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Update

Risk managers, insurers oppose NAIC's anti-fronting proposal

LOUISVILLE, Ky.—Risk managers and insurers are expected to testify today against a proposal by state insurance regulators that would prohibit most fronting arrangements.

Mostly critical comments are expected during a 2½-hour hearing at a National Assn. of Insurance Commissioners meeting in Louisville, Ky. No final action is expected at the hearing.

An Aug. 23 draft of the proposed "Limitations on Reinsurance Activities Insurers

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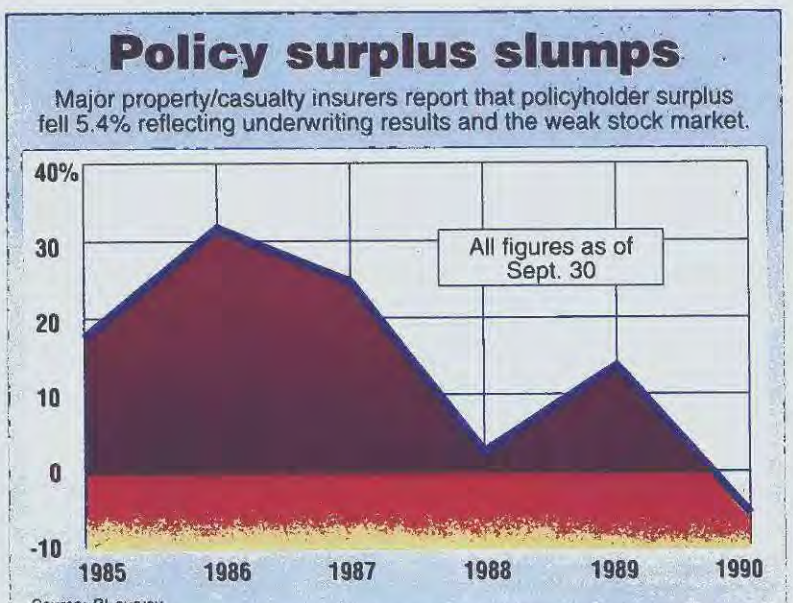
Lloyd's leader sees rate hikes



GRAPHIC BY JOHN SMITHER

Market begins to harden with renewals: Coleridge

By STACY SHAPIRO

LONDON—The worldwide commercial insurance market is beginning to harden as insurers begin writing year-end renewals, asserts David Coleridge, who is expected to be elected chairman of Lloyd's of London this week.

Underwriters have delayed work on renewals for several weeks while evaluating what kind of reinsurance protection they would have in 1991, said Mr. Coleridge, chairman of Sturge Holdings P.L.C., the largest underwriting agency at Lloyd's with 12% of the market's capacity.

The catastrophe reinsurance and retrocessional markets in London are tightening dramatically, triggered by the unprecedented string of disasters in the past 18 months and exacerbated by Lloyd's syndicates and reinsurers like CIGNA Reinsurance Co. (U.K.) Ltd. withdrawing from the market (*BI*, Nov. 19; Nov. 12).

But now that "business is beginning to be written again, there are hefty increases going on," Mr. Coleridge said in one of a series of interviews set up with journalists during the last few weeks.

He cited "hefty increases" on marine fleet and cargo rates. Rates also are rising for non-marine and aviation risks, he said, though he was not specific.

U.S. and European insurers, as well as London market underwriters, are quoting increases, according to Mr. Coleridge.

Rates are rising "everywhere" for both personal and commercial renewals, Mr. Coleridge said.

Already in London "there is very much more business being offered from the States and much more premium being obtained (in) general commercial business, not just in catastrophe business where there are very hefty rises of premiums being charged.

David Coleridge

"So it is happening," he said.

Mr. Coleridge's opinions are based on information from his company, which manages the largest aviation syndicate, the largest non-marine syndicate and one of the largest marine syndicates at Lloyd's.

Several British insurance companies also say they will either increase rates during year-end renewals or are now reviewing their rates (see story, page 56).

However, U.S. insurance company executives and analysts disagree with Mr. Coleridge's assessment that the market already has turned (see related story).

Mr. Coleridge, though, noted in an interview that market hardenings always commence in the same way. "The reinsurance market becomes absolutely impossible and no one can protect their accounts. And then tougher conditions are put in and (insurance) premiums are raised and retentions increase and people start to realize they have to underwrite properly.

"Things had to change and they are now beginning to change," he said.

Mr. Coleridge concedes that some underwriters will say that increases now taking hold are not enough to stem the huge underwriting losses compiled over the past several years. However, "it's a start," he said.

"It's the first time that there's been any sign of rates beginning to change," he pointed out. "I think it's very healthy. I'm delighted. It had to happen."

The market is turning now because the financial results of all insurers, including Lloyd's underwriters, are worse than they have been for many years, he noted.

Mr. Coleridge reiterated the prediction made earlier this year by outgoing Lloyd's Chairman Murray Lawrence that Lloyd's will report an overall loss for its 1989 underwriting year. That year will close in 1991 under Lloyd's three-year accounting system (*BI*, June 25).

And, profits are off sharply for British insurers. One main reason is claims from early 1990 wind-

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U.S. market observers do not expect rates to rise until late 1991

By JUDY GREENWALD

Despite news of rate increases from London, soft market-weary U.S. insurance industry observers now predict it will be late 1991 or early 1992 before U.S. commercial property/casualty rates rise substantially.

And nothing they see on the horizon is likely to accelerate that scenario.

U.S. property/casualty insurers continued to post weak results in the third quarter. And, this year's third-quarter and nine-month results appear better than they really are because Hurricane Hugo greatly depressed insurers' 1989 third-quarter and nine-month figures.

"In terms of comparisons, the results looked fairly good for certain companies because they were clipped by those catastrophes last year," said James F. Guenther, assistant vp at rating agency Duff & Phelps in Chicago.

However, deteriorating underwriting results and the weak stock market are beginning to take their toll on policyholder surplus, industry observers say.

Policyholder surplus reported by the major property/casualty insurers surveyed by *Business Insurance* declined 5.4% to $35.7 billion as of

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Ruling widens advertising liability cover

By STACY ADLER

SAN FRANCISCO—Many California policyholders may be able to obtain coverage for lawsuits alleging unfair business practices as a result of a recent court ruling that broadly interprets the advertising injury portion of the pre-1986 comprehensive general liability policy.

Coverage for "unfair competition," as defined under the advertising injury endorsement to the CGL policy, "encompasses any unlawful, unfair or deceptive acts committed against both a business competitor or the public," said the California 1st District Court of Appeal in its Nov. 15 ruling.

The court soundly rejected insurer arguments that "unfair competition" should be construed narrowly to mean only "palming off" or passing off a rival's goods as one's own.

In addition, the court said advertising "is not limited to paid announcements in print and broadcast media," but also includes all forms of communication, including one-on-one oral representations.

"This is the first published decision anywhere that adopts such a broad interpretation of advertising injury and unfair competition," says Jan T. Chilton of Severson & Werson in San Francisco, who represented policyholder Bank of the West in the litigation.

The ruling will help many policyholders in California facing consumer-related lawsuits alleging unfair business practices obtain insurer-paid defense and indemnification, said Mr. Chilton.

"Previously, most policyholders believed there was no coverage for such claims, and now it appears there may be," he said.

"Insurers are up in arms," said insurer attorney Julia A. Molander of Bronson, Bronson & McKinnon in San Francisco.

"From an insurer standpoint this case could be a disaster," she said. "The court was extremely frank in saying there is a duty to defend cases alleging unfair business

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Update

Plan to limit fronting criticized

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Act" permits states to prohibit a licensed insurer from ceding to an unlicensed insurer—directly or indirectly—direct business written to cover risks in the state if the reinsurer:

- Assumes 50% or more of the risk and receives special policy terms or authority over underwriting, marketing or policyholder services like claims handling.
- Controls, or is controlled by or affiliated with, a policyholder, producer or other person that controls the business.
- Is designated by the policyholder, producer or another controlling person.

These conditions exist in policies fronted for captive insurers.

However, under the proposed model law, state regulators could personally approve some fronting arrangements.

Many regulators say the proposal would help them keep fronting insurers solvent and bring non-admitted insurers under their authority.

The Risk & Insurance Management Society Inc. dismisses the proposal as "anti-consumer," saying it essentially would eliminate the fronting arrangements many of its members routinely use. Such arrangements, which generally are collateralized, "pose no undue threat," RIMS maintains.

An industry advisory committee calls the proposal "technically and conceptually flawed." And, other model laws give regulators enough authority over fronting arrangements, claims Lenore S. Marema, vp-legal and regulatory affairs for the Alliance of American Insurers.

Outhwaite clears hurdle

LONDON—A letter from a Lloyd's of London syndicate claims manager supporting a ceding company's decision to join the now-defunct Asbestos Claims Facility does not, in itself, bind the syndicate to pay asbestos-related claims, the British High Court says.

The ruling came in a dispute between Lloyd's of London syndicate 661, managed by R.H.M. Outhwaite (Underwriting Agencies) Ltd., and its cedant, Anton Underwriting Agencies Ltd.

Anton sued Outhwaite in 1989 for refusing to pay claims under a runoff reinsurance policy, even though an arbitration panel has declared the policy valid.

During discovery, Outhwaite released a letter sent by Outhwaite Claims Manager Fred Folwell to Richard Allan Lee, claims manager of Anton's broker Butcher Robinson & Staples Ltd., in which Mr. Folwell said Outhwaite "agrees to support the decision" by Anton to join the Asbestos Claims Facility created under the Wellington Agreement.

Mr. Folwell's letter was a response to a 1984 letter from Mr. Lee seeking his support.

British High Court Justice Hirst last week rejected all arguments that Mr. Folwell's letter bound Outhwaite to pay claims on the runoff policy that are related to the Asbestos Claims Facility, which shut down in 1988 (*BI*, May 30, 1988).

Anton is considering an appeal. And, the case continues over whether other factors may force the runoff policy to respond to asbestos-related claims against Anton settled through the facility, said Anton lawyer Mark Humphries, an assistant solicitor with Linklaters & Paines.

Reinsurers' results static

WASHINGTON—U.S. reinsurers posted a 106.8% combined ratio for the nine months ended Sept. 30, up slightly from the 106.7% a similar group posted in 1989, according to a survey of 66 reinsurers by the Reinsurance Assn. of America.

The nine-month figure—representing a 76% loss ratio and a 30.8% expense ratio—is a slight improvement from the 107.2% reinsurers reported for the first half of 1990 (*BI*, Sept. 17).

Surveyed reinsurers' nine-month net premiums written rose 5.5% to $7.8 billion from $7.4 billion a year ago.

Record asbestos award fought

ST. CROIX, Virgin Islands—Owens-Corning Fiberglas Corp. will seek to reduce or overturn a $26.3 million asbestos personal injury award—the largest-ever to a single asbestos victim.

A federal jury in St. Croix on Nov. 23 ordered the company to pay a 57-year-old former asbestos worker $1.3 million in compensatory damages and $25 million in punitive damages after finding that the company failed to warn of the dangers of asbestos.

A state court judge in San Francisco last April ruled Owens-Illinois Inc., a one-third owner of Owens-Corning, could tap as much as $960 million of insurance to pay asbestos bodily injury claims (*BI*, April 16). Owens-Illinois' insurers are appealing that ruling.

The trial judge has asked the Toledo, Ohio-based company and the plaintiff to submit written motions on whether the award should be reduced.

Owens-Corning is "very confident that this verdict will be overturned on appeal," a spokesman said. "It is our belief that the individual is not sick and therefore is not entitled to the damages."

"I hope this verdict sends a message to all asbestos manufacturers that they need to settle these cases quickly and fairly and before they reach the trial stage," said attorney Paul Minor of Minor & Guice in Biloxi, Miss., who represented plaintiff William R. Dunn.

Mr. Dunn, who lives in the Virgin Islands, claims he suffers from asbestosis caused by the insulation he installed for 30 years.

Smaller HMO premiums hikes

WASHINGTON—Employers can expect smaller increases in health maintenance organization premiums in 1991, a survey says.

Premiums will increase an average of 12.9% in 1991, down from 16.9% this year and 16% in 1989, projects the Group Health Assn. of America, an HMO trade group in Washington, D.C.

The survey of 44 HMOs with 11.8 million enrollees also found that nearly 90% of HMOs expect to report a profit or increase in surplus this year, up from 72% in 1989.

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Mental health costs

Large employers see 50% increases: Study

By JERRY GEISEL

Led by a nearly 50% increase among large employers, the cost of providing mental health and substance abuse benefits is rising at a torrid pace.

The cost of mental health and substance abuse benefits last year climbed 17.9% to $244 per employee on average from $207 in 1988, according to a new survey by benefit consultant A. Foster Higgins & Co. Inc. of New York.

But that increase, which includes both employer and employee contributions, is overshadowed by much steeper increases among larger employers.

Among employers with 5,000 to 9,999 employees, mental health and substance abuse benefit costs rose 56.5% last year to $291 per employee on average from $186 in 1988.

And per-employee costs for employers with 10,000 to 19,999 employees leaped 42.8% in 1989 to $267 on average from $187 in 1988.

The largest employers—those with more than 20,000 employees—reported the highest average per-employee mental health and substance abuse benefit costs last year: $319, up 43.7% from $222 in 1988.

Among all respondents with more than 5,000 employees, the cost of mental health and substance abuse benefits increased 47% in 1989 to $297 per employee on average from $202 in 1988.

For small employers, however, these per-employee costs remained generally flat.

Among employers with fewer than 1,000 workers, the costs increased 7.9% to $177 on average in 1989 from $164 the year before. And, among employers with between 1,000 and 4,999 employees, these costs declined 8.7% last year to $242 on average from $265 in 1988.

But small employers may be understating their actual mental health and substance abuse benefit costs, according to Foster Higgins, because insurance companies that write their mental health coverage typically provide little, if any, mental health and substance abuse utilization and cost data, the survey said.

Because larger employers typi-

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States cannot regulate self-funded plans

ERISA pre-emption upheld

By JERRY GEISEL

WASHINGTON—States cannot impose benefit requirements on employers that self-fund their health care programs, the Supreme Court ruled last week.

In the first decision to directly deal with the issue, the justices said the pre-emption provisions of the Employee Retirement Income Security Act of 1974 exempt self-funded health care plans from state rules that apply to policies sold by commercial insurers.

The "pre-emption clause is conspicuous for its breadth. It establishes as an area of exclusive federal concern the subject of every state law that 'relates' to an employee benefit plan governed by ERISA," Justice Sandra Day O'Connor wrote for the court.

The 7-1 decision overturned a 3rd U.S. Circuit Court of Appeals ruling involving FMC Corp. of Chicago.

The appeals court had ruled that a Pennsylvania law prevented FMC from seeking reimbursement for medical claims paid by its self-funded plan on behalf of a plan participant injured in an auto accident. The injured person later received a settlement from the person responsible for the accident.

Last week's Supreme Court ruling is an important, though possibly narrow, victory for employers that self-fund their health care plans, according to benefits experts.

The ruling ensures that self-funded employers will not have to comply with a hodge-podge of state benefit requirements. Those rules, which the Supreme Court in 1985 said apply to group health policies sold by commercial insurers (*BI*, June 10, 1985), would have made it difficult and expensive for self-insured employers operating nationwide to offer a uniform benefit package.

State rules, which often say that a policy must offer specific benefits like a certain number of days of mental health coverage, also drive up employers' health care

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Texas regulators reject work comp rate increase

By MICHAEL BRADFORD

AUSTIN, Texas—Employers in Texas will receive a reprieve from any increase in workers compensation insurance rates next year, following several years of double-digit increases.

The Texas State Board of Insurance last week cited sweeping reforms enacted last year in denying a request by the National Council on Compensation Insurance to raise rates 18.8% in 1991.

Rates are to be frozen at least through 1991.

The three-member insurance board made the decision after reviewing figures supplied by staff and outside advisers.

The board's staff had suggested a 19.9% increase, based on instructions by the board not to consider the reform measure, S.B. 1, when making its recommendation.

However, an outside actuary hired by the board to calculate the impact of the reforms on the state's workers comp system said the reforms could lower rates as much as 10% or increase them as much as 1%.

The board took all of these views into account when it decided not to raise rates.

The Texas Assn. of Business praised the board's decision to not raise rates.

"We felt like this was a step in the right direction for the business climate and future of the state," said Dane Harris, president of the TAB. "It's a vote of confidence in the workers comp bill."

Testimony at a hearing last week indicated that the reforms could save $300 million to $480 million, said Mr. Harris.

"We're extremely pleased that employers in Texas are finally getting a rate break," said a spokesman for the state's Office of Consumer Protection. "They're

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Inside

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- Atlantic Richfield Co. may benefit from a recent California Supreme Court ruling that cleanup costs are 'damages' under the CGL policy. **PAGE 66**
- USF&G Corp.'s new chairman and chief executive officer says he intends to develop a plan for all segments of the diverse company to pull in the same direction. **PAGE 67**

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Insurance regulation

Support begins to build for federal regulatory role

By MICHAEL BRADFORD

Can the states do it alone?

That's a question being asked more often by property/casualty insurance industry officials, members of Congress and even some state regulators.

After years of staunchly opposing any federal regulation of insurance, a growing number of insurance industry officials and others are coming to the conclusion that some federal regulatory role may not be a bad idea.

In fact, some think it's just a matter of time before Congress passes a law establishing some sort of federal insurance solvency regulatory mechanism that would supplement state regulation.

The increasing number of insurance company insolvencies and the opinion that the unconnected patchwork of state regulation is partly responsible for insurance company failures are the prime reasons behind the growing consensus in favor of some type of federal role in insurance regulation.

Virtually no one is advocating junking the current multistate system of insurance regulation. Instead, the federal government is being called upon to take a "limited" role, like giving the National Assn. of Insurance Commissioners the power to force states to adopt its model laws or adopting minimum federal regulatory standards that state insurance departments would be forced to follow.

However, others—including state insurance regulators—strongly assert that state regulation has worked well, while pointing to the prospect of a tangled and inefficient federal insurance bureaucracy.

Critics of a federal role in insurance regulation cite the savings and loan crisis as proof that the federal government can fumble when it is handed regulatory duties.

The debate over how property/casualty insurers should be regulated heated up following the investigation into several major insurer insolvencies by the House Oversight and Investigations Subcommittee. The panel, chaired by Rep. John D. Dingell, D-Mich., sharply criticized state solvency regulation in a report released earlier this year (*BI*, March 5; Feb. 26).

The subcommittee continues to hear testimony and the minority counsel to the panel predicts that legislation to create a federal role in regulating insurer solvency will be introduced next year (*BI*, Nov. 26), though a spokesman for Rep. Dingell said the subcommittee has not developed an agenda for future hearings or any specific legislative proposals.

A federal regulatory role is just one of several issues the subcommittee is considering, the spokesman pointed out, and those "questions are still currently under consideration."

Insurance industry leaders believe it's just a matter of time before members of the Dingell committee propose some sort of federal solvency oversight.

"I get the sense from the committee, both majority and minority members, that there will be some federal role in solvency regulation," said Robert E. Vagley, president of the American Insurance Assn. in Washington, D.C., who in testimony before the Dingell committee in September advocated limited federal "involvement" in solvency regulation (*BI*, Sept. 24; Sept. 17).

Subcommittee members "already have reached the determination that some federal role is indicated," Mr. Vagley said. "I get the further indication that they remain open as to the precise definition of that federal role."

Barbara Haugen, director of federal affairs with the National Assn. of Insurance Brokers in Washington, D.C., said, "I think we're going to see a lot of serious proposals on the table at the next Congress that will look toward federal oversight."

Ms. Haugen said there is a "real momentum moving toward federal oversight. We will see in 1991 proposals out of the Dingell committee that will be very specific."

While there is a growing consensus that a federal regulatory role is likely, there is no clear agreement on what that role should be, though nearly all say that any federal mechanism should support and complement—rather than replace—the current state regulatory system.

The Dingell committee is "very serious about changing the current regulatory structure, but I do not think it wants to create a federal regulatory insurance agency," Ms. Haugen said.

It is likely that a plan will emerge, Ms. Haugen speculated, that "will continue to rely in part on the state regulatory system. I think it is possible that we will have some type of federal overlay."

State regulation needs improvement, the AIA's Mr. Vagley emphasized, "but whatever regime we ultimately conclude would be a more effective and efficient system would contemplate the very substantial continuation of the state system of solvency regulation."

Mr. Vagley said some of the possibilities for federal regulatory involvement that the AIA is examining include:

- A self-regulatory organization similar to the National Assn. of Securities Dealers.

A federal board could develop standards for insurance companies and those standards would be implemented by state agencies.

That idea has been endorsed by CIGNA Corp. Chairman and Chief Executive Officer Wilson Taylor, who recently suggested the formation of a Federal Insurance Solvency Board, which would develop financial standards for insurance companies that could then be implemented by existing state agencies. The federally authorized board could include representatives from the insurance industry, the public and regulators (*BI*, Oct. 22).

- Empowering the NAIC to act as a state regulatory supervisor to enforce its own solvency requirements.
- Establishment of a "port of entry" concept, which would couple minimum solvency standards with the idea that an insurer domiciled in one state could obtain a license in another state by meeting those standards.

"We are still at the fleshing-out stage in developing these various concepts,"

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Trade barriers may not fall as talks stall

By LAURA MAZZUCA

BRUSSELS, Belgium—An agreement to remove international insurance trade barriers appears no closer today, when the latest round of General Agreement on Tariffs and Trade negotiations is scheduled to close, than it did four years ago when the talks began in Uruguay.

If negotiators for the 105 participating countries produce a general agreement on trade in services—which are included in the world trade talks for the first time—the U.S. insurance industry will benefit from the rollback of some restrictions blocking entry to foreign markets.

But if the round ends without reaching an accord, the industry will be forced to revert to the slower process of waiting for the United States to reach bilateral accords with individual nations, at a time when foreign insurers are rapidly making inroads into the U.S. market.

Wrangling over agricultural subsidies, the role of developing nations and how to treat state-owned service companies has bogged down this round of the GATT negotiations.

Because of these disagreements, the talks are "teetering on the abyss of a disaster," said Margaret S. Wigglesworth, executive director for the Coalition of Service Industries Inc., a Washington, D.C.-based group that represents 17 multinational service companies.

But negotiators, observers and advisers to the talks contacted before today's deadline said that the outcome of the negotiations could go either way.

"While I classify the chance of success as less than 50-50, I remain optimistic for one reason: I believe we have far too much to lose by walking away from the negotiation," said Henry G. Parker III, managing director of Chubb & Son Inc. in Warren N.J., in an October address to the World Trade Institute.

Mr. Parker is chairman of the International Insurance Council of the United States, an advisory committee to the talks composed of more than 40 multinational property/casualty and life/health insurers.

If the current round of negotiations fails, it will be the first time in the GATT talks' 44-year history that the talks did not produce at least some sort of trade agreement, he observed.

But even if the talks fail, "in a way it's still a victory, because we got services on the (negotiating) platform," said Stewart H. Steffey, senior vp of CIGNA Worldwide Insurance Co., a CIGNA Corp. unit.

"We need to keep our expectations realistic and, no matter what happens, realize it isn't a waste," he said.

The U.S. insurance industry ideally wants a multilateral agreement from the GATT talks to lower barriers to entry abroad. But Mr. Steffey said that the experience gained from these talks would serve the industry well in future bilateral negotiations with individual nations.

For example, the United States is preparing for trade talks with Mexico, which will probably begin in 1992, noted James H. Davies, past president of the National Assn. of Professional Insurance Agents and a member of the Insurance Services Advisory committee, which advises U.S. negotiators involved in the GATT talks.

Also, while trade discussions with Canada have recently ended, concurrent talks among all three nations are possible, he said.

If the current GATT talks end without any resolution of service issues, the experience gleaned from the service negotiations will serve the U.S. insurance industry well as it advises the government in negotiating with other countries on a bilateral basis, said Mr. Davies, who is president of Davies & Associates, an agency in Murray Hill, N.J.

"We've come a long way in gaining the understanding needed to negotiate services," agreed Maurice R. Greenberg, chairman, president and chief executive officer of American International Group Inc. in New York.

And although "it would be a tragedy if this round fails," Mr. Greenberg said he is convinced that "no result is better than a bad result," stressing that any GATT agreements must be well thought out before adoption. "What we must not do is build up a regulatory system that adds cost but doesn't really achieve anything."

The just-concluded Uruguay round of GATT talks—so named for the round's country of origin—not only

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Federal role

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said Mr. Vagley, adding the AIA—whose 240 members are primarily the major multiline, multistate insurers—expects to have more tangible proposals by early next year.

The Alliance of American Insurers in Schaumburg, Ill., is "committed to the primacy of state regulation but not to the exclusion of considering creative ideas on a self-regulatory system or some federal involvement," said President Franklin W. Nutter.

"We are open to the ideas advanced by the AIA, such as capitalization standards or the creation of a self-regulatory mechanism," he said.

"The AIA has taken more of an outward role than us, but we are always open to thoughtful ideas that would improve solvency regulation," Mr. Nutter said.

He noted that insurers that consider the current system of regulation too expensive in guaranty fund assessments and residual market charges and those with experience in dealing with federal agencies, like the Securities and Exchange Commission, are more open to a federal role in solvency regulation.

While considering alternatives, the 175-member Alliance is supporting the NAIC's efforts to improve state regulation, Mr. Nutter also said.

While the Washington, D.C.-based National Assn. of Casualty & Surety Agents believes regulation should stay with the states, regulation is "a complex problem and it's very possible that there could be some oversight capability on the part of the federal government," said Harry A. Koch Jr., a NACSA director and chairman of the group's legislative committee.

Mr. Koch said solvency standards determined on a federal level and administered by states could be helpful in establishing a uniform system for regulating and monitoring insurer solvency.

Oklahoma Insurance Commissioner Gerald Grimes said uniform national standards for financial examinations of insurers, even if they came from the federal government, could help state regulators.

"We definitely need to step up our ability to examine and monitor companies," said Mr. Grimes.

He suggested that a national organization with the power to conduct examinations and monitor insurers using a pool of trained specialists would provide uniformity on which all state agencies could depend when assessing the financial health of insurers.

New York Sen. Donald Halperin, D-Brooklyn, said he is studying the feasibility of "some type of federal charter" that would give the NAIC the authority to compel state regulators to adopt adequate solvency regulations.

Currently, if a state regulator decides not to comply with NAIC directives, "there is nothing to force him to do it," pointed out Sen. Halperin, who is past president of the National Conference of Insurance Legislators and chairman of COIL's state/federal relations committee.

"So I'm exploring the possibility of a federal mandate under which the NAIC could operate," he added. "If a state is incompetent or recalcitrant, there would be a way for the NAIC to get involved."

Patricia Borowski, vp-government and industry affairs for the National Assn. of Professional Insurance Agents in Alexandria, Va., said while it is too early to say exactly what steps should be taken to provide uniform regulatory standards among states, some type of central authority for the NAIC appears to be one of the most practical approaches.

State regulators are being challenged to develop uniform standards before the government steps in, Ms. Borowski said, and some form of federal regulation will be necessary if they don't move quickly.

If the states fail to solve their own regulatory problems, the PIA will support federal standards, she said.

"One of the things that we've called for is the possibility of getting the commissioners more authority," said George Shaffer, chairman of the government affairs committee of the Alexandria, Va.-based Independent Insurance Agents of America.

"I'm not sure exactly how you could do that," he added, but one way might be to give the NAIC the authority to enforce its standards.

Although such authority might be granted through a federal mandate, Mr. Shaffer said he is not in favor of completely turning over regulation to the federal government. "I'm not one who thinks they can do a better job."

In response to the Dingell subcommittee's report, Jack M. Nelson, an associate professor at The College of Insurance in New York, began working on a proposal that suggests creation of a "centralized agency, under the auspices of the (NAIC), to work with the states in policing solvency."

An executive summary of the proposal, which Mr. Nelson is preparing with Jim Barrese, an associate professor at the college, has been sent to the Dingell committee.

Messrs. Nelson and Barrese acknowledged in the summary that "it is probable that federal legislation is necessary to empower a centralized regulator. We suggest that Congress consider empowering the National Assn. of Insurance Commissioners or a task force under its direction."

The proposal calls for a centralized agency to "deal with the solvency issues of larger, multistate insurers and reinsurers and allow states to retain control over predominantly intrastate insurers and issues of policy structure and forms."

Consumer advocate J. Robert Hunter, president of the National Insurance Consumer Organization in Alexandria, Va., said that while he believes "the fundamental locus of regulation should be left to the states," there is a need for participation by the federal government.

Mr. Hunter suggested that the federal government's technological resources could be tapped to help state regulators with data collection and analysis.

"The federal government is good at data processing," said Mr. Hunter, and could, for example, provide studies on the economics of insurance cycles or other topics that regulators could use.

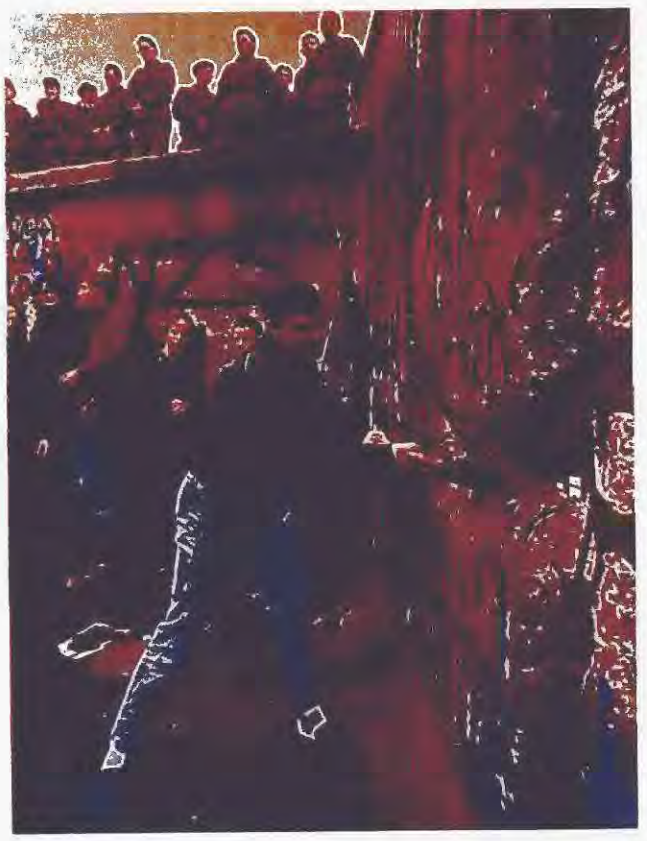
However, others—including state regulators and some insurance industry groups—see no need for a federal role in the regulation of insurers' solvency.

"State regulation has worked well for a hundred or so years," said North Carolina Insurance Commissioner Jim Long, who is expected to assume the presidency of the NAIC at the group's meeting this week in Louisville, Ky. "It may need some fine-tuning on reinsurance issues, but to turn it over to the federal government from the states, I don't see it happening."

Mr. Long said there is "a long track record now on how well the federal government has not done" in regulating private industries like savings and loans.

He also expressed concern that the Dingell committee has not asked for the NAIC's input in its investigation of insurance regulation. "It's strange, but we've yet

Continued on page 6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Destruction of the Berlin Wall, 1989.

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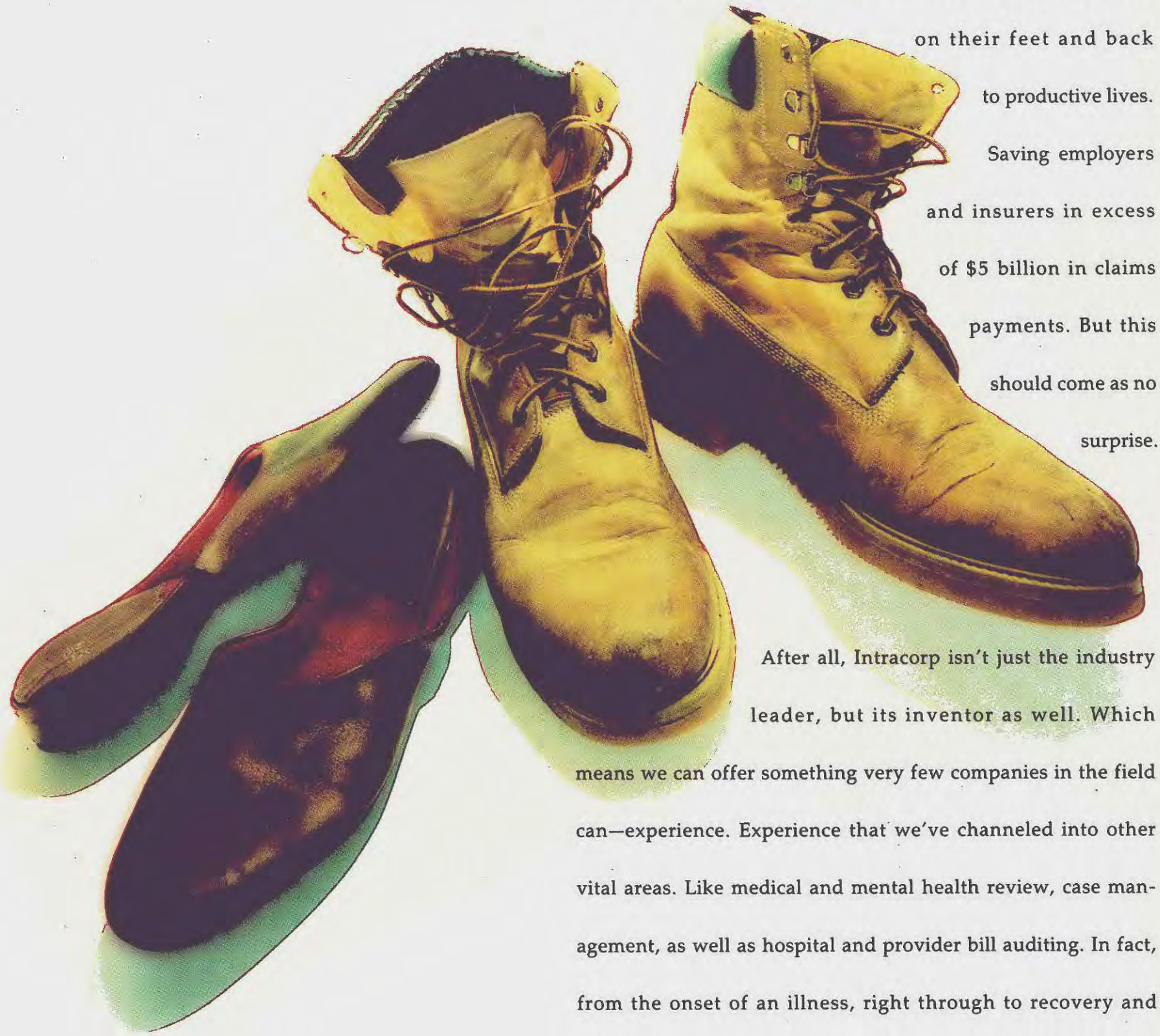

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INTRACORP

Federal role

Continued from page 4
to be called to testify."

"Personally, I don't see any need" for any federal role in insurance regulation, said James E. Saxton Jr., chairman of the Texas State Board of Insurance, which has itself been criticized for not adequately regulating insurer solvency (*BI*, Oct. 29).

However, Mr. Saxton said some states, like Texas, need stronger local authority to conduct more frequent financial examinations of companies.

North Dakota Insurance Commissioner Earl Pomeroy, the outgoing NAIC president, noted last month at the National Assn. of Independent Insurers annual meeting that there's danger in calling for a federal role in solvency regulation without defining what that role will be.

"We all know that what goes into a legislative process is not necessarily what comes out. So to embrace a notion of federal regulation before we are talking about a very clearly defined concept is extremely dangerous," he said (*BI*, Nov. 26).

The NAII in Des Plaines, Ill., representing more than 550 property/casualty insurers, remains "firmly committed to state regulation and firmly against the federal government acting at this point," says NAII President Lowell R. Beck.

"We don't need the federal government's help. Once we start down that road, we'll end up with dual regulation and rigidity in regulation," he said.

"But we don't have our heads in the sand," Mr. Beck emphasized. "We know we need stricter regulation and a will on the part of the regulators. Unless the states act over the next year, we're going to get some federal rules of some kind."

To help promote stricter state regulation of insurers, the NAII is committed to supporting legislative efforts around the country by states to adopt the model NAIC laws required for the states to meet NAIC accreditation standards, he noted.

"I've told commissioners to call me personally if they are not getting support for these changes," Mr. Beck said.

Mr. Beck also objects to suggestions that supporting state regulation of insurance is "an entrenched, not progressive" approach.

"To say we need a federal solution is not necessarily progressive. It could be the other way around. A federal solution was looked to years ago," he said.

Mr. Beck acknowledges there will be a "big split in the industry" over the role of the federal government in regulating insurers. "We have very different cultures in this industry, different delivery systems and different ways of giving service."

NAII members, he noted, "in a great number of states are the market leaders in personal lines and in small and medium sized commercial lines. They are small and medium sized companies and they relate to their customers on a personalized basis and see the world differently from the large, national companies."

Howard Greene, general counsel and director of governmental affairs of the Risk & Insurance Management Society Inc. in New York, reiterated RIMS' support for state regulation. "We think that states are closer to the business and in a better position to regulate it."

However, he noted that RIMS hasn't formed an opinion as to whether there should be some federal monitoring of insurer solvency. ■

'Lack of will' may hinder oversight by states

One major problem with state insurance regulation is that many regulators are reluctant to take action against a financially troubled insurer, some suggest.

Many regulators won't take action because they hold the opinion that "no one is going to go broke on my watch. In my view, that is totally wrong," noted consumer advocate J. Robert Hunter, president of the National Insurance Consumer Organization in Alexandria, Va.

Regulators instead should be on a "search and destroy mission," said Mr. Hunter. "They should be pushing mergers early" when it is possible for a weak company to join a stronger one and "taking companies down quick" when there is no hope, he said.

Regulators' unwillingness to take early action against a troubled company "is probably the most difficult" problem associated with state solvency regulation, said Robert E. Vagley, president of the American Insurance Assn. in Washington.

"Most of the incentives run against the closure of companies that are in severe distress and ought to be closed or the early identification of troubled companies," he said.

Mr. Vagley said that effective regulation is sorely lacking in this area.

Others note that regulators are under pressure to keep insurers going.

"There's a natural instinct to try and let a company work its way out of a rut," said Howard Greene, director of governmental affairs for the Risk & Insurance Management Society Inc. in New York. "Whether federal regulation would change that, I don't know. I don't think it's unique to state insurance regulators."

Albert Lewis, the New York superintendent of insurance from 1978 to 1983, said that "the most difficult thing for a regulator to do is call a company in and say, 'I'm taking you out of business.' Every time I took a company down, there was a lot of hollering and screaming."

Regulators lacking thorough knowledge of solvency regulation can be overwhelmed by insurer executives and their lawyers and actuaries giving "a lot of cock and bull" about how the company should remain in business, added Mr. Lewis, now an attorney with Cole & Dietz in New York.

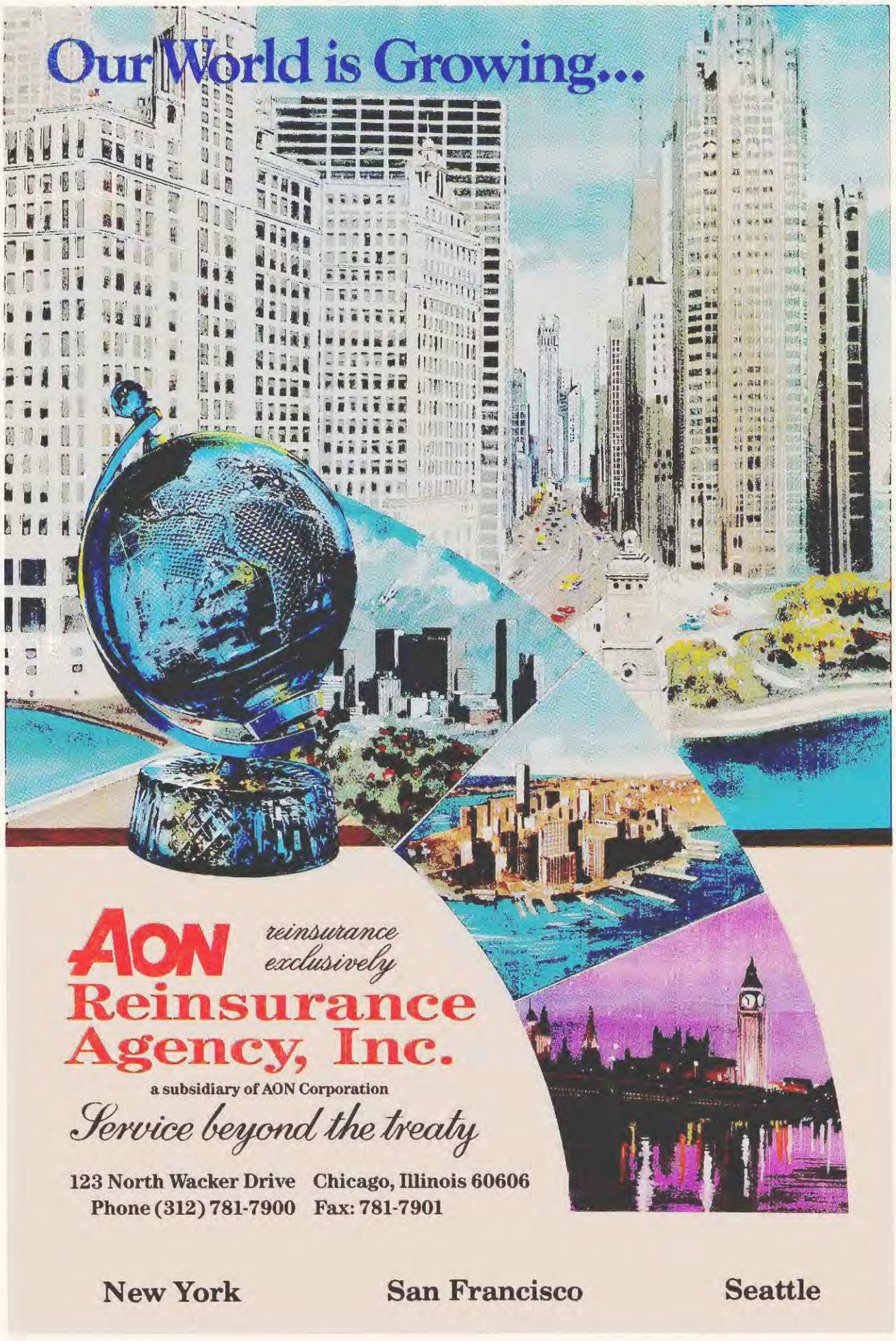
Threats of lawsuits can also scare regulators.

Regulators should be given some sort of immunity from lawsuits filed when they declare an insurer insolvent, contended Gregory A. Allgeier, president of the American Assn. of Managing General Agents in Kansas City, Mo.

"Regulators have no personal immunity and they are putting their personal assets on the line on a daily basis," Mr. Allgeier declared, suggesting that immunity would make them less reluctant to take action.

George Shaffer, chairman of the government affairs committee of the Alexandria, Va.-based Independent Insurance Agents of America, agreed that there should be "some way to get these commissioners immunity from a suit if they go after a company."

—By Michael Bradford



SUBSTANCE ABUSE IN THE WORKPLACE— THE WHITE COLLAR VIEW.

One in an ongoing series of conversations between Argonaut Insurance Company, our clients and their brokers, dealing with issues important to their business. The intent is to keep the lines of communication open. We invite your participation.

THE PARTICIPANTS: **MICHAEL DUNLOP,** *VP Risk Management for Countrywide Mortgage Bank, one of the nation's largest.* **ELISE KAPLAN,** *Personnel Manager for Countrywide.* **DON SCHAEFER,** *with Frank B. Hall Corporation, Countrywide's broker.* **STEVE LA SHIER,** *Senior VP Safety Management, Argonaut Insurance Company* **LARRY EVANS,** *Manager of Safety Management, Argonaut Insurance Company.*

MODERATOR Countrywide is a New York Stock Exchange Company. Just how big is it?

MD: We're the largest originators of loans in the United States, with about 100 branches in 28 states for retail operations and 12 wholesale branches located around major cities. We're primarily a mortgage banking operation with roughly 1100 employees, about 1000 of those white collar. So we're a sizeable operation with people located in various states.

MODERATOR What's prompted your company to address the problem of substance abuse? Is it an awareness of a problem in the corporate world as a whole, or do you have evidence of abuse within your own company?

MD: Generally, we just know there's a problem in the country as a whole. It's talked about a lot, it has to touch us in some way. We're a very dynamic company. When we recognize problems we get into them as fast as we can.

SL: What's the average age of your employees? And the ratio of men to women?

EK: We have a lot of women, including most of our branch managers. And I'd guess that the majority of our employees are in their 30s.

SL: From a statistical standpoint, the early 30s is a prime group for substance abuse, including alcohol. Let me ask you an interesting question. How would you describe the average alcoholic?

EK: I think you'd stereotype a male, at the end of his career. A burned out executive.

SL: Do you realize that close to 40% of the alcoholics in this country are women? And that 57% of all women now work? One of the keys to managing substance abuse in the workplace is teaching your managers to recognize it. And the first thing they have to learn is we're not just talking about the stereotypical guy.

MODERATOR Is there a real stress-related issue to alcoholism?

SL: When you talk to alcoholics, you'll find trying to deal with stress is how a lot of them got started. "I need a drink to relax." "I have to have that martini when I get home." But we're not talking just about the alcoholic or drug addict here. We're talking the abuser. There is a difference between a user, an abuser and an addict, and a company has to learn to separate the three. The abusers are the reasons you lose money. Not addicts, abusers.

MODERATOR Is there more to substance abuse than alcohol, cocaine and marijuana?

SL: There are more than 10 million prescription drug abusers in this country, a lot of them white collar executives. And the number one abused drug is valium. You can get a prescription from almost any doctor. Often that's how it starts, and it's all legal.

MODERATOR Does Countrywide have a stated drug policy?

EK: We have a policy of not using on the premises. We don't have a drug screening or testing program.

MODERATOR Are you setting one up?

MD: Yes. We've looked into programs two or three times in the last few years. And working with our corporate counsel, it's been very difficult to identify what kind of a program Countrywide can have.

MODERATOR Is that part of the problem? There isn't much out there in the way of successful models.

MD: On the health industry side, there's a lot of ideas about how to do it, but when you look at how many companies have done it, and at how many companies have gotten sued as a result, there isn't a lot of experience out there for people to hang their hats on.

MODERATOR Is that a big threat, potential litigation?

MD: In California it is.

LE: Do you see that as the major stumbling block for your company?

EK: That's certainly part of it, but I really think the bigger issue is that you can't see the problem.

DS: I think it's important to understand that Countrywide's a fairly young company. It's a very health conscious company. They have a corporate gym and a health director, which is not a common thing in this business. But it was an awareness of stress and the claims problem regarding stress that really caused Countrywide to become aware of the issue of substance abuse.

MODERATOR How was it manifesting itself? Claims, days off, employee theft?

DS: Stress was manifesting itself in terms of increased workers' compensation claims costs and the difficulty in buying workers' compensation insurance. Once they found out about it, they took a proactive approach to dealing with it. That led to looking at an employee assistance program which led them into an awareness of substance abuse and the attitude that, "Hey, substance abuse is a problem throughout society, what's to make us think it's not a problem here." Although they have not specifically identified, even now, a substance abuse problem.

