

Business Insurance

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Commerce Department proposes overhauling Risk Retention Act

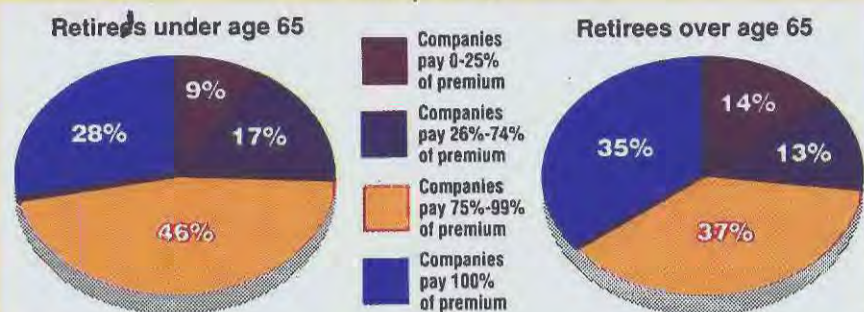
WASHINGTON—Congress should overhaul the federal Risk Retention Act to require that risk retention and risk purchasing groups be controlled by their members and not insurers or agents, the U.S. Department of Commerce recommends.

In a final report on implementation of the Risk Retention Act delivered to Congress last week, the department also recommends that risk purchasing group insurers be subject to minimum financial standards. Congress should hold hearings to determine

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Retiree health care coverage contributions

Most employers now pay a major portion of the premium cost of retiree health care coverage.



Source: TPF&C

BI/HOLLY SEGUINE

FASB rules to slash earnings 10% to 30%

By JERRY GEISEL

NEW YORK—Proposed accounting rules requiring the costs of retiree health care programs to be recognized on income statements will wallop corporate earnings, according to a new study.

The proposed Financial Accounting Standards Board rules could reduce pretax earnings by 10% on average but could slash pretax earnings for some companies more than 30%, according to employers that responded to a survey by TPF&C, the employee benefit consulting division of New York-based Towers, Perrin, Forster & Crosby Inc.

The rules could have a "stunning" im-

act on corporate earnings, said Richard Ostuw, a TPF&C vp in Cleveland.

More than half of responding employers believe the rules will reduce net worth by at least 11%.

But, employers are taking steps to better manage the cost of retiree health care plans and thus reduce the rules' impact on financial statements.

For example, more employers are making retirees pay a greater share of premium costs, while other companies are sharply limiting amounts they will pay for retirees' health care benefits.

And, in a novel approach to the funding problem, American Airlines

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Workers to pay now for retiree health plan

By LOUISE KERTESZ

FORT WORTH, Texas—In a novel move to contain future retiree health care costs, American Airlines Inc. in January will begin charging more than half of its active employees a monthly fee to prefund their retiree medical benefits.

The airline, which consultants say is one of the first major companies to charge active workers for their retirement health care benefits, will require 24,000 workers represented by the New York-based Transport Workers Union and about 26,000 non-union employees to contribute \$10 a month toward the cost of their retiree health care benefits.

And, American, a subsidiary of Fort Worth, Texas-based AMR Corp., will require future employees to pay significantly more toward their retiree health

care costs, resulting in those retirees paying approximately 30% of their retiree health care liabilities.

Workers who opt out of the prefunding plan will receive no medical benefits under the airline's self-insured retiree medical plan when they retire.

American eventually wants its entire active workforce of 80,000 to pay a monthly fee to prefund retiree medical costs, said Mary Jordan, manager of health planning and administration for the airline in Fort Worth.

American currently is discussing the prefunding plan with the American Pilots Assn. and will begin discussions with the Assn. of Professional Flight Attendants shortly, she said.

If the prefunding program is implemented companywide, "the average em-

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London market pulls in the reins

Rules tightened for marine line slips

By CAROLYN ALDRED

LONDON—Marine underwriters and brokers last week agreed to new restrictive London market underwriting rules that could reduce capacity and increase rates across the London-based marine and energy markets.

Hit by a series of massive losses, Lloyd's of London and London company market marine underwriters are taking radical steps to tighten their underwriting control over, and reduce capacity for, risks placed in the market through brokers' line slips.

Cargo insurance underwriters also have imposed similar restrictions on brokers' line slips.

A broker's line slip is prearranged capacity with underwriters for certain types of risks to certain limits. Until now, brokers have been able to commit all the underwriters on the slip to underwriting the risk by obtaining the approval of only the leading one or two underwriters on the slip.

Now, under the new rules, brokers will need the approval of up to six leading underwriters to bind a risk through a line slip and will have to inform following un-

derwriters of the business written within five days. In addition, brokers have agreed to cut the number of line slips they use and cut capacity offered through the remaining line slips by 25%.

"The situation has gotten so desperate we feel we need to introduce thorough safeguards," said John Parton, chairman of the Institute of London Underwriters, which represents London-based marine insurance companies.

"The market has simultaneously been driving down rates to inadequate levels while suffering a series of unprecedented losses," he said.

As a result of the new restrictions on brokers' line slips, it "will take more time to place a risk and will involve the brokers in some extra work" in seeing more leading underwriters and sending declarations out to every following underwriter, said Alan Jackson, a member of the committee of the Lloyd's Underwriters Assn., which represents marine underwriters at Lloyd's.

"It will take more time because brokers need to see three times as many leaders to

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Combined ratios continue climbing

Reinsurer slump

By JUDY GREENWALD

Underwriting results for U.S. reinsurers will continue to deteriorate at least through this year and perhaps into 1990, many reinsurers gloomily predict.

"I think you'll see further deterioration and, furthermore, it will continue on to next year," said Norman Wayne, president of CIGNA Corp.'s reinsurance division.

"I'm expecting the combined ratios for the industry to continue rising this year and next," says Steven H. Newman, chairman, president and chief executive officer of Underwriters Reinsurance Co. in Woodland Hills, Calif.

And, despite the impact of recent catastrophes, the overall reinsurance marketplace apparently has not yet turned, most reinsurance officials say.

The soft market is reflected in the nine-month results of 66 reinsurers surveyed by the Washington, D.C.-based Reinsurance Assn. of America.

U.S. reinsurers posted a 106.3% combined ratio for the first nine months of 1989, compared to a 102.1% combined ratio for the same period in 1988.

In addition, the industry's 106.3% com-

combined ratio as of Sept. 31 represents a deterioration of more than two percentage points from the 104% combined ratio posted in the first half of 1989.

Nine-month results include losses from Hurricane Hugo, but not the California earthquake or the explosion of the Phillips Petroleum Co. plant in Pasadena, Texas, which occurred in the fourth quarter.

Large reinsurers' experience reflected the overall industry's: The 20 largest reinsurers in terms of premium volume reported a 106.5% combined ratio for the first nine months, compared with a 101.8% combined ratio for the comparable period in 1988. The 20 largest reinsurers had reported a 103.5% combined ratio during the first half of this year.

In calculating the results of the 20 largest U.S. reinsurers, *Business Insurance* included the reinsurance results of Continental Casualty Co., a CNA Financial Corp. unit, and St. Paul Reinsurance Management Corp., a unit of the St. Paul Cos. Inc. The RAA no longer includes these divisions' results in its industrywide statistics because of antitrust concerns (*BI*, Oct. 2; Sept. 25).

"I think the numbers pretty well speak for

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Losses from Hurricane Hugo sink second small insurer

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Update

Risk Retention Act proposals

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those standards, the report adds.

The report also recommends that a single state—the state that a purchasing group declares as its principal place of business—regulate risk purchasing groups and their insurers' risk purchasing group activities. However, any state regulator would have the right to challenge financial solvency of any purchasing group insurer.

The report also recommends that purchasing group insurers provide more financial information to state regulators and that the National Assn. of Insurance Commissioners establish a central office to monitor risk retention and purchasing groups and their insurers.

In addition, the report recommends that risk retention and risk purchasing groups and insurers work with regulators to develop a voluntary accreditation program for the groups.

Bush endorses liability reform

WASHINGTON—The Bush administration last week endorsed federal product liability reform legislation.

The administration, noting that the hodgepodge of state liability laws creates uncertainty for business and inflates insurance costs, said it will back a bill introduced earlier this year by Sen. Robert Kasten, R-Wis. The bill, S. 1400, would eliminate joint and several liability for non-economic damages and bar product liability suits involving very old capital goods products (BI, July 31).

Administration officials also would like the bill to cap punitive damage awards and include a state-of-the-art defense.

"The administration initiative will remove a self-inflicted burden on U.S. competitiveness and help restore basic principles of fairness," the Council on Competitiveness said in a statement.

Subcontractor liability eyed

SAN FRANCISCO—A construction subcontractor will probably pay claims stemming from a construction accident in San Francisco last week in which five people were killed and 21 injured when a crane fell 19 stories to the street below, according to the general contractor.

Portland, Ore.-based Canron Western, the major subcontractor of San Francisco-based Swinerton & Walberg Co., the project's general contractor, "may absorb the majority of the liability," said Swinerton Risk Manager James Berriatua.

Swinerton was involved in two previous construction accidents in Los Angeles resulting in five fatalities. In each case, subcontractors' insurers responded, Mr. Berriatua said.

Canron's liability coverage was placed by Marsh & McLennan Cos. Inc. and underwritten by a Continental Corp. unit, said Canron General Manager James Pyle, who would not elaborate.

Canron subcontracted with The Erection Co. of Seattle, whose crane operator was killed in the accident.

The Erection Co. officials could not be reached for comment. American International Group Inc. insures the company, a source said.

An AIG spokeswoman in New York would not comment. Argonaut Insurance Co. writes Swinerton's liability coverage.

An early estimate of damage to the structure under construction, two other buildings and several vehicles is \$5 million, Mr. Berriatua said, adding that "other potential liability has not yet been assessed."

Cal/OSHA is investigating the accident.

Premium growth shrinking: III

NEW YORK—Premium growth in 1989 will set a record low if current trends hold, says the Insurance Information Institute.

The industry also posted a 109.1% combined ratio in the first nine months, up from a 105% combined ratio for the same period in 1988, according to the III, which based its analysis on data from the Insurance Services Office Inc. and the National Assn. of Independent Insurers. ISO and the NAI survey insurers accounting for 97% of U.S. property/casualty business.

In the first nine months of 1989, written premiums rose only 1.8% to \$155.7 billion from \$153 billion in 1988. Third-quarter written premiums were up only 0.3% over last year, according to the III.

A *Business Insurance* survey of major property/casualty insurers found that written premiums decreased 0.6% in the first nine months of the year to \$69.5 billion (BI, Nov. 27).

The industry's net underwriting losses increased to \$15 billion, a 76.5% increase from \$8.5 billion for the comparable period in 1988, the III said. Net investment income for the first nine months, excluding capital gains, increased 12.8% to \$22.7 billion from \$20.1 billion.

But, net income for the industry plummeted 20.1% to \$8.3 billion from \$10.4 billion in 1988.

Railroads win comp case

WASHINGTON, D.C.—In a unanimous decision favorable to railroad employers, the U.S. Supreme Court ruled last week that railroad employees who maintain coal-loading equipment at ship docks should be compensated for work-related injuries as longshoremen, rather than as railroad workers.

In combined cases, The Norfolk & Western Railway Co. and the Chesapeake & Ohio Railway Co. sought to reverse a Supreme Court of Virginia finding that allowed three employees to seek compensation as railroad workers.

The Longshoremen's and Harbor Workers' Compensation Act provides for no-fault compensation with speedy payment of scheduled benefits to workers and no separate awards for non-economic damages, said Wiley F. Mitchell, Norfolk's general counsel.

In contrast, railroad workers' claims brought under the Federal Employers' Liability Act usually result in jury trials in which an employer must be found negligent before an employee receives damages, which can include non-economic—but not punitive—damages, he added.

Many railroad employers criticize the FELA system as excessively litigious and unfair because employees may receive excessive or inadequate compensation.

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EC plans open market for all insurance lines

By CAROLYN ALDRED

BRUSSELS, Belgium—The European Community is planning to create a single European insurance market for all types of risks, not just large commercial risks, the European Commission says.

The commission should have a proposal for a new non-life insurance framework directive early next year, with a similar proposal on life insurance coming later in 1990, Sir Leon Brittan, the commission's vp, last week told the Comité Européen des Assurances, a group of influential European insurers.

"The aim of these two directives will be, quite simply, to achieve the single European insurance market," Sir Leon said.

"In that market, we will be proposing that companies should operate on a single insurance license," he said.

This will mean that "companies will be free not only to set up branches in other member states, but also to sell the full range of their products through freedom of services on the basis of a single authorization and supervision from the country where their head office is located," Sir Leon explained, adding that companies "will not

have to seek advance authorization for policies which they sell in another member state."

The proposed directives will affect all areas of insurance, including commercial property/casualty insurance for all companies, no matter how small; personal lines insurance; and group and individual life/health insurance.

Until now the dismantling of insurance trade barriers within the European Community has successfully addressed only large commercial buyers of property/casualty insurance while a pending life proposal would permit individual con-

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GAO studies cases in five states

Tort crisis questioned

By ADRIENNE C. LOCKE

WASHINGTON—Court awards in product liability cases may not be as erratic as many tort reform advocates have implied, the General Accounting Office says.

Although the average size of product liability awards varied widely among the five states examined by the GAO, the size of compensatory damages awarded is consistent with the type and severity of the plaintiff's injury or property damage, the GAO said in a new report.

In addition, the study found that punitive damages were awarded in only 20% of the cases decided in favor of the plaintiff, and that most of the punitive awards were reversed by higher courts or remanded to the lower courts for retrial, where they were often reduced.

And, while proposed federal product liability reform

legislation—including caps on non-economic and punitive damage awards—would add some uniformity to existing state tort laws, the GAO contends that most of the proposed reforms would affect only a few of the cases studied.

"Proposed federal reforms may have a limited impact in two respects," the report says.

"First, we found that payments in only a minority of the cases studied were so extreme (in terms of award size or departures from traditional standards of liability) that they would have been affected by proposed reforms. The reforms, however, may have a broader impact on litigation costs and the large number of cases settled before verdict," the GAO says.

"Second, federal reforms specifically targeted at product liability would have a limited effect on some of the problems in the tort system in general. . . . Federal reforms would do little to remedy the general

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Hugo losses overwhelm a second small insurer

By MEG FLETCHER

COLUMBIA, S.C.—A second small mutual insurer in South Carolina is in liquidation because of overwhelming Hurricane Hugo-related losses.

West Columbia-based Grange Mutual Fire Insurance Co. of South Carolina, which wrote primarily homeowners and some fire and extended coverage policies, was declared insolvent Nov. 27 by a state judge in Columbia.

As a result of this and an earlier

insolvency, the state's guaranty fund will have to borrow money to pay claims and may ask the Legislature to increase guaranty fund assessments on insurers.

However, Chief Insurance Commissioner John G. Richards said he is "confident" that Grange Mutual will be the last insurer to become insolvent as a result of hurricane-related losses.

He pointed out, though, that it may be months before regulators know whether insurers accurately estimated storm-related claims.

Hurricane Hugo caused an estimated \$2.5 billion in insured damage in South Carolina.

The 55-year-old Grange Mutual, which wrote \$738,545 in net premiums through Sept. 30, was declared insolvent based on Insurance Department projections that the insurer would be unable to pay about \$2.5 million of \$9 million in storm-related claims.

About 41%—or 3,000—of Grange Mutual's 7,300 policyholders suffered losses of about \$3,000 on av-

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- ✓ Multiple, unlimited punitive damage awards against the same company for the same conduct could be declared unconstitutional, a federal court says. **PAGE 24**
- ✓ Mexico is eliminating much of the protectionism that has plagued its insurance industry for years, says broker Douglas N. Smith in International Issues. **PAGE 29**
- ✓ Net premiums written by Bermuda-based insurers and reinsurers increased 4.8% last year to \$8.4 billion from \$8 billion in 1987, an official reports. **PAGE 42**

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Chicago jury takes swing at Cubs

By STACY ADLER

CHICAGO—In a decision that challenges decades of legal precedent and baseball tradition, a hometown jury says the Chicago Cubs must pay \$67,500 in compensatory damages to a spectator beamed by a foul ball.

However, attorneys representing professional sports teams predict the verdict will be reversed on appeal.

A well-established principle in sports law is that fans attending games accept the risks inherent in watching the contest and that sports teams are not held liable for injuries to spectators, the attorneys say.

In fact, most tickets to sporting events bear a specific statement that the teams accept no liability for game-related injuries, they point out.

The Nov. 24 verdict in Cook County Circuit Court stemmed from an incident at a 1983 game at Wrigley Field. A sharply hit foul ball by then-Cubs first baseman Leon Durham struck a 10-year-old boy in the face as he sat in the stands behind home plate.

The boy, Delbert Yates Jr., needed surgery to correct dou-

ble vision he suffered as a result of the accident. His medical expenses were estimated at \$15,000. The team attempted to settle the case for between \$10,000 and \$15,000, but the boy's attorney demanded between \$65,000 and \$75,000.

