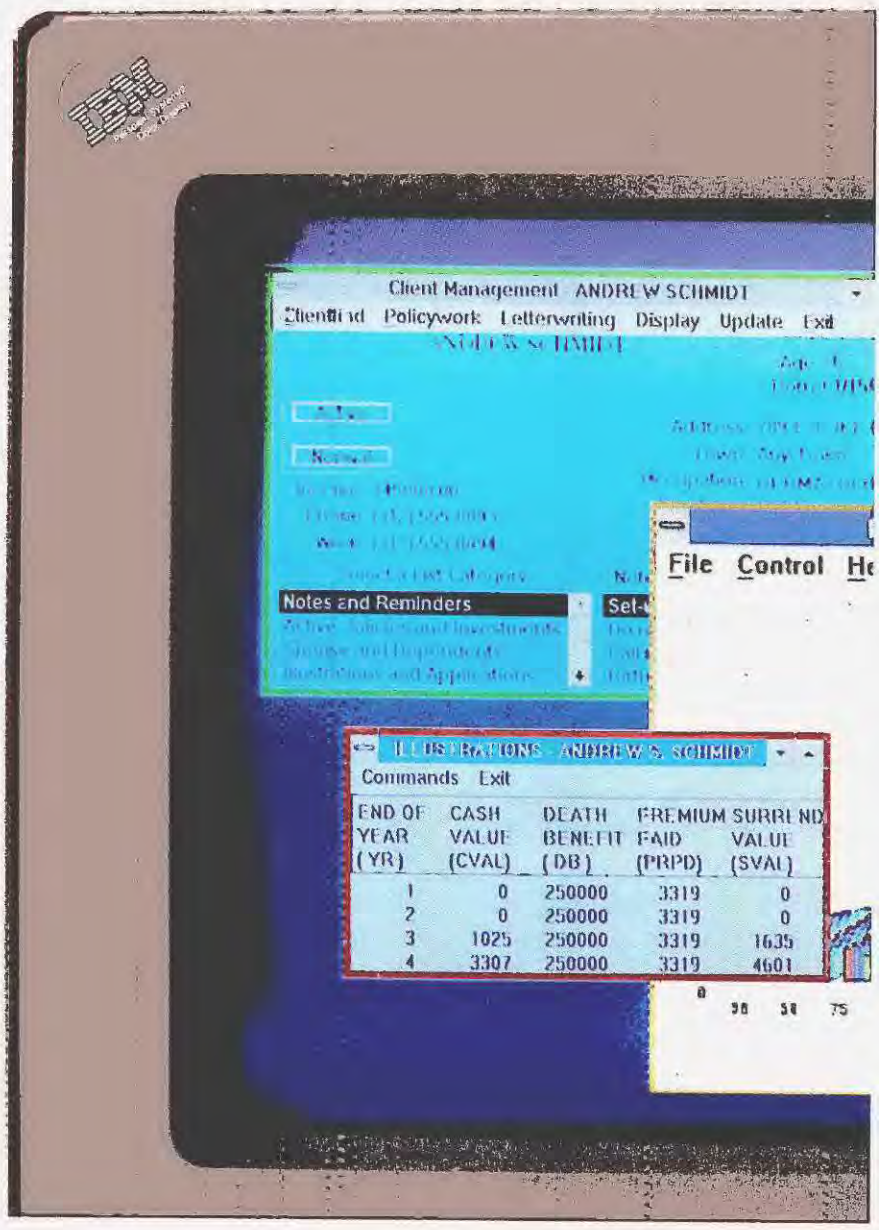
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DECEMBER

DEC. 9. SARA Title III and OSHA Right to Know seminar in Raleigh, N.C., sponsored by Environmental Resource Center; $379. **Also Dec. 10** in Dayton, Ohio; **Dec. 18** in Williamsburg, Va. ERC, 3679 Rosehill Road, Fayetteville, N.C. 28311-6634; 800-537-2372; 919-822-0449

DEC. 9. Hazardous Waste Management Under RCRA seminar in Dayton, Ohio, sponsored by Environmental Resource Center; $379. **Also Dec. 17** in Williamsburg, Va. ERC, 3679 Rosehill Road, Fayetteville, N.C. 28311-6634; 800-537-2372; 919-822-0449.

DEC. 9. Pollution Liability—The Law and Available Insurance seminar in Irving, Texas, co-sponsored by The Society of Chartered Property & Casualty Underwriters and the Dallas Chapter; $130 for society members; $140 for non-members; Bonnie Kinsley, Continuing Education Coordinator, The Society of CPCU, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355-0709; 215-251-2735.

DEC. 9-10. Finding Insurance Company Markets of Agents' Specialty Programs conference in New York City, sponsored by Executive Enterprises Inc.; $1,045. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

DEC. 9-10. How To Audit Your Insurance Program: Getting Your Money's Worth seminar in Los Angeles, sponsored by the American Management Assn.; $850 for AMA members; $980 for non-members. AMA, P.O. Box 319, Saranac Lake, N.Y. 12983; 518-891-0065.

DEC. 9-10. International Joint Ventures Strategic Alliances & Direct Entry forum in New York City, sponsored by the Institute for International Research Insurance Division; $1,195. Conference Administrator, IIR, 437 Madison Ave., 23rd Floor, New York, N.Y. 10022; 212-826-1260.

DEC. 9-11. Property-Casualty Insurance Accounting and the Statutory Statement conference in Chicago, sponsored by Executive Enterprises Inc.; $1,045. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

DEC. 9-11. Environmental Regulation Course in Philadelphia and Indianapolis, sponsored by Executive Enterprises Inc.; $1,045. **Also Dec. 10-12** in Honolulu; **Dec. 11-13** in Denver; **Jan. 14-16** in Dallas; **Jan. 15-17** in Orlando, Fla.; **Jan. 21-23** in San Francisco; **Jan. 28-30** in New York City; **Jan. 29-31** in Washington, D.C.; **Feb. 5-7** in Seattle; **Feb. 10-12** in Cleveland and New Orleans; **Feb. 18-20** in Dallas. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

DEC. 10-11. Health Care Cost Containment workshop in Chicago, sponsored by the Health Research Institute; $595. Also **Jan. 29-30** in Los Angeles; **Feb. 17-18** in Honolulu. Workshop Coordinator, Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 510-676-2320.

DEC. 10-11. Labor Management Health Care Cost Containment workshop in Chicago, sponsored by the Health Research Institute; $595. Workshop Coordinator, Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

DEC. 10-11. Plant-Level Environmental Compliance Course in San Francisco, sponsored by Executive Enterprises Inc.; $1,045. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

DEC. 10-11. Property & Casualty Loss Reserves: Understanding, Analyzing and Managing seminar in Chicago, sponsored by Deloitte & Touche; $850. Deloitte & Touche National Seminar & Conference Group, 1001 Pennsylvania Ave. N.W., Suite 350N, Washington, D.C. 20004; 800-654-8920; 202-638-7310.

DEC. 11. Environmental Audits seminar in Dayton, Ohio, sponsored by Environmental Resource Center; $379. ERC, 3679 Rosehill Road, Fayetteville, N.C. 28311-6634; 800-537-2372; 919-822-0449.

DEC. 11. The Insurance Industry at Year 2000 workshop in Baltimore, co-sponsored by The Society of Chartered Property & Casualty Underwriters and the Maryland Chapter; $90 for society members; $100 for non-members. The Society of CPCU, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355-0709; 215-251-2774.

DEC. 11. Prevention and Management of Stress Claims Workshop in San Francisco, sponsored by the Insurance Educational Assn.; $150 for IEA members; $175 for non-members. IEA, 100 California St., Suite 1100, San Francisco, Calif. 94111; 415-986-6356.

DEC. 11. Advanced Hazardous Waste Management seminar in Raleigh, N.C., sponsored by Environmental Resource Center; $379. ERC, 3679 Rosehill Road, Fayetteville, N.C. 28311-6634; 800-537-2372; 919-822-0449.

DEC. 11-13. The Region V Environmental Regulations Update Conference in Chicago, sponsored by Executive Enterprises Inc.; $1,045. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

DEC. 12. Advanced Cost Containment workshop in Chicago, sponsored by the Health Research Institute; $295. Also **Jan. 31** in Los Angeles; **Feb. 19** in Honolulu. Workshop Coordinator, Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 510-676-2320.

DEC. 12. Computer Security seminar in Newburgh, N.Y., co-sponsored by The Society of Chartered Property & Casualty Underwriters and the Hudson Valley Chapter; $100 for society members; $110 for non-members. Bonnie Kinsley, Continuing Education Coordinator, The Society of CPCU, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355-0709; 215-251-2775.

DEC. 12. How to Comply with EPA's Underground Storage Tank Requirements seminar in Raleigh, N.C., sponsored by Environmental Resource Center; $379. **Also Dec. 16** in Williamsburg, Va. ERC, 3679 Rosehill Road, Fayetteville, N.C. 28311-6634; 800-537-2372; 919-822-0449.

DEC. 12-13. Insurance Coverage and Practice seminar in New York City, sponsored by the Defense Research Institute Inc.; $370 for DRI members; $420 for non-members; some discounts apply. DRI, 750 N.

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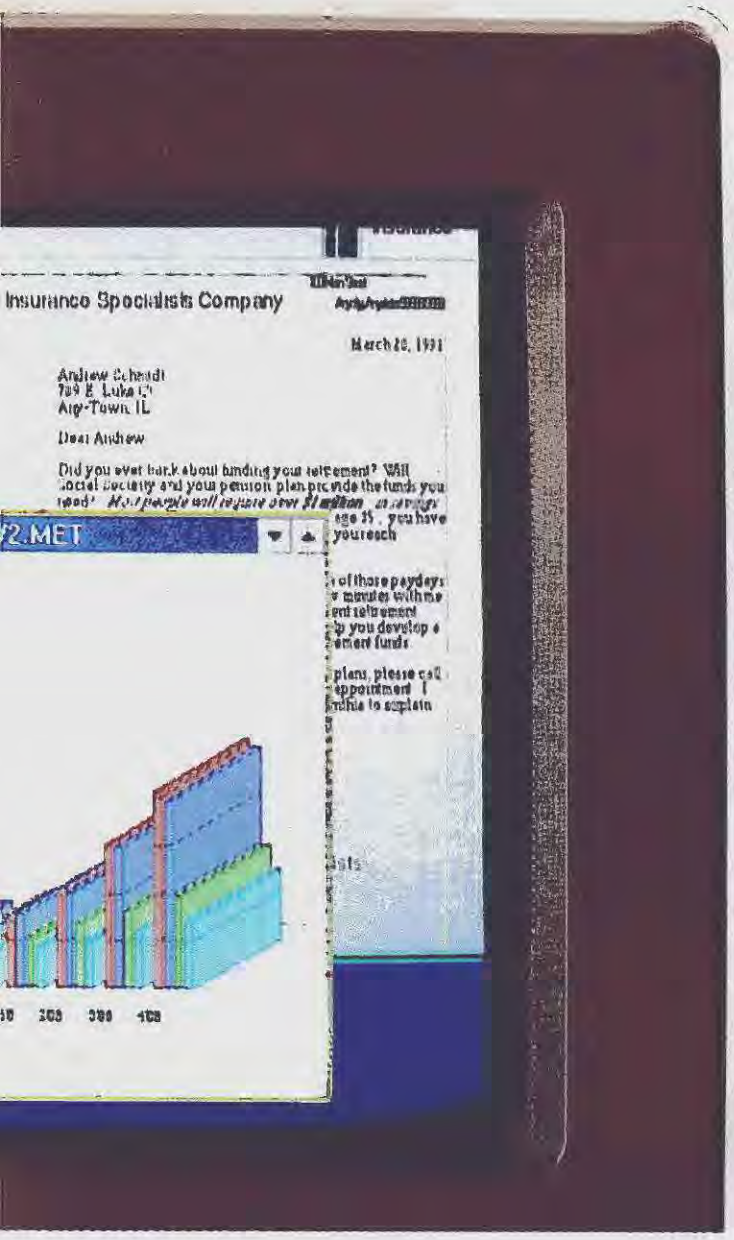


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Lake Shore Drive, Suite 500, Chicago, Ill. 60611; 312-944-0575.

DEC. 13. OSHA's Hazard Communication Standard: Training for Trainers seminar in Raleigh, N.C., sponsored by Environmental Resource Center; $379. ERC, 3679 Rosehill Road, Fayetteville, N.C. 28311-6634; 800-537-2372; 919-822-0449.

JANUARY

JAN. 9-11. Annual Tort and Insurance Meeting in Palm Beach, Fla., sponsored by the American Bar Assn. and the Tort and Insurance Practice Section; $220. Teresa B. Rafol, American Bar Assn., TIPS, 750, N. Lake Shore Drive, Chicago, Ill. 60611; 312-988-5672.

JAN. 12-14. Managing Mental Health Services in a Dynamic Environment conference in Phoenix, sponsored by the Group Health Assn. of America; $535 for GHAA members; $635 for non-members; add $80 after Dec. 16. GHAA, Conference Office, 1129 20th St., Suite 600, Washington, D.C. 20038; 202-778-3236.

JAN. 13-14. The Science of Environmental Law: An Introduction for Lawyers and Other Environmental Professionals conference in Washington, D.C., sponsored by Executive Enterprises Inc.; $1,045. Also **Feb. 27-28** in San Francisco. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

JAN. 13-14. Association and Group Captives Worker's Compensation and Alternative Risk Solutions Seminar in Austin, Texas, sponsored by the law firm of Grissom & Cain P.C.; $495. Noel Cain, 512-478-4059; or Jack Hofmann, 800-876-7744.

JAN. 14. Workers' Compensation and the Americans With Disabilities Act seminar in Oak Brook, Ill., co-sponsored by Rehabilitation Management Inc. and the Workers' Compensation Claims Assn.; $95. Naomi Velick, 708-773-2882, ext. 230.

JAN. 20-24. Preventive/Predictive Maintenance for Facilities: The Infrared Solution course in Dallas, sponsored by American Risk Management Corp.; $1,295 for five days; $1195 for four days; $995 for three days. **Also Feb. 17-21** in Atlanta; **May 11-15** in Atlanta; **June 15-19** in Dallas; **July 20-24** in Sacramento, Calif.; **Sept. 21-25** in Atlanta. ARMC, One Independent Place, Suite 500, 4807 Rockside Road, Cleveland, Ohio 44131; 216-447-1600.

JAN. 22-24. Health Agenda 1992 conference in Washington, D.C., co-sponsored by the Washington Business Group on Health and the National Assn. of Manufacturers; $550 for WBGH/NAM members; $625 for non-members. Washington Business Group on Health, 777 N. Capitol St., N.E., Suite 800, Washington, D.C. 20002; 202-408-9320.

JAN. 22-24. Risk Management—Taking Stock of Future Shock conference in Atlanta, sponsored by the Atlanta Risk and Insurance Management Society; $100 for RIMS members; $125 for non-members; $25 for students. Cheri Bellam, Rollins Inc., 2170 Piedmont Road, N.E., Atlanta, Ga. 30324; 404-888-2271.

JAN. 23-24. The 1992 Hawaii Captive Insurance Forum in Honolulu, sponsored by Towers, Perrin, Forster & Crosby Inc.; $795. Eileen Callahan, Conference Director, Towers Perrin, 100 Summit Lake Drive, 3S, Valhalla, N.Y. 10595; 914-745-4000.

JAN. 26-29. National Security and Risk Management Conference in San Diego, sponsored by the American Bankers Assn.; $680 for ABA members; $915 for non-members. ABA, 1120 Connecticut Ave., N.W., Washington, D.C. 20036; 202-296-9258.

JAN. 27-28. Managed Behavioral Healthcare seminar in Atlanta, sponsored by the Institute for International Research; $995; $795 for corporate benefit managers. Conference Administrator, IIR, 437 Madison Ave., 23rd Floor, New York, N.Y. 10022; 212-826-1260.

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Bad faith

Continued from page 1

have settled claims under retrospectively rated policies.

Spokesmen for both Kemper National Insurance Cos. and Employers Insurance of Wausau said their companies could not comment for this story due to involvement in similar pending litigation. Several other leading workers compensation insurers and brokers also declined to comment, but did not specify a reason.

The most recent decision on the issue comes from the Illinois Court of Appeals. In a May 8 decision the court said: "An insured should be able to state a cause of action for breach of the insurer's duty of good faith based on the insurer's failure to act reasonably when adjusting claims under a policy which contains a retrospective premium feature, notwithstanding the fact that the policy of insurance contains no express provisions imposing such a duty."

The court said that while insurers are "given broad discretion in adjusting claims as long as the settlement does not exceed policy limits," a different situation exists when the insurance policy contains a retrospectively rated premium.

The court reasoned that when an insurer acts negligently in adjusting claims under a retrospectively rated policy, the policyholder pays the price in the form of higher premiums.

"An insurer's failure to act reasonably when adjusting claims automatically subjects the insured to greater financial obligations in the form of increased premium rates," said the court.

The Illinois case stemmed from a lawsuit filed by National Surety Corp. of Chicago, a unit of Fireman's Fund Insurance Cos., to recoup $108,117 in unpaid premiums from Fast Motor Service Inc., a trucking company in Deerfield, Ill.

Fast Motor purchased workers comp coverage from National Surety from 1977 to 1979 and then renewed its coverage for 1979 to 1982.

However, Fast Motor subsequently refused to pay the retro premium, claiming that National Surety was negligent in paying a claim.

The court found the burden was on the insurer to prove that its handling of the claim was reasonable and done in good faith.

But, during the trial National Surety did not produce any files or produce any witnesses to testify as to why the insurer paid certain claims, according to attorneys. Rather, the insurer simply argued that the policyholder could not question its judgment in settling the claim.

The appellate court was not persuaded by this argument and affirmed a $75,000 jury award to Fast Motor.

National Surety decided not to appeal, according to its attorney.

The Delaware Supreme Court also has recognized the right of workers compensation policyholders to sue their insurers for negligent claims handling under retro policies.

In a 1989 decision involving Twin City Fire Insurance Co., a unit of Hartford Fire Insurance Co., and policyholder Corrado Brothers Inc., the court held: "An insurer may not settle a claim in which a retrospective premium will be imposed on the insured unless settlement is both in good faith and reasonable."

The court reasoned: "Despite the latitude imparted by policy provisions which authorize the insurer to settle a claim 'as it deems expedient,' it is recognized that there is a potential for conflict between the insurer and the insured if the settlement of a claim imposes residual consequences on the insured.

"Thus, the insurer's discretion is not unbridled where settlement of the claim will result in contribution by the insured of a deductible or reimbursable amount," said the court.

Twin City wrote workers compensation coverage for Corrado Brothers of New Castle, Del., from 1981 to 1982. The policies contained a retrospectively rated premium.

Twin City Fire paid $48,617 to settle a claim from a Corrado mechanic who injured his shoulder while repairing construction equipment. The insurer then billed Corrado $48,617 in the form of a retrospective premium. Corrado refused to pay the retro premium, claiming that the insurer had an obligation to discuss any settlements with the policyholder before making a decision.

While finding that Corrado did have the right to challenge Twin City's settlement of the workers comp claim, the court said the insurer does not have to contact the policyholder prior to making a settlement.

Ultimately, the court ruled in favor of the insurer, finding the insurer's settlement was reasonable. As result, the court upheld the lower court's ruling in favor of the insurer.

The Massachusetts Supreme Court in 1989 also recognized the right of workers comp policyholders to sue their insurers for claims handling negligence under retrospectively rated policies.

In a case involving Hartford Insurance Co. and Deerfield Plastics Co. of Deerfield, Mass., the Massachusetts high court ruled: "Hartford has the burden to prove that Deerfield sustained no loss because of Hartford's negligent claims investigation.

"Hartford should not be allowed to retain the payments in issue unless it shows it is entitled to them under its policy of insurance and that it has met its obligation, imposed by law, to act reasonably in making settlements where no money of the insured is involved," the court said.

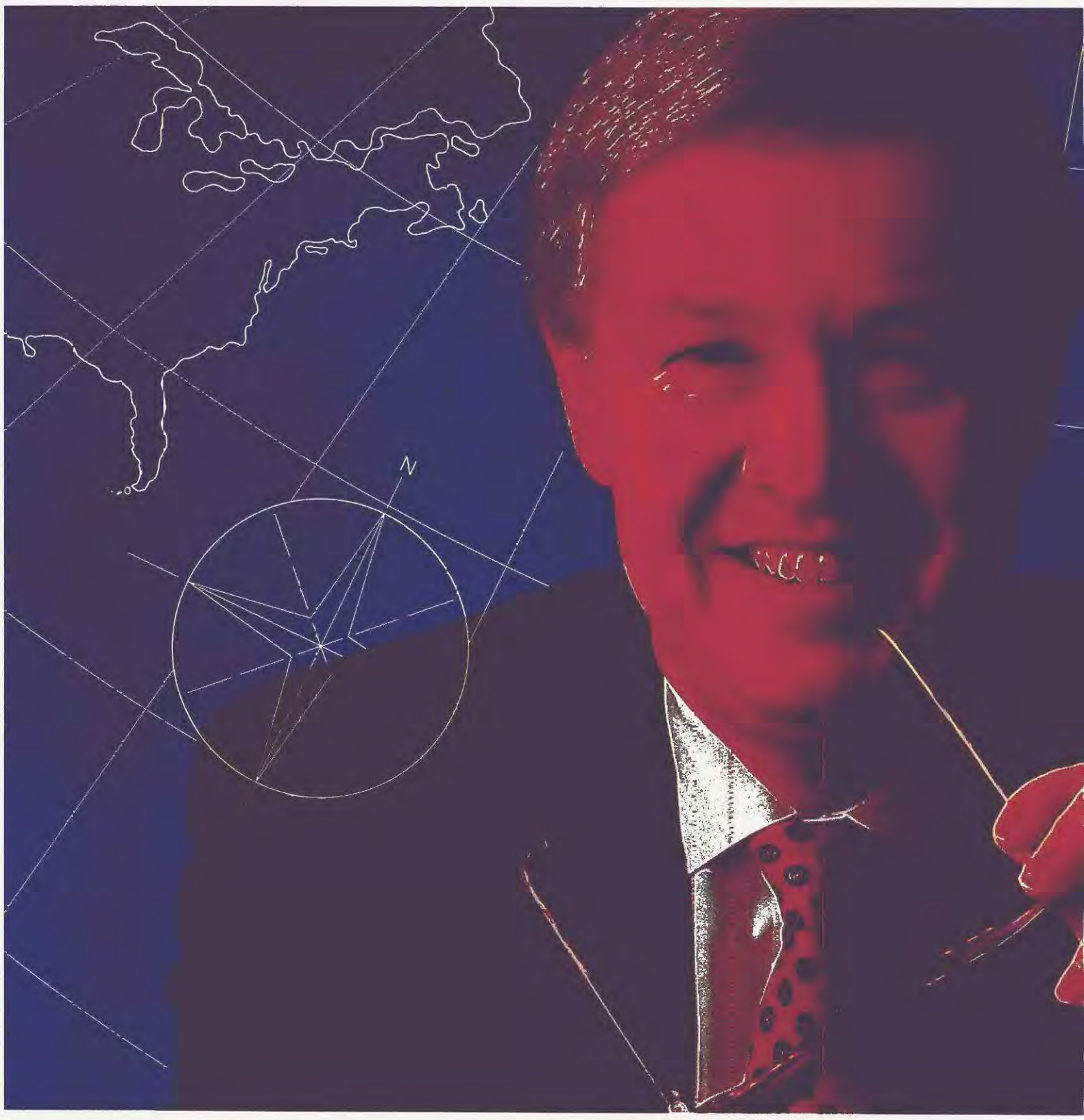
The decision stemmed from a lawsuit filed by Deerfield against Hartford over premiums paid under workers compensation policy with a retrospectively rated premium. The Massachusetts Supreme Court affirmed a trial court decision awarding Deerfield $49,984 for an industrial accident claim paid by Hartford.

The Kansas Court of Appeals in 1983 put the burden on insurers to prove that settlements made under retrospectively rated policies are reasonable.

In a case brought by the now-defunct Transit Casualty Co. of Los Angeles to recover unpaid retro premiums, the court said: "Presumably each payment made by

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OLD PROS ON

Continued from previous page
the (insurer) was based on documentation in its files. . . .Such documentation could be in the form of accident reports, medical reports, investigators' reports, adjusters' recommendations, lawyers' recommendations or any combination."

However, Transit did not introduce any of this material as evidence.

As the trial court put it: "The record is totally devoid of any evidence that the (insurer) made any investigation or inquiry and had come to a conclusion based upon reasonable evidence that the (policyholder) was legally obligated to pay the claims and, lastly, the record is devoid of any evidence that could form a basis of an opinion for a determination that the insurer had reasonable grounds to make the payments and was acting in good faith in that the amount of the claims were, in fact, reasonable."

As result, both the trial court and the appellate court found in favor of the policyholder, Topeka Transportation Co. Inc., a bus company based in Topeka.

The seminal case in this area of law dates back to 1968.

In a case involving Los Angeles-based Transport Indemnity Co., later known as Mission American Insurance Co., and Dahlen Transport Inc. of Newport, Minn., the Minnesota Supreme Court held: "An insurer does have an absolute right to settle claims made against its insured and covered by the terms of its policy when the funds of the insurers are being used to accomplish the settlement.

"But the situation is different where, as here, the company in settling claims for amounts of $5,000 for each occurrence is entitled to charge the amount of such incurred losses paid by the insurer to the account of the insured as a retrospective premium," the Minnesota court ruled.

"In effect, therefore, the insurer is making settlement of this category of claims with the insured's money," said the court.

The Minnesota court also put the burden on the insurer to prove the settlement was reasonable.

"The insurer, having been charged with the responsibility for investigating and adjusting the loss, is in possession of the relevant information upon which a determination of reasonableness and good faith must be based," the court said.

The decision stemmed from a lawsuit filed by Transport Indemnity against Dahlen Transport, a trucking company, to recover $14,725 paid to settle claims against the policyholder. Transport wrote four comprehensive general liability policies for Dahlen, one of which was retrospectively rated.

The five decisions, taken together, give policyholders a strong base from which to contest settlements made under retrospectively rated policies.

"These decisions are saying to insurance companies and policyholders in a retro program that despite the broad discretion given to insurers, there is an implied duty of reasonableness and good faith," said J&H's Mr. Rigo.

As a result, more employers could file litigation against their worker comp insurers, he said.

"Many insureds through their brokers already monitor what their insurers are doing," said Mr. Rigo. "These decisions could cause them to pay even closer attention."

Policyholder attorney Kurt Baranek agreed: "Policyholders are already asking more questions" of their insurers.

These decisions "give them the authority they need" to question their insurers' claims-handling practices in court, he said.

Such lawsuits will force insurers to introduce claims files as evidence and have claims handling personnel testify as to why the insurer made certain settlements, said Mr. Baranek of Fraterrigo, Best & Baranek in Chicago.

As a result, "insurers are worried about more second-guessing by policyholders," said Mr. Baranek, who represented policyholder Fast Motor in the Illinois case.

But an even greater fear is that policyholders will use these decisions as leverage to negotiate lower retrospectively rated premiums, he said.