MODERATOR As a broker, have you found claims costs to be the trigger? Do companies start to look for a problem before the claims start to pile up and the premiums accelerate?

DS: I expect that it's an unusual company that would take a proactive approach to a societal problem before it financially impacts the organization. The fact that our workers' comp claims costs have gone up is really why Argonaut's loss control people came in and started talking about the connection between accelerating costs and productivity. Once Countrywide started looking at the loss of productivity that accompanied the increased costs, they got excited about doing something about it.

MODERATOR So in other words, with many corporations too often it's the "If it ain't broke don't fix it" approach?

DS: I think they're just not aware of it. They have a company to run and mortgage banking is a very complex business with low margins in a complex society and you're running fast just to stay ahead.

MD: We looked at our 23 largest stress claims over the past five years and found out that 17 of them started as medical leave of absences. We felt there was something in there, something that happens, or doesn't happen, during that medical leave that turns it into a stress claim. It's also a matter of communications. We have to communicate to our employees that we're concerned about them. That they're out ill for some reason and we want to help them get back in a healthy state, however we can.

MODERATOR How do you communicate with your employees?

MD: We have a regular newsletter called the "Pipeline" that all employees receive. We have topical articles in there about what our senior management thinks is important to the company and within those articles they address subjects like substance abuse.

MODERATOR How do companies find the substance abusers?

SL: Well, the first thing you need to do is to approach substance abuse in the workplace from a safety and health issue. No one in this company is a police officer, no one is a district attorney. You want to approach the whole idea with the attitude of making it a more safe and healthful place to work. These people are not criminals. They need help.

Recent statistics show the substance abuser is sick three times as often as your average employee. That is a key indicator. You can look down through your list and say, "Okay, the average person takes two days here, three days there, maybe four days a year." You've got somebody over here with 12 or 15 days. That's a very good indicator that there may be some other problem.

LE: Loss runs are another area many companies look at to identify potential substance abusers. They look for individuals that have repetitive injuries. More than a few injuries a year, something is going on in a person's life that is causing them to be injured. That's something that's worth an in-depth look.

SL: You're asking your supervisors to manage a group of people. You've got a performer who's been with you for a couple of years and all of a sudden they're ill more often, they're late for work, their productivity drops, their judgment is impacted. Suddenly you have a mysterious disappearance. A company theft. These are the types of things a supervisor looks for.

MODERATOR What else?

SL: Obviously if a person walks in who can't keep their balance, if their speech is slurred, their pupils dilated, there's something wrong. Now you have to be careful. That person could very well be a diabetic who didn't have their insulin. You don't teach your people to be experts. You teach them to look for a reasonable suspicion that there is something out of the ordinary.

MODERATOR What do you do then? You have a supervisor who's not an expert but who has a reasonable suspicion something is wrong. You have legal counsel skittish about potential legal problems there. How do you address the problem without getting yourself into some serious trouble?

SL: The first thing I recommend is that it not be a hardline program. You're not out to get a criminal, you're not out to terminate employees, you're out to save them. The first thing that you need to consider is an EAP, an Employee Assistance Program. That doesn't mean you have to pay for the care. You just provide access. The problem may turn out to be that John Brown is having marital problems, not substance abuse at all. But if he's driving a company vehicle from one office to another and he's concerned about his wife who left him this morning and he crashes on the Hollywood Freeway, that's a comp claim that the broker and I now have to get involved with paying and that affects you. So before you implement any program, you have to decide what you're going to do with those people who have a problem.

Substance abusers are absent 2 1/2 times more often. Sick 3 times as often. And 65% less productive.

Continued next week

We'd like to hear what you have to say about substance abuse in the workplace, and about our discussions on topics that concern your business. Send your comments to Mike Crall, President, Argonaut Insurance Company, 250 Middlefield Road, Menlo Park, CA 94025.

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Opinions

Help improve regulation

THE SURGE IN DEBATE over how best to regulate the business of insurance for solvency is refreshing, to say the least.

The insurance industry, most will agree, does not have a reputation for embracing with open arms suggestions that it can and should do business differently.

However, we are relieved to see that that is changing, as evidenced in our spotlight report this week on trends in regulation. The three major property/casualty insurance trade associations all are very seriously and resolutely studying a multitude of proposals for improving regulation of insurer solvency.

Proposals for creating minimum financial standards for insurers and state regulation, a federally authorized self-regulatory organization and a federal liquidation and guaranty fund system, including mechanisms to encourage improved state regulation, are among the provocative proposals on the table.

And, as the trade associations ponder what role, if any, the federal government should have in the regulation of insurance, they are all working toward assisting states in improving regulation.

Specifically, it is heartening to hear the trade associations say they are encouraging their members to support state insurance departments in their requests that state legislatures adopt model bills proposed by the National Assn. of Insurance Commissioners to better and more uniformly regulate the industry.

We hope this concerted effort will preclude the special interest groups within the insurance industry from derailing certain model bills that do not entirely suit their tastes.

Adoption of the model laws is essential for states to meet the NAIC's criteria for accreditation under its new program to encourage improved state regulation.

The insurance associations also are supporting increased funding for state regulation where needed, sometimes even if it will mean higher fees charged to their members.

As the NAIC gathers this week for its annual election of officers, commissioners should turn the tables on the horde of insurance industry lobbyists and confirm insurance company commitments to this whole-hearted legislative support for NAIC model bills and funding for their departments.

Whether or not a federal role in insurance regulation is ultimately deemed necessary, every effort has to be made now to improve the existing system of state regulation. State insurance departments will continue to be the kingpins of insurance regulation, so the sooner their operations are improved, the better. And, in the midst of the stimulating debate over a federal role in the regulation of insurance, it cannot be overlooked that state insurance departments day-in and day-out now are the only regulatory authorities preventing and detecting insolvencies.

Letters

Insurer defense tactics don't deserve punishment

To the editor: In reading the letter from William Shernoff in the Nov. 12 edition, his dislike of insurance companies was striking. Somehow the company has become his litigation villain.

The appellation of arrogance has traditionally been applied to lawyers. Perhaps Mr. Shernoff's dislike of insurance companies was created by his contact with defense lawyers.

Insurance companies are heavy users of the defense bar. Legal defense work allows great opportunities for procrastination, inflated discovery, consultants and professional experts, appeals and other attempts to overwhelm plaintiff resources.

Likewise, the plaintiff's bar does not seem to be averse to using threats of litigation costs, allegations of violating the Racketeer Influenced and Corrupt Organizations law, or punitive damages to coerce defendants and their insurers.

These are not insurance company activities, but they are the accepted norms for civil litigation in this country. If these actions seem to be unfair, inefficient or unethical, this can be traced to the needs of lawyers to win. If they diminish justice and equity in their use, those in the legal profession should look to their own profession for any improvement. While insurance companies may use the system, they did not create it.

Finally, when did the concept of punitive damages change from the punishment of a negligent defendant to the punishment of insurance companies for their legal tactics?

Perhaps Mr. Shernoff is not aware that the insurer is not the defendant, but the defendant's monetary resource. If an insurer's tactics are deserving of punishment, then certainly the lawyers, as instigators of the legal tactics used, are just as deserving of punishment.

Robert L. Webster
San Francisco

Business Insurance welcomes letters from its readers. Please keep your comments as brief as possible. We reserve the right to edit letters for clarity or space. We will not publish unsigned letters. Send your comments to Letters to the Editor, Business Insurance, 740 N. Rush St., Chicago, Ill., 60611.

Health benefit tax would hurt workers

To the editor: Edward Martz was way off the mark in his comments on taxing benefits in a Nov. 19 letter to the editor. In trumpeting the taxation of employee health care benefits, Mr. Martz is overlooking several compelling issues.

First, sound federal tax incentives have spawned a comprehensive health care system that provides coverage to nearly 90% of full-time workers and their dependents. While there is a significant "revenue loss" to the Treasury for employer-provided health insurance, these health care benefits are a real bargain to Uncle Sam.

A recent study by the Assn. of Private Pension and Welfare Plans on the taxation of benefits showed that employer health programs paid 5.3 times the foregone federal revenues. No federal program can match that kind of return on the dollar.

The study also showed that those who benefit the most from this tax policy toward health benefits are workers with family incomes below $20,000. They get a relatively larger share of the actual benefits and a larger share of the related tax expenditure than their share of income taxes.

Does Mr. Martz really want to add to the significant tax burden of these working Americans?

Second, employees would not be alone in being taxed. If benefits are counted as additional income, employers would have an increased FICA tax burden. More importantly, Mr. Martz must know that once Congress discovers a revenue source, it is milked for all it's worth. More than likely, legislators would move to limit the employers' tax exclusion for benefits as well.

Finally, how do we structure a tax that is fair and equitable? Surely Mr. Martz must have heard of Section 89. Perhaps the only thing keeping Congress from

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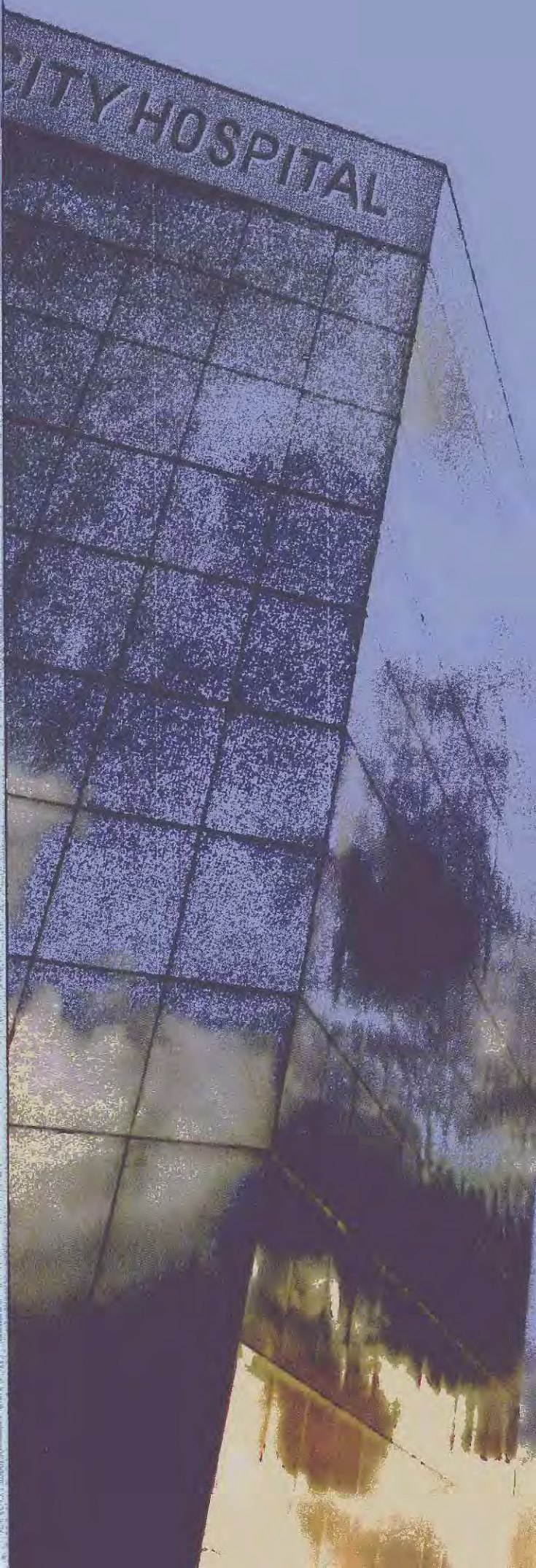

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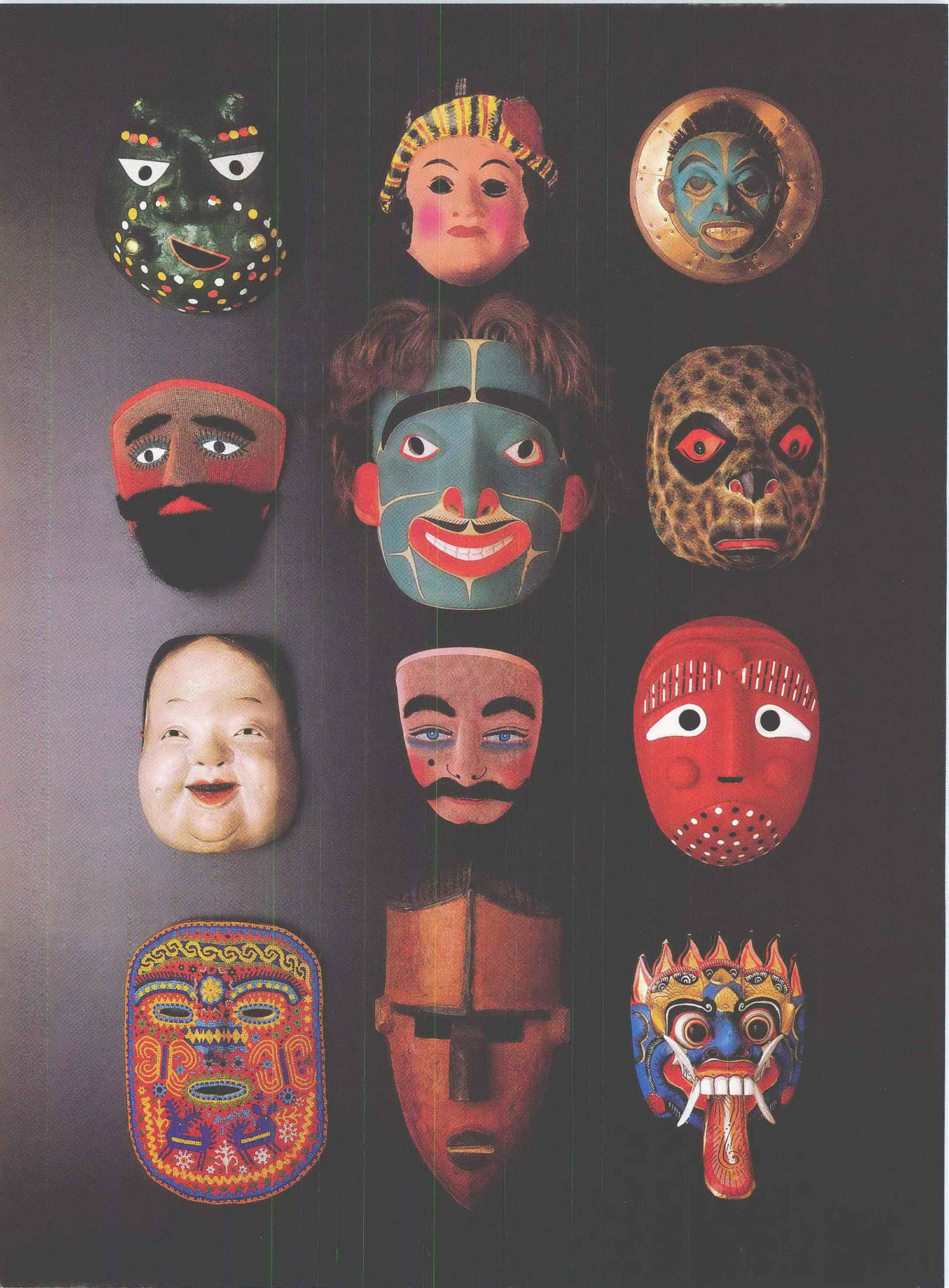

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Spotlight report

Regulators support NAIC accreditation

By MEG FLETCHER

State insurance regulators are enthusiastically endorsing an accreditation program designed to improve state regulation of insurer solvency.

And the New York and Florida insurance departments are moving to become the first departments to be accredited by the National Assn. of Insurance Commissioners, *Business Insurance* has learned.

Support for the accreditation program has become more widespread among state insurance regulators than many industry observers and regulators thought possible.

For example, Phillip Schwartz, vp-financial reporting and associate general counsel of the American Insurance Assn. in Washington, D.C., initially thought some states would be reluctant to agree to accreditation for fear of giving up their autonomy.

Some regulators have in fact criticized the program, but there has been no significant outcry, observers say.

The accreditation program is considered very important to the NAIC and the system of state insurance regulation, whose image has been tarnished by recent insurance company insolvencies.

State insurance commissioners hope accreditation will raise the threshold of regulatory practices and help persuade those critical of state oversight that a federal role in insurance regulation is not needed.

"The theory is that state insurance regulation is only as strong as its weakest link," said Richard P. Hefferan, vp-tax and accounting for the Alliance of American Insurers in Schaumburg, Ill.

Internally for the NAIC, the accreditation program "gives the NAIC more clout to get state regulators in line," said James E. Long, North Carolina's insurance commissioner and vp of the NAIC.

Accreditation would be based on whether state departments have authority, resources and programs to adequately regulate the solvency of insurance companies domiciled in that state (see story, page 13).

The concept of an accreditation program—spearheaded by Illinois Insurance Department regulators—was adopted by the NAIC in June 1989 after researching a similar program used by state bank regulators. The NAIC formalized the accreditation process a year later (*BI*, June 18; June 19, 1989).

The accreditation program is "truly a historic step for insurance regulation," said Earl Pomeroy, NAIC president and North Dakota commissioner.

"Consumers will benefit from this action, as standards identify the authority and the resources needed to protect the policyholder from insurance bankruptcy," he said.

Brokers eventually may consider not only an insurance company's rating but also at whether its state of domicile is accredited, according to Mr. Pomeroy.

Insurers could also benefit if those domiciled in accredited states are examined less often by regulators in other states.

The program also could lead to a streamlined approval process to be used when insurers seek authority to begin writing business in another state.

"It's a very significant step for the NAIC," said Mr. Long, who is in line to be elected NAIC president during the group's meeting this week in Louisville, Ky.

"Anything that would help to raise the standard of regulation is a positive," said Myron M. Picoult, senior vp and senior insurance analyst with Oppenheimer & Co. in New York.

However, one observer, who did not want to be named, said he thought the accreditation program was a public relations effort.

"Much of this is posturing to demonstrate to the federal government and the public that state regulation of insurance works and is very efficient," the observer said.

The accreditation program also may increase friction between complying states and those that cannot or will not meet the standards immediately, others point out.

"There will be increased pressure on states that don't meet the standards," Mr. Long said.

But unless all state insurance departments are accredited, there will be weak links in the regulatory chain, he said.

"We can't tolerate that," Mr. Long added.

Zack Stamp, director of the Illinois Insurance Department and chairman of the NAIC Financial Regulation Standards and Accreditation Committee, said the program is "a very big roll of the dice for the NAIC, as a voluntary association, to take."

If a substantial number of state insurance departments do not adopt the accreditation standards within a few years, "we give critics a stake to drive through our heart because we will have demonstrated we can't do our job," Mr. Stamp said.

But, so far, that fate appears unlikely.

State regulators' support of the program has been "tremendous," according to James Schacht, chief deputy director of the Illinois Insurance Department.

Since June 1989, all but one state insurance department has gone through a self-evaluation process, Mr. Schacht said, declining to identify the lone state.

In addition, *Business Insurance* has learned that the New York and Florida departments opened their records this fall for a confidential evaluation by an NAIC team consisting of three to six individuals drawn from a pool of former regulators, insurance industry executives and academics.

The results will be presented to Mr. Stamp's accreditation committee. If the committee votes to accredit the New York and Florida departments, the NAIC Executive Committee is expected to ratify the action, sources say.

NAIC officials say they do not plan to disclose which state departments the accreditation committee initially rejects.

In addition, eight other states are seeking to be accredited next year, according to Mr. Schacht.

And other state insurance commissioners have indicated that they intend to propose adopting state laws that would meet the accreditation standards, said Bob Zeman, associate general counsel of the National Assn. of Independent Insurers in Des Plaines, Ill.

Meanwhile, the New York Insurance Department is considering adopting an NAIC model act on producer-controlled insurers that is among those required by the accreditation program.

The NAIC also is beginning to offer states incentives to become accredited.

For example, regulators are required to examine insurers licensed in their states periodically, although

Continued on next page

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Continued from previous page
they may accept an examination from another state—usually the domiciliary state.

A proposed model law would let regulators accept only reports done by an accredited state insurance department.

This will provide an incentive for states to become accredited, regulators say.

Non-domiciliary states could avoid duplicating examinations and could instead target other troubled domestic companies earlier, insurance regulators say.

Mr. Long said he hopes that all 50 states will become accredited within the next five years.

All three property/casualty insurer trade associations support the NAIC's accreditation program.

"I think financial regulatory standards are useful, and I think it will be helpful to have all states in compliance," according to the AIA's Mr. Schwartz.

"It will go a long way to improve state regulation," he said.

However, the industry observer pointed out that the program—as part of a larger NAIC effort to bolster regulation of insurer solvency—is having some unintended consequences.

States have been so active in adopting new policies and procedures, like mandating certification of loss reserves, that they have "rattled the cage" of many insurers that previously had either complacently supported state regulation or had not thought about the topic, the industry observer said.

As a result, those insurers are now considering such options as a larger role for federal regulators in insurance regulation, he said (see story, page 3).

"The very response of state regulators is perhaps causing just the opposite of what they want to have happen," according to the industry observer. ■

Accreditation standards detailed

By MEG FLETCHER

Accreditation standards adopted by the National Assn. of Insurance Commissioners detail all procedures a state insurance department should follow to properly evaluate and regulate insurer solvency, the group says.

The NAIC describes the accreditation program as an outgrowth of its goal of setting uniform regulatory standards among state insurance departments through various model regulations, standardized reporting formats and manuals.

Establishing these standards, the commissioners say, would show governors and legislators what resources are needed to effectively regulate and monitor insurers.

For example, obtaining adequate staffing is a "big problem nationwide," said Fabian Chavez, insurance superintendent in New Mexico and a supporter of the program.

The six-page outline of the NAIC accreditation standards lists three categories the NAIC says reflect the full scope of a state regulator's duties: laws and regulations; regulatory practices and procedures; organizational and personnel practices.

To become accredited, a state must adopt laws and regulations that allow the regulator to:

- Examine an insurer's books and records and ask company officials pertinent questions under oath. That authority also should extend to the records and officials of affiliated companies, agents or managing general agents.
- Require an insurer to maintain an acceptable financial status, including minimum capital and surplus levels. Regulators should also be able to evaluate the quality of an insurer's assets and require companies to maintain a diversified investment portfolio and have adequate, actuarially certified, loss reserves.

An insurer should value its securities according to standards from the NAIC Securities Valuation Office and its Financial Condition (EX4) Subcommittee.

State law should proscribe the maximum net amount of risk to be retained by a property/casualty company, which should be no larger than 10% of the company's capital and surplus per risk. Regulators also should be able to require that all insurers reporting to the department file an annual statement that meets NAIC Accounting Practices and Procedures Manual requirements, and that domestic insurers participate in the NAIC Insurance Regulatory Information System.

- Operate under NAIC model laws or very similar laws that regulate holding companies, insurers in a hazardous condition, credit for reinsurance, audited financial reports, receivership, risk retention groups and producer-controlled insurers. State law also should provide for a guaranty fund or other mechanism to pay an insolvent insurer's obligations to policyholders.

The second part of the NAIC standards require a state regulator to follow proper regulatory practices and procedures, including having a staff of capable financial analysts as well as necessary data.

Regulators should use a priority system to ensure that they review ailing companies first, and insurers should be subject to various levels of review and reporting requirements to ensure adequate oversight.

Departments also should communicate all relevant data to departments in other states.

In conducting financial examinations, the department should have: resources to examine all domestic companies periodically, qualified specialists performing the examinations and a system of supervisory review of examination work papers.

Insurer examinations should follow the policies and procedures in the NAIC Examiners Handbook.

Adverse results should be promptly presented to the commissioner, who should notify other states in which the company transacts business.

The third part of the program calls for a department to have organizational and personnel practices including: minimum educational and experience requirements for staff members, adequate pay, periodic evaluations and a professional development program, which includes training and attendance at NAIC meetings for key regulators.

In addition, one individual—who reports directly to the commissioner—should be responsible for all financial regulation and surveillance.

An accredited state will receive a certificate that will be formally presented at the next NAIC meeting.

The NAIC expects that a certificate would be good for five years, subject to annual reviews of a state's self-evaluation.

But, if the standards change during that five-year period, an accredited state would be given a specified time period—perhaps two years—to implement those changes so it can maintain its accreditation, say regulators, who are still spelling out some of the fine points of the program.

NAIC officials say they do not plan to disclose which state departments were rejected by the accreditation committee.

If a department is rejected, a state regulator then would have three options: withdraw the request for accreditation; ask the committee to hold its decision in abeyance pending attempts to meet the standards; or ask the accreditation committee to reconsider its decision. ■

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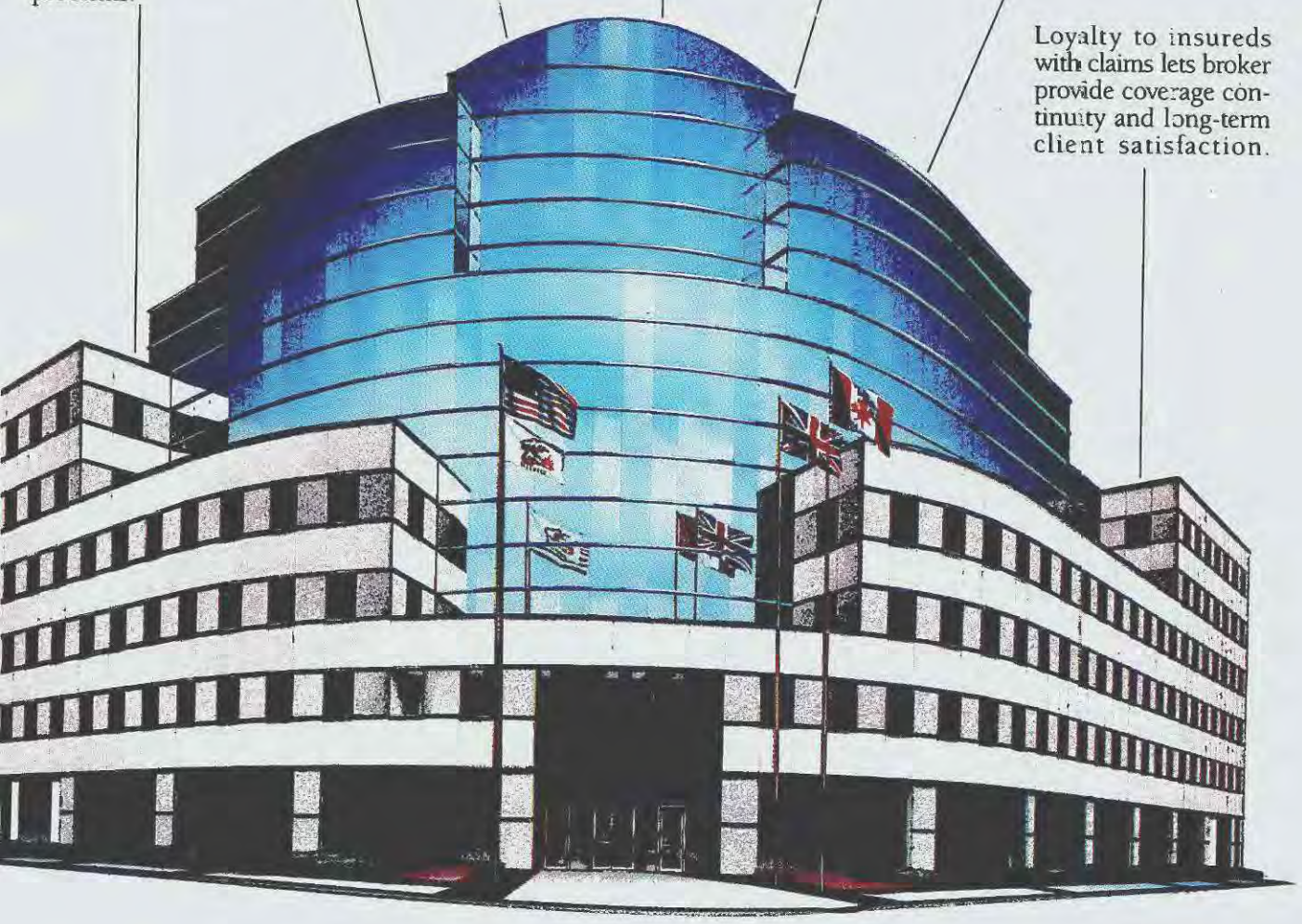


A N D S P E C I A L T Y I N S U R A N C E

Minnesota task force seeks tighter regs

By MICHAEL BRADFORD

ST. PAUL, Minn.—A Minnesota task force recommends giving state regulators more authority to scrutinize insurers' finances and to take quicker action against financially ailing insurers.

Composed of 10 insurance company presidents and four state Commerce Department officials, the group recommended, among other things, stricter monitoring of insurer capital and caps on junk bond holdings.

However, some industry spokesmen fear the panel's advice will be lost in the shuffle when a new governor takes office next year.

Normally Commerce Department officials—who are responsible for state insurance regulation—would draft a bill containing the task force's recommendations. But Thomas H. Borman, a major supporter of the Insurance Solvency Task Force, is unlikely to continue as commerce commissioner under Gov.-Elect Arne Carlson.

That complicates the process, according to Dave Cummings, president of the Minnesota Insurance Information Center, an insurer-funded public relations group.

Mr. Carlson, a former state auditor, won a narrow upset victory over Gov. Rudy Perpich in November.

However, Coleman Bloomfield, chief executive officer of Minnesota Mutual Life Insurance Co. and head of the task force, said he expects that a "new commissioner will be just as interested in strengthening solvency as his predecessor."

He predicts only a minimal slowdown in the panel's work. If there is a change in the commerce department administration, "we will be dealing with new people," he said. "It will take some time for them to study the contents of the report."

One proposal by the task force, which was jointly established in May by Mr. Borman and Minnesota insurers, is to improve regulation by giving the commissioner "flexibility to work with an insurer's management to address financial, rate, marketing and investment problems."

The task force proposal, along with other proposals, said Mr. Cummings, is designed to allow regulators to "come into the process at an earlier stage" rather than being relegated to damage control after companies fail.

The panel recommended that the department devise what it called "risk-adjusted" measures of capital to better account for risk in a company's investments and reinsurance. Regulators would develop separate formulas for life/health and property/casualty companies, with the latter also being required to annually certify loss reserves.

The task force also would cap the junk bond investments of domestic insurers at 15% of total admitted assets. Only a few states, including Florida, New York and Illinois, now limit non-investment grade bond holdings; those three states set the maximum at about 20%.

Insurance company directors, the solvency panel suggests, should have a role in guiding insurer investments. Directors, the report said, should "develop and maintain broad" policies on asset diversification, concentration of risks, interest rate risks, liquidity, real estate loans and real estate.

The panel also advised that insurers must establish procedures for the accurate valuation of distressed real estate loans.

The report also recommended that the Commerce Department better detect and monitor troubled insurers through a "more targeted examination approach" including:

- Auditing most insurers with a "significant percentage of premiums in Minnesota" at least once a year. Semi-annual or quarterly audits are recommended for "potentially troubled" insurers.
- Having auditors from outside the department assist in examinations.
- Increasing participation in the National Assn. of Insurance Commissioners' efforts to coordinate information exchange among states.
- Examining insurers that are "clearly in sound financial condition" only once every five years.

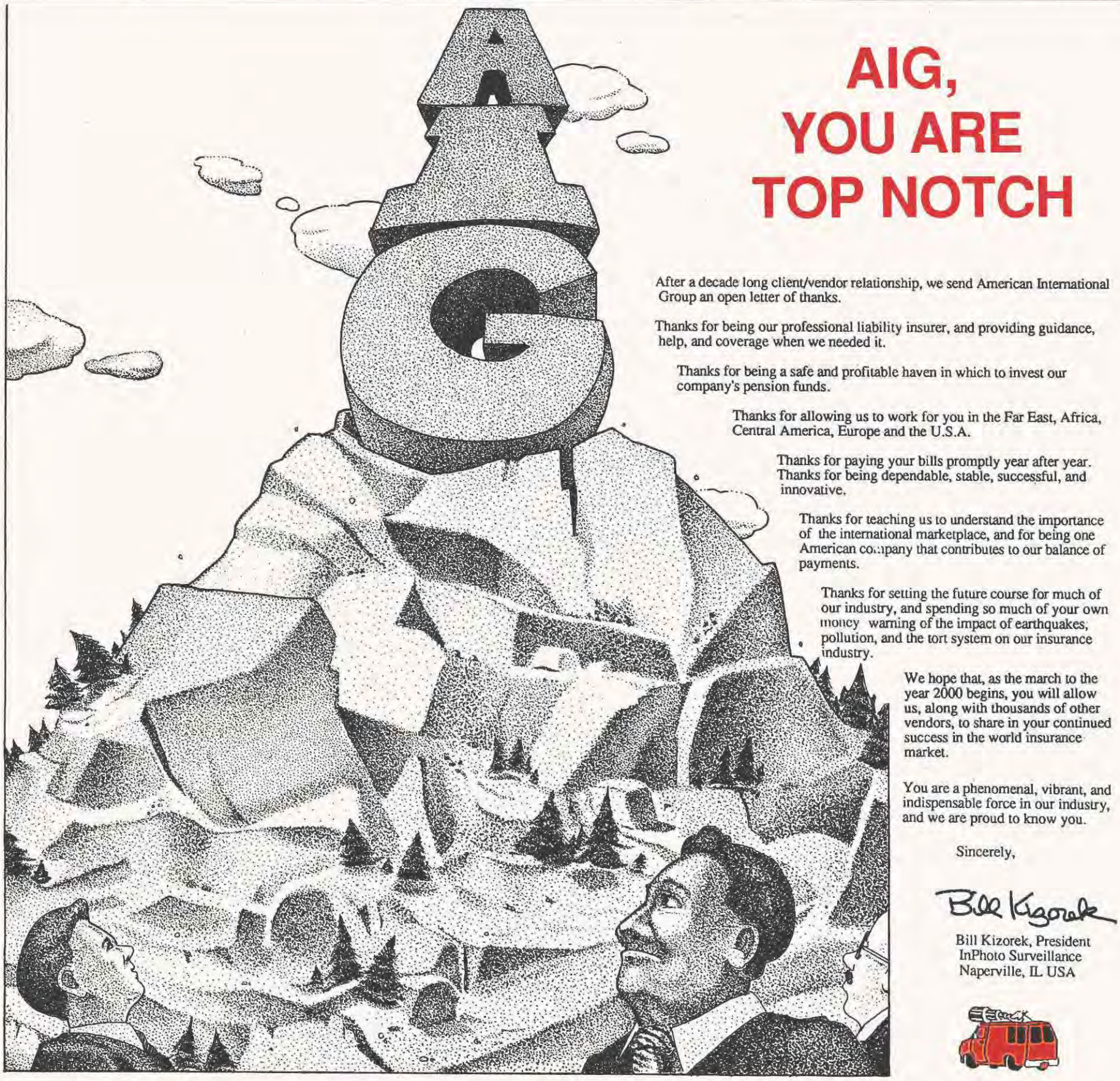
The task force also suggested amending the Minnesota property/casualty and life/health guaranty funds to bring them in line with the NAIC models. Little revision would be required for the property/casualty fund, but the life/health fund would need substantial reworking, the report says.

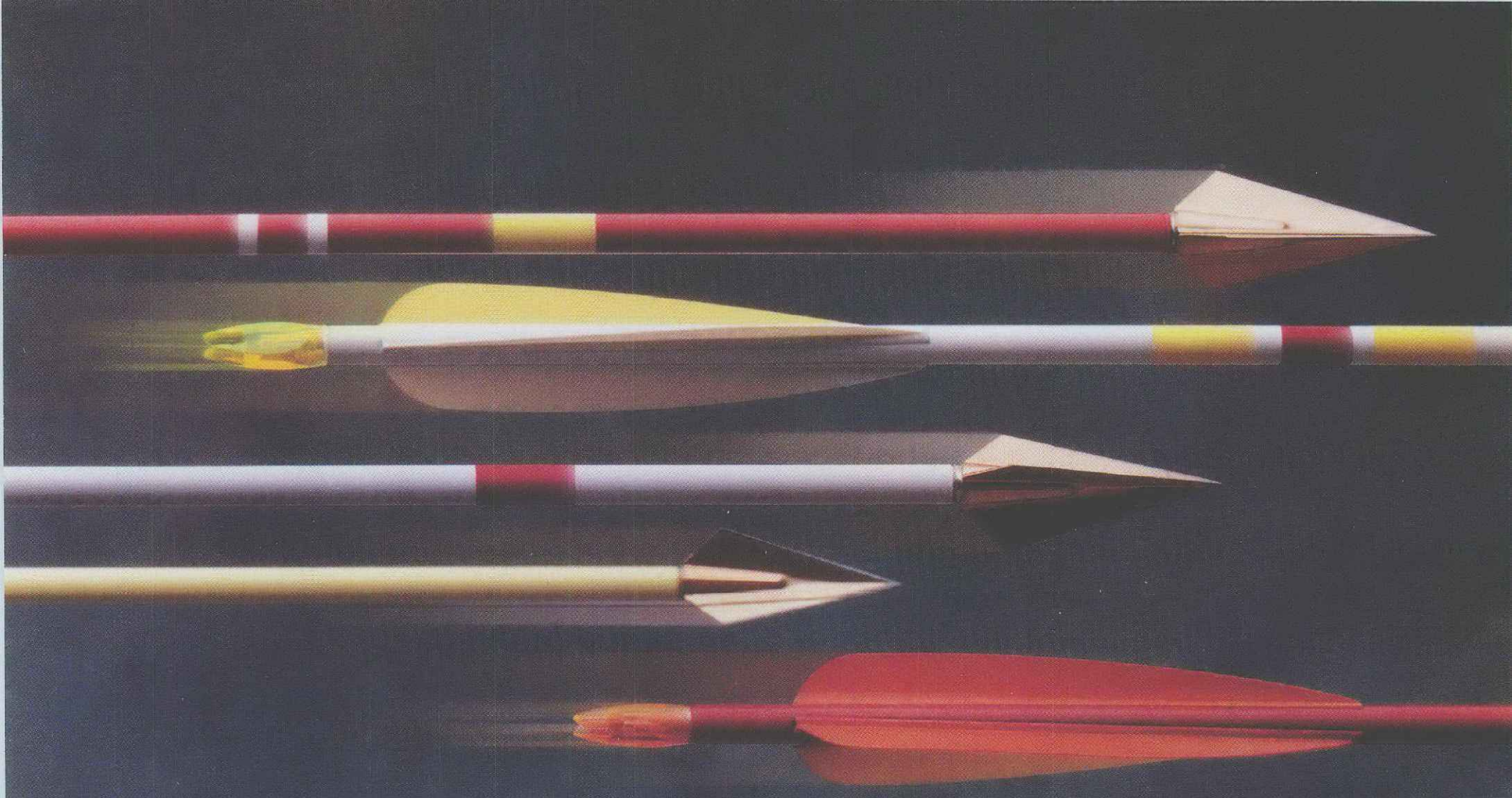
NAIC model laws on reinsurance regulation should also be adopted, the report says, including those covering the eligibility of reinsurers and financial reinsurance.

Like other state regulators, the Minnesota Commerce Department is seeking more money to hire staff. The task force said it "strongly supports the principle that the (department) have adequate qualified personnel to perform the additional responsibilities recommended in this report."

Added funding would probably come from higher fees on insurers operating in the state, though it is unclear which charges would be raised, said Mr. Cummings.

It is unclear how many more staffers would be needed, he said, though the report mentions a "substantial increase in the number of examination staff positions." ■





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Spotlight report

State regulators seek more money, staffers

By MICHAEL BRADFORD

State insurance regulators are asking for two things that they say will improve their work: more money and more people.

Regulators contend that they are doing an adequate job of monitoring solvency, though they say inadequate staffs and budgets cause some problems.

Pinched budgets mean insurance department staffers are not receiving the training they need and departments can't get the technology in place to improve efficiency, regulators and industry sources point out. Low salaries also make it difficult to attract and retain quality employees, they say.

Many insurance industry officials agree that regulators would do a better job with more money and larger staffs.

"The funding issue has got to be met," says Patricia Borowski, vp-government and industry affairs with the National Assn. of Professional Insurance Agents in Alexandria, Va.

"Critics of the insurance industry tend to point their barbs at insurance regulators, as if the insurance regulators didn't understand they need more money," she noted.

At the PIA, Ms. Borowski said, "our disappointment has always been directed at state decision makers: the legislatures and governors."

Insurance premium taxes make up large portions of state revenues, though regulators rarely get adequate funding for their operations, she contends.

Robert E. Vagley, president of the American Insurance Assn. in Washington, D.C., argued against raising premium taxes, but said more of those revenues should go to solvency regulation.

"I'm talking about dedicating more of the dollars that already are paid by insurance companies. . .to state solvency regulation," Mr. Vagley emphasized.

Only a "very small portion" of those taxes now go toward state regulation generally, much less state solvency regulation," he said.

'Critics of the insurance industry tend to point their barbs at insurance regulators, as if the insurance regulators didn't understand they need more money,' says Patricia Borowski of the National Assn. of Professional Insurance Agents.

Lack of funding means regulators are not adequately trained and cannot upgrade their computer equipment, he said. "I think they ought to have those resources because that will make them more efficient and more effective."

Albert Lewis, the New York superintendent of insurance from 1978 to 1983, said insurers should be responsible for providing some of the needed funds. "Companies should fund their own regulation they way they do in New York."

Companies in the state pay a fee based partly on the insurance department's projected needs and the insurer's premium volume, explained Mr. Lewis, now an attorney with Cole & Deitz in New York.

He agreed that regulators lack the staffs needed to examine filings to determine which companies are in trouble.

Regulation would be strengthened if departments could offer higher salaries to attract top-notch personnel, he added.

Insurance commissioners have "the most awesome responsibility" of any state regulator, Mr. Lewis remarked. They not only have to become experts in various types of insurance, but are responsible for administering the agency, he said.

Increased funding could help train personnel and attract more staffers to share the workload, Mr. Lewis said.

Insurers doing business in North Carolina will face higher fees to supplement state regulatory funding, said James E. Long, the state insurance commissioner.

Although North Carolina legislators have treated the department generously in the past, a large budget deficit made more revenue difficult to come by this year, Mr. Long said. So regulators will "be more creative" in using filing fees to raise revenue, he added.

James E. Saxton Jr., chairman of the Texas State Board of Insurance, maintains that his department does a good job of monitoring insurers.

A state grand jury and the state auditor disagree. Both recently criticized the Texas department for what they called lax enforcement of state laws (*BI*, Oct. 29; Oct. 8).

Mr. Saxton said he is pushing for legislation that will allow regulators to act more quickly against troubled companies and hopes to add 10 to 15 examiners by "readjusting the budget" to come up with salaries.

Regulators in smaller states are particularly strapped for funds, according to Oklahoma Insurance Commissioner Gerald Grimes.

Low salaries can result in too much turnover among staffers, he said, "and in a small state like mine, with 100 employees, if you lose one or two key employees, it's a big blow."

The Oklahoma department routinely asks legislators for more funding, he said, "but our state is like most others. Legislators have their priorities—things that are important in their minds, too."

The call for increased state funding is not unanimous.

Washington attorney George K. Bernstein told a national audience at a teleconference sponsored by the American Bar Assn. that departments have enough money and personnel to do their jobs properly (*BI*, Nov. 12).

With a total of 6,000 state insurance department employees and $300 million in funding for all 50 states, regulators are equipped to properly monitor insurers, Mr. Bernstein contends.

Instead of a lack of staffers and funding, Mr. Bernstein contends that there is a "lack of will" among regulators to act against financially troubled companies (see story, page 6). ■

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Spotlight report

Report recommends national guaranty fund

By KATHRYN J. McINTYRE

A national guaranty fund system and liquidation process is needed to cope with modern property/casualty insurance company insolvencies, a leading insurance consulting firm says.

Fragmented state funds "were not designed" for the large and complex insolvencies involving general liability coverage that comprise the most recent and anticipated failures, says Stewart Economics Inc. of Chapel Hill, N.C., in a recent report.

"They were not designed for general liability insurers faced with mass torts where disputes over coverage and underlying liability routinely last a decade," says the report "Insurance Solvency Guarantees."

Vital differences among state guaranty funds—including amounts guaranteed, extent of coverage, persons eligible for protection, premium bases for assessments and caps on assessments—can produce "uneven economic results and drawn-out litigation over large amounts of money," the report says.

In addition, the cost of liquidations involving general liability insurance increases with their complexity and geographic reach, the report notes. "Administering them will call for expertise which no insurance department now has."

Having outside law, accounting and consulting firms handle liquidations would be more costly than assigning them to a new national organization that would "build its own expertise and use it for more efficient liquidation."

Stewart Economics proposes that state regulators remain responsible for detecting troubled companies and taking necessary action, but the proposal also incorporates mechanisms to "provide additional stimulus to good state regulation," said Richard S.L. Roddis, the firm's managing director and a former regulator.

The report was commissioned by more than a half-dozen major property/casualty insurers following a May discussion of public policy issues with the three principals of Stewart Economics: Chairman Richard E. Stewart, also a former regulator; President Barbara D. Stewart, an economist; and Mr. Roddis. Among the insurers were United Services Automobile Assn., State Farm Mutual Automobile Insurance Co., Allstate Insurance Co., Liberty Mutual Insurance Co., Nationwide Mutual Insurance Co., USF&G Corp., Fireman's Fund Insurance Co. and Government Employees Insurance Co.

"We are not espousing any one company's position," Ms. Stewart said. "The report was underwritten by the group to get something out there to discuss."

Under the Stewart Economics proposal—contained in a 59-page report and detailed in a 67-page proposed text for legislation—Congress would create a National Insurance Guaranty Corp. to administer a national liquidation system and guarantee coverage for claims against insolvent insurers.

Insurance companies could elect to join the NIGC, freeing them from participation in state guaranty funds, and states could require insurers they license to join.

The agency would conduct the liquidations of insolvent members transferred to it after state insurance departments had brought regulatory proceedings. States could retain the control of a rehabilitation or liquidation, but NIGC coverage of claims would not apply.

As under the current system, the NIGC would be financed by assessments on insurers. The cost of covering claims exceeding the available estate of an insolvent insurer would be charged to insurers in the state and the line of insurance involved. This by-line assessment differs from the current system of assessing insurers in proportion to premiums in the state in all covered lines.

The by-line, by-state assessment system is designed "in the interest of fairness and of getting costs back into market prices so as to affect behavior," the report notes.

"The idea is to internalize the solvency risk to the class of insurance," Mr. Roddis said, adding that the report emphasizes that "it is the nature of the insurance that creates the insolvency hazard."

General liability insurance, the report explains, can create insolvencies "out of all proportion to its premium volume." General liability lines, as defined in the report, include professional liability coverages. They account for 11% of premiums, compared with 13% for workers compensation and 35% for personal auto insurance.

The report notes that insurers' difficulties in pricing general liability insurance due to "the long period of loss cost uncertainty and the complexity of the forces at work," along with adverse developments in underlying tort law and insurance contract rules, make the line especially vulnerable to underpricing, thus creating insolvencies. Also, during the last 30 years, policyholders increasingly have self-funded more predictable liability losses, leaving the less stable risks to be funded by insurance, the report notes.

Basing guaranty fund assessments not only on the line of insurance but also on the states from which the claims against the insolvent company arise is intended to "counteract any tendency for a state to use liberal tort law, suppressed rates and easy regulation to obtain a transfer of wealth from others," the report says.

The NIGC also would assess preinsolvency charges to cover operating costs and the initial costs of administering the estates of failed companies. These charges would be based on the risk of insolvencies posed by a line, state or even a company.