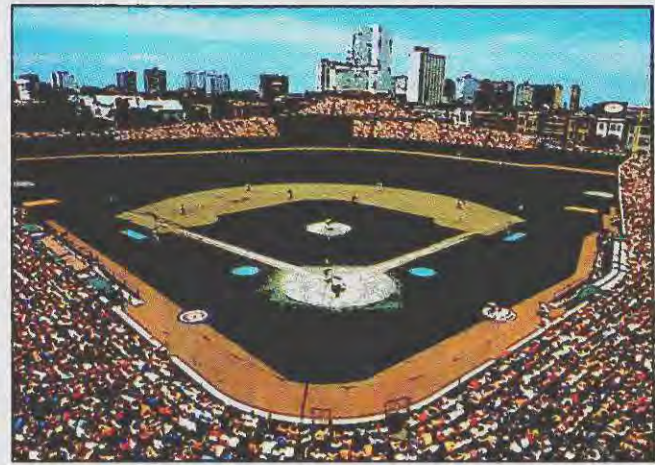
As a result, this was one of the few such cases litigated rather than settled out of court, attorneys say. And, the Yates case marks one of the first of its type to be heard by a jury.

At trial, the boy's attorney, Thomas R. Cirignani, successfully argued that there is an exception to the long-held standard that fans at sporting events attend the event at their own risk.

The Chicago-based attorney asserted that when a baseball club puts up a screen to protect patrons from foul balls, it recognizes the danger of sitting behind home plate. While the ball club does not have a legal duty to put up the screen, the screen must be adequate if one is installed, Mr. Cirignani argued.

In this case, the boy was sitting about 10 seats outside the area protected by Wrigley Field's screen, which is 72 feet wide and 30 feet high. Because the screen failed to protect

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In a sharp break with legal precedent, a fan at Wrigley Field collected damages after being hit by a foul ball.

Stephen Green

Aviation reinsurers limit policy period

By STACY SHAPIRO

LONDON—Major aviation reinsurers are trying to put a halt to the Jell-O-soft aviation insurance market by forcing aviation insurance underwriters to offer only 12-month policy periods, rather than 18-month policies.

The 18-month policies, which have been offered by aviation insurers since April, will not allow insurers—and hence their proportional reinsurers—to increase hull and liability insurance rates as soon as they would like to recoup their estimated \$650 million underwriting losses this year, including losses from two air disasters last week in Colombia and Korea.

The reinsurers, led by Swiss Reinsurance Co. in Zurich, Switzerland, are telling ceding underwriters they will cover only 12-month airline hull and liability insurance policies under their proportional reinsurance treaties.

Twelve-month policies covered by these treaties can be extended for three additional months, but the extension can be negotiated only 90 days before the renewal date, confirmed Carol Franklin-Engler, deputy head of the aviation department at Swiss Re in Zurich.

"The reason that we want to exclude (18-month policies) from proportional treaties is because airline rates have to be adjusted annually because the situation moves so fast," Mrs. Franklin-Engler said.

Swiss Re began consulting other aviation proportional reinsurers about a month ago about restricting 18-month policies.

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Mutual Fire reinsurer sued for \$65 million

By MICHAEL BRADFORD

HARRISBURG, Pa.—The rehabilitator of Mutual Fire, Marine & Inland Insurance Co. is suing GTE Reinsurance Co. Ltd. for \$65 million, contending that the reinsurer has refused to pay Mutual Fire claims under three treaties.

And, in a victory for the Pennsylvania Insurance Department late last month, the policyholder committee established in 1987 to monitor the progress of the rehabilitation was abolished by the state judge in Harrisburg who is considering a rehabilitation plan for the failed insurer.

The plan, filed by Pennsylvania Insurance Commissioner Constance B. Foster in her capacity as rehabilitator of the insolvent insurer, sought to dissolve the committee.

The suit against Bermuda-based GTE Re, also filed by Ms. Foster, asks for \$13 million in reinsurance

recoverables and loss adjustment expenses and \$52 million in punitive damages.

GTE Re "has undermined the rehabilitator's duty to collect assets of the estate," Ms. Foster contended in announcing the suit.

"Let this be a message to other reinsurers that we will do what it takes to recover reinsurance owed Mutual Fire," she warns.

Mutual Fire stopped underwriting in April 1986 and was placed in rehabilitation eight months later. It is currently insolvent by \$441.5 million, making it one of the largest insurer insolvencies ever. Only the insolvencies of Mission Insurance Group, Transit Casualty Co. and American Mutual Liability Insurance Co. and its affiliate American Mutual Insurance Co. are larger.

In 1985, Mutual Fire reported gross written premiums of \$136.3 million—\$60.6 million in direct writings and \$75.7 million in as-

sumed reinsurance.

Net 1985 premiums totaled \$42.7 million.

In the suit against GTE Re, the commissioner charges that the reinsurer has failed to pay \$11.5 million under a "quota share retrocession contract," also known as a "companion line treaty," that was in force from July 1981 through June 1985.

In addition, GTE Re owes \$1.5 million under an "international account obligatory surplus treaty" that provided reinsurance from April 1982 through June 1985, according to the suit.

And, GTE Re owes Mutual Fire \$50,000 in reinsurance recoverables and loss adjustment expenses under a "property and multi-line retrocession agreement" that was in force from July 1983 through June 1985, the suit says.

But an audit of Mutual Fire's books leads GTE Re to believe "the

Continued on next page

Island uprising causes mine coverage dispute

By KATE McILWAINE

MELBOURNE, Australia—An insurrection on a tiny South Pacific island is at the center of a \$400 million Australian (\$314.4 million) property damage and business interruption coverage dispute between a mine owner and its property insurers—including its own captive.

The majority mine owner, Bougainville Copper Ltd., suffered the losses when the mine and other BCL property were attacked by rebel forces that want the tiny South Pacific island of Bougainville to secede from Papua New Guinea.

The mine, one of the world's largest producers of copper and gold, is partially owned by the government of Papua New Guinea, which is an independent nation.

BCL shut down the mine May 21 to protect workers and has not reopened it.

Kevin Mutch, general manager-risk management of Melbourne-based CRA Ltd., which owns 53.6% of BCL, said the claim was for "principally loss of profits."

He also noted that the claim escalates by about \$2 million Australian (\$1.6 million) each day the



mine, located in the township of Panguna, remains closed.

However, he would not break down how much of the BCL claim represents business interruption losses and how much represents property damage.

Property damage caused by

"sabotage" and the business interruption losses are covered under the mine owner's property policy, according to BCL, whose Port Moresby headquarters are on Bougainville, about 370 miles east of Papua New Guinea in the Solomon

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Constellation acquisition still possible

By DOUGLAS McLEOD

NEW YORK—Opponents of the State Insurance Department's liquidation plan for Constellation Reinsurance Co. may submit alternative proposals to acquire the defunct reinsurer's assets and liabilities, a state judge has ruled.

While affirming an earlier ruling that the New York Insurance Department cannot be forced to accept such an alternative plan, State Supreme Court Justice Walter M. Schackman noted that the department has agreed to review such proposals and suggested that creditors pursue an "unofficial" effort to solicit bids for Constellation Re.

The Nov. 20 trial court ruling is the latest development in a protracted turf war between the New York department and several Constellation creditors over how the reinsurer's liquidation should proceed.

In a novel plan announced earlier this year, the Insurance Department's liquidation bureau proposed to commute all of Constellation Re's assumed reinsurance and retrocessional contracts, a process the liquidator says could pay Constellation Re policyholders 84 cents on the dollar (BI, Feb. 6).

Shortly after the liquidation plan was announced, Great American Insurance Co.—an American Financial Corp. unit and Constellation Re's largest creditor and retrocessionaire—proposed an alternative plan under which it would acquire Constellation Re's assets and liabilities (BI, Feb. 20).

Under this plan, Constellation Re policyholders could recover 100 cents on the dollar of claims, Great American contended.

However, Great American and other creditors supporting the concept of a buyout plan later complained that the liquidation bureau

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BI/HOLLY SEGUINE

Mutual Fire

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amounts requested aren't anywhere near" what the reinsurer might actually owe the failed insurer, said John Sarchio, an attorney with Chadbourne & Park in New York, representing GTE Re.

"The magnitude of the amounts that are being requested are in dispute," Mr. Sarchio said.

Actual amounts due cannot be calculated because GTE Re had both reinsured business for and ceded business to Mutual Fire, he said. Because some debts and credits of both companies could be offset, "it is impossible to tell" what might be owed, he said.

In 1986, when Mutual Fire filed a motion in U.S. District Court seeking an order requiring GTE Re to post a letter of credit securing its obligations under the companion line and international treaties, GTE Re demanded arbitration of disputes over the contracts and sought to have

the treaties rescinded.

GTE Re in May 1986 joined an arbitration proceeding already under way on behalf of Bermuda-based Norad Reinsurance Co. Ltd. Both reinsurers sought to rescind the companion line treaty for Mutual Fire in which both participated.

In the arbitration proceedings, a separate action was filed by GTE Re seeking to rescind its international treaty with Mutual Fire.

During arbitration, GTE Re alleged that Mutual Fire "made misrepresentations in order to induce (GTE Re) to enter into the treaties," according to court papers in the Pennsylvania department's suit against GTE Re.

"The misrepresentations were regarding the types of business, the limits, servicing of the business and the accounting for the business," Mr. Sarchio said.

While arbitrators denied GTE Re's request to rescind the treaties, they did agree that some risks should not have been ceded to GTE Re. As a result, arbitrators cut GTE Re's partici-

pation on the two treaties by 10.8%.

For example, GTE Re's first-year participation on the companion line treaty was reduced to 26.76% from 30%, and its first-year participation on the international treaty was reduced to 42.37% from 47.5%.

Norad's participation on the companion line treaty also was reduced by 10.8%.

GTE Re and Norad appealed the arbitration panel's decision to the 3rd U.S. Circuit Court of Appeals in Philadelphia, but the appellate court upheld the panel's decision.

Subsequently, Norad's parent, Philadelphia-based Berwind Corp., became the target of a suit filed by Ms. Foster in August that seeks reinsurance payments of about \$13.5 million to Mutual Fire.

Norad began liquidation proceedings last year after failing to reach a commutation agreement with Mutual Fire (BI, Oct. 17, 1988).

GTE Re "arbitrated all these issues and tried to get a rescission and they lost. Then they appealed and the ar-

bitration award was upheld," said Alexander Eratic, special deputy rehabilitator. "They just don't want to pay."

But Mr. Sarchio said the arbitration did not settle how much GTE Re actually owes Mutual Fire.

"A rescission or reduction of the percentage of GTE's participation has nothing to do with dollar amounts," Mr. Sarchio said. Arbitrators "didn't address dollar amounts," he added.

Meanwhile, the Pennsylvania Insurance Department scored a victory on Nov. 22 when Judge James Crumlish Jr. of the Commonwealth Court of Pennsylvania ordered the Mutual Fire policyholder committee abolished.

Judge Crumlish originally ordered formation of the policyholder committee in January 1987 over department objections. The department feared the committee would "usurp the duties and functions of the statutory rehabilitator," and it opposed paying the committee's legal fees

from Mutual Fire's estate.

Mutual Fire attorneys opposed formation of the committee because there was no provision for such a committee under Pennsylvania law (BI, Feb. 2, 1987).

"I don't think the committee was making any constructive contributions to the rehabilitation process at this time," Mr. Bratic said.

"We were seeing duplicative functions. My job is to make sure the policyholders get paid," he added.

Richard A. Brown, a policyholder committee attorney, said the committee "has never agreed with the rehabilitator" on the point of duplicative functions.

"Any creditor committee involves some duplication of functions just to monitor what the trustee is doing," he observed.

Mr. Brown said the committee only became involved in activities in which "the rehabilitator was not giving adequate attention, if any attention at all."

Mr. Bratic said Judge Crumlish's dissolution of the policyholder committee will eliminate some expensive and unnecessary proceedings.

Mutual Fire's estate paid approximately \$316,000 in legal fees to Baynard, Harrell, Mascara & Ostow in St. Petersburg, Fla., the law firm Mr. Brown was with before moving to the Washington, D.C. firm Spiegel & McDiarmid. In addition, approximately \$883,000 was paid to Spiegel & McDiarmid for representing the committee, according to Mr. Bratic.

About \$300,000 in additional fees were paid to the committee for advisers, including independent consultants in reinsurance and insurance, and accountants, according to Mr. Bratic.

In addition, Spiegel & McDiarmid has submitted for court approval a bill of around \$500,000, Mr. Bratic said.

Mr. Brown said the committee is "studying the implications of the court's order," but has not decided whether it will attempt to have the committee reinstated.

"Without the policyholder committee, there will be no separate representation with regard to policyholder interests," Mr. Brown said.

Meanwhile, Judge Crumlish is still studying a proposed revised rehabilitation plan submitted earlier this year (BI, March 6).

The plan calls for full payment of all claims of less than \$5,000 and prorated payments of all direct policyholder claims exceeding that amount.

An earlier version of the rehabilitation plan called for 100% payment of all direct policyholder claims.

Policyholder claims of less than \$5,000 represent about 70% of the total number of outstanding claims, but account for only 10% of the total value of all claims.

The rehabilitation plan would also dissolve the policyholder committee.

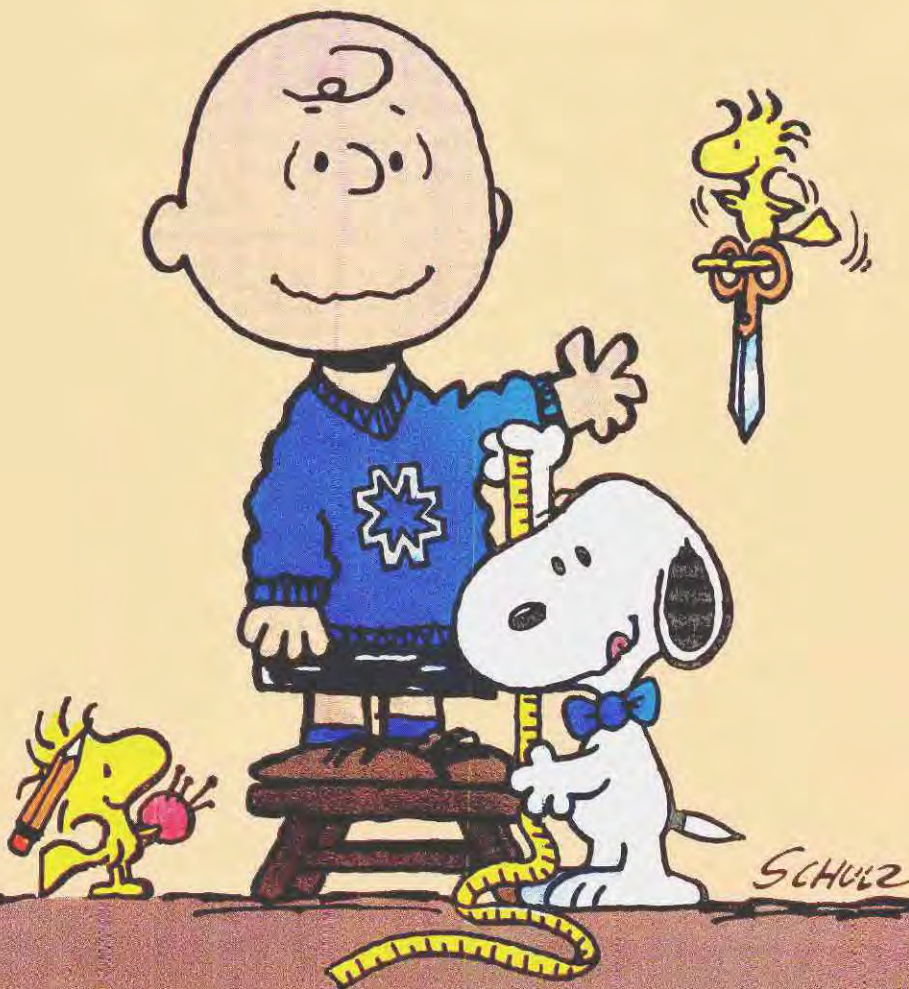
The Pennsylvania Insurance Guaranty Assn. already has paid approximately \$800,000 to direct policyholders in Pennsylvania.

Its own abolition aside, the policyholder committee generally has supported the proposed rehabilitation plan.

However, Mr. Brown had expressed concern that the plan contained "a lack of financial accountability" on the part of the rehabilitator. The committee felt that the rehabilitator should provide policyholders with regular financial reports on Mutual Fire to allow assessments of the plan's progress.

Mr. Bratic said he expects the judge to approve the rehabilitation plan soon. "The court is considering the plan and objections, and I expect we will have a decision in the near future."