In contrast, John N. Dore of Sanders, Smith & Cross in Chicago, who represented National Surety in the Illinois case, predicted that the decision would have very little impact.

"This is a narrow issue," said Mr. Dore. "The decision is limited to the facts of this case.

"I don't think it will engender more bad faith lawsuits" against insurers, added Mr. Dore.

Mr. Burdick of Argonaut disagreed: "In general when any appellate court decision sets precedent, it's cause for concern."

While these decisions may not create any new liabilities for insurers, they do articulate the principle that insurers must exercise care when settling claims, he explained.

"Before, if you provided poor service you risked losing the account; now you risk paying damages," said Mr. Burdick.

He suggested that workers compensation insurers consider meeting with their policyholders on a quarterly or biannual basis to review claims-handling procedures and reserves.

Chris Mansfield, general counsel at Liberty Mutual Insurance Co. in Boston, said he does not view the Illinois decision as creating open-ended liability for insurers. Rather, he said that "this is just a natural evolution in this area of the law."

"Courts over time will find ways to balance the business and legal issues involved here," predicted Mr. Mansfield.

One catalyst for these suits is the rising cost of workers compensation insurance, he said.

"The cost of the system is forcing people to pay more attention," explained Mr. Mansfield.

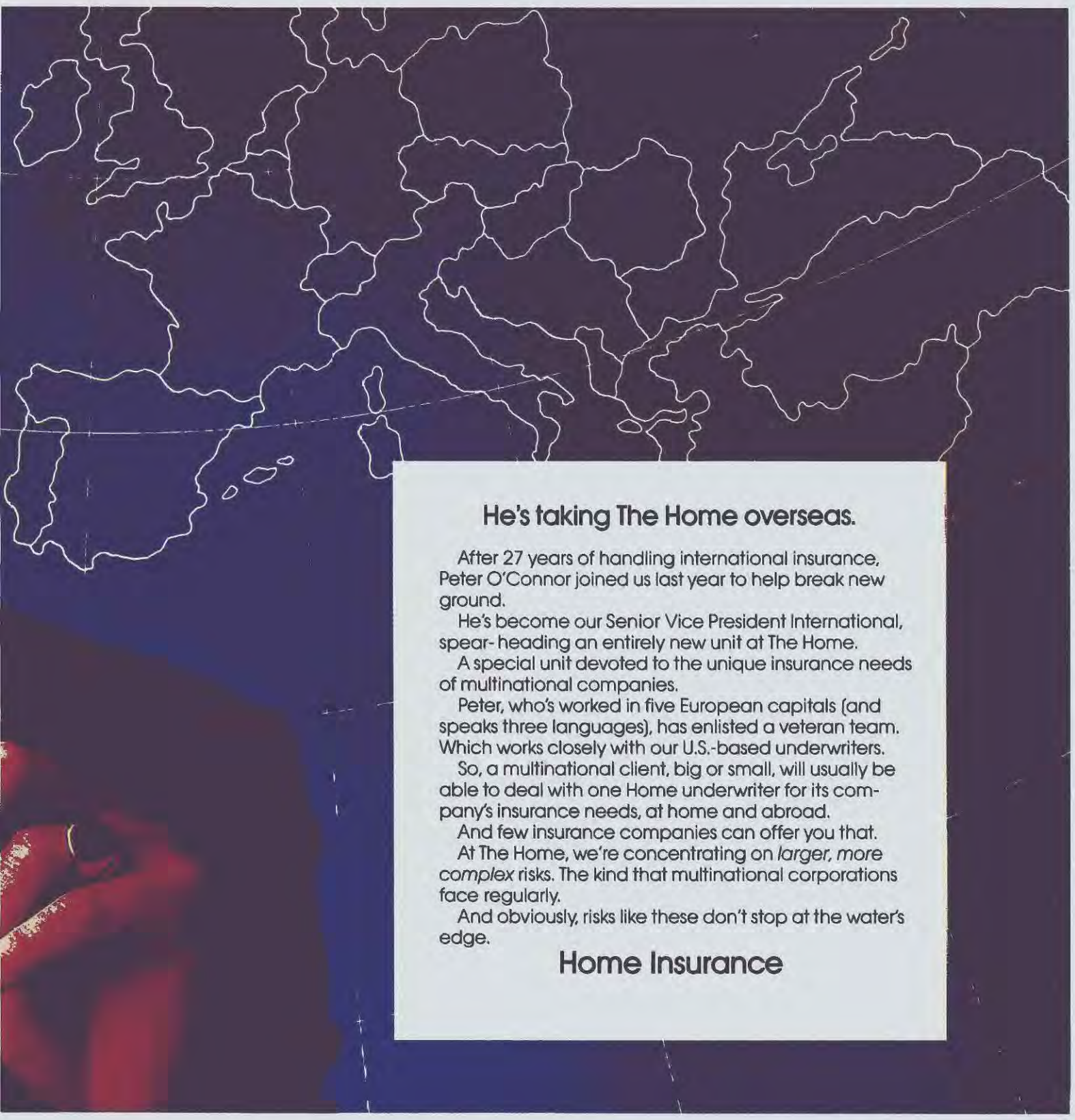
"We have all seen cases where insurers have been sloppy or lackadaisical and the policyholder is forced to pay more in its retro," said a broker who asked not to be identified.

If the insurance company's claims handling practices are sloppy, the policyholder should have the right to sue, the broker said. "Insurance companies should be responsible for their actions, which is to properly manage claims."

An insurer executive who asked not to be identified agreed: "These

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Bad faith

Continued from previous page

decisions could force some bad carriers to clean up their act and deliver a better-quality product."

But at the same time, the insurer noted that "there are employers who simply don't want to pay their bills.' Such policyholders could use the Illinois ruling and the other decisions to avoid or delay paying reasonable charges, he said.

"If these lawsuits proliferate they could be the death knell of retro premium policies," lamented another insurer executive who also asked not to be identified.

"Anyone could second-guess an insurer based on this," he said.

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National Surety Corp. vs. Fast Motor Service, 373 N.E.2d 1083 (Ill. App. 1991). Corrado Brothers Inc. vs. Twin City Fire Insurance Co., 562 A.2d 1188 (Del. 1989). Deerfield Plastics Co. Inc. vs. Hartford Insurance Co., 536 N.E.2d 322 (Mass. 1989). Transport Indemnity Co. vs. Dahlen Transport Inc., 161 N.W. 2d 546 (Minn. 1968). Transit Casualty Co. vs. Topeka Transportation Co., 663 P.2d 308 (Kan. App. 1983).

Insider trading

Hilb, Rogal & Hamilton Co.: John C. Adams, officer and director, purchased 4,000 shares of common stock at $11.88 per share on Oct. 24 and now directly holds 75,000 common shares.

Hilb, Rogal & Hamilton stock was trading at $13.25 per share on Nov. 21.

Humana Inc.: Patricia P. Davis, officer, sold 16,662 shares of common stock at between $27.25 and $30.63 per share from Oct. 3 to Oct. 18 and now directly and indirectly holds 3,824 common shares.

Humana stock was trading at $23.88 per share on Nov. 21.

Maxicare Health Plans Inc.: Chilmark Capital Corp., beneficial owner, indirectly purchased 72,480 shares of common stock at between $7.13 and $9 per share from Oct. 1 to Oct. 23 and now indirectly holds 195,660 common shares.

Neil J. Weisman, beneficial owner, indirectly purchased 8,015 shares of common stock at between $7 and $7.13 per share from Oct. 22 to Oct. 23 and now indirectly holds 302,004 common shares.

Maxicare stock was trading at $7.50 per share on Nov. 21.

The St. Paul Cos. Inc.: William H. Kling, director, purchased 1,000 shares of common stock at $61.25 per share on Oct. 28 and now directly holds 1,500 common shares.

St. Paul stock was trading at $65.50 per share on Nov. 21.

Scor U.S. Corp.: Nolan Asch, officer of subsidiary, sold 800 shares of common stock at between $15.75 and $15.88 per share on Oct. 2 and now directly holds 52,759 common shares.

Scor stock was trading at $15.88 per share on Nov. 21.

USF&G Corp.: Robert J. Hurst, director, indirectly purchased 545 shares of common stock and sold 545 shares at between $7.75 and $8 per share from Oct. 2 to Oct. 4. Mr. Hurst now directly and indirectly holds 1,000 common shares.

USF&G stock was trading at $6.63 per share on Nov. 21.

U.S. Healthcare Inc.: John S. Lavelle, officer, exercised an option for 13,000 common shares and also sold 13,000 common shares at between $3.75 and $30.50 per share on Oct. 23 and now directly and indirectly holds 1,040 common shares.

Scott Murphy, vp, sold 6,000 shares of common stock at $31 per share on Oct. 31 and now directly and indirectly holds 47,609 common shares.

Marshall V. Rozzi, officer, sold 17,000 shares of common stock at $29.63 per share on Oct. 23 and now directly and indirectly holds 35,083 common shares.

U.S. Healthcare stock was trading at $35.75 per share on Nov. 21.

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Insider Trading, compiled by Invest/Net Trading Group Inc. of Fort Lauderdale, Fla., from reports filed with the Securities and Exchange Commission, tracks stock sales and purchases by insurance industry directors and officers. The column is distributed by Tribune Media Services Inc.

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Agent/Broker Topics

A monthly editorial section sent exclusively to agents and brokers

Why is there no joy under the Big Top?

Tough times, changing times squeeze agent conventions

By LAURA MAZZUCA

It's circus-time for agents and brokers every fall.

Otherwise known as the annual agent conventions, these three-ring extravaganzas feature executive meetings, educational workshops and entertainment, all under the Big Top of a megahotel in some sunny locale.

For years, agency principals from across the country have flocked to Las Vegas, San Francisco, Orlando, Fla., or some other place (usually in the sun) to the jumbo conventions held by the Independent Insurance Agents of America and the National Assn. of Professional Insurance Agents.

Office staff and families come along. Much of the time is given over to schmoozing with fellow agents and perusing exhibit halls. Then, on the last night, there is entertainment from the likes of John Denver or Steve Lawrence and Eydie Gorme.

But economic realities are taking their toll: Over the last five years, attendance at both association conventions has dwindled (see chart, page 20B).

Take, for example, the IIAA convention earlier this fall in Honolulu (*A/BT*, Nov. 4). Total attendance was only 2,300—including spouses, insurance company representatives and vendors—compared with 4,000 in 1985, the last time the meeting was held in Honolulu.

"An agency today can't afford to send a couple of principals and a couple of salesmen to Hawaii," said Richard J. Kasyjanski, president of Members Services Inc. in Alexandria, Va., an IIAA division that plans the conventions.

He attributes the decline in attendance both to slack insurance market conditions and to the fact that there are simply fewer agencies than there were six years ago.

Post-convention telephone polls by the trade groups bear this out. Asked why they didn't attend, most agents cite scheduling conflicts or belt-tightening rather than shortcomings in, say, past speakers or hotels, said Marcie Bannon, director of conventions for the PIA in Alexandria, Va.

"When you're talking about investing $1,500 or $2,000 in convention travel, it kind of makes the choice for you," she said.

Convention planners predict that agents, squeezed by the economy, will come to expect more for their money under the Big Top.

"You're looking for two things: input from the industry and to have fun along with it," said Harlan E. Smith, president of C&H Smith Insurance Agency Inc., a Danville, Ill., agency with $1.5 million in annual premium volume.

Mr. Smith has attended IIAA conventions for the past 12 years. Attracted initially by the exotic sites, he now says the speakers and workshops must also be worthwhile to justify attending.

In hard times, the show goes on

Like everybody else in the industry, agent convention planners must keep a close eye on the bottom line.

An event's overall budget is based on advance enrollment. But plenty of fixed expenses can be scaled back to crunch the budget, said Ms. Bannon. These range from promotional material and postage costs to production costs like audiovisual materials, signs and keynote speaker fees.

"We're definitely more focused and conservative in years like this when money is tight," she said.

Little of the cost-cutting is readily apparent to the conventioneer. Fewer slide projectors are used in audiovisual presentations; fewer association staffers attend; and signs and banners from earlier meetings are reused.

On the other hand, convention planners must continue to present an attractive package.

"I think they'll still get attendance at the conventions in spite of market conditions," said Ronald F. Johnson,

Continued on next page



'The majority of you are not going to survive'

Until you learn to help yourselves, you will fall prey to the same old debilitating 'myths,' agents warned

By JOANNE WOJCIK

SAN FRANCISCO—Agency owners should stop deluding themselves that the tooth fairy is going to magically rescue them from the soft market doldrums and begin putting their financial houses in order, financial experts assert.

Agents that continue to believe in the myths that the insurance industry has perpetuated over time—that the market is going to turn around, that a new sales campaign will work or that merging is the answer—are only headed for financial ruin, warn Richard J. Morrison and Charles E. Crowley Jr., two experts in agency valuation.

Too many agencies "operate their businesses as if this particular industry were blessed with a whole array of helpful trolls and fairy godmothers who have no other purpose in life than to appear magically on the spot just as things look bleakest and pull the agent's business chestnuts out of the fire," Mr. Morrison said.

Indeed, the myth that outside forces are the reason behind agency financial woes "gets trotted out every time the going gets tough," remarked Mr. Crowley.

Agency owners must instead become financially savvy and control their own destinies in tough times, both experts said during a session titled "How to Manage Your Agency's Destiny in Turbulent Times" at the annual National Assn. of Professional Insurance Agents convention last month in San Francisco.

Mr. Morrison is president of Morrison Associates Inc., a Newton Centre, Mass.-based management consulting firm specializing in insurance agents and brokers, while Mr. Crowley is president of Tacanda Management Agency of Cheshire, Conn., and national treasurer of the PIA.

"The fault lies not in our industry, but in ourselves," asserted Mr. Crowley.

Both speakers admitted that external forces like the prolonged insurance price war, loss of respectability and the recession are all hurting sales volume, commissions, profit sharing and even interest income.

However, they also maintain that agencies that pay strict attention to their bottom lines will be equipped to weather these turbulent times in the insurance market.

"The majority of you are not going to survive," Mr. Morrison warned.

While some agencies will simply go out of business, others will merge, he said.

As a result, only about 20,000 independent agencies will be functioning by the year 2000, he predicted. This compares with 45,000 agencies operating at the beginning of the 1990s, down from 56,000 in 1970 and 62,000 in 1960,

Continued on page 20E

WHAT'S INSIDE

Do not live by Best alone
To avoid E&O claims when insurers fail, agents need to track information from a range of rating agencies and others.
Page 20G

Perception vs. reality
Agents, who are seen as closely tied to insurers, may face more bad faith suits.
Page 20F

Conventions

Continued from page 20B

rooms for its meeting, Mr. Kasyjanski and Jeffrey Etzkin, the group's convention planner, scout locations with hotels with enough capacity.

Also, when booking dates, the group must avoid conflicts with things like religious holidays and the annual National Assn. of Casualty & Surety Agents convention, which also is held during the fall, Mr. Kasyjanski said.

Further complicating matters is the possibility of a national IIAA-PIA merger. No contract has been signed for the 1996 IIAA convention, said Mr. Kasyjanski, because a dual convention might be more than the hotel could handle.

In the center ring. . .

Agents themselves have a say in selecting workshop topics, convention planners say.

Among the perennial favorites, according to an annual poll taken by the PIA, are market conditions, producer compensation, insurer solvency, perpetuation, business planning, and mergers and acquisitions.

Figuring that out is the easy part. It's the convention planners' job to put a new spin on these chestnuts, like examining insurance rating services and their role in insurer solvency or discussing new ways to motivate employees when discussing producer compensation, said Ms. Bannon.

Generally, "issues-oriented" topics are favored for the national PIA convention, because state conventions cover more technical areas, Ms. Bannon noted.

At IIAA, the convention planners work closely with Bill Anderson, the association's assistant vp of education, to identify "hot topics and hot speakers" by getting feedback from state associations, Mr. Kasyjanski said.

Again, issues like perpetuation, agency evaluation, growth and agency/insurer relationships are ever-popular topics that must be updated annually, he said.

Send in the clowns

Getting good speakers for the workshops and panel discussions is always a challenge.

Six years ago, when Ms. Bannon was planning conventions for the PIA chapters in New York, New Jersey and Connecticut, the most popular convention speakers were the "hired guns." These are the motivational speakers who can plug in "insurance agent" for "banker," "shoe salesman" or whatever other trade group they are addressing, she said.

Today, agent "success story" speakers are growing more popular. They offer at least one obvious advantage for trade groups: They come cheap.

And agents seem to find the nuts-and-bolts successes of their fellow agents more relevant. For IIAA member Mr. Smith, for example, one of the high points of the Hawaii convention was a panel of smaller agents who discussed new sales ideas in detail.

Planners confront another challenge when trying to book big names: Speakers have to be well-known, but not too familiar. Old-timers at least need an updated message.

IIAA tries to offer a variety of members and "hired gun" consultants, Mr. Kasyjanski said. The association also tries to strike a balance between insurance, motivational and management issues with both education and entertainment value, he added.

Regulars on the convention circuit include consultants: Roger H. Sitkins of Fort Meyers, Fla., "with a new message" of promoting personal lines sales; Charles S. Watson of Hartford, Conn., with customized producer compensation software; and Bill Vericker of Hartford, Conn., who speaks on perpetuation, producer compensation and other issues.

Relying on those consultants too heavily presents the real risk of boring agents.

"The problem with them is that I've heard almost all of those guys at least once before," said Mr. Johnson, the South Carolina agency president.

"There are only so many ways you can cut that," he said.

Like Mr. Smith, Mr. Johnson noted that he'd rather hear other agents relate how they solved a problem or improved agency operations.

If boredom is the greatest fear of a convention planner, "information overload" is not far behind.

Allowing ample "off time" during three or four days of workshops is important. Coffee breaks, moves to other rooms and breaks to visit the exhibit hall all are essential, said Ms. Bannon. The PIA limits its workshops and speakers to a maximum of two hours to avoid information overload, she said.

The sideshow

Trade exhibits can be a big drawing card at conventions. Interest, though, varies from year to year and among agents.

Market research indicates, according to Ms. Bannon, that large agencies—those with at least $10 million in annual premium volume—generally are more interested in

Continued on next page

Spouses finding the frill is (nearly) gone

Spouse programs can be a key part of the convention balancing act.

Not long ago, programs offered to spouses of convention-goers leaned heavily toward "shopping sprees and fashion shows," recalls Marcie Bannon, convention director for the PIA.

Neither event is yet a stranger on spouse program agendas, but the programs are at least branching out.

When Ms. Bannon first started planning conventions on a state basis, membership was more than 90% male. Little changed when she switched to the national PIA in 1986: Membership was 88% male. But today women, mostly agency principals, account for almost 20% of PIA members.

Because some of these women now bring their husbands to conventions and because wives are seeking something more substantial, spouse programs have changed considerably.

"They want hard-core stuff," Ms. Bannon said. Topics of recent PIA spouse workshops include managing personal finances and agency perpetuation in the event a spouse dies.

Good keynote speakers can be another attraction for spouses.

Take Margaret H. Quinn and her husband, George. President of a $1 million annual premium volume agency in Wilmington, Mass., Mrs. Quinn is a long-time IIAA member. But she had not attended a national convention in 15 years because her husband felt uncomfortable with both "shop talk" and frilly topics at the spouses programs.

This year, though, Hawaii lured both Quinns. After enjoying the addresses by the convention's keynote speaker, Lee A. Iacocca, Mrs. Quinn said they would both attend future conventions. ■

JANUARY — Consumer/Customer Relations

Issue: January 6
Ad Closing: December 19

What can independent agents do to help improve the insurance industry's image? *BI's Agent/Broker Topics* section will look at the programs that agents and their insurers are launching to help explain the problems facing the insurance industry ... and what the industry is doing to hold down the costs of insurance. In addition, editors will explore the steps agents can take to win goodwill—and increase business—in their communities.

FEBRUARY — Controlling Costs

Issue: February 3
Ad Closing: January 22

How do you hold the line in a recession?
BI's Agent/Broker Topics section will focus on what agents are confronted with in light of a recession coupled by soft market conditions. How have strategic plans been altered? What programs are being put on hold? Editors will talk tc agents about the changes they're making in their business operations.

MARCH — Agency-Insurer Relations

Issue: March 2
Ad Closing: February 19

As the property/casualty marketplace continues to squirm in the doldrums, are hostilities increasing between agents and their insurers? *BI's Agent/Broker Topics* section will look at the cost containment efforts put in place by insurers and how they are affecting independent agents. Editors will examine the major complaints that agents are leveling against their insurers.

Agent/Broker Topics

Agent/Broker Topics is a monthly demographic section published within the pages of *Business Insurance*, and sent exclusively to *BI*'s agent/broker subscribers. Advertisers in *Agent/Broker Topics* are positioned within an unparalleled editorial environment and reach an undiluted audience representing a wealth of purchasing power for insurance products and services. With an average premium volume of $14.91* million, 94%* of these influential readers take action as a direct result of the articles or advertisements they read in *Business Insurance*.

* An Audience Profile of the Business Insurance 'Agent/Brcker' Subscriber, 1990.

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Agency survival

Continued from page 20A

he said.

"It's easy to blame external forces. But in large measure, the blame for the attrition that affects the distribution system of the property/casualty insurance industry can be placed squarely on the shoulders of the managements of the firms within this industry," Mr. Morrison asserted.

The firms least likely to survive are those that both Mr. Morrison and Mr. Crowley labeled as "fiscally irresponsible" for not establishing an agency perpetuation plan.

Don't wait for the market to turn around before putting a perpetuation plan in place, Mr. Morrison said.

"Those of you who operate in the real world know that we no longer have the ability to understand the market cycles, let alone predict their duration," he said.

And thinking that an agency can sell itself into financial health is just wishful thinking, he added.

"Take a firm that couldn't sell itself out of a wet paper bag when times were good and tell me how it's going to turn itself into a lean, mean selling machine," he said.

And agency owners who think they can merge their way to health are only preparing for a huge double funeral, according to Mr. Morrison. "How two sick firms merging together suddenly become one healthy firm escapes me," he said, shrugging.

While in the short term, such a merger may produce slight gains by cutting overhead, in the long term the same problems that caused each firm's financial woes will only rear their heads again, according to Mr. Morrison.

There is only one way for agency owners to ensure their longevity, according to Messrs. Morrison and Crowley: Agency owners must become conversant in the language of finance and control.

"You must manage the financial side of your business," Mr. Morrison stressed.

Mr. Morrison used a case history as an example of an agency owner who let the financial side of his business get out of control as a means of frightening the audience of agents into action.

A southern Florida agency owner called Mr. Morrison literally in tears after his bookkeeping staff resigned.

"His most recent annual statement, prepared by an accountant who was his bookkeeper's cousin, was 2 years old, and he had received it a month before," Mr. Morrison recounted.

"He had never received and he had never asked for a single financial report from his bookkeeping department, and he didn't even have a password (for) his own computer system," he said.

Mr. Morrison hired a computer expert to break into the data base. Unfortunately, what was discovered only made the picture more bleak. "What the agency owner thought was a book of business turning out a half-million in net commissions" actually only generated $250,000 a year, he said.

In addition, the agency's debts—including payables to insurance companies—exceeded $1 million.

While Mr. Morrison admitted that the problem may have been a dishonest bookkeeper, he said it was the agency owner's own fault for not keeping closer tabs on the bookkeeper.

"You give your bookkeeper the car, provide him or her with a chauffeur's uniform and sit in the back seat reading a comic book while he or she takes your car for a spin. Then, you've taken yourself for a ride, and any problems that ensue are no one's fault but your own," he said.

While the Florida agency owner's situation may have been an extreme case, Mr. Morrison said it is not too far-fetched.

For example, another agency owner who hired Mr. Morrison to calculate his retirement income was very chagrined to find out that his agency had no value, he said.

Indeed, "many of you are in exactly this same position," Mr. Crowley said.

Any agency that has to hire an outside consultant to interpret its own financial status is "fiscally irresponsible," Mr. Morrison asserted.

Neither expert offered agency principals an easy method for becoming financial wizards overnight, primarily because that would be as fiscally irresponsible as believing in the tooth fairy.

"There are no answers," Mr. Morrison stressed.

What he offered instead were some sample operating ratios to measure agency progress over time.

Those ratios, which measure an agency's ability to meet short-term financial obligations, its operating efficiency and competitive health, can be used to compare where an agency is today to where it is headed.

For example, one ratio is cash plus accounts receivable divided by current liabilities, he said. Revenues per employee can also be used.

Cautioning that there are no benchmarks to measure agencies against, Mr. Morrison advised agents to set their own levels.

"Success is a journey, not a destination. And the ratios only help to mark your journey over time," he said. ■

Conventions

Continued from previous page

trade exhibits than smaller shops, possibly because they use more outside vendors.

And in soft markets, for instance, agents are less interested in the insurance company booths, she added.

Vendor participation also runs in cycles. Software firms and insurance companies are always on hand to hawk their wares. But lately, Mr. Kasyjanski reports, more wholesalers are pitching their tents at the conventions.

Convention location is also a major factor in the number of exhibitors. Only 95 made it to the 1991 IIAA convention in Honolulu, compared with 166 in Chicago last year, probably because of the expense of shipping booths and other materials, Mr. Kasyjanski said.

Setting up and taking down exhibits can create logistical nightmares, so several IIAA staffers are assigned exclusively to coordinate exhibit hall activity, he added.

The show must go on

Ms. Bannon and her staff begin working on the PIA national convention in great detail at the end of August. But since they also do consulting work for the state associations, they're busy with planning year-round, she said.

The end of the national convention brings no respite. "As soon as we get back to the office, the phones start ringing," she said.

And besides having to settle the final bills and related expenses, Mr. Kasyjanski and the IIAA convention staff go through a final post-convention "debriefing" to determine how to improve basic behind-the-scenes functions like scheduling, signage and moving people around, he said.

But post-convention wrap-ups and dealing with on-site glitches are just "the little things" a convention planner must deal with, Ms. Bannon noted. "I wouldn't trade this job for the world. . . .It's show biz." ■

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Agent/Broker Topics

Funding the hired guns of insurance lobbying

By JOANNE WOJCIK

SAN FRANCISCO—When it comes to protecting its members' pocketbooks, the National Assn. of Professional Insurance Agents puts its money where its mouth is.

About 22% of the organization's annual budget goes to lobbying on Capitol Hill, said Joel Wood, assistant vp-government affairs.

Another PIA staff member put the group's annual budget at $16 million, meaning the trade group's lobbying effort costs about $3.5 million a year.

That may not seem like much, concedes Mr. Wood. But when combined with the lobbying budgets of other insurance industry groups, including the American Insurance Assn., the American Council of Life Insurers and the Independent Insurance Agents of America, it adds up.

It takes a lot of money to fight proposals like those that would expand the authority of banks to sell insurance, alter the depreciation of intangible assets for tax purposes and repeal of the McCarran-Ferguson Act.

"The banking reform bill has failed twice, and in both instances we prevailed on amendments that would have given banks insurance powers," points out Mr. Wood.

While the PIA benefitted from legislators' reluctance to vote for a bill that appeared to be a bailout for the banking industry, the organization's lobbying effort really was focused on eliminating two provisions in existing law that permit banks to sell insurance in some instances, Mr. Wood explained.