"To strengthen the total system and to safeguard the national fund," the NIGC also would have the power to warn a state that one of its domiciled insurers was in hazardous financial condition. If the state did not take regulatory action within 60 days of the notice or if the member company did not seek receivership with the NIGC within 75 days, the NIGC's guaranty obligations would cease.

Financial analysts with the agency could audit members when required.

In addition, "NIGC guarantees would be designed so that large policyholders, brokers, reinsurers and other professionals in the private sector would have financial incentives for close surveillance of the financial condition of insurance companies," the report says.

For example, to make insurance buyers more vigilant about insurer solvency, the NIGC would pay claims subject to a uniform cap of

Continued on next page

DIFFICULT

REINSURANCE

PROBLEM?

Continued from previous page
$300,000, but recovery to policyholders would be reduced by any underlying self-insured retention or underlying insurance provided by a solvent insurer. For example, if a policyholder had an SIR of $100,000 applicable to a $500,000 claim against $400,000 in excess insurance written by an insolvent excess insurer, the NIGC would pay only $200,000.

In addition, the NIGC would cover claims of $100,000 to $200,000 filed by the policyholder at 90% and only 80% for the portion from $200,000 to $300,000.

The NIGC also would demand that a policyholder with a net worth exceeding $50 million reimburse the NIGC for any liability claim paid following the insolvency of its insurer.

"That approach seems well-suited to general liability insolvencies, where a single policyholder can have many claims against it and where the policyholder may be large but the claimants individually small," the report says.

As an incentive for reinsurers to watch the credit quality of ceding companies, a reinsurer would not be permitted to offset amounts it owes an insolvent insurer for claims by amounts it is owed in reinsurance premiums.

Stewart Economics recommends that the NIGC include a "mix of public and private participation and state and federal governments," with its directors drawn from insurance companies, state insurance departments and the federal government.

While initially the NIGC would be required to accept for membership all licensed insurers except surplus lines and reinsurance companies, it could set higher qualifications for membership to take effect five years after adoption.

The three property/casualty insurance trade associations are reserving judgment on the proposal.

"It deserves attention and does have some allure," said Robert E. Vagley, president of the American Insurance Assn.

But, it "misses the political mark" in terms of the concerns in Congress over the role of foreign reinsurance, mismanagement, and theft and fraud in insurance company insolvencies, he said.

It also does not call for removing large commercial insurance buyers entirely from guaranty fund coverage and assessments, which the AIA supports, Mr. Vagley pointed out.

While not committing to a specific cut-off, Mr. Vagley suggested that only commercial insurance buyers with less than about $1 million in revenues should receive guaranty fund protection.

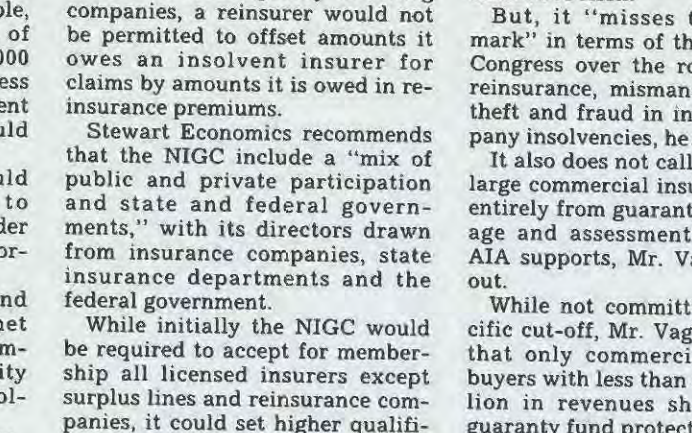
"We have members who consider (the report) a very constructive contribution," said Lowell R. Beck, president of the National Assn. of Independent Insurers. "But a question is how can you so succinctly separate a national guaranty fund from the regulation of rates and the setting of inadequate rates?

"There are serious problems and questions, but I can't say we won't favor it," he said.

Franklin W. Nutter, president of the Alliance of American Insurers, said: "We have it under careful study. We have neither embraced it nor rejected it."

However, Mr. Nutter is concerned that if the proposed NIGC did not assume much of the financial examination and oversight currently conducted by the states, it would not necessarily improve state regulation.

Mr. Roddis responds that the NIGC "is not intended to supplant state regulation," but its power to audit insurer members would be used on a "targeted basis" that would "provide additional stimulus for good regulation." ■



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GATT talks

Continued from page 3
marks the first time that services have been included in GATT negotiations, but also marks the debut of the insurance industry as an active participant.

Advisory committees like the International Insurance Council, the National Assn. of Insurance Commissioners' international task force and the Coalition of Service Industries Inc. have been working closely with U.S. negotiators from the Office of the U.S. Trade Representative and the Commerce and Treasury departments.

In fact, the insurance industry was instrumental in getting the GATT talks even to consider services as negotiable, according to Ms. Wigglesworth of the Coalition of Service Industries.

The coalition was founded in 1982 by AIG's Mr. Greenberg to represent multinational service companies from all sectors that had been held back from international expansion because of trade restrictions.

"As recently as 1974, most of official Washington could not even spell the word 'services,' " said Chubb's Mr. Parker. "And yet service industries account for 70% of the gross national product of the United States."

But while multinational insurers like AIG, Chubb and CIGNA have been at the forefront in developing an international services agreement, overseas markets have been largely neglected by the rest of the U.S. insurance industry, said Patricia A. Borowski, vp of government and industry affairs for the PIA.

This attitude has permitted foreign insurers to get a toehold in the U.S. market through acquisitions and increased activity by foreign producers placing business in the United States, she contends. Recent examples, she said, include the purchase of Fireman's Fund Insurance Co. by German insurer Allianz A.G. Holdings (*BI*, Aug. 6), and a more recent bid by foreign investors for The Home Insurance Co. (*BI*, Oct. 8).

In 1986, 143 insurance branches, subsidiaries and agencies established in the United States by foreign entities accounted for $33 billion in sales, or almost 8% of the U.S. insurance market, Chubb's Mr. Parker said. It is safe to assume that the figure is considerably higher today, he added.

But while insurers from foreign countries continue to stream into the United States, many of these same countries maintain stringent restrictions on the entry of foreign investors into their own insurance markets—some of which, like India, are state-run monopolies, Mr. Parker said.

For example, 26 countries do not allow foreign insurers to operate in any way, said Chubb's Mr. Parker. Thirty or so others mandate that all, or a portion, of risks written by a foreign insurer be placed with a state-owned or controlled reinsurance monopoly; and about 63 countries provide international insurers with only limited access to their markets by restricting licenses granted to only a few classes of business, he added.

These restrictions may cost U.S. insurers growth potential since overseas insurance markets are growing more quickly than the U.S. market.

"We grew 2.1% domestically last year (in property/casualty premium), while Europe grew at twice that rate, and Asia at six times that rate," Mr. Parker noted.

It is these issues that the insurance advisory committees have pressed for in the Uruguay round of GATT.

But while the negotiators have willingly presented the insurance

Continued on next page

GATT talks

Continued from previous page
industry's point of view, the proceedings have been bogged down on several fronts.

Because this is the first time services are being discussed, having been postponed from the Tokyo round of GATT that concluded in 1980, the negotiators are at a disadvantage because they must create new guidelines, said Ms. Wigglesworth of the Coalition of Service Industries.

The Uruguay round also represents the first time that less-developed countries and a new unified Germany have been invited to participate, she added.

Upcoming changes in the European Community have introduced unforeseen complexities, and specific issues like farm subsidies have threatened the talks as a whole, Ms. Wigglesworth said.

While these other issues do not directly affect the separately negotiated services issues, they disrupt the "balance of commitments and concessions," which is the "glue" that holds the talks together, said a spokesman for AIG.

Because that balance is so vital to the GATT talks, negotiations are structured in three levels, according to the spokesman: the main, or "Superlevel"; the "Group for Negotiation on Services"; and the "Financial Services Annex."

Only the financial services talks involve insurance.

The Superlevel discussions, which are the main focus of the GATT talks, are divided into 14 subgroups covering goods, like agriculture, textiles and other products. These talks have been deadlocked over agricultural subsidies, among other things.

The second level, involving the GNS discussions, is negotiated by 15 nations separately from the talks on goods and products, and covers services like construction, law, entertainment, telecommunications, aviation and "anything you can't drop on your foot," the AIG spokesman said.

The main focus of the GNS, from the U.S. perspective, is how to improve the ability of U.S. firms to enter into and compete in foreign markets, he said.

Financial issues seem to be 'the brightest area there is on this gloomy landscape,' says Ms. Powers.

The GNS talks have been attempting to draft a general agreement that would serve as a framework for negotiation on the entire services sector, excluding insurance and other financial services. The negotiations were stalled though, partly because of bitter disagreements over the draft's wording and because of the failure of the Superlevel negotiators to reach an agreement.

Some problems in the GNS were caused by the U.S. negotiators insisting that aviation, maritime and basic telecommunications services be excluded from any agreement, the AIG spokesman said.

Such "carve-outs" could preserve arrangements, like airplane landing rights, that the United States has with other countries.

But they also threaten a basic tenet of the GATT talks, that of "most favored nations," in which all signatories to an agreement would be extended the same arrangement, he said.

The insurance industry is concerned that by creating such exclusions, the United States could invite similar demands by foreign countries, possibly in insurance, the spokesman said.

Insurance, banking and securities are dealt with exclusively in the Financial Services Annex, a spinoff of the GNS talks. These three service areas have special requirements that a general services trade agreement would not address, the spokesman said.

While the financial services level addresses many of the same issues as the GNS talks, it is dealing with more specifics and "tougher, more binding language," he said.

On insurance, the annex addressed a range of issues on how countries are required to treat foreign insurance and reinsurance companies operating in their markets. Issues included admittance into foreign markets, licensing, financial obligations, and flow of profits into and out of the market.

With negotiations on the Superlevel and the GNS bogged down, the Financial Services Annex seems to be "the brightest area there is on this gloomy landscape," said Linda F. Powers, deputy assistant secretary for service industries in the Commerce Department.

However, others say the insurance talks have produced their share of discord.

Several nations are confused by the U.S. system of multistate insurance regulation, said Mr. Davies of the Insurance Advisory Committee.

As Europe makes strides toward uniform regulation and licensing (see story, page 37), some countries see U.S. multistate regulation as a barrier to foreign insurers, he said.

Mr. Parker of Chubb contends that because the U.S. system applies the same basic criteria to foreign and domestic companies, it is not really protectionist. "We are not really imposing on them what we don't impose on our own domestic companies," he said. "But that, of course, does not prevent them from seeing it as an issue."

He noted, however, that 31 states do not allow foreign, state-owned insurers to be licensed, which he said can be a barrier to insurers in France and other countries.

Foreign negotiators are also concerned with separation between the U.S. insurance and banking industries. Banks in Europe and elsewhere routinely sell insurance, but problems could arise, said Chubb's Mr. Parker, if foreign insurance companies try to sell banking products through their U.S. subsidiaries.

This may eventually put pressure on U.S. legislators to amend the "fire walls" now separating the insurance and banking industries, he said.

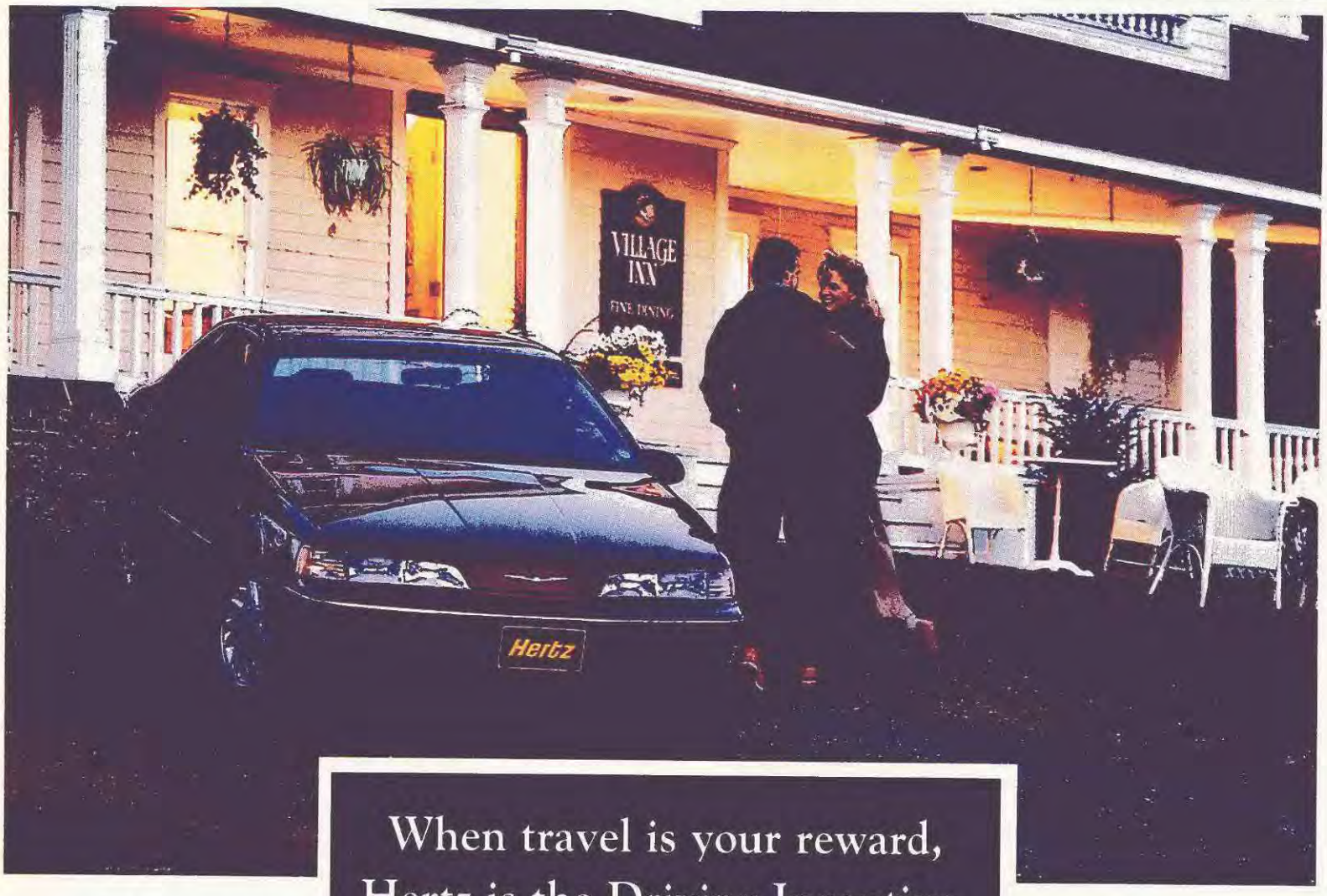
Some GATT advisory organizations, like the National Assn. of Insurance Commissioners, are concerned that a financial services agreement could take precedence over state regulation, said Hawaii Insurance Commissioner Robin Campaniano, chairman of the NAIC's international task force.

However, "it's hard to take aim at a moving target," he said, explaining that since the language of the proposed agreement changes literally from morning to afternoon, it is almost impossible to tell whether it would affect U.S. regulation.

Negotiators themselves say the current draft would not affect the 50-state regulatory system, according to a spokeswoman for one negotiator.

If negotiators fail to reach an agreement by today in the Uruguay round of GATT, countries will revert to bilateral negotiations between countries or blocs, said Ms. Wigglesworth.

A new round of GATT negotiations would commence only when signatories to the talks reach a consensus that a new round is needed, she noted. ■



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Spotlight report

Regulators scrutinize investment risks

By MEG FLETCHER

State insurance regulators are taking steps to limit insurers' risky investments as a way to help ensure life/health as well as property/casualty insurer solvency.

Most of the scrutiny has focused on life insurers' use of high-yield, high-risk junk bonds.

Regulators also are reviewing insurer participation in other investment vehicles like real estate and mortgage loans to assess whether the depressed real estate market threatens insurers' financial stability.

Small insurers are particularly vulnerable to investment problems, experts note, though even huge multiline companies can be affected. Travelers Corp., for example, recently announced it was adding $650 million to real estate and mortgage loan reserves, resulting in a $300 million net loss for the third quarter (*BI*, Oct. 15).

The House Oversight and Investigations Subcommittee, which investigated several major property/casualty insurer insolvencies and issued a report highly critical of state insurance regulation, is emphasizing the need for state regulators to monitor insurance company investment practices (*BI*, March 5; Feb. 26).

"At a minimum, junk bonds, penny stocks and risky real estate investments should be strictly monitored because a long-term promise to pay claims must be matched by investments that will provide necessary short-term liquidity and long-term stability," the subcommittee said in the report it released in February.

Risky investments, however, have not been a primary cause of insolvencies among property/casualty insurers because the development pattern of the claims they pay requires that property/casualty insurers invest in instruments that provide greater liquidity than that offered by junk bonds or real estate investments.

Larger holders of junk bonds tend to be life/health insurers.

A report finalized in September by the National Assn. of Insurance Commissioners on all insurers' non-investment grade securities portfolios indicated that some individual insurers had some problems that state regulators should examine on a case-by-case basis, said Robert Klein, the director of research for the NAIC in Kansas City, Mo.

"There are some companies that have problems, but overall we are not looking at a major crisis," added Bruce Schowengerdt, director of financial services for the commissioners group.

"It's a major problem for some (life/health) companies and a minor problem for others," said Myron M. Picoult, senior vp and senior insurance analyst with Oppenheimer & Co. in New York.

All states already have adopted laws that control insurer investments by requiring that insurers diversify their investments and avoid undue risk.

New York, Illinois and Florida, for example, also cap insurers' high-risk bond holdings at generally 20% of an insurer's admitted assets.

Some states are also considering tougher rules. For example, the Florida Insurance Department expects to propose that some limits be placed on mortgage investments, said Tom Gallagher, Florida's insurance commissioner and treasurer.

"In general, insurers appear to become comfortable with their domestic state's investment code and resist any effort to radically change the law other than to recognize current investment practices," according to a position paper by the Alliance of American Insurers in Schaumburg, Ill., a property/casualty insurance trade group.

However, "investment codes vary considerably from state to state and quickly become out-of-date as a result of the unending stream of new investment products," the Alliance said.

In addition to state laws, the NAIC-approved annual statement since 1986 has required all insurers to report the bonds they own categorized by investment grade and quality as determined by the NAIC Securities Valuation Office.

Slumping junk bond and real estate markets still worry state insurance commissioners, but "it's not nearly as bad as we first thought," said James E. Long, the insurance commissioner of North Carolina.

During the past year, the NAIC examined possible investment safeguards and evaluated their potential market impact, he said.

"We have got to come out with a reasonable approach," said Mr. Long, who currently is the NAIC's vp and who is expected to be elected president at the group's meeting this week in Louisville, Ky.

In June, for example, the NAIC changed its Securities Valuation Office manual to allow regulators to more closely monitor insurers' junk bond investments (*BI*, June 18; May 14).

The NAIC increased the number of bond designation categories to six from four on Schedule D of its reporting blank, which insurers will use for reporting 1990 data. The new categories, which parallel those used by other financial rating agencies, are: AAA to A; BBB; BB; B; CCC and below; and in or near default.

In addition, the NAIC cut approximately in half the time that life insurers have to accumulate a special reserve that cushions them against potential stock and bond losses.

That change in the "mandatory securities valuation reserve," however, will be phased in over five years, beginning in 1991, to ease the impact of the change, said Terry Lennon, assistant deputy superintendent and a chief examiner at the New York Insurance Department. He chairs the NAIC's High-Yield Securities Working Group which proposed the changes that the NAIC adopted.

Other changes make asset valuation rules stricter for property/casualty companies, which lack such a security account.

Property/casualty insurers can carry bonds rated AAA through BB at amortized cost on their 1990 annual statement. After that, only bonds rated AAA through BBB can be carried at their amortized cost, while the remainder must be carried at market value.

Regulators now also require all insurance companies to categorize

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Continued from previous page
bonds as publicly or privately placed.

The changes in the NAIC's bond reporting rules generally are supported by a key industry trade group.

The American Council of Life Insurance "has supported the NAIC improvements in the regulation of bond investments," said Paul A. Reardon, director of investment research for the ACLI in Washington, D.C.

"There is the possibility of substantially increased risk if an (insurer's) investment portfolio is overweighted in any particular type of investment," Mr. Reardon observed.

However, regulators and insurers disagree over what constitutes "overweighting."

"We are concerned with solvency; we want to be able to keep promises we make to policyholders and pension annuities," Mr. Reardon said.

However, at least one financial analyst thinks the NAIC's changes do not go far enough.

While Oppenheimer's Mr. Picoult says the changes are a step in the right direction, he believes the phase-in schedule dilutes their effectiveness (*BI*, July 2). Mr. Picoult would have preferred to see all the changes become effective at the end of 1990.

A more forthright approach is needed to raise the credibility of the NAIC itself and most insurers, whose assets and capital are generally "overstated," Mr. Picoult said.

"It all comes back to one thing: Regulation of the insurance business has been less than spectacular," he added.

Along with adding its new bond reporting requirements, the NAIC also is considering beefing up its regulation of insurers' junk bond holdings and other high-risk investments.

Mr. Lennon's working group now is discussing capping insurers' junk bond holdings, perhaps at the 20% level that a handful of states currently maintain, he said.

"An attempt will be made to get together a first draft of a cap model" at the NAIC meeting this week, Mr. Lennon said. Though a proposal might be offered for comment at the meeting, it would not be adopted this week, he said.

"I think the NAIC will tighten up again," said Herbert Goodfriend, an independent financial consultant in New York.

"They are not through with the industry yet," he said.

The likelihood that the NAIC will propose caps on insurers' junk bond holdings appears to be enhanced by the fact that the New York Insurance Department, of which Mr. Lennon is a chief examiner, now is considering further tightening its limits on the amount of junk bonds a life insurer can hold.

New York regulators propose to retain the overall 20% cap on life insurers' junk bond investment, while instituting new limits that restrict the amount of assets a company can invest in lower-quality bonds within the six NAIC rating categories.

Specifically, the department wants to limit the amount of bonds held by a life insurer that are in or near default to 1% of its admitted assets. In addition, it wants to limit the amount of bonds rated CCC or below to 3% of admitted assets while it wants to cap the amount of bonds that are rated B or below at 10% of admitted assets.

'It all comes back to one thing: Regulation of the insurance business has been less than spectacular,' observes Myron M. Picoult, senior vp and senior insurance analyst with Oppenheimer & Co. in New York.

While the proposal does contain some exceptions to these caps to allow insurers to purchase additional bonds from a company in order to protect the insurer's investment in the company, the additional investment cannot exceed 0.5% of the insurer's admitted assets.

Also, the proposal would make all—rather than some—privately-placed bonds subject to these rules.

"The proposed amendment was necessitated by the new NAIC rating system for obligations and was also prompted by concern over the current condition of the high-yield, high risk obligation market," according to a statement by the New York Insurance Department.

"When we adopted our junk bond regulation in 1987, our goal was to protect policyholders and ensure that life insurance companies acted prudently and not become vulnerable to changing market conditions," said New York Insurance Superintendent Salvatore R. Curiale. "Recent economic news has shown that a high concentration of these obligations can damage the financial stability of life insurers."

The New York Department held a hearing last month on the proposed amendment and is accepting comments on it until Dec. 17.

The department will review the comments and decide whether to modify the amendment, which was originally scheduled to go into effect Jan. 2.

In addition to looking at beefed-up junk bond rules, the NAIC is considering other ways to enhance insurer solvency by regulating insurers' investments.

For example, regulators are developing a formula for determining a mandatory valuation reserve for all types of a life insurer's assets, including real estate and mortgage loans, not just securities, Mr. Lennon said.

However, a recent NAIC report on life insurers' long-term mortgage holdings found that of the $261 billion in mortgages held by life insurers, only "a relatively low figure"—2.3%—are in default, Mr. Schowengerdt said.

The NAIC also may review its valuation of private placement bonds, for which it is difficult to determine a market price since they are not actively traded on the open market.

Some property/casualty companies are also concerned that the NAIC may try to require them to set up a mandatory securities valuation reserve, such as life insurers must establish, even though property/casualty companies historically invest in higher-rated bonds than life insurers. ■

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Federal regulation unnecessary: Panelists

By JUDY GREENWALD

NEW YORK—Federal regulation of insurer solvency is not necessary, a prominent state insurance regulator and the president of the National Conference of Insurance Legislators agree.

New York Insurance Superintendent Salvatore R. Curiale and COIL President Mike Stinziano, an Ohio state assemblyman, disagreed with John J. Byrne chairman of Fireman's Fund Insurance Co., who advocates some form of federal regulation, at a solvency symposium in New York last month sponsored by the National Assn. of Insurance Commissioners.

Mr. Byrne, who made similar remarks at a seminar in October (*BI*, Nov. 12), criticized current insurance regulatory accounting practices during the panel discussion, titled "Solvency Surveillance of the Insurance Industry in the 1990s: The Challenge for State Insurance Regulators."

Insurers carry assets at book value, not market value, and do not carry liabilities at their real worth, Mr. Byrne pointed out. This inflates the industry's true statutory surplus, he said.

NAIC

These factors, along with the cost of insurer insolvencies, mean the system "needs some help," Mr. Byrne said.

"Maybe a little national solution here is called for," he said when asked whether federal solvency regulation is becoming more palatable to insurers

Mr. Byrne added that, over the past few months, more insurers have come to agree federal solvency regulation is needed, although the change of heart is generated by concern about market conditions, rather than worries about insolvencies.

New York's Mr. Curiale disagreed that a federal role is needed in insurance regulation.

"The responsibilities of the insurance commissioners and superintendents is a heavy one," said Mr. Curiale. State regulators, however, have done a "magnificent job" over the last 125 years and, with the efforts of the NAIC, "we can continue to do a magnificent job."

Regulators are now faced with eroding insurer assets and underestimated liabilities. But 50 insurance departments working to solve these problems are a "lot better" than having only the federal government work on them, said Mr. Curiale. He added that the savings and loan crisis "showed that's the case."

Inequalities with state regulation "can be improved," Mr. Curiale said.

Mr. Stinziano's comments also triggered a discussion with Mr. Byrne over federal regulation.

Mr. Stinziano, who is also chairman of the Ohio House Insurance Committee, noted that both the NAIC and COIL expect to devote a great deal of time to insurer insolvency.

Not all the states have enacted the NAIC-proposed model laws to help beef up solvency regulation, noted Mr. Stinziano. This means that state adoption of the NAIC Solvency Policing Agenda for 1990, which was approved by the NAIC in December 1989, will be a "tough row to hoe in the months and years ahead," according to Mr. Stinziano.

An NAIC plan to improve solvency regulation has five objectives: uniform evaluation of reinsurance-related issues; state implementation of minimum standards for financial regulation; assessment of the NAIC's current examination process; enhancement of solvency support mechanisms; and review of capitalization and reserve requirements as well as annual statement disclosures (*BI*, Dec. 18, 1989).

Not everyone shares "a sense of urgency" about enacting the solvency agenda, Mr. Stinziano explained.

State legislatures are absorbed with concerns about the economy, and very few consider insurer insolvencies a high priority, he noted, adding that legislatures are more likely to focus on automobile and health insurance availability and affordability.

In addition, state insurance departments have also found it hard to come by the funds needed to implement financial regulatory standards and the NAIC solvency agenda.

Many, noted Mr. Stinziano, will have difficulty maintaining their current appropriation levels, let alone increasing funding.

He urged a joint effort to lobby for state funds. Commissioners should work closely with key legislators to help insurance departments obtain a significant share of new state tax revenues, he said.

"This effort is going to need the support of industry around the country," also, said Mr. Stinziano.

A joint effort is also needed to improve solvency regulation. Without such leadership many of the proposals to improve solvency regulation could "simply gather dust," he said.

However, Mr. Byrne responded that there is a 50-year history of legislative apathy toward NAIC recommendations.

"I know nothing is going to happen" at the state legislative level, said Mr. Byrne, adding that he took Mr. Stinziano's comments to mean the same thing—that states are unlikely to make changes.

Mr. Byrne then asked Mr. Stinziano whether he agrees that federal regulation is needed.

"Hell no," responded Mr. Stinziano. State oversight, though imperfect, is better than federal regulation would be, he said, also pointing to the S&L crisis.

Support for increasing spending on insurance regulation will vary among the states, Mr. Stinziano said. But support for beefed-up solvency regulation will be even lower at the federal level, he added.

Paul Sweeney, senior vp and chief financial officer of John Hancock Property & Casualty Holding Co. in Boston, said regulation changed significantly in the 1970s and 1980s, but "further change is still required."

Almost all insurer insolvencies can be traced to management action or inaction, Mr. Sweeney said, observing that there is no foolproof system to totally prevent failures.

Regulators can, however, cut down on failures by:

- Introducing minimum capital requirements that are uniform from state to state, conservative

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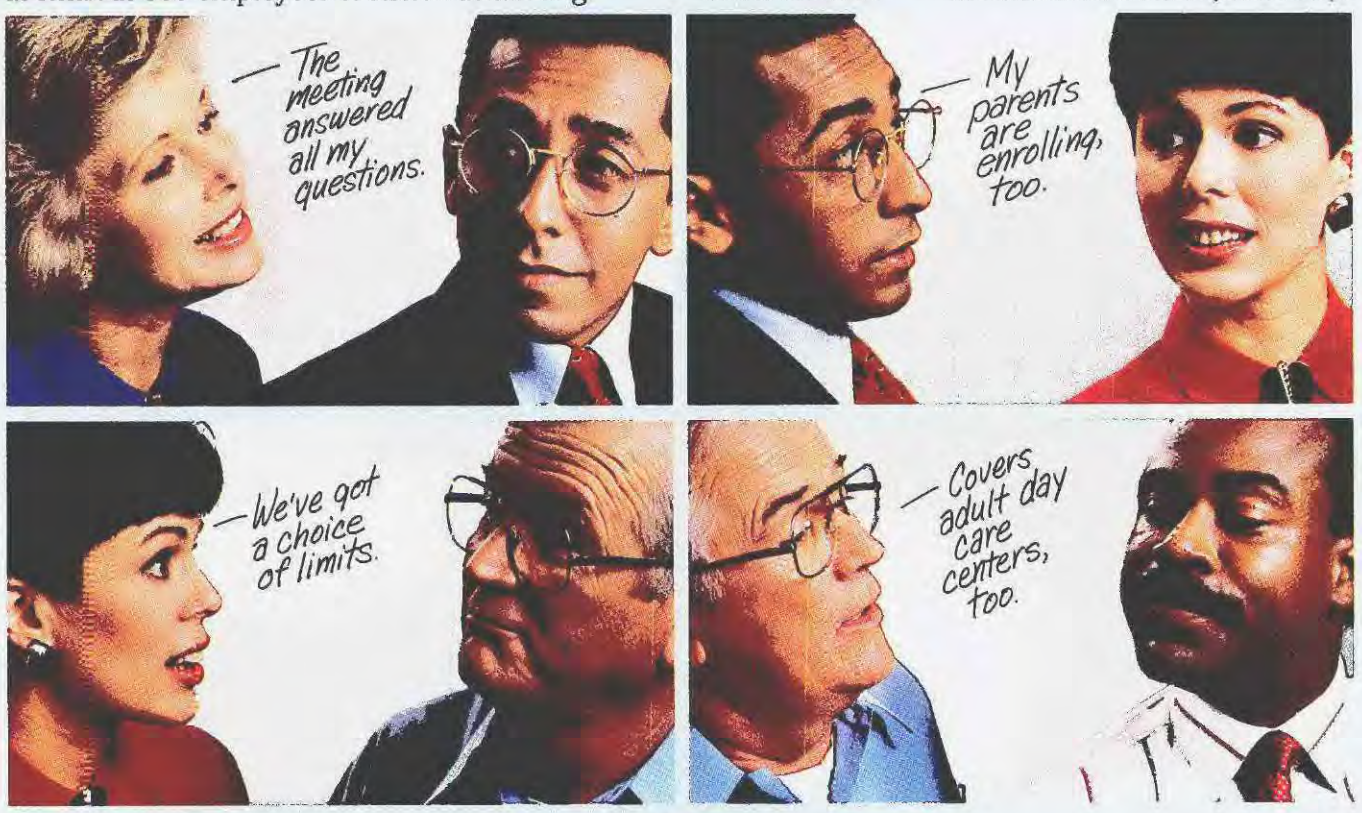

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Continued from previous page
and relate to the type of risk being insured.

Requirements, for instance, should be different for medical malpractice insurers and property insurers, according to Mr. Sweeney.

An NAIC panel, he noted, is now working on the issue of risk-based capital requirements. He said he hoped the recommended capital requirements would be tied to increases in the Consumer Price Index or reflect a similar approach that would prevent erosion of capital because of inflation.

'It's time for the NAIC to grow teeth,' says Paul Sweeney, of John Hancock Property & Casualty.

- Separate the "black hats" and the "white hats."

Mr. Sweeney recommended that regulators not spend resources investigating companies that are making money and have good leverage and equity positions simply because it is those companies' turn to be examined.

Departments instead should be able to shift their resources to focus on the "black hats." An NAIC committee is now examining this issue as well, Mr. Sweeney said.

- More closely monitor rapid premium growth and excessive leverage among insurers.

Company surveillance must be expanded, he said, noting that careful surveillance with early intervention can enhance insurer solvency.

"It's time for the NAIC to grow teeth," Mr. Sweeney said.

Another panelist—John E. Shelk, minority counsel to the House Energy and Commerce Committee—discussed the findings of the panel's Oversight and Investigations Subcommittee study of insurer insolvencies.

The panel concluded that state insurance regulation would have to be vastly improved to protect policyholders against insolvencies (*BI*, Feb. 26).

He noted that the subcommittee, chaired by Rep. John D. Dingell, D-Mich., concluded that while the magnitude of the insurance industry's problems is not the same as that of the savings and loan industry debacle, some of the same early warning signs and "disturbing parallels" have emerged.

"There are serious insolvency problems in the industry, but there is no crisis," said Mr. Shelk.

The problem, he added, is that because there is not a crisis, people then dismiss the need to do anything at all.

Mr. Shelk also noted, as he did at the National Assn. of Independent Insurers' annual meeting earlier last month, that legislation to create a federal role in insurer solvency regulation will be introduced when Congress reconvenes next year (*BI*, Nov. 26).

Earl Pomeroy, the NAIC president and North Dakota insurance commissioner, moderated the session. ■

Attendance at symposium tops forecast

NEW YORK—The National Assn. of Insurance Commissioners' first symposium on insurer solvency drew a bigger audience than expected.

Held Nov. 19-20 in New York, it attracted 390 registrants, nearly 100 more than the group anticipated.

"We thought we might get to 300," a spokesman said.

The spokesman added that NAIC officials were "very happy" with the turnout, which they attributed to heightened interest in solvency issues that has accompanies a congressional investigation into several large insurer failures.

A similar meeting is planned for next year, although the time and place haven't yet been determined.

For more information, contact the National Assn. of Insurance Commissioners at 120 W. 12th St., Suite 1100, Kansas City, Mo., 64105; 816-842-3600.

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Spotlight report

Regulators find RICO a powerful tool

By DOUGLAS McLEOD

NEW YORK—Federal and state anti-racketeering laws are regulators' most powerful weapons in fighting insurance fraud, several experts say.

NAIC The federal Racketeer Influenced and Corrupt Organizations law and similar statutes in more than 20 states are the best way to combat con artists who could bankrupt insurer after insurer with impunity, according to a panel of experts.

"All other avenues of redress pale in significance beside RICO," said G. Robert Blakey, the University of Notre Dame law professor who drafted the federal RICO law.

He and other experts spoke at a National Assn. of Insurance Commissioners symposium on insurer solvency last month in New York.

Adopted as part of the 1970 Organized Crime Control Act, RICO was largely ignored until about 1980 when prosecutors and plaintiffs' lawyers began using it in civil fraud cases, Mr. Blakey noted.

He sought to dispel what he said were "myths" that have grown up around the law:

- That it was intended to deal only with traditional organized crime. Mr. Blakey sums up this notion as: "If your name doesn't end in a vowel, you shouldn't be charged."

On the contrary, he suggested, the law was meant to cover a broad spectrum of criminal and civil violations.

- That it has produced a flood of criminal and civil racketeering cases.

About 140 criminal RICO cases are filed each year, he said. And only about 80 of the 20,000 civil suits filed each month contain RICO counts.

- That it induces settlements by intimidating defendants with the "racketeer" label and the threat of treble damages.

In fact, Mr. Blakey said, the opposite has occurred. Enraged civil defendants have refused to settle as long as RICO charges remain in a complaint.

The spreading use of RICO in civil litigation has led business and professional groups—including accountants, lawyers and insurance companies—to push for modifications, Mr. Blakey said.

He attacked these efforts—which he jokingly described as attempts to "chloroform" the law rather than reform it—as self-interested.

He wondered rhetorically if anyone could cite a single instance of an accounting firm or law firm blowing the whistle on a deteriorating savings and loan before the S&L scandal blew up.

"They were the dogs that didn't bark," he said of the accountants and lawyers, adding that these groups, fearing RICO actions, had pushed for retroactive limits on potential liabilities.

Arguing against proposed RICO reforms, Mr. Blakey noted that a House reform bill introduced this year would limit recovery to "major participants" in a racketeering scheme. He likened this to limiting prosecution in a bank robbery to the robber who shot a teller and letting off the person who gave him the gun or drove the getaway car. Or, he added, it would be like charging only a corrupt S&L executive without charging the accountants, lawyers and investment bankers who supported a fraudulent scheme.

"RICO has made a lot of people mad in this country," including corrupt politicians and white-collar criminals, Mr. Blakey observed. "To be associated with anything that makes these kind of people mad makes me proud."

Fraud-induced insurer insolvencies are often "bust-out schemes," in which a dishonest operator takes over an insurer, writes large amounts of business and finds various ways to bleed cash from it before leaving the broken hulk for regulators to liquidate, according to Stephen E. Kravit, a former federal prosecutor and lawyer with the Milwaukee firm Kravit, Waisbrun & DeBruin.

Other insolvencies, he added, result from incompetent managers trying to stave off failure by covering up deteriorating results with large volumes of new business.

Mr. Kravit pointed out several characteristics of bust-out schemes, some of which warn of potential trouble:

- False insurer financial statements, designed to cover the con artist's tracks during the scheme.
- Rapid growth of premium volume generated by price-cutting and expansion into lines of business the company hasn't traditionally written. An auto insurer starting to write animal mortality risks, for example, should tip off regulators.
- Delegation of most of the insurer's functions—such as underwriting and claims service—to "outside" parties controlled by those involved in the scheme. Fees and commissions for these services are one way to siphon cash out of the company.
- Heavy dependence on offshore reinsurers, chronically overdue reinsurance recoverables and reinsurance "contracts" that are not in writing. Ceding reinsurance to entities controlled by those running a fraudulent scheme is another way of removing cash from the insurer.
- High litigation budgets, reflecting the insurer's plan to fight all claims.

When regulators suspect that a company is at the center of a fraudulent scheme, they should subpoena documents and secure testimony under oath from company officials, Mr. Kravit advised.

While a scheme is ongoing, participants may lie under oath, providing support for later prosecution, he noted.

"They are locked into a story they cannot deviate from," he observed.

Mr. Kravit also advised regulators to develop company "insiders"—such as recently fired employees or former accountants—as witnesses in fraud cases.

Fraud has contributed to several of the largest insurer failures ever, added John E. Shelk, minority counsel to the House Energy and Commerce Committee and its Oversight and Investigations Subcommittee.

The subcommittee, which recently issued a report on insurer failures, did not conclude, however, that fraud is rampant in the insurance industry.

But it did note several problems in regulators' efforts to cope with fraud. These include the built-in conflict of interest facing liquidators, who may avoid investigating fraud for fear that reinsurers may then use the findings to refuse

Continued on next page

Five Years Ago, This W
Considered An Inte

Continued from previous page
payment of reinsurance claims.

Mr. Shelk also recommended eliminating guaranty fund coverage for sophisticated commercial policyholders. Doing so, he said, would spare individual policyholders from having to pay for insurer collapses caused by the low-ball pricing fraud artists commonly use.

Illinois Insurance Director Zack Stamp disputed the assertion that fraud is the main cause of insurer failures. "Well-meaning, totally honest, totally good people can get an insurance company in trouble," he said.

He also lauded RICO as a crucial weapon in fighting con artists, who can use their due process rights to delay or evade regulatory action. "They have all the ability to hide and dodge, so that's why we need RICO," he said.

James E. Long, North Carolina's insurance commissioner, moderated the panel. ■

NAIC actions bolster regulation: Bell

By DOUGLAS McLEOD

NEW YORK—The National Assn. of Insurance Commissioners has taken major strides toward improved solvency regulation since Congress began investigating the adequacy of state regulation two years ago, a panel of experts says.

Among other things, the NAIC has adopted a solvency policing agenda that calls for accreditation of insurance departments in states that have adopted NAIC model insurance regulations, panel members noted (see story, page 3).

The group also strengthened insurer financial reporting requirements with expansion of convention statement reporting for loss reserves and overdue reinsurance recoverables, experts said at an NAIC symposium last month in New York.

"The NAIC solvency policing agenda is by far the most promising program to strengthen solvency regulation that I have ever experienced," said Fletcher Bell, Kansas insurance commissioner and former NAIC president.

NAIC

Mr. Bell maintained that state regulation has served the public "remarkably well," but added that "that doesn't mean we can't improve."

If NAIC model laws are widely adopted by state legislatures and the solvency policing agenda begins to work, "we have gone a long way towards addressing our solvency problems," Mr. Bell said.

Many current recommendations for improving solvency regulation aren't new ideas: Some were put forward in the 1982 Bell-Budd report, a study of regulation by a group headed by Mr. Bell and Travelers Corp. Chairman Edward H. Budd, according to Clyde Fulton, vp and controller with Travelers in Hartford, Conn.

That group, for example, recommended concentrating regulatory resources on insurers with a higher risk of problems rather than expending the same resources on all companies.

Regulators should use data from the NAIC Insurance Regulatory Information System, along with independently audited financial statements, to identify high-risk companies on which to focus their attention, Mr. Fulton said.

Following a recommendation in the Bell-Budd report, regulators should also make their regular examinations brief and concise, a goal they can reach by—for example—using information supplied by companies' independent auditors and actuaries rather than duplicating their work.

Regulators should also devote more resources to examiner training and development, he added.

Robert M. Solitro, deputy New Hampshire insurance commissioner, also made a case for activist regulation.

"We must change the perception of the industry running ahead of regulators," Mr. Solitro said, citing as an example of this perception an old joke that NAIC is really an acronym for "No Action Is Contemplated."

Insurance industry officials complain about the volume of data they are required to provide, but the data is crucial to monitoring solvency, Mr. Solitro said.

The NAIC last year expanded reporting requirements and is now collecting information that should help improve evaluations of a company's financial position, he noted.

Starting with 1989 statutory statements, the NAIC greatly expanded the Schedule P analysis of losses and loss expenses to allow a more comprehensive assessment of loss reserves, he said.

Meanwhile, insurers were also required to report undisputed paid loss reinsurance recoverables that were more than 90 days past due and take a 20% penalty on all reinsurance balances owed by slow-paying reinsurers (*BI*, Nov. 12).

This provision resulted in an aggregate $543 million in penalties taken by property/casualty insurers last year, which Mr. Solitro said has had a significant impact on the way ceding insurers do business with their reinsurers.

Mr. Solitro also called on industry leaders—who have sometimes fought tighter state regulation—to support state efforts to improve solvency policing.

"Regulators are willing to change. We need the industry's support," he said.

Wayne Kauth, a partner with accounting firm Ernst & Young, questioned whether recent NAIC actions will really head off insolvencies, however.

"Insolvencies have been here forever. They are not unique to the insurance industry, and we are going to continue to have them," he said.

NAIC model laws like those requiring independent audits and actuarial certification of loss reserves and new and expanded schedules in insurer convention statements may not do much to prevent failures, he said.

Regulators should instead focus more on damage control by reacting more quickly when they spot companies in trouble, Mr. Kauth recommended.

They must shorten the lag between the time a company is identified as troubled and the time it is liquidated, he said. While it is difficult to pinpoint exactly when a company has become insolvent, it's better to liquidate the company when it is $5 million in the hole than waiting until the insolvency expands to $50 million, he said.

Asked later what sanctions should be imposed on insurance departments that do not obtain NAIC accreditation, Mr. Bell replied that the lack of accreditation itself is probably an adequate sanction.

Also participating in the panel discussion was Joan Lamm-Tennant, an associate professor of finance and insurance at Villanova University in Philadelphia. William H. McCartney, insurance director of Nebraska, moderated the panel. ■

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Regulators told to lobby for tougher solvency laws

By DOUGLAS McLEOD

NEW YORK—State insurance regulators are facing a serious political challenge in convincing legislatures to adopt stricter solvency regulations recommended by the National Assn. of Insurance Commissioners, experts say.

If state legislatures do not soon support regulators, the federal government could assume some role in insurance regulation, a panel of politicians and insurance industry officials said at an NAIC symposium last month.

Legislatures must adopt NAIC model laws that would be required to be in place for insurance departments to receive NAIC accreditation, the panel pointed out. Accreditation is the cornerstone of an NAIC plan to improve oversight of insurer solvency (see story, page 12.

"Improvement has got to be made in insurance regulation or we are going to be faced with changes that some of you may not feel very comfortable with," warned Nebraska state Sen. Don Wesely, D-Lincoln.

Sen. Wesely is co-chairman of a task force on insurance insolvencies set up by the National Conference of State Legislatures, which last month announced a joint initiative with the NAIC to encourage legislatures to strengthen solvency regulation.

Both groups will press state legislatures to adopt the model acts needed to assure their insurance departments' certification by the NAIC, said Sen. Wesely and NAIC President Earl R. Pomeroy.

State legislatures, which pass the laws governing insurance regulation and approve insurance department funding, have not made solvency a high priority, Sen. Wesely observed.

The Nebraska Legislature, he noted, is facing 700 bills next year, and this workload is low compared with most other states.

"Legislatures respond to pressure," he said. "The pressure has not been high enough. The industry has not pressed hard enough; the regulators have not spoken loudly enough."

This may be changing, Sen. Wesely said.

He noted that frustration with legislative inaction has grown among regulators, insurers and the House Oversight and Investigations Subcommittee, which earlier this year released a report citing numerous regulatory failures (*BI*, March 5; Feb. 26).

Federal interest in insurance regulation, along with the fallout of the savings and loan scandal, has opened some legislators' eyes, Sen. Wesely said.

That, however, is the first step in a long and rough road to enacting needed laws, he said. This process includes drafting legislation, finding powerful legislative sponsors, scheduling committee hearings, having the bills voted out of committee to the floors of state legislatures, moving bills to a vote and getting governors to sign them.

Despite the difficulties, Sen. Wesely urged regulators and concerned legislators to push for solvency legislation.

"1991 is the year we have got to move on this," Sen. Wesely said, adding that he would like to see several states take legislative action next year.

He cautioned regulators not to expect miracles, noting that "legislatures cannot turn around on a dime."

He also warned that supporters of solvency laws should not paint too dire a picture of the insurance solvency problem.

"You have to build concern, but not so much that legislators panic," he advised.

One problem facing improved solvency regulation is the highly politicized debate over "marketplace regulation" of price and availability of coverages, observed Illinois Deputy Governor John E. Washburn, a former Illinois insurance director and NAIC president.

The overriding public concern relates to controlling price and availability of coverages like automobile insurance, Mr. Washburn said, noting that insurance company solvency is not a great concern for the general public.