But, Edward F. Mannino, of the Philadelphia firm Baskin, Flaherty, Eliot & Mannino, representing GTE Re in the Mutual Fire rehabilitation plan proceedings in Commonwealth Court, said he would be "surprised if there is a decision before early next year" on the plan. ■



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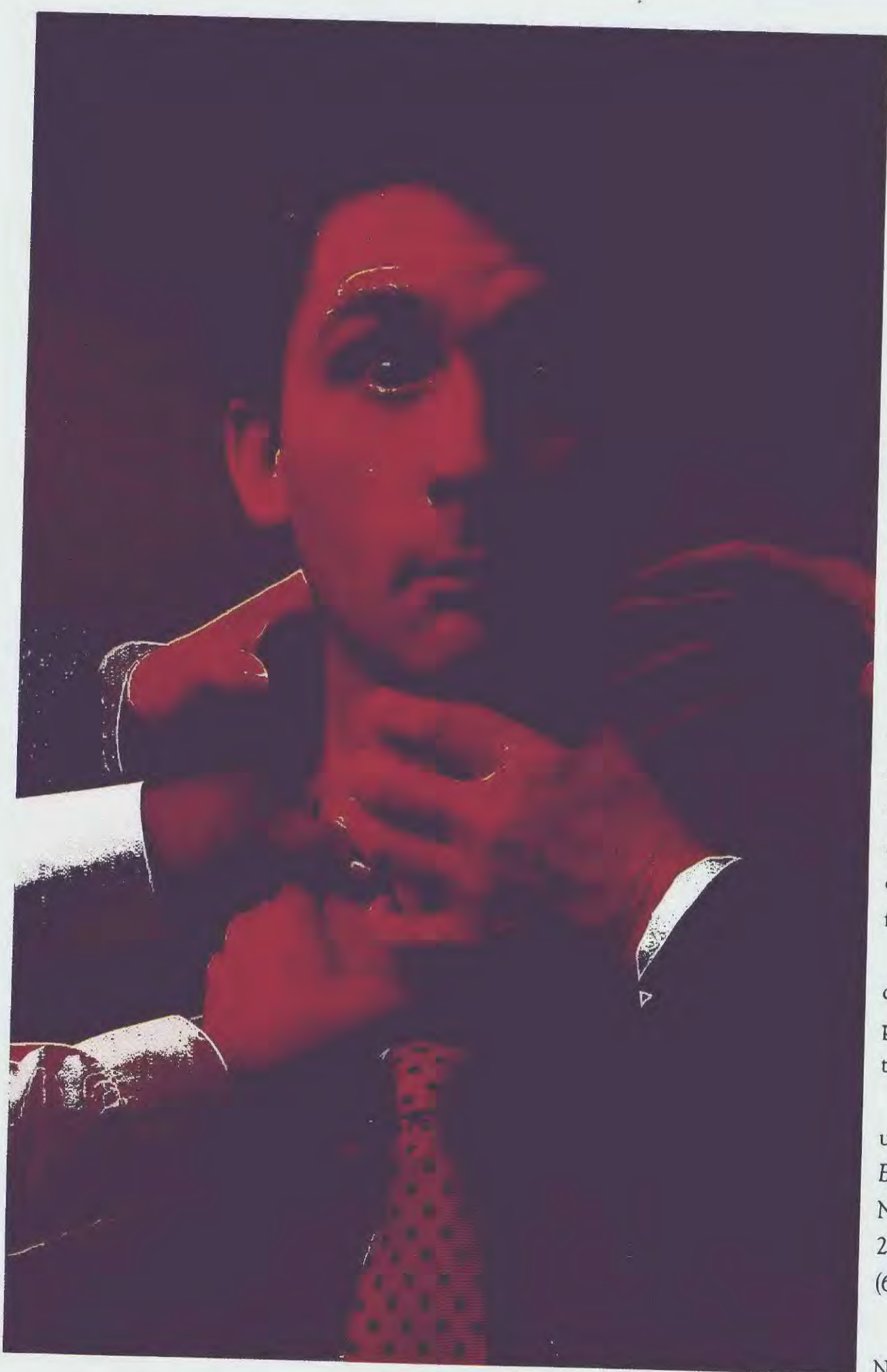
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Northwestern National Life Insurance Co.

Aetna to offer workers adoption benefit

By MICHAEL SCHACHNER

Aetna Life & Casualty Co. will soon contribute up to \$2,000 toward the cost to employees of adopting a child.

In addition, the Hartford, Conn.-based insurer reports that its year-old family leave program has nearly cut in half the number of women who leave the company permanently to care for their newborn children.

The adoption contribution, effective Jan. 1, will be taxed as income to the employee, said Sherry Herchenroether, director of family services at Aetna.

To be eligible, employees must submit receipts and proof of adoption to Aetna.

The adoption benefit can be used to pay legal expenses; expenses as-

Benefit beat

sociated with traveling outside the country; and court fees associated with adopting a child below the age of 18, Ms. Herchenroether explained.

The benefit is intended to soften the impact of the cost to employees of adopting a child, which in most cases exceeds \$500, she said.

The adoption benefit is available to all 43,000 Aetna employees.

In a related development, Aetna has credited its new family leave program with reducing turnover among female employees.

Since the family leave program was implemented in June 1988, only 12% of the women who had babies left the company perman-

ently, down from 23% who resigned for this reason in 1987, according to a recent study the insurer conducted.

A total of 214 of the 1,323 women who took maternity leave between June 1988 and June 1989 took advantage of the family leave program, which provides up to six months of unpaid leave with full benefits.

Of those opting for family leave, 54 terminated their employment either during or after the leave period. However, among women who did not participate in the family leave program, twice as many women—108—left the company immediately after maternity leave.

The company offers paid maternity benefits of up to six weeks for normal births and up to eight weeks for births with complications or for Caesarean sections. Employees receive benefits equal to two weeks' salary for approximately every year of service.

Any Aetna employee responsible for caring for injured or sick dependents or newborn children is eligible for the family leave program.

While the family leave program made a significant dent in employee turnover costs, Ms. Herchenroether could not say exactly how much the program reduced Aetna's total turnover costs.

Employee turnover costs totaled about \$94 million in 1988, Aetna estimates.

Aetna self-insures its employee

benefit plans with the exception of health care, where a few outside health maintenance organizations are offered.

Actuary survey

At least twice as many flexible benefit plans will be offered by the year 2000, predicts an overwhelming majority of respondents to a recent survey of U.S. and Canadian actuaries.

Large-scale changes in employer-sponsored pension plans also are imminent by the year 2000 as defined benefit plans lose ground to defined contribution plans and 401(k) plans become more prevalent, the survey's respondents predicted.

And nearly a third of the survey respondents predict that the federal government will institute mandated health care benefits through the workplace by the year 2000, with employers picking up most of the tab.

Flexible benefit plans will account for at least 20% of all employee benefit plans by the year 2000, predicts nearly 91.8%, or 451 of the 491 pension actuaries that responded to the Forecast 2000 survey sponsored by six large North American actuarial associations.

Flex plans, which permit employees to tailor a benefit plan to their individual needs by selecting from a variety of benefit options, currently make up about 10% of all employee benefit plans, the survey estimates.

Of the 481 actuaries that responded to the question, 139, or 28.9%, predicted that flex plans will make up 20% of all benefit plans by the year 2000; 189, or 39.3%, predicted that flex plans will make up 30% of plans; 62, or 12.9%, of respondents predicted flex plans will make up 40% of plans; and 61, or 12.7%, predicted that flex plans will make up more than half of all U.S. employee benefit plans. Thirty respondents, or 6.2%, said that the percentage would remain at 10%.

Actuaries cite two primary reasons flex plans will become more popular: employers will be pressured to comply with employee demands for greater benefit choices, especially among two-wage-earner couples; and flexible benefit plans will be used to control the increasing costs of employer-paid benefits.

Large-scale changes in employer-sponsored pension plans also are imminent by the year 2000, the Forecast 2000 survey found.

For example, 91.8%, or 436 of the 475 respondents to the question on 401(k) plan prevalence, predict the benefit will be offered to more workers in the year 2000 than it is today.

Presently, 24.2% of the U.S. workforce, or 27.5 million employees, are employed by companies that offer 401(k) plans, according to an Employee Benefit Research Institute survey based on U.S. Census Bureau statistics. This is up nearly 600% from 1983 when 7.1% of the workforce, or 7.1 million employees, were offered the benefit (BI, Nov. 27).

Respondents to the Forecast 2000 survey see defined benefit pension plans falling by the wayside as government regulations become increasingly complex, making the cost of operating the plans too burdensome for many employers.

Currently, about 70% of U.S. employees are covered by defined benefit pension plans, the survey estimates. However, by the year 2000, the percentage will fall to 60% or less, predicts 76.7%, or 367

Continued on page 10

HUMAN RESOURCES DEPARTMENT
MEMO
Director
Mr. Simpson
Re: Claims Payments
getting a lot of complaints from our
company is very
for a change
me.

WHILE YOU WERE OUT
DATE: 5/14/88 TIME: 1:30 PM
FROM: [redacted]
PHONE NO: [redacted]
TELEPHONED: [redacted]
PLEASE CALL: [redacted]
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Opinions

Protect AIDS patients

WHEN WILL EMPLOYERS stop trying to eliminate or restrict health care coverage for AIDS-related treatments?

This kind of discriminatory plan design had better be abandoned soon or employers will rightfully find that their group health care plans will be subject to even more government regulation than they are now.

Just over a year ago, Phoenix, Ariz.-based Circle K Corp. decided to exclude from its self-funded health care plan coverage for illnesses that it determined were caused by "lifestyle choices" (*BI*, Aug. 15, 1988). The company's stated purpose: to reduce costs by excluding coverage for illnesses and accidents that in its judgment could have been avoided if employees had acted properly, including AIDS contracted from sexual activity or drug use. It also wanted to send a message to homosexuals and drug users that they should not work for the company.

We are thankful that, following a blast of adverse publicity, Circle K dropped the "lifestyle" exclusion before it ever had occasion to even consider denying a claim under the plan exclusion.

Now, just more than a year later, another employer has decided to discriminate against AIDS patients. H&H Music Co. in Houston has adopted a lifetime medical benefits limit for AIDS-related treatment under its self-funded health care plan of \$5,000—not enough to cover the life-sustaining medication AZT for even a year (*BI*, Nov. 27). AZT treatment costs an estimated \$6,500 annually, since the price was recently reduced by the manufacturer.

An H&H employee diagnosed as having AIDS is suing his employer, and the employer's former health insurer that now administers the self-funded plan, for the full \$1 million of coverage he had been entitled to under the previous plan.

Company attorneys, meanwhile, point out that H&H has a perfect legal right to limit coverage for AIDS treatment because, as a self-funded employer, H&H is not subject to Texas insurance laws that currently prohibit sublimits in insured health plans and, as of Jan. 1, will prohibit AIDS-related exclusions. Under the Employee Retirement Income Security Act of 1974, self-funded benefit plans are not subject to state insurance laws mandating policy provisions.



H&H is thumbing its nose at fair and decent treatment of AIDS patients and is inviting amendments to ERISA, or another federal law, to prohibit this kind of outrageous behavior by self-funded health care plans.

As we said in opposing the former Circle K plan provision (*BI*, Aug. 22, 1988), group health plans must provide employees with the means to pay for necessary medical care for injury and illness without subjecting employers to financial ruin. Plans adopting these special exclusions will not fulfill that purpose. Yes, employers are paying the bulk of the cost of providing health benefits, but they also receive a tax deduction for that cost.

Just as Congress long ago stopped employers from applying sublimits to coverage for pregnancy, or even excluding coverage for pregnancy, legislators will surely outlaw sublimits on AIDS-related treatment.

And, with the tendency of Congress to meddle in employee benefit plans, opening up the issue of eliminating sublimits on AIDS-related coverage could explode into a debate on mandating the entire scope of a group health care plan, down to required limits, deductibles and even employer contributions. That kind of micro-management of employee benefits plans is in no one's interest.

Letters

Direct contracts don't restrict patient choice

To the editor: I was pleased with the large and generally positive response to my Perspective article, "Contract Directly for Mental Health Care" (*BI*, Oct. 16).

One of the main issues raised in these responses is freedom of choice. The contention seems to be that my recommended approach for managing mental health care costs by directly contracting with a local group private practice on an exclusive or semi-exclusive, risk sharing basis would restrict the choice of providers available to patients and lead to dissatisfaction and complaints. I hope to show, though, that my recommendation actually improves choice in most situations.

I would like to proceed by first examining the situation where choice purportedly exists, i.e., where there are no restrictions on a patient's choice of providers.

The typical patient does not choose his or her mental health provider in a vacuum. There are many factors that enter into the decision, many of which are not in the best interests of the patient. For example, it is well known among providers—and advertising executives—that aggressive marketing and advertising brings results.

Therefore, it is not uncommon to find patients or families in crisis reaching for the first visible provider, which often means responding to a television or radio advertisement. Needless to say, the fact that some providers advertise more than others has little if any bearing on the quality of care provided and some analysts would venture to say that there is a negative correlation between advertising budgets and the care provided.

Some patients choose from a list of preferred providers or request a referral from their primary care physician. Most provider lists commonly are formed by

mail or telephone solicitations by preferred provider organizations, health maintenance organizations or management companies, often with little knowledge of the providers except that they are licensed and insured. In my 10 years of experience, I know for a fact that being licensed or insured is only one factor to consider in assessing the quality and ethics of a provider. In fact, there are a good number of licensed and insured professionals who routinely participate in fraudulent billing, misutilization of benefits, etc.

Other variables affecting choice of provider include: word of mouth referrals, which are not as common in mental health as in other health care areas; proximity to the provider, which has nothing to do with the provider's credentials; and referral by some other professionals (e.g., health care professional, teacher, minister, etc.).

The patient does not really have totally free choices in any of these situations and, in fact, is basing a choice on some rather dubious reasons. For example, many referrals to providers are made on

Continued on page 10

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Letters

Continued from page 8

the basis of their personality and/or social activities rather than training expertise.

The approach I outlined in my article improves choice for several reasons.

First, the providers in a quality group private practice are not only licensed and insured but also are directly monitored on an ongoing basis for the purpose of assuring quality, ethics and proper utilization patterns.

The provision should always exist that if a service is unavailable in the group service practice then it should be secured elsewhere with the group practice assuming payment responsibility.

Making the arrangement semi-exclusive gives the patient additional choice, although there should be an additional fee associated with using a provider "out

of network" (It is a truism that there is always a price for freedom.)

A quality private practice will have already screened the various hospitals and facilities in the community to arrive at the most appropriate and cost-effective choices. Therefore, the patient is not at the mercy of facilities that are benefit-driven and use slick advertising to lure patients into admissions.

A good group practice should have formal grievance procedures, ethics committees and utilization review/quality assurance committees to protect everyone's interests. This is rarely the case in the free market, where all sorts of clinicians—some with very questionable training or practice patterns—attempt to market themselves and compete to be patients' choices.

A conscientious group private

practice also can avoid some of the problems currently plaguing the mental health field, such as conflicts between fourth-party case managers and providers, diagnostic manipulations by providers to ensure reimbursement, credentialed providers "supervising" providers with lesser credentials and signing off insurance forms to obtain payments, etc.

It is ironic that some individuals who criticize any restriction of providers seem comfortable with the various treatment restrictions that are imposed by utilization managers.

It is wrong to give patients the freedom of choice for providers yet impose some rather severe restrictions in services.

It is, in my opinion, better to impose reasonable restrictions on providers but allow those providers and their patients an adequate

range of treatment alternatives to ensure the best prognosis.

It is erroneous to assume that so-called "free choice" leads to quality and ethical care. Putting some reasonable limits on choice of providers using well-founded criteria will make patients more informed consumers who can make wiser decisions.

Leo H. Bradman
Chairman

Bradman Therapy Centers
North Miami Beach, Fla.

Credit for quote belongs to expert in management

To the editor: I sincerely appreciate your reporting on my Oct. 19

presentation at a Risk & Insurance Management Society seminar in the article, "Loss Control Vital in Cutting Comp Costs" (BI, Nov. 13). However, in the closing paragraph, you mention that I stated, "The only things that evolve by themselves in an organization are disorder, friction and malperformance."

Although quite profound, that is not my statement but that of Peter Drucker, the world-renowned organization management expert, and we indicated his name on the slide to give him credit for the statement.

What I said was, "The only things that evolve by themselves in an organization are disorder, friction, malperformance and safety programs."

Harry P. Mirijanian

President
Applied Risk Control Corp.
Orangeburg, N.Y.

Actuary survey

Continued from page 6

of the 478 actuaries that responded to the question.

More than half—51.5%—of those respondents believe the number of employers offering defined benefit pension plans could plummet to 50% or less.

Among the reasons for the decline were:

- Increased complexity of government regulations, cited by 275 respondents.

- Lack of advantages to employers because of new regulations aimed at increasing portability and achieving other government aims, cited by 164 respondents.

- Increasing wages, pressure to compete internationally and other factors making benefits under this type of plan too costly to provide, cited by 80 respondents.

Actuaries were permitted to select more than one response in this section.

Approximately 69%, or 324 respondents, predict that portability will be a requirement of all employer-sponsored pension plans in the year 2000.

Addressing health care coverage for the uninsured, approximately 30%, or 143 respondents, predicted that the federal government will impose compulsory health insurance through the workplace, with employers paying most of the costs.

Another 24.3%, or 116 respondents, believe the federal government will establish a national health care system; 10.3%, or 49 respondents, said Medicaid or Medicare would likely be expanded; 10.5%, or 50 respondents, said risk pools would be established requiring employer contributions; 9.2%, or 44 respondents, predicted increased tax incentives for providing health insurance; and less than 1% believed taxes on insurance companies would be used to provide coverage for the estimated 15 million uninsured U.S. workers.

However, nearly 16%, or 74 respondents, predicted that the government will not take action.