One is a 1990 Delaware statute that would allow national banks to use their Delaware subsidiaries to sell and underwrite insurance nationwide. That law was upheld by a federal appeals court (*BI*, June 17).

Both the Delaware law and a federal law that since 1916 has permitted banks in towns with fewer than 5,000 people to sell insurance could put competitive pressures on independent agents.

What's particularly disturbing about the "small town" exception, argues Mr. Wood, is that the U.S. comptroller of the currency has ruled that any national bank can open a subsidiary in a town with fewer than 5,000 people and begin selling insurance.

"We view both of those loopholes as potential threats to permit banks to sell insurance by allowing banks to win through the regulatory and court process what they cannot win through the legislative process," he asserted.

Another issue near and dear to the hearts of independent agents is the taxation of intangible assets, like renewal lists.

A provision in the 1987 omnibus tax bill that would have eliminated agents' ability to depreciate their renewal lists was removed before passage. But "this hasn't stopped the IRS," Mr. Wood said. "They've been taking an increasingly jaundiced view of agency renewal list amortization."

An internal memo issued by the IRS in 1990 stated that "wherever goodwill is present in a transaction, goodwill cannot be separated from the transaction," Mr. Wood paraphrased. "This left a tremendous uncertainty in the market."

Goodwill, the value of intangibles

Continued on next page

Opportunity knocks, and top agents answer

SAN FRANCISCO—Professional insurance agents should view problems as opportunities rather than as obstacles, asserts Daniel J. Blum, the new president of the National Assn. of Professional Insurance Agents.

"If we look at the forces that affect our business as a series of problems, we're not going to make it," Mr. Blum told insurance agents gathered for the 60th annual national PIA convention held Nov. 15-21 in San Francisco.

"If you really think the business is full of gloom and doom, it will be—for you," he warned. "But not for others. The fact is: What may be a problem to one agent is a business opportunity for someone else.



Mr. Blum



Mr. Sutton

"And agents who are going to prosper will be those who know an opportunity when they see it," Mr. Blum said during his inaugural address.

Mr. Blum, president of The Insurance House, a commercial insurance agency in Lafayette, La., succeeded Tommy Sutton, the 1990-91 PIA president, at the recent meeting.

Mr. Sutton, president of the J.T. Sutton Agency in Kinston, N.C., also encouraged agents to think positively during his state of the association address.

"Doomsayers believe agents live in a world of diminishing options. But I am convinced that this reshaping of the industry will offer new choices for agents who have the courage to reinvent their business and seek new financial frontiers," he said.

Also honored during this year's convention was Michael Conners II, president of Conners & Reddy in Cohoes, N.Y., who was named 1991 Professional Agent of the Year.

Mr. Conners, who serves as a continuing education instructor for PIA chapters in New York, New Jersey and Connecticut and is an approved speaker for the Society of Certified Insurance Counselors, was recognized for his leadership in agent education and as an industry spokesman.

Approximately 1,500 agents, exhibitors, speakers and guests attended the 1991 annual convention, which was held at the San Francisco Hilton.

Next year's convention will be held Nov. 8-11 at the Walt Disney World Dolphin hotel in Lake Buena Vista, Fla.

For more information, contact Rebecca Membane at PIA National, 400 N. Washington St., Alexandria, Va. 22314-9980; 703-836-9340; fax: 703-836-1279.

—By Joanne Wojcik

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Continued from previous page
like a respected company name and employee morale, is not eligible for the favorable tax treatment accorded depreciable assets like machinery.

Since the 1990 memo, the IRS has stepped up audits of insurance agents who traditionally have treated their renewal lists as depreciable.

Most of those audited agents have been able to negotiate settlements with the IRS. But the settlements have "significantly reduced their intangible tax deductions," Mr. Wood pointed out.

While the PIA has publicly lended its support to H.B. 3035, a bill introduced by Ways and Means Committee Chairman Dan Rostenkowski, D-Ill., that would establish a uniform 14-year depreciation schedule for all intangible assets, including goodwill, it is far from ideal, said Mr. Wood.

The reason a 14-year depreciation schedule was selected was because that's the point at which the measure becomes revenue-neutral and will not reduce federal tax revenues, Mr. Wood explained.

For agents, though, seven or eight years would be a more reasonable depreciation schedule, he contended.

Still, the Rostenkowski measure is far less onerous than other proposals put forward thus far, such as H.R. 563, introduced by U.S. Rep. Brian Donnelly, D-Mass., that would essentially codify the current IRS interpretation of the tax law on intangibles, according to Mr. Wood.

But the Rostenkowski measure faces a threat from another front, according to Mr. Wood: The computer software industry, for which 14 years represents "an eternity."

Modification of McCarran-Ferguson remains a heated issue on Capitol Hill, and one that the PIA has opposed since the call for reform intensified during the last hard market.

"It's critical mass was reached in 1985-86 during the insurance availability and affordability crisis," Mr. Wood recalled.

But while consumer groups continue to promote changes to McCarran-Ferguson by appealing to fears of price-fixing conspiracies, Congress has instead focused on solvency regulation issues, according to Mr. Wood.

He characterized the situation humorously:

On one side of the hall in the Rayburn House Office Building, one of buildings on Capitol Hill housing congressmen's offices, allegations are being made in the Judiciary Committee that insurers are getting together in smoke-filled backrooms and setting prices like a cartel. On the other side of the hall, the Energy and Commerce Committee is expressing concerns that the insurance industry is unstable and in danger of becoming the next savings and loan industry crisis.

"The only conclusion I can draw is that the insurance industry is engaging in a massive conspiracy to lose money," he quipped.

Seriously, the House Judiciary Committee's recent passage of H.R. 9, sponsored by Committee Chairman Jack Brooks, D-Texas (*BI*, Nov. 25), has focused new attention on the battle to modify McCarran-Ferguson.

The PIA's new president issued a statement reacting to the vote, which occurred during the organization's national annual meeting in San Francisco.

"Rather than making insurance more available and less expensive, H.R. 9 would harm consumers by denying many insurance companies a cost-effective method to collect and analyze claims data," said PIA President Dan Blum, who assumed office during the meeting.

But "adding more costs to insurer operations would make independent insurance agents less competitive in the marketplace," he said.

"Because of these ominous consequences, agents throughout the country will work hard to stop this flawed bill from going any further in the legislative process," Mr. Blum vowed.

But rather than seeking amendments to water down the Brooks proposal, "we want a straight up or down vote," Mr. Wood said. "We're not interested in amending this bill."

And if the House floor vote on the Brooks bill divides primarily along party lines; as is expected, the insurance industry lobby has a good chance of prevailing.

"Then we will need only 50 or 60 Democrats to win, and we've already got 20 Democratic House members who were employed either by insurance agencies or insurers," Mr. Wood said.

But Mr. Wood is not overly confident about defeating the Brooks proposal.

"We can't take the Republican votes for granted in a consumer vs. the industry battle. There's a lot of election-year pressure," warned the lobbyist. ■

Avoiding the wrath of bad faith juries

By JOANNE WOJCIK

SAN FRANCISCO—Tracking insurers' claims handling practices is one way that agents can avoid exposure to bad faith lawsuits, an expert warns.

PIA NATIONAL

"Think about who sits on juries in bad faith cases—insureds, not agents or insurers," said John O'Connell, an insurance professor at the American Graduate School of International Management in Glendale, Ariz.

"So how would you expect them to rule" when they believe a fellow policyholder is being unfairly denied coverage by an insurance company? he asked agents.

That question came in a workshop at the annual National Assn. of Professional Insurance Agents convention last month in San Francisco.

Realizing that policyholders serve as jurors explains why some juries tack on huge punitive damage awards in bad faith suits, Mr. O'Connell said.

And publicity surrounding successful bad faith cases can generate even more such suits, he added.

While few agents have so far been named in bad faith lawsuits against insurers, they can be brought into the litigation through their perceived connection to the insurance company involved, according to Mr. O'Connell.

"Perception is almost more important than the actual actions involved," he stressed. "Tell that to your people in your offices."

Usually, agents are named separately for their errors or omissions in handling an insurance transaction, Mr. O'Connell explained. But there's a fine line that determines what is actually an E&O claim and what is a bad faith claim, he added.

And he predicts that agents will increasingly be named in bad faith litigation.

While most states' bad faith laws require as a standard of proof that an insurer must have intentionally harmed a policyholder, ambiguity in insurance policies and inconsistency in insurers' actions also can give rise to bad faith verdicts, according to Mr. O'Connell.

For example, an insurer's claim that a health insurance policy has a $1 million lifetime limit per policyholder is misleading, since the limit only applies while the policy is in force, he explained.

And an agent that fails to explain this to the policyholder can be considered to be acting in bad faith, Mr. O'Connell cautioned.

"What will you say when a lawyer has you on the stand in court and he asks you why you sold that particular policy to the insured?" he asked the agent audience.

In addition to coverage terms, an agent should know the limits of the policies he or she is selling, Mr. O'Connell advised.

There are other areas in which an insurer can be perceived to be acting in bad faith, he said.

For example, when an insurer consistently offers to compensate third parties for the diminished value of a vehicle after it is involved in a collision—in addition to repair costs—but does not offer the same for its own policyholders, it can be found to be acting in bad faith, he said.

An insurance company's push for the use of aftermarket parts when repairing a policyholder's automobile also can open an insurer's—and agent's—exposure to bad faith, he said.

Fraud also has been cited as a basis for bad faith activity, according to Mr. O'Connell.

"It is deceptive to say a policy covers something it really doesn't," he said.

For example, "replacement cost coverage" provided in some homeowners policies must, in fact, pay for the replacement of everything covered, regardless of its original cost, he said. But there are often disputes about what should be replaced, he noted.

An agent also can be considered to be acting in bad faith when he or she fails to offer customers proper limits for their exposures, according to Mr. O'Connell.

For example, an agent should offer an auto insurance policy with uninsured or underinsured motorist limits at least as high as the third-party liability limits offered; otherwise the policyholder has less coverage to respond to his or her own losses, he said. ■

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Agent/Broker Topics

Limiting agents' E&O exposure

By JOANNE WOJCIK

SAN FRANCISCO—Agents should develop an errors and omissions prevention program during the soft market to prepare for an onslaught of professional liability claims when rates rise, an expert says.

PI NATIONAL

And, as more insurers head into financial trouble, agents should consider solvency when placing business, suggests Ronald Anderson, a Newport Beach, Calif., attorney specializing in agent and broker professional liability.

Agents also should beware of liability issues when placing business with non-admitted markets, Mr. Anderson warned at a workshop at the annual National Assn. of Professional Insurance Agents convention held here last month.

"E&O claims track hard and soft markets," Mr. Anderson explained. "Right now, we're in a lull. But when the market changes, I'm sure that the frequency is going to increase."

Agents are particularly vulnerable when the insurers with which they place business become insolvent. To shield against such claims, he advised agents to monitor solvency on their own to spot potentially troubled companies early.

He suggested agents "average out" the findings of all the rating agencies. "Don't put too much reliance in A.M. Best Co." alone, he said.

Other sources of solvency data include Demotech Inc., which tracks risk retention groups, pools and syndicates; Moody's Investors Service Inc.; and Standard & Poor's Corp.

Agents should also assess insurer finances on their own. For example, Mr. Anderson noted that agents should be wary of those with combined ratios above 110%.

An insurer's surplus should also grow at 10% annually to keep up with inflation, he said.

But too much growth can also present problems. When business increases more than 20% to 25% annually, an insurer could be heading for trouble, Mr. Anderson said.

Another warning sign is delayed payments. "A carrier that slows the rate at which it normally pays claims, returns premium refunds or pays commissions may be suspect," he said.

Wholesale withdrawal from a particular territory or line of business may be a precursor to trouble, said Mr. Anderson. When results are good, an insurer "does not suddenly withdraw from underwriting a line of business or withdraw from a state or a territory," he said.

However, an insurer willing to write indiscriminately may be headed for trouble, he added.

Unexpected insurer management changes may signal internal problems, according to Mr. Anderson. "Watch for low employee morale and a high turnover."

A change in auditors or other unusual changes, like a shift in reserving practices, also should be viewed with suspicion, Mr. Anderson said.

Rumors and other informal clues can also prove valuable. For example, independent adjusters working with an insurer may sense problems when the company slows down claims payments. This can occur long before a regulator gets wind of problems, Mr. Anderson explained.

He cautioned agents, though, not to spread the rumors, since that, too, can invite liability.

"Never say anything derogatory about an insurance company or insurance company personnel," he warned. "If you bring liability on a principal (an insurer), you can be held liable for a principal's losses."

Admittedly, this can put an agent between a rock and a hard place, he said. More agents are being sued when insurers with which they have placed business become insolvent, but agents have their hands tied when it comes to warning customers, Mr. Anderson observed.

Using non-traditional markets, like pools, captives, risk retention groups and risk purchasing groups can pose an E&O threat to an agency since they are not highly regulated.

Before placing business with these alternative markets, Mr. Anderson suggests that agents make sure their E&O liability coverage will respond to any liability claims associated with them and that they inform the policyholder of why its coverage is being placed with a non-admitted insurer.

And, "always call at least one underwriter and make sure they won't write the business" before placing coverage with a non-admitted insurer, making a note in the customer's file of the details of the admitted company's refusal, he advised. "Don't just rely on the underwriting guidelines" to determine that an insurer is likely to reject a risk, he warned.

Agents also should be aware of the financial status of surplus lines brokers, according to Mr. Anderson.

To ensure that the surplus lines broker itself is sound, ask for a financial statement, details of E&O coverage and details on its ownership, he said. The surplus lines broker's license number should appear on all insurance contracts with which it is connected.

And, above all, "don't sign a wholesale agreement with a hold-harmless clause," he said. ■

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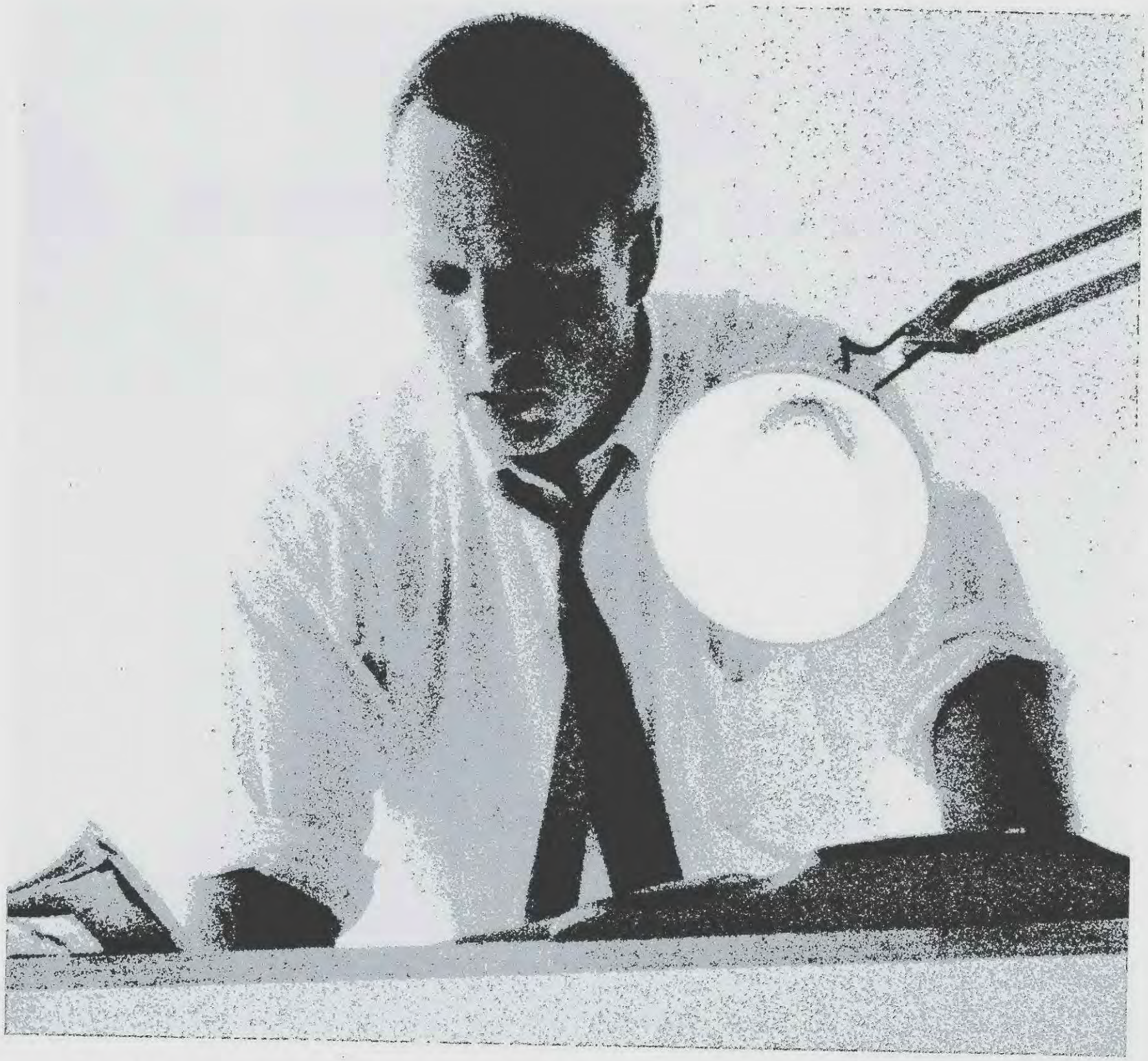
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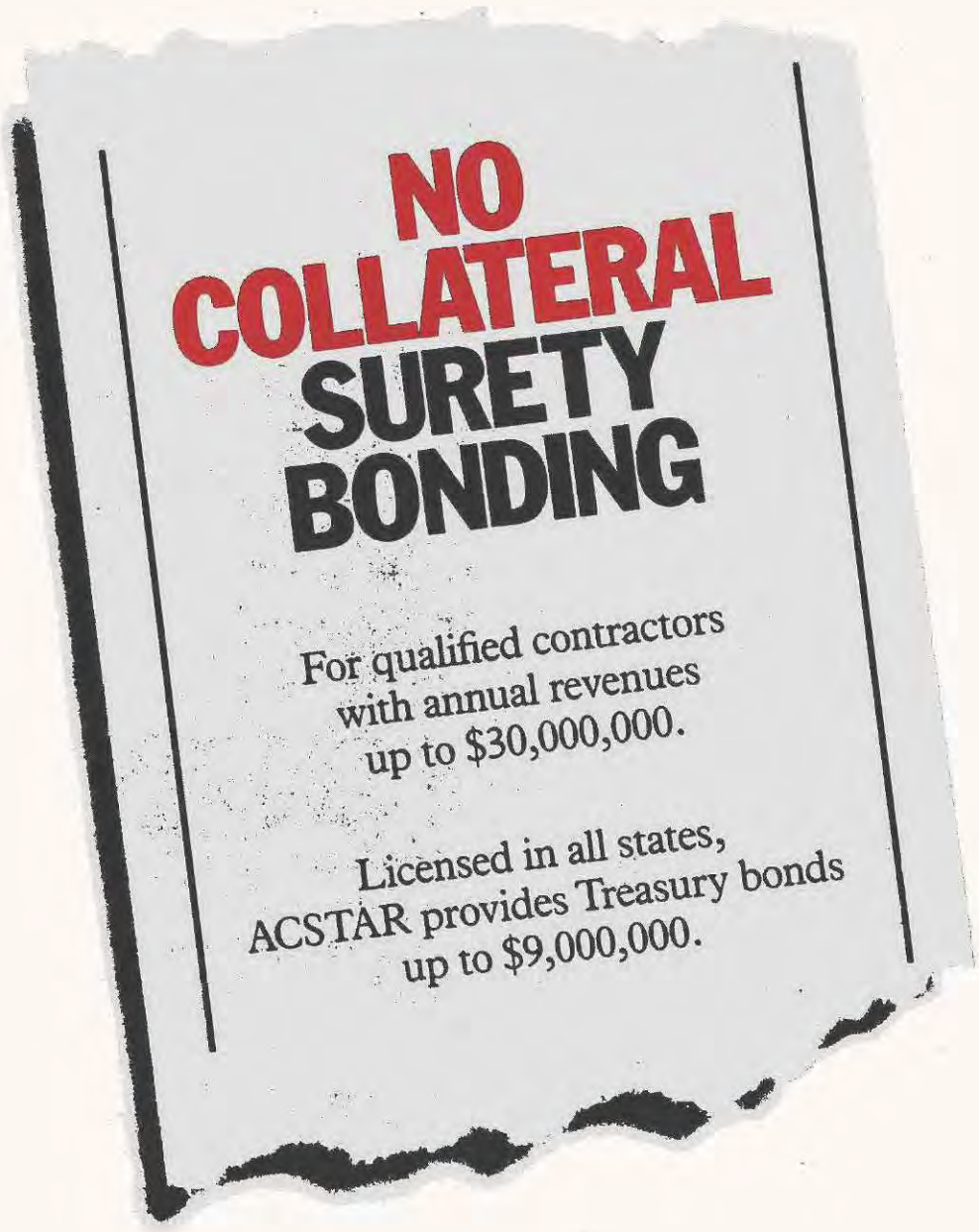
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ASK A BENEFITS ACTUARY

Non-discrimination rules not simple recipe to follow

Q **Are the new pension non-discrimination rules really simple?**

A A client called the other day and announced that he was giving consideration to performing in-house the non-discrimination tests under the Internal Revenue Service's recently issued final regulations for pension plans (*BI*, Sept. 16).

The client company sponsors numerous defined benefit plans which have a variety of benefit formulas. Some of the benefit formulas are Social Security offset formulas, and include a reduction for a percentage of the primary insurance amount under the Social Security system. These formulas do not allow for the simplified non-discrimination compliance through the use of design-based "safe harbors" under the final regulations.

I indicated to my client that the non-discrimination requirements for defined benefit plans were complex, and that the most efficient use of his resources might be to have us perform the tests. My client responded, "What do you mean, the tests are complex! Thomas Terry of the Treasury Department says the 'cookbook approach' of the final regulations is a 'simplification.' "

I was stunned. After having labored through the 400-plus pages of the material, I could not imagine how these regulations and the word "simplification" might be used in the same sentence.

My client and I agreed to an exchange of information. I was to send him a complete set of the final non-discrimination regulations, and he would send me the news account of Mr. Terry's remarks.

When my client and I next spoke, I tried to put Mr. Terry's remarks in perspective. The final non-discrimination regulations, when compared to the proposed regulations, include additional detailed, step-by-step instructions for certain calculations needed to perform the general non-discrimination test for a defined benefit plan.

In most cases, the general non-discrimination test is used by plan sponsors for plans with benefit formulas that do not comply with the design-based safe harbors. The general test requires the calculation of an estimated benefit accrual for a year for each employee. My client would need to use the general test in order to demonstrate compliance with the non-discrimination regulations. Arguably, this change in the final regulations—the "cookbook approach"—might be viewed as a simplification.

However, the final regulations are a cookbook with a few unusual characteristics:

- Most cookbooks can be read and understood by a broad cross-section of people. This cookbook is accessible to a very few people: attorneys who have some background in employee benefits law, benefit consultants, actuaries and knowledgeable and determined employee benefits professionals.
- In most cookbooks, many recipes will produce the desired result for any cook: a delicious food or beverage. The final regulations literally contain hundreds of recipes or variations on recipes for demonstrating compliance with the non-discrimination requirements. But many of these recipes will not achieve for every plan sponsor the desired result of compliance.

For example, some "recipes" in the final regulations calculate the normal accrual rate (the estimated benefit accrual calculated for each employee) using the "annual method." Some plan sponsors may be able to pass the test using the annual method while others may not. One of the complex tasks of working with the non-discrimination regulations is determining which of the "recipes" in the regulations will work for a particular plan sponsor.

- Most cookbooks' recipes list ingredients that are easily obtained. For some plan sponsors, one key ingredient for using the non-discrimination cookbook—census information—may be difficult to bring together in a single location.

From this perspective, the final regulations are anything but simple.

My client agreed. He had started to work his way through the regulations, but quit when they made his head hurt. He did note, however, that they were a marvelous cure for his insomnia. ■

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

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



Mr. Miner

This month's column on actuarial issues in the benefits field is written by William J. Miner, an actuary with The Wyatt Co. in Chicago. Richard E. Sherman, president of Pacific Actuarial Resources in Ashland, Ore., answers actuarial questions in the casualty field. Susan M. Werner, director of risk management at Hardee's Food Systems Inc. in Rocky Mount, N.C., answers risk management questions.

Dennis J. Nirtaut, manager of employee benefits at Continental Bank Corp. in Chicago, answers questions on employee benefit plans. Mr. Miner's and Mr. Sherman's columns appear alternately on the first Monday of each month. Ms. Werner's and Mr. Nirtaut's columns appear alternately on the second Monday of each month. Mr. Miner's next column will appear in February.

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

Workers comp is remedy for victim of stress

A co-worker's intentional infliction of emotional distress was a compensable "accident" under the Workers Compensation Act, the Supreme Court of Wisconsin ruled.

Jan K. Jenson was the clerk-treasurer of a village. Guy Little Sr. was later elected president and trustee of the village board. After taking office, Mr. Little proposed that Ms. Jenson's work hours be cut in half despite her existing contract. Furthermore, Mr. Little told the board that Ms. Jenson was doing a bad job and accused her of dishonesty.

Ms. Jenson sued Mr. Little for intentional infliction of emotional distress. The trial and intermediate appellate courts dismissed her suit concluding that her remedy was exclusively under the Workers Compensation Act.

On appeal, Ms. Jenson argued that Mr. Little's actions were intentional and only unintentional conduct gave rise to workers comp liability.

However, the court said that it had consistently held that an intentional act comes within the purview of the Workers Compensation Act. The trial court decision was affirmed.

Jenson vs. Employers Mutual Casualty Co., Supreme Court of Wisconsin, April 17, 1991 (*BI*/03/N.-$10).

Legal briefs

Corrosion damage

The corrosion of a roof installed by a construction company was a progressive and continuous condition and occurred under each successive general liability insurance policy, according to the Colorado Court of Appeals.

In 1973, Pinkard Construction Co. installed a roof for a school district. Immediately following construction, the roof began corroding and did so progressively until its collapse in 1984, when the corrosion was discovered.

From 1977 until the date of the roof collapse, Pinkard was insured by American Employers' Insurance Co. under a series of successive primary and umbrella comprehensive general liability policies. Pinkard submitted a claim to American, which in turn brought this action seeking a determination of its liability.

The trial court determined that American's obligation to indemnify was limited to the terms of the policy in effect on the date the roof collapsed.

On appeal, Pinkard argued that as the corrosion was progressive and continuous, coverage was triggered under each policy. The appellate court noted that all of the policies here were of the occurrence type rather than claims-made or discovery type. Under occurrence policies, the court said, property damage can arise from a continuous process as long as the damage was unintended and unexpected and occurred during the policy period. It was undisputed that corrosion occurred during each policy period, thus triggering coverage, the court said.

American Employers Insurance vs. Pinkard Construction, Colorado Court of Appeals, Aug. 2, 1990, *rehearing denied* Sept. 6, 1990, certiorari granted March 11, 1991 (*BI*/04/N.-$10).