Also speaking on the panel were Barbara B. Gregg, executive director of the Montgomery County, Md., Office of Consumer Affairs; Southgate Jones Jr., a past president of the Independent Insurance Agents of America and president of J. Southgate & Son Inc. of Durham, N.C.; and W. Craig Heston, chairman and chief executive officer of Utica Mutual Insurance Co. of New Hartford, N.Y.

Florida Insurance Commissioner Tom Gallagher moderated the panel. ■

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Oversight of reinsurers called inadequate

By JUDY GREENWALD

NEW YORK—There is still room for improvement in reinsurance regulation, according to an Illinois regulator.

"There's always more that can be done," said James W. Schacht, deputy director of the Illinois Insurance Department last month at a National Assn. of Insurance Commissioners symposium on insurer solvency.

"I don't think the regulation is adequate," he said.

Mr. Schacht said that in the past, reinsurance regulation has focused on the credit granted to primary insurers for the risk they cede to reinsurers, while today regulators are studying how reinsurance is transacted.

Norris Clark, chief of the financial analysis division with the California insurance department, urged states to adopt a number of NAIC model laws related to reinsurance. "I think the industry is going to have to support that at the state legislative level."

For instance, the NAIC last year amended a model law to toughen the standards reinsurers must meet for ceding insurers to receive credit for reinsurance. The commissioners group also adopted a model law for licensing reinsurance intermediaries and managing general agents.

Uniformity is needed to make reinsurance regulation effective, commented Lawrence D. Cluff, assistant director of the U.S. General Accounting Office in Washington, D.C.

In a study released in May, the GAO concluded that alternatives to state regulation of reinsurance may be needed if states fail to implement reforms recommended by the NAIC (*BI*, June 4).

Mr. Cluff also called for reinsurers to make more and better information available to the NAIC and state regulators. States need adequate resources and training as well, he said.

Regulators are at a significant disadvantage because they are "always in a reactive position" and therefore they must do whatever is necessary to reduce that disadvantage, commented Mr. Cluff.

Robert Hall, senior vp and general counsel for the American Re-Insurance Co. in Princeton, N.J., observed that timely reinsurance issues were discussed at an NAIC meeting—in 1950.

Some regulators who have not been connected with the reinsurance business for a long time, Mr. Hall added, see reinsurance regulation problems that at times look like they "came from outer space."

In fact, he said, problems often come up, are "resolved in a fashion," then disappear, only to reemerge later in "slightly different form."

Regulators should look at historical solutions and see if they can be adjusted to fit today's needs, said Mr. Hall.

Mr. Hall also told regulators that "reinsurers are your friends," noting that both reinsurers and regulators are concerned with solvency.

Reinsurers can help regulators solve their problems, Mr. Hall pointed out. "Don't think of reinsurers as the enemy. Truly, they can be allies."

Participants also discussed financial reinsurance regulation, generally agreeing that financial reinsurance transactions should be permitted if they provide a real economic benefit to the ceding company, as opposed to creating illusory or cheap surplus.

Mr. Cluff of the GAO said he does not believe the insurance industry "is another (savings and loan crisis) waiting to happen," but it must learn from that industry's mistakes.

One of the things it has to learn, said Mr. Cluff, is that "capital is important, and phony capital is phony and doesn't get you anywhere."

If the purpose of financial reinsurance is to artificially inflate an insurer's surplus position, it must be addressed by regulators, said Mr. Cluff.

Responding to Mr. Hall's quip that "all reinsurance is financial," Mr. Schacht, the Illinois regulator, compared reinsurance to pornography. "You know what it is when you see it," he said, quoting the now-famous words of former U.S. Supreme Court Justice Potter Stewart.

Mr. Schacht said he does not believe that financial reinsurance should be totally prohibited, because it can help a ceding company emerge from difficulty.

The objective of financial reinsurance regulation should be to do away with illusory surplus, said American Re's Mr. Hall. Perhaps the way to grapple with the issue of regulating financial reinsurance is to focus on the types of transactions that regulators "don't like" rather than scrutinize all types of financial reinsurance transactions, he said.

The concern, responded Mr. Cluff, should not be with whether a financial reinsurance transaction has taken place, but with "whether or not these transactions create an appearance of surplus."

Continued on next page

Gerald D. Stephens, CPCU
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British prefer their regulatory system

By CAROLYN ALDRED

LONDON—Insurance regulation in the United Kingdom could be improved, but the system outperforms its American counterpart, according to British insurance industry officials and securities analysts.

Far fewer insurance companies have been declared insolvent in the United Kingdom than have failed in the United States, they point out.

However, U.K. regulation is being closely scrutinized—on both sides of the ocean—following the collapse of the line slip managed by E.S. Weavers (Underwriting) Agencies Ltd.

The slip disintegrated after financial problems were uncovered at some of the slip's current and former insurers (*BI*, April 2).

As of year-end 1989, Walbrook Insurance Co. Ltd., which supplied more than half of the Weavers slip's capacity when it suspended underwriting in March, had net liabilities of 460.2 million pounds ($742.8 million at appropriate exchange rates) and net assets of 465.4 million pounds ($751.2 million), leaving it 25.8 million pounds ($41.6 million) short of the British solvency requirements (*BI*, Nov. 12; Nov. 5).

Four smaller insurers owned by Weavers' and Walbrook's parent company, London United Investments P.L.C., are estimated to be insolvent by a total of nearly 100 million pounds ($196.6 million at current exchange rates) (*BI*, Nov. 12).

The British insurance regulatory system includes both regulation by the Department of Trade and Industry and self-regulation by vari-

Continued on next page

Reinsurance

Continued from previous page

Turning to the issue of risk transfer in financial reinsurance, Mr. Hall said the question of defining transfer of risk is like the search for the Holy Grail, adding that the criterion used in defining transfer of risk is whether economic risk is involved in the transaction.

Perhaps, suggested Mr. Schacht of the Illinois Insurance Department, regulators should require insurance companies to submit an objective opinion that a reinsurance contract transfers some form of economic risk.

Experts also discussed abuses of fronting arrangements.

Mr. Schacht said more should be done to make sure that fronting arrangements are reported as two transactions: one between the policyholder and the primary insurer and the second between the primary insurance company and the reinsurer.

Both transactions should be reflected in the insurer's annual statement, according to Mr. Schacht.

Defining transfer of risk is like searching for the Holy Grail, says Robert Hall.

This is the only way to make it clear to the primary insurer that it is liable for the risk it assumes in a fronting arrangement and that it is, in turn, ceding the business to another company from which it must collect.

Mr. Schacht said if that is accomplished, he does not believe fronting arrangements present a problem. In a number of instances, he added, fronting can be useful for commercial insurance buyers.

Mr. Cluff commented that it "seems strange" to forget the importance of insurer retention in fronting arrangement.

A fronting insurer that cedes all the risk to a reinsurer has no incentive to underwrite the risk properly, according to Mr. Cluff.

"I think the insurance companies should not be allowed to pass off all the risk," he said.

Mr. Schacht responded that structuring regulations so that there are clearly two transactions in a fronting arrangement addresses some of the problems that have developed in the past, when the primary insurer felt it was just collecting a fee for fronting the business.

Noting that many fronting insurance companies do not recognize that they have obligations for the business they front, Mr. Clark said there have clearly been some fronting abuses.

But he recommended against trying to solve fronting problems exclusively by demanding more extensive disclosure. Doing so would just puts a greater strain on regulators, he said.

Ron Taylor, the insurance commissioner in Arkansas, moderated the session. ■

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Continued from previous page
ous sectors of the insurance industry.

The British secretary of state for trade and industry, the government minister in charge of the DTI, is ultimately responsible for authorizing insurers in the United Kingdom.

To obtain authorization, insurers must show they have sufficient capital; a sound three-year business plan; and that controllers, directors and managers are fit and proper persons to carry on insurance business.

"Unlike in many other countries, reinsurers have to be authorized as well as direct insurers. Insurers are authorized for specific classes of business and may not write business in classes for which they are not licensed," according to the DTI.

Once authorized, insurers submit detailed annual returns to the DTI, which are then released to the public.

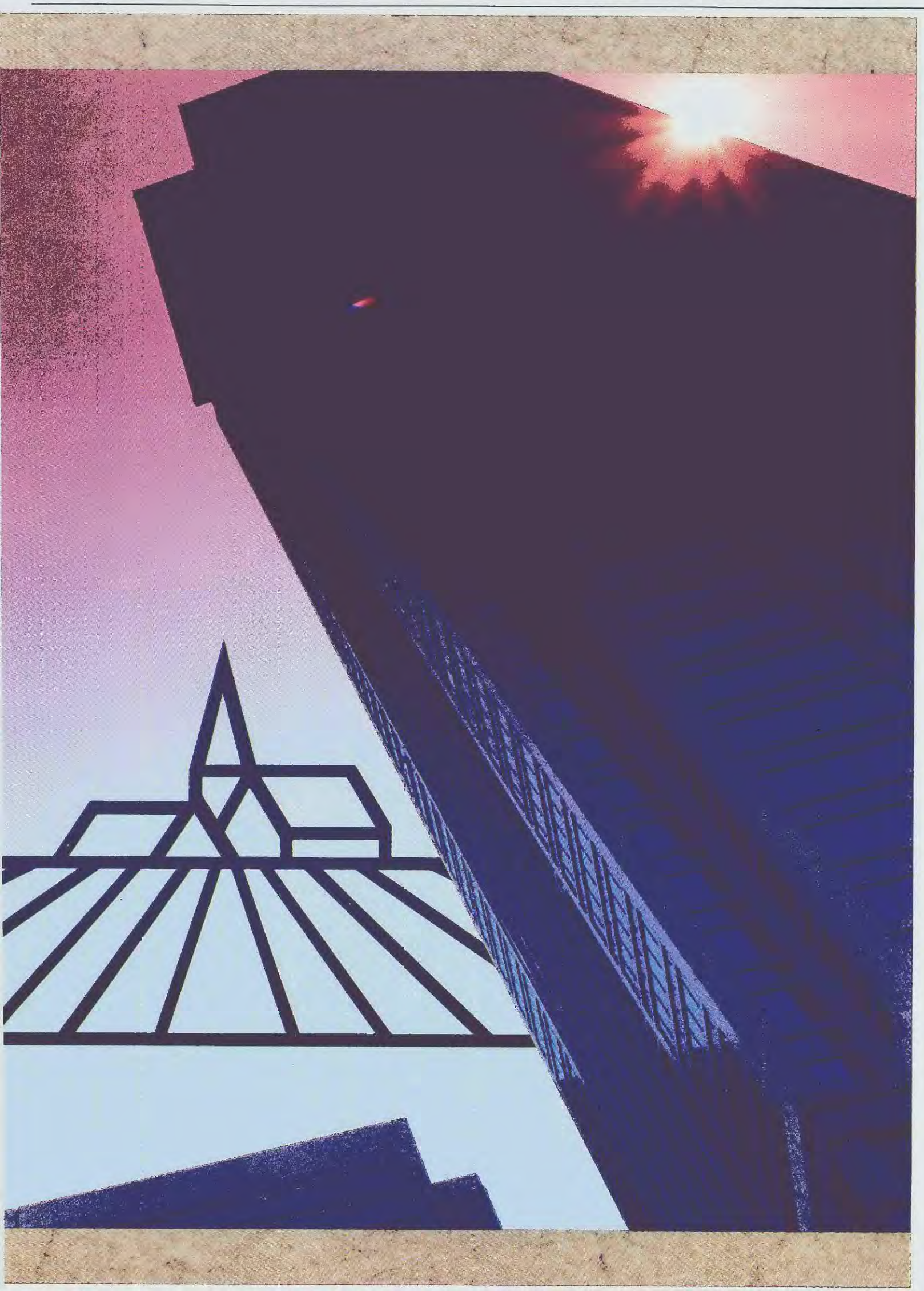
After department officials, and often outside actuaries, examine the returns, the department can request additional returns either quarterly or semi-annually, if it deems the additional returns necessary.

Management changes also must be approved by the DTI.

"The DTI has wide powers of intervention if a company cannot meet its required margin of solvency or if policyholders appear at risk. It may require more information, including more frequent reporting; conduct investigations; limit the amount of businesses; withdraw authorization; and, ultimately wind a company up," according to a statement prepared by the department for *Business Insurance.*

In its role as insurance regulator, the DTI concentrates solely on solvency and does not, like many European and U.S. regulators, approve insurance rates or policy forms.

Staff members also do not rehabilitate or liquidate companies. Instead, accountants are usually appointed to handle run-offs.



Because its role is limited, the agency has only a small staff to regulate 830 authorized insurers. Its 80-member staff is tiny compared with some state insurance departments in the United States.

The department is, however, adding staff and upgrading computer facilities. It is also "increasing the level of expertise available with the insurance division by (recruiting personnel) from the financial services sector," said the DTI's statement.

Insurance in Britain is also self-regulating, to a degree. For example:

- The government does not monitor Lloyd's of London underwriters and syndicates. Instead, they are monitored by the Corporation of Lloyd's under a recently established system.
- The Institute of London Underwriters, representing most of the London market's leading marine company underwriters, monitors the solvency of its member companies, although all ILU companies also are monitored by the DTI.
- The Assn. of British Insurers has a detailed code of conduct that covers members' marketing and selling of non-life insurance.
- Several bodies set up by the Financial Services Act of 1986 regulate life insurers.
- British insurance brokers must be registered through the Insurance Brokers Registration Council. Lloyd's brokers must be approved under Lloyd's own brokerage regulations and must follow a code of conduct established for Lloyd's brokers.

'The London market has a sophisticated system of people blowing whistles,' a broker says.

And most major London brokerages, like those in the United States, have security teams or committees to investigate insurers with which they place business.

Brokers, which share such information through informal information networks and meetings, also will often alert the rest of the market—including government regulators—to potentially troubled insurance companies.

The Department of Trade and Industry "maintains close contacts with other regulators of financial services industries and Lloyd's," the agency said.

"The London market has a very sophisticated system of people blowing whistles when trouble is brewing," noted one London broker, who added that the DTI acts "very promptly and very efficiently" when alerted to potential trouble spots.

Weavers' collapse, however, has raised concerns that the department is under-staffed and unable to fully analyze insurance company data.

Observers attribute another potential DTI weakness to the British civil service system. Staff members often are shifted out of the insurance division after several years, resulting in a high percentage of insurance regulators with little experience in the industry, they say.

This practice is currently being reviewed by the department.

The DTI recently increased the amount of information it seeks from insurers and is increasing its computer capabilities to process this information, according to John Tattersall, a partner with the London accounting firm of Coopers & Lybrand Deloitte.

"Where I have criticism is that they have been caught between up-

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Continued from previous page

grading the information available in annual reports and their ability to analyze it," Mr. Tattersall said.

"The DTI doesn't have a lot of people working there, which is part of the problem," said Chris Pountain, an insurance stock analyst with Morgan Stanley International in London. But even with more people, it would be difficult to analyze the London market because the type of business written and the type of insurers there are far more complex than in traditional domestic markets, he said.

"The DTI is fine when it comes to monitoring U.K. mainstream companies, but there is clearly a question mark over the London market," Mr. Pountain said, referring to Lloyd's and other international insurers and reinsurers.

"I am not sure how well the regulators have understood the London market," he said.

For instance, "there had been rumors surrounding the security of the LUI insurers for some time in the London market and the DTI should have acted earlier. If some more concerted action had been taken earlier, (the current situation) may have been prevented," Mr. Pountain said.

'There is clearly a question mark over (DTI regulation of) the London market,' says Chris Pountain of Morgan Stanley. 'I am not sure how well the regulators have understood the London market.'

The DTI would not comment on its action in the LUI case.

"A lot of the problem is that it is very difficult to look at the DTI returns of London market companies and see whether they are solvent," Mr. Pountain said. Those returns do not provide full details of reinsurance programs or adequate "information about the risks which are insured," he explained.

"The DTI needs to update what it asks for. All figures in the DTI returns are gross of reinsurance, which is crazy," added Andrew Crean, an analyst with London-based stockbroker Credit Lyonnais Laing & Cruickshank P.L.C.

"The class categories (included in the DTI returns) are too vague. We need far more detailed analysis of long-term business," said Mr. Crean.

"There ought to be more interpretative analysis such as that provided in the U.S. 'yellow perils,' " said Mr. Crean, referring to the annual statements U.S. insurers file with state regulators.

"Recent situations such as NEMGIA and LUI highlight that controls may be aren't working," said an executive of the Assn. of British Insurers, referring to the collapse of the Weavers slip and the insolvency of National Employers Mutual General Insurance Assn. Ltd. (*BI*, May 21).

However, much of the problem at Weavers was that the line slip consisted of a wide network of insurers that, in some cases, reinsured one another, he noted.

"The DTI hasn't been very efficient in recent months. We were all surprised that they didn't latch on to the Weavers situation earlier," said one broker.

"There seems to be a political reluctance for them to get heavily involved in the day-to-day aspects of the industry and they don't seem to have the manpower and will to cope with the problem," he added.

Despite recent setbacks in the London market, most observers in London argue that regulation in the United Kingdom still far surpasses that in the United States.

"There are more (insurer) failures in the U.S. every year than the rest of the world put together," said one broker, adding that the "number of insurance companies in the U.K. that have failed have been small and economically insignificant."

At least Walbrook "was stopped from trading—before becoming insolvent—and policyholders are going to see some of their money," said Mr. Tattersall of Coopers & Lybrand Deloitte.

Bearing in mind the high-risk, long-tail business common in London and that it "is seen increasingly as a market of last resort," the number of insolvencies has been very small, he noted.

"I think the regulatory environment in the U.K. is stronger than the U.S. because the licensing. . .is better-supervised," said Paul McNamara, a partner with accountant Ernst & Young in London.

"We haven't had many insolvencies here compared to the U.S.," he added.

"If you look around the U.S., the problems they have had have been just ghastly in terms of numbers and size. We haven't had any major insolvencies in years. The London market has regulated itself in terms of security remarkably successfully," said a London broker.

Self-regulation in London is helped "by having a small, compact market where negotiation is done face-to-face and everyone knows each other," he added. ■

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New E.C. non-life rules to take effect by 1992

By DENISE CLAVELOUX

BRUSSELS, Belgium—New European Community regulations should be in place to establish a truly unified market for non-life insurance by the end of 1992, when the single E.C. internal market will be implemented.

A proposal the E.C. Commission made earlier this year—and that must still win the backing of the E.C. Council of Ministers—will enable an insurer authorized in a one member state to set up branches and to provide services for individual consumers throughout the community (*BI*, July 9).

Insurers will be subject to the regulation of the nation in which they are domiciled.

The new license system will allow insurance buyers to have access to the widest range of products available within the European Community, an E.C. official says.

Sir Leon Brittan, the E.C. financial services commissioner, said that the new rules would establish a true single market in insurance which will apply in all E.C. countries. "Up to now there have been 12 separate markets for non-life insurance, which has cramped competition, pushed up prices and reduced consumer choice," he said.

To open a branch in another E.C. nation, a non-life insurer will just have to notify its home country authorities. They will then forward details about solvency and services to the next country.

Insurers also will be able to offer certain non-life coverages—like fire, theft and personal liability—directly to consumers in other E.C. countries without having to set up a branch office. Notification of regulators would follow the same procedures.

For the system to work, all member states must agree on certain standards, such as the representation of assets covering technical reserves, according to the European Commission. Solvency margin guidelines will also be uniform.

The European Community already is moving toward a single market for the non-life sector, even though E.C.-wide regulations have not yet been approved.

The first E.C. Non-Life Directive, adopted in 1973, attempted to coordinate national rules for authorizing insurers and set basic solvency standards. Companies, however, still had to seek separate authorization and national regulations still varied widely.

The Second E.C. Non-life Directive, which came into effect on July 1 this year (*BI*, July 2; May 16, 1988), allowed coverage for large commercial risks to be placed across national borders.

The non-life framework directive will complete the picture by extending this freedom to all non-life policies.

Observers predict that the rules will spur intense competition.

"We are gearing up for it—the competition is going to be enormous. Some companies may not be able to cope when the market is completely opened up, and will not be able to provide competitive services. They could become the subjects of takeovers, or some may just go under," said Wauthier Robyns of UPEA, the Belgian insurance association.

The E.C. Council also may soon make joint ventures between insurance companies easier. The council is expected give insurers certain automatic exemptions from an E.C. ban on restrictive practices.

Insurer, for example, would be able to freely form cooperative reinsurance and co-insurance ventures, particularly groups and pools; share loss information; and jointly verify and approve safety and security equipment.

Mergers between insurers in different member states have also been streamlined by E.C. legislation that took effect in September. A special E.C. office now evaluates each merger to see if it has anti-competitive implications for the entire market. In addition, the office has a limited amount of time to act on a merger proposal.

Within the next few months, the E.C. Commission also will propose new rules for life insurers that will be identical to the liberalized regulations proposed for non-life insurance. ■

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Hong Kong exodus

Firms can offer array of benefits to retain workers

By Douglas N. Smith

MANY COMPANIES IN Hong Kong are experiencing record high employee turnover rates as speculation about government stability after 1997—when the colony reverts to Chinese ownership—increases. Three factors have made companies especially concerned to keep their top executives: the tight labor market in Hong Kong, 25% average turnover per year and brain drain caused by emigration.

Concern about turnover is based on several causes:

- People are emigrating to seek a more secure future in a more stable political and economic environment.
- People are seeking higher pay opportunities in a tight labor market.
- People are looking for better career opportunities with more progressive companies.

Emigration is a big concern. It is estimated that more than 55,000 people will leave Hong Kong in 1990. Of this group, the vast majority are professionals like managers, computer specialists, accountants, doctors and teachers.

Recent surveys indicate that most people leaving Hong Kong would prefer to go to the United States, Canada or Australia. Since the U.S. immigration quota for Hong Kong is only 5,000 people per year, most emigrants opt for Canada and Australia. In 1989, Canada took in more than 20,000 people from Hong Kong. It does not appear that this situation will reverse in the near term and it could become worse.

Some companies are beginning to assist key employees with emigration. Foremost on the list of nations are Singapore, Australia, New Zealand, France and the United States.

In addition, in the United Kingdom, Parliament has just approved a program to allow up to 50,000 Hong Kong families the right of abode in the United Kingdom—a right that will be exercisable at any time.

Most U.S. companies with operations in Hong Kong are taking the following measures:

- Assisting their employees to file a "block application" for emigration to Singapore.

Singapore has an immigration quota of 20,000 professionals from Hong Kong. The right of abode visa entitles successful applicants to reserve the right to immigrate to Singapore for up to five years, and it is further extendible for another five years.

It is estimated that more than 55,000 people will leave Hong Kong in 1990 . . . .the vast majority are professionals like managers, computer specialists, accountants, doctors and teachers.

To our knowledge, only about 15,000 applications have been approved so far.

- Obtaining L-1 work visas to allow key employees to work in the United States.

Upon landing, applications are made for either the third ("professional") preference or sixth ("skilled or unskilled labor") preference under the U.S. immigration allocation system.

We understand that the waiting period for the sixth preference is now more than five years; visas are being granted to applications filed before Jan. 8, 1987. Since the maximum period of stay under an L-1 visa is five years, many applicants waiting in the United States are being forced to leave. Visas

International issues

under the third preference are now being processed for applications made before Jan. 15, 1989.

- Filing for permanent resident visas in the United States under the third and sixth preferences for key employees while they work in Hong Kong.

This method allows a company to retain key employees until a visa is issued.

Compensation also is a very real concern in Hong Kong. Pay increases during the past year have averaged close to 20%. In many cases, companies are paying up to 50% more to replace employees who have left. Over the past few years, the overall quality and standard of staff in Hong Kong has dropped while pay levels have increased dramatically, causing widespread overemployment.

Evidence suggests that cash compensation alone does not guarantee employee loyalty and its long-term effectiveness is often questionable. We suggest considering other alternatives such as:

- Deferred compensation.

BI/HOLLY SEGUINE

This can be quite effective in staff retention. There are various ways to design such a program. As an example, a portion of an employee's compensation can be deferred as a "gratuity payment" to be paid two or three years hence. There is no taxable event until payment is actually made. However, such a program is only effective if the deferred amount is significant.

- Stock options, which can be allocated to employees on a class-year basis.

Such options can be discounted at the time of the grant. On a rolling basis, each class of options granted will not become exercisable until two or three years hence, and the options must be exercised sequentially.

- Housing allowances.

In addition to being tax-effective, this program can be an effective staff retention arrangement.

Generally, the value of free housing supplied by an employer to an employee is taxable only up to 10% of a person's remuneration. For example, suppose an employee is paid a total salary package of $350,000 Hong Kong ($44,933 U.S.) per year. The package can be structured so that the company agrees to pay a salary of $200,000 Hong Kong ($25,676 U.S.) and rent of $150,000 Hong Kong ($19,257 U.S.). Therefore, the employee's taxable income is $200,000 Hong Kong ($25.676 U.S.), plus 10%—or $15,000 Hong Kong ($1,926 U.S.)—of the housing allowance.

Housing allowances can be arranged for employees irrespective of whether they already own a house.

- Domestic maids.

If the employee hires his own domestic maid and the employer subsequently reimburses the employee

Evidence suggests that cash compensation alone does not guarantee employee loyalty and its long-term effectiveness is often questionable.

for his or her expense, the reimbursement will be subject to the Hong Kong salaries tax. However, if the employer hires the maid directly, the employee will not be subject to any Hong Kong tax on the benefit.

Under the Hong Kong labor law, all domestic maids must be hired by individuals and not companies. However, an internal memorandum from the company authorizing the employee to hire a maid on the company's behalf may substantiate that the maid is, in fact, an employee of the company. Through such an arrangement, there is basis to treat salaries paid the employee's maid directly by the company as a non-taxable benefit.

Many professional employees employ domestic servants in Hong Kong. It is estimated that there are approximately 55,000 domestic servants from the Philippines alone working in Hong Kong.

- Club memberships.

There will be no tax to the employee if his employer joins a club as a corporate member and nominates the employee to be its representative. In addition, club dues paid by the employer on behalf of the employee are not taxable income to the employee.

- Preferential use of company assets.

The basic principle underlying the taxability of other non-cash benefits under the Hong Kong salaries tax is that benefits-in-kind that are not readily convertible into cash are not taxable.

The benefits derived from the use of company assets, like cars and furniture registered in the company's name by an employee, are not considered convertible into money and, thus, are not taxable to the employee.

- Holidays.

"Holiday allowance" is specifically exempt from the salaries tax. The company can grant an allowance to an employee for vacation air fares or a package tour that includes food, transportation expense and lodging for the employee and a spouse and children.

- Flexible compensation.

Companies can effectively present to an employee a total compensation package—incorporating some of the arrangements mentioned earlier together with other employee benefit programs like life insurance, medical coverage, disability insurance, vision care, wellness programs and vacation time—that would make other job offers less attractive.

In the present environment such arrangements make sense. ■

Douglas N. Smith is vp and manager of the International Department of Johnson & Higgins in New York. His column appears the first Monday of every month.

Health cost controls can broaden liability

By CHRISTINE WOOLSEY

HONOLULU—Employers and trustees of health care plans have a fiduciary responsibility to investigate ways to contain health care costs, asserts an attorney who specializes in employee benefit law.

"It is my legal opinion that, even if you don't adopt any of these programs, it is a breach of fiduciary duty not to have investigated cost containment techniques," said Sarah Kenyon Kraw, a partner in the San Jose, Calif.-based law firm Kraw & Kraw.

Employers also have an obligation to clearly communicate any cost containment provisions to plan participants. Any provisions in the program that will affect the level of benefits provided, as well as any appeal procedures, should be fully outlined, Ms. Kraw said during the 36th annual Employee Benefits Conference sponsored by the International Foundation of Employee Benefit Plans and held Nov. 9-14 in Honolulu.

"Make sure the communication is not full of 'legalese' or fine print" and clearly defines the responsibilities of the plan participant and treating physicians, she said.

Employers, trustees and plan administrators who decide to implement cost containment programs—such as managed care networks, employee assistance programs or utilization review requirements—have their work cut out for them in assuring that the programs meet their needs and protect the employer or the plan from potential legal liabilities, Ms. Kraw said.

Employers should, for example, be sure the hold harmless language in their contracts with cost containment vendors—including UR firms, health maintenance organizations and preferred provider organizations—is very specific because of a wave of a new type of medical malpractice lawsuits, Ms. Kraw said.

For example, Ms. Kraw described a recent wrongful death suit in California filed against an insurer and a utilization review organization that denied further hospital benefits for a teen-ager admitted to the hospital's psychiatric facility. Because the UR firm denied further benefits, the attending physician discharged the boy, who committed suicide soon after his release, she said.

At issue is whether the insurance policy stipulated that the utilization firm had the authority to deny benefits to the boy, even though the physician deemed the treatment medically necessary. The contract in question said that if the physician thought the care was medically necessary, his decision was final, Ms. Kraw said.

"The medical community says that denial of payment equals denial of care, and the courts seem to be buying into this," she said.

But, the "defendants argued that utilization review is important as a matter of public policy," she said.

A judge, in a preliminary ruling, has allowed the case to go to trial.

As a result, employers should be sure cost containment firms are not the final decision makers when benefits are ordered denied. If a cost containment vendor is found liable in a medical malpractice lawsuit, plaintiffs may also allege that the employer breached its fiduciary duty by contracting with the firm, Ms. Kraw warned.

"These cases are becoming fashionable now and we'll see many, many more of them," she said.

It is also a good idea to include indemnification clauses and "hold harmless provisions" in contracts with cost containment vendors, Ms. Kraw added.

She noted that in medical malpractice cases involving denial of care or benefits, plaintiffs may sue the offending doctor, the employer, the health insurer, the utilization review company and any other cost containment outfit involved in making health care decisions.

"There is nothing wrong with indemnification provisions," she said. She noted that, for example, PPOs can add employers to their medical malpractice insurance policies as named policyholders. "It's a little added cost, but it gives you protection."

She said employers interested in establishing cost containment programs should carefully select program providers, demand comprehensive contracts with those providers, clearly communicate the provisions of the program with plan participants and monitor the program once it is in place to be sure it is fulfilling its purpose.

When approached by individuals marketing a particular cost containment program, employers should analyze additional options available to them and compare them to their benefit plan needs. A program that works for one company may not necessarily be right for all companies, Ms. Kraw said.

Employers also have to consider the likelihood of a cost containment program's success before implementing the program, Ms. Kraw said.

And, employers should evaluate the program's cost, she said. For example, are the anticipated savings worth the cost of the program? "If the program will cost an additional 50 cents per plan participant, you should ask whether you'd like to use that 50 cents for something else," she said.

Also in evaluating the program's overall cost, employers must look for any indirect costs associated with implementing the program, such as the cost of administration, Ms. Kraw said.

The impact of the program on plan participants also must be weighed, she suggested. "Is it too hard to understand or so complicated" that plan members will not use it? If so, the program is probably not worth the investment, Ms. Kraw said.

Employers that decide to implement some type of cost containment program must be very prudent about the selection process, Ms. Kraw said, suggesting that employers obtain competitive bids.

"Get more than one quote and get a full presentation" from the cost containment vendor being considered, she recommended. Even if there is only one such vendor serving an employer's geographical area, the employer should at least compare the program's costs and services with industry standards, she said.

"I can't think of a situation in which you won't benefit from comparisons. You may not get apples to apples, but even an apple to orange comparison will be helpful," she said.

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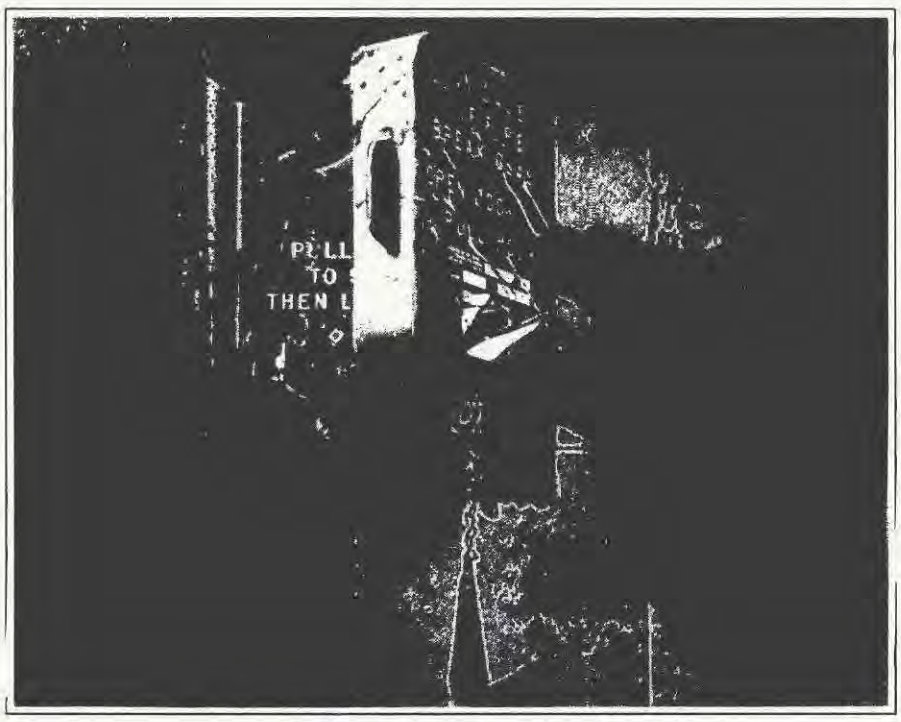

MARCH 29, 1994

Continued from previous page

Employers also should look at the credentials and financial statements of cost containment companies, Ms. Kraw said.

She stressed that employers should not rely on any financial statements included in marketing materials.

As an example, Ms. Kraw related an incident in which an employer considering contracting with a cost containment vendor found that a financial statement in the firm's marketing package had a different name on its letterhead than the name of the bidding company. The company named on the financial statement was not in any way affiliated with the bidding company.

When confronted, the bidding company explained that it substituted the other company's financial statement for its own because its own financial statement was not as impressive.

Other areas meriting close attention include the internal operating procedures of the cost containment company, Ms. Kraw said.

For example, employers should ask what specific quality control measures are in place, including how health care professionals are selected by the company to participate in managed care networks and whether there are any internal financial arrangements between the participating physicians and the cost containment vendor that might affect the quality of care.

In addition, a straightforward appeals process should be explained by the cost containment vendor to the employer—and by the employer to the employee—for cases in which benefits are denied and the denial is challenged by the plan participant, she said.

Once an employer selects a cost containment vendor, it should require a comprehensive contract. And, one of the most important elements of the contract is a termination clause, Ms. Kraw noted.

"There is no reason to remain with a program for three, four or five years if it is no longer meeting your needs," she said.

In addition, fiduciary liability should be clearly outlined in a contract with a cost containment vendor, Ms. Kraw said. The contract must clearly define the responsibility of plan participants, participating physicians, program providers and other providers, administrators and plan trustees, she said.

Employers also can stipulate in the contract that they must receive reports that provide specific information the employers want. "You want the outfit to provide meaningful and useful reports to you. Don't accept the canned reports the program is designed to generate," Ms. Kraw said.

She also warned employers not to accept arguments that a certain type of information cannot be provided because it is confidential. "You should retain the right to get behind this" excuse, Ms. Kraw advised. Many employee assistance programs will claim they can provide only summarized reports and cannot provide usage reports that identify which employees or dependents are using substance abuse or mental health services, she pointed out.

An audience member pointed out that many states require a court order for employers to gain access to the names of plan participants using substance abuse or psychiatric services.

Ms. Kraw agreed but said that "it isn't appropriate for plan fiduciaries to give such deference to state laws requiring confidentiality."

"You shouldn't be buffaloed by these plans. You are plan fiduciaries, and you have a right to that information. Providers of substance abuse and mental health care do want to get paid, and it's absurd to think they don't have those names somewhere. When initially negotiating that deal, set something up to make sure you have access to that information. If they won't provide you with it, don't contract with them."

After employers adopt cost containment provisions in the health care plan, they should review reports on the plan's performance, Ms. Kraw recommended. "Your consultants and plan administrators can look at them, but at some point the board of trustees should dig into the program" to be sure it is working and generating measurable savings, she said.

However, if the program is saving a significant amount of money, employers must check that those savings are not compromising quality care. "Be sure the quality control measures discussed are being used," she warned.

Marshall Wortman, president of Benefit Plan Consultants Inc. in Marina del Ray, Calif., moderated the session. ■

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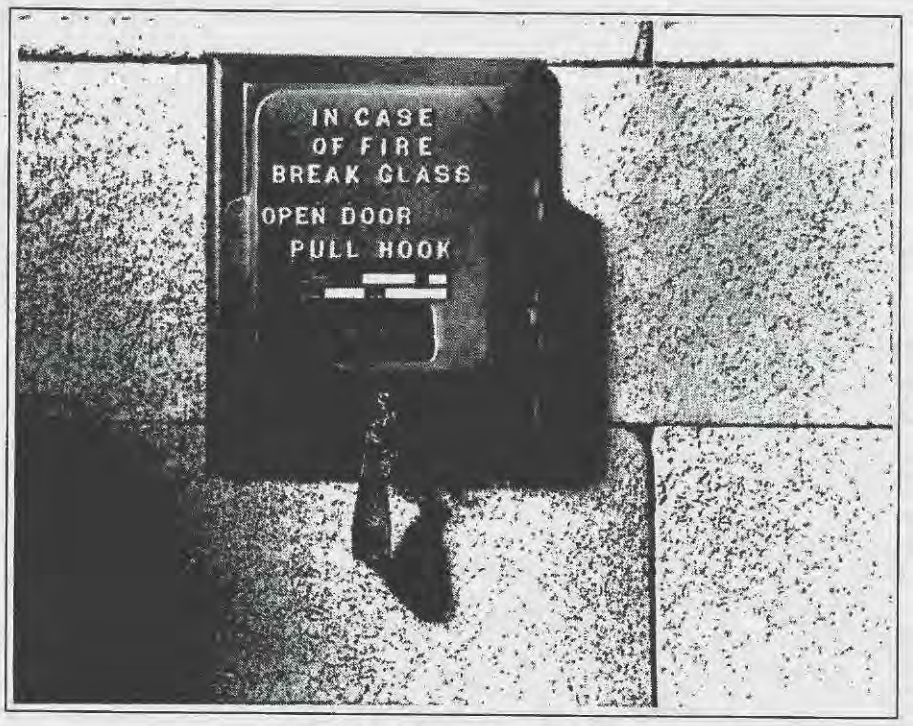

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IT PAYS TO BE CAREFUL.

Worker needs will alter future benefits

By CHRISTINE WOOLSEY

HONOLULU—Employers must listen closely to their employees when designing benefit programs for the next century, according to a futurist.

The workforce is in a state of volatile change and employers that want to attract and retain quality workers will have to increasingly use benefits as an incentive, said Heather P. Kurent, senior associate for the Institute for Alternative Futures, a consulting group in Alexandria, Va.

"This is a consumer-driven society and consumers set the agenda-not management," Ms. Kurent said.

However, at the same time, employers can encourage employees to accept part of the responsibility for controlling benefit costs through good health practices, she said at the 36th annual Employee Benefits Conference, sponsored by the International Foundation of Employee Benefit Plans and held Nov. 9-14 in Honolulu

Employers will find that their employee benefit plans must be designed to meet the specific needs of the groups they will employ in the 21st century, Ms. Kurent said.

Family concerns, for instance, will be a top priority, she said.

Noting the growing dominance of women in the workforce, Ms. Kurent said that employers will have to design benefits that address daycare needs.

U.S.-born white males will represent only 15% of new entrants to the labor force between 1985 and 2000, down from 47% in 1985, according to data cited by Ms. Kurent from the Hudson Institute, a Washington-based think tank.

Meanwhile, U.S.-born white females will represent 42% of the labor force by the year 2000, up from 36% in 1985, a 16.7% increase, she said.

Women, who "will work at all levels, including part-time," will demand benefits to meet their family needs, Ms. Kurent said.

Benefit plans will have to reflect the reality that "husbands, wives and even children are working," she said.

Ms. Kurent also observed that as the economy becomes less industrialized, new labor unions may place different demands on employers.

"Union membership has declined to 16% of the workforce, paralleling the decline of the industrialized economy," she said.

A significant portion of the labor force now holds service jobs, and those workers generally do not belong to unions.

But, labor unions could rise again to represent white-collar workers, who will be organized around a completely different set of issues, Ms. Kurent said. Employers "will have to think about parental leave and flex time given these demographics."

Ms. Kurent also pointed out that training and re-training workers may become an increasing responsibility for employers in the future.

As cutbacks are made in government-sponsored educational programs and the cost of advanced degrees increases, employers may find that the responsibility for financing education and training increasingly will fall in their laps, Ms. Kurent said.

Corporations badly need to acquire highly skilled employees to remain competitive and tuition reimbursement programs may be one technique to attract such workers, she said.

Part of the reason highly trained employees are absent from the workplace is because "most high technology is produced in military labs and is under tight security, keeping that genius under wraps."

That practice is preventing the United States from achieving international competitiveness with countries like Japan, she said. The Japanese, for example, do not develop most of their high technology as part of military projects so they "haven't had to keep their bright people" out of the mainstream economy.

In addition, in today's mobile society, workers are more likely to move from company to company, so employers will have to offer enticing benefit programs to create loyalties and retain highly skilled workers, she said.

Minorities and immigrants also place greater demands on employers as they achieve a greater presence in the labor pool, she noted.

Ms. Kurent said Hudson Institute data showed that non-white workers will comprise 20% of the labor force by the year 2000, up from 10% in 1985. In addition, immigrants will represent 23% of the workforce by the year 2000, up from 7% in 1985.

Employers "must treat women, minorities and the disabled as very precious resources" because they will make up a predominant portion of the workforce in the year 2000, she said.

The aging workforce also will have a significant impact on benefit design in the future, Ms. Kurent predicted.

Life expectancy has increased dramatically, and at the same time, "acute diseases that kill have been replaced by diseases that harm rather than kill," she said.

As a result, employers will find more of their retiree medical benefit dollars are being spent to treat these ailments, she said.

Employers also must realize that given increased life expectancy, 65 is no longer a realistic retirement age, Ms. Kurent noted. Employees typically live 15 to 20 years past age 65 so the normal retirement age may have to be pushed back.

Cost containment will be the key to redesigned benefit plans in the 21st century, according to Ms. Kurent.

Employers should continue to focus on such efforts as managed care and utilization review to contain rising health care costs.

At the same time, employers should encourage sophisticated self-care for their employees.

"The responsibility is on the individual, fairly or unfairly, to take care of some of these problems," she said.

To help employees address health concerns, employers should implement employee assistance programs that include wellness overviews, stress management, alcohol and drug education and therapy, and parenting education.

Promoting good health will result in "healthy companies" and could become part of an employer's public relations and recruitment strategies, Mr. Kurent said.

"You are telling workers, 'This is a healthy workplace that you can stay in,' " she said.

Albert L. Meric Jr., executive vp of Wright Investors' Service in Bridgeport, Conn., moderated the session. ■

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Firms must take part for case management to work well: Expert

By CHRISTINE WOOLSEY

HONOLULU—Employers must take an active role in the case management of catastrophic and chronic illnesses and injuries, according to a utilization review and home health care expert.

Effective case management can cut benefit plan costs and improve the quality of care and the quality of life for patients suffering from catastrophic or chronic illnesses, said Mary Anne Carpenter, vp of review programs for Downers Grove, Ill.-based HealthCare COMPARE Corp., one of the largest independent UR companies in the nation.

"Case management is a win/win situation," Ms. Carpenter said at the 36th annual Employee Benefits Conference sponsored last month by the International Foundation of Employee Benefit Plans in Honolulu.

Patients benefit from an individualized coordinated treatment plan, she explained. Physicians unfamiliar with a particular diagnosis may benefit from the case managers' help in coordinating care and from medical specialists typically on staff at case management organizations.

And, Ms. Carpenter said, because "physicians speak medical and payers speak insurance, often times case managers can help both parties communicate with each other and understand each other's objectives.

She noted that case management is especially effective and necessary to control the costs of medical treatment for patients with either catastrophic or chronic illnesses or injuries.

But, employers have to take an active role in case management to make it as effective as possible, according to Ms. Carpenter.

Among the catastrophic cases for which case management is best suited are:

• Illnesses associated with the human immunodeficiency virus, which causes Acquired Immune Deficiency Syndrome.

"You have to put AIDS in perspective," she said. "It's a condition that is terminal and can cost plans lots of money. It fits right in with cancer and other catastrophic diseases in terms of costs."

While the number of new AIDS cases is continuing to increase, the costs associated with treatment of the disease have decreased in recent years, according to Ms. Carpenter.

She pointed out that the Centers for Disease Control in Atlanta reported 35,238 new cases of AIDS in 1989, a 9.4% increase from 32,196 new cases reported in 1988.

But, she said, original treatment cost projections of $100,000 to $150,000 per case have not been the norm. Rather, total costs per case from diagnosis until death have averaged $75,000.

Part of the reason treatment costs have been maintained at 50% to 75% of original projections is because of the availability of a variety of outpatient, home-based and community support services for people with AIDS, Ms. Carpenter said.

However, she noted that these types of services are running into problems. Lack of federal funding for these types of services means the cost to employers of treating AIDS probably will rise as AIDS patients increasingly tap into employer-sponsored health care benefits to pay for treatment, she said (*BI*, Oct. 22).

• Organ transplants.

"More plans are providing coverage for organ transplants because not all of them are considered experimental anymore," Ms. Carpenter pointed out.

However, employers should include in benefit plan documents clearly worded exclusions dealing with the appropriateness of organ transplants.

Continued on next page

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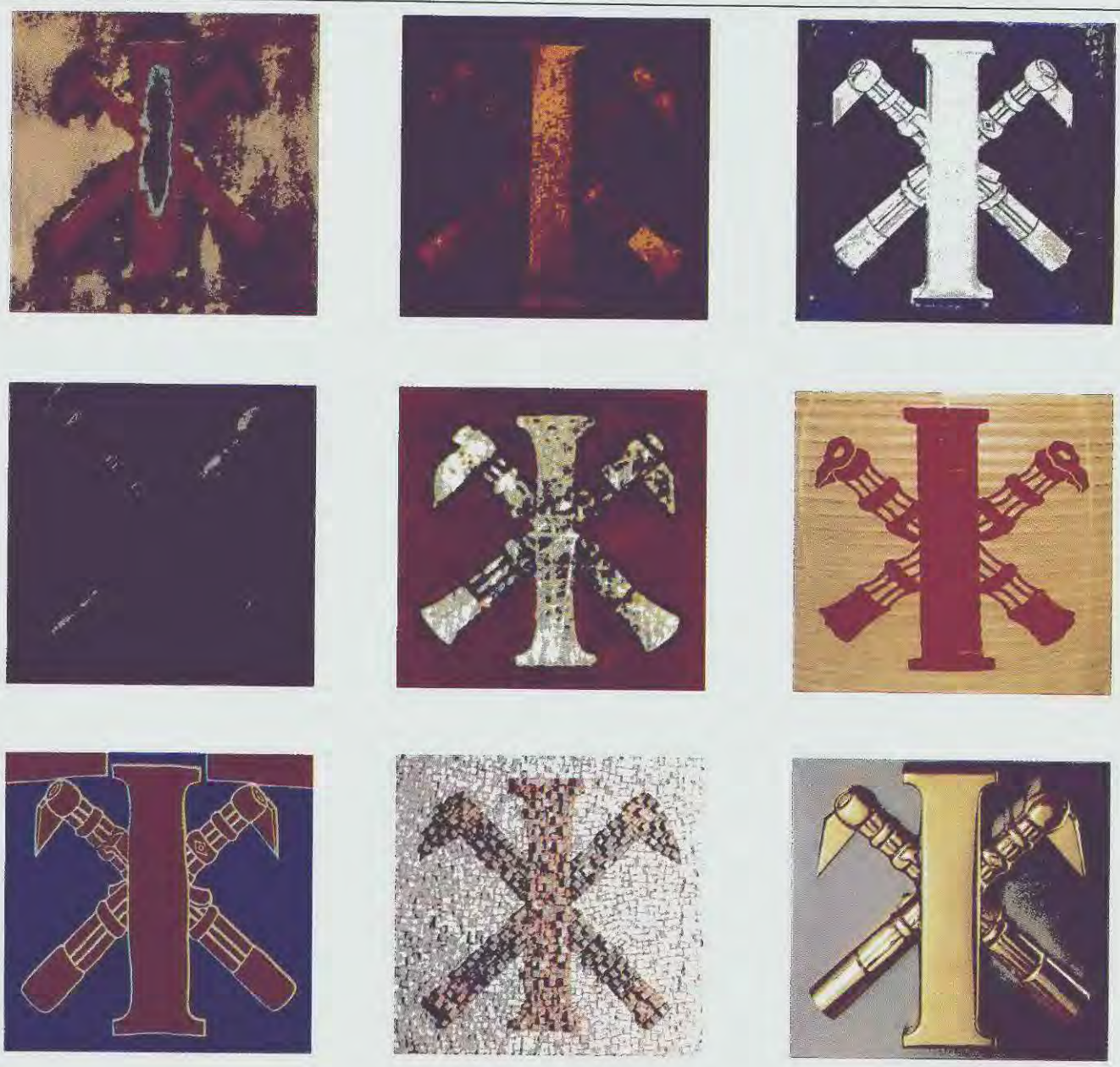

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Case management

Continued from previous page

She warned that some surgeons will perform organ transplants on any patient who "needs" one—even if the chances of success are minimal. As an example, she cited a situation when a doctor recommends a liver transplant for a chronic drug user.