Survey respondents also forecasted that employers will provide a wider range of benefits to their employees in the next century.

However, these added benefits will not be without their price: Nearly 80% of the respondents believe the value of health benefits will be taxed in some way in the year 2000.

Forecast 2000 was sponsored by the American Academy of Actuaries, the American Society of Pension Actuaries, the Canadian Institute of Actuaries, the Casualty Actuarial Society, the Conference of Actuaries in Public Practice and the Society of Actuaries.

Copies of the survey are available free of charge by writing Elizabeth Kelley, account supervisor with Edelman Public Relations Inc., 1420 K St. N.W., 10th Floor, Washington, D.C. 20005. ■

Hugo knocked the power out of almost



Tom Kaye
Home Office Property Examiner—Long Grove, Ill.

Fred Nintzel
Division Property Claim Manager—Summit, N.J.

Nancy Johnson
Senior Claim Representative—Charlotte, NC

When Hurricane Hugo swept through the Carolinas devastating homes and businesses, much of metropolitan Charlotte—including the Kemper office—was left without power for days.

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The lights are back on now, most of the claims have been resolved, and most of the special task force members have returned to their home territories.

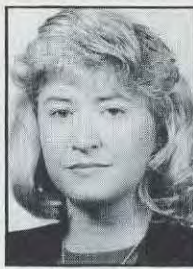
At issue

Will repeal of the Medicare Catastrophic Act increase your retiree health care costs?



Rick Zoog
Director-employee benefits
Colgate-Palmolive Co.,
New York

From our perspective, we do think it will have a cost impact because we were expecting a decrease in retiree costs. Long term, we guess it is going to add 10% to 15% in additional costs for our over-age-65 liability segment. However, because that segment represents only one-ninth of our total medical liabilities, the immediate impact will be less significant.



Nancy M. Nobles
Vp-human resources
Southern Union Co.,
Austin, Texas

I do not feel the repeal of the act will significantly increase the company's expenses for providing retiree benefits. Southern Union currently uses the carve-out methodology for payment of benefits, which limits the cost exposure for the company. However, the retirees could bear additional costs that are not covered under our plan.



Gloria Werner
Benefits manager
Super Valu Stores Inc.,
Minneapolis

Doubtful! According to our actuary and health insurer, our savings from 1989 Part A benefits were not significant. And, it's possible that Medicare Catastrophic will be revisited and some of the 1989 improvements may be re-enacted.



Cathy Corse
Manager-employee benefits
Barnett Banks Inc.,
Jacksonville, Fla.

The repeal of the Medicare Catastrophic Act will increase Barnett's retiree medical bill next year and in years to come. We had hoped to reduce our retiree medical liability, and like other employers, we're disappointed with the repeal.

Compiled by Christine Woolsey

Australian work comp systems under fire

By KATE McILWAINE

SYDNEY, Australia—Australian companies in several states should opt out of government-run workers compensation coverage programs and instead self-insure their workers comp risks because the government plans are inadequate and costly, says a leading Australian risk manager.

Because of the immense variation in coverage and the cost of coverage through the plans, funding workers compensation is the most difficult task confronting risk managers in Australia, said Ian Deayton, group risk and insurance manager for Liverpool, New South Wales-based Inghams Enterprises Pty. Ltd., a major poultry producer and thoroughbred horse stud operator.

Mr. Deayton, who was named 1989 Risk Manager of the Year by the Assn. of Risk & Insurance Managers of Australia, and representatives of some states' workers comp plans outlined problems and merits of the plans during a panel discussion at the annual ARIMA conference in Sydney Nov. 12-15.

For example, Mr. Deayton criticized New South Wales' plan as "absolutely stupid" because the



plan makes it impossible for risk managers to budget for workers comp premiums.

Mr. Deayton also criticized South Australia's plan because he says it has not provided data for risk managers to assess the financial performance of the state plan.

And, workers under most government plans can "bludge," or bum "their way through life" if they are injured, since there are few incentives in the plans for workers to return to their jobs, he said.

In addition, Mr. Deayton even questioned the no-fault concept, asking why an employee who "deliberately goes against safety rules" should be compensated if he sustains an injury as a result of his own actions.

Mr. Deayton also criticized the practice of lump sum payouts under many government plans, claiming that injured workers often are "miraculously cured" after receiving such payments and are able to, for example, vacation overseas.

As a result of these problems in government workers comp plans "both drumsticks and a wing of every chicken" go to pay Inghams workers compensation premiums, even though Inghams expects its 5,500 employees to abide by safety regulations, Mr. Deayton said.

But if employers self-insure and administer their own workers comp claims, employers would be able to make sure that they are not overcharged for medical costs, he said.

Mr. Deayton also suggested that the federal government enact legislation allowing all businesses operating in more than one Australian state to establish a single workers comp self-insurance program.

Observers also criticized the
Continued on next page

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Australian comp

Continued from previous page
practice in many government plans of cross-subsidization, under which workplaces with better safety records subsidize those with bad records so employers' workers comp premiums do not vary greatly.

Cross-subsidization is the most common complaint from employers in the South Australia plan, said Garry McDonald, chief manager-funds and liabilities for South Australia's WorkCover workers comp program.

Cross-subsidization results from a "belief that work-related accidents should be a broad-based community responsibility," as well as a desire that workers compensation be a tool for economic development, Mr. McDonald explained.

"The rationale is that internationally competitive activities, the manufacturing industry in particular, are the engine of economic

growth and lower costs for high-risk industries help produce a more competitive internationally exposed sector," Mr. McDonald said.

But he questioned the validity of that rationale.

Cross-subsidization also is among the major problems that employers in New South Wales have with the government plan, said Garry Brack, executive director of the New South Wales Employers' Federation in Sydney.

Workers comp premiums for employers in the NSW plan are determined by using a complex formula that allows WorkCover to manipulate premiums to eliminate differences in premiums costs among plan participants, and that is "a fundamentally bad premium arrangement," Mr. Brack said.

The manipulation of premiums reduces the incentive for good risk management, he explained.

The principle of cross-subsidization is misguided because industries with the worst safety records have no incentive to improve, said Ron Sackville, a lawyer and chairman of Victoria's Accident Compensation Commission, which administers Victoria's WorkCare system.

Mr. McDonald also expressed concern about variations in levels and types of benefits and access to compensation under the different state workers comp plans.

"It is also a concern that the coverage rules of the different states often permit workers traveling between states the option as to which set of benefits they will choose if injured," he said.

For example, at a company with offices in more than one state, an employee who travels between states for his job can select the state program under which he would be covered if injured on the job.

However, Mr. Sackville of Victoria's Accident Compensation Commission said there are social and economic objectives to be considered and the quality of the employer has to be taken into account when considering self-insurance.

"I don't trust employers when the choice is between their economic self-interest and doing justice and getting the best deal for their employees," Mr. Sackville said, adding that he is ideologically opposed to self-insurance of workers compensation.

Observers also gave their perceptions of specific government plans.

For example, NSW WorkCover plan officials are debating whether rehabilitation would work in both small and large businesses because small businesses do not always have suitable duties for injured workers returning to work.

The long-term cost of rehabilitation may far exceed expectations, as they have in Victoria, pointed out Mr. Brack of the NSW Employers' Federation.

Overall, though, NSW's WorkCover program is "equitable, affordable and financially responsible," said Ian Ramsay, acting general manager of the NSW Workers Compensation and Rehabilitation Authority in Sydney.

The program had a surplus of Australian \$336 million (\$264.1 million) as of June 30, according to Mr. Ramsay.

Reforms to the program this year—developed after consultation with representatives of employers, the union movement, insurers and the legal and medical professions—have increased benefits, he noted.

Improved benefits were made possible in part by abolishing coverage for claims from workers injured while traveling to and from work, known as "journey claims," which had amounted to \$30 million Australian (\$23.6 million) annually, Mr. Ramsay said.

The enhanced benefits did not

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Australian comp

Continued from page 12

lead to an increase in the average premium rate.

And, under a new law, injured workers have limited access to common law remedies and can recover up to \$180,000 Australian (\$141,480) if employers are found at fault. However, employees would give up their rights to WorkCover benefits.

The improvements are evident in increased employer occupational health and safety programs, Mr. Ramsay said.

However, it still is too early to judge whether the plan, which was introduced in 1987 and amended this year, is working, Mr. Brack said.

Mr. Brack noted that the NSW government has promised on-going reviews of the whole system, particularly the problems he outlined. While this is "comforting," one will have to wait to see if the promise is kept, he said.

The Victoria plan, WorkCare, has unfunded incurred-but-not-reported liabilities estimated at \$4.1 billion Australian (\$3.22 billion), according to the latest figures presented in the Victorian Parliament on Nov. 16.

Mr. Sackville told ARIMA delegates that the Victorian plan is suffering because the government that set it up had unrealistic expectations.

But, the perception that WorkCare has been a failure is misleading, Mr. Sackville argued.

Mr. Sackville, chairman of the Accident Compensation Commission in Victoria since 1985, also said he is skeptical of actuarial estimates of surpluses or liabilities in workers compensation plans.

Inaccurate predictions of workers comp losses are partly responsible for the Victorian plan's difficulties, he said. As a result of those predictions, coverage through the program has been underpriced since the day it was introduced.

Recent legislative amendments, aimed at reducing the unfunded liabilities, resulted in an increase in premiums to an average of 3.3% of payroll from 2.4% of payroll, he noted. The maximum rate was lifted to 7.7% from 3.8% of payroll.

Mr. Sackville supported the increases, claiming that the Victorian government's expectations that premiums generated under the former rate structure would have been sufficient to fully fund the program over 10 years, are "unduly" optimistic and that there has been a lack of financial incentives to encourage reduced claims.

In addition, cross-subsidization was reduced in the most recent reforms with the introduction of bonuses and penalties of up to 50% of premium based on claims history, he pointed out.

Mr. Sackville also agreed with Mr. Deayton's criticism that flaws in the plan have permitted some low-income workers to receive 100% of pre-injury earnings, though the program was intended to provide only 80% of earnings as an incentive to return to work.

The workers' compensation programs in both NSW and Victoria have been the subject of major industrial disputes (BI, Oct. 9).

South Australia's WorkCover plan has been in place for two years and as of June 30 had 58,000 registered employers with 75,000 work locations. Some 83% reported no claims in the previous 12 months, 9% reported one claim and 8% had more than one claim.

It is too early to assess whether the plan could be fully self-funded, Mr. McDonald.

"In a 2-year-old scheme, it is not possible to know how effective prevention and rehabilitation programs will be in containing the number of long-term claims. But those claims are the major influence on costs," he said. ■

Risk managers seek recognition

By KATE McILWAINE

SYDNEY, Australia—The risk management profession in Australia lacks recognition, says an officer of the Assn. of Risk & Insurance Managers of Australia.

A recent survey of ARIMA members found the status of the profession is improving, but corporate management's awareness of the risk manager's function remains "inadequate," Kevin Mutch, the organization's membership director, said during the Nov. 12-15 conference in Sydney.

While the role of a risk manager is known by those within the discipline, it is not fully understood by managers or at the "mineface," said Mr. Mutch, risk and insurance manager for Melbourne-based mining company CRA Ltd.

And the association does not help matters: About 60% of respondents said organization objectives were inadequately publicized. Respondents recommended ARIMA conduct more seminars and briefings for industry and government.

Association of
Risk & Insurance
Managers of Australia



ARIMA is a leader in educating risk managers about their role and responsibilities, and communication among organization members was rated highly by respondents, said Mr. Mutch.

Still the Australian risk management organization could learn

from the U.S.-based Risk & Insurance Management Society Inc., some members agreed.

In the conference's opening address, RIMS President Ronald W. Stasch said ARIMA, like RIMS, is an excellent vehicle for putting theory into practice. He said RIMS has worked with the academic community to implement studies of risk management theory to improve recognition of and expertise within the profession.

"It is from this that we cultivate a meaningful body of knowledge which is then available to our membership. It is the educational value that makes membership worthwhile," he said.

As a result, U.S. corporate management is becoming more enlightened about risk management, and there is growing support from in-

surers and brokers, Mr. Stasch said.

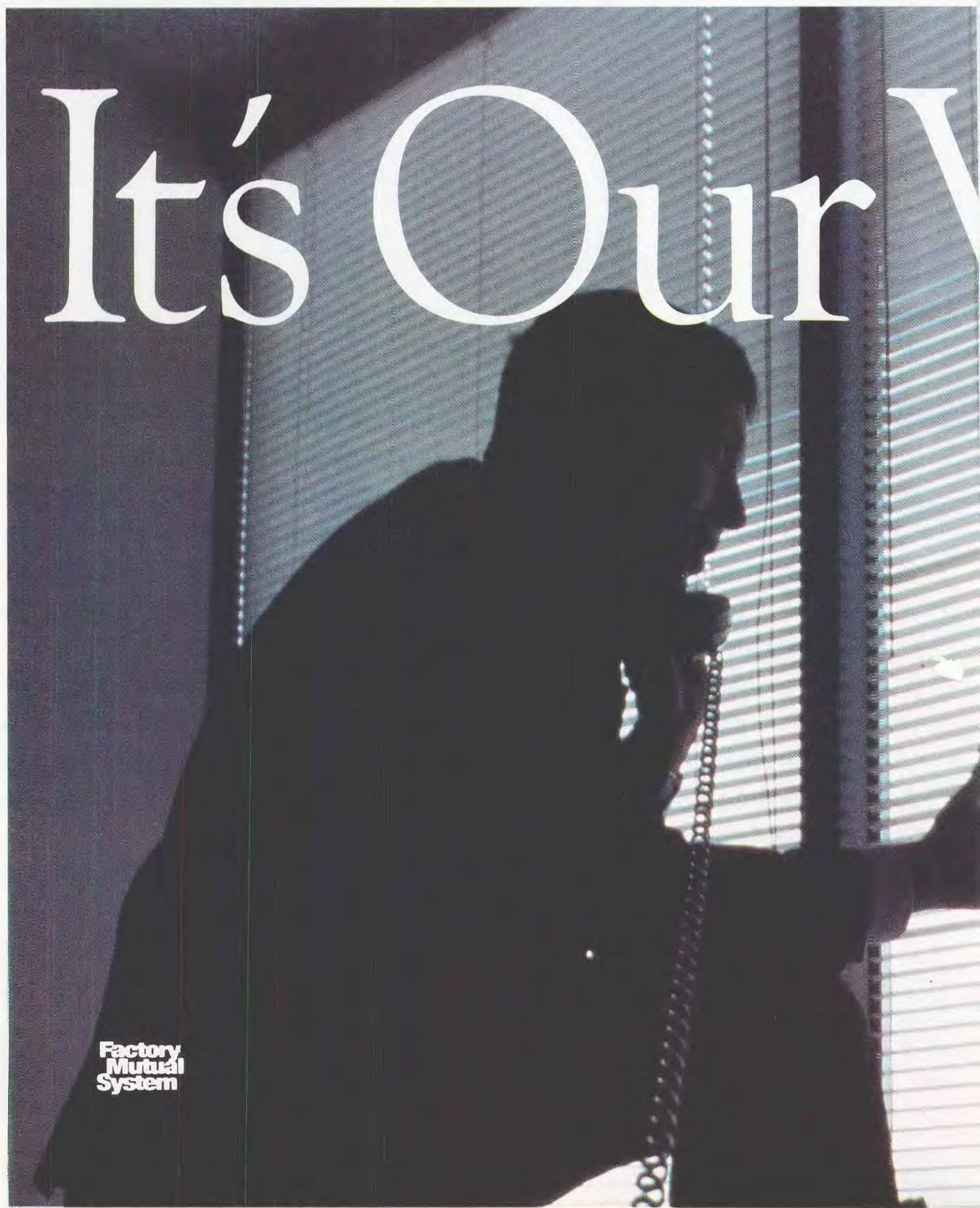
Teamwork and a greater degree of respect are more evident now than in the past, he added.

RIMS also has established a roundtable of experienced risk managers to follow relevant trends and issues. The think tank's discussion papers will encourage competency in the profession and further establish the importance of risk management within corporations, he said.

Meanwhile, there currently is more focus on insurance than on risk management in the Australian risk management profession, said Mr. Mutch.

However, former ARIMA President Bill Dunne said the soft market is partly responsible for the

Continued on next page



Factory
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Continued from previous page emphasis on insurance.

"Buying insurance is easier than loss control in the current climate," explained Mr. Dunne, who led the organization from 1985 to 1987.

This is partly because insurers will not reward risk managers' loss control efforts, said Michael W. Cooper-Mitchell, deputy chairman of Sedgwick U.K. (National) Ltd. in London.

Underwriters often give little encouragement to risk management practice "in the area it really counts—the premium," he said.

For example, although discounts on business interruption insurance are offered to companies that install sprinkler systems and other fire protection equipment, few underwriters are willing to factor professional contingency planning arrangements into premiums, he noted.

And in product liability insurance, "all too often underwriters

are guided by past claims experience. Few are prepared to structure their rating to provide a direct financial incentive to invest in (product) quality control systems," he added.

Mr. Cooper-Mitchell also said underwriting workers compensa-

the extent that it is unable to stop unsafe practices by crew members on board ship, he noted.