TMJ syndrome claim denied

A Louisiana appellate court ruled that treatment for temporomandibular joint syndrome did not arise due to an "injury" within the meaning of major medical provisions of a group health insurance policy.

Floyd Humphrey was covered under his employer's group health policy issued by Aetna Life & Casualty Co. His now-ex-wife Ingeborg, a covered dependent under the plan, was diagnosed as suffering from TMJ. Aetna paid the maximum dental benefit of $1,000 under the plan and denied additional coverage for extensive crown and bridge work costing nearly $17,000. The dental limits did not apply to dental work and orthodontic treatment "due to injury." Mr. Humphrey sued Aetna and won in trial court.

On appeal, Mr. Humphrey maintained that his wife's infirmity was "accidental" because it was an unfortunate occurrence causing loss. However, the court said such interpretation would require Aetna to be liable for benefits for every ailment known to man. The court was satisfied that the policy language was unambiguous and that Ingeborg did not sustain an "injury" as contemplated by the policy language. The trial court decision was reversed.

Humphrey vs. Aetna Life & Casualty Co., Court of Appeals of Louisiana, Oct. 16, 1990, *rehearing denied* Dec. 5, 1990 (*BI*/03/Aug.-$10). ■

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

Compton to be chairman, CEO at Aetna

Ronald E. Compton will succeed **James T. Lynn** as chairman and chief executive officer of Aetna Life & Casualty Co. when Mr. Lynn, who has held the post since 1984, retires March 1. Mr. Compton will retain his title of president.

Mr. Compton, who joined the Hartford, Conn.-based insurer as a property/casualty underwriter in 1954, was promoted several times before moving to Aetna's American Re-Insurance Co. in 1980, where he rose to president. Mr. Compton returned to Aetna in 1987 and a year later was named president.

Also at Aetna, **Thomas S. Carpenter** named vp of property/casualty field operations.

Other insurer changes:

William T. Zavaglia named president of American Continental Life Insurance Co., a unit of MMI Cos. Inc. in Deerfield, Ill. He had been a partner in charge of health care consulting for Ernst & Young in Cincinnati.

Thomas E. Geissler named vp at Hartford Steam Boiler Inspection & Insurance Co. in Hartford, Conn. He will be responsible for the management of insurance products and services for small business.

John H. Gillespie, manager of the Chubb & Son Inc. office in Boston, and **Timothy J. Szerlong**, manager of the Chicago office, named senior vps of the Chubb Corp. unit. Also at Chubb & Son: **Donald E. Barb**, a manager of special risk casualty claims at the Warren, N.J., headquarters, elected vp; and **Thomas R. Cornwell**, the manager of the company's electronics industry insurance department, named a vp.

Bert H. Blanton Jr. elected vp-insurance operations at Crum & Forster Corp. of Basking Ridge, N.J. In addition, **James M. Jensen** elected vp of The North River Insurance Co., a Crum & Forster unit in Kansas City, Mo.

John Burville will join ACE Ltd., the high-layer excess liability facility in Bermuda, as senior vp-product development/actuary effective Jan. 1.

Paula Burton named senior vp with Transport Life Insurance Co., a Primerica Corp. unit based in Fort Worth, Texas. Most recently Ms. Burton had been a consultant.

Sally Hamilton named director of underwriting for New Mexico Mutual Casualty Co. in Albuquerque.

Gregory E. Murphy appointed vp and controller at Selective Insurance Group Inc. in Branchville, N.J.

Comings & goings: industry

Reinsurance

William L. Healy promoted to senior vp at Bell Nicholson Henderson (USA) Inc., the New York-based reinsurance intermediary unit of the London brokerage. Also, **George J. Daddario** and **Nicholas P. Roberto** named vps.

American Re-Insurance Co. of Princeton, N.J., announced these changes at its AM-Re Brokers Inc. unit: **Mahmoud Abdallah**, who heads the parent company's international division, appointed executive vp and managing director; **William Godfrey** promoted to senior vp from vp and is responsible for the treaty and facultative divisions; and **John Varca** named senior vp to head the finite risk division.

Earlier, American Re-Insurance named several new vps: **Melissa Salton**, who is responsible for the traditional actuarial pricing unit of the Am-Re Managers Inc. unit; **Joseph Sarosi**, who is responsible for coordinating and structuring financial insurance and reinsurance at Am-Re Managers; **Ruby Schmidt**, with the domestic insurance company operations division; and **William Sparke**, who is responsible for direct property underwriting at Am-Re Managers.

Other suppliers

Noble Lowndes has named **Peter Brew** North American managing director, overseeing the U.K.-based employee benefit consultant's 12 U.S. offices. Mr. Brew, who will be based in East Orange, N.J., previously was managing director of Noble Lowndes in Ireland.

Coopers & Lybrand made several recent appointments: **Reed A. Keller** appointed vice chairman of the actuarial, benefits and compensation consulting division in New York; **Andrew J. Lawler** named managing partner of actuarial, benefits and compensation consulting in the New York and New Jersey region, based in New York City; and **Patrick M. Lynch** named senior consultant in the casualty and risk management consulting operations in Atlanta. Previously, Mr. Keller had been national operations director for the division, Mr. Lawler was a partner and Mr. Lynch previously was a vp and risk management consultant with Corroon & Black Corp.

David K. Stoudt named executive vp and partner of benefit consultant Corporate Healthcare Strategies Inc. in Lancaster, Pa. Mr. Stoudt previously served as a benefit specialist with Lincoln National Corp.

Prudential Asset Management Co. promoted **Harold R. Hopkins** to vp and director. He will oversee defined contribution annuity and savings programs. Mr. Hopkins, who will be based in Moosic, Pa., previously oversaw sales, marketing, record keeping and other aspects of the company's defined contributions programs.

Jessica Christensen promoted to executive vp of Jardine Risk Management Inc. in Los Angeles, a unit of Jardine Insurance Brokers Inc. Ms. Christensen previously was senior vp in charge of financial operations.

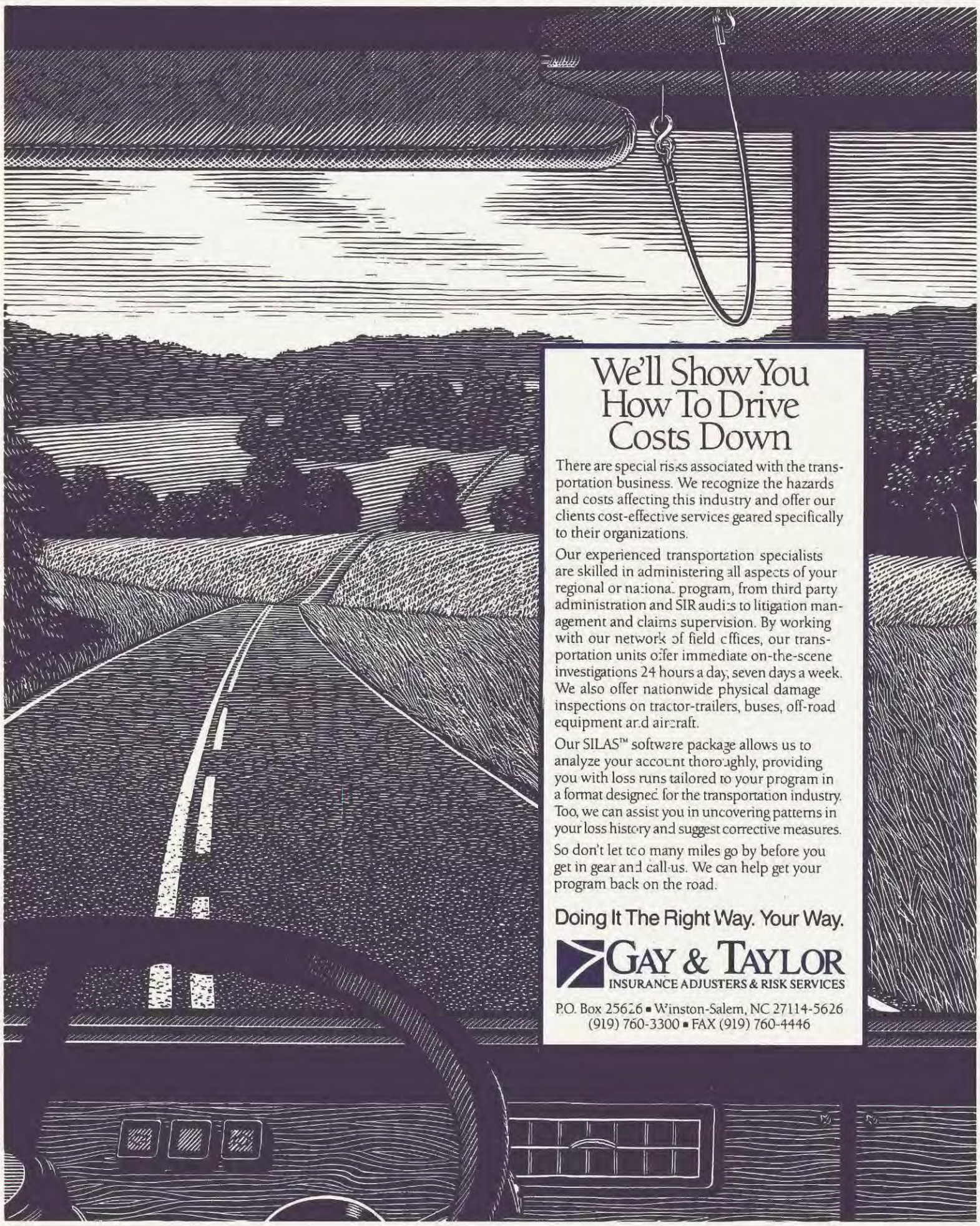
Carl J.P. Daly named president of Jardine Pinehurst Management Co. Ltd. of Bermuda. The Jardine Insurance Brokers unit specializes in managing single-parent and association captives.

Buck Consultants Inc. announced several promotions: **Edward William Fox** named benefit consultant in the Group Consulting Services Department in Secaucus, N.J.; **Marilyn Miller** named communication consultant in the San Francisco office; and **Leslie McKee** appointed associate benefit consultant in the firm's New York office.

Thomas L. Handley named a principal of The Miller Group, an Overland Park, Kan.-based consulting and actuarial firm. Mr. Handley previously was vp-actuarial services for Blue Cross & Blue Shield of Kansas City.

John F. Rath elected president and chief executive officer of Rasmussen Agency Inc. in East Orange, N.J. Rasmussen, a unit of W.R. Berkley Corp., develops and administers self-insurance programs for governmental and quasi-governmental entities. Mr. Rath previously was a senior vp at CIGNA Property & Casualty Insurance Co.

Ruth Ladner promoted to senior vp of GENESYS Software Systems Inc. of Methuen, Mass., in which she will oversee new business development for the human resources systems vendor. ■



Claims practices

Continued from page 1

Principal Financial Group—also have discussed possible alternatives to the Berman bill with House committee staffers. However, they have not unveiled a proposal.

Meanwhile, employers have formed a new lobbying group—the Coalition for the Preservation of ERISA Preemption, or CoPEP—to oppose the Berman bill.

More than 50 trade groups and employers—including Exxon Corp., FMC Corp., General Motors Corp., Honeywell Inc. and Motorola Inc.—signed a CoPEP letter delivered to all members of the House of Representatives blasting the legislation as unnecessary. The letter complained that the measure would lead to more litigation and higher health care costs.

Business groups criticize the Blues' proposal on several fronts. For example, they argue that automatically awarding attorneys' fees to prevailing plaintiffs would encourage litigation, driving up health insurance costs.

"It is a backdoor approach to increasing litigation. Judges under ERISA have discretion to award attorneys' fees. Why take that discretion away from those—judges—who are intimate with the facts of a case?" asked Mark Ugoretz, president of the ERISA Industry Committee, a Washington, D.C.-based benefits lobbying group representing large employers.

Business groups defend their strategy of a no-holds-barred approach to fighting the Berman bill. They argue that to even discuss alternatives concedes that changes in sanctions for mishandling group health care claims are justified.

"If legislation is wrong, we have no option other than to fight it, which we have been and are continuing to do," said Ellen Goldstein, director of health care policy at the Assn. of Private Pension & Welfare Plans in Washington, D.C.

"The danger of discussing an alternative is (that) you are conceding there is a problem. It is too soon to discuss alternatives when there is no evidence of a problem," said Chris Bowlin, associate director of employee benefits at the National Assn. of Manufacturers in Washington, D.C.

Business groups contend that any alternative put forth by insurers runs the risk of being incorporated in the Berman bill, leaving intact what they consider the most objectionable part of the measure: subjecting group plan insurers to state remedies, including punitive damage awards.

"It is like feeding a meatball to a lion and believing that will be enough to satisfy the lion's appetite. The lion still will want your arm and your leg," a business lobbyist said.

But the Blues' Mr. Dennett rejects that reasoning. Rep. Williams, the Labor-Management Relations Subcommittee chairman, specifically called on the industry to develop an alternative to the Berman bill, he said.

"Rep. Williams always has been genuinely interested in alternatives. There is a real desire on his part to look at alternatives," Mr. Dennett said.

"Had we not put forth an alternative, there was a high probability that the full committee would have rushed to judgment without considering other options," he explained.

Rep. Williams last week saluted insurers for trying to develop an alternative.

"These suggestions are serious, good-faith efforts to respond to my repeated requests for compromise proposals," Rep. Williams said.

Rep. Williams also pointed out that a committee vote on the Berman bill, which had been tentatively set for Nov. 14, was delayed to give committee members more time to discuss alternatives.

However, business lobbyists say that the heat they helped put on Rep. Williams, as well as opposition from Democratic party leaders in Montana—Rep. Williams' home state—are the real reasons the committee vote was scrubbed.

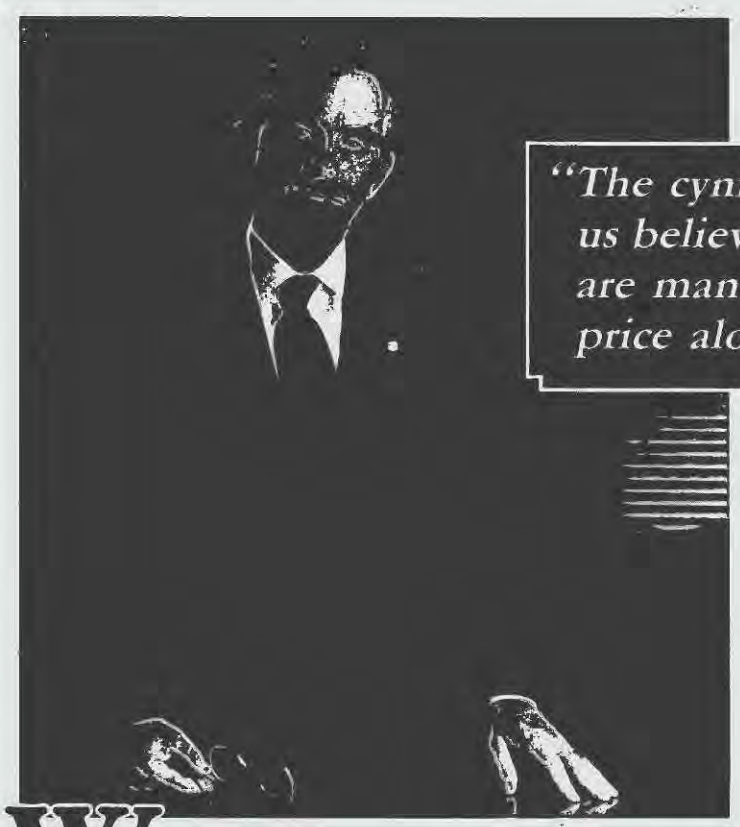
They also question how much support there is for the Berman bill or any alternatives on the full committee, contending that the drive is being led by committee staffers, not members. ■

Cooperating in devising alternatives to the Berman bill 'is like feeding a meatball to a lion and believing that will be enough to satisfy the lion's appetite,' says one business lobbyist. 'The lion still will want your arm and your leg.'

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Santa risks

Continued from page 1

that underwrites Santa-related coverages.

But, as retailers followed customers from the cities to the suburbs and sprawling malls took the place of free-standing department stores, retailers began sharing many services, including the annual Santa display.

As a result, Santa Claus and his helpers now are most often found in the center court of suburban shopping malls in sets that simulate his North Pole workshop or other holiday scenes.

And rather than place a store or mall employee in the role of Jolly St. Nick, malls usually hire a photographic services company that provides a Santa, his helpers and other crew members for the holiday season.

Malls hiring a Santa through an independent contractor require it to provide proof that it carries appropriate insurance coverage, typically $1 million in commercial general liability insurance.

CGL coverage for Santa-related risks is primarily written by surplus lines insurers, which will write the coverage for the length of the holiday season.

The policies cover most liability exposures. While they generally exclude coverage for claims of sexual molestation, that exclusion can be negotiated, some insurers say.

However, many malls do not require such coverage for molestation because Santa's contact with children is usually under the watchful gaze of both parents and crew members.

Most CGL policies for Santa-related risks have deductibles ranging from $1,000 to $5,000 per occurrence, said Cheryl Purtle, vp with Willis Corroon Corp. in St. Louis, who places coverage for a Santa photo contractor.

Rates for the CGL coverage range from about 60 cents to $1.50 per $100 of the photo service's receipts during the holiday season, she added.

A Santa photo service crew also should be concerned about its liability for fire damage to other merchants' property should a candle lighting ceremony go awry or its electrical equipment send off sparks, insurers say.

Many CGL policies include coverage for this risk, while some contractors have the mall contractually assume that exposure. And, in some cases, the coverage can be written separately, said Jack L. Johnson, executive vp of underwriting for GAINSCO Inc. in Fort Worth, Texas, a surplus lines insurer that underwrites Santa-related policies.

Most malls also require Santa photo crews to agree to hold the mall harmless in the event of a claim.

In addition, some malls also require that the malls, their owners and the mall merchants' associations be listed as additional named insureds on a Santa crew's policies.

Some surplus lines insurers charge an added fee for each named insured, said Willis Corroon's Ms. Purtle.

Most Santa-related liability claims stem from trips and falls by youngsters rushing to see Santa and the adults accompanying them.

And, payouts can be higher than expected because the injured party is usually a child.

For example, several years ago GAINSCO handled a case involving a child visiting Santa who fell off of a Santa platform and bumped his knee and head.

The child's parents alleged that he sustained a concussion and the claim resulted in a payout of at least $5,000, said Joseph D. Macchia, chairman, president and chief executive officer of GAINSCO.

"If you are dealing with a child, the sympathy is with the child," said Norman D. Terry, GAINSCO's senior vp-claims.

"In today's litigious society, almost anything can happen," said Mr. Macchia.

Risk managers suggest several measures to ensure a safe and happy Christmas at malls and stores that feature a Santa Claus, including:

- Eliminating the number of steps children have to climb to reach Santa and having a helper—or an "elf"—help a child on and off Santa's lap.
- Providing Santa with coloring books or stencils to give children instead of candy or small toys to prevent any choking incidents.
- Inspecting Santa's "workshop" rigorously before they are opened for the season and then on a daily basis to make sure that there are no loose electrical cords or other hazards.
- Removing live poinsettia plants from walkways where young children wait to see Santa, substituting silk ones.

Most Santa-related liability claims stem from trips and falls by youngsters rushing to see Santa.

Concern about parents' perceptions of poinsettias' yellow buds as poisonous prompted Woodfield Mall in Schaumburg Ill., to substitute silk plants a few years ago, said Jim Linowski, general manager of the mall, which is the fourth-largest in the nation.

Mr. Linowski's staff did this to make parents feel more comfortable; plant experts informed his staff that the plant's buds were not a hazard, he noted.

Another occasional source of yuletide claims is from adults who allege that they suffered injury by falling over the stanchion-and-rope devices used to form waiting lines.

But, Willis Corroon's Ms. Purtle contends that many such claims—and others—are "engineered" by people who are out to make "a buck."

Risk managers also emphasized the importance of carefully screening Santa applicants to weed out those with criminal records and less serious flaws—like non-twinkling eyes—before allowing them to don the traditional red suit with white fur trim.

Successful applicants for Western Temporary Services Co.'s "Santa School" are generally "happy people" who like children and Christmas, said Marilyn Mig-

Continued on next page

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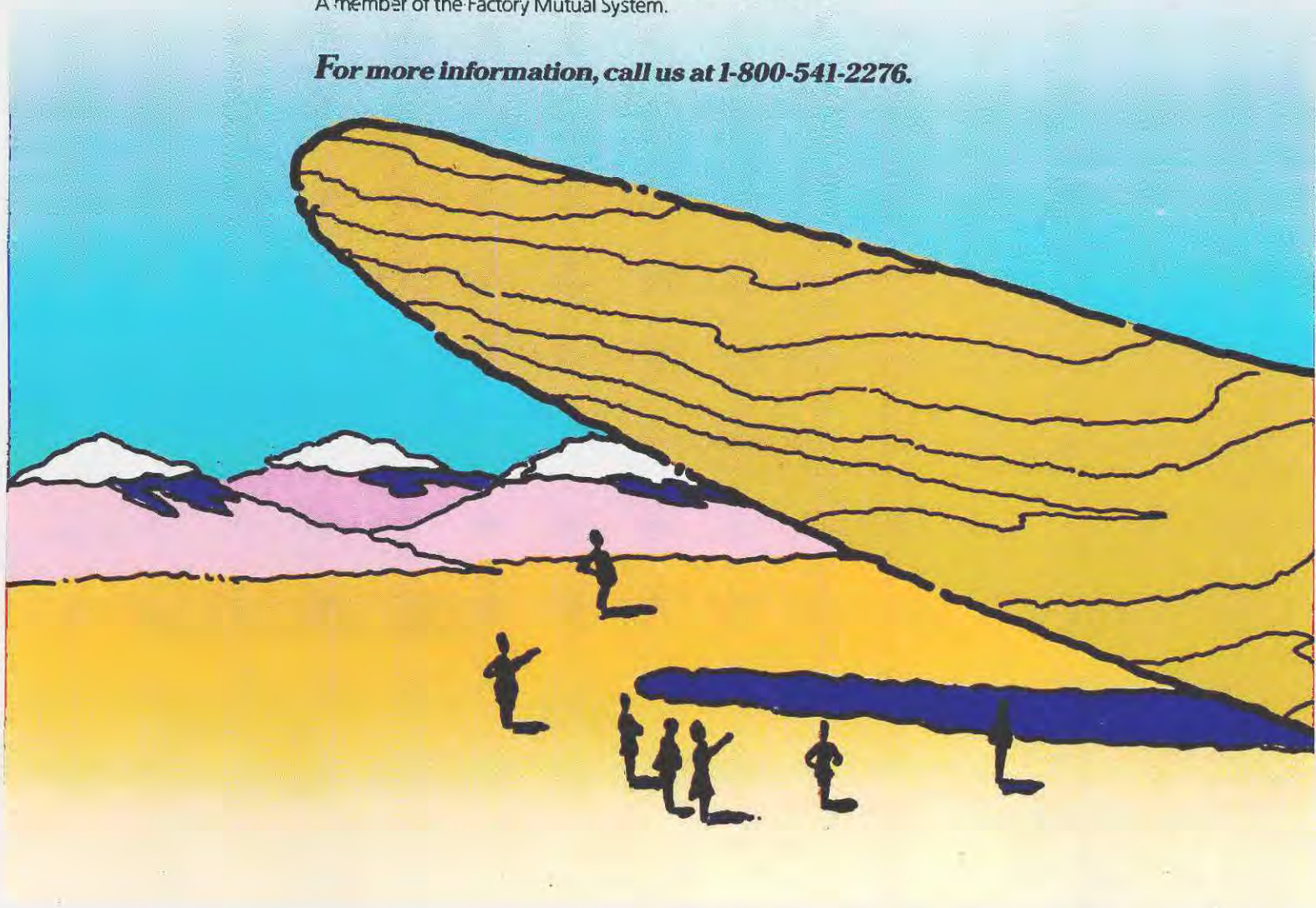
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Continued from previous page
liorini, manager of the company's Lakewood, Calif., branch.

Santa School graduates come from all ethnic groups and sometimes have special communication skills, like the ability to communicate with a deaf child through sign language, she said.

As a result, Santas generally are not the type of temporary worker who takes a job with the intent of filing a "bogus" workers comp claim, which is a problem with some other temporary workers in California, she said.

"The general rule is very simple: Extreme vigilance," said Allen Birk, operator of A&B Portraits, a Modesto, Calif.-based photographic services company that provides Santa crews.

Some shopping malls also use one of their own employees—rather than the photo service's Santa—to attract shoppers by arriving at the mall after Thanksgiving in a novel way.

For example, the Santa "in-residence" at Coronado Mall in Albuquerque, N.M., is a temporary employee of A&B Portraits that the mall hires as an independent contractor, along with a photo crew.

However, the shopping mall has one of its own full-time staff members portray Santa arriving at the mall shortly after Thanksgiving, which is an event that does not fall under the independent contractor's contract.

Over the years, Santa has safely arrived at the Coronado Mall astride a horse, riding in a horse-drawn carriage or on a trolley, said Beth Beckley, the mall's retail licensing manager.

"The arrival of Santa kicks off the holiday season," said Michael Horvath, director of corporate insurance for the Edward J. DeBartolo Corp. in Youngstown, Ohio, which owns or operates 75 regional malls in the United States.

However, ringing in the yule season with a visit from Santa also may ring in the claims season, though claims stemming from these type of promotions are infrequent, sources say.

In one case that resulted in a claim, Santa arrived at the New Orleans Center shopping mall by "floating" down from the top of the Louisiana Superdome with the aid of a tether.

The promotion resulted in "the most unusual" Santa Claus-related claim the DeBartolo corporation has ever had, according to Mr. Horvath.

Santa apparently caused "a couple of hundred dollars damage" to the Superdome roof. Although the Santa was employed by an independent contractor, which carried most of the insurance related to his appearance, the mall had agreed to indemnify the Superdome for any damage to the structure caused by Santa's appearance.

In other years, DeBartolo malls have had Santa arrive by parachute or delivered in a large parcel, but no claims resulted from those events, he said.

Grinch-like curbs also have to be placed on Santa's behavior sometimes, all in the name of risk management.

For example, the Santa who lights the 20,000 lights on the 40-foot Christmas tree on Palm Beach's Worth Avenue shopping district is required to arrive standing in the back of an antique car, Rolls Royce or other vehicle as he is driven through a throng of 2,500 children and adults, said Jesse Newman, president of the Palm Beach Chamber of Commerce for 20 years.

The Santa, who comes annually from Finland as part of a Finnair promotion, would prefer to arrive in town riding a large motorcycle like the one he personally owns, but Mr. Newman won't let him.

"We are looking at the safety factor," he said.

Overall, most insurers and risk managers say that Santa-related liability claims are very infrequent.

"It's usually a pretty good class of business to write," said Western World's Mr. Russo.

For example, Woodfield Mall, which expects 23,000 children to visit its Santa this year, has never had a Santa-related claim in its previous 19 years of operation, said Mr. Linowski.