Ms. Carpenter also stressed that employers must implement these coverage exclusions prospectively, not after a costly transplant has taken place.

If a health care plan does cover transplants, employers and case managers should be certain transplants are being performed at high-quality facilities that use expert medical professionals. Such "centers for excellence" are being identified and utilized by most of the major health insurers, she said.

However, employers still should verify themselves that a high-quality transplant team is indeed practicing at such a facility. "It is the expertise of the surgical team that helps, not the facility itself," Ms. Carpenter explained.

- High-risk pregnancy cases.

Mothers with a high risk of premature birth should be identified so an appropriate and cost-effective treatment plan can be developed as soon as possible.

Ms. Carpenter also noted that

'Patients don't read their plan benefits. They just assume that everything is paid for,' says Ms. Carpenter.

chronic illnesses are even more costly than catastrophic illnesses and that many chronic illnesses, like diabetes and acute allergies, should be handled by a case manager.

Citing a Hewitt Associates study on the types of cases appropriate for case management referral, Ms. Carpenter said 68% of 216 diagnoses showing a need for case management were for "chronic disease."

And, the chronic disease cases represented 78.1% of the total costs of the 216 cases examined. Only 15.5% of total costs related to catastrophic cases.

The remaining 6.4% of costs was related to mental health and substance abuse.

"There is a tremendous opportunity for coordination of care and negotiation of costs" for chronic conditions, Ms. Carpenter said. "But unless you look closely at these cases, you'll miss them because the dollar amounts come in sporadically—$10,000 here, $7,000 there."

Several signs can be used to identify patients whose chronic medical cases should be handled by a case manager, according to Ms. Carpenter. Those include:

- The secondary diagnosis of a patient being admitted to the hospital as well as the primary diagnosis.

For example, a patient admitted to the hospital with a bleeding ulcer may in fact be suffering from a particular type of cancer, she said. "Those secondary diagnoses will alert case managers that this may be a chronic disease," she said.

- The number of hospital readmissions for a patient.

"Frequent readmissions are a sign. If you put in case management early, you can help avoid readmissions and make sure care is coordinated."

- Multiple doctors.

If a doctor is unaware that the patient is seeking treatment from other physicians, the patient could suffer health problems caused by multiple medications that are not coordinated. Each doctor may prescribe drugs without knowing what other medications the patient is taking. Often, one drug cancels out the effect of the other.

- Frequent emergency room visits.

"Many people do not have primary doctors they can call when they are not feeling well," so they wait until their condition deteriorates to the point that they have to seek emergency room care—the most expensive place for treatment, Ms. Carpenter said.

In addition to identifying which cases should be managed, employers should inform physicians and hospitals that they have a case management program, Ms. Carpenter stressed.

To be effective, case managers "want to be there when the treatment plan is being established," not when the treatment plan has been in place six months.

And, persuading physicians to alter their treatment plan is difficult, she said.

Timely communication with health care providers also assures that employers and case managers can negotiate fees with the providers at the same time they discuss the types of treatment plans for catastrophic or chronic cases.

"There is a lot of slack in the cost of health care and there is lots of room for negotiation," according to Ms. Carpenter.

But, employers may face resistance from physicians or medical facilities that are not accustomed to discount arrangements. And, those providers will certainly be reluctant to offer any discount after a treatment plan has been in place for a while, she noted.

In addition, patients must be informed if there are any aspects of their treatment through case management that are not covered by their employer-sponsored health care plan, Ms. Carpenter advised.

"Patients don't read their plan benefits. They just assume that everything is paid for," she observed.

"Good outcomes" of case management can be measured in different ways, Ms. Carpenter noted.

A reduction is benefit plan costs because of the elimination of unnecessary medical treatment is one measure, she said.

Another measure is an improvement in the quality of care that patients receive. But, savings associated with quality care are more difficult to quantify, she acknowledged.

Improving the quality of life is another outcome measurement of case management, Ms. Carpenter said.

Katherine A. Hesse, a partner in the Quincy, Mass.-based law firm Murphy Hesse, Toomey & Lahane, moderated the session. ■

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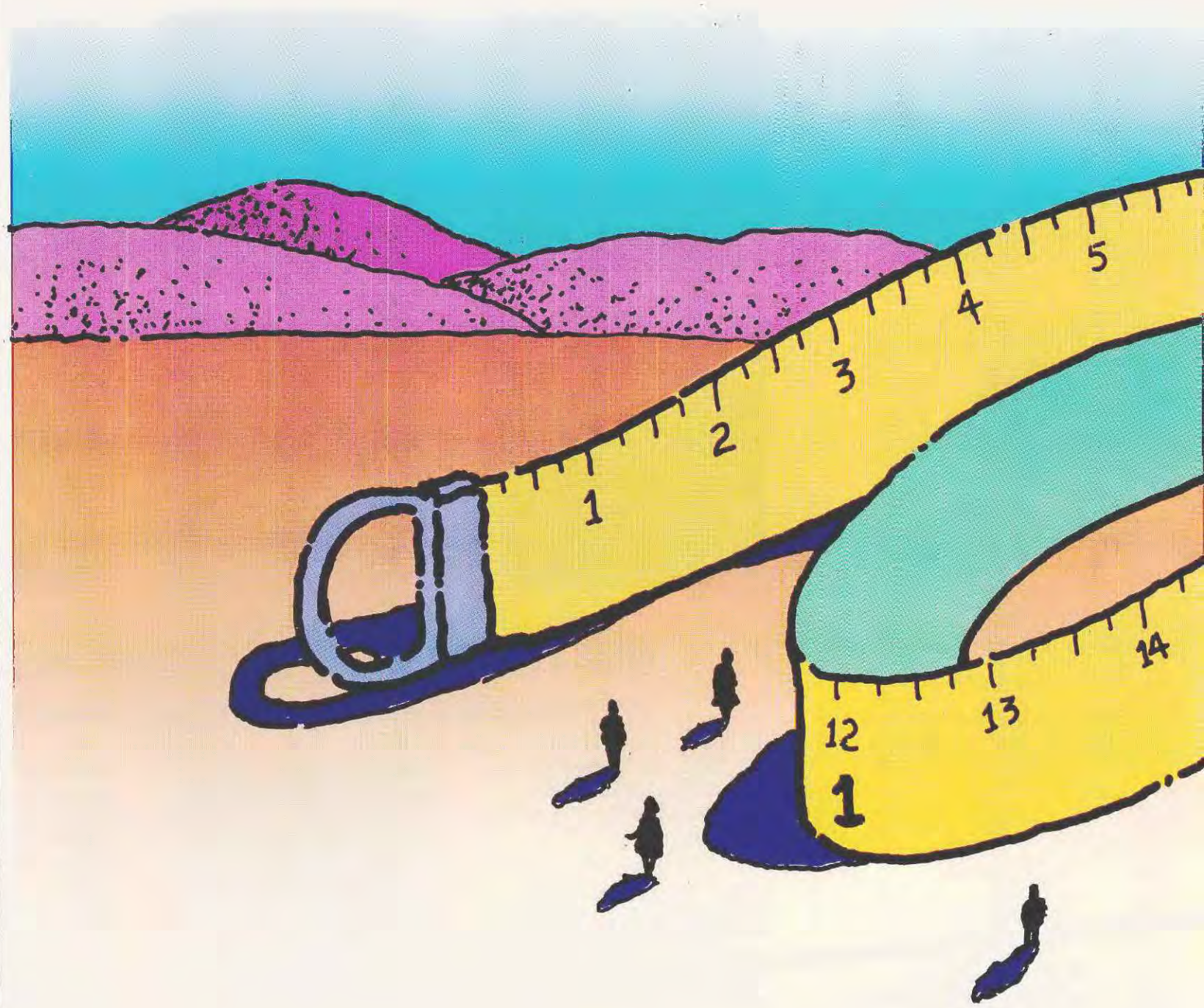

Employers told to define health plan goals

By CHRISTINE WOOLSEY

HONOLULU—An attack on rising health care costs in the 1990s requires evaluating current health care plan goals and examining alternative methods to achieve those goals, says a benefits expert.

Employers also will have to, among other things, redefine what constitutes a medical necessity; form employer health care coalitions to work with the medical community to reduce overutilization while assuring quality health care; and encourage lifestyle changes to improve the health of plan participants, says Lee Jost, president of benefit consultant Lee Jost & Associates in Brookfield, Wis.

Although "real thought about planning can best be done in smaller groups," there are many general strategies employers can adopt when considering the direction their health care plans will take in the future, Mr. Jost said.

Approximately $648 billion will be spent on health care in the United States this year, a whopping increase of 167.8% from $242 billion in 1980, Mr. Jost said.

During the same period, employers generally saw their health care costs rise 11% to 20% annually, he said during a packed presentation attended by corporate benefit managers and union health and welfare fund trustees during the 36th annual Employee Benefits Conference sponsored last month by the International Foundation of Employee Benefit in Honolulu.

"Tomorrow's costs are the sum of yesterday's costs, habits and trends," Mr. Jost said, noting that new influences will drive the nation's and employers' health care costs even higher.

Among those influences is the aging of the U.S. population.

For example, in 1980, people older than 65 comprised 11% of the U.S. population. But, by the year 2030, people older than 65 will make up 21% of the population, Mr. Jost said.

And, he warned, that segment of the population will require an increasing portion of the health care dollar.

For example, in 1980, people older than 65 required 105 million days of hospitalization, he said. By the year 2000, they will require 275 million days of hospitalization, according to Mr. Jost.

Another factor driving health costs upward is that many physicians now are recommending exploratory surgery to eliminate any doubts they may have about diagnoses, rather than practicing "cognitive medicine," he said.

New diagnostic and treatment methods also drive up health care costs, he said.

And, of course, new diseases, like Acquired Immune Deficiency Syndrome, boost health care costs, Mr. Jost said.

To combat these influences, employers will have to define, and in some cases redefine, the purpose of their health care plans, he said.

Specifically, he said, employers must decide what is the most important goal of their plans: Are they offered to protect all employees and dependents from financial ruin as the result of catastrophic illness? Or, are they offered to "provide as many (people) as possible with small dollar benefits or eliminate as much out-of-pocket expense as possible?"

Most employers have "accepted the responsibility to protect employees for the long-term against the impact of unforeseen medical expenses," he said.

But, employers now must evaluate the specifics of their benefits plans to meet that goal in the future, he said.

Gathering data on employees' medical care utilization is an important first step, Mr. Jost said. An employer should document the number of hospital days covered under its plan and compare that to data gathered by other companies.

Mr. Jost suggested that employers should "look for norms," and consider such questions as: "Do we have a higher incidence of certain diagnoses?" and "Why do we have three times the number of admissions for treatment of alcohol and drug abuse?"

More importantly, employers should ask themselves: "Can we afford to continue in this direction?"

Specific strategies that can help cut future health care costs include reducing unacceptably excessive hospital stays to published norms, Mr. Jost said. Employers should, for example, reduce unnecessary surgeries by requiring workers and dependents to obtain second surgical opinions, he said.

Employers also may have to redefine what constitutes a "medical necessity" as part of managing health care costs, Mr. Jost said.

"Recent court decisions seem to require that plans have a working definition of medical necessity, especially in cases where a claim is being denied," he explained.

"The legal decisions seem to say (medical necessity) incorporates community standards," he noted.

One definition of medical necessity could encompass all health care that the patient and the health care provider decide is necessary, he said.

However, another definition of medical necessity could be that only health care related to life-threatening cases are "necessary," Mr. Jost pointed out.

"Both are unacceptable," he said.

"The challenge is to determine how our definition of medical necessity affects our costs," he said.

Mr. Jost suggested that "more

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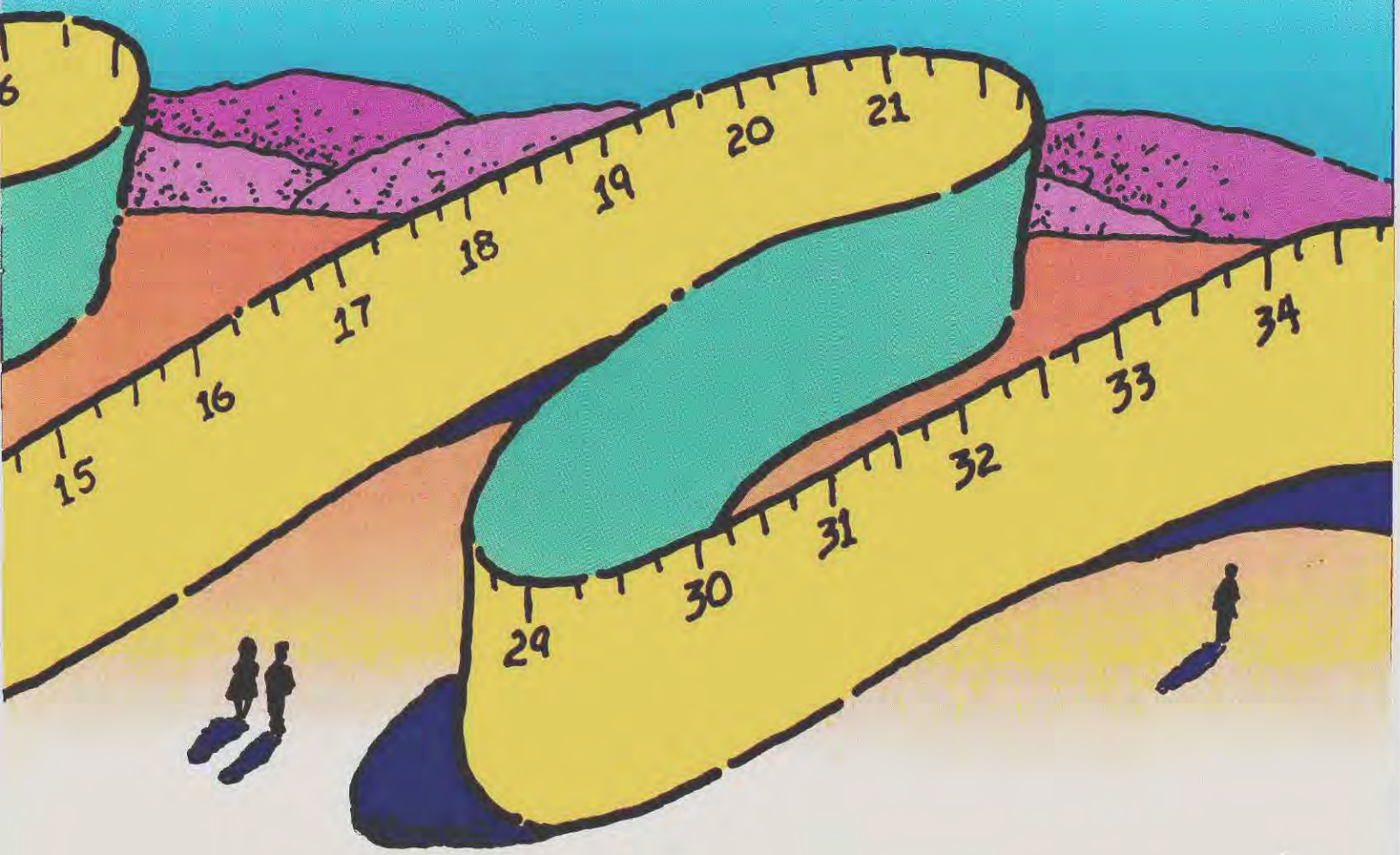

Health care goals

Continued from previous page

thoughtful interaction needs to take place between the patient and provider based in part on what the patient is willing to pay without plan coverage."

For example, the medical community has stated that as much as "one-third of all coronary bypass surgery is unnecessary," Mr. Jost pointed out.

In addition, the rate of Caesarean-section births in some areas of the country have been identified by medical experts as too high, Mr. Jost said.

He also said that knee replacements for the elderly and excessive therapy for sports injuries could be added to the list of treatment for which coverage should be denied or limited.

Employers must consider what is "appropriate" care when defining medical necessity, he said. Medical appropriateness can then be used as a basis for denying certain claims.

New definitions and plan design changes can be better implemented if employers work together and seek cooperation from the medical community, Mr. Jost said.

Participation in employer health care coalitions can create the mutual support necessary to persuade hospitals and physicians to participate in employers' cost containment efforts.

Employers that band together may be better able to collect data on hospital costs and lengths of stay from providers in their regions, he noted.

Once such data is collected, employers will be better able to "identify and reward cost-effective providers," Mr. Jost said.

And, while quality of health care is difficult to measure, one method of determining quality is to evaluate the "outcome of care, including complications and deaths" associated with care from a particular doctor or hospital, he said.

Mr. Jost also stressed that "the fewest number of resources are needed to achieve a favorable outcome. Poor quality costs more."

For example, Mr. Jost referred to the results of a study of New Jersey hospitals that measured the highest-quality outcomes of surgery for nervous disorders. In that study, the highest-quality hospital charged an average of $5,742 per case, while the lowest-quality hospital charged $8,649 for the same services.

When attempting to collect quality data from hospitals, "trustees and purchasers of health care services are finding an ally in the investment community," Mr. Jost noted.

Investors now are considering the quality of care hospitals provide "as part of their assessment of the hospital's creditworthiness," he said.

"Some observers expect the investing public will shift attention away from the hospital's equipment and staff size when judging quality and will instead look at statistics on quality of health care and outcome data," he said.

Employer coalitions should attempt to persuade hospitals to adopt quality-of-care assessment systems and share the results with them, Mr. Jost said.

In addition, employers should ask hospitals to adopt a prospective pricing system that would include "standardized health care product descriptions and then disclose the prices for those services," Mr. Jost said.

Employers could become much better educated consumers if they are aware that there are fixed prices for some diagnoses and per diem prices for others, he said.

"Your partnership with hospitals, developed through employer coalitions, can be used to negotiate charges," as well, Mr. Jost said.

Preferred provider arrangements could be developed by identifying cost-efficient providers and encouraging them to implement comparative performance systems. Those providers with the highest-quality outcomes would gain a competitive advantage, he said.

"Once the hospitals provide you with data, you can assure the survival" of the highest-quality hospitals by giving them your business, Mr. Jost said.

Employers also must educate employees that they have a personal responsibility in helping to manage health care costs, according to Mr. Jost.

"Educational materials and counseling may encourage healthier lifestyles and reduce the incidence of certain illnesses," Mr. Jost explained.

And, implementing "wellness programs can result in a reduction in the intensity of medical care," he said.

Many of "the illnesses being treated today are the result of conditions that started years ago," he said. As a result, employers should invest in programs like mammography screenings, nutrition programs, cardiac rehabilitation, smoking cessation, prenatal care and stress management.

In addition, employers can provide workers with the advice of physicians, dieticians and other health professionals about their diet, weight, blood pressure and exercise habits during group meetings or company health fairs, Mr. Jost suggested.

However, he pointed out that persuading workers to change their lifestyles may not be easy because many employees and dependents do not think it is the employers' place to tell them how to live their lives.

John Calascebetta, administrator of the Joint Industry Board of the Electrical Industry in Flushing, N.Y., moderated the session. ■

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IFEBP meeting attracts 7,100

HONOLULU—More than 7,100 people attended the 36th Annual Employee Benefits Conference sponsored by the International Foundation of Employee Benefit Plans and held in Nov. 9-14 in Honolulu.

The Brookfield, Wis.-based educational organization offers information services, research publications, an online benefits database and a student intern program. The IFEBP also administrates the Certified Employee Benefit Specialist program.

The IFEBP's membership consists of 33,000 individuals representing more than 7,200 professional firms, corporations, trust funds and public employee funds throughout the United States and Canada. The organization sponsors nearly 50 educational conferences each year.

The 37th Annual Employee Benefits Conference will be held Nov. 8-13, 1991, in San Diego.

For more information about the IFEBP contact Dean Ossanna, Director of Marketing and Membership, IFEBP, 18700 W. Bluemound Road, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700. ■

Agent/Broker Topics

A monthly editorial section sent exclusively to agents and brokers

Goodbye, good old days

After years of backslapping, agents in for a rude awakening

By LAURA MAZZUCA

ATLANTA—Like Gen. Sherman's flaming advance through this city, which signaled the end of the Civil War and the demise of the Old South, major shifts in the insurance industry could spell the end of an old order for agents.

Cutbacks by financially squeezed insurers, an impending economic downturn and creeping competition from foreign insurers all mean "the good old days and good old ways have disappeared forever," said J. Thomas Sutton III, new president of the National Assn. of Professional Insurance Agents.

"No crystal ball can truly predict what the agency system will look like at the end of this century," said Mr. Sutton in his inaugural address during the 59th annual PIA convention in Atlanta last month. "But it is certain that the pace of change will accelerate in the 1990s."

That feeling of change was evident throughout the meeting. During cocktails with insurers in hospitality suites or comparing soft-market battle scars at a party in the city's Georgia Freight Depot, agents clearly felt things were different this year.

One topic dominating conversations was an apparent truce in the agents' own version of the Civil War.

Consolidation talks between rivals PIA and the Independent Insurance Agents of America continued a week before the convention. The second round of talks produced agreement on several "fundamental building blocks" of a new organization, including having agencies as membership units, as well as a logo and name: "Professional Independent Insurance Agents."

Joint agent panels studying finance, governance and various programs are scheduled to meet again early this month.

As part of their plan to enter consolidation "lean and mean," PIA directors voted at the convention to eliminate 19 past presidents no longer active in the group from its board of directors. The board now has 61 members.

Even differences between the national PIA and its Minnesota affiliate, which will consolidate with the IIAA of Minnesota in January, were ironed out (see story, page 48G).

"Looking out for our members' interest is at the roots of our merger talks with the IIAA," said outgoing PIA President Richard Yingling (see story, page 48B). "I hope we've made it clear that the main reason for these talks is the market difficulties our members are experiencing." Mr. Yingling will continue to guide the consolidation talks.

If conference topics are any indication, agents are going to need all the help they can get to survive the '90s.

In a panel discussion titled "What's Happening to the Partnership?" executives from four insurers and the incoming president of the National Assn. of Insurance Commissioners drew a grim picture of the agency system's future.

They predicted lower agency commissions and canceled contracts. Battered by high loss ratios in personal auto and workers compensation coverages, public pressure, and the weight of other companies' insolvencies, insurers are looking for ways to reduce operating costs, said the experts.

'The days of backslapping and lunch-buying are over. . .And I welcome it,' says R. Keith Like of Kemper. 'When it gets easy, too many mediocre performers succeed.'

Insurers' rate of return on net worth over the past 16 years was more than 2½ points lower than the average of Fortune 500 companies while the risks were as great or greater, said Fred R. Marcon, president of the Insurance Services Office Inc., in a preface to the panel.

As a result, insurers are exploring other methods of distribution, including banks and direct writers. This all spells bad news for independent agencies that can't stay competitive.

"The days of backslapping and lunch-buying of 20 years ago are over," said R. Keith Like, executive vp of Kemper National Insurance Cos. in Long Grove, Ill.

He predicts that the number of agencies and insurers will drop by the year 2000, with the 15 or 20 largest insurers gobbling up smaller insurance companies and many others dying altogether.

"And I welcome it," Mr. Like said. "When it gets easy, too many mediocre performers succeed."

Direct writers and banks will continue to gain market share, predicted James E. Long, North Carolina insurance commissioner and vp of the National Assn. of Insurance Commissioners.

Federal intervention could also prompt radical changes for agents.

Robert B. Morgan, president of Cincinnati Insurance Co., predicted that federal authorities would become involved in regulation if problems in workers compensation and personal auto lines continue.

And foreign competition will make independent agents fight for market share, experts say.

In an earlier interview with *Business Insurance*, James H. Davies, a former PIA president who is now on an industry advisory committee to the General Agreement on Trade and Tariffs talks, warned that European insurers would increasingly make inroads into the U.S. market by setting up U.S. subsidiaries or buying American insurers outright (see story, page 48H).

Agents also must continue to deal with ongoing wild cards like an increasing number of insurer insolvencies, pressures within their own operations and consumer backlash.

At the convention, Mr. Yingling released a critical letter to Joan Claybrook, president of Public Citizen, a consumer advocacy group that has reported that five major U.S. insurers would be "at risk" in case of a severe economic downturn (*BI*, Oct. 29; Oct. 22).

PIA officials said the situation is particularly touchy since Public Citizen is represented on the board of directors of PIA's Consumer Insurance Interest Group.

"I wish you had taken advantage of our good working relationship and consulted with us in advance regarding the study," Mr. Yingling wrote in the Nov. 6 letter. "Instead, you chose sensationalized words and methods that led you into needless controversy."

Mr. Yingling said he has not received a reply. Others at the PIA say current industry criticism of the consumer group

Continued on next page

Agent/Broker Topics

Careful hiring

Continued from previous page
suited for directing and motivating others. They have big egos, are very task-oriented and thrive on challenge.

Their weaknesses include impatience.

Individuals with this trait frequently are agency producers and owners, according to Mr. Folger.

•Influencing.

Influencers are optimistic, "people-oriented" individuals who like to interact with others and crave social recognition and acceptance, he said.

They fear rejection and tend to be disorganized.

•Steadiness.

They need to serve others and are cooperative group players. Loyal and consistent, they do not react well to change or instability.

•Compliance.

People with a high compliance quotient are very concerned about living up to their own high standards, according to Mr. Folger. They are accurate and intuitive but do not like having their work criticized.

They can be overly critical of themselves and others.

A well-run agency needs all of these personality types, according to Mr. Folger. Managers who are aware of this will be better able to hire as well as motivate employees and help avoid personality clashes.

In hiring a clerk/typist, for example, Mr. Folger suggested hiring someone with the appropriate skills and a high compliance or steadiness quotient.

These personality types also do well as customer service representatives and in other support staff roles.

He cautioned against the current trend of attempting to turn CSRs into producers.

Although the transformation may work if the CSR has a more aggressive secondary personality trait, the compliance or steadiness personality types as a rule do not accept well the level of rejection inherent in selling, according to Mr. Folger.

Several standard tests—some designed specifically for the insurance industry—can help agency managers assess personality types, Mr. Folger pointed out. These should be used after a candidate makes the "first cut" by demonstrating that he or she has the necessary job skills.

Agencies must apply such tests consistently to avoid discrimination suits, according to Mr. Folger.

Because values, or "the things that people believe," are difficult to assess, they are also the most neglected area of hiring, Mr. Folger said.

But a clash of values between the employee and the organization is one of the primary reasons for a poor match, according to Mr. Folger.

Managers should first rank job values for the agency—like customer service or loyalty in a family-run agency—as well as its taboos—like arguing with customers or failing to keep accurate records.

"Find deep, engrained values about business and interview against them," Mr. Folger recommended.

If a candidate does not feel strongly about traits an agency values, chances are that the candidate is not right for that particular agency.

However, as with the "wants and musts" list, keeping the values list short to avoid alienating candidates is important, Mr. Folger stressed.

If an agency manager takes all these criteria into consideration before hiring—and uses the job description as a benchmark for later performance reviews—the candidate and the job should be a good fit.

Yet no matter how carefully employees are chosen, some just do not work out. Managers then face the unpleasant task of firing the employee.

An employee should be fired only after all remedies have failed, Mr. Folger said. But once managers decide to fire a worker, they should do so quickly and tactfully, he said.

"Think of firing as necessary surgery," he said. "It hurts, but it's in the best interest of the organization."

Careful word choice is important, he said, advising managers to say something like: "I have made the decision to fire you today." Stating that the decision has been made precludes requests for a second chance.

And, Mr. Folger stressed, the word "fired" should be used. Euphemisms like "let you go" or "terminate" could leave doubt about what is happening.

However, Mr. Folger suggested giving employees the chance to "resign" by offering a pre-written resignation letter. This will have no bearing on future unemployment costs for the agency but does give the employee the chance to leave with his or her self-esteem intact, he said.

Employees may express a range of emotions, from tears to rage, but the manager must not react, Mr. Folger.

This gives employees the opportunity to "wind down" and come to terms with the situation, Mr. Folger said.

Managers also should explain why an employee has been fired or asked to resign. And they should offer the employee a letter of reference prepared in advance that focuses solely on the former employee's strengths and does not mention that he or she was fired or asked to resign.

Final wages, benefits or severance should be prepared beforehand and given at this time, Mr. Folger said.

In closing, the employer should ask the employee to gather his or her belongings and leave the office within 15 minutes.

Then the manager should shake the employee's hand, wish him or her well and have an assistant help the employee clean out his or her desk and escort the employee to the door.

For employees who are quitting, the agency should forego the usual two-week notice period—especially if the employee is disgruntled, Mr. Folger recommended.

Instead, the departing employee should be given his two weeks' salary and told to leave at the time of the resignation.

The firing process should involve only the manager or agency principal and the employee, unless company policy requires that a third party be present. In that case, the benefits manager is a good choice, Mr. Folger said.

Because the rest of the agency staff undoubtedly will know what is going on, the manager should explain the situation to them afterward to facilitate the "healing process" and to head off office gossip, Mr. Folger suggested.

Mr. Folger suggested that managers fire employees on Monday mornings and never on Fridays to avoid having other employees speculate about the situation over a weekend. ■

Agents are urged to be bold and creative

By LAURA MAZZUCA

ATLANTA—Independent agents must combine toughness and creativity to survive market changes in the 1990s, says the new president of the National Assn. of Professional Insurance Agents.

"Meeting the challenge of change will require bold and creative solutions," J. Thomas Sutton III said in his inaugural statement at the PIA annual convention held Nov. 11-14 in Atlanta.

"We cannot solve tomorrow's problems with yesterday's approaches," he said.

One major problem is that insurers are "rethinking the role of independent agents in the overall marketing mix," Mr. Sutton said. "In many cases, our role is being diminished and even eliminated."

Increasingly, insurers—facing financial problems of their own—are experimenting with direct writing, reducing commissions and eliminating personal lines to cut costs.

As a result, agents cannot afford to rely as heavily on insurers as they had in the past, he said.

"Where we cannot maintain markets with traditional carriers, then we must look outside the agency system," he said. For example, foreign insurers looking for new marketing strategies can be "a valuable source of business," added Mr. Sutton.

As computers and the momentum of free market forces bind together national economies, the global marketplace may become a new playing field for independent agents, Mr. Sutton said.

"This global marketplace could increase competition in our markets," he said. "But it may also bring us new business. Maybe the foreign carriers that land on our shores will bring new markets in personal lines, and maybe they will sell through independent agents."

To tap into the foreign market, the PIA is involved in the current round of GATT trade negotiations, as well as talks with Europe's largest producer association, Mr. Sutton added (see story, page 48H).

The proposed merger of the PIA and the Independent Insurance Agents of America also will strengthen agencies, he said. Talks between the longtime rivals are continuing (*A/BT*, Sept. 3).

"We have moved beyond the politics and emotionalism," he said. "We are approaching the issues as businesspersons and will take the strengths from each organization and create the greatest value to our members."

Mr. Sutton, though, cautioned state affiliates to forego actual mergers for a year until the national merger study is completed.

Despite the challenges agents will face in the 1990s, many elements of the independent agency system will remain the same, he predicted.

Customer service, Mr. Sutton said, will continue to be of paramount importance. And service will require more technical knowledge and attention from all staffers—from customer service representatives to principals.

The insurance industry's image also will have to be polished throughout the 1990s, he said.

"In this age of information overload, we also must work harder than ever to tell our story to the American public as a whole," he said. "Not enough consumers truly appreciate the value of the service we provide. We must change that perception."

The trade group will continue its consumer education and public relations programs, but it must also listen closely to consumers, Mr. Sutton said. "Unless we respond to the legitimate concerns of consumers, they will continue trying to impose their own brand of justice through punitive and often misguided solutions such as Proposition 103."

Mr. Sutton is president of the J. T. Sutton Agency in Kinston, N.C. He and his wife, Mary Howard, are both actively involved in the Carolinas PIA chapter.

On the national level, Mr. Sutton for three years has been vice chairman of the company relations committee, chairman of the strategic long-range planning committee and is serving his third term on the executive committee. He also was vp in 1988-1989. ■

PIA crowds down sharply

ATLANTA—The theme of the 59th annual National Assn. of Professional Insurance Agents conference was "Building Tomorrow Today," but few agents were on hand to do the building.

Reported final attendance of 1,400 was the lowest in three years and less than half last year's record crowd of 3,000.

Those that did come were disappointed when the scheduled keynote speaker—Buck Rodgers, former advertising executive of International Business Machines—bowed out at the last minute and technical glitches forced the cancellation of a computer workshop.

And the exhibit area, though popular, was less crowded than it was at last year's convention. Almost 100 software companies and other firms were on hand to discuss their products.

Notables included a pair of cougar cubs and a boa constrictor at the Mutual of Omaha Insurance Co. booth and the ever-popular shoeshine girl from Agency Management Services Inc. of Norwell, Mass.

An even bigger head-turner, however, was the Bavarian Motor Works A.G. display of its top-of-the line sports model. The German luxury car maker also donated a model 525i that was raffled off at the convention and, as part of the promotion, offered test drives. . .around the hotel. Agent Bob Adams of Milwaukee was the lucky winner.

Next year's convention is scheduled for Nov. 17-20 in San Francisco.

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Agent/Broker Topics

Tracking insurer finances, file by file

By LAURA MAZZUCA

ATLANTA—Recent gargantuan insurer insolvencies have raised policyholder concerns and made agents more inviting targets for lawsuits charging them with placing coverage with financially unstable insurers.

Agents can protect themselves to some extent by using a simple "solvency watch" to track insurer performance, said James T. Harrison Jr., president of Security Bond Associates Inc., an agency in Tallahassee, Fla., and an insurance educator.

He advises agents to compile all available information—rating service reports, press releases on financial performance, newspaper articles or other clippings—on each insurer they represent in separate folders.

Such records serve as an internal errors and omissions standard and can be used as a legal defense, Mr. Harrison said during a workshop titled "It's in the Fine Print" at the annual National Assn. of Professional Insurance Agents conference last month in Atlanta.

To avoid duplication of efforts, a single employee should be appointed to review items on file at least quarterly, said Mr. Harrison. Principals can use the files to help evaluate whether a company can and will continue to pay claims. Clients should be apprised of any solvency concerns in writing, he added.

"Agents sell claims-paying ability, not the insurance product itself," Mr. Harrison said. "But if the product fails, where does the product liability fall?"

Agents used to be far less concerned with solvency, because courts historically did not hold them liable so long as an insurer was solvent when it wrote a policy.

A 1987 Texas court ruling qualified that exemption considerably. The case, involving a Fort Worth broker, gave agents both "a warning and a second chance" to reassess their role in insolvencies, said Mr. Harrison (*BI*, Sept. 28, 1987).

A bowling alley owner initially was awarded $700,000 in damages when he claimed agent Higginbotham & Associates was negligent in placing his multiperil policy with a low-rated insurer. After fire destroyed the bowling alley, the owner discovered his insurer was insolvent.

An appeals court overturned the jury verdict on appeal. But in doing so, the court imposed upon agents several duties:

- To use solvent insurers.
- To monitor the financial condition of insurers.
- To protect the policyholder when the solvency risk becomes too great.
- To disclose solvency information to policyholders.

With U.S. insurer insolvencies rising—to 43 last year from eight in 1980, according to the National Assn. of Insurance Commissioners (see chart)—agents need to be more diligent than ever, Mr. Harrison said.

Insurers heading for insolvency do exhibit warning signs, according to Mr. Harrison. No single item signifies that a company is in trouble, but, taken together, they are a good indication of a financially troubled insurer, he said. These warning signs include:

- High commission levels combined with low rates.

A prime example of this, he said, was Champion Insurance Co. of Baton Rouge, La., which had rates about 40% lower than rates for comparable coverage before it was declared insolvent in June 1989.

- Delays in claims payments and return of unearned premiums.
- Changes in agency contracts, particularly in termination procedures that would favor the insurer.
- Reductions in contingency and profit-sharing agreements.
- Entry into a market in which an insurer lacks history or expertise or into a market that other insurers have abandoned.
- Major changes in senior and mid-level management.
- Frequent change in certified public accountants.

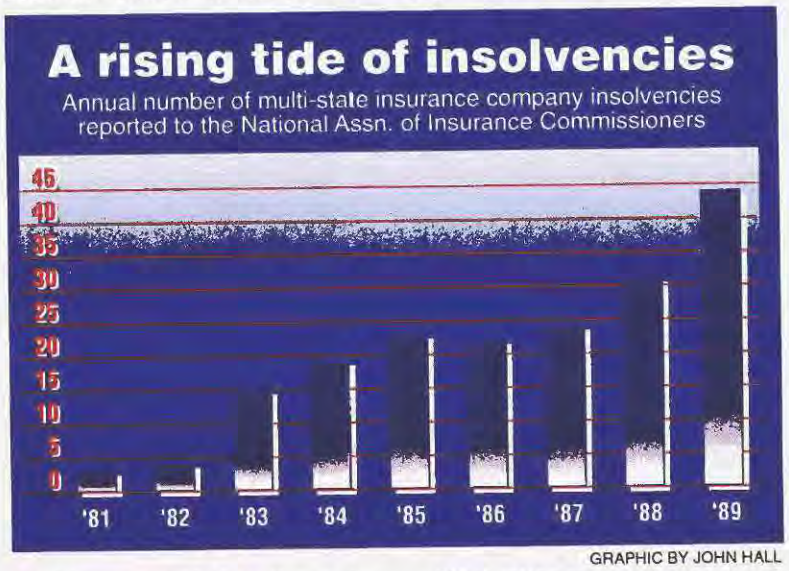
Several auto insurance specialists that recently failed in Florida, for example, would have triggered this criteria after switching to local CPAs from national firms, he said.

- Fluctuating loss reserves and consistently large differences between paid losses and reserves for losses.
- High and/or rising combined ratios.

If, for example, for every $1 the insurer takes in, it spends or reserves $1.50, 50 cents comes from surplus.

- Frequent complaints by policyholders or other insurers to state insurance departments.
- Unfavorable opinion on the agent "grapevine."

One of the most obvious warning signs is a drop in the insurer's rating from A.M. Best Co. or a poor showing on the NAIC's Insurance Regulatory Information System tests.



GRAPHIC BY JOHN HALL

Other rating services have entered the business recently, but the Best's rating remains the "Bible," or "starting point" in tracking insurer solvency, Mr. Harrison said. Even A.M. Best, he said, has felt the consumer uneasiness about insurer solvency: The 1990 edition, its most current, contains added detail on how to read the ratings.

Best's rating guide contains quantitative and qualitative evaluations of an insurance company over five years. Quantitative factors include profitability, leverage, liquidity and reserves. The qualitative evaluations include the spread of risk, amount and soundness of reinsurance, quality and estimated market value of assets, adequacy of reserves and management.

Ratings range from A+, or Superior, to C−, or Fair, and rating modifiers can give further information. For instance, an Ac insurer is rated Excellent, but the "c" indicates a decline in the "contingent" area since the last rating. Although insufficient to affect the financial rating, the change warrants the added reservation.

A "q" modifier means "qualified," and refers to external factors that

Continued on next page

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Continued from previous page
could affect the insurer, like Proposition 103 or poor auto markets. A "w" means Best has put the insurer under surveillance; and an "x" means that the insurer's status has been revised during the year.

A financial performance index introduced in 1990 rates new or small insurance companies—which may not qualify for Best's standard ratings—from one, or "strong," to nine, or "not assigned."

And an advance company report from Best can be used with the key rating guide to give a more detailed account of variables like cash infusions.

The supplemental report costs $10 per insurer.

Another option for agents monitoring insurance companies' finances is the use of IRIS reports from the NAIC, Mr. Harrison said. The IRIS reports are designed to have both statistical and analytic phases, but only the statistical phase is now available.

However, the 11 different ratios used in IRIS reports are frequently difficult to interpret, Mr. Harrison warned. A detailed explanation of the ratios—which include premium to surplus, change in writings, investment yield, and liabilities to liquid assets—is available from The Insurance Forum, a newsletter published in Ellettsville, Ind.

Other, newer tracking systems and sources of information on insurers include:

- The National Assn. of Independent Insurers/Insurance Services Office Inc. Operating Results and Fast Track Monitoring System.
- Moody's Investor Services, for 54 insurers.
- Standard & Poor's Corp.'s Insurance Rating Book.
- Demotech Inc. of Columbus, Ohio, which also rates self-insurance pools and health maintenance organizations.

To track a new, unrated insurer's financial health, Mr. Harrison suggested reviewing:

- The financial statement prepared by its certified public accountant.
- A copy of the blank statement filed with the state insurance department for admission.
- Information on reinsurers.
- Any actuarial review of its loss reserving techniques.
- Its domicile and that state's reputation for regulation.
- Resumes of the company's senior managers.

This is not an unreasonable request, he said, since the information is required for state permits or charters. ■

Minnesota agents reach accord

ATLANTA—The Minnesota chapters of the National Assn. of Professional Insurance Agents and the Independent Insurance Agents of America will combine memberships next month and meet as a single body, though each will retain some individual officers under an agreement approved last month.

After more than a month of negotiations, the groups resolved a thorny revenue sharing question by delaying the formal merger of their for-profit service corporations.

That delay allows the national PIA to approve the merger without revising its affiliation agreement with its Minnesota chapter. The PIA had threatened to disenfranchise its Minnesota affiliate unless the group turned over half of the commissions it would earn from an errors and omissions insurance program run by the IIAA because that program competes directly with an E&O program sponsored by the PIA (*BI*, Nov. 5).

But, under the agreement, both the PIA Members Assistance Assn. and the IIAA Agents Assistance Assn. will continue to sell E&O and group health insurance to members.

With both marketing separate coverage, neither national association will receive revenue from the Minnesota group, said Harlan Rise, president of the Minnesota PIA chapter.

Officers from both groups approved the merger terms at the PIA convention in Atlanta last month.

Most of the chapters' functions are to be consolidated and all members of either group will belong to the merged association, said Mr. Rise.

The boards will remain the same except for a common president, vp and national directors.

A jointly owned subsidiary will be created to manage generic office functions, Mr. Rise said.

The subsidiary also will market workers compensation and managing general agency services on behalf of the State Fund Mutual Insurance Co., the for-profit corporation Minnesota set up as an alternative market (*A/BT*, July 2).

Both the PIA and IIAA names and logos will be used in identifying the Minnesota group.

—*By Laura Mazzuca*

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Agent/Broker Topics

GATT could level field for U.S. agents: Davies

By LAURA MAZZUCA

International trade talks scheduled to conclude today could remove restrictions on U.S. service industries—including insurance agents and brokers—in foreign markets.

Disagreements over agricultural subsidies, though, could still derail the multilateral General Agreement on Tariffs and Trade negotiations (see story, page 3).

"The Europeans, frankly, are trying to make it difficult in all areas for the United States to get involved over there," said James H. Davies, past president of the National Assn. of Professional Insurance Agents and a member of the Insurance Services Advisory Committee.

Mr. Davies, president of Davies & Associates, an agency in Murray Hill, N.J., is the only agency representative on that committee, which advises U.S. government negotiators in the GATT talks.

U.S. agents and brokers are at a disadvantage abroad, Mr. Davies says. For example, in many European Community and South American countries, U.S. agents placing business for clients with branches in those countries are required to place the business through a domestic insurer.

And, in some countries, like France, foreign producers placing business with a French insurer can do so only through a domestic producer.

But, many foreign countries do not require licensing and testing of their own producers, while U.S. producers must undergo licensing and testing both at home and in some countries abroad.

Without changes, U.S. producers, especially smaller ones, could lose business to foreign producers, Mr. Davies says.

The current round of talks, which began in Uruguay in 1986, is the first to include services. But an accord in the Uruguay Round, scheduled to end in Brussels, Belgium, today, is in jeopardy.

Although the financial services component—which includes banking, insurance and securities issues—has been progressing, failure to agree on a major area like agriculture will threaten any service agreement, he said.

All has not gone smoothly in the financial services talks, either. Several nations are confused by the U.S. system of multistate insurance regulation, Mr. Davies said.

With Europe moving toward a single regulatory and licensing system for agents and brokers, the lack of similar uniformity in the U.S., with its current multistate regulation system, is becoming more of a problem for U.S. producers who must serve clients operating both in different states and in foreign countries, he explained.

And, as more mid-sized U.S. businesses open branches overseas, the smaller agent or broker risks losing the entire account to a foreign or multinational brokerage, he said.

Multinational brokers with branches in foreign countries can easily place business abroad. Small agencies, however, do not have that presence and must become licensed in multiple countries before they can conduct business there.

But insurance representatives involved in the GATT talks say current U.S. insurance regulation is not threatened. Rather, the advisory committee has discussed some possible alternatives.

One proposal recommends federal regulation of international insurers and state regulation of domestic and regional companies, Mr. Davies said.

This two-tiered system would place foreign insurers under closer scrutiny and protect producers by monitoring insurer solvency.

"If you're going to deal with all these foreign countries, both state and national have to have a role in regulation," he said. "There must be a clearinghouse from a regulatory standpoint."

The clearinghouse approach could also apply to agents and brokers, Mr. Davies said. Such a clearinghouse could be run by the National Assn. of Insurance Commissioners.

Using this system, producers seeking licensing abroad could access experts to advise them of requirements rather than having to research country-by-country requirements themselves, he said. The system could also link U.S. producers with overseas insurers and producers when needed.

By offering smaller agencies this expertise, the clearinghouse concept could allow them to attract and retain multinational clients.

Separate U.S. regulation of banks and insurers also confuses foreign officials, Mr. Davies said. Banks in Europe can sell insurance and insurers provide banking services, he noted.

Despite U.S. agents' fears whenever banks and insurance are mentioned in the same breath, Mr. Davies believes that applying a European system could be a boon to U.S. agents. Agents could benefit from marketing banking products, he explained. ■

January

Errors & Omissions

Agents and brokers are using many methods to reduce the potential for errors and omissions claims. BI editors will report on examples of how agents and brokers can review their operations and implement loss prevention programs. Plus, they'll provide tips on how to select the right E&O insurer for a particular agency or brokerage.