However, Mr. Cooper-Mitchell said the insurers would respond to his criticisms by saying that risk managers were interested only in buying insurance at the lowest price.

Insurers would further argue that this has reduced underwriting standards and inhibited the industry from getting involved in encouraging good risk improvement practices and in discriminating against bad industrial practices, he said.

"That may be true of some risk managers, but most are genuinely interested in encouraging good practice within their organization and are sincere in seeking backing from their insurance carriers," said Mr. Cooper-Mitchell.

"The growth of captives over the years shows that many risk managers are prepared to put their money where their mouth is," he said. ■

The marine market is now 'mesmerized to rate cutting,' says Michael W. Cooper-Mitchell.

tion exposures is often "a purely mathematical exercise using past statistics," even though many employers are introducing better safety practices and health promotion programs.

Meanwhile, the marine market is "mesmerized to rate cutting" to

'Bogus' broker makes its pitch to win account

By KATE McILWAINE

SYDNEY, Australia—Taronga Enterprises is trying to select the best Australia-based insurance broker to place its business out of the 20 it has interviewed.

Parasitic Intermediaries thinks it is the best broker for Taronga and makes a bid for the company's business.

The amusing but poignant negotiations between the pair of fictitious companies in this role-playing exercise were conducted at the annual conference of the Assn. of

Risk & Insurance Managers of Australia, held last month in Sydney.

Len Hanning, a joint managing director from the broker Heath Fielding Australia, played the role of a broker for Parasitic Intermediaries.

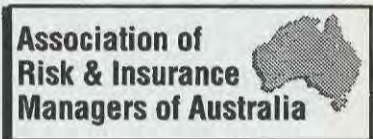
Paul Bawcutt, managing director of the U.K.-based Risk & Insurance Research Group Ltd. and author of books on risk management and captive insurance companies, played the part of a risk manager from Taronga Enterprises.

Mr. Hanning told Mr. Bawcutt that Taronga could expect a Parasitic broker to have "the predictive abilities of Nostradamus, the negotiating skills of a merchant in a Baghdad bazaar, degrees in accounting and law and the occasional ability to perform miracles."

More seriously, he said, a broker should present a full analysis of the client's risk exposures and develop an appropriate insurance program and then take the program to underwriters and negotiate the scope and price of the coverage.

Perhaps a captive should be involved in the insurance program, Mr. Hanning said.

However, many brokers are "blurring the parameters" of their expertise by moving into other areas such as managing captive insurance companies, according to



Mr. Hanning. Captive management requires special skills, and "there is a conflict of interest when a broker is also the manager of a captive," he said.

If Taronga were to select Parasitic as its broker, Parasitic would provide an annual review of the client's insurance program and appoint an account manager who would be responsible for every facet of Taronga's business, Mr. Hanning said.

But Parasitic would not restrict Mr. Bawcutt's contact with underwriters—particularly if they were able to invite him to the Melbourne Cup, Australia's most prestigious racing event held annually on the first Tuesday of November, Mr. Hanning quipped.

"You're more likely to get a sympathetic response if the insurer understands your business," Mr. Hanning said.

Parasitic also would "pinch someone else's staff" if the broker had insufficient personnel to cope with the increased workload, he added.

In response to a question from Mr. Bawcutt, Mr. Hanning said he could not guarantee the security of the insurance companies that with whom he places Taronga's business. But he noted that Parasitic's security committee in London and the Insurance & Superannuation Commission in Australia monitor insurers continuously.

"We're very concerned at Parasitic about the soft market," Mr. Hanning added.

Mr. Bawcutt told Mr. Hanning that he would choose a broker according to subjective and objective considerations, as well as "the availability of a box at the Melbourne Cup."

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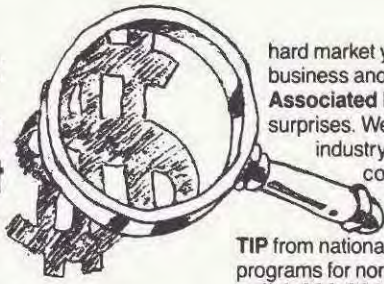
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Tokyo quake greatest fear of insurers

By **KATE McILWAINE**

SYDNEY, Australia—A Tokyo earthquake is the event insurers fear most, according to a leading brokerage executive.

Losses in such a quake could total \$670 billion, Michael W. Cooper-Mitchell, deputy chairman of London-based Sedgwick U.K. (National) Ltd., told delegates to the Assn. of Risk & Insurance Managers of Australia conference Nov. 12-15 in Sydney.

That Tokyo Bank estimate from 1987 represents at least 23% of Japan's gross national product, he said.

It easily would surpass the combined cost of the recent slew of catastrophes: the \$3 billion October 1987 windstorm in Southeast England and northwest Europe; the \$1.4 billion Piper Alpha North Sea oil platform fire last year; Hurricane Hugo; the California earthquake; and explosion of a Phillips Petroleum Co. petrochemical plant.

A Tokyo quake would also greatly disrupt financial markets because insurers would be forced to liquidate assets to pay claims, he predicted.

"Stock market falls could create paper losses far in excess of the direct earthquake damage," said Mr. Cooper-Mitchell.

To date, major catastrophes—both man-made and natural—have shown that the insurance industry can cope with paying the losses from major disasters, Mr. Cooper-Mitchell told ARIMA delegates.

For example, underwriters have paid single-event losses like Piper Alpha, he said. There also are other single-limit risks around the world that exceed Piper Alpha's value, he predicted.

Underwriters also have been able to pay the bigger, long-tail liability losses—such as those

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caused by asbestos—that in the United States alone may end up costing more than \$25 billion, he said.

But there are some risks the underwriters think are too unpredictable to take a chance on, according to Mr. Cooper-Mitchell.

"The industry has distanced itself from the provision of coverage for gradual pollution and certain nuclear risks and some of you may not like the way it has done that," he said.

"But it is arguable that there are some activities of man which have, as an inevitable side effect, a destructive impact on the environment and that it is not the role of the insurance industry to pick up the bill."

And there are risks yet to be identified that could pose megalosses on the insurance market, he said.

For example, the industry could be hit by a loss affecting computer networks in world money markets, he said.

"If some evil genius succeeded in planting a virus which effectively destroyed these networks, the subsequent losses could be far in excess of a Piper Alpha," he said.

Also, while underwriters so far have been able to pay all claims from natural disasters, the result of a natural mega-loss is difficult to assess, said Mr. Cooper-Mitchell.

"The effect of a mega-loss on trade and business generally must be considered," he said. "The insurance industry's health in terms of its ability to earn money on its investments is closely linked with the health of major trading na-

Continued on page 18

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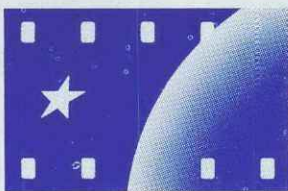


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Quake predictions

Continued from page 16
tions."

However, there are some predictions available on the cost to insurance companies of such "mega-losses."

For example, Mr. Cooper-Mitchell predicted that if an earthquake the magnitude of the 1906 San Francisco earthquake hit Northern California today, the insured losses would exceed \$40 billion.

That estimate represents about 20% of the U.S. property/casualty insurance industry's total 1987 premium volume of \$190 billion, Mr. Cooper-Mitchell said.

According to figures from A.M. Best Co., total U.S. property/casualty insurance premium volume for 1987 amounted to \$193 billion.

"If the U.K. insurance market could handle a loss representing 10% of its annual premium income

without a hiccup (referring to the 1987 windstorm loss of \$1.8 billion in the United Kingdom), could the U.S. market cope with a loss of 20%?" Mr. Cooper-Mitchell asked.

Also, a study by the National Committee on Property Insurance, a U.S. insurer-supported organization, shows that an earthquake measuring 8.6 on the Richter scale along the New Madrid fault line in the central United States would produce estimated property losses of \$52 billion.

And an earthquake measuring 7.5 on the Richter scale occurring along the Newport Inglewood fault in Los Angeles County would produce losses of more than \$70 billion, according to the committee's study.

While many homeowners and businesses in seismically active areas do not insure against shock—or earthquake—damage, studies suggest that at least half the insurance claims would be for fire dam-

age and there would be many other workers compensation, automobile and liability claims.

"Given the innovative approach to interpretation of policy wordings by the U.S. courts, they might find that earthquake shocks could be brought within a policy word-

ing, even though not specifically insured," Mr. Cooper-Mitchell warned.

He also noted that the effects of an earthquake would not be evenly spread across the insurance industry.

"Some carriers would find them-

selves wiped out with knock-on effects for other policyholders," he said.

And Mr. Cooper-Mitchell warned that there would be a reduction in insurers' capacity. All buyers would find coverage was less available and costs higher. In-

insurance companies could pick and choose the risks they wanted to cover.

Meanwhile, Mr. Cooper-Mitchell said premium rates in the commercial insurance market are hardening worldwide, and recent catastrophic losses have hastened the

process.

Property/casualty insurance rates will turn upward toward the end of this year, he predicted.

Although some risk managers may argue against the need for increased rates, he said the insurance industry has to be allowed to generate reserves for the increasing number of natural disaster losses that are an inevitable consequence of the spread of development into areas prone to floods and earthquakes.

Australia also has "its fair share" of exposures to brushfires, wind, floods and earthquakes, Mr. Cooper-Mitchell pointed out, suggesting that risk managers should talk with their industry colleagues about ways to mitigate the impact of these natural disasters.

"When a disaster occurs, it is an absolute loss of wealth. Neither the government nor the insurance industry can create wealth. They can only redistribute it," he said. ■

'Given the innovative approach to interpretation of policy wordings by the U.S. courts, they might find that earthquake shocks could be brought within a policy wording, even though not specifically insured,' says Mr. Cooper-Mitchell.

Leadership skills a must, management expert says

By KATE McILWAINE

SYDNEY, Australia—Risk managers should know how to manage people as well as risks, because people are a company's most valuable resource, according to a management expert.

Managing human resources is a fine-tuning aspect of the risk manager's role that requires skill, expertise and persistence, said Tony Clyne, managing director of the New South Wales government's Business and Consumer Affairs Department.

It involves leadership rather than just management, because people cannot be manipulated the way data can, and inefficient personnel management will prevent an organization from changing and growing stronger, he stressed dur-

Association of
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Managers of Australia



ing remarks at the Assn. of Risk & Insurance Managers of Australia conference in Sydney Nov. 12-15.

Risk managers should have clear goals that are flexible enough to be changed when necessary, according to Mr. Clyne.

"To manage without a plan is a crime," he said. People should try to fit into the plan and contribute to it, he added.

"Be someone with a vision and communicate with your employees," he stressed.

Good management also involves making decisions, even if they are the wrong ones, Mr. Clyne asserted.

"The choice is yours, but if you don't make a decision, you shouldn't be at the top," he added.

Mr. Clyne also advised risk managers to practice what they preach and exhibit honesty, firmness and fairness in their leadership.

"Manage yourself effectively, professionally and personally," he said.

"People are your best resources. Get your team harnessed, take risks yourself, and always keep fine-tuning your plan," Mr. Clyne said. ■



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Proposed Australian legal reforms criticized

By KATE McILWAINE

SYDNEY, Australia—The Australian Law Reform Commission's product liability proposals and a bid by lawyers to introduce contingency fees came under fire during the Assn. of Risk & Insurance Managers of Australia's annual conference in Sydney Nov. 12-15.

While agreeing that current product liability laws are inadequate, insurance law expert Geoff Masel said he is opposed to the ALRC's proposal to widen the scope for action against manufacturers of unsafe products.

And insurance premiums could skyrocket if a Victorian Law Institute proposal to introduce contingency fees for attorneys is adopted, warned Rod Waites, director-manager for Australia of C.E. Heath

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The ALRC's product liability reform proposals are "radical and unique," said Mr. Masel, a consultant to the large Australian law firm Phillips Fox.

Insurers and manufacturers also strongly oppose the ALRC proposals, the economic impact of which the Australian Industry Commission is studying (BI, Nov. 13).

Under the ALRC proposals, manufacturers would be liable for any injury and/or damages that occur as a result of the way goods "act." However, manufacturers also could use a series of defenses to reduce compensation payable, including:

- Whether the claimant's knowledge of the product would lead a reasonable person to appreciate

the risk of using the product.

- Whether the product defect could have been discovered or anticipated by scientific means when it was manufactured, or the so-called state-of-the-art defense.

However, Mr. Masel said the ALRC's requirements for applying

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Managers of Australia**



the state-of-the-art defense are so strict that it is unlikely the defense would ever succeed in practice.

As a result, manufacturers that develop new products could face huge risks, he said.

- Whether the product "acted"

as it did to comply with a legal standard. In such a case, the government entity that set the standard would be responsible for the injury or damage.

But Mr. Masel predicted that governments would never establish product standards due to the potential liability from products that met the standards but still caused injuries.

Mr. Masel also predicted that insurance and legal costs would rise if the ALRC proposals are adopted.

And insurance cost and availability also could be affected by a proposal to institute contingency fees for lawyers, said Mr. Waites of Heath Casualty & General.

Some insurers may discontinue underwriting liability insurance altogether, while others may offer liability coverage only to policy-

holders that also assume sizable self-insured retentions, he predicted.

Many insurers, including Lloyd's of London underwriters and major European reinsurers, are closely monitoring Australia's legal reforms, according to Mr. Waites.

"They are concerned that our society is becoming far too litigation conscious and the attitude and interpretations of our courts too liberal," he said.

He dismissed lawyers' claims that contingency fees would improve consumer access to the legal system as "an invention," contending that the fees would instead give rise to tort blackmail.

The insurance industry, as one of the largest users of lawyers, would be forced to increase premiums to cope with rising litigation costs and court awards, he said.

"It is in the interest of lawyers in a contingency fee structure to maximize (awards), not compromise," Mr. Waites said.

Australian courts already are at a breaking point, and the Victorian Law Institute's proposals would only further swamp the system.

Mr. Masel also criticized the High Court of Australia for being inconsistent. While the court is reluctant to disturb common law precedent in some decisions, it has completely overturned it in others, Mr. Masel said.

Conflicting decisions make it difficult for the legal and risk management community to predict future trends in the law, he said.

Australian state statutes also are difficult to interpret, he said.

For example, the Victorian Accident Compensation Act, which is part of the state's workers compensation law, is "mind boggling in its obscurity," he said.

Even Victorian County Court Judge Hart has described it as "the most poorly drafted piece of legislation I have ever seen," according to Mr. Masel. ■



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Johns Hopkins names hospital risk manager

Comings & goings: buyers

Paul Rosenberg, 38, named vp, general counsel and secretary of Johns Hopkins Health System and The Johns Hopkins Hospital in Baltimore. In this newly created position Mr. Rosenberg oversees professional and general liability insurance, risk management and compensation. He reports to Dr. Robert M. Heyssel, president of the Johns Hopkins Health System. Previously Mr. Rosenberg was director of legal affairs and risk management for the University of Rochester and its Strong Memorial Hospital in Rochester, N.Y. While there he also served as an as-

sistant professor of medical humanities. Prior to that he administered a liability self-insurance program for the University of Cincinnati Medical Center. Mr. Rosenberg holds a bachelor's degree from Brown University in Providence, R.I., and a doctor of law degree from the University of Cincinnati. He is a member of the National Health Lawyers Assn., the National Assn. of College and University Attorneys, the American Society of Hospital Attorneys and the American Society for Hospital Risk Management. In addition he is a deputy member of the Risk & Insurance Management Society.

Georges Balcer, 47, has been named director of risk management at Stone Container Corp. in Chicago. In this newly created position he coordinates the risk management activities of Stone's worldwide paper-making and packaging operations. Mr. Balcer reports to Michael B. Wheeler, vp, treasurer and assistant secretary. Previously, Mr. Balcer was risk and insurance manager for Consolidated-Bathurst Inc. in Montreal. Consolidated Bathurst was acquired by Stone last March. Mr. Balcer attended the University of Ottawa in Ottawa, Ontario. In addition, he is a deputy member of the Risk & Insurance Management Society, and is a co-founder of the RIMS Hockey "All-Stars," which face off during the annual RIMS conference to benefit the Robert S. Spencer Memorial Foundation Inc., which provides scholarships to students studying risk management and insurance (*BI*, April 3).

Richard E. Crum, 57, has been named corporate risk manager of Giddings & Lewis Inc. in Fond du Lac, Wis. In this newly structured position he is responsible for property/casualty, group health, workers compensation and product liability coverages. He reports to Robert D. Kamphuis, treasurer. Mr. Crum previously served as an independent risk management consultant to Giddings & Lewis, which makes factory automation equipment. Prior to that, he was corporate risk manager for the company from 1978 until 1984. Following a restructuring of the company in July, the position of risk manager was re-created at Giddings & Lewis. He holds a bachelor degree in business administration from Marquette University in Milwaukee.

Jerry W. Robinson, 43, named director of risk management and insurance at The Enstar Group Inc. in Montgomery, Ala. In this newly created position he oversees property/casualty insurance, safety and loss control programs and claims management. He reports to Charles B. Paterson, executive vp and general counsel. Prior to joining Enstar, a financial services and specialty retailing firm, Mr. Robinson was assistant risk manager and claims administrator for Kinder Care Inc. in Montgomery, Ala. Prior to that, he was director of risk management at West Point-Pepperell Inc. in West Point, Ga. He received a bachelor of science degree from Auburn University in Auburn, Ala. Mr. Robinson is a deputy member of the Risk & Insurance Management Society.