Woodfield's Santa is provided by Twinstante Inc. of St. Peters, Mo., whose "Santa Plus" program provides Santa photo crews to 300 locations in 43 states.

Observers attribute the lack of claims to the kind of people who are drawn to this Christmas tradition, either as Santa's visitors or as Santas themselves.

"Santa Claus attracts the type of patrons to the mall we would want to see—families and children," said Mr. Horvath of DeBartolo Corp. "They are orderly and their actions predictable."

In addition, representatives of the Volunteers of America Greater New York Inc. say that no one can remember an employee theft or a general liability claim stemming from its "Sidewalk Santa" program.

The organization, which purchases insurance for both types of risks, hires at least 25 homeless men to don Santa suits and stand by collection boxes—simulated chimneys—throughout midtown Manhattan.

The Santas collect about $40,000 annually in donations for the needy.

The men are paid only about $35 daily in addition to a percentage of the contributions they receive and a bonus for working every day during the season, said Dottie Watkins, director of communication.

The only problem with the Sidewalk Santa program is that "occasionally kids want to pull Santa's beard down," Ms. Watkins said. "I guess it's the season."

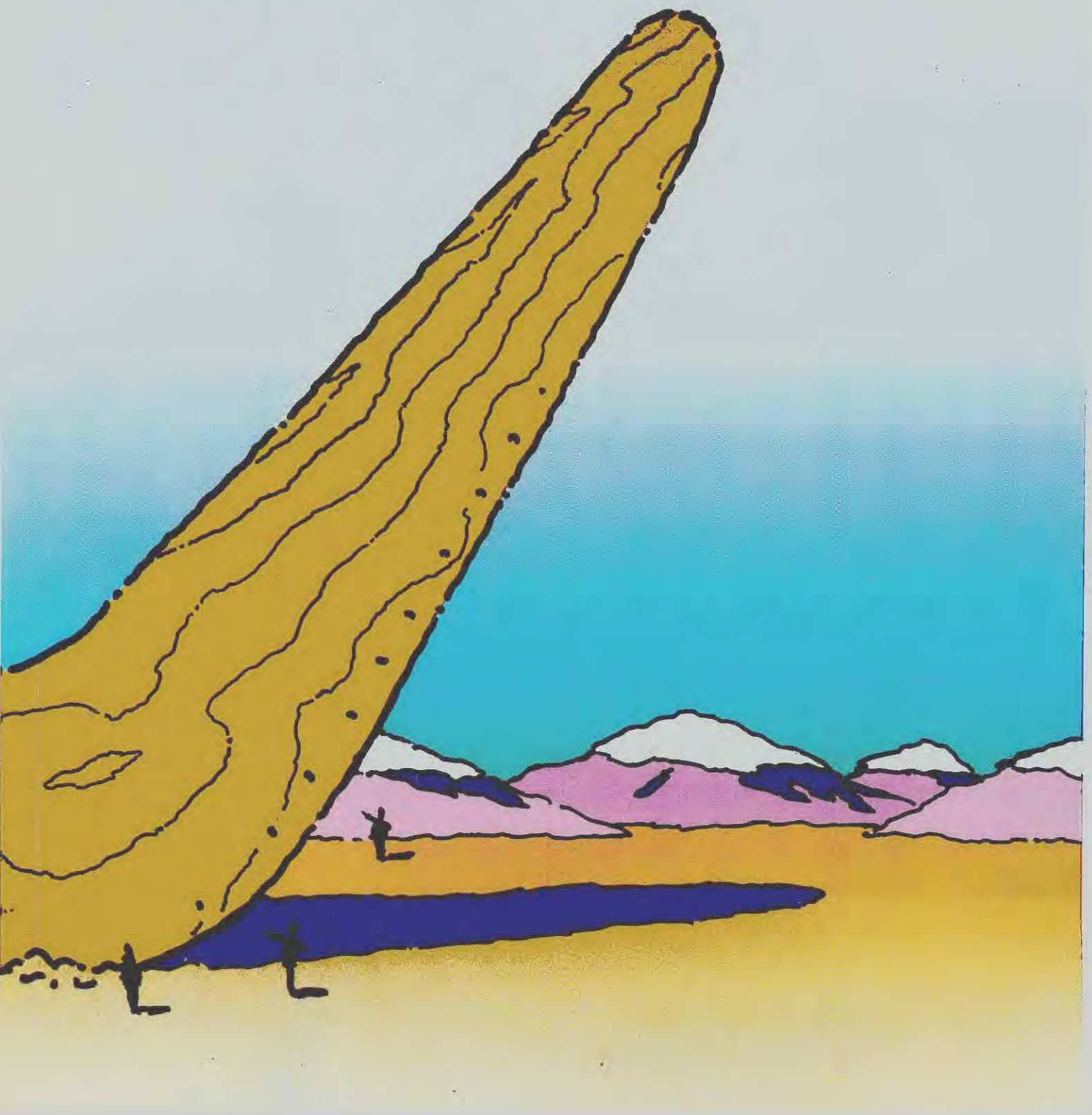
The Chicago-area Salvation Army reports that it has never had a Santa-related claim from its annual Christmas party for 3,000 underprivileged youngsters.

During the parties, children are entertained by a variety show before passing by Santa, receiving a gift and boarding buses to return to their homes.

To control the large numbers of children attending the party, the self-insured organization hires professional ushers.

Although the Salvation Army has a risk management program, such parties are "calculated risks," spokesmen acknowledged. However, for the Salvation Army, "you do the best you can but put your trust in God," one spokesman pointed out. ■

k year
dorsement.



Reporting rules

Continued from page 2

not constitute an admission by the manufacturer that the product is dangerous or defective.

Under the proposed rules, manufacturers would be required to file a report within 30 days after the third final settlement or judgment, regardless of whether a judgment is subject to appeal.

The proposed rules also would prevent the commission from disclosing settlement or judgment information contained in the reports. But, in limited circumstances, certain congressional committees would be able to request information from the CPSC.

Immediately following passage of the Consumer Product Safety Act in November 1990, the CPSC staff began drafting the proposed rules.

In an initial draft, the commission suggested that a single adverse verdict or settlement in a product liability lawsuit alleging serious injury or death would trigger a manufacturer's duty to report.

But in the most recent—and likely to be final—interpretation of the rules, the CPSC staff held that three adverse verdicts or settlements involving a single product model in a 24-month period would be required before the reporting requirements were triggered.

Manufacturers are generally pleased with how the CPSC is interpreting the new law.

"The business community felt that a one-lawsuit reporting requirement contradicted the legislative history of the statute," said Kerrie L. Hook, an attorney with Collier, Shannon & Scott in Washington, D.C., who represents manufacturers.

The business community also felt that without the confidentiality requirement, plaintiffs' attorneys would use the information supplied to the CPSC to generate lawsuits.

But, while manufacturers are pleased with the proposed final rules, many questions remain unanswered.

First, it is not clear how the commission would treat "nuisance-value settlements" of meritless claims, which are made by manufacturers simply to avoid costly litigation.

"The new regulations don't address nuisance-value settlements," said Ms. Hook. "It doesn't advance consumer safety" to have these cases reported.

Another "key question" that remains is what would constitute a "particular model" within the rules, said Paul Laurenza, a lawyer with Petit & Martin in Washington, D.C., who represents manufacturers.

He said manufacturers will seek more guidance in how to determine if a product represents a distinct model from another similar product.

Product liability attorney Victor Schwartz of Crowell & Moring in Washington, D.C., suggested that rules also be revised so that manufacturers and plaintiffs involved in a settlement could agree that the initial lawsuit was wrong and avoid the reporting requirement.

Finally, Mark Austrian of Collier, Shannon & Scott warned manufacturers that "initially the CPSC will be looking for test cases." The commission will be looking to fine companies that fail to report under the rules to set an example, he said.

"The agency is monitoring the federal court docket, looking for product liability cases that should have been reported," agreed Ms. Hook.

Consumer groups expressed frustration at the new interpretation of the Consumer Product Safety Act, particularly the three-action threshold for reporting to the commission.

"This provision does not go far enough to protect the public," said Kristen Rand, counsel for the Consumers Union in Washington, D.C.

"The goal of the provisions was to dramatically increase reports, and this won't do it," she said.

Furthermore, the new rules "definitely have loopholes," she said.

For example, because the rules would require three adverse judgments or settlements within a 24-month period, manufacturers could simply avoid settling three claims within the prescribed period and avoid reporting, Ms. Rand said.

Mary Ellen Fise, product safety director for the Consumer Federation of America in Washington, D.C., also criticized the revised rules.

"We supported having all claims reported to the commission," said Ms. Fise. "This would allow the CPSC to track problems better."

There are other problems with the proposed rules, as well, she said:

First, it takes a long time for a product liability lawsuit to reach the stage at which a final judgment is entered, she said. But before a final judgment is entered, a dangerous product may remain on the market.

Second, in some instances when consumers are aware of a dangerous product, they may not file an actual lawsuit with the company, but rather, will settle their dispute early. Again, the dangerous product remains on the market, she said.

Third, confidentiality provisions within the rules would prevent consumers from learning about dangerous products, Ms. Fine warned.

"The CPSC is the only government agency that has what is in effect a gag order," she said.

The Federal Trade Commission, the Federal Drug Administration and the National Highway Traffic Safety Administration all disclose this type of safety information to consumers, said consumer advocate Robert Adler, associate professor of legal studies at the University of North Carolina School of Business Administration in Chapel Hill.

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Comments on the proposal should be sent by Dec. 27 to Office of the Secretary, Consumer Product Safety Commission, Washington, D.C. 20207, or delivered to Room 420, 5401 Westbard Ave. Bethesda, Md., 20816.

DECEMBER CLOSINGS

SET YOUR DATES

issue:	December 16 — Reader Service
closing:	December 3
editorial feature:	Benefits: Market Report — Directory: Benefit Consultants
demographic section:	Insurer Topics: Mergers/Acquisitions/Divestitures
issue:	December 23
closing:	December 10
editorial feature:	Combined Year-End Issue: Year-In-Review
issue:	January 6
closing:	December 19
editorial feature:	Risk Management: Market Report
issue:	January 13
closing:	December 27
editorial feature:	Employee Benefits Information Resource

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INTERNATIONAL

2 insurers to acquire stakes in Skandia

By MARIA KIELMAS

STOCKHOLM, Sweden—Norway's UNI Storebrand A/S and Denmark's Hafnia Insurance Co. Ltd. teamed up to acquire major shareholdings in Sweden's Skandia Insurance Co. Ltd. under transactions announced late last month.

The attempted creation of a new Scandinavian insurance alliance by the investors was not welcomed by Skandia or stock analysts, who complain that the three insurers already are fierce competitors and question what new strength will be created.

Sweden's largest bank, Skandinaviska Enskilda Banken, on Nov. 22 transferred the majority of its 28.2% share option in Skandia.

The bank's transfer of an option to buy 23.3% of Skandia to UNI Storebrand and Hafnia late last month puts to rest more than a year of uncertainty over the future of the bank's option. SEB itself will exercise the option for the remaining 4.9% of Skandia shares.

However, that uncertainty was replaced by questions about the effectiveness of the new Scandinavian insurance alliance that will be created by Skandia, UNI Storebrand and Hafnia.

SEB, UNI Storebrand and Hafnia made identical statements following the option reassignment, reporting that their ultimate aim is "creating the basis for Scandinavian ownership of major, internationally competitive bank and insurance companies."

The first step, they say, will be a restructuring, initially in the insurance sector. UNI Storebrand and Hafnia intend to sell part of their Skandia shareholding to a Finnish insurance company and a leading European reinsurer, their statement said. They would not identify either company, but said they would be new shareholders. Finland's Pohjola Insurance Co. Ltd. already holds 10.5% of Skandia.

Following the restructuring, the companies said their holdings in Skandia would be:

- UNI Storebrand, 25%.
- Hafnia, 9%.
- SEB, 4.9%.
- The unnamed Finnish and European companies, 8.8%.

The companies' statement also said the agreement between SEB and the two insurers includes an understanding to "investigate, without prejudice, the possibilities of joint cooperation within the banking and insurance sectors in Scandinavia."

The future ownership of Skandia was first questioned in October 1990, when AB Investor and AB Providentia, two key holding companies of Sweden's Wallenberg group, and Tidnings AB Marieberg, part of the Bonniers publishing group, granted SEB an option to acquire 21.7 million shares, or 28.2% of Skandia's share capital. The share option price amounted to 4.72 billion Swedish krona ($773.1 million at Oct. 1, 1990 ex-

Continued on next page

BERMUDA

BICL alters underwriting practices

By ROGER SCOTTON

HAMILTON, Bermuda—Bermuda-based mutual liability insurer Bankers Insurance Co. Ltd. is making key changes in its underwriting practices as its fiscal year draws to a close.

Also, the insurer expects to report that written premiums rose 64% in the year ended Nov. 30 to $9 million from $5.5 million a year earlier. The insurer is owned by 24 U.S. banks and bank holding companies and offers directors and officers liability insurance and financial institution bonds with limits of $10 million on a primary or excess basis.

BICL intends to cease underwriting bankers blanket bond coverage and will no longer provide difference-in-conditions drop-down policies.

But, BICL says, in an effort to be "more responsive to the needs of the market," it is now offering one-year directors and officers policies in addition to the three-year, prepaid policies it has been underwriting since its formation in 1986.

BICL consultant Edith Lichota, who is acting as vp-administration, explained that the insurer will write one-year D&O and corporate reimbursement policies for banking organizations that become members by payment of a one-time premium surcharge. Ms. Lichota

Continued on page 33

Japanese reinsurance rates to rise

By KATE McILWAINE

TOKYO—Underwriters in Japan expect total 1991 insured typhoon losses—estimated at $3.5 billion—to raise catastrophe reinsurance rates for Japanese insurers, but they are not yet willing to predict whether primary insurance rates will follow suit.

Nobuo Hara, general manager-international department of the Japan Marine & Fire Insurance Assn. in Tokyo, said typhoon losses from Jan. 1 though Oct. 17 totaled 340 billion yen ($2.66 billion).

That figure includes an estimate of 290 billion yen ($2.27 billion) in claims for Typhoon 19, which hit Japan's Pacific Ocean coastline Sept. 27-28 (*BI*, Nov. 18; Oct. 7). Mr. Hara said claims from that typhoon are still coming in, so the total 1991 loss figure would increase.

Robert N. Gordon, regional vp of American International Group Inc. in Tokyo, said four times the usual number of typhoons hit Japan this year. He estimates insured losses from the storms will reach 450 billion yen ($3.52 billion) this year, including losses from Typhoon 19, which hit the southern island of Kyushu. Mr. Gordon said uninsured losses could be "nearly the same again."

Mr. Hara said it would be "some time before we get the final settlement" from Typhoon 19. "It will increase, I'm afraid, but I'm not sure (of the amount) at this stage," he added.

Shinjiro M. Goh, general manager of the risk management department at Fuji Fire & Marine Insurance Co. Ltd. in Tokyo, said the insurance industry had received 330,000 claims from Typhoon 19 and he estimated insured losses from that storm at 320 billion yen ($2.5 billion).

Mr. Hara said Typhoon 19 primarily damaged domestic residences and crops, particularly apple orchards that were nearing harvest.

Mr. Goh said he was aware of several major commercial losses. He did not have figures for the claims, but said the biggest losses were for damage to:

- Three cranes and a plant roof at a shipyard owned by Mitsubishi Corp.
- Twelve thousand new cars at the Matsuda plant at Yamaguchi.
- Twelve hundred new cars at Nissan Motor Co. Ltd.'s Kyushu plant.
- Eight hundred sixty new cars at a pier owned by Honda Motor Co. Ltd.
- A 14,800-acre lumber forest in the Ohita prefecture, which incurred heavy wind damage.

Continued on page 31

Labuan attracts offshore insurer



LABUAN, Malaysia—The first offshore insurer has been established in Labuan, one of the world's newest captive domiciles.

MNI Offshore Insurance (L) Ltd., a unit of Malaysia National Insurance Sdn Berhad, was capitalized at $11.8 million Malaysian ($4.3 million at current exchange rates) and is licensed as both an offshore insurer and an underwriting manager in Labuan.

MNI's move to Labuan comes in the wake of the Malaysian government's plan to make the island an international offshore financial center.

The Malaysian government is devoting $369.4 million Malaysian ($135 million) in funds to improve Labuan's infrastructure, said Malaysian Finance Minister Datuk Seri Anwar Ibrahim at a recent conference on Labuan co-sponsored by MNI and the Risk & Insurance Research Group Ltd. of London.

In addition, there are "substantial financial outlays" from the private sector and the government telecommunications company to improve the island's business resources, he said.

An area of 66.7 acres has been earmarked for the development of an "international financial park" where the offshore insurance sector can set up offices, delegates to the conference were told. Also to be built in Labuan is an international school, "high-class" hotels and a 105-bed hospital.

But while Labuan is being upgraded, offshore companies can operate management offices from Kuala Lumpur, the capital of Malaysia, the finance minister said.

"The fact that Labuan is not yet a highly developed metropolis need not discourage us, because many a successful financial center started off in a very modest manner," said Risk & Insurance Research Group in a paper written earlier this year on the "opportunities in Labuan in the insurance field."

"It should be our endeavor to create the facilities in anticipation of utilization rather than wait for the demand to develop before initiating the action," the consultant said. "Labuan is centrally situated in Southeast Asia, and once the air services are suitably augmented, it should be advantageous to make Labuan a regional center for operations in East Asia and the Pacific for insurers and reinsurers from Europe, the United Kingdom or the United States, as well as for operations set up by corporations from

Continued on page 31

Answers sought from ex-LUI chief

Court weighing whether Wilson is in contempt

By STACY SHAPIRO

LONDON—Peter Wilson, the former chief executive of London United Investments P.L.C., is refusing to shed light on what happened to $43 million that allegedly should have been collected by LUI subsidiary H.S. Weavers (Underwriting) Agencies Ltd.

Mr. Wilson so far has refused to answer questions from Department of Trade and Industry inspectors about the diversion of the reinsurance commissions to some Liechtenstein trusts.

The Court of Appeal in London is deciding whether Mr. Wilson should be forced to answer the questions or be held in contempt of court (*BI*, Nov. 25). The decision is expected before Christmas.

A lower court had ruled that Mr. Wilson must answer questions or be found in contempt. That July ruling came from Justice Scott in the Chancery division of Britain's High Court.

In 1989, British authorities ordered LUI insurance units, including Walbrook Insurance Co. Ltd., to stop writing new business. Administrators were appointed for the parent company in 1990, and the DTI was kept informed about the contents of the administrators' reports, Justice Scott pointed out.

Mr. Wilson resigned from the Weavers board in June 1990 and from the LUI board several months later.

Shortly after his resignation from LUI, the Weavers administrators issued a writ in the High Court against Mr. Wilson and two other former Weavers directors: Henry Weavers and Ronnie Driver, a former LUI chairman. Also named in the writ were three Liechtenstein "entities or companies" that have become known as the "Smith" companies, and two individuals, a Mr. and Mrs. Smith, who controlled them (*BI*, Nov. 5, 1990).

According to Justice Scott's ruling, the administrators' writ alleges that:

- Weavers, which purchased quota-share reinsurance treaties from Munich Reinsurance Co. between 1976 and 1989, was "entitled" to commissions on the business placed with Munich Re. The commissions varied between 5% and 6.5% of total premium.
- Over that period, the commissions totaled $43 million. However, it is alleged that "none of this found its way to Weavers," said the judge.
- The premiums were paid directly to one or the other of the Smith companies in Liechtenstein.
- Whichever Smith company received the premium would deduct the commission and transmit the

Continued on page 32



Peter Wilson has refused to answer questions about the diversion of the reinsurance commissions to some Liechtenstein trusts.

Skandia deal

Continued from previous page
change rates), or 217 Swedish krona per share ($36).

This autumn, UNI Storebrand in several stages acquired 15 million Skandia shares on the open market, equivalent to 19.5% of Skandia (*BI*, Nov. 4; Sept. 30). Hafnia held 14,000 shares in Skandia.

UNI Storebrand's purchases fueled speculation that SEB might exercise its option to buy a stake in Skandia.

However, under the agreement between the bank and two insurers:

- As of Nov. 22, SEB assigned to UNI Storebrand and Hafnia the option to acquire 17.9 million Skandia shares, or 23.2% of share capital.

SEB will exercise on its own behalf the remaining option for 4 million shares, or 4.9% of Skandia equity.

- UNI Storebrand and Hafnia guarantee to exercise the purchase option on 11.1 million shares, or 14.5% of the total, with payment on Dec. 13. The option on the outstanding 6.8 million shares, or 8.8%, will be exercised with payment on Feb. 28.
- The two insurers will pay 222 Swedish krona ($38.16) per share on Dec. 13 and 225 Swedish krona ($38.68) per share in February. As a result, the two insurers will pay about 4 billion Swedish krona ($687.6 million at current exchange rates) for their shares.

However, under the SEB option package, the purchase price agreed to rises to 244.2 and 250 Swedish krona ($41.98 and $42.98) on the respective exercise dates. SEB will pay the difference, which is expected to be total 415 million Swedish krona ($71.3 million).

In addition to the above agreement, SEB has guaranteed to underwrite a new issue of Hafnia shares up to a maximum of 700 million Danish krone ($120.3 million), with preferential rights for existing shareholders.

While the bank will incur a loss on the transaction, a spokesman for SEB in Stockholm said that the size of the total loss will not be determined until year-end.

The spokesman said that Skandia management scuttled SEB's original hopes for a bank-insurer merger. "It could have been a combination of not believing in bank-insurance synergies and a protection of their own interests," he speculated.

Skandia President Bjorn Wolrath said in a statement after the stock option transactions were announced that it was too early to go into detail how the new shareholder structure will affect the company. This will have to be discussed with the new owners, he said. "UNI and Hafnia did not tell us of their intentions before today's announcement," he said.

"Of course, it is good that we don't have the SEB option hanging over our heads anymore, but we don't know much about Storebrand and Hafnia's future intentions," a Skandia spokesman said.

The Skandia spokesman said fierce criticism of the transaction by stock market analysts, particularly in London, is justified, since the three insurers are competitors.

"We are competitors with these companies," he said, referring to UNI Storebrand and Hafnia. He pointed out that Skandia has "a very good company in Norway," Vesta General Insurance Co., and Royal Chartered General Fire Insurance Co. Ltd. in Denmark, both wholly owned subsidiaries. "We think there will be problems in the future," the spokesman said.

Mike Wheelhouse, insurance analyst with Hoare Govett Ltd., a London securities firm, said the basis of the whole deal to create a pan-Nordic insurance giant is questionable.

"For a start, there already is a pan-Nordic insurance company. It's called Skandia. Then, putting together these separate companies does not create a company which is competitive in the world market. It is wholly defensive and just closes off the Scandinavian market.

"I think these people (UNI Storebrand and Hafnia) should stop playing little Napoleons and get on with some insurance," Mr. Wheelhouse said.

He noted that because attempts at overseas expansion by UNI Storebrand were not successful, "how on earth can they run Skandia, which is one of the biggest reinsurers around and one of the largest foreign insurers in the U.S.? It's ludicrous."

Mr. Wheelhouse said the investment does nothing for UNI Storebrand's policyholders and shareholders. He charged that the insurer is "messing around with life policyholders' " assets in its acquisition of the Skandia stake and that shareholders of the Norwegian insurer had seen their investment cut in half over the last year. The initial investment in Skandia was partly financed by contributions from UNI Storebrand's life insurance subsidiary, Storebrand Livsforsikrings A/S (*BI*, Sept. 30).

The new shareholdings also raise questions about competition in the Norwegian market, Mr. Wheelhouse said. UNI Storebrand currently holds about 30% of the Norwegian insurance market while Skandia's Vesta subsidiary holds 12% to 15%.

"No company should have more than 50% of the insurance market in a developed economy," Mr. Wheelhouse charged, noting that UNI Storebrand approaches that with this deal.

UNI Storebrand has filed a request with the Norwegian government's Banking and Insurance Committee for control of 25% of Vesta, in proportion to its holding in Skandia, a UNI Storebrand spokesman said.

The spokesman disputed the notion that the acquisition of the Skandia stake was a questionable investment of life insurance policyholders' funds. UNI Storebrand's life insurance subsidiary, Storebrand Livsforsikrings, will contribute only 10% of the 4 billion Swedish krona ($687.6 million) acquisition costs.

He also rejected criticism that the size of the new Nordic insurance group will have nothing to do with its potential profitability. "Size is important for reinsurance. What is going on is major structural change."

The spokesman for the Norwegian insurer could not comment on possible changes to Skandia's board and top management.

In addition, UNI Storebrand's power to force such changes could be limited since no single Skandia shareholder can hold more than 30% of voting rights.

A Skandia spokesman agreed, saying, "we could get 30 people from Vesta who hold just one share to a general meeting and they will have the same power as Storebrand."

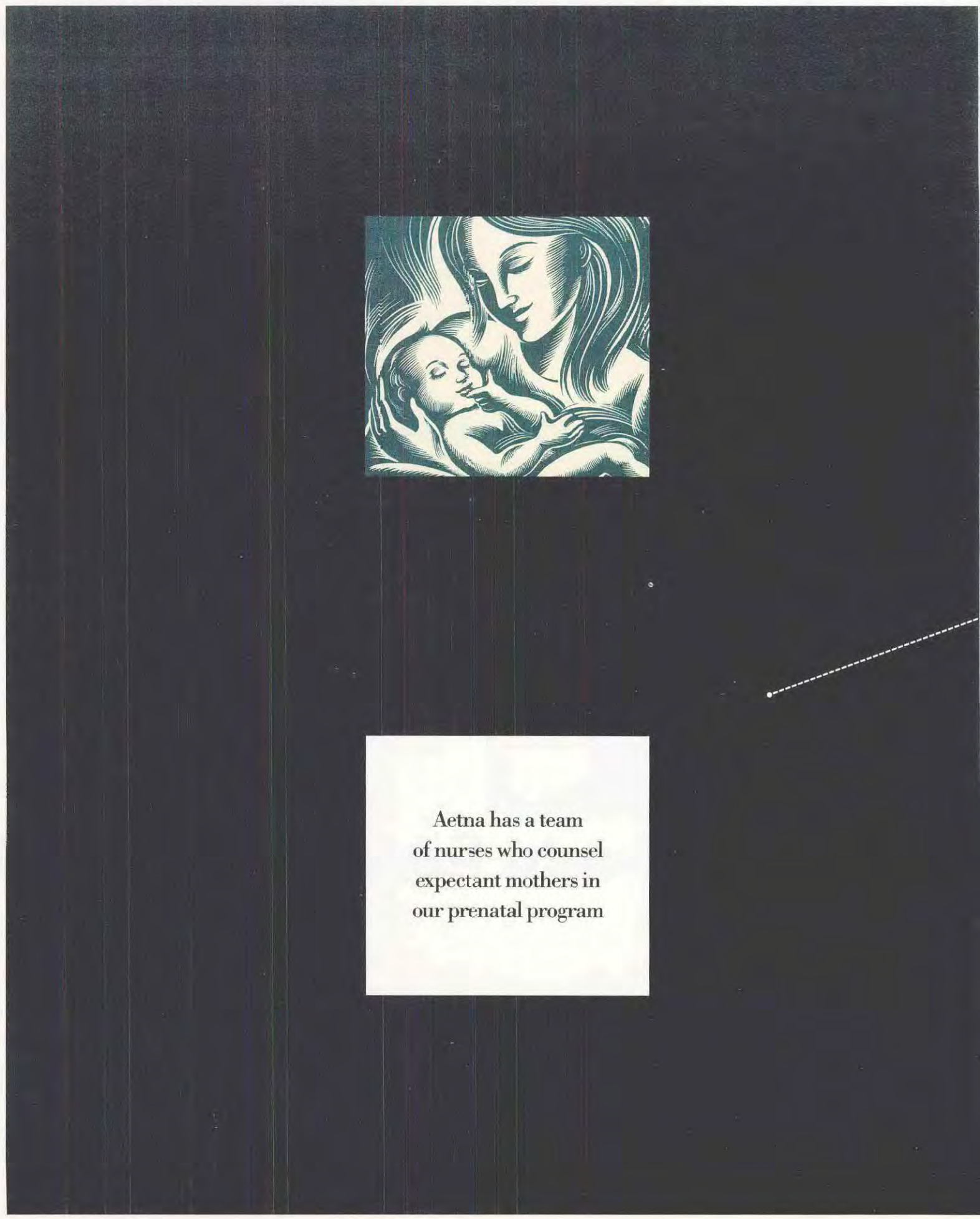
Hafnia's participation in the Skandia carve-up was a logical move for the Danish insurer, a spokesman in Copenhagen said. "Hafnia believes that it is important to be strong in international terms, and if we think in terms of the size of Danish insurers we will be blown out of the market."