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February

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What are agents expecting from their insurers and vice-versa? BI editors will focus on the special pressures agencies and insurers exert on each other as a result of the continuing soft market. And, they'll look at how each side relies on the other to prepare for a change in market conditions.

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Business Insurance

INTERNATIONAL

Lloyd's may reinsure open accounts

By CAROLYN ALDRED

LONDON—Lloyd's of London is expected to give the go-ahead this week to the creation of a reinsurance company to write runoff reinsurance for syndicates unable to close their underwriting accounts because of huge and uncertain liability exposures.

Many Lloyd's members are now stuck on syndicates that are unable to close their accounts, which is causing growing anxiety in the market.

Between 1,000 and 2,000 members facing huge losses on open years already are suing several Lloyd's underwriting agencies and the number of members resorting to litigation is quickly growing.

For instance, another 100 members filed lawsuits last month against underwriting agency John Poland & Co. Ltd.

"My own view is that a decision (about the runoff company) will be made at the council meeting" on Dec. 5, said David Coleridge, who is expected this week to be named chairman of Lloyd's effective Jan. 1 (see story, page 1).

"Many of us feel that this is the way forward. We should be able and try to close these years with a reinsurance company that's owned by Lloyd's," he added.

Approval for Lloyd's to set up a runoff reinsurance company already has been granted by the British Department of Trade and Industry, according to a Lloyd's spokesman.

Under the proposal, the liabilities of syndicates with open accounts will be assessed and the syndicates will be charged a premium, which—together with investment income—will be designed to cover any future losses.

Payment of the premium will allow the syndicates to cede their past liabilities to the runoff company and close their open accounts.

"Any premiums quoted to close the open years will be as commercial as is reasonably possible. And that, of course, can be expensive," said Mr. Coleridge.

As a result, some members may be unwilling to pay a large premium up front to close an account. The Lloyd's Council likely will debate on Wednesday whether syndicate underwriters will be entitled to pay such premiums on behalf of all syndicate members.

In the event that all members of a syndicate fail to agree to pay a runoff premium, Mr. Coleridge believes that each member should be given the option of paying an individual premium to close his own personal account.

The capitalization of the new reinsurance company will depend on how much business it will write. However, it will be financed either by a guarantee from Lloyd's Central Fund, by cash "or a combination of both," according to Mr. Coleridge. It will not be capitalized through a cash call on all Lloyd's members, he said.

The Central Fund, which is used when syndicate members are unable to pay losses, is financed through annual assessments of all members.

Lloyd's announced last month that it will increase the Central Fund to 1 billion pounds ($1.98 billion) by the mid-1990s from the current 385 million pounds ($761.9 million). The move to expand the fund is being undertaken for several reasons, including the increasing number of Lloyd's members unwilling to pay losses, according to Mr. Coleridge.

The Lloyd's runoff company likely will start cautiously, at first accepting only a limited amount of liabilities, sources say.

Mr. Coleridge predicts that it will take five to 10 years to close all the current open syndicate accounts.

Although the creation of a runoff reinsurance company by Lloyd's may help resolve the problem of open accounting years, it is a huge gamble for the market to take.

Assessing what is an adequate premium to charge for accepting syndicates' outstanding liabilities, including incurred-but-not-reported losses, can be a hit-or-miss gamble, and several Lloyd's underwriters have found themselves in severe trouble—and with open accounting years—after writing similar runoff reinsurance policies.

For example, Lloyd's underwriter Richard Outhwaite wrote dozens of unlimited runoff reinsurance policies for Lloyd's syndicates and insurance companies in the early 1980s and now faces losses totaling hundreds of millions of dollars.

Syndicates managed by Merrett Underwriting Agency Management Ltd. also are reeling from huge losses and are unable to close their past underwriting years because of liabilities from runoff policies they

Continued on next page

GLOBAL BRIEFS

Grand Union finances ailing

HONG KONG—Grand Union Insurance Co. Ltd. is facing severe problems in paying claimants, the Hong Kong-based company warned brokers at a meeting in London late last month.

As a result of "serious cash-flow problems and increasing difficulties in recovering balances from remaining reinsurers," the insurer is offering to commute policies, said Vp C.C. Wong.

Grand Union stopped underwriting two years ago, Mr. Wong said.

Brokers, meanwhile, allege that the company has been stalling claims payments for several years. Many policyholders are suing in British and Hong Kong courts to secure claims payments (*BI*, April 4, 1988).

Cash-flow problems have left Grand Union "unable to meet in full the outstanding liabilities," confirmed Andrew Flowers, director of Conocean International Adjusters Co. Ltd., which is acting as London agent for Grand Union.

It is too early to estimate Grand Union's liabilities or the extent of its insolvency, he added.

Grand Union is asking all policyholders to present estimates of their liabilities as soon as possible, Mr. Flowers noted.

Unless policyholders agree to commutations, the company "would likely go into liquidation," he said, adding that Grand Union proposes to put itself into voluntary liquidation after the settlements have been reached.

Grand Union wrote a worldwide account of insurance and reinsurance, including non-marine, marine and aviation business, for more than 20 years, said Mr. Flowers.

—By Carolyn Aldred

Broker held liable

SYDNEY, Australia—A supermarket owner has settled its dispute with its broker after an underwriter denied liability for a claim that resulted from devastating floods in May in outback Aus-

Continued on page 56

BERMUDA BRIEFS

Focus liquidation challenged

By ROGER SCOTTON

HAMILTON, Bermuda—The voluntary liquidation of Focus Insurance Co. Ltd. has been placed on hold after the Bermuda Supreme Court appointed new provisional liquidators to oversee a court-administered winding up.

The court ordered the action despite the fact that Focus—formerly Trenwick Reinsurance Co. Ltd.—was already in the hands of privately appointed liquidator Julian Ashby and was undergoing what is known in Bermuda law as a "members voluntary liquidation." Such a legal proceeding is usually initiated by the shareholders of still-solvent companies.

Mr. Ashby said he is petitioning the court to put aside its winding-up order.

"We are in the process of challenging the appointment of provisional liquidators," he said. "As a result, everything is in limbo at this stage and will probably remain there until we get into court."

Mr. Ashby stressed that he had "no reason to believe Focus was insolvent" and pointed out that he was "fully aware of a liquidator's obligations under the law."

The liquidators named by the Supreme Court are David Lines and Peter Mitchell of Coopers & Lybrand in Bermuda. The circumstances leading to their appointment are unclear and neither of the accountants would discuss the unusual affair, nor identify on whose behalf they are acting.

However, they are believed to represent the receiver of insolvent Mutual Fire, Marine & Inland Insurance Co. of Philadelphia, which is known to be a dissatisfied creditor of Focus. Mutual Fire's own receiver, the insurance commissioner of Pennsylvania, in October began a court action in Bermuda Supreme Court against Focus, just two to three weeks after the Bermuda company went into members voluntary liquidation.

Mr. Ashby said he was not at liberty to discuss dealings with or identify Focus creditors. But, he said he was aware of one contingent creditor with whom the previous Focus management had a dispute and who had "launched an unjustified and unwarranted attack" on him.

Mr. Ashby said the creditor had complained that Focus had not paid a certain sum of money to it and had recently begun a court action to have Focus placed in compulsory liquidation.

"Part of our dispute is how I was served with the summons to attend this liquidation hearing," he explained. "I was off the island in Australia at the time. This summons should have been either served on the liquidator personally or on the company's registered office. Neither of those things happened and our argument for the order to be set aside will say that we were not properly served."

As a result of the alleged improper summons, Mr. Ashby was not represented at the court hearing at which the provisional liquidators were appointed for Focus.

"This whole thing was totally unwarranted," complained Mr. Ashby. "If people had been having a problem with Focus, they could easily have come to me and spoken about it."

The Bermuda Supreme Court has effectively stayed all Focus proceedings until Dec. 11, when a full

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Political parties outline positions on U.K. pollution

By STACY SHAPIRO

LONDON—Britain's three main political parties all agree that "the polluter pays" principle should be incorporated into any legislation to protect the environment.

However, they differ on how rigid regulations that enforce this principle should be, according to representatives of British political parties speaking at a one-day conference last month on "The Business Implications of the Environment White Paper and Future Environmental Legislation," sponsored by London-based Environmental Policy Consultants.

The ruling Conservative Party believes that market forces and cooperation from business, rather than strict regulation, can protect the environment.

The Labor Party, on the other hand, would like to enforce stronger regulations, including the creation of an Environmental Protection Executive that would be similar to the U.S. Environmental Protection Agency.

Meanwhile, the Social Democratic Party goes even farther in recommending a change in tax policy to punish polluters.

These political differences are important to U.K. businesses, since a general election must be held by June 1992. Under British law, the prime minister must call an election within five years of the time the party was elected to power, as well as once every five years that the party remains in power.

The general election could be moved up in light of the recent resignation of Prime Minister Margaret Thatcher and the subsequent election by Conservative Party members of former Chancellor of the Exchequer John Major to succeed her. Polls have shown that the Labor Party could win the next election outright or form a coalition government with the Social Democrats.

"All of us appreciate the challenges which lie ahead and which must be overcome if we are to pass our world on intact to our children," said David A. Trippier, who was U.K. minister of state for the environment in Mrs. Thatcher's administration.

"And all of us, I hope, recognize that none of these ideals will come to fruition unless we enlist the full and undivided support of business and industry," said Mr. Trippier.

However, "there is to be found on the fringes of politics an antediluvian Green tendency," he said. "Its advocates appear to look forward to environmental salvation in a world shorn of its power stations or its oil refineries, where the masses, deprived of the undoubted benefits that these innovations bring, eke out a satisfying existence in harmony with their weaving."

But, "it is only through the wealth that only a free-market economy can create that we will equip ourselves financially to pay conservation's daunting bill," he said.

Businesses might ask why they should be subject to environmental legislation and regulation—all of which raise their costs, Mr. Tripper noted.

But, he pointed out that today in the United Kingdom, environmentally conscious consumers are on the march; investors are favoring environmentally friendly businesses; and employees want to work for environmentally aware companies.

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Runoff policies

Continued from previous page

wrote.

It is largely because of these problems that there no longer is any market for runoff reinsurance, noted Mr. Coleridge.

"There's been so much misery and so much damage to Outhwaite and others writing the runoffs. It really prevented that market from flourishing (although) it may start again in years to come," he said.

"If it did start again, Lloyd's own reinsurance company would be delighted to have somebody else to compete. Lloyd's will only start this company because there is no other apparent market to write the runoff for these syndicates and close" the open accounting years, Mr. Coleridge explained.

Under Lloyd's accounting system, syndicates close each underwriting year after three years. So, for example, the 1987 underwriting year was closed at year-end 1989. This system is designed to allow claims development to occur and thus give syndicate managers a better estimate of total profits or losses.

Syndicate managers estimate the likely level of outstanding liabilities at the end of three years and pay an appropriate reinsurance premium, known as reinsurance to close, into the next underwriting year.

Reinsurance to close is necessary because a syndicate's membership changes each year.

However, since the mid-1980s syndicates increasingly have been unable to close their underwriting accounts after three years because they could not assess their past liabilities, particularly U.S. asbestos and pollution exposures.

And in most cases liabilities have increased as the account remains open.

In an increasing number of cases, members—faced with huge losses on open underwriting years—are suing syndicate managers and their own members' agent.

In a recent development, members of syndicates managed by Lloyd's underwriting agency John Poland & Co. Ltd. filed lawsuits last month against Poland and 20 members' agents.

Members of the open 1985 underwriting year of syndicate 105/106/109 and the open 1986 underwriting year of syndicate 108, all managed by Poland, have so far incurred losses totaling about 20.5 million pounds ($40.6 million), according to the syndicates' accounts.

Some 100 Poland syndicate members are suing Poland and the members' agents that placed them on the syndicates in High Court in London for negligence and breach of duty.

Many of the members note that huge losses stemming from coverage written in previous years have been amassing in one underwriting year left open by each syndicate.

Poland's managing director, Trevor Bradley, explained Poland's decision to leave the underwriting years open in a letter sent to all members last month.

"No one is happy to be involved in an open year. It is not a happy experience for us, or for Lloyd's generally. However, open years must occur where the syndicate concerned is unable to make a realistic assessment of what premium should be paid to the next year's names on the syndicate for them to take on the outstanding claims," he explained in the letter.

"In the case of the two Poland open syndicates, this is what happened, largely because the notifications of claims from previous years—particularly as a result of U.S. asbestosis and pollution (claims)—were escalating rapidly. It would have been unfair, at this point, to the next year's names not to have left the years open," he noted.

Mr. Bradley, who says the lawsuit had not yet been served on Poland as of last week, also explained in the letter that Poland's errors and omissions underwriters are not prepared to "compromise in any way whatsoever" in meeting members' claims.

Poland plans to close the open years as soon as it can, Mr. Bradley told members.

Meanwhile, he warned that litigation would be counter-productive and could cost the members vast amounts of money.

However, it seems that many Lloyd's members are prepared to risk huge legal costs in seeking compensation for their losses.

Lloyd's members who are suing R.H.M. Outhwaite (Underwriting Agencies) Ltd. and 81 Lloyd's members' agents over hundreds of millions of dollars in underwriting losses unanimously voted in October to boost their litigation war chest.

At the first annual general meeting of the Outhwaite 1982 Names' Assn., 750 members of the 1982 underwriting year of syndicate 317/661, underwritten by Richard Outhwaite, voted to provide an additional 600,000 to 700,000 pounds ($1.2 million to $1.4 million) on top of the 1.2 million pounds ($2.4 million) they already have contributed to finance litigation.

'No one is happy to be involved in an open year,' says Poland's Trevor Bradley.

Meanwhile, the members pledged an additional 2.35 million pounds ($4.7 million) to be paid in April 1992 should they lose the trial, due to take place next October, and be forced to pay the legal costs of their opponents.

The members claim that Mr. Outhwaite was negligent and reckless in writing more than 30 runoff policies reinsuring the past liabilities of other syndicates and insurance companies. Many of the runoff policies were written on an unlimited basis and underwritten 100% by Mr. Outhwaite's syndicate.

In many ways, the Outhwaite case exacerbated the problem of open accounting year to a crisis point.

Most of the syndicates that bought runoff reinsurance policies reserved for their past liabilities on the basis that they had excess-of-loss runoff reinsurance.

However, by 1987 Mr. Outhwaite had begun to dispute many of the runoff policies he had written, claiming the ceding underwriters misrepresented and failed to disclose risks. As a result, many of the cedants were forced to keep open their underwriting accounts pending an outcome of the disputes. This led to an explosion in the amount of underwriting years left open in 1987 and 1988 for the 1985 and 1986 underwriting accounts, respectively.

In addition, syndicates 418/147 and 421, both managed by Merrett, also began disputing runoff reinsurance policies they had written.

Several syndicates have been forced to boost their reserves after losing arbitration awards to Outhwaite or Merrett or agreeing to renegotiate the terms of the runoff policies.

Continued on next page

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For example, members on open years of two syndicates managed by Pulbrook Underwriting Management Ltd. faced cash calls this year totaling more than 45 million pounds ($76.1 million in May) following the resolution of disputes over runoff reinsurance policies they had purchased (*BI*, May 28).

Members of syndicate 334's 1985 underwriting year had to pay 29.4 million pounds ($58.2 million) this year after an arbitration panel ruled that Merrett syndicate 418/417 could void a runoff reinsurance policy it wrote for syndicate 334 (*BI*, March 5; Feb. 12).

Also, members of syndicate 90's 1982 underwriting year faced a cash call of about 17 million pounds ($28.7 million in May) following a settlement of a dispute over a runoff policy 50% written by Outhwaite.

Under the settlement, Outhwaite syndicate 317/661 paid $64 million —and may have to pay a further $37.5 million—toward syndicate 90's $250 million in outstanding losses (*BI*, May 28).

Some 340 members of syndicate 90 are suing Pulbrook for negligence over the way the runoff contract was placed with Outhwaite, according to David Tiplady, a lawyer with D.J. Freeman & Co. in London.

The members also are considering whether to sue Winchester Bowring Ltd., the London broker that placed the runoff policy, said Mr. Tiplady, who is acting for the members.

In addition, 260 members of syndicate 334 also are considering taking legal action against Pulbrook over the runoff reinsurance contract placed with Merrett, he noted.

According to the arbitration decision concerning syndicate 334 and Merrett syndicate 418/417, syndicate 334's underwriter failed to disclose material facts to underwriter Stephen Merrett, according to Clive Francis, chairman of syndicate 334's 1985 Names' Steering Committee.

The situation with syndicate 334 is made more complex because the Pulbrook agency was acquired by the Merrett agency and members are urging Lloyd's to investigate the whole affair, accusing the underwriters of misconduct (see story, page 51).

Other litigation filed by Lloyd's members following huge losses on open underwriting years includes:

• Lawsuits filed by more than 600 members of syndicate 553, managed by CJW (Underwriting Agents) Ltd., against members' agents and CJW for tens of millions of dollars of losses on the syndicate's open 1984 underwriting year (*BI*, Jan. 9, 1989).

• Lawsuits filed against the Corporation of Lloyd's and members' agents by 65 members of syndicates formerly managed by Oakeley Vaughan (Underwriting Agencies) Ltd. (*BI*, Jan. 9, 1989).

Mr. Coleridge blames the U.S. tort system for the liability losses that have caused syndicate accounts to be left open because total liabilities cannot be assessed.

"Everyone knows that the American court system is a bit tricky and has caused a lot of pain and suffering in the world insurance industry," he said. However, Lloyd's accepts that it has to live with the outcome of the decisions if it wants to continue to underwrite coverage in the United States, he added.

However, some "names can't accept that. . . .They think that if they are asked to pay money there must be some negligence," Mr. Coleridge said.

"If you remind them that they are in the risk business, then they think that it's all terribly unfair and they say the unfairness is that some of the losses to which they are being asked to contribute have come from the past. They seem to forget that when they joined Lloyd's, they took over a portfolio which gave them access to very fine business built up over many, many years," he noted.

"One would like for all these cases to disappear, but I don't think they will. I think they will be heard and it would be presumptuous of me to predict what will happen. It's up to the courts to decide," Mr. Coleridge said.

If, however, any of the names are successful in their actions against their agents, "it would be a terrible precedent" for Lloyd's, he warned.

•

International Editor Stacy Shapiro contributed to this story.

Members seek probe of runoff disputes

By CAROLYN ALDRED

LONDON—Several Lloyd's of London members are urging the Council of Lloyd's to investigate disputes over runoff reinsurance policies written by Lloyd's syndicates.

A Canadian member has asked Lloyd's to investigate alleged misconduct stemming from a runoff dispute between syndicates managed by Merrett Underwriting Agency Management Ltd. and Pulbrook Underwriting Management Ltd.

And a leading members' agent has called on Lloyd's to take a more active role in resolving the growing number of disputes between syndicates.

The Canadian member's allegations surround runoff reinsurance policies written in the early 1980s by syndicate 418/417, which is managed by MUAM.

Uncertain losses from the runoff policies have left syndicate 418/417 unable to close its 1985 underwriting account. The syndicate this year asked its 4,000 or so members to pay 35 million pounds ($69.3 million at current exchange rates) to cover losses it has so far incurred on the 1985 account (*BI*, June 11).

In particular, the member's allegations center on a runoff reinsurance contract accepted by syndicate 418/417 on behalf of syndicate 334, managed by Pulbrook.

Members of syndicate 334's 1985 underwriting year had to pay a cash call of 29.4 million pounds ($58.2 million at current exchange rates) earlier this year after an arbitration panel ruled that MUAM syndicate 418/417 could void a runoff reinsurance policy it wrote for syndicate 334 in 1981 (*BI*, March 5).

According to the arbitration decision between syndicate 334 and MUAM syndicate 418/417, MUAM was entitled to void the contract because syndicate 334's underwriter failed to disclose material facts to syndicate 418/417 underwriter Stephen Merrett.

However, the arbitration panel also ruled that for syndicate 418/417 to accept a risk that was known to include "exposure to latent disease including asbestosis, which at that time was causing concern in the market without initiating a detailed dialogue with the underwriter of 334 was,

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Runoff disputes

Continued from previous page

in our view, foolhardy. . .and bordered on conduct which could be described as grossly negligent."

The matter is made more complex since Merrett acquired the Pulbrook agency in the mid-1980s from Stewart Wrightson Holdings P.L.C. Other members claim the acquisition led to a conflict of interest within Merrett Holdings P.L.C., the agencies' parent company.

Moreover, syndicates managed by MUAM also write a substantial portion of Pulbrook's errors and omissions' insurance coverage, creating a further conflict of interest, according to Clive Francis, chairman of the syndicate 334 Names' Steering Committee.

Kenneth R. Lavery of Oakville, Ontario, a member of syndicate 418/417 as well as syndicate 334, has filed a complaint with Lloyd's Names Interests Department under Lloyd's Bylaw No. 11 of 1989.

The bylaw imposes a duty on members of the market to "report all instances of misconduct other than those which it is reasonable to regard as being of a minor nature."

Misconduct, as defined by the bylaw, includes:

- Conduct in a manner "which is detrimental to the interests of Lloyd's policyholders, the Society (of Lloyd's), members of the Society, Lloyd's brokers, underwriting agents or others doing business at Lloyd's."
- Conduct of "any insurance business in a discreditable manner or with a lack of good faith."
- And, conduct "in any manner which is dishonorable or disgraceful or improper."

According to Mr. Lavery's complaint, the misconduct bylaw was violated by:

- Mr. Merrett and the directors of MUAM for "issuing false annual reports" for the 1982, 1983 and 1984 underwriting years of syndicate 418 and for not leaving open the 1982 underwriting year accounts because of the "impossibility of determining the liability in respect of asbestosis on 11 runoff policies underwriting by Merrett syndicate 418/417."
- Accountant Ernst & Young for "falsely giving a true and fair-view audit opinion on the closing of the accounts."
- Underwriter Michael Turner, underwriter Ronald Verrall and the directors of Pulbrook for allegedly issuing a false annual report for syndicate 334 in 1982 that "concealed from their names and prospective names the amount of long-tail non-marine business written."

Had the syndicate management been "honest," then Mr. Lavery's members' agent "would have been alerted and would not have put (him) on this syndicate in 1984," he says in his complaint.

- Lloyd's broker Winchester Bowring Ltd., Messrs. Turner and Verrall, and directors of Pulbrook for "concealing material facts and failing to act in utmost good faith in placing a runoff policy with Merrett (syndicate) 418, as determined in the arbitration report" between syndicates 418 and 334.
- Mr. Merrett, Pulbrook and the directors of Stewart Wrightson for "orchestrating an affair riddled with personal conflicts of interest resulting in substantial pecuniary advantage to Stephen Merrett and others."

Mr. Lavery said that as of last week Lloyd's had not yet acknowledged his complaint. Lloyd's would not comment on the matter.

Mr. Merrett has denied all alleged misconduct. He pointed out that he personally did not write the runoff reinsurance contract for syndicate 334.

He also said that following the acquisition of the Pulbrook agency, Merrett Holdings maintained separate management of the two agencies and each agency employed separate legal advisers until the runoff dispute was resolved earlier this year to ensure that the conflicting interests of Lloyd's names were properly protected.

Although Mr. Merrett confirmed that MUAM-managed syndicates write a "substantial" part of Pulbrook's E&O coverage, he said the syndicates do not lead the coverage and there is a clear policy that ensures that MUAM syndicates take no part in any claims handling decisions where they or associated companies are or may be in an adversarial position.

Regarding Mr. Lavery's suggestion that syndicate 418/417 should have left its 1982 year of account open rather than transfer the liabilities to its 1985 year, Mr. Merrett said that it was not until 1988, when the 1985 year was about to be closed, that it became clear that information had been withheld regarding the runoff policies.

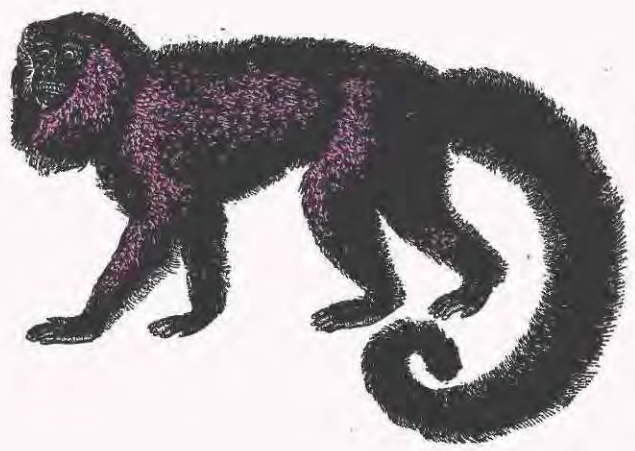
Meanwhile, a leading members' agent is calling on the Council of Lloyd's to help resolve a growing number of internal disputes between Lloyd's syndicates, like the one between Merrett and Pulbrook.

Members are increasingly concerned that reinsurance contracts their syndicates purchased from other Lloyd's syndicates are being voided because of technical and legal reasons, said James M. Sinclair, managing director of Willis Faber & Dumas (Agencies) Ltd.

Honoring policies has been a "cornerstone of Lloyd's" throughout its 300-year history and policies placed within the market should be no different, he said.

"If you have a breakdown of market practice and discipline, it should be dealt with at the top" and the central authority should take the lead in resolving the situation, he noted.

"The members see internal discipline as having broken down and syndicates trying to wriggle out of what members see as valid contracts," he said. ■



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Pollution policies

Continued from page 49

"Look around at your competitors —at other companies in general—and you will see case after case where Green considerations have become part of the bloodstream of management," he said.

In line with these beliefs, Mr. Trippier's department published the government's White Paper on the Environment in September, which "sets out a strategy in which the market, and ways of influencing it, play a prominent role," he said (*BI*, Oct. 15).

The White Paper stresses the "polluter pays" principle, "which, let us not forget, is a market mechanism," said Mr. Trippier. And market forces are a more effective way to get businesses to clean up the environment than regulation, he added.

In addition, Queen Elizabeth II recently signed the Environmental Protection Act, which calls for potential polluters to obtain special authorization from Her Majesty's Inspectorate of Pollution before engaging in business that could generate pollution (*BI*, Oct. 15).

The act introduces "a comprehensive new system of integrated pollution control to regulate emissions to all media—air, land, and water," said Mr. Trippier.

The pollution controls established by the legislation call for the use of "the best available technology not entailing excessive costs," now commonly referred to by British industry as "BATNEEC."

However, the new act does not make British industry liable for the cost of cleaning up past pollution incidents, Mr. Trippier said.

Also, the Conservative government is not forcing all businesses to conduct mandatory environmental audits, though it is "very advisable" to do so, Mr. Trippier told the conference. Ninety-six percent of all of U.K. businesses have fewer than 200 employees, and the costs of such audits could cripple them, he said.

Britain's two other political parties, however, criticize the conservative government's White Paper and call for more regulation and stricter enforcement.

Bryan Gould, the Labor Party's shadow secretary of state for the environment, said there has been a "generally disappointing reaction" from the public in regard to the White Paper because it didn't go far enough to regulate polluters.

According to Mr. Gould, a possible reason the White Paper did not go as far as pundits had earlier suggested was that Mrs. Thatcher decided the environment was no longer a big political issue.

Also, the Conservative government has a "temperamental hostility to regulation," he said.

The lack of strong regulation in the White Paper "has led to what I know to be business' greatest worry about environmental protection policies, and that is uncertainty," said Mr. Gould. "What business wants primarily is certainty and a level playing field. You need to know first that the environmental measures to be implemented can be planned for, and phased in, within feasible timescales.

"Secondly, you need to be assured that business across the European single market is facing the same obligations, with no room for cowboys," he said.

British businesses must clean up their act or they "will be taken to the cleaners" by businesses in other countries that "recognize that a modern, environment-friendly, energy-conserving plant is also highly efficient and a big contribution to economic success," said Mr. Gould.

"That is why a central theme of Labor's environmental program is the establishment of strong independent watchdogs—the centerpiece of which will be the Environmental Protection Executive," said Mr. Gould.

The EPE will be able to help local businesses by issuing licenses to operate when local residents are wary about the environmental impact a new industry might have, Mr. Gould suggested. As a condition of the license, the company would have to "continuously monitor its emissions," he said. And the results of the monitoring by the EPE would be published, he added.

The Labor Party's policy document also identifies a range of "tools for sustainable development" to enforce a safer environment and still allow business to flourish, he said.

For example, instead of allowing businesses the defense of BATNEEC, as the White Paper does, the Labor Party suggests "strict controls on permissible emissions," which other E.C. nations have developed, according to Mr. Gould.

Also, the Labor Party believes that environmental audits should be mandatory and public knowledge, he said.

Mr. Gould pointed out that his party's plan for the environment calls for regulatory standards patterned along the lines of Britain's E.C. partners. "The next Labor government will offer a partnership for the planet to Green groups, industry and other bodies," he said.

Meanwhile, the Social Democrats have also issued a policy statement on the environment, titled "What Price Our Planet," which is "the most cohesive, radical and far-reaching set of proposals ever put together by a British political party," said Simon Hughes, a Social Democrat environment spokesman.

Mr. Hughes criticized the Conservative government's White Paper, which he said "contains so few new proposals." He said it was a document for the 1980s, rather than for the future.

But, the Social Democrats believe that not only should there be an Environmental Protection Executive, as endorsed by the Labor Party, but also that the U.K. Department of the Environment should have the same powerful status as the British Treasury, Mr. Hughes said.

The Treasury dictates the government's economic policy and budgets, which must be followed by all other governmental departments, whereas the Department of the Environment at the moment has no authority over any other government department.

The Social Democrats also believe that the environment and the economy should be linked "to make sure the tax system acts as an ally in our efforts to attain a sustainable society," said Mr. Hughes.

The tax system could be used to penalize businesses that pollute and give incentives to those that don't, he said.

In addition, the tax benefits associated with receiving company cars should be abolished, since cars are considered to be the second worst environmental offender after electricity consumption, Mr. Hughes said.

"Where is the logic in the financial perks that mean 80% of cars entering central London each day are company cars?" he asked.

The Social Democrats also propose the introduction of a "pollution-added tax," whereby a tax would be added to every industrial process that discharges pollution to air, water or land.

The amount of the pollution-added tax would be determined by the volume and potency of the pollutant, he said.

He told the conference that the Social Democrats' proposals break new ground in their "completeness and in the degree to which they go. There is little doubt in my mind that this is the direction in which the British government and all governments will sooner or later—and hopefully sooner—have to go." ■

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Unified E.C. pollution rules expected

By STACY SHAPIRO

LONDON—A working party of the E.C. Commission is considering the need to harmonize economic and fiscal policies to enforce environmental standards throughout the European Community.

These fiscal policies—such as charges, taxes or deposits on products or businesses that create pollution—can lead to uneven competition within the European Community, says the working party in a recent report.

Therefore, "a harmonized application of economic instruments" is needed, the working group says, "to avoid barriers to trade within the internal market resulting from artificial differences in cost structures."

The need for unified economic and fiscal instruments will be one of several items examined by the working group, which is composed of experts from each of the E.C. member states and is reviewing E.C. environmental policy. The group's final recommendations are expected to be published by the end of the year.

The measures developed by the working party will be discussed by the E.C. Commission next year and possibly implemented in 1992, according to Nigel Haigh, director of the Institute of European Environmental Policy in London, in a speech at a conference on the United Kingdom's recent White Paper on the Environment in London last month.

Mr. Haigh noted that the European Community now dictates basic environmental policy to all E.C. member nations, including the United Kingdom. "You cannot now think of British pollution legislation without thinking of European legislation," he said.

In fact, Mr. Haigh quoted a British government official as saying that the United Kingdom's recently passed Environmental Protection Act is "heavily influenced" by E.C. environmental law.

And, the official noted several sections of the act are designed specifically to implement E.C. directives, according to Mr. Haigh. This included the section of the act calling for integrated pollution control procedures (*BI*, Oct. 15).

The European Community's environmental policy is not only infiltrating each member nation's laws, but is also becoming more influential in international circles, said Mr. Haigh.

"The E.C. will play an increasing role in international conventions with other countries," he said.

For example, the European Community already has played a role in negotiating the Montreal Protocol on the protection of the ozone layer, Mr. Haigh said.

In addition, the European Community has called for all member nations to eliminate carbon dioxide emissions by the year 2000, Mr. Haigh said, noting that the United Kingdom's position is that such a ban should not occur until the year 2005.

While the European Community has legislated numerous environmental principles, such as the "polluter pays" doctrine, the working group contends that to fulfill the objectives of these measures, "environmental policy needs to be strengthened and a more forceful set of (economic) instruments must be used than has been available in the past.

"Even though in certain member states and sectors there has been a decoupling between economic growth and energy use, present regulations and incentives are evaluated to be insufficient to compensate (for the) environmental impact of this growth in the medium and long term," the working group says in its report.

One "striking example" of the use of economic instruments has been the voluntary creation of an E.C.-wide tax incentive for using unleaded gasoline, the working group says.

In a program inaugurated last year, member states increased the tax on leaded gas, thus increasing the price at the pump and encouraging citizens to use unleaded gas. The push for unleaded gas is a precondition for the widespread introduction of the catalytic converter in cars, the working group noted.

"Only a substantial price differential between leaded and unleaded petrol was able to generate a massive switch in consumer behavior," says the working group.

However, an uneven use of such charges on products "is more likely to affect competition" than change behaviors, the group said. For example, if there is a charge placed by one country on environmentally harmful products, or a pollution tax is imposed on business, "then producers or consumers are inclined to shop abroad and avoid the charge, diminishing the effectiveness of the charge," said the group.

"As a result, it is necessary to harmonize the product charges/taxes/deposits or to develop a framework indicating how member states can apply these (fiscal) instruments without infraction of the community law," the group said. ■

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INTERNATIONAL

Firms detail environmental policies

By STACY SHAPIRO

LONDON—Every business should establish its own environmental policy or face the economic consequences, corporate environmental experts recommend.

The policy should reflect the objectives of the company to improve its environmental impact and be "dynamic, flexible and pro-active," advise 3M United Kingdom P.L.C. and The Environment Council, both of London.

A full risk assessment or environmental audit of a company's strengths and weaknesses also "is an essential step towards establishing a coherent environmental policy," says a brochure compiled by the two organizations titled, "Integrating Environment into Business—A Guide to Policy Making and Implementation."

The brochure was distributed to the more than 200 business officials who attended an environmental conference in London last month, sponsored by Environmental Policy Consultants of London.

Ultimate responsibility for 3M U.K.'s corporate environmental policy rests with the company's chairman and chief executive officer, the brochure noted. However, responsibility for formulating implementation strategies has been assigned to a corporate environment council made up of employees from all sectors of the company.

3M U.K.'s environmental policy sets out its objectives and measurable environmental goals. "The current corporate goals, to be achieved by the year 2000, are to reduce emissions to air, land and water by 90%, from a 1987 base," the brochure says.

An environmental policy can improve the relationship of the company with consumers, environmental lobbyists, the investment community and insurers, 3M U.K. and The Environment Council point out in their brochure.

"There is concern that the U.K. insurance industry will struggle to provide cover for polluting industry if European (Community) legislation, due to be in force by the end of the 1990s, is not amended," the brochure says.

"Under the E.C. directive on civil liability for damage caused by waste, consumer pressure groups would be able to take firms to court for damaging the environment. Companies would be forced to pay much larger pollution insurance premiums than at present as a consequence."

Increased insurance premiums are some of the more severe financial repercussions that could result from a negative or passive approach to environmental pressures, the two organizations note. "Fines, injunctions, even prison sentences also have obvious implications for profitability and shareholder confidence."

Along with distributing the brochure, Richard Smith, 3M U.K.'s manager of environmental health and safety, shared his views with conference attendees on the British government's recent White Paper outlining its position on the environment (*BI*, Oct. 15).

"I personally had expected the White Paper to contain explicit details of the environmental agenda beyond the Green Bill," he said, referring to the recently passed Environmental Protection Act. "Instead, I found that I was aware of most of the principles of policy which it contained and was a little disappointed to find that it contained no great revelations of detail."

However, the most significant change that will take place resulting from the White Paper and the Environmental Protection Act for many British manufacturers is that they "will be faced with environmental controls for the first time," he added.

For example, small painting businesses using more than five tons of paint a year will be regulated and will have to clean up their emissions according to the "best available technology not entailing excessive costs" criteria, known as "BATNEEC," that is outlined in the White Paper, he said.

Applying for and obtaining consent from local authorities to run their business in line with these restrictions "will be traumatic," said Mr. Smith. "The requirement to get involved with on-line monitoring, sampling and reporting of results will be new territory."

And for larger manufacturers, it will be a "major task" to convince them that the very stringent pollution control standards outlined in the White Paper are necessary, have a genuine environmental benefit and are affordable, Mr. Smith said.

"We do need to critically examine the level of performance which is required," he said, adding that the "best available" technology is not necessarily "environmentally best."

However, Mr. Smith said he is relieved that the British government is not considering legislation to saddle businesses with the cost of cleaning up waste that has been dumped in the past, a liability that his company's parent—Minnesota, Mining & Manufacturing Co. of Minneapolis—must cope with in the United States.

Meanwhile, one of Britain's largest chemical conglomerates, Imperial Chemical Industries P.L.C., spent more than 225 million pounds ($363 million at appropriate exchange rates) last year on a variety of environmental programs, said Michael Wright, U.K. Environmental adviser for ICI.

The expenditure is part of ICI's environmental policy established by the corporation's board.

Mr. Wright noted that the principal executive officers of each of ICI's international businesses and the chief executive officers of each of its subsidiary companies have been given the responsibility "for establishing environmental standards in their businesses," said Mr. Wright. "The CEOs are accountable for establishing, implementing and monitoring environmental policy for their own subsidiary company."

Each ICI subsidiary or regional organization must report annually to the board on its environmental performance, said Mr. Wright. Among the areas that are monitored are: compliance with legislation; progress on plans to improve the environment; number of pollution complaints received; and number of abnormal events.

Each ICI unit or regional operation also has its own environmental resource staff, said Mr. Wright. Typically, this includes an environment management team supported by special technical staff employed in research and development or engineering departments.

Each unit also carries out environmental audits regularly, he said.

ICI also has a "group environmental laboratory" at Brixham in the British county of Devon that has just been expanded at a cost of 3 million pounds ($5.9 million at current exchange rates) and a "central toxicology laboratory" at Alderley Park in Cheshire.

"Both these laboratories have worldwide reputations for the quality of their work," said Mr. Wright.

In addition, "within ICI we are building a data base of information and contacts" to improve the environment. "The aim is to help anybody with a problem find out quickly who in ICI can help and what information we have," said Mr. Wright

ICI also has a small team of environmental advisers at corporate headquarters who "keep track of legislative developments across the world, foster best (environmental) practice throughout ICI and help formulate our environmental policy," said Mr. Wright.

ICI not only monitors and controls its own emissions but also is developing techniques and products that can be used to allow industry to better co-exist with the environment. For example, ICI has developed a biodegradable plastic derived from sugar, said Mr. Wright.

ICI also has discovered how to produce a fungicide using three chemical reaction steps rather than six, which reduces the amount of waste to 10% of what was previously created. "Eliminating the waste at source is clearly better than cleaning up afterward," he said.

The company also has reduced its energy consumption by half in the last 20 years, which in turn has reduced its costs, he added. Also, "ICI pioneered the quantitative assessment of safety risks and the use of hazard and operability studies to identify safety problems when new plants were being designed," said Mr. Wright. "These studies are now being extended to embrace environmental problems, as well as safety and operability.

"To apply quantitative risk assessment to all situations will use more resources than we have," he noted. However, semi-quantitative analogy methods are being developed to help ensure environmental safety, and "we believe that these will achieve the results we want with the resources available." ■

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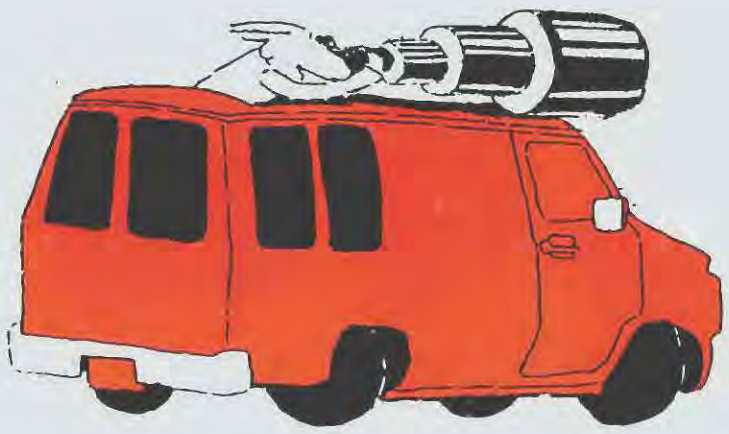

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GLOBAL BRIEFS

Continued from page 49

tralia (*BI,* July 2).

A New South Wales Supreme Court judge last week ratified a settlement between the supermarket owner and Sydney-based broker Lowndes Lambert (Australia) Ltd., a unit of Lowndes Lambert Group P.L.C. The amount was not disclosed, but lawyers close to the case say the amount totaled more than $1 million Australian ($769,000).

Jim Watson, managing director of Sydney-based Northern, Western & Southern Supermarkets Pty. Ltd., had sued Lowndes Lambert alleging breech of contract and negligence. He also sued his property insurer, A.M.P. Fore & General Insurance Co. Ltd. of Sydney, a unit of Australian Mutual Provident Society.

The insurer denied claims that, including business interruption, totaled more than $1 million Australian after the store in Nygan, 370 miles northwest of Sydney, was flooded after heavy rains.

Mr. Watson alleged that he had purchased flood coverage, but the insurer said the policy did not cover floods. He then sued Lowndes Lambert for failing to negotiate the coverage requested.

Mr. Watson had placed the coverage with Bain Clarkson Pty. Ltd., but that company was acquired by Lowndes Lambert in late 1989.

After a four-day trial in October, Mr. Justice Brownie ruled early last month that the brokerage was liable but the insurer was not. He ordered the supermarket owner and Lowndes Lambert to settle on damages, adding that an arbitrator would decide damages if they could not.

The judge ruled the broker had failed to negotiate the proper coverage and incorrectly advised Mr. Watson on the policy terms.

—By Kate McIlwaine

Broker acquisition

AUCKLAND, New Zealand—Minet International (Holdings) Ltd. last week announced that it had acquired for an undisclosed amount New Zealand-based insurance brokerage and risk management company David Archer Group and its subsidiaries.

In New Zealand, David Archer & Associates Ltd. will be merged with Minet Insurance Brokers (NZ) Ltd. to become Minet Archer Ltd.

In Australia, the businesses of David Archer & Associates and Minet Australia Ltd. also will be merged. However, Minet consulting unit Securityguard Risk Management will continue to operation as a separate division.

David Archer, who holds 20% of the equity of the new company in New Zealand, become managing director of Minet Archer; with Jim McGriskin as chief executive of Minet International's operations in Australia and New Zealand.

"Minet is committed to expanding its operation in the region," said Mr. McGriskin, "and the acquisition of this successful specialty broker will provide the group with a really strong presence in New Zealand."

—By Stacy Shapiro

Trygg-Hansa merger

STOCKHOLM, Sweden—Swedish insurer Trygg-Hansa Holding AB is planning to acquire Mutual Swedish Pension Group.

If the merger, scheduled to take effect Jan. 1, is completed, the combined companies will have annual premium volume of 21 billion krona ($3.8 billion) and will manage pension funds totaling about 220 billion krona ($39.7 billion).

"SPP's strength in the area of retirement pensions will complement Trygg-Hansa's all-inclusive range of insurance for individuals and companies," Trygg-Hansa said.

Trygg-Hansa is a major investor in a group that is attempting to acquire Home Insurance Co. from AmBase Corp. in a transaction valued at $970 million (*BI,* Nov. 19; Oct. 8).

—By Carolyn Aldred

LONDON

British insurers ponder rate hikes

By STACY SHAPIRO

LONDON—Several British insurers—many of which recently reported disastrous results for nine months ending Sept. 30 because of weather-related losses—may increase their rates for 1991 renewals.

General Accident P.L.C.—with a pretax loss of 73.3 million pounds ($137.9 million) compared to a 137.1 million pounds profit for the first nine months of 1989 ($222 million)—says it will increase premium rates.

"Remedial action has been and will continue to be taken, addressing premium levels and operating costs in each area of our business," the insurer reported. "We have also undertaken a far-reaching review of our worldwide operations and we will be implementing structural changes progressively over the next 12 months. Our prime task remains the restoration of profitability."

GA's poor results stem largely from the European windstorms earlier this year and a dry summer in the United Kingdom that caused subsidence claims, the company said.

GA's surplus has shrunk by more than 1 billion pounds to 1.5 billion pounds ($2.9 billion) on Nov. 12 from 2.55 billion pounds ($4.2 billion) at the start of this year, says a report by stock analyst Barclays de Zoete Wedd Research Ltd. This is largely due to the dramatic drop in stock prices this year.

Consequently, the company's solvency margin has eased back to a "barely comfortable" 51% ratio of assets to liabilities from a strong 82% over the same period, the report says.

Commercial Union P.L.C.'s nine months results fared better, although there was still a marked drop in pretax profits to 27.2 million pounds ($51.2 million) from 110.3 million pounds ($178.6 million) at the same time in 1989.

Chief Executive Tony Brend stated that the insurer's worsening results in the third quarter were largely due to "increased subsidence claims; a greater incidence of large claims; and a continued high level of competition for non-life business, which is also being affected by slowing economic activity in the United Kingdom."

CU's nine-month results were also affected by the European storms in January and February, which cost the company 55 million pounds ($103.5 million), including 22 million pounds ($41.4 million) to reinstate its reinsurance protection, he said.

The company is currently reviewing the state of the market to decide whether to increase rates for next year, but no decision has yet been made, said a CU spokesman.

Royal Insurance P.L.C.—which reported a pretax loss of 91 million pounds for the nine months to Sept. 30 ($171.2 million) from a pretax profit of 125.1 million pounds ($202.6 million) for the first nine months of 1989—also is expected to review its rating, says the Barclays report.

Meanwhile, B.A.T Industries P.L.C. announced a drop in its nine-month pretax profits to 599 million pounds ($1.1 billion) from 1.07 billion pounds ($1.7 billion) largely because of losses at its U.K. insurance subsidiary, Eagle Star Insurance Co. Ltd.

B.A.T's pretax loss includes 15 million pounds ($28.2 million) of "smooth capital appreciation"—an accounting mechanism unique to Eagle Star, which tries to smooth over its capital gains and losses over a five-year period.

Eagle Star also uniquely includes its deferred investment gains and losses in its shareholders funds rather than in its income statement, though these losses or gains are included in B.A.T's income statement. A 212 million pound ($398.9 million) drop in Eagle Star's investments included in its shareholder funds is therefore also included in B.A.T's income statement as an exceptional deduction.

The "exceptional investment depreciation" at Eagle Star was caused by the "very low level" of the stock market on Sept. 30, says B.A.T.

Nevertheless, Eagle Star's solvency margin stood at 56% on Sept. 30, "comparing favorably with other industry leaders," said B.A.T.

Eagle Star has also reserved 200 million pounds ($395.8 million) so far this year for commercial mortgage guarantee insurance coverage written in the United Kingdom, which it fears may produce claims due to falling property values.

New broker formed

Lloyd's of London broker Leslie & Godwin Ltd. has formed a new venture led by a former deputy chairman of Alexander Howden Ltd. to combine its marine, energy and North American talents into one operation.