We'd like to report on staff changes in your company's risk management, safety and employee benefits departments. Just drop a note to Paul Winston, Copy Editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590, or call 312-649-5442. Please send a photograph, too.

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Merrett syndicates to reduce activity in LMX marketplace

By CAROLYN ALDRED

LONDON—Lloyd's of London syndicates managed by Merrett Underwriting Agency Management Ltd. are pulling out of London's non-marine excess-of-loss reinsurance market.

Syndicates 421 and 418/417, which write about \$40 million of non-marine retrocessional business between them, will significantly reduce their retrocessional underwriting next year, said Ken Randall, managing director of parent Merrett Holdings P.L.C.

Non-marine syndicate 421, underwritten by Dennis Purkiss, will write no non-marine LMX business next year, he confirmed.

Currently LMX business represents about 40%, or \$10 million, of syndicate 421's premium volume, Mr. Randall estimated.

Syndicate 418/417, one of the largest syndicates at Lloyd's, also will reduce its retrocessional underwriting and will write no more "spiral" business, he said.

Excess-of-loss retrocessional business written by London underwriters for other London-based ceding companies often is described as LMX business. In recent years there have been growing concerns about the extent to which London underwriters reinsure each other, which causes claims to "spiral" in the market as they are passed from one underwriter to another for years after a loss occurs.

Some market observers fear that the LMX market provides illusory capacity, is inherently weak and creates an inability among underwriters to accurately determine their risk exposure.

"The view that we take is that the non-marine LMX market has lost sight of underwriting fundamentals," said Mr. Randall.

Meanwhile, attempts to increase retention levels and co-reinsurance requirements in the non-marine LMX market, following Hurricane Hugo and the California earthquake, are failing, said Mr. Purkiss.

"The London market has lost sight of its function. The whole concept of LMX is sound but the problem is that the market has lost its direction. It's far too heavily involved in retrocessional business," said Mr. Purkiss.

Broker network

Small and mid-sized insurance brokers increasingly are looking at ways to compete with the large, international brokerage companies as the insurance industry gears up for the removal of trade barriers within the European Community.

For example, some smaller brokers are forming relationships and networks with brokers in other countries on a similar basis to the UNISON worldwide network of brokers.

A formal agreement was reached this fall among 13 brokers to form a network of independent, correspondent brokers embracing the European Community and other countries.

The network, which is dubbed the International Broker Network by its members, includes:

- Corporate Risk P.L.C., based in Edinburgh, Scotland.
- Alec Finch & Co. Ltd. of Manchester, England.
- K.R. Chapman Sage, Correduria de Seguros S.A. of Madrid, Spain.

London

- Jean Crab et Ses Fils S.A. of Brussels, Belgium.
- Graffner Assurantie of Amsterdam, Netherlands.
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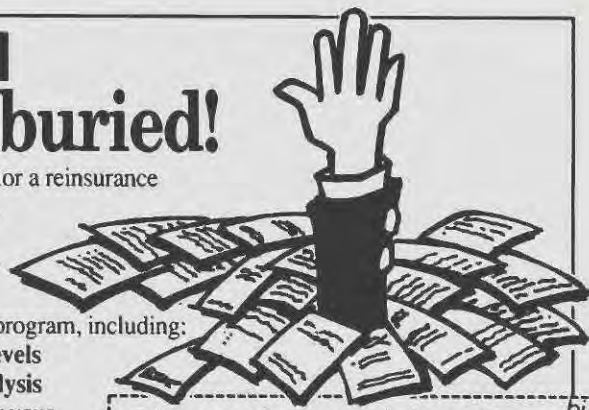
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- James Jakson (Pty.) Ltd. of Johannesburg, South Africa.

"During the early part of 1988 we discussed the evolution of a free market in insurance services and decided that a European presence was vital, not only for future business development, but also to provide a better service to our existing clients," said Corporate Risk Chairman Douglas Smith.

However, "as a Scottish-based independent company, setting up branch offices or establishing a presence by acquisition was impracticable due to the massive financial investment required. We decided therefore that the only option realistically open to us was to identify comparable companies throughout the EC who shared the same objectives and seek to form an association or network," he explained.

In a separate development, London broker Lowndes Lambert Group Holdings P.L.C. is putting together a Europe-wide property and liability line slip for corporate clients and their European subsidiaries.

The coverage will be underwritten by insurers based throughout Europe and will be led in each country by an insurer based in that country, according to Richard Shaw, chairman of Lowndes Lambert.

Lowndes Lambert plans to have its Euro-Master Cover ready for January 1991 with maximum limits of up to about 50 million pounds (\$78.2 million), said Mr. Shaw.

Meanwhile, Lowndes Lambert is continuing to add offices and correspondent brokers throughout Europe.

So far, the broker's network in Europe includes:

- Paris-based La Securite Nouvelle, in which Lowndes Lambert has a 45% stake.
- Lowndes Lambert Italy S.p.A. in Milan and Rome.
- Interbroker of Barcelona, Spain, fully owned by Lowndes Lambert.
- Lothar Walter Schenk, a correspondent broker based in Munich, West Germany.
- Nicos Macropoulos, a correspondent broker based in Athens, Greece.

Lowndes Lambert also is discussing links with a Dutch broker and a Belgian broker, said Mr. Shaw.

Meanwhile, Lowndes Lambert is buying the Australian brokerage subsidiaries of rival London broker Bain Clarkson Ltd.

Lowndes Lambert currently specializes in brokering construction risks in Australia, and the acquisition of Bain Clarkson's retail brokerage operation will broaden its business in Australia, according to Mr. Shaw.

As a result of the deal, Lowndes Lambert Australia Holdings will consist of two operations: Lowndes Lambert Australia, specializing in construction insurance brokerage, and Lowndes Bain, a retail brokerage.

Bain Clarkson sold its operations for about \$7.5 million Australian (\$5.9 million U.S.), though it will retain a 20% stake in Lowndes Bain, said Bain Clarkson Chairman Simon Arnold.

The combined operation is expected to produce revenues of about \$20 million Australian (\$15.7 million U.S.), according to Mr. Shaw.

New brokerage

A small insurance brokerage and a North American team from Lloyd's broker Blackwall Green Ltd. have merged to form London-based Stirling Cooke Insurance Brokers Ltd.

Stirling Cooke was formed in October by the non-North American insurance brokerage Stirling Insurance Brokers Ltd. and a team of 10 people from Blackwall Green, headed by Mark N. Cooke.

The new company hopes to fall under the umbrella of Lloyd's brokerage Windsor Insurance Brokers Ltd. as soon as Lloyd's approves

the arrangement, said Mr. Cooke, Stirling Cooke's managing director. Stirling Cooke hopes it will become a Lloyd's broker in its own right in the next few years, he said.

The new brokerage, with about 30 employees, expects to produce annual brokerage revenue of 1 million pounds (\$1.56 million), including about \$750,000 in revenues from North America.

The North American team specializes in reinsurance of North American self-insured accident and health plans, workers compensation risks and self-funded property risks.

Mr. Cooke began his career at Lloyd's brokerage group Leslie & Godwin Ltd. in 1976 and set up the North American reinsurance side of Blackwall Green in 1985.

He said he left Blackwall Green "amicably" because "you don't get the opportunity to set up your own Lloyd's broker that often."

Professional liability

The regulatory authority for British investment consultants and brokers still plans to introduce a compulsory professional liability insurance program, despite failing to get its first plan off the ground.

The Financial Intermediaries, Managers & Brokers Regulatory Assn.—dubbed FIMBRA—has "embarked on a consultation process with trade associations with a view to establishing some sort of compulsory professional indemnity plan for members as soon as possible," said a FIMBRA official.

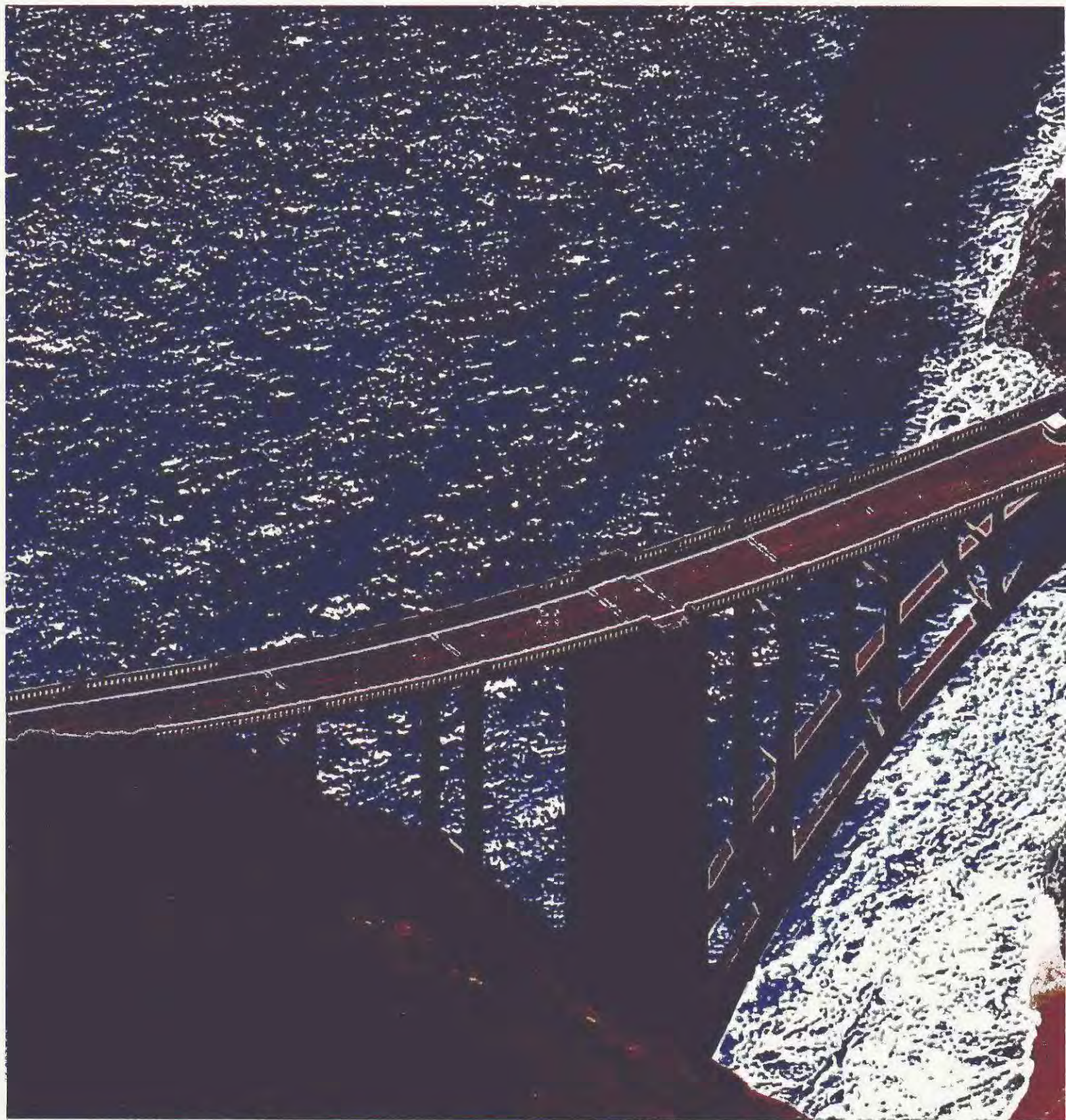
FIMBRA was set up as a self-regulatory association to monitor financial and investment consultants, advisers and brokers following enactment of the Financial Services Act of 1986.

The proposed insurance plan will indemnify FIMBRA members for awards made against them by an investment referee, an independent arbiter empowered by FIMBRA to award compensation to investors with genuine complaints against FIMBRA members.

The investment referee can award up to 50,000 pounds (\$78,000) per complaint. However, the proposed insurance program would provide unlimited indemnification for a series of awards stemming from one incident, said

Continued on next page

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the FIMBRA official.

FIMBRA's first attempt to put together a compulsory plan was abandoned just days before it was to start when the underwriter refused to provide unlimited coverage for a series of awards resulting from the same incident or error.

The program, administered by London broker Pointon York Vos Ltd. and underwritten by Lloyd's of London underwriter Alec Sharp, was supposed to be compulsory for all FIMBRA members beginning Nov. 1.

However, Mr. Sharp in mid-October proposed to cancel the binding authority he had granted to PYV, claiming he had misunderstood the terms of the program.

Mr. Sharp said the coverage he was offering was limited to 50,000

pounds for all awards stemming from one incidence of negligence, while PYV claimed the binding authority granted up to 50,000 pounds in coverage for each and every referee award "notwithstanding that two or more judgments, claims or complaints against an individual insured arose out of the same negligent act, error or omission" by the insured.

Mr. Sharp since has agreed to offer coverage against the referee awards, but only up to specified policy limits, not the unlimited coverage that FIMBRA seeks, said Clive Hawker, a PYV director. "The minimum level of cover is 100,000 pounds (\$156,400) for any one claim and an automatic option exists to increase...cover to 250,000 pounds (\$391,000) for any one claim," according to PYV.

In addition, "quotations will be

provided for excess sums insured up to 20 million pounds (\$31.2 million)," it adds.

But, because of the limits imposed by Mr. Sharp, the PYV plan "no longer meets FIMBRA's requirements for a compulsory insurance plan," said the FIMBRA official.

The PYV plan continues to be available to FIMBRA members on a voluntary basis and a "substantial" number of members have purchased the coverage, said Mr. Hawker of PYV.

FIMBRA, meanwhile, still "is looking at all possibilities" to establish a compulsory insurance arrangement for members providing unlimited liability coverage for awards made under its investment referee system, the FIMBRA official said.

However, FIMBRA's chairman,

Lord Elton, and several council members already face a vote of no confidence proposed by about 1,500 of the association's 8,200 members at FIMBRA's annual general meeting this month because of the failure of the first plan, confirmed the official.

D&O claims

Litigation against British corporate directors and the need for directors and officers insurance protection in Britain will continue to increase, according to Lloyd's of London underwriter John Wetherell.

Government legislation and several court cases have increased the liabilities facing British corporate directors in recent years, he said in a speech last month to members of the Insurance Institute of London.

For example, if a British company becomes insolvent, its former directors could face a string of claims, including those:

- From the company's liquidator under the Insolvency Act of 1986.
- For damages to investor shareholders.
- From creditors whose debts are not paid in full.
- From the British Customs and Excise department and the Inland Revenue for various taxes.

Individuals increasingly are being faced with personal consequences for actions taken in the course of their work, Mr. Wetherell noted.

"Will directors of ability and quality be prepared to serve on (company) boards that do not provide sufficient insurance protection to cover them against the potential financial disaster that could befall them as a result of their actions when serving as directors?" Mr. Wetherell asked.

"It is my belief that an increasing awareness of the wide exposure to litigation will lead more and more directors to seek insurance protection," he said.

Moreover, "I do not believe that the exposures will remain solely with the boards of large and sophisticated companies, but will spread to what may at present be considered low-risk categories. I foresee increased pressure on such groups as management committees of blocks of flats, housing co-operatives, school parent-teacher associations, golf club committees, charitable organizations, church committees and other seemingly innocuous groups," he added.

"I am quite certain that the present interest and concern about the environment will eventually focus critical attention on the directors and managers of those entities seen to be responsible for damage to the land, sea and air," noted Mr. Wetherell.

Meanwhile, the British Companies Act, passed by Parliament last month, clarifies that companies may purchase liability insurance for any "officer or auditor," provided that the purchase of the insurance is stated in the company's annual report.

The legal ability of a company to purchase D&O coverage for its employees previously had been unclear, sources say.

Comings & goings

Nicholas Baring will become chairman of London-based Commercial Union Assurance Co. P.L.C. following the retirement of **Sandy Marshall** next April. Mr. Marshall became chairman in 1983. Mr. Baring, 55, has been deputy chairman of CU since 1983.

Kenneth L. Hammond has been appointed chief executive officer of Prescott Management Services Group, a subsidiary of London broker Minet Holdings P.L.C. that provides captive management and risk management consulting services.