Hafnia had hoped to strike a cooperative agreement with Denmark's largest insurer, Baltica Holding, and acquired a 33.7% stake in Baltica in the process. "But they weren't keen on a merger, so we had to look elsewhere," the spokesman said. Hafnia has since sold some of its shares.

The new Nordic insurance group will leave individual companies to work in their national markets, but cooperate on the international front, he said. Policyholders "will be serviced at a national level by the same companies," he said.

The Hafnia spokesman acknowledged that the new structure is a defensive one: "If you have cooperation, you have a defense against

Continued on next page



INTERNATIONAL

Continued from previous page
predators."

However, Hafnia's participation in the arrangement also raised concern among insurance analysts.

Standard & Poor's Insurance Rating Services last week placed the AA– claims-paying ability rating of the Hafnia Insurance Group on Creditwatch with negative implications after the insurer announced its participation in the deal.

S&P said that it would meet with Hafnia management to discuss how the Skandia transaction will be financed and what impact it will have on Hafnia's earnings potential and the liquidity of its insurance operations.

Meanwhile, the Hafnia spokesman explained that Skandia was not informed in advance of the UNI Storebrand/Hafnia move because it was apparent that Baltica had launched a rival bid for the Skandia option held by SEB. "But the Skandia board was given information by SEB management," he added.

The spokesman also noted that Skandia's Mr. Wolrath has been quoted in the Swedish press as saying "he is looking forward to doing business with professionals—that's insurance people, not banks."

Skandia's spokesman confirmed that the Swedish insurer had earlier pursued a possible merger with Baltica, which is part of the Colonia Victoire Group controlled by France's Cie. Financiere de Suez.

But insurance analysts say such a structure would have fared little better than their expectations for the current group.

"If you subscribe to the notion that concentration in the European market is an inevitable process, then it makes more sense to pursue the Baltica-Colonia-Victoire path. But you don't know which course that would have taken and which would have been the dominant management culture in the group," said Jonathan Lawlor, an analyst at Kleinwort Benson Securities in London.

Regarding the present arrangement, Mr. Lawlor said, "It's hard to guess the extent to which the Norwegian government is behind this."

Hoare Govett's Mr. Wheelhouse noted that Norway's financial sector is undergoing a severe crisis. "Because there is no effective banking sector in Norway at the moment, the Norwegian government could agree to Storebrand being the country's one financial institution capable of expanding abroad," he speculated.

In light of this atmosphere, Mr. Lawlor questioned whether anti-monopoly forces in the market could squelch the new alliance, thereby possibly undermining the strength of the country's largest financial institution, UNI Storebrand.

"There are certainly some strong anti-competitive elements in this new arrangement," he said. ■

Typhoon losses

Continued from page 29

• A commercial apple orchard in northern Japan that suffered serious damage to crops.

AIG's Mr. Gordon said the typhoon losses were the biggest ever suffered by the heavily regulated Japanese insurance market. "Companies have gone through their catastrophe covers and out the other side," he said.

Most Japanese insurers place their catastrophe reinsurance coverage in the London market, Mr. Gordon noted.

Japanese insurers have approximately $1.1 billion in reinsurance cover, London sources agree.

In addition, Munich Reinsurance Co. in Germany has incurred 200 million deutsche marks ($126 million) of the Typhoon 19 loss, according to Chief Executive Horst Jannott.

Fuji Fire & Marine's Mr. Goh said Japanese insurers, with only one or two exceptions, suffered losses from the typhoon exceeding their excess-of-loss covers.

"Most Japanese companies are now trying to purchase back-up line reinsurance cover in the London market to prepare themselves for future big losses," he said.

Mr. Goh agreed Typhoon 19 is the largest insured loss suffered by the Japanese market. His company's losses so far are about 20 million yen ($156,500), he noted.

Mr. Goh, who visited the island of Kyushu in October, said there was a lot of visible damage.

"Many roofs are covered by yellow plastic sheets. There is a shortage of tiles and labor, so many will not be fixed before the end of the year," he said.

The Japan Marine & Fire Insurance Assn.'s Mr. Hara said he did not know how much reinsurance Japanese insurers had in place to cover typhoon losses, but said Japanese ceding companies were expecting increases in their catastrophe reinsurance rates.

"We are very much afraid of that, particularly from the overseas reinsurance companies," he said.

A spokesman for Japan's national reinsurance company, Toa Fire & Marine Reinsurance Co. Ltd. in Tokyo, said it was too early to say what the company's payout for Typhoon 19 would be and he could not say how much reinsurance Japanese ceding companies had purchased.

Mr. Hara said it was too early to assess whether tariff-based insurance rates would be increased in Japan because of the losses. But, he added, the 25 domestic insurance companies and 35 foreign insurers that comprise the rating association would meet soon and put forward recommendations to the Ministry of Finance, which controls insurance rates in Japan.

Fuji's Mr. Goh said the Japanese Fire Rating Bureau had not yet announced any plans for a rate hike. ■

Labuan

Continued from page 29
Japan, Korea, Hong Kong, Taiwan, Australia and other places."

According to RIRG, the new domicile is regulated under the Offshore Insurance Act, 1990, which requires that new offshore companies:

• Have capital of at least $7.5 million Malaysian ($2.7 million) for an offshore insurer, $10 million Malaysian ($3.7 million) for a professional reinsurer or $1 million Malaysian ($365,400) for a captive insurer.

• Be managed by a Labuan office, either by its own management or a licensed offshore underwriting manager in Labuan, which is run by "fit and proper persons."

• Maintain a minimum solvency margin of 20% of net premium income for non-life insurance, 3% of the actuarial valuation of liabilities for life insurance and $1 million Malaysian ($365,400) for a captive insurer.

• File annual audited returns to the Bank Negara Malaysia, which oversees insurance regulation, within six months of the end of the financial year. The auditor must be from a list approved by the bank.

• Pay annual license fees, which vary depending on the type of business written. The fee is $30,000 Malaysian ($10,962) for non-life insurance; $10,000 Malaysian ($3,654) for captive insurance business; $5,000 Malaysian ($1,827) for offshore insurance managers; and $5,000 Malaysian for offshore insurance brokers.

Offshore companies will be taxed at 3% of annual net profits or a flat rate of $20,000 Malaysian ($7,308).

Authorities plan to continue taxing non-residents of Labuan at 35% of their Malaysian-sourced income.

In addition to MNI Offshore, several captive managers have been formed in Labuan (*BI*, April 29).

—By Stacy Shapiro

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Wilson appeal

Continued from page 29

remaining premium to Munich Re.

"The $43 million (was) retained by the Smith companies," said Justice Scott.

"It is not known to the administrators, and it is not apparent from the books of Weavers, why Weavers did not itself deduct the commission to which it was entitled and itself transmit the premium net of commission to Munich Re," the judge said. "It is not known what service the Smith companies rendered or were expected to render to Weavers to warrant the retention of the $43 million."

Also mentioned in the administrators' civil suit, though not accused of any wrongdoing, is Russell Reinsurance Services Inc. The three LUI directors owned 66.7% interest in the Southfield, Mich.-based company (*BI*, May 22, 1989).

Russell Re has nothing directly to do with the lost Munich Re commissions, said Justice Scott. "But certain details regarding Russell Re are pleaded in the (civil action) for the purpose of an inference being drawn of some connection between Mr. Wilson and the Smith companies," he said.

Weavers' administrators are bringing the civil action against Mr. Wilson and the other defendants to recover the missing $43 million. They allege that Mr. Wilson and others "were involved in a criminal fraudulent conspiracy to extract from Weavers the commission due to it in respect of the Munich Re business," said Justice Scott. "It is fair to say that Mr. Wilson has consistently denied that he was involved in any wrongdoing in respect of the Munich Re commissions or otherwise."

The day after the civil writ was issued in October 1990, the DTI launched its investigation into the "affairs of LUI," said Justice Scott. The matter also was considered by the Serious Fraud Office, but the office is not actively pursuing an investigation "pending further discussions with the DTI," he said.

In February this year, DTI inspectors sent written questions about the Munich Re commissions to Tarlo Lyons, a law firm representing Mr. Wilson. Twice (once through his lawyers) Mr. Wilson refused to answer. "The main grounds of the refusal was that his answers might tend to incriminate him," said Justice Scott.

Lawyers for Mr. Wilson claim the inspectors have no right to question their client. The inspectors were supposed to investigate the affairs of LUI and not Weavers, the lawyers said.

While "Mr. Wilson has no more obligation to answer the questions of invalidly appointed inspectors than he has to answer the questions of officious meddling busybodies," the inspectors had been validly appointed to look into the entire affairs of LUI and its subsidiaries and its past directors, the judge ruled.

Weavers "was an important wholly owned subsidiary of LUI; so was Walbrook. $43 million was thought to have gone missing from (Weavers). The extraction of that sum from Weavers' profits over the period 1976 to 1989 would have had a significant effect on LUI's consolidated balance sheet at the end of the period," said Justice Scott.

"Moreover, the involvement of the Smiths or the Smith companies with Russell Re, also an LUI subsidiary, and the fact that Mr. Wilson and Mr. Driver (I'm not sure about Mr. Weavers) had been for most of the period senior directors of LUI, made the decision to appoint inspectors to investigate the affairs of LUI rather than simply to investigate the affairs of Weavers not only a justifiable but also, in my opinion, a logical one," he ruled.

Mr. Wilson's lawyers also made a self-incrimination argument. Because the inspectors are trying to establish Mr. Wilson's "guilt or innocence of crime" related to the missing commissions, the lawyers argue, he should be entitled to refuse to answer on the grounds that he might incriminate himself.

Justice Scott rejected that argument. He ruled that under section 434 of the Companies Act of 1985, Parliament has abrogated the common law privilege against self-incrimination in order to allow inspectors to investigate alleged malfeasance.

The High Court, the said, has already upheld the DTI's right to question several men involved in the scandal-tainted acquisition of United Distillers P.L.C. by Guinness P.L.C. The Court of Appeal let that ruling stand.

Allowing Mr. Wilson to refuse to testify on account of self-incrimination also would hamper investigations by DTI inspectors, he added. "If the witnesses can simply refuse to answer, pleading the privilege against self-incrimination, the inquiries will, I think, in many cases be wholly frustrated.

"It is a regrettable feature of commercial and corporate fraud in these modern times that facilities are available for sophisticated fraudsters to prevent the trail leading to the unraveling of the fraud from being followed up," he said.

"The secrecy provisions of some countries' corporate and banking laws operate to this effect," the judge said. Laws governing "nominee shareholding in offshore companies do so as well. There is often no alternative if frauds and dishonest strategems are to be laid bare but to demand answers from those who are in a position to give them." ■

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DECEMBER 23

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DECEMBER 10

Directory: Benefit Consultants

INTERNATIONAL

BERMUDA

Continued from page 29

was a leader in the formation of the insurer while senior vp-risk management of Irving Trust Co. in New York.

The non-refundable surcharge will be equivalent to 10% of the first-year premium, ranging from $30,000 to $100,000.

Previously, BICL's policies were written for a three-year period and were available only to members that had made a contribution to the company's capital and surplus proportionate to their size and exposure.

Three-year policies in the future only will be available to existing members and, according to a BICL notice to brokers, "new members electing to contribute surplus."

Explaining the new direction, Ms. Lichota said: "BICL found that its three-year polices were difficult to work into existing programs, most of which were one-year primary policies."

She added that BICL, which is managed by International Risk Management (Bermuda) Ltd., has also broadened the discretion of its underwriter, allowing the company to follow most commercial D&O forms, "including allowance of some prior acts cover and the establishment of retroactive coverage dates where the underwriter deems such provisions appropriate."

"All prior acts were previously excluded, but it's possible we'll still need to exclude environmental cover," she said. "Additionally, the admission of new members has also been made an underwriting decision and will no longer require executive committee approval. This should help make us more flexible, while at the same time making it less difficult for eligible banks to become BICL members."

Membership in BICL is open only to commercial banks or bank holding companies subject to the jurisdiction of the Federal Reserve Board and which have a minimum of $2 billion in assets, though consideration will be given to insuring members' affiliates with smaller asset bases.

Mrs. Lichota said BICL decided to stop writing bankers blanket bonds because "there's so much commercial bond capacity available in the market right now that there's no need for ours."

The decision will affect just four existing policies, which have generated almost $350,000 in premiums for BICL, she noted.

The decision to stop writing DIC drop-down policies will affect a similar number of members.

"We've stopped writing DIC policies because we're seeing more and more submissions of a following-form nature, so we're more exposed to the growing list of disputes among underlying insurers over which policy should respond.

"Of course, we could still provide DIC cover when we follow an underlying DIC form, but we felt the most practical way for BICL to continue providing capacity without added complications was by dropping this type of policy."

Also in the future, all BICL contracts are to be governed by Bermuda law, instead of U.K. law, Mrs. Lichota said. Because Bermuda has now built up a body of insurance and arbitration law, "it is now more efficient for us to come under Bermuda law," she explained.

Mentor dividend seen

Mentor Insurance Ltd. liquidators Charles Kempe and Nigel Hamilton say they expect to pay creditors at least $60 million of the roughly $790 million they claim from the insolvent Bermuda insurer in a first dividend.

The figure could be higher, though, as the liquidators expect the dividend to be at least 10 cents on the dollar, payable March 31, 1992. Mentor, a captive of New Orleans-based Ocean Drilling & Exploration Co., was ordered into liquidation in June 1985.

Mr. Kempe said a second and final dividend is possible in three to four years. "It's possible we'll be completing the winding up inside 11 years, which would be a real accomplishment and a feather in Bermuda's cap considering the size and complexity of this liquidation," he said after the Nov. 14 annual meeting of Mentor creditors in Hamilton, Bermuda.

However, Mr. Kempe's enthusiasm failed to excite the creditors. Emerging from the meeting, the liquidator acknowledged his announcement about the planned dividend was met with silence from the 26 creditors in attendance.

Mr. Kempe said the payout will consume about a third of the estate's liquid assets of almost $200 million. He said the final size of the dividend will partly depend on the impact of U.S. environmental liability claims against Mentor. These claims could reach $600 million, although much of that will be covered by reinsurance, he said, noting the figure represents a worst case estimate.

"We're taking actuarial advice on the environmental exposure, but we've had precautionary notices that, if they mature, could lead to claims of the order of $600 million, which is substantially covered by reinsurance protections," Mr. Kempe said.

"We're also still adjudicating on claims and calculating set-offs, so we don't know yet the final size of the dividend. But we know we're going to be able to pay a minimum of 10 cents," he said.

Mr. Kempe said the timing of the next dividend would depend on contingencies like Mentor's environmental claims.

Mr. Kempe said creditors were not told of the size of a recent proposed settlement with Pinnacle Reinsurance Ltd. (*BI*, Sept. 23).

Pinnacle was one of 11 defendants the liquidators of Mentor that the liquidators sued in connection with Mentor's collapse. ■

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INTERNATIONAL

A season on the brink in London

'Turmoil' seen in catastrophe reinsurance

By STACY SHAPIRO

LONDON—The London property catastrophe reinsurance market is "in a state of turmoil" as the year-end renewal season begins later than in recent memory, a London brokerage executive says.

Because of massive amounts of red ink in the market, a serious loss of confidence and the withdrawal of underwriters almost daily, the renewal season—which normally starts on Oct. 15—had not even begun by the end of November, said Ray Salter, deputy chairman of Willis Faber & Dumas Ltd.

There's a "total implosion of retrocessional capacity" for ceding insurers seeking property catastrophe coverage, meaning that many insurers will be forced to retain more risk, Mr. Salter said. Premium capacity is down 10% or 11% at Lloyd's of London and about 30% in the overall London market for property catastrophe excess-of-loss reinsurance, he said.

And there is "considerable rerating" going on at the moment, with ceding companies accepting rates that were unacceptably high 12 months ago, Mr. Salter said during an afternoon forum on the 1991/1992 renewal season sponsored by the London Insurance & Reinsurance Market Assn.

Underwriters are quoting catastrophe reinsurance premium increases of up to 50% (*BI,* Nov. 4, Nov. 18).

Normally, by the end of November, a public discussion about the renewal season is academic, because much of the business is already placed, Mr. Salter said. But this year, renewals had not even seriously begun as of Nov. 21, the date of the forum.

Mr. Salter warned that there were only 23 shopping days left until Christmas and only 26 working days left until the end of the year.

"In view of the extremely late start to this season, we are all going to have our work cut out for us to provide full service to our clients," Mr. Salter said. "May I therefore use this forum to make a plea for extremely full manning for underwriting offices and Lloyd's boxes for the next five weeks or so."

The mood at the forum was somber, with the 150 attendees aware of the serious state of the London market as it accelerates toward year-end reinsurance renewals.

"What a disaster we see before us," summed up Stephen Riley, deputy general manager (non-life) for Swiss Reinsurance Co. (U.K.) Ltd.

The London reinsurance market is reeling from more than $25 billion in catastrophe losses since 1987. In addition, the U.K. insurance industry is being hammered by 4 billion pounds ($7.18 billion) in mortgage indemnity insurance claims paid to British-based banks following the repossession of thousands of homes in the United Kingdom.

The concerns of the London market also have been complicated by the recent $3.4 billion series of typhoons in Japan and $1.2 billion in insured losses from the fire in Oakland, Calif. (*BI,* Nov. 4; Oct. 28).

The result has been red ink on the bottom lines of the major U.K. insurers and Lloyd's syndicates, forum attendees were told. Lloyd's syndicates also are closing and merging, while several LIRMA member companies have shut down (*BI,* Nov. 4).

Although some contend there has never been a London reinsurance renewal season like this before, others say conditions were worse after Hurricane Betsy in 1965, when the London market drastically tightened.

"It's only those of us who have been around a few million years that will survive the current pall that we are currently going through on a philosophical and economic basis," said Michael Harris, Lloyd's underwriter for a syndicate managed by A.J. Archer & Co. Ltd.

Mr. Harris began his career at Lloyd's in 1965 on a syndicate managed by R.J. Kiln & Co. Ltd. A month later, Hurricane Betsy blew in.

Betsy was a "proper loss" that today would cost the market $7.5 billion, he said. The average loss in 1965 for a Lloyd's member—in today's terms—was about 60,000 pounds ($107,400), whereas the average loss for each Lloyd's member in 1989—the underwriting year that closes at the end of 1991—is estimated to be about 30,000 pounds ($53,700), said Mr. Harris.

"So in simple terms, it's only half as bad as in 1965," he said.

After Betsy, "severe retrenchment took place" in the London market, Mr. Harris pointed out. More than 25 Lloyd's syndicates and between 15 and 20 insurance companies closed their doors in London, he said.

But those that survived prospered and grew in the 1970s and early 1980s, said Mr. Harris. "During this period of time, when people started making money, confidence came back," he said. Sadly, he added, so did the "hideous" London market excess-of-loss reinsurance "spiral," in which the same risk is reinsured several times in the market, creating false capacity.

'It's only those of us who have been around a few million years that will survive the current pall that we are currently going through on a philosophical and economic basis,' says Michael Harris, a Lloyd's underwriter.

In addition, "many companies were attracted by the style of Lloyd's underwriting," said Mr. Harris, and many foreign companies set up branch offices, "increasing the illusion of massive capacity."

Apart from Hurricane Alicia in 1983, "everything went swimmingly," said Mr. Harris, until Oct. 16, 1987, when he filed a claim for 487 pounds (about $900) for the loss of roof tiles during the hurricane-force windstorm that struck the southeast of England. "This one single claim was the beginning of the end of the LMX spiral," he said jokingly, to a round of laughter.

Following the October 1987 windstorm, the London market was hit by a string of disasters that "everyone knows," said Mr. Harris.

Mr. Salter estimated these catastrophic losses have caused $25 billion in insured damage since 1987.

For Swiss Re, the disasters have created an underwriting loss of 250 million pounds ($447.5 million) and caused the reinsurer to post a 120% loss ratio last year, said Mr. Riley. This is in line with LIRMA company statistics, he said (see story, page 35).

The conclusion is that "rates are woefully inadequate," said Mr. Riley, particularly in the property catastrophe field. "Rates must rise substantially in the next 12 months."

Many underwriters are now addressing the problem and improving the "quality of underwriting," Mr. Riley said. As year-end renewals begin, "rates are moving significantly in the reinsurer's favor" for property catastrophe coverages.

But if there are no significant rate increases during the upcoming renewals, many reinsurers will pull out of the market rather than write business at inadequate rates, he warned. "Senior managers everywhere have woken up to the problems."

Continental European reinsurers are acting responsibly and not offering coverage at inadequate prices, he said. Although continental European reinsurers have not faced losses as severe as those hitting London reinsurers, the continental Europeans are suffering high loss ratios in the German property business and must swallow the cost of expensive acquisitions in anticipation of the single European insurance market, Mr. Riley said.

Mr. Salter of Willis Faber, however, warned London underwriters not to be too reactionary in raising rates.

"Business lost by London does not come back again in a hurry," he said. "Quite clearly, the market is in a most serious situation. . .(but) once an account is lost, it is difficult to recapture it, if at all."

Although Mr. Salter is not pleading for lower rates or weaker terms in contracts, he did ask that underwriters distinguish between good risks and bad ones, and between loyal clients and those that come in and out of the market.

Mr. Salter did have one optimistic thought, however. The "current state of upheaval will lead to a stronger market in the future."

Mr. Riley also called for quicker payment of reinsurance premiums to London underwriters.

About 20% to 25% of premiums paid through LIRMA are paid late, he said, explaining that brokers must improve the timing of payments. "We need every penny we can get," he said.

Already during this year-end renewal season, some other changes have occurred, A.J. Archer's Mr. Harris observed.

Reinsurers in London are now insisting that primary insurers impose a $200 deductible in coverage for every home in the Cayman Islands and rates for these risks have risen, Mr. Harris said. He tried to impose similar deductibles "per roof" in the United Kingdom when reinsuring U.K. insurance companies, but the insurers found other underwriters to write the reinsurance without deductibles.

Mr. Harris also suggested that reinsurers share a portion of the risk with their ceding companies through co-reinsurance.

Mr. Harris and the others who spoke at the forum also called on the British government to allow insurers to establish tax-free catastrophic reserves similar to those allowed in continental Europe.

Munich Reinsurance Co., for example, sets aside a certain amount of money in a mandatory "fluctuation" reserve on a tax-free basis to pay for future losses, a former Munich Re executive testified during the trial over losses by a Lloyd's syndicate managed by R.H.M. Outhwaite (Underwriting Agencies) Ltd. ■

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Oregon

Continued from page 3

ment division, which is part of the Department of General Services.

State government executives "saw a tremendous amount of money going out and said 'enough is enough,' " said Gary Deverell, director of safety at Fairview Training Center, the state's residential facility for the developmentally disabled and mentally retarded.

The governor's order required state agencies to "develop a comprehensive safety action plan embodying the elements of disability prevention, management commitment and accountability, safe work environment and practices and safety training." The plans were to be submitted to the risk management division at the Department of General Services "for approval and ongoing review."

The Department of General Services was then required to report to the governor annually "on progress in achieving improved safety in the workplace."

"Every agency had to respond according to their own culture and philosophy, and they all did very well," Mr. White said.

But the agencies at first reacted in somewhat "standard fashion," he recalled: "Agencies called and asked for a copy of a plan."

"We said, 'No, we'll tell you five things you might do, but you have to have your own plan.' If we had given them a plan off the shelf, it would have been too easy. As it is, they came up with a huge variety of plans—as different as night and day, some five pages long and some 50 pages long—all aimed at that particular agency's needs," Mr. White said.

No outside consulting firms were used in the effort, state officials said.

"We formed a team," explained Mr. White, which consisted of himself, an occupational safety and health nurse, two loss consultants from the State Accident Insurance Fund and a representative from Ore-OSHA, the state workplace safety organization.

"We just met together, every week for probably the first year. We served as a marketing unit" for the governor's workplace safety mandate. "We went out and sold it to agencies," he said.

The group also met with labor leaders, whose historical role has been to champion safety in the workplace, for their input and support, Mr. White said.

"Then we served as a myth-debunking unit, focusing on rumor control" about what managers can and cannot do to control workers comp costs, he quipped.

One of those myths was managers' "knee-jerk reaction that (more employee) training solves everything, and then they go back to doing business the same old way. 'No,' we said, 'it's a management issue. Go make it better,' " Mr. White explained.

"That gamble was right. Agencies didn't need (additional) training initially. They needed to change what they were doing" to handle claims more efficiently and prevent injuries, he asserted.

Another myth that had to be debunked was that it was illegal for managers to talk to the doctor treating an injured worker about the injured employee's condition and what type of work the employee could handle while recovering. "A lot of them believed the myth that it's an invasion of privacy," Mr. White said.

Managers also were "afraid to call the worker at home. They thought somehow the State Accident Insurance Fund" had the exclusive right to contact the worker to inquire about the worker's condition and when the employee could return to work or modified duties, he said.

Another myth was that labor contracts prevented managers from trying to get the employee back to work as soon as possible, Mr. White said.

"If we followed a model, it was the one described by Dan Petersen," a University of Arizona professor and author of "Safety Management, A Human Approach," Mr. White said.

"Petersen's basic premise, which is similar to ours, is that safety and loss control are just fundamental parts of management, not unique programs. Worker injuries are an indication of the management of the workplace, not a technical issue to set aside and deal with in isolation. Those fences have got to be torn down," Mr. White said.

The agencies produced 'a huge variety of plans—as different as night and day, some five pages long and some 50 pages long—all aimed at that particular agency's needs,' says David White, administrator of Oregon's risk management division.