The new company, to be called Leslie & Godwin Insurance Brokers Ltd., will be a subsidiary of Leslie & Godwin, which itself is a unit of Frank B. Hall & Co. Inc. The new unit will be headed by Bernard Steinart, former deputy chairman of Howden until 1987, when he left to pursue his own interests.

Mr. Steinart joined Howden in 1984 from Sedgwick Group P.L.C. along with Howden's current chairman, Dennis Mahoney.

Also joining the new venture are three other former board directors of Howden: Brian Ainsworth, Mike McDermott and Ian Waite, who until recently was deputy chairman of Howden and chairman of its marine and energy division.

Altogether, 22 of the 36 "specialists" recruited for the new company have come from Howden, including Igor Best-Devereux, deputy chairman of Howden's marine and energy division; Howden marine and energy managing directors Richard Allardyce, Mike Beard, Geoff Sloan and Neil Golder; Linda Wells, vp of Howden in Toronto; and Jay Cox, vp of Howden in New York.

Other recruits have joined from other brokers including Mark Kettle, former managing director of Gallagher Plumer North America Ltd., and several brokers from Minet Holdings P.L.C.

The new company, which will employ more than 200 people, will be based in London with subsidiary operations being set up in Canada and the United States.

Leslie & Godwin Insurance Brokers Ltd. will focus on clients in the energy field, combining all aspects of marine, North American property and casualty coverages for both onshore and offshore energy operations.

The move by the Howden executives to the new Leslie & Godwin operation stunned the London market and caused major movements of people in the London market as Howden tried to replace those who left (*BI,* Oct. 22). ■

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BERMUDA

Continued from page 49
hearing will take place on Mr. Ashby's petition to set aside the order.

Focus was acquired by Forum Re Group (Bermuda) Ltd. almost three years ago and has been in runoff ever since. Focus management last October wrote to creditors advising them that, according to U.S. generally accepted accounting principles, the company's liabilities "far exceed its assets."

However, under Bermuda law, which allows reserves to be discounted, the company had capital and surplus of $802,840.

Management warned creditors that because of changes in laws governing solvency on an undiscounted basis, Focus would be in violation of legal requirements by the end of 1989. It then proposed a commutation plan, which it said would "help meet its obligations to its creditors as best as it can in view of its current difficulties."

Reinsurance disputes

Reinsurers could save themselves considerable trouble and expense by paying more attention to contract wordings and seeking legal advice before executing contracts, an attorney says.

English courts ultimately will reach solutions to contract wording disputes "slowly and painfully," warned attorney Jan Woloniecki at a recent meeting of the Bermuda Insurance Institute.

Mr. Woloniecki, a civil litigation specialist with the Bermuda firm of Milligan-Whyte & Smith, cited two recent cases decided by English judges. He also is currently under contract to a British publishing house to write a text on English reinsurance law.

One of the cases centered on a "follow the settlements clause," which he said is commonly found in insurance contracts. The other involved what he called a "classic problem" over the conflict of various laws and determining which law governs a reinsurance contract when the parties have neglected to specify the applicable law.

Mr. Woloniecki warned against "plucking various standard clauses out of the air and tossing them into a reinsurance policy" and said that if there is anything to be learned from the "great saga of reinsurance litigation," it is that prevention is better than a cure.

Litigation and arbitration are expensive means of resolving commercial disputes, he said. But, not every dispute raises horrendously difficult questions of law and facts, he added.

"Many collection problems revolve around the simple phenomenon of can't pay, won't pay," Mr. Woloniecki noted.

"Where there is in substance no dispute as to liability, although the precise quantum of a claim may be in doubt, the law places a simple and effective remedy in the hands of any creditor," he said. "As Dr. (Samuel) Johnson once observed, 'When a man knows he is to be hanged in a fortnight, it concentrates the mind wonderfully.' "

A ceding company may serve upon the reinsurer a statutory demand under Section 162 of the Bermuda Companies Act of 1981, which gives the reinsurer three weeks to pay or face a winding-up order.

"Of course, if a reinsurer is in fact insolvent, the specter of liquidation forms. But that is a story for another day," Mr. Woloniecki said.

Some reinsurers may feel that commutation at any price is surely a better solution to reinsurance disputes than litigation, he observed.

"I would hesitate to say any price. There must surely come a point at which a deal is proposed that is simply commercially unacceptable and pursuing litigation in the courts is the only alternative," he said.

Mr. Woloniecki told the members of the Bermuda Insurance Institute that the reinsurance industry can take advantage of an impressive body of case law and console itself with the thought that although the legal problems posed by some reinsurance disputes are difficult, they are not impossible to solve.

He argued that vigorously attacking a commutation offer of, for example, 10 cents on the dollar may make good economic sense.

And, in some cases, "a scorched earth approach in the form of issuing statutory demands and threatening liquidation can sometimes prove effective," he said.

Yet it would be stretching credulity to lay the blame for "an explosion of reinsurance litigation" at the feet of the legal profession, Mr. Woloniecki said.

"A casual glance at the law reports over the last 10 years or so reveals many important points of principle being argued before the (U.K.) Court of Appeal and. . .the House of Lords," Britain's highest court, he said. "For every case that goes to trial, there are dozens which settle out of court. Recently one commercial judge was heard to complain that every other matter before him seemed to be a reinsurance dispute."

Mr. Woloniecki said that it was evident that the immense economic strains suffered by the worldwide reinsurance industry had caused business relationships based on mutual trust to break down.

But, he argued, "I would suggest to you. . .that to blame lawyers for reinsurance litigation is rather like suggesting that prostitutes are the cause of immorality. Alas, the oldest and the second oldest professions exist to fulfill a human need, founded no doubt upon original sin." ■

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INTERNATIONAL

Loss adjusters remain impartial: Executive

By KATE McILWAINE

ADELAIDE, Australia—Loss adjusters can remain impartial even though they are paid by insurers, says a senior loss adjuster.

An adjuster "must demonstrate impartiality and independence by his or her actions," said Robert W. Richards, managing director of McLaren, Dick & Co. (Vic.) Pty. Ltd.

He must "clearly explain his role and responsibilities to the insured. . .and if the insured (disagrees with his assessment), this must be included in the loss adjuster's report," said Mr. Richards at the annual Australian Insurance Law Assn. conference last month in Adelaide.

Mr. Richards and other experts spoke at a panel discussion on conflicts of interest among loss adjusters, brokers and lawyers.

If information obtained confidentially by an adjuster from a policyholder could threaten his coverage, Mr. Richards said he "suspected" that using the information would "violate the insured's rights."

Michael Pickering, an insurance lawyer with Dunhill, Madden & Butler in Melbourne, agreed.

Loss adjusters are not bound by the doctrine of confidentiality and professional privilege that binds attorneys, he said. But disclosing confidential information to an insurer that prejudices the right to coverage would violate a policyholder's rights, he added.

Roger C. Becker, technical director with the National Insurance Brokers Assn. in Melbourne, said policyholders may occasionally need their own loss adjustment experts. He added that he hoped those cases could be kept to a minimum.

Australia Insurance Law Assn.

But he also noted that the use of insurer staff adjusters, rather than independent adjusters, is a concern because staff assessors cannot "operate at arm's length."

Meanwhile, brokers spend a lot of time emphasizing the difference between themselves and agents—their technical skills, wider access to markets and independence, Mr. Becker said. But then they "confuse the issue by operating binders, owning underwriting agencies or even acting as life (insurance) agents," he said.

He questioned whether a broker could claim independence when the brokerage was partly or wholly owned by an insurer and whether a broker could claim to represent a policyholder when he is paid a commission by an insurer.

Panelists also discussed other issues related to balancing the rights of insurers and policyholders.

Ken C. Fleming, a lawyer based in Brisbane, argued that judges and juries should not be told of the existence of insurance in tort litigation. Australian case law, which follows English precedents, has a historical bias against insurers, he said.

Because insurance is often irrelevant to a lawsuit, it should not be mentioned in court, he claims.

"Knowledge of insurance could cause an injustice to one or other of the parties," he said. "If counsel are conducting themselves properly, the fact of insurance, if it is irrelevant, will never find its way before a judge."

However, defendants should not be shy about disclosing insurance if it is necessary to do so in the interests of justice or if it is not "prejudicial to the main game."

Mr. Pickering also called on insurers to codify their underwriting practices as a way of proving nondisclosure of information by policyholders that contest the denial of coverage.

Insurers could use their guidelines in court to illustrate what limits and deductibles would have been imposed had all relevant information been disclosed, or to show that they may not have accepted the risk at all, Mr. Pickering said.

He said an underwriter should accept the "cream of the business" in a hard market. Yet in a soft market, when underwriters are less

Continued on next page

Arson called major problem for insurers

ADELAIDE, Australia—Between 40% and 45% of the fires reported in the United States each year are intentionally lit, according to an arson investigator in California.

Direct property losses alone from those fires are $5 billion, John De Haan, a criminologist with the California Bureau of Justice, pointed out at an Australian Insurance Law Assn. conference last month in Adelaide.

Australia Insurance Law Assn.

"If we could wave a magic wand and eliminate fires and fraud we could reduce premiums by a third," he said.

Mr. De Haan noted, however, that arson is not viewed as a serious crime.

"It took 60 years for it to be considered a significant crime in the United States," Mr. De Haan pointed out.

And some state governments in Australia define arson as "malicious mischief," he said. "That's inconceivable."

Mr. De Haan also noted that criminal laboratories, which concentrate on crimes like murder and rape, do not support arson investigations.

The Insurance Council of Australia has estimated that fraud across all lines of coverage comprises 15% of claims payouts, or $1.2 billion Australian ($1 billion U.S. at applicable exchange rates) in 1988.

—By Kate McIlwaine

HOW HOBBS MINIMIZE YOUR COST OF RISK.

Continued from previous page
choosy about the business they write, underwriting guidelines become even more important.

"In a hard market, where rates are high and capacity low, the underwriting process may involve a lower proportion of risks accepted; in a soft market there is likely to be a higher proportion.

"In these conditions underwriting practices depend on a range of controls to prevent unnecessarily high adverse risk selection. These controls involve premium rates, imposition of deductibles" and the use of endorsements and exclusions, Mr. Pickering noted.

He said guidelines should indicate the basis on which business could be written, how it could be rated and what sort of deductibles and limits would be applicable. The types of risks that should be declined should be noted, Mr. Pickering said. ■

Australia outlines new insurer rules

By KATE McILWAINE

ADELAIDE, Australia—The aborted sale of two life insurance companies has prompted the Australian government to toughen requirements on life and non-life insurers.

The recent changes include restrictions on insurer acquisitions and increased solvency requirements. Richard Beetham, the insurance and superannuation commissioner, and John Hanks, the deputy commissioner, outlined the changes at an Australian Insurance Law Assn. conference last month.

Mr. Beetham said he welcomed the changes, which the Australian Parliament is expected to approve next year. "Something good comes from adversity," he said.

Commissioners had been trying to change insurance laws for some time, said Mr. Beetham, but action was hastened by an investigation into the failed sale of North Sydney-based Occidental Life Insurance Co. of

Australia Ltd. and Regal Life Insurance Ltd. of Melbourne.

A federal court on Nov. 7 appointed a judicial manager for both insurers, units of Battery Group Ltd. in Melbourne. The manager—Richard Grellman, a partner with KMPG Peat Marwick—will be required to prepare a financial report on the companies for the Insurance and Superannuation Commission.

According to court papers, Battery Group, which has been experiencing financial problems, had attempted to sell the companies to an Australian shell company. Policyholder funds of $65 million Australian ($49.8 million) were allegedly transferred in the deal, the court was told.

The life insurers are taking separate court action to get the funds back. That action, filed in Supreme Court in the state of Victoria, has been recessed until Dec. 21.

Mr. Beetham said the Insurance and Superannuation Commission's powers would be expanded under the changes to the Life Insurance Act of 1945 and the Insurance Act of 1974, the major laws governing Australian insurers.

All insurers would have to notify the ISC in advance of proposed changes in ownership or control. And the commission would be allowed to block acquisitions it considers contrary to national or public interest.

"It is highly desirable for the government to vet acquisitions of life and general (non-life) companies," Mr. Beetham said.

The ISC will have the power to freeze assets while it investigates a proposed acquisition. And the commission can request that the insurer hire an independent auditor to assess its long-tail liabilities.

In addition, the government will impose a new solvency requirement on all insurers of $2 million Australian ($1.53 million), 15% of outstanding claims or 20% of premium volume, whichever is greater. The current solvency requirement, set in 1984, is $1 million Australian ($766,000) or 20% of premium volume, whichever is greater.

In another regulatory change, people convicted of insurance-related crimes and people who have declared insolvency or bankruptcy would be barred from becoming a director or officer with an insurance company, Mr. Beetham said.

Public disclosure requirements also will be tightened for insurers. Only three of the 15 statutory returns the ISC requires can now be released to the public: profit statements; underwriting accounts; and balance sheets. The new rules would let the commission release any insurer statement it wishes.

Policyholders cannot adequately analyze insurers with just the information now available, Mr. Hanks said.

In a question-and-answer session following Mr. Hanks' speech to the AILA conference, Sydney insurance law consultant Frank Hoffman noted that Australia requires less public disclosure of insurer finances than most other nations.

Mr. Hanks defended all the proposed changes, noting that Australian regulation is less stringent than in comparable countries.

Nothing in the proposed changes will restrict insurer rates or investments, Mr. Hanks said, adding that Australian regulations would still allow "relative ease of entry into the insurance market."

Mr. Hanks also noted that failures of Australian insurance companies are extremely rare, with the collapse of the Australian unit of British-based National Employers' Mutual General Insurance Assn. Ltd. the only Australian insolvency since 1984 (*BI*, Oct. 22; May 21).

Mr. Beetham also noted at the conference that insurers would be given time to comply with the changes. While he said he expected that insurers would be given up to five years to comply, he noted that no firm schedule had been announced.

In addition to these changes, Mr. Beetham said the commission will continue to review other possible changes to insurance laws. Premium financing companies will be included in the review, he said.

Meanwhile, while the ISC is concerned about the practices of some Australian insurance agents, Mr. Beetham said he did not favor minimum academic requirements for agents and brokers.

However, he criticized insurers for failing to take action against "undesirable market practices" by some agents.

Mr. Hanks questioned whether it was the ISC's role to determine who could or could not be and agent, but Mr. Hoffman, the insurance law consultant, argued there is a need to improve the standards and level of knowledge among agents and brokers. ■

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DECEMBER

DEC. 9-11. Barbados Captive Conference in Barbados, co-sponsored by Tillinghast and Coopers & Lybrand; $625. Eileen Callahan, Conference Director, Tillinghast, 100 Summit Lake Drive, 3 South, Valhalla, N.Y. 10595; 914-745-4611.

DEC. 10-11. California Insurance Regulation Conference 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. National Conference on Drunk Driving in Washington, D.C., sponsored by Insurance Information Institute; $185. Suzanne Kuntz, conference registrar, c/o Courtesy Associates, 655 15th St. N.W., Washington, D.C. 20005; 202-347-5900.

DEC. 10-12. Environmental Regulation Course in Albuquerque, N.M., 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. 10-14. Life Insurance Annual Statement Workshop in Winston-Salem, N.C., sponsored by Booke & Co.; $1,395. Insurance Company Services Division of Booke & Co.; 919-748-1120.

DEC. 11. Congress 1991: How Far Will They Weave the Benefits Web? seminar in Washington, D.C., sponsored by William M. Mercer Inc.; No charge. Gayle Mansuy, 202-293-9422.

DEC. 11. Retiree/Catastrophic Workshop in Chicago, sponsored by the Health Research Institute; $295. Workshop Coordinator, Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

DEC. 11-12. The Third Annual Environmental Claims and Litigation Conference in Washington, D.C., 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. 11-12. 9-10. 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. 11-12. Labor/Management 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. 11-14. Life Insurance Annual Statement Overview seminar in Winston-Salem. N.C., sponsored by Booke & Co.; $1,295. Insurance Company Services Division of Booke & Co.; 919-743-1120.

DEC. 12. National Health Proposals Workshop in Chicago, sponsored by the Health Research Institute; $295. Workshop Coordinator, Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

DEC. 12. Expectations and Realities: The Insurance Industry and the International Decade for Disaster Reduction forum in Boston, sponsored by the National Committee on Property Insurance; no charge. Karen Gahagan, Director-Information Services, NCPI, 10 Winthrop Square, Boston, Mass. 02110; 617-423-4620.

DEC. 12-14. The 1991 Region V Environmental Regulation 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. 12-14. Environmental Regulation Course in Los Angeles, sponsored by Executive Enterprises Inc.; $1,045. **Also Jan. 15-17** in San Francisco and **Feb. 19-21** in San Diego, Calif. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

DEC. 13. Advanced Cost Containment workshop in Chicago, sponsored by the Health Research Institute; $295. Workshop Coordinator, Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

DEC. 13-14. The Impact of Environmental Regulations on Business Transactions: Real Property Transfers and Mergers and Acquisitions seminar in New York City, sponsored by the Practising Law Institute, $550. Ann Tracy, PLI, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700.

DEC. 13-14. Rational Managed Care Participation seminar in Williamsburg, Va., sponsored by Temple University School of Business and Management; $695. Temple University, Center for Healthcare Administration and Finance, School of Business and Management, 393 Speakman Hall, Philadelphia, Pa. 19122; 215-787-8154.

DEC. 13-14. Employee Benefits Law conference in New York City, sponsored by the Institute for International Research; $895; $795 for two or more attendants. Karen C. Parnell, 437 Madison Ave., 23rd Floor, New York, N.Y. 10022; 212-826-3340, ext. 3091.

DEC. 14. Maximizing Coverage; Minimizing Costs seminar in Indianapolis and Emporia, Kan., sponsored by The Society of Chartered Property & Casualty Underwriters; $115 for Society of CPCU or Independent Insurance Agents of Kansas members; $145 for non-members; add $15 after Nov. 30. Tricia Hogan, Continuing Education Coordinator, The Society of CPCU, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355-0709; 215-251-2773.

JANUARY

JAN. 7-11. Modern Safety Management seminar in Calgary, Alberta, sponsored by the International Loss Control Institute; $855 for members; $950 for non-members. **Also Jan. 14-18** in Atlanta and London; **Jan. 28-Feb. 1** in Cleveland and Vancouver, British Columbia; **Feb. 4-8** in Toronto, Mexico City, and London; **Feb. 11-15** in Atlanta; **Feb. 25-March 1** in San Francisco; **March 4-8** in Calgary, Alberta; Lexington, Ky.; and Atlanta; **March 11-15** in San Juan, Puerto Rico, and Salt Lake City; **March 18-22** in London and Los Angeles. ILCI, P.O. Box 1898, 4546 Atlanta Highway, Loganville, Ga. 30249; 404-466-2208.

JAN. 8-9. Annual Meetings and Joint Industry Conference in New York City, co-sponsored by American Insurance Assn., Insurance Information Institute and Insurance Services Office Inc.; no fee. Invitation only to membership of the three organizations. Diane Portantiere, Insurance Information Institute, 110 William St., New York, N.Y. 10038; 212-669-9200.

JAN. 10. An Advanced Course on Business Interruption Exposures and Their Treatment workshop in Newburgh, N.Y., co-sponsored by The Society of Chartered Property Casualty Underwriters and the Hudson Valley Chapter; $75 plus $20 exam fee; add $15 after Dec. 27. Bonnie Kinsley, Continuing Education Coordinator, The Society of CPCU, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355; 215-251-2735.

JAN. 10-11. Practical Strategies for Managing a Cost—Effective Injury Prevention Program in Santa Clara, Calif., sponsored by the Southern California Safety Institute; $385. **Also March 12-13** in Irvine, Calif.; **March 26-27** in Fresno, Calif.; **April 11-12** in Ontario, Calif. Southern California Safety Institute, 3858 Carson St., Suite 210, Torrance, Calif. 90503; 213-540-2612.

JAN. 13-16. Communicating with the Customer conference in Orlando, Fla., sponsored by the Insurance Marketing Communications Assn.; $300 for IMCA members; $350 for non-members. William Hadley, executive director-IMCA, 62 Northgate Road, Wellesley, Mass. 02181; 617-266-8400.

JAN. 13-16. Medical Issues/Data Management Conference in Tucson, Ariz., sponsored by American Managed Care & Review Assn.; $445 for AMCRA members; $575 for non-members; add $100 after Dec. 28. AMCRA, 1227 25th St. N.W., Suite 610, Washington, D.C. 20037; 202-728-0506.

JAN. 14-15. Understanding the Scientific Principles Behind Environmental Regulation: The Scientific and Technical Survival Course for Lawyers and Managers in Washington, D.C., sponsored by Executive Enterprises Inc.; $1,045. **Also Feb. 28-March 1** in San Francisco. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

JAN. 14-18. Accredited Safety Auditor seminar in Calgary, Alberta, sponsored by the International Loss Control Institute; $1,050 for ILCI members; $1,250 for non-members. **Also Jan. 21-25** in Atlanta; **Feb. 11-15** in Mexico City; **Feb. 25-March 1** in Vancouver, British Columbia; Cleveland; Madrid, Spain; **March 4-8** in San Francisco; **March 11-15** in Atlanta and Lexington, Ky.; **March 18-22** in San Juan, Puerto Rico. ILCI, P.O. Box 1898, 4546 Atlanta Highway, Loganville, Ga. 30249; 404-466-2208.

JAN. 15-16. Increased Solvency, Investment and Capital Requirements for Insurance Cos.

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Business Insurance

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in 1991 conference in Washington, D.C., 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.

JAN. 15-17. Environmental Regulation Course in San Francisco, sponsored by Executive Enterprises Inc.; $1,045. **Also Feb. 19-21** in San Diego and **March 12-14** in Los Angeles. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

JAN. 17. Twelfth Annual Conference in Orange, Calif., sponsored by the Orange Empire Chapter of Risk & Insurance Management Society Inc.; $70. Jeff Stevens, Society Director, City of Santa Ana, 20 Civic Center Plaza, Santa Ana, Calif. 92701; 714-647-5470.

JAN. 22. An Advanced Course on Business Interruption Exposures and Their Treatment in Allentown, Pa., co-sponsored by the Society of Chartered Property and Casualty Underwriters and the Lehigh Valley Chapter; $80, plus optional exam fee of $20; add $15 after Jan. 8. Tricia Hogan, Continuing Education Coordinator, The Society of Chartered Property & Casualty Underwriters, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355; 215-251-2773.

JAN. 22-23. Spencer's 1991 Legislative and Regulatory Review in Washington, D.C., sponsored by Charles D. Spencer & Associates Inc.; $425 for subscribers to Spencer publications; $500 for others. Charles D. Spencer & Associates, 250 S. Wacker, Suite 600, Chicago, Ill. 60606; 312-993-7900.

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Washington

Surety law to speed cleanups: Lobbyist

By ADRIENNE C. LOCKE

WASHINGTON—A new law exempting surety bond issuers from strict liability for personal injury or property damage claims from Superfund cleanups could hasten federal cleanup efforts, says an insurance lobbyist.

President Bush recently signed into law S. 3187, which was introduced by Sen. Quentin N. Burdick, D-N.D.

The law restricts liability by permitting only the insured contractor to make a claim on a surety bond and, if the contractor should default, by holding the surety liable only for the cost of completing the cleanup under the terms of the contract.

The liability limits apply only to bonds issued within two years of the law's enactment.

Insurance lobbyists view that condition, added in an amendment by Sen. Howard M. Metzenbaum, D-Ohio, as a test to see if surety companies will once again issue bonds to hazardous waste cleanup contractors.

Martha Hamby, director of federal affairs at the Washington, D.C.-based American Insurance Assn., which helped draft the bill, said she is confident that surety bond issuers will resume writing the coverage.

If Congress would help define "the role of the surety, and if we knew what the rules are, then we could participate in the marketplace," she said.

By returning to the market, surety insurers could speed up the award of federal cleanup contracts, Ms. Hamby said.

Lack of surety bond capacity has hindered efforts by the U.S. Environmental Protection Agency to find contractors to bid on the projects, according to the agency (*BI*, Sept. 10).

The Comprehensive Environmental Response, Compensation and Liability Act, also known as Superfund, left surety companies open for the pollution liabilities of the contractors to which they issued bonds. That exposure forced them to stop writing the coverage, Ms. Hamby said.

Limiting surety underwriter liability also will reduce cleanup costs by increasing the number of companies that can bid for EPA contracts, she said.

The lack of surety bond coverage "was costing the cleanup program money," she added.

Health group head

An insurer executive and former Harvard University administrator will become president of the Washington Business Group on Health next month.

Mary Jane England, vp of medical services at Prudential Insurance Co. of America in Roseland, N.J., will replace Willis B. Goldbeck, who founded the business lobbying group and is resigning "to pursue other opportunities."

After joining Prudential in 1987, Dr. England helped develop managed care health products and policies.

She had been associate dean of the John F. Kennedy School of Government at Harvard and was director of the school's Littauer master's degree in public administration program, beginning in 1983.

In 1979 she designed and help set up the Department of Social Services in Massachusetts. She was the department's first commissioner.

Dr. England has a medical degree from Boston University School of Medicine.

Hazardous materials

A new law, S. 2936, signed last month by President Bush increases the maximum civil penalty to $25,000 from $10,000 a day for violations of the Hazardous Materials Transportation Act, which regulates truckers carrying hazardous material (*BI*, Sept. 10).

The new law also will:

- Require trucks carrying hazardous materials to have safety permits.
- Make it illegal to tamper with or remove any label, markers or descriptions of contents on vehicles used to transport hazardous materials.
- Designate certain routes for transporting hazardous materials.
- Restrict rail transportation of high-level radioactive waste and spent nuclear fuel to trains operated exclusively for that purpose.

Besides increasing maximum penalties, the new law sets a minimum fine for violations at $250.

An amendment added to the bill will require companies that transport hazardous materials to buy safety permits to defray enforcement costs. This provision originally was in the House version of the bill, H.R. 3520.

The House also accepted the Senate recommendation to add 30 inspectors to the Department of Transportation. The House bill would have added 200.

The amendment to the bill also included restrictions, like some blanket restriction on using the same vehicles to transport hazardous materials and food, food products and drugs. ■

Letters

Continued from page 8

taxing health benefits is the inability to design such a tax that does not unfairly affect the sick and the aged or the young and healthy, and recognizes regional cost differences in health care.

In order to retain the pluralistic and comprehensive web of coverage that we now have, the insured pool must include those with the lowest risks. If we tax their benefits, however, the young and the healthy may opt out. This is not a way to achieve broader coverage in the United States

It is nice to think that taxing benefits would either lower everyone's taxes or that the revenues would be used exclusively to provide health coverage for those without.

Dream on Mr. Martz.

Ellen L. Goldstein
Director of Health Policy
Assn. of Private Pension
& Welfare Plans
Washington, D.C.

Psychiatric care cuts health costs

To the editor: I am writing in response to an Oct. 15 article, "States Reconsider Health Plan Mandates," which noted the cost of psychological services but failed to mention the now well-documented cost savings of psychological services.

Research shows that when psychological care is effectively provided within a comprehensive health delivery system, the cost of the benefit is more than offset by reductions in medical utilization and related savings. The addition of psychological coverage to health care benefit plans can actually decrease the overall long-term cost per plan enrollee.

Since psychologists are instrumental in reducing patients' psychological stress levels and accompanying medical complaints, they reduce overall medical costs. Heart disease, high blood pressure, insomnia, ulcers and other serious illnesses, including even cancer, have been linked to stress, which can be effectively treated by psychological care.

According to the article, "HIAA researchers found that a few benefit mandates actually decreased premiums." Home health care and coverage for stays in extended care facilities are two such mandates. Visits to a psychologist should have been added to the list.

Bryant L. Welch
Executive Director for
Professional Practice
American Psychological Assn.
Washington, D.C.

Rate increases

Continued from page 1

storms that cost European insurers an estimated $8 billion or more.

"The British tariff companies have made a mess of it. The European companies are doing no good at all, even in Munich. We're all suffering," Mr. Coleridge said.

Mr. Coleridge contends that the windstorms should have turned the market six to nine months ago.

However, "insurers are incredibly slow to react (because) of the absolute devotion they all have to market share," he said. "Everyone's frightened of putting rates up. I think it's because the (world) insurance market is too big."

U.S. insurers also "have been doing appallingly badly," he pointed out.

Mr. Coleridge predicts a worldwide contraction. "A lot of people will pull out. And in America, they'll pull out all over the place—out of classes—and they're already doing it."

During the mid-1980s, when liability coverage often was unavailable or unaffordable, many U.S. corporations formed policyholder-owned facilities—like ACE Ltd. and X.L. Insurance Co. Ltd.—or used other alternative risk financing mechanisms.

Many predict that the premiums that left the commercial insurance market during the crunch of the mid-1980s will never return.

That scenario does not seem to worry Mr. Coleridge. He contends that underwriters will raise rates more slowly this time around.

"If people want to go on writing insurance—captives or not—at the sort of prices they've been charging, let them do it. They'll just have another loss-making side to their businesses," he said.

"A captive can only thrive if it puts a proper premium for the risk it says it will run. If rates go up and there are a number of small captives set up, then so be it. We don't have a monopoly on the market."

Besides, he said, there is enough insurance business in the world to utilize the capacity from Lloyd's and most other insurers. "Insurance is a growth industry and more business is coming in all the time, unless there is a severe world recession.

"We'll have a marvelous time for the next three years and be sensible and be responsible, because what we don't want to do is repeat what happened in 1985 when rates went up too fast and too heavily and then you drag in again a lot of new competition," he said.

Lloyd's capacity will support rate increases expected throughout next year, Mr. Coleridge said. Premium capacity next year will increase slightly from the 1990 figure of 11.1 billion pounds ($21.8 billion at current exchange rates), he said.

Only 300 new members are joining in 1991, compared with 2,000 who are resigning. About 7,000 existing members are increasing their capacity now.

Unless the market attracts more new members, he warns, capacity will not be adequate in 1992 or 1993.

Mr. Coleridge would like premium capacity to rise to 15 billion pounds ($29.5 billion) in the next five years. To do so, Lloyd's needs to attract more new members and get members to increase their commitment.

Mr. Coleridge, who is expected to take over as chairman on Jan. 1, endorses several proposals to make Lloyd's more attractive to members and policyholders alike.

First, he would encourage trimming overhead to increase profits. He said he hopes that the current review of the self-regulatory bylaws will reduce some of the paperwork and other red tape that now burdens agencies.

He also favors eliminating at least five of the 20 committees set up by the Council of Lloyd's. Reducing the number would make the remaining ones more efficient, he said. "They don't need as many committees. It all costs time and money."

The Corporation of Lloyd's also would consider gradually cutting its staff to trim overhead, he noted.

"We all have to cut our costs these days, and Lloyd's has to cut its costs, too," he said.

His own company, Sturge, is conducting a staff audit to determine whether cuts can be made, he said, and other underwriting agencies and brokers are doing the same.

The industry generally must become leaner and more efficient, just as other financial services industries have, Mr. Coleridge said.

He also believes that to become more efficient, Lloyd's syndicates will have to either grow or specialize.

As a result, there will be far fewer Lloyd's syndicates, but the syndicates remaining will have between 300 million and 500 million pounds ($590.7 million to $984.5 million) in capacity, he said.

Lloyd's largest syndicate in 1990, marine syndicate 418 managed by Merrett Underwriting Agency Management Ltd., had a capacity of $216.2 million pounds ($425.7 million).

Between 20 and 30 syndicates have either shut down or merged this year because of losses or heavy overheads, Mr. Coleridge said. Only 100 to 150 syndicates, of a current 401, will stay in the market for the next two to three years, he predicts.

Critics have said that Mr. Coleridge's scenario could take the edge off of Lloyd's entrepreneurial style because fewer new underwriters will be given the chance build up small new syndicates.

However, Mr. Coleridge said: "I don't want to talk anyone down. But I think one has to face the facts of life, that's all. The clock doesn't stand still.

"I think that small syndicates can start, but they have to really have something special to offer—some expertise that nobody else has."

Brokers will no longer support small syndicates that do not specialize since they can save time by placing larger amounts of business with larger syndicates or insurance companies, he explained.

A lack of broker support is one reason smaller syndicates are according to Mr. Coleridge.

"I want a more efficient market," Mr. Coleridge said. "The bigger units can have much better backup. And they've got money to have very good management information, technology, the best staff they can get. I don't think we can go on like we used to. The world has changed."

To attract more members, Mr. Coleridge also supports a proposal for a new reinsurance company to be set up by Lloyd's to handle the run-off of open syndicates years (see story, page 49). The Council of Lloyd's is expected to vote on it this week.

Mr. Coleridge also said that he is looking forward to 1991 when:

- A unified claims system will be developed, under which marine, non-marine and aviation underwriters will use the same procedure to process claims, though they will retain separate claims offices. Mr. Coleridge hopes that markets eventually will unify their claims offices into a central office.
- The barriers among the marine, non-marine, aviation and motor markets will be eliminated, allowing the formation of composite syndicates that will be able to write all types of business.

"I will do my very, very best for 1991," said Mr. Coleridge. ■

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Secretaries, Treasurers, contollers and other Financial Personnel	4,505
Risk/Employee Benefits:	
Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations	10,830
Sub-total	**25,592**
Associations	511
Government, Unions and Educational Institutions	1,289
Commercial Consumers	
Sub-total	**27,392**
Insurance Agents and Brokers	9,815
Insurance Companies	7,891
Accountants, Actuaries, Attorneys & Consultants	3,377
Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers	1,218
Others Allied to the Field	1,693
TOTAL	**51,386**

* Source Business/Occupational breakdown of qualified circulation, May 28, 1990 issue, as submitted to BPA for June 1990 BPA Publisher's Statement.

NOTICES

PUBLICATION NOTICE
NOTICE OF CLASS-TYPE ACTION

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NOTICE IS HEREBY GIVEN, that the New Jersey Commissioner of Insurance, in his capacity as Liquidator of Integrity Insurance Company, has brought suit against a group of defendants including Integrity's officers and directors, Integrity's parent companies and Touche Ross, Integrity's accountant. The Liquidator's suit claims that some of the defendants engaged in negligence, mismanagement, breach of fiduciary duties and fraud, and thereby caused the insolvency of Integrity from 1981 onward. The lawsuit further claims that the defendants then negligently and/or fraudulently failed to disclose the company's true economic condition by preparing and disseminating materially false financial statements which were detrimentally relied upon (either directly or indirectly) by policyholders in purchasing policies, by others in continuing to transact business with Integrity, and by the New Jersey Insurance Department and other regulators in allowing Integrity to continue to transact business. But for such conduct, the pleadings allege, New Jersey's Insurance Department would have shut down the company in 1982 or 1983 instead of 1987 or taken other remedial action to minimize or cure Integrity's insolvency.

Notice has been sent to known policyholders, creditors and other interested persons that anyone wishing to assert a personal claim or to proceed independently of the Liquidator's suit must respond and provide certain information by February 8, 1991 or be barred from doing so. If you wish to receive a copy of the Notice previously sent, please contact the court-designated Special Master listed below:

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This Notice is given in accordance with an Order of the New Jersey Superior Court.

/S/ WILLIAM C. MEEHAN, J.S.C.

Advertising injury

Continued from page 1

practices."

Further, "there are few exclusions that would eliminate coverage" for such claims, she said.

"Potentially there is coverage for almost anything under this decision," said Richard de Saint Phalle of Crosby, Heafey, Roach & May in Oakland, Calif., who represented Industrial Indemnity Co. in the litigation.

"The court said unfair competition includes anything illegal," said Mr. de Saint Phalle. "Every other case has rejected this view."

As a result, attorneys predict enormous pressure will be placed on the California Supreme Court to review the decision.

Industrial Indemnity, a unit of Crum & Forster Inc. in Basking Ridge, N.J., filed a petition late last week for a rehearing by the appellate court.

If the rehearing is not granted or does not result in a revised ruling, the insurer will ask the California Supreme Court to review the case, said Mr. de Saint Phalle.

In the meantime, insurer attorneys hope the impact of the decision will be limited to California because the court based its interpretation of "unfair competition" on a California consumer protection statute that broadly defines unfair competition.

In addition, the court's ruling is limited because the post-1986 commercial general liability policy was revised to exclude the term "unfair competition" from the advertising injury portion of the policy, attorneys note.

However, the court's expansive interpretation of "advertising" would be applicable to policyholders with post-1986 CGL forms, said Ms. Molander.

The dispute arose after San Francisco-based Bank of the West tendered 32 unrelated unfair business practice lawsuits to Industrial Indemnity, which wrote general liability coverage for the bank from 1984 to 1988. Primary policy limits were $1 million per year. Excess policy limits were $25 million in 1984 and 1985, but dropped to $5 million in 1986 and 1987.

The lawsuits alleged different types of unfair business practices. For example, one lawsuit alleged the bank was guilty of unfair competition in an auto insurance premium financing program whereby insurance agents and brokers received a small fee for referring business to the bank. The plaintiffs in this lawsuit alleged the bank advertised its premium financing program and was guilty of unfair business practices because of the high interest rates charged for the financing.

Industrial Indemnity denied coverage for the claims and refused to defend the bank. The insurer subsequently filed suit in state court in California seeking a declaration that the advertising injury portion of its policies did not require the insurer to provide a defense or indemnification for these type of claims.

The standard-form pre-1986 CGL policy provides: "The company will pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of personal injury or advertising injury."

The broad-form advertising injury endorsement to the policy provides: "advertising injury means injury arising out of an offense committed during the policy period occurring in the course of the named insured's advertising activities, if such injury arises out of libel, slander, defamation, violation of the right of privacy, unfair competition, or infringement of copyright, title or slogan."

The trial court concluded that "unfair competition" and "advertising injury" should be interpreted narrowly.

The trial court said "unfair competition" should be given its common law definition, which is restricted to passing off a rival's goods as one's own. The trial court said "advertising injury" should be construed narrowly as well, but did not elaborate.

The appellate court reversed that decision, finding that both "unfair competition" and "advertising injury" must be interpreted more broadly.

"The term 'unfair competition' as used in the standard-form CGL must be given the broad statutory meaning in order to provide coverage for all unlawful and unfair business practices committed against either a business rival and/or the general public," said the appellate court, noting the term is given a broad definition in California law, case law, dictionaries, legal essays and textbooks.

Specifically, the court noted that California Business and Professions Code Section 17200 defines unfair competition to "mean and include unlawful, unfair or fraudulent business practice and unfair, deceptive, untrue or misleading advertising. . . ."

The appellate court also gave a broad interpretation to the term "advertising injury."

"Under standard dictionary definition 'advertising' includes any activities designed to bring a seller's goods or services to the attention of potential buyers or to induce them to buy. The term is not limited to paid announcements in print and broadcast media," the ruling stated.

'The sophisticated insured argument days are coming to an end,' says William S. Boyd.

The court went on to note that other California appellate courts have interpreted "advertising" broadly.

"Even one-on-one oral representations are advertising under the California case law," said the court.

"This decision mandates that insurers provide a defense (for many types of unfair business practice claims) because there is a clear possibility of coverage," said policyholder attorney Denis Rice of Howard, Rice, Nemerouski, Canady, Robertson & Falk in San Francisco. Mr. Rice filed an amicus curiae brief in this litigation on behalf of the Western Assn. of Venture Capitalists.

"Venture capitalists must be sensitive to whether they have coverage for these type of cases," explained Mr. Rice.

Policyholder attorney William S. Boyd of Brobeck, Phleger & Harrison in San Francisco said the court's decision also would be important in the savings and loan industry.

"The significance of this case is its potential application to the savings and loan industry problems," he said. S&Ls, as well as the government agencies that take over insolvent thrifts, could benefit from the ruling, explained Mr. Boyd.

However, insurer attorney Royal Oakes of Barger & Wolen in Los Angeles, criticized the court's ruling.

"The court's definition of unfair competition is not only too broad, but it is virtually limitless. Instead of adopting the common law meaning of passing off a rival's goods as your own, the court says any act that is deceptive, unfair or unlawful triggers coverage," he said.

"When was the last time a lawsuit didn't allege such conduct?" he asked.

"Anything that anybody does that is wrong or unfair would be unfair competition under this decision," said Mr. de Saint Phalle, Industrial Indemnity's attorney.

Further, "anything a company does in relation to marketing or selling its products would fit this court's definition of advertising," he said.

"In effect, the decision reverses decades of California law holding that lawbreakers cannot pass off onto their insurers the sting of being required to return what the courts call their 'ill-gotten gains,' " said Mr. de Saint Phalle.

The result of the decision will be that "honest businessmen paying CGL premiums will be required to underwrite the dishonest practices of their competitors in the form of higher premiums," he said, noting that insurers will increase current premiums to cover the cost of these types of claims they never intended to cover under old CGL forms.

"A lot of people in the insurance industry were surprised by this decision," said insurer attorney Paul E.B. Glad of Sonnenschein, Nath & Rosenthal in San Francisco.

"The court of appeal resolved. . .the definition of unfair competition and the issue of what constitutes advertising in a manner that is inconsistent with the position taken by a number of insurance companies," he said.

As a result, Mr. Glad and several other attorneys say there is an excellent chance the Supreme Court will agree to review the decision.

In its court papers, Industrial Indemnity also argued that even if the court found the term "unfair competition" ambiguous or susceptible to more than one reasonable interpretation, it need not automatically construe the language to provide coverage because the policyholder, Bank of the West, was a sophisticated insured with substantial bargaining power.

The court did not agree: "The CGL policy and the extended coverage endorsement thereto were standard industry forms which were sold to the bank on a take-it-or-leave-it basis. . . .In such a situation, the insurer must be held responsible for any ambiguity in the language of the insurance policy."

This portion of the appellate court's decision mirrors the California Supreme Court's ruling earlier this month in a pollution coverage dispute involving FMC Corp. (*BI*, Nov. 26). The Supreme Court also said that insurance coverage should be granted if policy language is ambiguous, even when the policyholder is large and sophisticated.

The California appellate court's decision is another affirmation that ambiguous insurance policies "must be interpreted to provide coverage even for large businesses," said policyholder attorney Mr. Boyd.

"The sophisticated insured argument days are coming to an end," said Mr. Boyd. "Unless there is evidence that the policyholder negotiated specific policy language in question, the normal rules of construction apply" whereby ambiguities in policy wording are construed against the insurer.

However, insurer attorney Mr. Oakes said: "It is unfair to construe ambiguities against an insurer when a sophisticated entity such as a bank is doing business with the insurer.

"It is simply not fair to hold the insurer to a higher level of conduct," he said.

While the ruling is seen as victory for policyholders, it also could trigger more suits by consumers against companies under the California consumer protection statute.

Prior to the ruling, plaintiffs suing under the consumer protection statute generally could only receive restitution for actual losses, attorney say.

However, in addressing the statute, the ruling seems to suggest that plaintiffs in these types of suits could collect damages exceeding their actual losses, which could create a flood of new consumer-protection lawsuits against policyholders, attorneys say.

"This could open the floodgates for all types of lawsuits against insureds under the California statute," said Mr. de Saint Phalle.

The appellate court is the second California court this year to rule on the advertising injury portion of the pre-1986 CGL form.

Santa Clara County Superior Court Judge Conrad L. Rushing in February ruled in a case involving Technical Equities Corp., an investment and real estate firm, that "when an investor suffers an injury as a result of receiving and relying on materials distributed by the company, the investor is injured as a result of unfair competition" and thus the insurer is liable for indemnification under the advertising injury portion of the CGL form (*BI*, July 30).

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Bank of the West vs. The Superior Court of Contra Costa County, Industrial Indemnity Co. et al., real parties in interest, California Court of Appeal 1st Appellate District, No. A050298.

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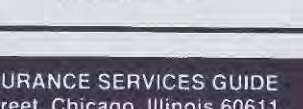

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Mental benefits

Continued from page 2

cally self-insure their health programs, including coverage for mental health and substance abuse, they would have more concrete data on utilization and costs.

"Only 40% of survey respondents with fewer than 5,000 employees were able to determine mental health/substance abuse costs, compared to 71% of large employers. With little or no hard data available, smaller employers may be underestimating their mental health costs. Unfortunately, the average increase reported by larger employers may provide the more accurate picture of the current mental health care cost trend," the survey said.

These cost increases are detailed in "Mental Health and Substance Abuse Benefits Survey," the largest report of its kind. The survey is based on the responses of 1,943 employers.

"These increases are of a magnitude that they should grab employers' attention," said John Erb, a managing consultant with Foster Higgins.

Employers indeed are trying to rein in soaring mental health and substance abuse benefit costs.

Substance abuse benefit costs, however, generally account for only a small portion of total mental health and substance abuse expenses, the survey said. Substance abuse benefit costs and mental health costs are combined for this survey because "in some cases the data is only available to employers in this format." In addition, these claims often have elements of mental disorders and substance abuse.

Nonetheless, about 40% of respondents cover substance abuse treatment separately from mental health benefits.

"By separating mental health and substance abuse benefits, an employer can limit substance coverage to a single course of treatment without restricting mental health coverage to the same degree," the survey notes.

"Employers' interest has been piqued by these rising costs. They are now focusing their attention on the cost problem" with many limiting benefit coverages, Mr. Erb said.

For example, among the 60% of respondents that cover mental health and substance abuse treatment under one program, 87% said they limited inpatient benefits, up from 75% in 1988. Limits include capping lifetime and annual benefits and imposing a maximum on the number of covered days for inpatient care.

While results vary depending on the cost containment strategy, limiting benefits clearly helps hold down costs, according to the survey.

Employers that have imposed one or more limitations on inpatient coverage for mental health and substance abuse benefits reported average costs of $230 per employee, 18.4% less than the $282 per employee for employers without any limitations.

The most successful cost containment strategy is imposing an annual dollar limit on covered inpatient care for mental health and substance abuse benefits, the survey found.

Employers with annual dollar caps on inpatient care reported annual per-employee costs of $199 on average in 1989, which is 24.3% less than the $263 reported by employers without such caps.

Annual dollar limits varied widely, though the median cap was $10,000.

While such an annual dollar cap will cut costs, employers have to be careful not to set too low a limit, Foster Higgins warns.

"In setting a maximum, employers should carefully consider what amount will still provide employees with adequate coverage. In most parts of the country, a $10,000 maximum will pay for 21 days of inpatient care, which will not cover the standard 28-day substance abuse programs and may not be enough to treat acute mental illness," the survey noted.

"You may send a conflicting message to employees. You are telling them, especially if you have an employee assistance program, that you want them to seek help but you are not providing the needed coverage," Mr. Erb said.

The most common employer limitation on inpatient mental health and substance abuse benefits is a lifetime dollar maximum on benefits.

Last year, 58% of employers said they imposed a lifetime maximum on benefits, up from 35% in 1988.

Among employers capping lifetime inpatient mental health and substance abuse benefits at a fixed dollar amount:

- 57% set a lifetime cap of at least $50,000.
- 25% capped benefits at between $20,000 and $49,999.
- 6% limited benefits to $20,000.
- 12% capped benefits at less than $20,000.

While implementing a lifetime dollar maximum on inpatient benefits is relatively easy and caps plan liability for catastrophic expenses and long-term custodial care, it is not likely to have much short-term impact, according to the survey.

Mental health costs for plans with a lifetime maximum provision were $227 per employee, or 6.2% less than the per-employee cost of $242 among plans without such a limitation.

And, Foster Higgins' Mr. Erb notes that capping lifetime inpatient benefits to a fixed dollar amount would not, for example, have much of an impact on employers with high employee turnover.

The survey also found that nearly half, or 46%, of employers limit the number of covered days for inpatient treatment per year or benefit period.