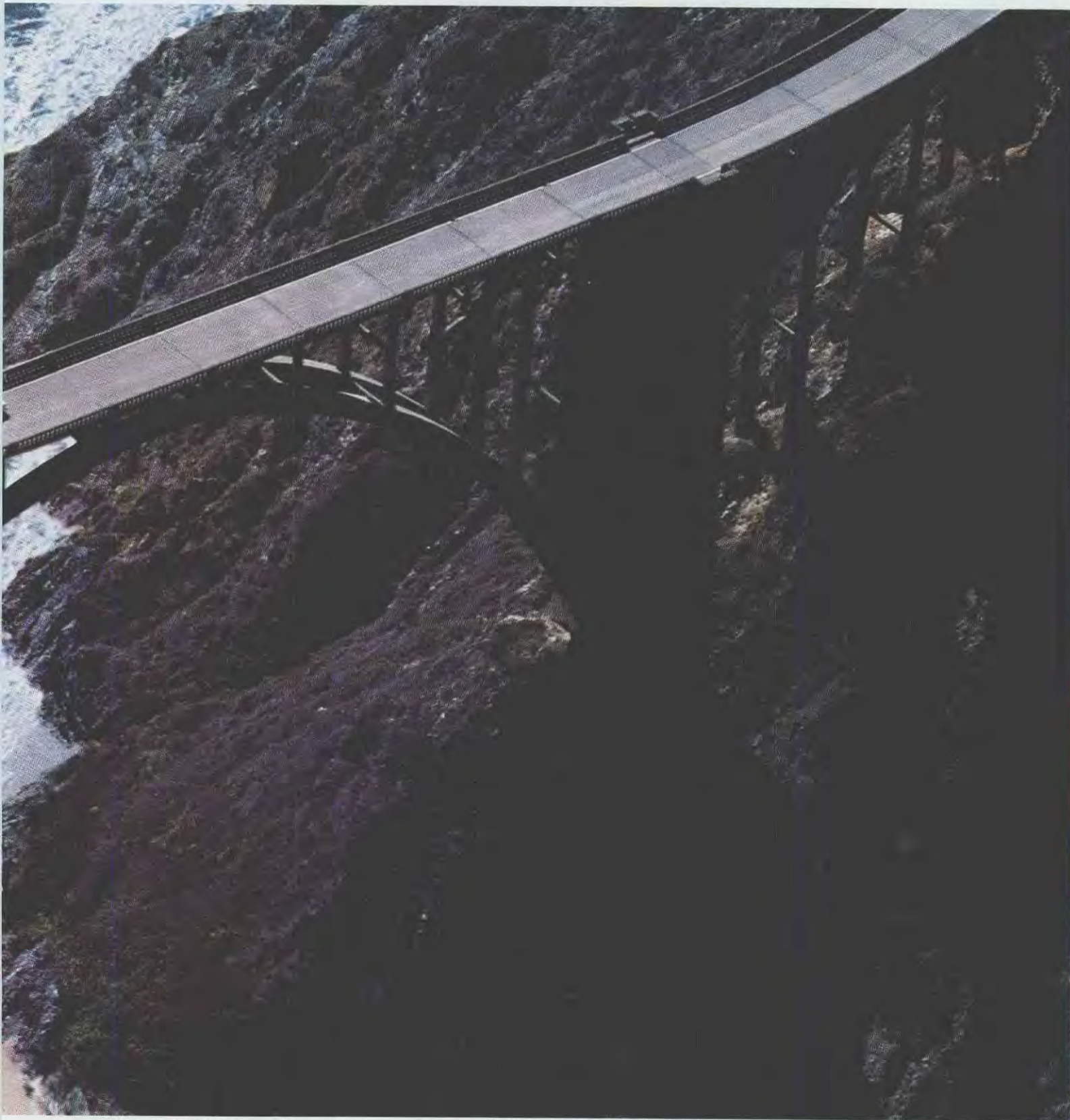
Other appointments at Prescott include: **John H. Sewell** named managing director of risk consulting (Europe); **Colin R. Newell** named managing director of Prescott Management (Bermuda) Ltd.; and **Ian McCathie** appointed managing director of Prescott Management (Guernsey).

S.J. Quick has been appointed managing director of the newly formed North American Property division of Lloyd's of London broker J.H. Minet & Co. Ltd.

Bain Clarkson Ltd. has appointed **Peter A. Grebbie** to the newly created position of director of the Far East region. Mr. Grebbie, who will continue as managing director of Bain Clarkson's Hong Kong operations, Incheape Insurances (HK) Ltd., will be responsible for coordinating and expanding the broker's network of offices in Asia.

Lloyd's of London broker Denis M. Clayton & Co. Ltd. has appointed **Lawrence M. Oliver**, **Adam M.C. Sayers** and **Robin A. Ward** as directors of its North American division.

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Unlimited punitive awards could be barred: Court

By STACY ADLER

NEW YORK—Multiple, unlimited punitive damage awards against the same company for the same conduct could be declared unconstitutional, the 2nd U.S. Court of Appeals indicated in an asbestos case.

While declining to review the constitutionality of such awards, the 2nd Circuit recently said: "The multiple imposition of punitive damages for the same course of conduct may raise serious consti-

tutional concerns."

However, the court said review of those concerns was precluded by the asbestos company's failure to address the issue more thoroughly at trial.

"It appears the appellant neither adequately raised this legal argument nor made sufficient record on it in the trial court," explained the court.

The suit involved a dispute between a shipyard worker and Celotex Corp., a unit of Jim Walter Corp. in Tampa, Fla. Celotex in

There is 'a need for a uniform, national rule on the issue' of punitive damages the appeals court says.

1972 acquired asbestos manufacturer Carey Corp. and all its liabilities.

Jack P. Racich worked as a ship-

yard worker from 1923 to 1974, during which time he was exposed to asbestos products. Through his exposure to asbestos Mr. Racich contracted asbestosis, a progressive and irreversible lung disease caused by inhaling asbestos fibers.

A jury awarded Mr. Racich \$165,000 in compensatory damages and \$100,000 in punitive damages, later cutting the compensatory award 10% due to Mr. Racich's contributory negligence.

Celotex argued that imposing

punitive damages without a maximum limit offends a notion of fundamental fairness inherent in the 14th Amendment's due process clause.

While indicating there might be merit to the argument, the court said Celotex did not produce enough evidence to support its position.

"Whatever limits on punitive damages might inhere in the due process clause would depend on consideration of the amount and circumstances of prior punitive damage awards," said the court. "However, appellant (Celotex) apparently failed to bring to the district court's attention the existence and details of such awards against it."

Juries have awarded more than \$155 million in punitive damages against Celotex in 1989, according to Asbestos Litigation Reporter and Mealey's Litigation Reports-Asbestos. However, most of these verdicts are subject to post-trial motions and appeal.

Attorneys for the company say they will not appeal the new ruling.

In affirming the lower court award in an Oct. 5 decision, the 2nd Circuit also indicated that any action on unrestrained punitive damage awards must be national in scope.

"Particularly in the context of mass tort litigation, (there is) a need for a uniform, national rule on the issue," the court said. "Under all circumstances, we believe that such a step, if it is to be taken (and we express no view as to that), is best left for Congress or for a higher judicial authority."

The 2nd Circuit noted that the U.S. Supreme Court also recently cited the due process clause in questioning the constitutionality of unlimited punitive damage awards.

In *Browning-Ferris Industries Inc. vs. Kelco Disposal Inc.*, all nine Supreme Court justices indicated that they want to consider whether such punitive awards violate the due process clause (BI, July 3).

However, the court ruled that *Browning-Ferris Industries* did not make the due process argument early enough in the proceedings for the court to address it on appeal.

"The 2nd Circuit decision once again shows that courts may be receptive to due process arguments, but they must be explicitly made in the trial court with an ample record both in terms of the facts and briefing materials," said product liability attorney Victor Schwartz of Crowell & Moring in Washington, D.C.

Celotex attorney Andrew Berry of McCarter & English in New York said: "Somewhere, sometime in the not too distant future some court is going to say 'no more!' to punitive damages."

Mr. Berry said eliminating multiple punitive damage awards for the same course of conduct is especially appropriate in asbestos cases.

"The sheer volume of the litigation and the repeated demand for punitive damages have had a detrimental effect, in some cases depriving plaintiffs of compensatory damages," he said. In addition, the awards have forced some asbestos manufacturers into bankruptcy, he noted.

For example, Raymark Industries Inc. was forced into bankruptcy by a \$75 million punitive damage award in 1987 (BI, Nov. 16, 1987).

Jack P. Racich and Gertrude C. Racich vs. The Celotex Corp.; U.S. Court of Appeals for the 2nd Circuit, No. 89-7164.



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SONY

End to Mexican protectionism?

Plan may end 50 years of overregulation for maquiladoras

By Douglas N. Smith

BY AND LARGE, the Mexican government has historically controlled insurer solvency through a combination of strict underwriting, tariff rates and restricted entry into the marketplace. While intended to support the local market, these measures have actually encouraged policyholders to seek more cost-effective non-admitted coverage for perils such as flood and earthquake.

But in a break with tradition, Mexico's proposed Solvency Margin System—a new productivity plan for the financial and insurance sectors—aims to eliminate much of the protectionism that has overregulated the Mexican insurance industry for more than 50 years. The deregulation process is expected to benefit policyholders by allowing:

- Dismantled tariff rates.
- Master "all risk" excess/difference-in-conditions policies to be issued in Mexico. Besides allowing local loss recovery, premiums are tax deductible.
- Policy terms and conditions that are comparable to those offered in more advanced markets.
- Potential coverage for current mandatory gaps, such as 25% coinsurance on earthquake property damage.

Although these changes are awaiting legislative approval by the Camara de Diputados, critics of Mexico's maquiladora industry already fear that a more competitive insurance market will foster a new influx of "in-bond" plants.

Indeed, at year-end 1988, Mexico's maquiladora industry numbered more than 1,500 in-bond plants and approximately 390,000 employees. Maquiladoras, which are the country's second largest foreign-income earner, process imported materials and components into exportable products that are destined primarily for U.S. markets. Bilateral treaties permit the imported materials and components to enter Mexico duty-free as long as 80% of the reworked or finished product is re-exported from Mexico. Likewise, reciprocal U.S. tariff rules levy custom duties only on the goods' value-added in Mexico, primarily the cost of labor.

Mexico's wages, which presently average \$1.40 an hour in Tijuana maquiladoras, have been kept low by frequent peso devaluations. For this reason, Mexico's 2,000-mile northern border area has been edging out South Korea and other Pacific Rim countries as a low-skill, low-wage job locale.

Since the boom in this sector is expected to continue, let's examine the mechanics of insuring a maquiladora.

In cases where the insurance interest is situated in Mexico, the law provides that all insurance must be written with insurance companies authorized to do business in Mexico. Non-admitted insurance premiums are not allowed as local income tax

International issues

deductions.

Depending on the type and size of the maquiladora, construction typically takes 15 months from start to finish. During this time, the U.S. multinational's investment should be protected through both the construction and the post-construction phase.

The construction phase starts before breaking ground, when a contractor's all-risk policy is issued. This policy protects all parties against losses arising from either direct damage or third-party liability. A typical contractor's all-risk policy includes admitted coverage for physical damage to materials, structures and machinery, extra expense, debris removal, transit, storage, and installation of machinery and equipment.

Typically, the general contractor purchases the insurance and builds the cost into the contract price. In Mexico, however, the U.S. multinational should purchase insurance directly because legal contractors often do not understand the potential insurance expenses that a U.S. multinational can face. As a result, policy limits and conditions that are adequate for a Mexican contractor may be insufficient for a U.S. multinational.

A contractor's all-risk policy can be denominated either in pesos or U.S. dollars. But the policy premium and any losses must be paid in the same currency in which the policy was written.

Although the contractor's all-risk policy will provide post-construction coverage for the installation and testing of all machinery and equipment, the post-construction phase should actually begin when the construction phase is about two-thirds completed. In fact, the post-construction phase allows the maquiladora investor to organize both an insurance and an employee benefits program before construction and testing terminates.

The following recommendations should help U.S. risk managers to organize components of a maquiladora insurance program:

- **Fire insurance.** Fundamentally, two fire insurance policies are critical to a post-construction insurance program.

First, a peso-denominated fire policy should be written to cover buildings and contents purchased in Mexico. The peso policy should include an inflation-guard endorsement to ensure that the policy's limits will keep pace with Mexico's inflation rate (until the pre-selected inflation percentage amount has been used up).

Next, a U.S.-dollar policy should be written to cover imported raw materials, equipment and machinery. The U.S. multinational alleviates the risk of underinsurance arising from

currency devaluations when imported goods are insured in U.S. dollars.

- **Business interruption and extra expense insurance.** Since maquiladoras do not generate profits in Mexico, their interdependency exposure is best insured under the U.S. parent's program. But, continuing expenses and ordinary payroll are primary local concerns in the event of a loss. Thus, extra-expense coverage should be contracted locally to assist the maquiladoras after a major loss.

- **Transit coverage.** U.S. risk managers usually purchase a single policy that covers the entire transit cycle back and forth across the border. The policy can either be issued in the United States or Mexico, depending on terms of the sale. Mexican policies are available on an annual sales-based rate. The latter method is very popular because it reduces the local client's administrative work.

- **General liability insurance.** Since maquiladoras generally export all of their products, the U.S. parent should maintain appropriate product liability coverage on all imports. Otherwise, a maquiladora's general liability policy should cover the usual third-party exposures.

What policy limit is most appropriate in Mexico? The answer depends on the location, as well as on the assembly process, of the maquiladora. In general, U.S. multinationals are counseled to carry a minimum liability insurance limit equivalent of \$200,000. But, when a U.S. multinational uses a worldwide casualty insurer to front a policy, the worldwide program limit should be maintained locally.

- **Money and securities coverage.** Payroll security is a big area of concern because Mexican law requires that most employees be paid in cash. However, a maquiladora should establish security procedures before considering a local insurance policy. For example, armored vehicles can be hired to deliver the payroll and, for an additional fee, guards will distribute the payroll to each employee.

Money and securities coverage is very expensive in Mexico due to poor underwriting experience. Also, coverage applies on a scheduled basis, so the policyholder must report new locations immediately. Some U.S. companies have found it less expensive to institute security measures than to pay inflated tariff premiums for local money and securities insurance.

- **Burglary coverage.** Shift-operated businesses, such as maquiladoras, will always face the possibility of theft because large numbers of employees move around the plant at least three times a day. When adequate procedures are in place, however, the frequency and severity of such issues can be cut.

- **Automobile insurance.** To protect

against automobile hazards, the maquiladora first must identify its exposure. Questions to ask include:

- ✓ Are U.S. company-owned or leased vehicles traveling across the border to Mexico? If so, are they traveling on personal or company business or both?

- ✓ Are maquiladora-owned or leased vehicles traveling in Mexico?

- ✓ Are maquiladora- or employee-owned vehicles traveling across the border to the United States?

- **Workers compensation and employers liability insurance.** In Mexico, workers compensation is handled directly by the social system and employers liability insurance is not usually purchased since the local exposure is minimal.

- **Employee benefits.** Many maquiladoras today offer a growing number of employee benefit plans to all levels of employees, from assembly line workers to executives. Local life insurance companies administer most employee benefit programs. These include life insurance policies that cover both natural and accidental death, as well as policies for permanent disability and group major medical benefits. Aside from tax advantages, maquiladoras expect employee benefit plans to improve workers' productivity while attracting and retaining qualified personnel.

The types of benefit plans instituted by many maquiladoras include: obligatory plans (i.e., federal work law, social security and housing development fund); contractual plans based on the needs of individual contracts; and voluntary plans.

Time is one main criteria for structuring an employee benefits program. For example:

- ✓ Short-term plans may include a savings fund, a grocery allowance, tuition and scholarships, transportation allowances and productivity bonuses.

- ✓ Medium-term plans may include major medical and maternity expenses.

- ✓ Long-term plans may include retirement benefits, as well as coverage for permanent disability and death.

Barring a free trade agreement between the United States and Mexico, which does not appear imminent, maquiladoras are here to stay.

So if your corporation has plans to invest in a maquiladora, you must remember: Review your insurance needs before breaking ground—not after.



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.

ASK A BENEFITS ACTUARY

Non-discrimination rules for 1989 need simplifying

Q

What are the welfare benefit non-discrimination rules of 1989?

A

This question comes from a benefit manager who has noted that Internal Revenue Code Section 89 was recently repealed (*BI*, Nov. 13). The benefit manager has heard that Section 89 non-discrimination tests have generally been replaced with the health and welfare benefit

non-discrimination rules that were in effect prior to the Tax Reform Act of 1986. However, the benefit manager is not familiar with these rules.

The non-discrimination rules for health and welfare plans now in place for 1989 are generally simpler than the Section 89 rules, but they are not without their complications.

The group of employees in whose favor a plan cannot discriminate varies from benefit to benefit. In addition, some difficult calculations are required when a plan is found to be discriminatory.

For group term life insurance plans, IRC Section 79 now requires that a plan not discriminate in favor of "key employees" with respect to eligibility to participate and the type and amount of benefits available to participants.

As defined in the top heavy rules for pension plans, a key employee is an employee who during the current plan year or for any four preceding plan years meets one of the following criteria:

- Is an officer of the employer receiving annual compensation greater than 50% of the defined benefit dollar limitation (for 1989, 50% of \$98,064, or \$49,032).
- Is one of 10 employees receiving annual compensation from the employer greater than the defined benefit dollar limitation and owning the largest interests in the company.
- Is a 5% owner of the company.
- Is a 1% owner of the company and receives annual compensation in excess of \$150,000.

The prohibited group—the group in whose favor a plan cannot discriminate—for group term life insurance is different from the prohibited group for qualified retirement plans.

In general, a qualified retirement plan cannot discriminate in favor of a "highly compensated employee," as defined under IRC Section 414(q).

A highly compensated employee for 1989 is an employee who during 1989, or 1988:

- Was a 5% owner of the company.
- Received compensation in excess of \$81,720 (\$78,353 for 1988).
- Received compensation from the employer in excess of \$54,480 (\$52,235 for 1988) and was in the top 20% of employees in terms of compensation.
- Was an officer of the organization and received compensation greater than 50% of the defined dollar benefit limitation, subject to some limits on the number of officers.