"Workers comp injuries are a barometer of management, we told them. If you're at war with organized labor, with your employees, your claims will be up and rising," he asserted.

"And the last three years have proven that. We have seen improvement in agencies' atmosphere and attitudes as they improved their work comp situation because managers have had to listen to their workers" when they requested changes in work conditions, Mr. White said.

In addition, the risk management division in 1988 launched a quarterly newsletter, "RisKeyNotes" to convey needed information about workers comp issues to the state's 6,500 managers. "We used it to tell them what they've never been told before about workers comp and work-related injuries," he said.

"If you have an MBA, the odds are you never had a class in safety and work comp. We have some really good managers out there who really did not know they had a role in this at all," he pointed out.

"The message we gave them from the top down is, 'This is your responsibility,' " he said.

"Division administrators were held personally responsible for meeting" injury-reduction goals, agreed Mr. Kuhn of the Department of Insurance and Finance. "In their annual performance appraisals, that was one thing they would be measured on."

As a result, "agencies began to find they could actually improve their effectiveness at the same time they were improving safety," Mr. White said.

Much of the credit for the tremendous savings in workers comp costs is due to a vigorous application of an early return to work program by the managers of state agencies, state officials said.

However, managers had to be educated about what early return to work means, Mr. White said.

"When we mentioned it to managers they said, 'We always return an employee as soon as the doctor says he's 100% ready.' But early return to work is always less than 72 hours" after an injury, he said.

Time loss payments begin after an injured worker is off for three days, Mr. Deverell explained. "If you got those people back to work" before time loss payments began, "then there would only be medical claims."

Managers also were "asking the wrong questions" of the doctor and the worker. They were asking "What's wrong with the worker?" instead of "How can we modify the work" so the injured worker can return as quickly as possible, Mr. White said.

The Fairview Training Center, by far the agency that generated the greatest workers comp losses, also cut costs the most over the past two fiscal years—nearly 86%. The agency was expected to generate $63 million in workers comp losses but instead only generated an estimated $9 million in claims during that period.

Like most state facilities for the developmentally disabled, Fairview still generates the greatest number and most costly workers comp claims, state officials said.

That is because the 24-hour operation, which has 2,000 employees and 550 clients, is like "a small city" with a great variety of workers, Mr. Deverell said. Fairview employs pharmacists, hospital workers, dentists and trades people like cooks, gardeners, sewing room workers and construction workers, Mr. Deverell said.

"One of the first things we attacked was claims management," Mr. Deverell said. "No one was keeping track of how many people were getting hurt. No one was monitoring how long they were off work," he explained.

"We alerted our supervisors. As soon as someone filed a claim, the supervisor would immediately get hold of the doctor and the safety staff, find out what kind of restrictions the injured worker was under and find a modified job that matched those restrictions," Mr. Deverell said.

"Once workers were on modified duties, they could be monitored. They were in touch with their supervisors and peers. We didn't lose them out there. We also required that each time they visited the doctor they bring an updated evaluation so that we could move them back gradually to their old jobs," Mr. Deverell said.

"This helped set up a real good relationship with the medical community, and the local hospitals took to calling us and letting us know that one of our injured employees was being seen," he said.

A program designed to get injured employees back to work as soon as possible also helped the Department of Insurance and Finance cut its workers comp costs, though specific savings are unavailable, according to Mr. Kuhn.

"We put a lot of responsibility on the direct supervisor" to determine "what the employee feared and how to remove it so the work would be less threatening to

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INTERNATIONAL

Catastrophe losses 'dwarfed' 1990 premium growth: LIRMA

LONDON—The London reinsurance market's 18% increase in gross premiums last year was dwarfed by its whopping 65% increase in paid claims from major worldwide catastrophes, according to the London Insurance & Reinsurance Market Assn.

While total gross premiums grew to 2.7 billion pounds ($5.21 billion at year-end 1990 exchange rates) in 1990 from 2.3 billion pounds ($3.7 billion at year-end 1989 exchange rates) in 1989, paid claims rose to 3.31 billion pounds ($6.39 billion) from 2 billion pounds ($3.22 billion) in 1989, recently published figures show.

These percentages, however, fail to take into account the 7.35 billion pounds ($13.16 billion) in outstanding claims that have been carried forward into members' 1991 accounts, according to the association.

"There has been some growth in premium volume from 1989 to 1990, but the results reflect the well-known deterioration arising from catastrophe losses," said a LIRMA report on reinsurance statistics between 1982 and 1990.

In particular, gross combined loss ratios for non-proportional property reinsurance treaties and marine proportional and non-proportional treaties hovered around 240% in 1990, the group says.

LIRMA began compiling the statistics, based on information from 60 to 70 of its 135 members, in 1982 under one of its former associations, the Reinsurance Offices Assn. To make the information relatively consistent, the same members are surveyed each year.

The statistics show that in every year except 1985, the LIRMA members have produced loss ratios over 100%, according to Stephen Riley, deputy general manager (non-life) of Swiss Reinsurance Co. (U.K.) Ltd. The loss ratios for 1990 and 1991 will be at least 140%, he said at a recent forum on the 1991/1992 renewal season (see related story).

The LIRMA statistics confirm "the sorry picture" of the London market, said Mr. Riley. The inescapable conclusion is that "rates are woefully inadequate," he said.

The latest LIRMA statistics give an up-to-date picture of the losses that have seriously affected the property catastrophe reinsurance market in London.

But a gulf remains between gross and net losses, the group says, because the LMX spiral distorts gross losses and delays net retained losses for years. "It remains to be seen how long it will take before true net figures are recorded," the association said.

This year's totals for some of the major catastrophic losses hitting LIRMA members are:

- The October 1987 windstorm in Europe, with gross incurred losses of 544.6 million pounds ($974.8 million at current exchange rates) and net losses of 97 million pounds ($173.6 million).
- The Piper Alpha oil rig disaster in 1988, which has a gross incurred loss of 817.6 million pounds ($1.46 billion) and a net loss of 146.7 million pounds ($262.6 million).
- Hurricane Hugo in 1989, with gross incurred losses of 1.1 billion pounds ($1.97 billion) and net incurred losses so far of only 168.4 million pounds ($301.4 million).
- The January 1990 European windstorm, with gross incurred losses of 1.1 billion pounds ($1.97 billion) and net losses of 224.3 million pounds ($401.5 million).

Meanwhile, the statistics also show that LIRMA's members moved slightly away from writing proportional property and casualty reinsurance treaties in 1990 to writing more non-proportional treaties.

Though 21.6% of total gross premiums of 2.3 billion pounds ($3.7 billion) in 1989 were paid for proportional property treaties, this percentage dropped to 19% of 2.7 billion pounds ($5.21 billion) in 1990. Non-proportional property treaties increased to 24.3% of gross premiums in 1990, from 19% in 1989.

About a quarter of LIRMA members' business came from the U.K. property/casualty market in 1989 and 1990 and about 20% from the U.S. property/casualty market. The rest came from continental Europe, other parts of the world and marine and aviation business, according to the report.

—By Stacy Shapiro

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them," Mr. Kuhn said.

As the department's safety officer at that time, Mr. Kuhn interviewed the injured worker and his or her supervisor and asked the employee to demonstrate the work as best as he or she could.

"I would analyze the movement, the various postures, then I'd actually sit down and do their job for 15 minutes," Mr. Kuhn said.

Then, along with medical records from the physician, "we would come up with a modification" of the job, Mr. Kuhn said.

State agencies also zeroed in on other causes of workers comp claims.

For example, because some of Fairview's clients are not ambulatory and need to be lifted regularly, "a good portion of our injuries were back injuries, which are very expensive claims," Mr. Deverell explained.

The agency remodeled and modified its facility to reduce the necessity for employees to lift patients. For example, it purchased special bath tubs into which clients could be lowered in a sling, avoiding back strain for a worker.

"It doesn't take a lot of money" to reduce workers comp claims, Mr. White noted. Fairview spent $150,000 on lifting devices, which contributed to saving "millions."

"A permanent total disability can cost $500,000," agreed Mr. Deverell.

In addition, "we did little things" like reducing the size of scoops and pans in the kitchen and the size of laundry bags, so lifting them would be easier, Mr. Deverell continued.

"We also implemented a lot more comprehensive lifting training," he said.

Fairview safety officers have been meeting weekly with residential facility managers and with the SAIF since Gov. Goldschmidt's executive order. "Before it was just shuffling papers. Now we're setting goals" to reduce injuries and workers comp costs, Mr. Deverell explained.

The SAIF also ensured that Fairview safety officers would be present at workers comp hearings to participate in the discussion of the injury and its compensability.

"Before, this was new and took a lot of extra work. It's just part of the culture now," Mr. Deverell said.

Another tactic used by the Department of Insurance and Finance to help nip claims in the bud was requiring the department's supervisors to file incident report forms —which previously were first filed along with claims—"at the inkling of an injury," Mr. Kuhn said. "An incident is something that could turn into an injury: a sore elbow or back," he explained.

The incident report "would head off a medical-related claim," Mr. Kuhn said. "Then I would call up the supervisor and ask if I could look at the work station" with an eye toward modifying it.

After such an examination, some jobs—like those that consisted solely of word processing—were eliminated.

Other jobs, like "pulling staples out of hundreds of documents each day" in an office or pulling and sorting small trees manually at the Department of Forestry were mechanized.

Still other work was modified to make it ergonomically safe.

"In 1987 we had archaic computer work stations," Mr. Kuhn said. "We had to think up creative ways to modify those until we were able to get ergonomically correct furniture," he said.

"One of the biggest obstacles was convincing people that we actually needed to buy equipment," Mr. Kuhn continued. That was achieved by showing management the annual cost of cumulative trauma claims, in terms of time loss and medical treatment, compared with the lower cost of ergonomic equipment, he said.

During the 1989/1990 and 1990/1991 fiscal years, the Department of Insurance and Finance had more than 50 cumulative trauma injuries, and the injured workers had either filed claims or were moving in that direction, Mr. Kuhn said.

"The average (total) cost for one of these claims was $8,700," and those injured workers typically were off work for two months and sometimes up to a year, he said.

Only about 15 such claims were filed in fiscal year 1991.

"Ergonomic equipment works," Mr. Kuhn asserted. "It takes time for employees to adjust to new habits," but when they do, claims are reduced, he said. "A lot of it isn't new science, it's just being persistent," he concluded. ■

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Business Insurance

American Transit

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says the company writes more than 70% of the medallion cab market.

Last month's liquidation petition is not the first time American Transit has run into regulatory trouble: The New York department tried to place the insurer in rehabilitation in 1979 after concluding it was insolvent by $1.1 million as of year-end 1978, court papers show. However, a state judge dismissed the rehabilitation petition after a trial in March 1980.

American Transit's latest trouble began when the department completed a triennial exam in June.

While American Transit had reported surplus of $11.9 million as of year-end 1989, the exam report concluded the insurer was actually insolvent by $39.9 million at that time.

The exam report cited several problems with American Transit's operations, including that:

- The insurer's $23 million in loss and loss adjustment expense reserves were deficient by $32.4 million. Using an actuarial review by consultant Milliman & Robertson Inc., the department concluded that reserves should have totaled $55.4 million at the end of 1989.

Milliman & Robertson estimated that this reserve deficiency widened to $49.4 million by the end of 1990.

- A $10.9 million asset claimed by the company for agents' balances receivable or uncollected premiums was overstated by $12.3 million. Examiners found that American Transit could not provide documents backing up premiums receivable on taxi policies or state assigned risk plan business.

The report also notes that there is no written agreement between ATIC Management and American Transit spelling out premium accounting and settlement requirements and that the parent settles accounts with American Transit on an "as needed" basis. Examiners found this "unfair and inequitable," since it deprives American Transit of investment income on ATIC Management's premium collections.

- American Transit claimed a $2.9 million asset representing reinsurance recoverable from "an insurer in liquidation." While the exam report does not name the reinsurer, it is identified in papers filed by American Transit as NEM Re Insurance Corp., which was ordered into liquidation by a New York court in August 1990. Insurance Department examiners disallowed the asset.

- American Transit did not report any provision for unauthorized reinsurance, when it should have reported a $1.7 million provision relating to excess-of-loss reinsurance agreements with Atlantic Gulf & West Indies Underwriting Group of Barbados. Two AGWI contracts provide coverage for deficiencies in American Transit's case and incurred-but-not-reported loss reserves, according to the report.

The report notes that American Transit could not provide actual contracts evidencing the AGWI coverage, but had only copies of cover notes.

The report also questions whether the AGWI contracts are valid reinsurance. Among other things, the exam states that the amount of coverage provided through a series of reinstatements is actually less than the premium ceded by American Transit until the final reinstatement. Thus no transfer of risk occurs until the final reinstatement, the report says.

American Transit and AGWI officials could not be reached for comment on the coverage.

AGWI is not licensed as an insurer in Barbados, but Atlantic Gulf & West Indies Management Inc. is registered as a management company, according to Barbados government records. AGWI promotional material has described the company as a manager for a pool of offshore reinsurers.

Barbados government records list Richard Adeline, former chief financial officer of the now-defunct Insurance Exchange of the Americas, as AGWI's secretary and treasurer. But, Mr. Adeline says he is no longer associated with the company.

After giving American Transit time to cure the insolvency cited in its exam report, the New York department notified the company in October that it planned to seek a rehabilitation order.

On Oct. 29, though, American Transit filed a complaint in state Supreme Court seeking an injunction blocking rehabilitation proceedings.

The complaint argued that American Transit is in "no danger" of becoming insolvent. It also charged that the Insurance Department's examiner told company officials shortly before the exam report was issued that he had found an impairment of only $2.8 million.

American Transit's own actuary, Tiller Consulting Group Inc. of St. Louis, also found several errors in the Milliman & Robertson review backing up the exam report's findings, according to the complaint. The complaint also charges that the Insurance Department refused to let Milliman & Robertson review its own findings in light of the Tiller complaints.

In an affidavit supporting the insurer, Tiller President Margaret Tiller said American Transit's reserves were deficient by only $4 million at the end of 1990, leaving the insurer with surplus of $9.8 million.

American Transit President Edward T. McGettigan Sr. also argued in an affidavit that the insurer would be irreparably injured if a rehabilitation action were allowed to go forward, since all of the company's taxi policies renew on Dec. 31.

The "cloud" cast on American Transit by the Insurance Department action would destroy its business, Mr. McGettigan predicted.

Instead of filing a rehabilitation action, though, New York regulators filed a liquidation petition Oct. 29. In addition to charging that American Transit was insolvent by $39.9 million at the end of 1989, the petition also said that a Milliman & Robertson review of the company's 1990 statutory statement showed that the insolvency amounted to $35.6 million as of Dec. 31, 1990.

At an Oct. 30 hearing, a New York judge denied an Insurance Department request to enjoin American Transit from doing business but issued a temporary restraining order barring the insurer from "the waste or disposition of its property."

A copy of the restraining order was later served on Chemical Bank in New York, which then froze about $20 million in American Transit deposits, court papers say.

That action brought American Transit lawyers back to court, arguing that the Insurance Department had violated the restraining order by serving it on Chemical Bank, thus interfering with the insurer's business.

State regulators were conducting a "vendetta" against American Transit, charged the insurer's lawyer, Steven A. Berger, a partner with the New York firm of Berger, Steingut, Tarnoff & Stern.

At American Transit's request, Judge Saxe on Nov. 1 found that the Insurance Department had violated the restraining order by serving it on Chemical Bank in a way that caused the bank to freeze American Transit's accounts.

Judge Saxe issued an injunction barring the department "from taking any actions that interfere with (American Transit's) normal transaction of business."

Department lawyers strenuously denied violating the original order and asked the judge to lift the "unprecedented" injunction barring regulatory interference with the insurer.

Taken literally, the injunction would "completely immunize" American Transit from state regulation, the department argued.

Judge Saxe denied the department's motion on Nov. 13 and the next day appointed Leonard Cohen, a retired state judge, as a "special referee" in the case. ■

N.C. questions 42% comp rate request

RALEIGH, N.C.—North Carolina Insurance Commissioner James E. Long has scheduled a public hearing for today on a requested 41.8% workers compensation rate increase in the state.

In its notice of the hearing, the Department of Insurance held that the "rates proposed appear to be excessive and unfairly discriminatory."

However, a spokesman for the North Carolina Rate Bureau in Raleigh, which sets rates for all of the state's workers compensation insurers, said that the loss experience of the workers comp system in North Carolina required a significant rate increase.

The spokesman noted that the rate bureau had requested a 29.3% workers comp rate increase last year but instead only received an 18.9% increase.

That increase took effect on Jan. 1 of this year.

A spokesman for the North Carolina Department of Insurance could not predict when the final decision on the 1992 rate increase request will be made, though he did say that the hearing will probably not be finished in one day.

—By Mark A. Hofmann

Healthy companies

Continued from page 3

ment approaches for the creation of healthy companies in the next century, he said in an interview.

Among other things, the new organization will identify what is healthy and unhealthy work and test whether, overall, healthy companies outperform unhealthy companies in marketplace success and investor return.

Many companies are now confronting a crisis, Mr. Rosen said. They are suffering from low productivity, low employee morale, high turnover and an increase in work-related stress claims and on-the-job injuries, all of which affect the company's overall performance and stagnate profitability.

Companies can reverse this trend —and get a handle on health care costs at the same time—by, among other things, identifying certain sources of job stress and attempting to eliminate them, Mr. Rosen said.

Some of the worst culprits associated with actual work tasks or responsibilities are the repetition and monotony of a dead-end job; excessive work demands and deadline pressure; piecework; and excessive red tape, paperwork and bureaucracy, he said.

Employers also should eliminate psychological pressures on workers, like lack of privacy, absence of control and autonomy, excessive performance monitoring, multiple supervisors and confusion about goals and responsibilities, according to Mr. Rosen.

Technology also can cause stress, especially for employees who work with machines, he pointed out. For example, many times the work pace is determined by the machine; an employee may be inadequately trained to operate the machine; or the machine and equipment may be outdated or poorly maintained.

"The worst combination, according to employment experts, (is when) employees are pressured to constantly produce, have little control over their tasks and receive little support from management," Mr. Rosen summed up.

Employers should no longer think of an employee as someone who simply works for them eight hours a day, according to Mr. Rosen. Rather, employers must begin paying attention to their workers' minds, bodies, relationships and families, he said.

"Companies that ignore the total person will receive a very painful lesson in terms of the costs of employing a person who has physical and/or mental ailments or whose family life is a source of stress," Mr. Rosen said.

Some companies are trying to address this through expanded benefit programs, he pointed out.

"The old, narrowly defined health insurance and pension packages are now considered entitlements, so employers are developing a broader set of work-life benefits," he explained.

For example, group health benefits have been expanded to encompass wellness programs, fitness centers and employee assistance programs, he said.

However, "while this trend certainly increases a company's attractiveness to new employees, it marks just the beginning of confronting the crisis," Mr. Rosen said.

Mr. Rosen's research has identified some preliminary characteristics of healthy workplaces, and Healthy Cos. will test and apply these characteristics during its development of new management approaches. He has found that these companies offer:

- Work environments organized in ways that protect employee health, safety and well-being.
- Meaningful work through designing and producing products in which people can take pride and find meaning.
- Continuous opportunities for people to learn, update and expand their skills and adapt to changing work requirements.
- Equitable compensation that recognizes the contributions that individuals make.
- Appropriate transition packages to allow employees to re-educate or relocate themselves in the event of technological obsolescence or termination.
- Open sharing of information with employees on conditions of work, the operations of the organization and the choices it faces.
- Direct employee involvement in designing work and shaping the organization's goals, values and processes.
- The creation of mechanisms that respect the individual's privacy and right of expression, that ensure equality of treatment and that provide fair procedures for resolving grievances.

'Employers are developing a broader set of work-life benefits,' says Mr. Rosen.

"This kind of organization may sound far-fetched—a corporate utopia that only dreamers or the very naive would believe in. For many companies, it is," Mr. Rosen concedes in his book.

"But among the millions of businesses in this country, some are quietly, decisively transforming themselves into healthy companies. They are driven by an unshakable conviction that only a healthy company will be alive and competitive in the coming years."

Among the mavericks of this movement are employers like American Telephone & Telegraph Co., Federal Express Corp., General Electric Co., Intel Corp., Levi Strauss & Co. and Southwest Airlines Co., according to Mr. Rosen. Executives at several of these companies are quoted in his book.

"I know that good health is high on everyone's list of personal priorities," says Robert Allen, president and chief executive officer of AT&T. "It is also a business priority, because a healthy, growing and competitive enterprise depends on the health, vitality and energy of individuals."

"Power and profits will go to companies smart enough to make their workplaces, work practices and training programs the most attractive," said GE Senior Vp Frank Doyle.

The ideal job, however, consists of more than the absence of stressors, according to Mr. Rosen. "It entails a series of challenges a person feels well-suited and sufficiently skilled to meet, mixed in with a reasonable dose of decision-making authority, regular feedback and support, occasional pressure and intensity because of the importance of the job and enough variety and stimulation to be interesting."

As Healthy Cos. identifies what really makes a healthy company, it plans to create an international data base of best business practices from a broad base of healthy organizations. Those organizations will include national and international; private and public; and large, medium-sized and small companies, Mr. Rosen said.

The data will be communicated widely over the next decade. It is unclear how the data will be disseminated or who will be able to tap into the data base, he said.

Healthy Cos. also plans to develop a national communication strategy to build awareness and acceptance among public- and private-sector decision-makers of the need to invest in healthy organizational practices, Mr. Rosen said.

In addition, it plans to identify, publicize and celebrate leaders and leading organizations considered innovators in the field to disseminate success stories.

To help employers apply what they learn about healthy organizations, Healthy Cos. plans to develop a national strategy for educating individuals, business leaders and organizations regarding healthy business practices, Mr. Rosen said.

In addition, Healthy Cos. will offer counsel and support to those business leaders who wish to incorporate healthy practices and programs into their existing organizations.

Healthy Cos. soon will begin conducting a series of six to 10 interactive learning forums with top business leaders around the United States, Mr. Rosen said. Those breakfast forums, to be sponsored by a leading local chief executive officer, will combine a series of brief presentations and discussions with business leaders about their best workplace practices and the obstacles and barriers that impede progress toward the development of healthy organizations, he said.

It currently is uncertain whether these breakfast forums will be open to the public, Mr. Rosen said. While the meetings are designed in part to alert people to the importance of creating healthy work environments, Mr. Rosen said he wants to encourage business leaders attending to be frank, although some may not want to reveal how unhealthy their companies are.

None of this will happen overnight, Mr. Rosen admits. "At a minimum, we're talking about a 10-year effort."

But, the payoff will be worth it, he said. "When people and organizations work well together, they promote high value, high-quality products and services, fulfill their missions, produce human development and contribute to their communities and society," he said. ■

Behavioral health network targets self-insured firms

Self-insured employers in the Chicago area can now directly contract for behavioral health care services from Evangelical Health Systems of Oak Brook, Ill., and Lutheran General Health Care System of Park Ridge, Ill.

The boards of the two hospital systems have jointly established a specialty preferred provider network called Behavioral Health Direct. Each of the hospital systems will own 50% of the for-profit business.

Included in the provider network are hospitals, rehabilitation facilities, outpatient programs, psychiatrists, social workers, psychologists and certified alcohol and drug abuse counselors in the Chicago area.

Behavioral Health Direct will contract with Parkside Medical Services Corp. of Park Ridge, Ill., to provide services in six locations, along with Evangelical Health System's five hospitals and Lutheran General Hospital in Park Ridge, Ill.

Behavioral Health Direct will offer self-insured employers:

- Case management of inpatient and outpatient care and utilization review, including pre-certification, concurrent review, discharge planning, on-site and peer review and estimates of cost savings.
- Referral service to specialists and/or non-network providers.
- Crisis intervention services, including a 24-hour phone service.
- Consulting on benefit plan design and policy development.

"Employers' psychiatric and substance abuse costs can be controlled without giving up quality," said Julie Tye, vp of special services at Parkside Medical Services. "We believe we can provide effective care, while also providing efficient care," she said.

Dr. Robert G. Zadylak, chairman and medical director of the department of psychiatry at Evangelical Health System Hospital and Medical Center will be medical director of Behavioral Health Direct. Roy R. Kaufman, formerly manager of mental health and addictions at Health Chicago Inc., will be executive director.

Behavioral Health Direct will begin contracting with self-insured employers immediately and expects the full network to be running in early 1992, according to Ms. Tye.

For more information, contact Mr. Kaufman at Behavioral Health Direct, 205 W. Touhy Ave., Park Ridge, Ill. 60068; 708-698-155; fax: 708-698-1482.

J&H facility in U.K.

Johnson & Higgins, a member of international brokerage network UNISON, is establishing a new risk management consulting operation in the United Kingdom.

The new facility, J&H Global Risk Management Consultancy, will be headquartered in London. It will provide risk management services, including alternative risk financing program consulting, captive feasibility and domicile evaluations, independent captive program and management reviews, property and liability loss control, corporate risk profiling, risk management information systems and actuarial services, as well as the development of new property/casualty insurance products.

Ken Hall, managing director of UNISON's captive management company in Luxembourg, will move to London to serve as vp and manager of the new facility. Mr. Hall has worked for J&H in the alternative risk financing area for 10 years, serving clients in the United States, Japan and Europe.

Markets

In addition, Sarah J. Laycock has been appointed senior risk management consultant of the new facility.

Previously, Ms. Laycock was group risk manager at Chloride Group P.L.C., a diversified manufacturing company in London.

"We believe that establishing a risk management facility in the U.K. will help enhance the appreciation throughout Europe of the growing risk management options available in today's global environment," said Richard E. Meyer, executive vp and director of J&H in London.

For more information, contact Ken Hall or Sarah Laycock at J&H Global Risk Management Consultancy, 18 Mansell St., London E1 8AA; 44-71-945-7700.

UNUM drops 401(k)s

Disability insurer UNUM Corp. says it is withdrawing from the 401(k) market.

The withdrawal, which is expected to be completed by the end of 1992, will allow UNUM to focus resources on its tax-sheltered annuity business and disability and other speciality insurance products, the Portland, Maine-based insurer said in a statement.

UNUM will stop actively marketing 401(k) plans and—to minimize disruption to existing customers—will offer a no-cost transfer of 401(k) service responsibilities to Preferred Benefits Corp., a subsidiary of the insurer in Fort Washington, Pa.

UNUM will manage the $500 million in assets associated with its 401(k) business until maturity and intends to sell Preferred Benefits Corp. in 1992, though that company will stay in the 401(k) business.

A pretax charge of about $16 million will be taken against UNUM's fourth-quarter earnings to cover the estimated costs of withdrawing from this line of business.

The decision is consistent with the company's "stated business objective of operating only in those markets in which we can achieve a leadership position," said James F. Orr III, UNUM's chairman and chief executive officer.

About 100 affected employees are expected to be reassigned to other areas, he said.

Claims alliance

Claims administrator Gallagher Bassett Services Inc. and Thomas Howell Group, a claims adjuster headquartered in London, have formed a global working alliance.

The companies will offer claims management, loss control consulting and implementation, property appraisals and loss adjusting services to domestic and international employers through a network of 400 offices worldwide.

Clients will be able to purchase risk management and claims adjusting services on a bundled or unbundled basis.