Among employers limiting days for inpatient coverage:

- 4% provide less than 30 days of coverage.
- 41% impose a 30-day maximum.
- 18% limit the number of days to between 31 and 45.
- 18% limit the number of days to between 46 and 60.
- 19% provide coverage for more than 60 days of inpatient care.

Limiting the number of covered days during a year should give employers more control over costs, according to the survey.

With the typical daily hospital charge for mental health and substance abuse treatment at about $500, a 30-day annual maximum on covered days would limit covered charges to $15,000 annually.

Surprisingly, though, the cost of mental health and substance benefits was about the same for employers that limit the number of covered days each year compared with employers that do not impose such a limitation, according to the survey.

For outpatient care, 76% of employers place an annual dollar limit on how much their plans will pay, while 65% impose a lifetime cap on benefits and 62% require higher coinsurance for mental health and substance abuse services than for other outpatient services.

Among employers with an annual dollar cap on outpatient coverage for mental health and substance abuse care, the median annual maximum was $2,000 per employee. The median lifetime maximum was about $50,000.

In addition, among plans that require higher coinsurance charges for outpatient treatment for mental health and substance abuse problems than other medical problems, employees typically pay 50% of eligible charges, according to the survey.

Other survey findings include:

- Mental health and substance abuse costs varied widely by geographic region. Costs were lowest in the Mountain states—averaging $169 per employee in 1989—and highest in the mid-Atlantic region—averaging $289 per employee.

The survey notes that 97% of the respondents in the Mountain states have imposed some type of limitation on inpatient mental health and substance abuse benefits compared with 81% in the mid-Atlantic region.

- Thirty-two percent of employers screen at least some of their employees for substance abuse as part of a pre-employment physical, up from 24% in 1988.
- Forty-eight percent of employers provided an employee assistance program in 1989, and 10% said they plan to offer one within a year.

Employers with EAPs spent $272 per employee on average in 1989 for mental health costs, 36% more than the $200 spent by employers without EAPs.

"Given that a primary function of EAPs has been to refer employees to mental health care providers, it is not surprising that they tend to increase utilization," the survey says.

- Nine percent of employers said they provide separate utilization review programs for inpatient mental health and substance abuse treatment than provided for other medical problems, while 6% had separate UR programs for mental health and substance treatment performed on an outpatient basis.
- Five percent of respondents said they had a separate preferred provider organization for mental health and substance abuse treatment.

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Copies of the "Mental Health and Substance Abuse Benefits Survey" are available for $100 per copy from A. Foster Higgins & Co. Inc., Research and Survey Services, 212 Carnegie Center, CN 5323, Princeton N.J. 08543-5323; 609-520-2441.

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Summary of major property/casualty insurers' nine-month results

Ranked by change in net income. All amounts in thousands of dollars.

Rank 1990	Consolidated revenues 1990	Net income 1990	Percent increase (decline) 1989-1990	Combined[1] ratio 1990	Combined[1] ratio 1989	Net premiums written 1990	Percent increase (decrease) 1989-1990	Pretax underwriting income (loss) 1990	Percent increase (decline) 1989-1990	Pretax investment income 1990	Percent increase (decrease) 1989-1990	Policyholders surplus 1990	Percent increase (decrease) 1989-1990
	Corporate			Property/casualty operations									
1 Reliance Ins. Co. & subs.	2,873,570	298,195	432.1	108.6[2]	106.7[2]	1,403,256	1.6	(100,587)	(8.1)	164,599	(2.8)[1]	N/A	N/A
2 USF&G Corp.	3,417,000	41,000	173.3	113.2[2]	109.9[2]	2,768,000[2]	(1.9)	(320,000)	(10.7)	432,000	(7.9)	1,190,000	(16.0)
3 Fremont General Corp.	462,408	20,335	152.3	107.5	105.3	335,306	40.3	(25,144)	(102.1)	63,713	49.6	204,182	10.6
4 Fireman's Fund Ins. Cos.	261,768	120,207	35.4	116.9	120.7	2,090,214	0.2	(346,835)	16.2	354,262	2.0	1,219,491	(10.8)
5 Berkshire Hathaway Group	416,161	184,265	33.5	121.1	108.7	154,625	(35.9)	(36,639)	(25.0)	242,643	40.3	N/A	N/A
6 Royal Group (U.S. subs.)[2]	N/A	(50,900)	30.2	125.0	121.9	1,551,600	(8.7)	(382,100)	(5.3)	259,200	10.9	733,600	(10.4)
7 Chubb Corp.	3,145,000	367,200	17.1	100.5[2]	100.9[2]	2,174,700	5.8	(19,100)	10.8	362,100	11.4	1,297,200	(11.8)
8 Hartford Insurance Group	6,569,000	224,000	16.7	107.9	107.0	4,689,000	(2.3)	(428,000)	(11.7)	691,000	7.3	2,632,000	(1.2)
9 The St. Paul Cos. Inc.	2,931,305	297,913	9.7	103.8	106.2	2,291,215	9.0	(95,474)	30.3	467,171	1.9	1,444,294	(0.2)
10 Argonaut Insurance Co.	407,438	58,463	8.3	105.8[2]	101.6[2]	325,506[2]	17.6	(22,497)[2]	(208.5)	100,847[2]	20.4	368,169	(0.9)
11 Continental Corp.	4,231,400	88,000	7.8	113.5[2]	114.0[2]	3,451,400[2]	(4.1)	(465,600)	5.0	553,200	4.2	N/A	N/A
12 Old Republic Int'l	913,632	77,626	6.3	105.1	110.1	491,734	11.9	(50,751)	21.8	116,472	5.8	706,419	3.9
13 American International Group	11,353,198	1,060,346	4.0	99.1[2]	99.6[2]	6,998,865	2.6	2,556	103.1	777,829	10.9	N/A	N/A
14 General Re Corp.	2,204,200	458,100	2.8	98.9[2]	99.8[2]	1,590,500	14.4	(10,700)	(182.9)	524,800	5.4	2,708,100	4.3
15 Hartford Steam Boiler	414,318	59,392	1.6	87.4	82.8	224,454	5.5	27,825	(24.4)	30,773	3.0	335,399	4.6
16 Sentry Insurance Cos.[2]	1,002,179	38,179	(8.8)	105.6	105.7	858,314	8.8	(54,812)	(13.2)	112,347	1.6	599,716	(0.3)
17 Aetna Life & Casualty Co.	14,430,600	472,200	(10.2)	113.8	114.4	4,819,400	(2.7)	(657,200)	6.8	810,600	5.7	2,488,400	4.4
18 SAFECO Corp.	2,378,522	185,681	(15.9)	107.1	103.2	1,268,748	5.4	(87,998)	(138.7)	210,429	8.7	959,884	(6.4)
19 Transamerica Ins. Group	1,588,928	47,607	(16.1)	110.6	110.9	1,364,855	11.1	(149,560)	(11.1)	186,495	13.7	1,027,157	3.1
20 Lincoln National Corp.	5,990,200	132,300	(22.9)	109.1[2]	105.8[2]	1,802,400	1.3	(162,100)	(47.2)	220,000	(6.4)	1,212,700	(15.9)
21 Ohio Casualty Corp.	1,223,549	69,383	(27.0)	104.5[2]	102.7[2]	1,107,417[2]	5.5	(55,508)	(52.0)	134,399	(4.9)	487,883	(17.4)
22 CIGNA Corp.	11,396,000	211,000	(44.2)	116.0	116.0	4,439,000	1.0	(700,000)	-	641,000	-	1,820,000	(13.4)
23 CNA Financial Corp.	7,330,000	301,900	(45.9)	115.0[2]	113.3[2]	4,890,000[2]	14.5	(766,200)[2]	(27.3)	856,800[2]	11.8	3,090,000	1.0
24 Crum & Forster Inc.	3,152,400	92,700	(61.4)	113.5	118.2	2,399,300	(5.1)	(333,800)	27.5	446,100	(1.5)	1,010,500	(41.0)
25 Travelers Corp.	8,543,500	(306,000)	(200.0)	115.4	114.4	3,313,500	(7.2)	(517,200)	(8.2)	572,400	4.9	2,056,900	-
26 Home Insurance Cos.	1,802,000	(130,000)	(204.0)	110.1[2]	109.6[2]	1,533,000	(4.2)	(175,000)	(12.9)	247,000	(9.2)	778,000	(12.0)
— Nationwide Mutual Ins. Co.[2]	N/A	N/A	N/A	109.9	107.6	4,185,986	(3.3)	(313,485)	(13.1)	541,904	4.6	2,856,266	(2.9)
— Commercial Union Ins. (U.S.)[2]	N/A	N/A	N/A	110.4[3]	111.9[3]	1,002,500	6.1	(117,100)	4.3	127,000	2.9	548,600	(2.7)
— Liberty Mutual Ins. Co.[2]	N/A	N/A	N/A	112.5	116.1	4,736,974	(1.5)	(432,422)	30.3	798,698	5.9	2,487,144	5.4
— Kemper National P/C Cos.[2]	N/A	N/A	N/A	118.6	108.9	2,225,579	16.5	(422,174)	(124.7)	236,053	3.4	1,410,553	(14.5)
Cumulative	98,438,276	4,419,092	(19.1)	110.3	110.1	70,487,348	1.3	(7,217,605)	(3.0)	11,281,834	5.2	35,672,557	(5.4)

[1] After dividends [2] Statutory [3] Before dividends N/A—Company did not provide data

Insurance rates

Continued from page 1

Sept. 30 from $37.7 billion a year earlier.

Surplus increased a reported 2.7% in the first half of 1990.

The nine-month 1990 decline in surplus was the first among the insurers surveyed by *BI* since year-end 1984, when they reported an 8.3% drop (*BI*, March 25, 1985).

The decline is surplus "still begs the question of the adequacy of liability reserves and the viability of reinsurance recoverables, and it could very well be that stated surplus is still too high," said Robert Branche, principal of Branche Research Group in Morrisville, Pa.

Yet, despite decreasing surplus, U.S. insurance experts disagree with David Coleridge, who is expected to be elected the next chairman of Lloyd's of London this week, that pricing in the overall insurance market in Europe and the United States is turning higher (see story, page 1).

Retrocessional and catastrophe reinsurance markets are tightening, but U.S. observers said that does not mean primary insurance rates will rise immediately.

"I don't buy it," said Robert A. Anker, president and chief executive officer of American States Insurance Co., a unit of Fort Wayne, Ind.-based Lincoln National Corp.

"It's real clear there's certainly significant additional pressures on London to increase pricing, particularly catastrophe (reinsurance) pricing, but the normal posture is it takes at least a year between the time London effects a change and the time it really happens to the rest of the world."

Mr. Anker also noted that U.S. insurers are now using less reinsurance than they did at the bottom of the last cycle, so London reinsurers "have a less immediate impact on turning the market than they did the last time."

Ed Santos, chief financial officer for Transamerica Insurance Group in Woodland Hills, Calif., said catastrophe reinsurance rates have increased substantially in London but that rates "have not hardened at all that we're aware of" in the overall reinsurance market, much less the primary market.

Allan Levin, senior vp at Standard & Poor's Corp. in New York, noted that while tightening in the catastrophe reinsurance and retrocessional market could lead to a tightening of primary rates in the United States, "that's something that takes time to wind through the system."

Most U.S. industry observers predict it will be at least late 1991 or early 1992 before primary insurance rates rise substantially on a widespread basis.

In fact, while Mr. Anker said he does not disagree with predictions of a turn by late 1991 or 1992, though he accepts it "with a large amount of caution."

While American States has been successfully obtaining 4% to 6% increases in the small to medium-sized business segment in which it specializes, Mr. Anker said he is "not going to pretend it's easy to get those kind of increases."

And, rates for bigger and more hazardous risks are "if anything more price-competitive now than six months ago. It's not clear at all to me that there are precedents to cause a cycle change," Mr. Anker said.

"Finally and ultimately what causes the cycle to turn is fear among senior management of a company that they will lose their jobs if they don't get something fixed, and that's not the issue we're looking at yet," Mr. Anker said.

"We don't see much evidence of price tightening in our area," said Bernard C. Hlavac, vp and treasurer at Sentry Insurance Cos. in Stevens Point, Wis.

"We're just surprised that there hasn't been any movement in pricing thus far," he noted.

"If it hasn't happened yet, we think it will be well into 1991 before we see any significant tightening up for the market," Mr. Hlavac added.

It will be well into 1991 or 1992 before the market tightens up significantly "unless the (stock) market goes down or underwriting results erode rapidly," Mr. Hlavac commented.

"There seems to be nothing on the horizon at the moment which would suggest there's going to be a turn. I think the turn right now is indefinite," said Barbara Stewart, president of Chapel Hill, N.C.-based Stewart Economics Inc.

But, when it does come, the market turn will be gradual rather than sharp as was the case in the mid-1980s, she said.

"My guess is it might not be for another year or so," Ms. Stewart added. That prediction is based on the assumption of very serious deterioration in insurer financial results and negative cash flows, she said.

"I'm continuing to expect the industry to deteriorate through '91 on an underwriting basis," said David Anthony, an analyst with Fox-Pitt, Kelton in New York. He predicted the pricing cycle will turn sometime in the third or fourth quarter of next year.

It will be at least mid-year 1991 before there is a general turn in pricing, agreed W. Dolson Smith, an analyst with Firemark Inc. in Morristown, N.J. Surplus remains overabundant and insurers are still seeking market share, both of which would dictate against a market turn, he said.

"We don't really see anything happening right now that would lead us to believe we're going to see a quick end to this," said George Yonker, assistant controller at Seattle-based SAFECO Corp.

Mr. Yonker said he now expects a turn in late 1991. "What we're seeing out there just doesn't give any indication people out there are ready to make a change," he observed.

"I really think there are enough negative fundamentals that have been brewing here that are starting to hit home," said Peter Taylor, vp for New York-based Scudder, Stevens & Clark's research department.

However, he said that prices would not change significantly during year-end renewals and it is likely to be late 1991 before there is a significant market turn.

The "negative fundamentals" cited by Mr. Taylor include costs growing faster than premiums, the need to add to reserves, increased taxes and lower investment income.

Substantial surplus has afforded a "comfort level" that hindered a market turn, he said. But, he noted, that surplus is now starting to erode.

Some observers said they were not sure when the market will change.

"I don't think anybody really knows," said Myron M. Picoult, senior vp and senior insurance analyst at Oppenheimer & Co. in New York.

While late 1991 or 1992 may not be a bad guess, "everyone just keeps pushing it out," Mr. Picoult said.

"I think it's still a gray area, and it doesn't look like there's a lot of change in the pricing markets currently," said C. David Mencer, controller of Hamilton, Ohio-based Ohio Casualty Co.

"I don't have any clues as to whether it's going to change. It would seem that the external forces are probably going to be acting against any major shifts," he said.

In a recession, the small and medium-sized businesses on which Ohio Casualty focuses "probably aren't going to be able to afford significant price increases," Mr. Mencer said.

A market return probably remains far off, say U.S. observers, who also note that results remain disappointing.

Besides the decline in policyholder surplus, other nine-month statistics among the 30 insurers surveyed by *Business Insurance* were equally uninspiring:

- Underwriting losses rose another 3% to $7.2 billion for the first nine months of 1990 from $7 billion in that period last year. Underwriting losses had increased 22.6% in the first half of the year (*BI*, Sept. 10).
- Net written premium growth continued to flatten, increasing just 1.3% to $7.05 billion for the first nine months of 1990 from $6.96 billion for the comparable period in 1989. This is a further drop from the 1.8% growth in the first half and the 2.3% growth in the first quarter.
- The nine-month combined ratio was 110.3%, compared with 110.1% for 1989. This is also a further deterioration from the 109.9% combined ratio reported in the first half.
- With premium growth slowing and the stock market faltering, investment income increased by just 5.2% to $11.3 billion in the first nine months of this year from $10.7 billion in the same period in 1989. This is a decline from the 5.8% increase posted in the first half.
- Net income plunged 19.1% to $4.4 billion in the first nine months of this year from $5.5 billion a year earlier, or more than double the 8.6% decline posted in the first half of 1990.

"In general, (the results) were as expected," said Michael A. Lewis, first vp with Dean Witter Reynolds in New York. He said he had not expected strong results, "and they weren't."

However, Mr. Lewis noted, there were a "few surprises," including:

- The strong 14.4% net premium growth reported by General Re

Continued on next page

Insurer results

Continued from previous page
Corp., which the company has attributed to increased demand for reinsurance, particularly for facultative business.

- The "very disappointing" results at USF&G Corp., which reported a $19 million operating loss in the third quarter compared with an $8 million loss for the same period in 1989. USF&G also cut its quarterly dividend by 66% to 25 cents share (see story, page 67).
- That Travelers Corp. added $650 million to its real estate and mortgage loan reserves as well as cut its common stock quarterly dividend by one-third to 40 cents a share (*BI*, Oct. 15).

Other observers said they were unsurprised by the nine-month results.

"I thought they were basically in line with what I was expecting, which was continued pressure on the commercial side," said Duff & Phelps' Mr. Guenther.

The nine-month results were "a confirmation of everything one would have expected," said Gloria Vogel, associate director at Bear, Stearns & Co. Inc. in New York.

Factors that distinguished the quarter included sluggish premiums and "still skimpy" reserves, she noted. Investment asset quality was the main issue, with many companies showing realized losses as they sold their junk bonds or tried to achieve higher quality in their investment portfolios, she said.

David Wells, an analyst with Fitch Investors Service in New York, observed that "at this point in the cycle" above-average performers are distinguishing themselves from companies with poor showings.

"By and large, I didn't think earnings were that disappointing, but going forward, I think they're going to get a lot worse," said Firemark's Mr. Smith.

However, he noted that the weakness of this year's third-quarter results is disguised by last year's poor third quarter results as a result of Hurricane Hugo.

Other observers agree no improvement is anticipated in fourth-quarter results.

"It doesn't look like anything is going to change in the fourth quarter," Ms. Vogel said. While cash flows will be lower, they will still be positive, so there will be no incentive to raise rates, she said.

"More of the same" is in store for the rest of the year, agreed Duff & Phelps' Mr. Guenther. "I don't think we're going to see anything but fairly depressing results, but not enough to turn things around."

Insurers still have too much surplus "to really shake things up," he explained.

"We're very pessimistic as far as the fourth quarter," said S&P's Mr. Levin. "There may be some reserve contributions to be recorded."

"The pricing environment is no better, and there's just not very much to be optimistic about," he said. ■

ARCO may benefit from recent FMC ruling

Cleanup cover sought

By STACY ADLER

LOS ANGELES—Atlantic Richfield Co. may be one of the first policyholders to try to take advantage of a recent California Supreme Court ruling that cleanup costs are "damages" that are covered under comprehensive general liability policies.

The Los Angeles-based oil company is suing more than 70 insurers in state court for the costs of cleaning up more than 50 hazardous waste sites nationwide.

The lawsuit comes on the heels of the California Supreme Court's ruling earlier this month in a case involving FMC Corp. in which the court ruled that the costs of cleaning up polluted property or repaying the government for doing so are "damages" covered by a CGL policy (*BI*, Nov. 26).

The state high court also held that coverage should be granted whenever policy language is ambiguous—even when the policyholder is large and sophisticated.

ARCO denied that its lawsuit—filed Nov. 21 in Los Angeles—is a result of the state high court ruling in the FMC case.

The ruling, however, "will be extremely helpful," said ARCO attorney Wondie Russell of Heller, Ehrman, White & McAuliffe in San Francisco. "It gets these threshold issues out of the way."

Dozens of U.S. insurers are named as defendants, including Aetna Casualty & Surety Co., Travelers Insurance Co. and Fireman's Fund Insurance Cos. Dozens of foreign insurers, including Lloyd's of London underwriters, are also included. And, the lawsuit names the California Insurance Guarantee Assn. because insolvent Midland Insurance Co. and Mission Insurance Co. each wrote policies for ARCO.

The suit seeks a declaration that the insurers, which wrote primary and excess CGL coverage for ARCO and its predecessors from the 1940s to the present, are liable for providing a legal defense and indemnification for all the hazardous waste claims now pending against the oil company. And, the suit seeks a declaration that there is coverage for any future claims.

Private parties and government entities, including the federal government, have filed dozens of suits claiming the company is responsible for pollution on their property.

These underlying claims allege property damage to surface water, groundwater and land, as well as bodily injury resulting from the presence of pollutants allegedly produced, generated or disposed of by ARCO or its predecessors.

"The environmental actions currently pending or resolved in the past against ARCO represent actual or potential liability of many millions of dollars," the suit says.

The ARCO suit claims the insurers have "not honored their obligation under these insurance policies."

In addition to asking the court to declare that its insurers must defend and indemnify it against the underlying hazardous waste claims, the lawsuit also asks the court to rule on trigger of coverage and defense costs.

ARCO claims that any of its CGL policies would be triggered "as long as any part of the injury or damage occurred during the policy period."

The company further claims that the insurers should pay "all costs, including attorneys' fees and supplemental expenses."

Finally, ARCO claims in the suit that it "is entitled to have its insurance policies and those issued to its predecessors interpreted in a reasonable manner which maximizes its insurance coverage."

Insurers named in the lawsuit would not comment.

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Atlantic Richfield Co. vs. Aetna Casualty & Surety Co. of America et al., Superior Court of the State of California County of Los Angeles, No. BC015575.

Supreme Court ruling

Continued from page 2
costs.

With the latest Supreme Court decision, "It seems that employers with self-funded plans will be free from complying with state insurance regulations," said H. Woodruff Turner, a partner with Kirkpatrick & Lockhart, the Pittsburgh law firm that represented FMC.

"The decision confirms the breadth of ERISA pre-emption on state insurance laws," said Michael Langan, a principal with TPF&C in Valhalla, N.Y., the benefits consulting division of Towers, Perrin, Forster & Crosby Inc.

Still, experts note, the decision does not entirely resolve whether ERISA exempts all types of self-funded health plans.

Because the FMC case involved a company that totally self-funds its plan, it isn't known whether the justices would have reached the same decision if the plan had purchased stop-loss insurance.

"This decision does not address stop-loss insurance," said Mary Lynn Eubanks, a consultant with Hewitt Associates in Lincolnshire, Ill.

"The ruling involves a very 'clean' case, where an employer totally self-funded its health care plan. But in the real world, there are many types of arrangements" in which plans are partially insured, noted Francesca Bruno, a consultant with A. Foster Higgins & Co. Inc. in New York.

Indeed, according to a Foster Higgins survey, only 17% of employers in 1989 self-funded their health care plans without stop-loss insurance, while 35% purchased stop-loss coverage and 16% purchased a minimum premium plan, a hybrid arrangement that contains elements of insurance and self-insurance (*BI*, Jan. 29).

The FMC case involved a 1987 car accident that left Cynthia Ann Holliday, the teen-age daughter of an FMC employee, permanently injured. The FMC health care plan paid more than $100,000 of her medical expenses.

Ms. Holliday later settled a suit against the driver of the car in which she was riding for $49,875, plus interest. FMC then said it would seek reimbursement from the settlement for the medical expenses it had paid on her behalf. Ms. Holliday's family refused to reimburse FMC, which then sought a court ruling.

Both federal district and appeals courts ruled that Section 1720 of the Pennsylvania Motor Vehicle Financial Responsibility Law barred FMC from seeking reimbursement. That law bars a party, like an insurer, from seeking subrogation or reimbursement for its expenses in actions arising out of the use of a motor vehicle.

The Supreme Court, though, said that the Pennsylvania law could not be applied to a self-funded plan like FMC's under the pre-emption provisions in ERISA.

Justice O'Connor wrote that the state law has a "reference" to employee benefit plans. But the pre-emption clause, she wrote, gives federal authorities broad and exclusive concern over state laws concerning benefit plans.

Pre-emption of state insurance laws was necessary to ensure that benefit plans would be governed by a single set of regulations and not a "patchwork scheme of regulation," Justice O'Connor wrote. ■

Update

Airport fire loss in millions

DENVER—United Airlines expects insurance purchased by the company managing its jet fuel storage facility at Stapleton International Airport in Denver to cover millions of dollars of losses from a tremendous fire at the facility.

However, there has been no decision about whether insurers of management company AMR Combs or United will have to respond to the losses, said Jack Browning, vp and general manager of AMR Combs, a subsidiary of AMR Corp., parent of American Airlines Inc.

Fort Worth, Texas-based American could provide no details of the management company's insurance.

A United spokeswoman said the fire consumed 2.6 million gallons of fuel and destroyed four United tanks at the 12-tank facility. A Continental Airlines Corp. tank also was damaged.

Airline industry sources put the value of the fuel lost in the inferno at $2.6 million to $3.1 million, based on current market prices.

Fuel losses are significantly larger than they would have before Iraq invaded Kuwait in August. At United's pre-invasion costs, the fuel loss would have been $1.6 million.

No estimates of property damage were available late last week. And, investigators had not yet determined the cause of the fire.

The United spokeswoman would not say whether AMR Combs' coverage or the airline's insurance would replace revenue lost from 14 canceled flights.

The blaze began on Nov. 25, the Sunday following Thanksgiving, which traditionally is one of the year's busiest days for airlines.

Continental hired Williams, Boots & Coots Firefighters & Hazard Control Specialists Inc. to fight the fire. A spokeswoman for the Port Neches, Texas, firm said the blaze was extinguished in less than an hour last Tuesday.

Illinois restricts ailing HMO

SPRINGFIELD, Ill.—Health Plan of Central Illinois Inc. is prohibited from selling or issuing new contracts until the Peoria-based health maintenance organization brings its net worth up to state minimum levels.

The state Department of Insurance issued a notice of impairment on Nov. 28, after finding that the HMO's net worth had fallen $484,143 below the required minimum of $1.5 million.

The HMO is allowed to renew existing contracts.

A "couple of major employer groups" that are not renewing their contracts caused the financial difficulties, said Jack Messmore, supervisor in the Insurance Department's life, accident and health regulatory action unit. The HMO lost 18,700 of its 26,000 enrollees as of Dec. 1, he said.

Regulators last week gave the company until Wednesday to restore its net worth to the required minimum level, but can extend that deadline up to 60 days. As of late last week, Health Plan of Central Illinois had not formally responded to the state action, Mr. Messmore said.

Representatives of the HMO could not be reached for comment.

Equitable denies troubles

NEW YORK—The Equitable Life Assurance Society of the United States strongly denies rumors circulating in financial markets last week that it missed a bond payment and was planning to file for bankruptcy.

"The Equitable is in solid financial condition and is going about business as usual. Any rumor to the contrary is absolutely false and unwarranted," said Equitable President John J. Melone in a statement.

"The company is a leader in all its markets, has strong cash flow from operations, is highly liquid and has approximately $62 billion in assets. The unfounded accusations are totally wrong, are without merit and do a grave disservice to the company and its customers," he said.

Mr. Melone also said that he does not know how the rumors, which he described as "outrageous and extremely irresponsible," started.

Work comp rates

Continued from page 2
allowing S.B. 1 to work," he said of the State Board.

The rate freeze was "as close to our recommendation (a 0.6% rate decrease) as they could get," he said.

Businesses in the state were outraged when the NCCI requested a double-digit rate hike only a year after the sweeping workers comp reforms were passed (*BI*, Nov. 26). The reforms will take effect Jan. 1.

Work comp rates for Texas businesses climbed by an average of 22% this year after average increases of 18.7% in 1989, 25% in 1988 and 17.7% in 1987.

Roy Wood, the NCCI director of government, consumer and industry affairs for Texas, said insurers are "disappointed (the State Board) did not see fit to raise rates."

The NCCI sees "a need to reach rate adequacy" before taking into account the impact of the workers comp reforms, he said.

The NCCI has not decided if it will request a re-hearing, he added.

Insurers will have to make an "individual decision" whether to discontinue writing workers comp coverage in Texas, Mr. Wood noted.

Workers compensation insurers in Texas are squeezed not only by inadequate rates but also by assessments they pay to cover deficits in the Texas Workers Compensation Assigned Risk Pool, he said.

Insurers lost about $582 million on workers comp business in the state last year and $580 million the year before, according to the NCCI.

Mr. Harris of the TAB pointed out that while Texas "has not been a profitable market for insurers over the last few years, at the same time employers have been driven to the wall and are trying to hold on" as workers comp costs have risen.

"In view of the projected savings from the bill, it was important to hold the line" on rate increases, he added. ■

'Strategist' to lead battered USF&G

By JUDY GREENWALD

BALTIMORE—USF&G Corp.'s new chairman and chief executive officer says he is a "strategic manager" who will develop a plan for all segments of the diverse company to pull in the same direction.

"I see the opportunity of taking a strong company and making it better," said Norman P. Blake Jr., who late last month resigned as chairman of Chicago-based Heller International Corp., a $7 billion commercial financial services organization, to take over the helm at USF&G.

A key element in his plan will be to make USF&G's property/casualty insurance operation more competitive by offering better service, he added.

With a reputation as a turnaround specialist, Mr. Blake is expected to bring a fresh perspective to the troubled company.

Former Chairman Jack Moseley took early retirement last month as the company announced a 66% cut in quarterly dividend 66% to 25 cents a share and a $75 million cost-cutting program (*BI*, Nov. 12).

USF&G Corp. reported a consolidated net loss of $15 million for the third quarter ended Sept. 30, and a $19 million operating loss. For the comparable period a year ago, USF&G posted a $17 million net loss and an $8 million operating loss.

Its $11.1 billion portfolio includes $943 million in junk bonds and $1.02 billion in real estate holdings.

On Monday, the day Mr. Blake's appointment was announced, USF&G's stock closed at $7.88, down 13 cents. Shares had rebounded to $8.75 on Thursday, still far below the 52-week high of $30.63.

"Frankly, it's a challenge," said Mr. Blake. "I like to think that I can make a difference in the management of companies and build value."

Mr. Blake said a strategic "game plan" will permit USF&G to better use its resources and enable its various units to be more efficient and productive.

Besides property/casualty insurance and reinsurance, USF&G also has life insurance units and financial services operations like investment management and advisory units, real estate and computer leasing management units, and strategic and organizational planning units.

Mr. Blake's background is strong in both junk bonds and real estate, both problems for USF&G. At Heller, Mr. Blake gained experience lending money for leveraged buyouts, which often involve high-risk, high-yield securities as subordinated debentures.

This background, he said, will enable him to look at the junk bond issues' underlying credit "and provide some meaningful judgment."

Mr. Blake, who also described himself as a "hands-on manager," said he hopes to apply a fresh perspective as an outsider to the commercial property/casualty business.

In particular, he said, he wants to make USF&G's property/casualty operation more competitive by improving quality of service at the branch level, including speeding up response time and increasing productivity.

USF&G is a committed independent agency company but lacks any well-known product specialties, which leaves it particularly vulnerable to movements in the overall cycle.

Mr. Blake said he does not believe his lack of background in insurance will be a disadvantage. "But, very candidly, I know I don't know the business, and I have committed myself to getting to understand the business."

Asked if he expects his tenure at USF&G to last only until he feels he has successfully turned its problems around, Mr. Blake said, "I haven't really given much thought to it."

Stock analysts, all of whom stressed they do not know Mr. Blake, generally described his appointment as promising. His financial background will be helpful, while a property/casualty expert could be appointed president to oversee insurance operation, they say.

Mr. Moseley, USF&G Corp.'s former chairman, had also assumed the presidency of the company's property/casualty operations after Paul Scheel retired earlier this year.

Other outsiders have succeeded in the property/casualty business. One who was cited is Continental Corp. Chairman and Chief Executive Officer John P. Mascotte, who was executive vp at Newark, N.J.-based Mutual Benefit Life Insurance Co. when he joined Continental as president and chief executive officer in 1981.

USF&G apparently was seeking an outsider, said W. Dolson Smith, an analyst with Firemark Inc. in Morristown, N.J.

"I think that's somewhat a positive in terms of perception from outsiders that things will be run differently there," he said.

USF&G needs a different approach, and Mr. Blake is an outsider with a turnaround reputation, Mr. Smith said.

Pointing to USF&G's junk bond portfolio, he added, "It's good they have somebody with a broad financial services background who can add new insights."

Herbert Goodfriend, a New York-based independent analyst, said that to be successful Mr. Blake must have a mandate to make changes and feel under no obligation to continue prior management's philosophy.

Mr. Blake also will have to win the respect of both employees and the investment community, as well as act promptly, said Mr. Goodfriend.

Mr. Goodfriend said Mr. Blake's lack of a commercial property/casualty background is not necessarily a disadvantage. "You can buy brains in that business if you want them."

As an outsider, Mr. Blake will not feel hindered by tradition or history, which could be an advantage, said Mr. Goodfriend.

"He's not the living room name I think everyone expected," commented David Wells, an analyst with Fitch Investors Service in New York.

USF&G had two options, said Mr. Wells: Appoint someone with a substantial background in property/casualty insurance "with an excellent record of doing good stuff," or find an outsider with a good record on turnarounds.

Of the first option, "there aren't enough to go around" in the property/casualty business, Mr. Wells said. "Knowing something about the insurance business is far from a certification he'll do a good job," he commented. Many senior managers who work for property/casualty companies for a long time "aren't very good at it."

Knowing the property/casualty business "inside and out" is probably not a prerequisite anyway, said Mr. Wells, who noted Mr. Blake has a reputation as a "very, very professional, competent business manager."

Charles Ronson, an analyst with Baird, Patrick & Co. Inc. in New York, also praised the selection.

"I think naming an outsider who is presumably competent and rather successful and who is below the age of 50. . .is not going to hurt them and will probably bring some objective input to bear on the situation."

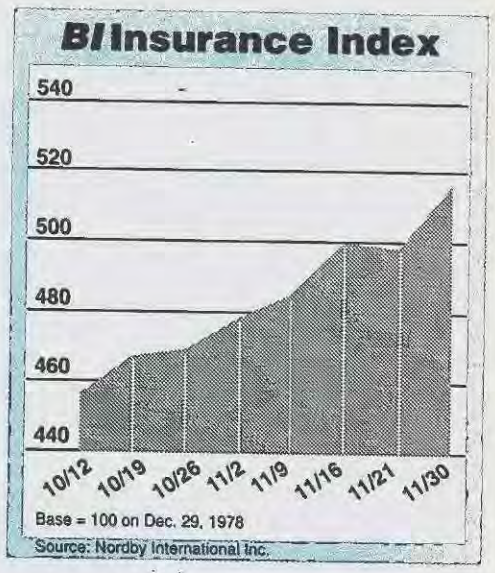
Obviously, in certain types of businesses, a chief executive needs a specialized background, Mr. Ronson said. But, he added, "I don't think you really do in the field of insurance.

"They've got enough people at USF&G who know property/casualty" and running such an operation is not like being the captain of a nuclear submarine, Mr. Ronson said. "It's not that hard to learn, frankly."

Robert Branche, principal of the Branche Research Group in Morrisville, N.J., disagreed.

"I personally would have liked the board to have gotten a real strong property/casualty guy," Mr. Branche said, adding "certainly the property/casualty operation needs the heavy work."

If its property/casualty operation does not work, neither will USF&G, he said. ■



Insurance industry stocks shot up last week, as the *Business Insurance* Index rose 8.8 points to 516.2 on Nov. 30, from 497.4 on Nov. 21. Advancing issues were led by Pacificare Health Systems, up 24.1%; Frank B. Hall & Co. Inc., up 23.2%; and USF&G Corp., 18.8%. Declining issues followed AmBase Corp., down 33.3%; American Indemnity Financial Corp., down 17.7%; and Kemper Corp., down 6.4%. The most active issue during the week was USF&G, 3.4 million shares traded. The *BI* Index gained 3.8% for the week, outperforming other market indices: the New York Stock Exchange Composite was up 1.9%; The Standard & Poor's 500 was up 2.0%; and the Dow Jones 30 Industrials climbed 0.8%.

British Issues

Nov. 29 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Commi Union	483	22.1	28.7	5.9	499—483	
Genl Accident	500	15.1	33.4	6.7	514—485	
Gdn Royal Exch	196	17.2	15.3	7.8	204—195	
Royal	416	22.2	34.0	8.2	426—398	
Sun Alliance	324	11.6	16.7	5.1	339—324	
Brokers						
Bradstock	253	11.6	10.0	3.9	253—253	
CE Heath	448	13.2	34.5	7.7	450—440	
Hogg Group	166	11.0	9.7	5.8	166—166	
Lloyd Thompson	304	20.3	10.0	3.3	304—304	
PWS Holdings	85	12.9	3.3	3.9	85—85	
Sedgwick Grp	229	17.2	16.0	7.0	231—228	
Steel Brrl Jones	285	16.9	14.7	5.1	285—261	
Willis Corroon	249	18.4	16.0	6.4	256—249	

Source: Philip Olsen, Insurance Industry Analyst London

BI Industry Stock Report

NOVEMBER 26, 1990 THROUGH NOVEMBER 30, 1990

		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	22.00	2.90	-30.16	34.00	16.13	406	1.00	4.55	18	9.18	2.40
Corroon & Black	NYS	32.50	0.00	-15.03	39.88	0.13	0	1.36	4.18	16	12.73	2.55
Gallagher Arthur J. & Co.	NYS	24.13	-0.52	-2.53	25.75	19.75	21	0.60	2.49	19	5.33	4.53
Frank B. Hall	NYS	2.63	23.24	-12.50	4.25	2.00	89	0.00	0.00	-4	-2.80	-0.94
Hilb, Rogal & Hamilton	OTC	14.75	7.27	-20.81	20.50	11.25	77	0.36	2.44	20	4.60	3.21
Marsh & McLennan	NYS	76.00	4.11	-2.56	87.00	59.75	553	2.60	3.42	18	10.56	7.20
Poe & Associates	OTC	9.00	12.50	-32.08	13.00	7.75	20	0.40	4.44	13	1.93	4.66
BROKERS	AVERAGE		7.1	-16.5					3.1	14		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	36.75	9.70	-11.71	46.25	28.50	286	0.44	1.20	10	25.06	1.47
Berkshire Hathaway Inc.	NYS	6345.00	2.75	-26.43	8900.00	5675.00	0	0.00	0.00	20	2869.00	2.21
ITT (Hartford Group)	NYS	46.88	1.07	-21.71	61.38	40.25	886	1.72	3.67	6	56.33	0.83
Sears (Allstate)	NYS	26.13	1.46	-32.58	41.88	22.00	3050	2.00	7.66	8	37.75	0.69
CONGLOMERATES	AVERAGE		3.7	-23.1					3.1	11		
INSURERS/REINSURERS												
Aetna Life & Casualty	NYS	38.63	7.29	-33.41	62.00	29.00	2720	2.76	7.15	7	58.11	0.66
Ambase Corp.	NYS	0.50	-33.33	-96.04	14.00	0.31	789	0.00	0.00	0	29.08	0.02
American General	NYS	28.88	3.13	-11.83	50.63	23.50	1337	3.20	11.08	6	34.68	0.83
American Heritage	NYS	20.88	4.38	-26.75	24.63	19.63	6	1.00	4.79	10	22.60	0.92
American Indemnity/Fin'l	OTC	3.50	-17.65	-56.25	8.75	3.38	7	0.08	2.29	-2	17.38	0.20
American International	NYS	73.50	6.14	-12.91	89.13	57.00	1773	0.44	0.60	11	41.92	1.75
Aon Corp.	NYS	34.50	5.73	-18.58	43.25	26.75	333	1.52	4.41	9	19.62	1.76
Argonaut Group	OTC	57.00	0.00	-17.24	78.00	53.00	34	1.60	2.81	7	36.83	1.55
AVEMCO Corp.	NYS	24.50	2.60	0.51	30.13	21.13	10	0.44	1.80	16	9.52	2.57
Baldwin & Lyons Inc.	OTC	18.75	0.00	-12.79	24.00	18.25	1	0.28	1.49	7	20.80	0.90
Belvedere Corp.	ASE	2.38	18.75	-56.82	5.63	1.75	39	0.04	1.68	-3	8.03	0.30
Chandler Insurance	OTC	6.00	6.57	-48.94	12.50	4.50	197	0.00	0.00	3	9.53	0.63
Chubb Corp.	NYS	50.00	6.95	-47.85	51.38	34.63	1419	1.32	2.64	9	55.49	0.90
CIGNA Corp.	NYS	39.75	6.34	-34.02	64.88	33.25	970	3.04	7.65	11	66.64	0.60
CNA Financial Corp.	NYS	61.50	2.93	-38.50	108.75	49.50	141	0.00	0.00	11	54.87	1.12
Continental Corp.	NYS	24.00	2.65	-23.51	34.25	15.75	1088	2.60	10.83	8	41.36	0.58
Durham Corp.	OTC	25.50	-5.56	-17.07	34.00	23.00	1	0.92	3.61	11	26.32	0.97
Fund American Corp.	NYS	48.00	1.85	36.17	51.88	29.50	299	0.68	1.42	120	32.74	1.47
Fremont General Corp.	OTC	13.00	6.12	-35.40	22.50	10.13	79	0.80	6.15	4	19.09	0.68
Frontier Insurance Group	NYS	18.63	-0.03	0.68	33.00	14.13	0	0.00	0.00	8	7.29	2.55
General RE Corp.	NYS	89.25	4.84	-0.83	95.00	69.00	1381	1.52	1.70	13	29.04	3.07
Hanover Insurance Co.	OTC	23.00	4.55	-24.59	32.25	21.00	11	0.44	1.91	10	32.03	0.72
Harleysville Group	OTC	20.50	12.33	-25.45	27.38	13.50	16	0.64	3.12	6	18.94	1.08
Hartford Steam Boiler	NYS	46.00	3.95	-15.21	62.13	43.50	185	1.80	3.91	12	18.94	2.43
Kansas City Life Ins.	OTC	30.25	0.00	-15.68	36.50	30.00	6	1.12	3.70	7	39.22	0.77
Kemper Corp.	NYS	20.13	-6.40	-57.41	51.00	17.13	1057	0.92	4.57	72	29.97	0.67
Lawrence Insurance Group	ASE	7.13	-0.07	0.00	9.13	6.50	0	0.36	5.05	11	4.40	1.62
Liberty Corp.	NYS	41.88	4.04	-1.47	50.25	36.88	9	0.92	2.20	9	31.82	1.32
Lincoln National	NYS	41.25	12.24	-32.38	62.50	30.75	248	2.72	6.59	8	49.19	0.84
NAC Re Corp.	OTC	32.13	-1.91	-11.38	39.25	25.50	373	0.20	0.62	14	22.81	1.41
Navigators Group	OTC	29.25	4.46	6.36	33.75	24.75	20	0.00	0.00	11	15.22	1.92
Nobel Insurance LTD.	OTC	2.75	-2.14	37.50	3.75	1.50	20	0.00	0.00	-275	7.76	0.35
NWNL Companies	NYS	16.38	-0.03	-58.54	44.13	11.75	0	1.32	8.06	3	37.50	0.44
Ohio Casualty Corp.	OTC	37.38	10.32	-21.73	50.75	26.75	300	2.32	6.21	10	33.30	1.12
Old Republic Int'l	NYS	22.38	-2.72	-12.68	27.63	19.00	162	0.76	3.40	5	30.70	0.73
Orion Capital Corp.	NYS	15.75	-1.56	-32.26	24.75	13.00	41	0.92	5.84	5	19.72	0.80
Phoenix RE Corp.	OTC	7.38	9.26	-43.27	15.50	5.00	27	0.20	2.71	-10	12.99	0.57
Protective Life Corp.	OTC	13.25	1.92	-7.02	14.63	10.25	34	0.76	5.74	7	14.54	0.91
Provident Life	OTC	15.13	0.83	-41.55	30.13	12.00	390	0.92	6.08	4	23.24	0.65
Re Capital Corp.	ASE	12.13	-0.04	-16.38	15.25	11.50	4	0.00	0.00	9	14.43	0.84
RLI Insurance Corp.	NYS	12.50	4.17	40.85	14.75	8.25	20	0.44	3.52	6	12.42	1.01
St. Paul Companies	OTC	63.00	4.56	5.00	63.50	47.00	1120	2.40	3.81	7	43.47	1.45
SAFECO Corp.	OTC	30.00	2.99	-24.53	42.38	25.13	836	1.36	4.53	8	24.87	1.21
SCOR U.S. Corp.	NYS	11.50	12.20	-19.30	14.50	8.38	11	0.20	1.74	10	10.61	1.08
Seibels Bruce Group	OTC	5.00	7.99	-54.02	11.75	4.25	62	0.36	7.20	-1	13.75	0.36
Selective Ins. Group	OTC	13.25	-2.79	-30.72	20.25	12.75	38	1.04	7.85	5	15.72	0.84
Statesman Group Inc.	OTC	1.50	17.19	-45.45	3.00	1.25	121	0.04	2.67	3	4.19	0.36
Tokio Marine & Fire	OTC	48.00	4.62	-36.32	77.25	34.50	58	0.26	0.54	29	70.93	0.68
Torchmark Corp.	NYS	46.75	-2.67	-18.34	58.75	38.00	544	1.40	2.99	11	13.23	3.53
Transamerica	NYS	33.50	4.69	-24.93	45.00	23.25	486	1.96	5.85	9	34.63	0.97
Travelers Corp.	NYS	13.50	3.85	-63.39	38.88	11.50	2741	1.60	11.85	-7	44.85	-
Trenwick Group Inc.	OTC	20.50	-1.20	-15.90	25.50	16.25	164	0.48	2.34	9	16.91	1.21
United Fire & Casualty	OTC	33.75	1.50	2.27	35.00	28.75	1	1.32	3.91	8	22.56	1.50
USF&G Corp.	NYS	9.50	18.75	-67.93	30.38	7.50	3389	1.00	10.53	6	22.87	0.42
UNUM Corp.	NYS	47.25	11.49	-1.05	57.13	32.13	816	0.80	1.69	9	31.20	1.51
USLIFE Corp.	NYS	29.50	0.00	-34.81	46.88	23.25	89	1.48	5.02	7	54.34	0.54
Unitrin	OTC	31.50	2.01	NA	34.75	24.50	484	0.80	2.54	16	54.34	0.58
Washington National	NYS	11.50	0.00	-59.29	28.75	11.25	106	1.08	9.39	48	32.90	0.35
USLICO Corp.	NYS	15.00	-0.86	-36.84	24.50	14.75	70	1.00	6.67	6	27.73	0.54
Zenith National Ins.	NYS	10.88	4.77	-42.00	19.38	9.88	118	0.88	8.09	7	13.81	0.79
INSURERS/REINSURERS	AVERAGE		3.0	-25.5					4.3	6.6		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	14.25	7.55	-32.94	23.63	9.75	389	0.00	0.00	12	3.54	4.03
HMO America Inc.	OTC	6.13	2.08	-20.97	8.13	4.25	88	0.00	0.00	9	1.12	5.47
Pacificare Health Sys.	OTC	16.75	24.07	-35.58	28.75	12.00	380	0.00	0.00	11	6.35	2.64
Safeguard Health Enter.	OTC	4.63	-2.63	-45.59	9.25	4.00	104	0.00	0.00	10	2.99	1.55
Sierra Health Services	ASE	10.63	3.66	19.72	11.00	5.50	184	0.00	0.00	133	0.62	17.14
United Healthcare Corp.	OTC	20.25	6.58	65.31	20.75	7.88	1126	0.12	0.59	21	0.34	59.56
United Medical Corp.	ASE	7.25	5.38	20.83	11.38	6.00	4	0.20	2.76	10	5.70	1.27
U.S. Healthcare	OTC	25.38	4.08	78.07	25.00	9.63	0	0.36	1.42	22	3.07	8.27
HMOs	AVERAGE		6.3	6.1					0.6	29		
ALL COMPANIES	AVERAGE		3.7	-20.6					3.6	10		

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