"The alliance brings to us the capability of offering risk management and claims services outside the United States to broker clients in Europe or U.S. multinationals with operations overseas," said John Gallagher, vice chairman of Arthur J. Gallagher & Co., the brokerage parent of Gallagher Bassett.

While the working alliance will allow risk managers to receive their claims administration and risk management consulting services from one source, both Thomas Howell and Gallagher Basset "will maintain strict independence from one another and strict confidentiality," Mr. Gallagher explained.

Gallagher Bassett was the fifth-largest claims administrator in the United States serving self-insurers in 1990 (*BI*, Jan. 28).

New drug benefit firm

Complete Health Services Inc., a managed care company, has formed a new subsidiary specializing in managed prescription drug benefits.

The new company, Rx Management Inc., will offer claims administration, consulting, drug formularies and utilization review by clinical pharmacists to employers interested in managing their prescription drug costs. The company's utilization review program is designed to identify cases of misuse and fraud, according to David K. Morris, president of the new company.

Like its parent, Rx Management is based in Birmingham, Ala.

Claims will be processed by a computer system connected with participating pharmacies, Mr. Morris said.

And, he noted, the company will provide customized reports detailing prescription drug utilization patterns and cost data.

The new firm is located at 2160 Highland Ave., Birmingham, Ala. 35205; 205-939-4709; fax: 205-939-4713.

Unbundled services

Employers can purchase unbundled risk management services from a new subsidiary of Reliance National Risk Specialists of New York.

National Risk Services Inc. will provide services like risk financing program design, captive feasibility analysis and implementation assistance, workers compensation cost containment, loss prevention and engineering and actuarial analysis on an unbundled basis.

James D. Blinn has been appointed chief operating officer of the new unit. Previously, he was a principal and manager of property and liability consulting services in Chicago with the Tillinghast division of Towers, Perrin, Forster & Crosby Inc.

Reliance National Risk Specialists is a unit of Reliance Group Holdings Inc. of New York.

For more information, contact Mr. Blinn at 77 Water St., New York, N.Y. 10005; 212-858-6551.

New offices

Benefit and actuarial consultant **Milliman & Robertson Inc.** opened a new office in Irvine, Calif. The address is 7700 Irvine Center Drive, Suite 870, Irvine, Calif. 92718-2930; 714-753-7733.

Consumer Health Network, a South Plainfield, N.J.-based preferred provider organization, moved into larger offices. The new address is 908 Oak Tree Road, Suite C, South Plainfield, N.J. 07080; 908-754-6200.

Buck Consultants Inc., a New York-based benefit consulting firm, opened an office in Melbourne, Australia. The address is Buck Consultants Pty. Ltd., Ground Floor, 484 St. Kilda Road, Melbourne, VIC 3004 Australia; 61-3-653-9321. ■

Update

New deadline set in LUI dispute

Continued from page 2

The petition to wind up the LUI units—Kingscroft Insurance Co. Ltd., El Paso Insurance Co. Ltd., Lime Street Insurance Co. Ltd. and Mutual Reinsurance Co. Ltd. of Bermuda—has been postponed several times already to allow further talks with creditors.

Privately, many other KELM creditors also say they will not support any additional continuances if a deal is not struck.

The PPB, which is responsible for paying 90% of all legitimate claims on private individual U.K. insurance policies, is the LUI units' major creditor. Many of the policyholders are U.S.-based hospitals, accountants, lawyers and other professionals who believe that the board is responsible for paying their liability claims if the insurers cannot pay.

But, on Feb. 24, in another High Court action, the PPB will seek clarification on whether it must cover claims by U.S. professionals.

Bill to extend benefit tax breaks

WASHINGTON—Congress last week approved a bill to continue through June 30 the tax-favored status of employer-provided educational assistance benefits and a tax break for the self-employed who buy health insurance.

Under the measure, H.R. 3909, employers can continue to reimburse employees for up to $5,250 in educational expenses without employees being taxed on the reimbursement.

In addition, the self-employed can deduct from their federal taxes 25% of their health insurance premiums.

Both tax breaks had been set to expire on Dec. 31.

Court rules for N.J. auto writers

TRENTON, N.J.—In a major victory for private passenger automobile insurers, a New Jersey appeals court has ruled that the Insurance Department must establish higher rates for a temporary pool for bad drivers.

The Nov. 21 ruling requires Insurance Commissioner Samuel Fortunato to "take immediate action to set proper rates" in the Market Transition Facility, a state-run personal auto pool for about 1 million high-risk drivers. A spokesman said the commissioner would comply.

The pool, which replaced the Joint Underwriting Assn. last fall, is scheduled to operate through September 1993. At current rates, the pool has accrued about $400 million in underwriting and operating debt and could accrue a total $1.1 billion debt by the time it expires, according to various independent studies. Under the Fair Automobile Insurance Reform Act of 1990, insurers are responsible for paying off any pool debt.

In a 1990 suit, Allstate Insurance Co., Aetna Casualty & Surety Co. and Liberty Mutual Insurance Co. charged that they needed a defined role in the ratemaking process and attributed the growing pool losses solely to its rate structure. Regulators increased rates for the pool's worst drivers by 18.6% in May.

"Two experts suggested that rates need to be increased by 60% for the pool to break even. Now the court has agreed that rates are obviously too low for the pool to break even. Insurers need a role in the proceedings," said a spokeswoman for Allstate, which cites auto insurance losses as the reason it wants to leave the state's property/casualty market entirely (*BI*, Sept. 23). State regulations require insurers that stop writing personal auto business to surrender their licenses for all other lines.

Briefly noted

A banking bill passed by the House of Representatives last week would close the **"Delaware loophole"** that allows banks with a Delaware charter or that own a Delaware-chartered bank to underwrite insurance on a nationwide basis. The bill, S. 543—which would also refinance the Federal Deposit Insurance Corp.—was expected to receive Senate approval last week. . . .The Internal Revenue Service expects to release final regulations this month to help employers determine whether they can run IRS pension plan non-discrimination tests on a separate-line-of-business basis. Earlier proposed **so-called SLOB rules** were criticized as unworkable. Meanwhile, the Senate Finance Committee last week urged Treasury Department Secretary Nicholas Brady to delay the non-discrimination rules. The IRS earlier said employers next year could retroactively amend their plans to comply with the rules but that the rules would go into effect on Jan. 1 as scheduled (*BI*, Nov. 25). . . .A wide-ranging storm system, assigned Catastrophe No. 91, caused an estimated **$45 million of insured property damage** in eight states stretching from Washington to Illinois Nov. 16-20, reports the Property Claim Services division of the American Insurance Services Group. . . .Two leading underwriters of **U.S. marine and non-marine business** at Lloyd's of London have retired and have been replaced by two other well-known underwriters. Dick Hazell has retired as underwriter of syndicate 190 and will be replaced by John Wetherell. Gale Coles has retired as underwriter of syndicate 573 and will be replaced by Stephen Bishop. . . .About one-third—$458 million—of Mutual Insurance Co. of New York's $1.5 billion in **guaranteed investment contracts** moved to Metropolitan Life Insurance Co. by a Nov. 15 deadline under an agreement between the two insurers to reduce MONY's exposure to poorly performing commercial mortgages and bolster MetLife's GIC business with pension plans (*BI*, Oct. 28). MONY "never put any expectations on the amount of money that would transfer to MetLife and is pleased with the amount," a spokesman said. And, "$458 million is a very workable amount," a MetLife spokesman said. . . .A federal judge in Philadelphia has denied a motion by Alexander & Alexander Services Inc. and Shand, Morahan & Co. Inc. to dismiss a Pennsylvania Insurance Department lawsuit charging that they contributed to the collapse of **Mutual Fire, Marine & Inland Insurance Co.** (*BI*, Feb. 18.) A&A and Shand had argued that the Pennsylvania department, Mutual Fire's rehabilitator, had no standing to sue on behalf of the insurer's policyholders. . . .Upjohn Co. says it will defend and indemnify any U.S. physician named in a lawsuit alleging damages from **Halcion** if the doctor followed instructions on the package insert. Sales of the company's widely prescribed sleeping medication were banned in the United Kingdom, Finland and Norway in early October. Upjohn is appealing those bans.

Market cycles study

Continued from page 3

petitive dynamics, it was prolonged and worsened by interest rates, which hit an all-time high in 1981 and spiked again in 1984, the study says.

The result was a record high industry combined ratio of 118% and a record low return on net worth of 1.9% in 1984, as well as rising insolvencies, which peaked at 49 in 1985.

"On balance, the experience of the early 1980s indicates that high interest rates do in fact result in increased availability and lower prices for some lines of insurance, but also in lower profitability for insurers," the ISO study concludes.

"Later, lower interest rates in 1985, 1986 and 1987 coincided with more rapid premium growth and improved profitability."

Changes in the economy coincide with various trends in different types of insurance, the report notes. For example:

- Premiums for long-tail lines—like auto liability or general liability—rise and fall more readily with changes in interest rates than do premiums for short-tail lines like auto physical damage. Since insurers hold long-tail premiums for longer periods before paying claims, these premiums are more sensitive to interest rate changes, the study explains.

ISO found that for every 1% rise in the one-year Treasury bill rate between 1969 and 1990, there was a corresponding 0.2% decline in premiums for long-tail lines and a 0.1% decrease in premiums for short-tail lines.

- High interest rates have coincided with a slowdown in reported losses in long-tail lines. For every 1% increase in one-year Treasury bill rates between 1969 and 1990, ISO found a 0.2% drop in long-tail line losses.

This suggests that insurers may have been discounting their loss reserves to reflect expected future investment earnings, the study says.

The study found no relationship between interest rates and losses in short-tail lines, since claims payouts are relatively quick.

ISO also found correlations between economic changes and loss experience in specific property/casualty lines, including workers comp and manufacturers and contractors liability.

Examining workers comp data from 30 states between 1980 and 1986, the study found that:

- The frequency of claims for lost income grew with economic expansion, while lost income and medical claims both grew with rising interest rates.

ISO found that growth in real GNP produced growth in the frequency of lost income claims, which represented 21% of all workers compensation claims studied. Reasons include the likelihood that workers put in longer hours at a more hectic pace during a strong economy, increasing the possibility of injury.

The share of overall employment represented by the relatively hazardous manufacturing and construction segments also grows during an economic upturn, producing more worker injuries, the study suggests.

Meanwhile, rising interest rates put more financial pressure on many businesses, causing them to delay buying new equipment or performing proper maintenance of machinery in the workplace, creating more lost income and medical claims.

- The severity of workers comp claims grew at a faster pace than increases in medical costs or wages.

'High interest rates do in fact result in increased availability and lower prices for some lines of insurance,' the ISO study concludes.

The study found that each 1% increase in an ISO-modified consumer price index for medical care typically coincided with a 1.4% increase in workers comp medical claim severity between 1980 and 1986.

Possible reasons include doctors' increasing use of "defensive" treatment strategies that involve costly new procedures, ISO suggests.

Separately, the ISO study looks at the effect of economic factors on claims frequency and severity for manufacturers and contractors premises and operations insurance, which covers bodily injury and property damage to third parties at or near a manufacturing or construction site.

Examining industry M&C loss data from 1973 to 1987, ISO found that:

- The frequency of M&C bodily injury claims falls in a strong economy and rises in a weak one, as the mix of construction activity changes.

Tough economic times can lead manufacturers and contractors to cut costs by operating in a less safety-conscious manner, the report notes. In addition, potential claimants who are financially strapped may file claims they otherwise would not.

The M&C bodily injury claims data shows a correlation between high claims frequency and high unemployment, suggesting that claims frequency rises in a weak economy.

However, the ISO study suggests that rising frequency more directly results from cyclical shifts in the construction industry: A strong economy produces a rise in less-hazardous single-family residential construction, while commercial and industrial construction represents a larger share of the business during a weak economy, the study notes.

"To the extent that residential projects are less dangerous than non-residential projects. . .M&C claim frequency will tend to fall during periods of strong economic activity and to rise when the economy is weak," ISO concludes.

- M&C bodily injury claim severity grew faster than increases in medical care, legal costs and underlying wages. Between 1973 and 1987, bodily injury claim severity rose 290%, while an ISO inflation-adjusted consumer price index for medical care, legal and other costs rose 210%.
- M&C property damage claim severity also rose faster than the increase in an ISO-modified index measuring the inflation-adjusted cost of covered goods and services. While property damage claim severity rose 290% from 1973 to 1987, the ISO index rose only 160%.

The difference may reflect increases in repair costs not adequately measured by the index or increases in jury awards and the resulting impact on insurers' claim settlement practices, ISO concludes.

The ISO study also examined personal auto liability and homeowners coverages.

For example, in the auto liability line, ISO found that bodily injury claim frequency declined with a rising unemployment rate as fewer people drive to work or drive on vacations. The study found that bodily injury claim frequency increased with a reduction in car weights.

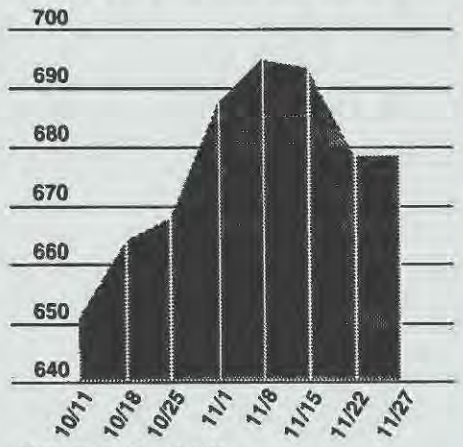
Auto property damage claim frequency dropped as the proportion of older drivers increased, ISO found.

In the homeowners line, the study found that claim frequency increased with high unemployment and interest rates and that theft claim frequency increased during rough economic times.

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Free copies of the study, "Changes in the Economic Environment: Insurance Implications," may be obtained by writing to Insurance Services Office Inc., Corporate Communications Department, 7 World Trade Center, 17th Floor, New York, N.Y. 10048.

BI Insurance Index



Base = 100 on Dec. 29, 1978
Source: Nordby International Inc.

Insurance industry stocks fell only a fraction during a shortened period due to the Thanksgiving holiday, as the *Business Insurance* index slipped 0.1 points to 678.3 on Nov. 29 from 678.4 on Nov. 22. Advancing issues were led by Safeguard Health Enterprises, up 10.9%; Chandler Insurance Co., up 7.7%; and Travelers Corp., up 6.3%. Declining issues followed FHP International Corp., down 13.1%; Pacificare Health Systems, down 10.6%; and HMO America Inc., down 7.6%. The most active issue was FHP International, 7.7 million shares traded. The *BI* Index dropped 0.03%; the New York Stock Exchange Composite was up 0.03%; the Standard & Poor's 500 gained 0.1%; and the Dow Jones 30 Industrials lost 0.09%.

British Issues

Nov. 26 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	462	N/M	30.7	6.6	468	454
Genl Accident	446	N/M	35.7	8.0	446	429
Gdn Royal Exch	146	N/M	15.9	10.9	146	135
Royal	287	N/M	34.7	12.1	291	284
Sun Alliance	315	N/M	18.7	5.9	315	303
Brokers						
Bradstock	161	18.3	6.0	3.7	162	161
CE Heath	482	16.7	34.5	7.1	495	482
Hogg Group	185	11.0	10.7	5.8	197	183
Lloyd Thompson	237	23.8	6.0	2.5	245	237
Lowndes Lmbrt	344	17.1	15.3	4.4	350	344
PWS Holdings	82	9.6	4.7	5.7	82	82
Sedgwick Grp	217	20.6	16.0	7.4	219	213
Steel Brrl Jones	315	16.6	16.3	5.2	324	315
Willis Corroon	249	13.0	17.6	7.1	249	237

Source: Philip Olsen, Insurance Industry Analyst, London

BI Industry Stock Report

NOVEMBER 25, 1991 THROUGH NOVEMBER 27, 1991

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander	NYS	19.88	1.27	-14.05	27.63	18.88	347	1.00	5.03	18	9.77	2.03
Gallagher Arthur J. & Co.	NYS	21.75	-1.14	-6.45	28.38	19.00	37	0.64	2.94	19	5.88	3.70
Frank B. Hall	NYS	3.38	3.85	-6.90	4.38	2.13	99	0.00	0.00	-5	-5.24	-0.64
Hilb, Rogal & Hamilton	OTC	13.25	0.00	-10.17	17.50	11.25	11	0.40	3.02	23	3.56	3.72
Marsh & McLennan	NYS	71.63	0.88	-8.17	87.25	69.13	282	2.60	3.63	17	14.77	4.85
Poe & Associates	OTC	11.75	1.08	83.59	12.50	6.50	15	0.32	2.72	13	2.52	4.66
BROKERS	AVERAGE		0.8	5.4					2.5	12		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	28.25	0.00	-24.67	32.25	22.25	29	0.32	1.13	12	23.89	1.18
Berkshire Hathaway Inc.	NYS	8375.00	1.52	25.47	9000.00	5875.00	0	0.00	0.00	-36	4612.00	1.82
ITT (Hartford Group)	NYS	52.50	-0.47	9.38	63.00	44.88	821	1.72	3.28	6	64.01	0.82
Sears (Allstate)	NYS	36.00	1.05	41.87	43.50	24.38	1291	2.00	5.56	12	37.38	0.96
CONGLOMERATES	AVERAGE		0.5	13.0					2.5	-1		
INSURERS/REINSURERS												
AEGON N.V.	NYS	66.50	-1.66	5.98	70.63	54.75	13	2.30	3.46	7	N/A	N/A
Aetna Life & Casualty	NYS	37.50	1.35	-3.85	49.13	31.88	837	2.76	7.36	7	64.23	0.58
American General	NYS	41.25	0.92	34.15	43.63	26.50	423	2.00	4.85	10	37.14	1.11
American Heritage	NYS	29.88	0.84	42.26	32.25	20.00	1	1.08	3.62	12	19.25	1.55
American Indemnity/Fin'l	OTC	4.63	-5.13	42.31	7.75	2.75	0	0.08	1.73	14	12.93	0.36
American International	NYS	86.50	3.13	12.52	102.00	68.13	750	0.48	0.55	12	45.34	1.91
Aon Corp.	NYS	36.50	1.39	5.04	41.75	29.75	70	1.60	4.38	10	18.50	1.97
Argonaut Group	OTC	25.25	1.00	18.36	33.38	19.00	24	0.68	2.69	7	48.26	0.52
AVEMCO Corp.	NYS	21.88	-2.78	29.95	27.25	15.75	9	0.40	1.83	16	9.55	2.29
Baldwin & Lyons Inc.	OTC	27.50	4.76	46.67	27.50	17.00	3	0.28	1.02	8	24.29	1.13
Belvedere Corp.	ASE	3.00	0.00	20.00	3.75	2.00	5	0.04	1.33	12	7.65	0.39
Chandler Insurance	OTC	3.50	7.69	-49.09	7.25	2.13	22	0.00	0.00	-2	5.95	0.59
Chubb Corp.	NYS	66.25	2.32	22.12	75.25	45.50	691	1.48	2.23	10	35.19	1.88
CIGNA Corp.	NYS	52.25	1.95	27.83	58.75	36.00	592	3.04	5.82	11	73.15	0.71
CNA Financial Corp.	NYS	89.50	1.70	30.42	99.00	57.38	104	0.00	0.00	13	70.23	1.27
Continental Corp.	NYS	25.38	-0.49	2.01	30.63	22.50	578	2.60	10.25	11	37.83	0.67
Durham Corp.	OTC	36.25	0.00	29.46	37.75	24.50	0	1.00	2.76	20	28.04	1.29
Fund American Corp.	NYS	67.00	0.00	29.16	67.75	47.75	36	0.68	1.01	11	36.11	1.86
Fremont General Corp.	OTC	23.50	-1.05	62.07	25.50	11.88	175	0.88	3.74	7	19.13	1.23
Frontier Insurance Group	NYS	24.25	0.00	27.63	25.88	16.03	12	0.00	0.00	10	11.20	2.17
Gainsco Inc.	ASE	12.13	0.00	59.02	12.88	4.50	7	0.04	0.33	15	3.37	3.60
General RE Corp.	NYS	88.75	-0.56	-4.57	102.50	83.75	618	1.68	1.89	12	37.50	2.37
Hanover Insurance Co.	OTC	39.50	-1.25	49.06	39.50	22.00	244	0.44	1.11	17	37.44	1.06
Harleysville Group	OTC	18.00	5.11	18.03	21.34	12.16	11	0.64	3.56	9	22.99	0.78
Hartford Steam Boiler	NYS	50.38	-0.74	3.33	63.75	43.63	42	2.00	3.97	13	17.05	2.95
Kansas City Life Ins.	OTC	34.50	0.00	11.74	36.00	30.25	2	1.20	3.48	8	39.22	0.88
Kemper Corp.	NYS	35.38	-2.08	48.95	41.00	19.25	253	0.92	2.60	8	34.20	1.03
Lawrence Insurance Group	ASE	9.38	0.00	33.93	9.75	6.38	0	0.48	5.12	15	4.71	1.99
Liberty Corp.	NYS	44.38	-0.28	7.90	48.00	39.00	9	1.00	2.25	13	23.86	1.86
Lincoln National	NYS	51.75	-0.24	20.35	55.25	37.00	124	2.92	5.64	9	45.16	1.15
Markel Corp.	OTC	18.00	-1.37	53.19	20.75	10.25	4	0.00	0.00	8	3.22	5.59
Mutual Risk Mgmt. Ltd.	NYS	29.38	2.17	-	33.50	17.00	52	0.20	0.68	26	-	-
NAC Re Corp.	OTC	24.00	2.67	-27.27	28.34	19.34	53	0.16	0.67	12	18.90	1.27
Navigators Group	OTC	31.50	0.00	44.27	35.00	18.75	0	0.00	0.00	17	13.52	2.33
Nobel Insurance LTD.	OTC	4.00	0.00	33.33	5.13	2.75	6	0.00	0.00	5	7.76	0.52
NWNL Companies	NYS	29.38	3.52	74.07	37.25	14.63	135	1.40	4.77	8	42.73	0.69
Ohio Casualty Corp.	OTC	47.00	1.35	14.63	50.25	33.25	44	2.48	5.28	9	36.38	1.29
Old Republic Int'l	NYS	34.63	2.59	51.37	35.00	19.75	44	0.72	2.08	8	33.09	1.05
Orion Capital Corp.	NYS	32.50	-0.38	85.71	33.50	15.50	39	0.92	2.83	9	20.42	1.59
Phoenix RE Corp.	OTC	9.00	0.00	16.13	10.25	6.75	13	0.20	2.22	13	13.30	0.68
Protective Life Corp.	OTC	18.50	-1.99	24.37	23.00	12.50	50	0.84	4.54	7	16.29	1.14
Provident Life	OTC	20.00	1.27	14.29	24.50	14.38	308	1.00	5.00	6	25.88	0.77
Re Capital Corp.	ASE	14.38	0.88	11.65	18.63	11.75	9	0.20	1.39	11	15.05	0.96
Reliance Group Holdings	NYS	4.13	-2.94	-10.81	7.50	4.00	38	0.32	7.76	3	5.61	0.74
RLI Insurance Corp.	NYS	15.75	-1.56	8.62	16.38	11.38	18	0.48	3.05	8	14.41	1.09
St. Paul Companies	NYS	68.00	0.00	8.37	74.25	57.00	0	2.60	3.82	8	52.00	1.31
SAFECO Corp.	OTC	42.63	2.10	29.66	44.75	28.50	446	1.48	3.47	10	31.50	1.35
SCOR U.S. Corp.	NYS	15.13	-0.82	22.22	16.50	10.50	2	0.24	1.59	9	11.19	1.35
Seibels Bruce Group	OTC	5.88	4.44	38.24	8.88	4.25	21	0.36	6.13	-84	7.35	0.80
Selective Ins. Group	OTC	17.00	2.26	28.30	18.00	12.50	2	1.04	6.12	9	18.91	0.90
Statesman Group Inc.	OTC	5.69	-1.08	263.92	6.38	1.25	127	0.00	0.00	17	2.48	2.29
Tokio Marine & Fire	OTC	49.00	1.03	3.70	56.50	40.50	27	0.00	0.00	-	70.93	0.69
Torchmark Corp.	NYS	52.63	0.96	7.67	58.50	45.63	153	1.60	3.04	12	16.70	3.15
Transamerica	NYS	38.63	0.98	18.39	40.00	29.63	225	2.00	5.18	15	36.56	1.06
Transatlantic Holdings	NYS	33.63	-2.18	22.83	39.38	24.50	5	0.20	0.59	11	18.38	1.83
Traveler's Corp.	NYS	19.13	6.25	15.04	25.38	12.50	571	1.60	8.37	5	41.44	0.46
Trenwick Group Inc.	OTC	25.75	-1.90	11.35	30.00	20.25	1	0.72	2.80	9	21.71	1.19
United Fire & Casualty	OTC	44.13	-0.28	25.62	58.00	32.50	7	1.32	2.99	9	35.39	1.25
USF&G Corp.	NYS	6.25	-3.85	-16.67	12.50	6.13	773	0.20	3.20	-1	11.96	0.52
UNUM Corp.	NYS	74.63	1.88	60.05	78.00	41.50	119	1.04	1.39	12	37.25	2.00
USLIFE Corp.	NYS	43.38	-2.25	54.91	47.00	26.88	163	1.64	3.78	9	60.34	0.72
Unitrin	OTC	35.00	5.26	13.82	41.50	29.25	197	1.00	2.86	14	30.70	1.14
Washington National	NYS	15.38	3.36	41.38	16.00	9.38	29	1.08	7.02	-7	26.86	0.57
USLICO Corp.	NYS	17.00	-0.73	7.09	21.00	14.75	3	1.00	5.88	-81	29.44	0.58
Zenith National Ins.	NYS	15.13	0.00	11.01	18.50	10.38	23	1.00	6.61	126	13.14	1.15
INSURERS/REINSURERS	AVERAGE		0.7	30.6					3.6	10.2		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	10.75	-13.13	-29.51	29.75	9.88	4704	0.00	0.00	9	5.44	1.98
HMO America Inc.	OTC	12.25	-7.55	88.46	17.13	5.38	362	0.00	0.00	13	0.61	20.08
Pacificare Health Sys.	OTC	23.25	-10.58	43.08	42.50	14.50	373	0.00	0.00	12	6.55	3.55
Safeguard Health Enter.	OTC	7.63	10.91	60.53	8.88	4.13	83	0.00	0.00	18	3.53	2.16
Sierra Health Services	ASE	13.75	-2.65	0.00	29.50	9.63	38	0.00	0.00	7	1.78	7.72
United Healthcare Corp.	NYS	60.00	-0.21	158.06	64.75	18.38	269	0.06	0.10	29	3.76	15.96
United Medical Corp.	ASE	6.88	3.77	-14.06	10.88	5.88	1	0.20	2.91	11	8.79	0.78
U.S. Healthcare	OTC	35.63	-1.04	21.28	38.00	15.25	2288	0.44	1.24	18	3.38	10.54
HMOs	AVERAGE		-2.6	41.0					0.5	15		
ALL COMPANIES	AVERAGE		0.3	27.7					3.0	10		

System design: Nordby International Inc.

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