The identification of key employees rather than highly compensated employees is certainly one complication in the 1989 non-discrimination tests for group term life insurance plans.

A group term life insurance plan is considered not discriminatory in favor of key employees with respect to eligibility to participate if it meets one of the following tests:

- The plan benefits 70% or more of all employees of the organization.
- At least 85% of all employees who are participants under the plan are not key employees.

- The plan benefits a classification of employees set up by the employer and found by the secretary of the Treasury not to discriminate in favor of key employees.

- In case of a cafeteria plan, the plan meets the requirements of IRC Section 125.

In determining whether a group term life plan is discriminatory with respect to eligibility to participate, certain employees may be excluded from consideration: employees who have less than three years of service; part-time or seasonal employees; and employees not included in the plan that are covered by a collective bargaining agreement.

A group term life insurance plan is considered not discriminatory in favor of key employees with respect to the type and amount of benefits available if the benefits available to key employees are also available to all participants.

A plan will not be considered discriminatory only because it bases benefits on a uniform percentage of compensation.

In testing group term life insurance plans, the tests are to be done on a controlled group basis. This represents a change from the pre-Tax Reform Act rules, since those tests were not required on a controlled group basis.

If a group term life insurance plan is discriminatory, the actual cost of coverage for a key employee—or, if greater, the cost of coverage based on IRS tables under IRC Section 79—must be included in taxable income. The determination of actual cost can be a difficult calculation since it requires the allocation of a portion of the employer's net premium (the total premium less the policy dividends, premium refunds or experience rating credits) to each employee. The allocation is to take into account both the amount of insurance provided to the key employee and the employee's age.

This allocation can be difficult when a single policy dividend is paid for several coverages (for example, group term life insurance coverage, medical coverage and long-term disability insurance). Even without this complication, the allocation of cost to key employees can be a very laborious calculation.

Self-insured medical plans cannot discriminate in favor of "highly compensated individuals" with respect to either eligibility to participate or benefits provided. These rules are applied on a controlled group basis.

To avoid being considered a self-insured medical plan, a plan sponsor must transfer risk of loss to an unrelated third party under a group accident and health insurance policy or to a health maintenance organization. Administrative services only arrangements are considered to be self-insured.

One complication in determining whether a self-insured medical plan is discriminatory concerns determining who comprises the prohibited group. Surprisingly, the group of highly compensated individuals can be different from the highly compensated employees under IRC Section 414(q).

A highly compensated individual for purposes of a self-insured medical plan is:

- One of the five highest-paid officers.
- A shareholder who owns more than 10% of the value of the stock of the company.
- Among the highest paid 25% of all employees.

A self-insured medical plan does not discriminate in favor of highly compensated individuals with respect to eligibility to participate if:

- 70% or more of all employees participate.
- 70% or more of all employees are eligible to participate and 80% or more of those eligible actually do participate.

- Employees participate under the plan based on a classification set up by the employer and found by the secretary of the Treasury not to discriminate in favor of highly compensated individuals.

Certain employees may be excluded from determining if a plan discriminates with respect to eligibility to participate: employees who have less than three years of service; employees who have not attained age 25; part-time or seasonal employees; and employees not covered under the plan but who are

covered under a collective bargaining agreement.

The coverage tests are very similar to some of the current pension coverage requirements. The IRS has issued complex proposed regulations to implement these pension coverage requirements. Fortunately, the legislative history to the repeal of Section 89 notes that while the self-insured medical plan coverage rules (and those applicable to group term life insurance plans) are similar to the pension coverage rules, the secretary should, where appropriate, interpret those rules in a manner different from those that apply to qualified retirement plans, even where the statutory requirements are similar. It is unclear what effect regulations from the Treasury Department will have on these coverage rules.

A self-insured medical plan is discriminatory with respect to the benefits it provides unless all benefits provided to participants who are highly compensated individuals are also provided to all other participants.

When a plan provides self-insured medical benefits to highly compensated individuals that are not provided to all other participants, the reimbursements paid under the plan to highly compensated individuals are subject to tax. If a plan discriminates with respect to eligibility, then a fraction of the reimbursements paid to the highly compensated individuals under the plan is taxable income.

The numerator of the fraction is the total amount reimbursed to all employees under the plan for the plan year. It may be difficult for claims administrators to determine the numerator of this fraction without the employer specifying the individuals who are "highly compensated individuals."

Several non-discrimination tests apply to cafeteria plans on a controlled group basis. A cafeteria plan is considered to discriminate in favor of key employees, as defined above, if the non-taxable benefits provided to key employees exceed 25% of the aggregate benefits provided to all employees under the plan.

A cafeteria plan also is prohibited from discriminating in favor of "highly compensated individuals" with respect to eligibility to participate and "highly compensated participants" with respect to contributions or benefits. For purposes of determining if a cafeteria plan is discriminatory, the group of "highly compensated participants" can differ from both the group of highly compensated employees and from the group of highly compensated individuals used in determining discrimination for a self-insured medical reimbursement plan.

For cafeteria plans, a "highly compensated individual" is an individual who is:

- An officer.
- A shareholder owning more than 5% of the voting

Continued on next page

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

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

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



Mr. Miner

Mr. Miner's and Mr. Sherman's columns appear alternately on the first Monday of each month. Mr. Duva's and Ms. Werner's columns appear alternately on the second Monday of each month. Mr. Miner's next column will appear in February.

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

Construction hazards

By The Insurance Institute of America

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

This month's question, answered on the basis of material presented in ARM 55, "Risk Control," highlights risk control measures for countering hazards to which buildings are particularly vulnerable during their construction.

Q: For each of the following sources of hazards to which buildings under construction are particularly vulnerable—cutting and welding, construction sheds, temporary heaters, wind and flammable liquids—explain in detail the nature of this vulnerability and describe two appropriate loss control practices for controlling that hazard.

A: In keeping with the question's wording, the following answer describes only one of the many hazards (and two appropriate controls for that hazard) for each of the hazard sources specified in the question. Many other answers would have earned full credit.

• Cutting and welding are particularly hazardous in construction sites because they generate sparks, often very close to large quantities of combustible construction materials. These activities also require

Loss control cuts building exposures

A.R.M. exercises

tanks of compressed oxygen and/or acetylene that may explode or rupture.

Suitable safety measures include minimizing the quantity of flammables in the areas where welding and cutting are done and chaining all oxygen or acetylene tanks to prevent them from becoming "rockets" if they do rupture.

• Construction sheds are very vulnerable to fire damage because they are often only temporary buildings made of wood or other combustible materials, erected without sprinkler protection to hold large quantities of flammable materials very near construction activities in convenient but exposed locations.

Suitable countermeasures include locating construction sheds at safe distances from actual construction activities and controlling ignition sources near these sheds.

• Temporary heaters to warm construction workers are a particular danger because they are a major ignition source, often poorly maintained and frequently refueled while still lit by untrained workers. Furthermore, these heaters may tip because they are placed on unlevel ground or are

bumped by construction equipment or workers.

Two precautions against these losses are to carefully maintain properly selected heaters and to select and thoroughly train those employees authorized to start and refuel them.

• The walls and roofs of buildings under construction are more subject to wind damage while the building is open to the elements than they are in a closed structure that winds cannot so easily enter.

Appropriate controls include proper design and application of roofs as well as anchoring or weighing down each wall and roof element as it is erected.

• Flammable liquids are a particular hazard at construction sites, where conditions often make it difficult to properly store, mark and handle the frequently large quantities of such liquids that construction activities require. Furthermore, many construction activities involve potential ignition sources from which it may be difficult to separate all flammable liquids.

Suitable controls include storing flammables in isolated shelters on the boundaries of construction sites and transporting only minimal amounts within the site during daily construction activities.

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

Anxiety attack over layoff not compensable

Being laid off because of modernization was a normal working condition, according to a Pennsylvania appellate court. Thus, the court held that a bookkeeper's subjective anxiety reaction to that fact did not provide a basis for a workers compensation award.

Zetta Kemp had been employed as a bookkeeper for the Elkland Electric Co. for more than 10 years. She allegedly was in good health until she read in a newspaper article that her job would be eliminated because her employer was going to computerize her department. Subsequent conversations with her employer confirmed this information. Ms. Kemp learned that she would be laid off in March 1985. Soon after learning this, Ms. Kemp began to experience certain symptoms including insomnia, colitis, loss of weight, depression, chronic pains and discomfort. She filed for work comp benefits alleging that she had sustained a work-related psychic injury caused by her employment or, rather, her unemployment. She was denied benefits.

Legal briefs

The appellate court noted that Ms. Kemp had suffered no inability to perform her work duties and there was no indication that she was mistreated in any way by her employer. According to the court, where an employee seeks compensation "benefits alleging a psychic injury, the injury must arise in the course of employment and be related thereto, and its occurrence must be adequately pinpointed." Furthermore, the court said that the employee must demonstrate that the injury was due to a subjective reaction to normal working conditions. Being laid off because of modernization was a normal working condition, the court concluded. The court affirmed the denial of benefits. *Kemp vs. W.C.A.B. (Elkland Electric Co.)*, Commonwealth Court of Pennsylvania, Nov. 9, 1988 (BI/02/Oct.-\$10).

New cancer treatment covered

In a decision only recently reported, an

Ohio appellate court held that immuno-augmentive cancer therapy was covered by a group health insurance policy as a "medically necessary" service, even though the therapy was not approved for use in the United States.

Edith Taulbee and her husband were covered by a group health policy issued by Travelers Corp. Jerry Taulbee was diagnosed with a nodular-type lymphoma—a malignancy—by biopsy in January 1984. Initial chemotherapy was unsuccessful.

In March 1985, he went to the Immuno-Augmentive Therapy Bahamas Ltd. clinic in the Bahamas to receive treatment known as immuno-augmentive therapy for the malignancy. Such treatment was an unproved cancer therapy not approved for use in the United States. The treatment lasted from March 4, 1985, to May 31, 1985, with observed marked improvement. Mr. Taulbee submitted

claims for the medical services, including the IAT treatment, which alone cost \$8,480. The insurer denied this portion of the claim asserting that such charges were not that of a hospital or physician. This suit ensued. The trial court ruled for Mr. Taulbee.

The appellate court said that reasonable minds could find that the charges here for physicians' services for medical care and treatment were within the coverage provided by the insurance policy. The court was satisfied that Mr. Taulbee had introduced competent evidence that the immuno-augmentive therapy was effective. *Taulbee vs. Travelers Cos.*, Court of Appeals of Ohio, Dec. 7, 1987 (BI/03/Oct.-\$10).

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

Ask a benefit actuary

Continued from previous page
stock of the company.

- Highly compensated.
- A spouse or dependent of an individual described above.

A "highly compensated participant" is a "highly compensated individual" who is also a participant.

A cafeteria plan is not considered discriminatory with respect to eligibility to participate if it bases eligibility on a classification of employees set up by the employer and found by the secretary of the treasury not to be discriminatory in favor of highly compensated employees (as defined under IRC Section 414(q)); and,

if the plan does not require an employee to complete more than three years of employment as a condition of participation under the plan.

A cafeteria plan will not be considered discriminatory in favor of highly compensated participants with respect to contributions and benefits where qualified benefits and total benefits (or employer contributions allocable to statutory non-taxable benefits and total benefits) do not discriminate in favor of highly compensated participants. Certain special rules also apply for determining whether a cafeteria plan that provides health benefits is discriminatory. Fortunately, the non-discrimination tests for 1989

for dependent care assistance plans are generally the same as those required in prior years. However, tests for non-discrimination are, with respect to highly compensated employees, as defined under IRC Section 414(q). Consequently, some employers will then have four distinct "prohibited groups" for determining whether health and welfare plans are discriminatory.

One hopes that Congress' zeal to relieve employers of unduly burdensome and overly complex non-discrimination rules does not end with the repeal of Section 89. There are certainly many obvious ways to simplify health and welfare non-discrimination rules that are still on the books.

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Physical Damage by
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New budget bill to increase maximum Social Security tax

By ADRIENNE C. LOCKE and JERRY GEISEL

Washington

WASHINGTON—Social Security taxes paid by employers and highly-paid employees will rise next year under a provision in the recently passed budget reconciliation bill.

Under the provision, the Social Security Administration will include pretax contributions to 401(k) salary reduction plans in the formula that determines the maximum amount of wages subject to the FICA tax.

Pretax employee 401(k) contributions are not currently considered.

With the change in the calculation formula, the maximum amount of wages subject to 1990 Social Security tax will be \$51,300, according to the Social Security Administration. Prior to that change, the maximum amount of wages that were to have been subject to the FICA tax next year

would have been \$50,400, up from \$48,000 this year.

As of Jan. 1, employers and employees each will pay a FICA tax of 7.65%, up from 7.51% this year.

With this increase in the wage ceiling, the maximum tax paid by employers will rise to \$3,924.45 per worker in 1990, up from the previously scheduled maximum of \$3,855.60.

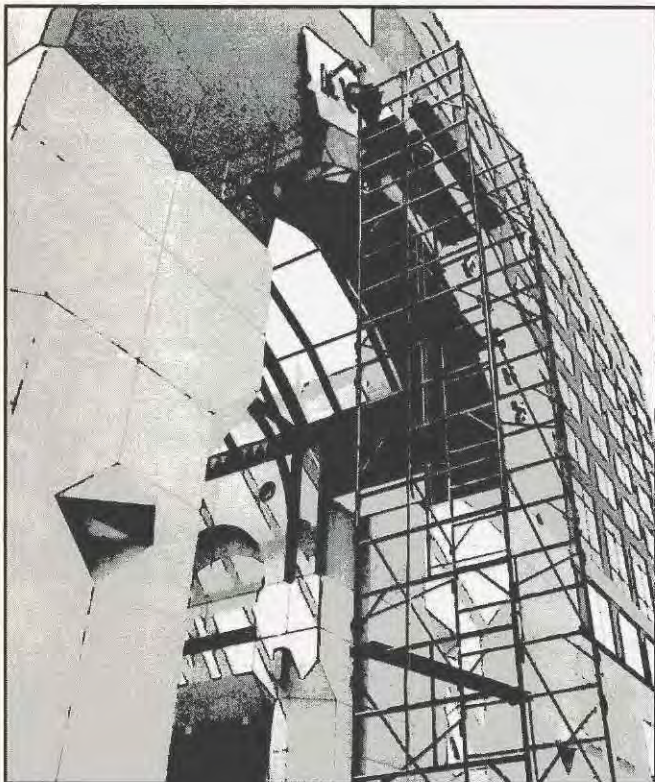
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Agent/Broker Topics

A monthly editorial section sent exclusively to agents and brokers

Agents eye life sales as a new addition

Cross-sales can aid account retention

By LAURA MAZZUCA

Adding life insurance to a property/casualty agency's product offerings can provide not only a competitive edge but a new source of revenue—once an agency gets out of the starting blocks.

But while recent surveys found that four-fifths of all agencies now are selling some life insurance or financial services products, those sales account for only a tiny portion of total agency business in most cases. Lack of time and lack of expertise in the life insurance business are commonly cited as reasons for disappointing results.

More agents than ever are selling individual financial products—such as life insurance, disability coverage and estate planning services—to the executives of their corporate commercial clients because "they realize they have to do it in order to hold onto their accounts," said Kim Patterson, an agency consultant and president of Creative Insurance Marketing in Red Bank, N.J.

The benefits are obvious, experts say. Individual life and financial products—or "income replacement products" as one agent more broadly termed them—are a natural for agents to cross-sell to commercial clients, a good way to reinforce retentions and can be a low-overhead income generator.

Statistics show that more

agencies are taking up the call. A recent Independent Insurance Agents of America survey found that 80% of its members sell some form of life insurance. However, individual life sales account for only 5% to 6% of responding agencies' total income, the survey found.

Recent statistics from the National Assn. of Professional Insurance Agents of Alexandria, Va., tell a similar story. While three-quarters of PIA's nationwide members sell some form of individual life or health-related products, 65% of those that do say the sales comprise 25% or less of the agency's total book of business, said a PIA spokesman.

And of that 65%, almost half say that life/health sales make up less than 4% of the agency's book of business.

Agency management consultants like Russell Miller Inc. in San Francisco suggest that an independent agency's life insurance revenues can comprise as much as 25% of its property/casualty commissions.

The number of property/casualty agencies adding life insurance departments will continue to show "slow but steady increases," not all of which is attributable to agents' increasing ambition, said Richard J. Kasyjanski, vp of agency services for the IIAA in Alexandria, Va.

Some of increase reflects agency mergers, as strictly property/casualty agencies acquired agencies with life de-

partments, said Mr. Kasyjanski.

And, the rise also reflects multiline insurers increasingly requiring life volume commitments from their property/casualty agencies, according to Mr. Kasyjanski (see story, page 32H).

Agency observers, and agents themselves, say that a lack of time and of expertise hurt some agencies that try to expand into life insurance and financial products.

"Most property/casualty agents are so overwhelmed with their own business that asking them to sell life is like saying, 'Why don't you sell cars or real estate in your spare time?'" said Loren L. Coppock, president of Davis-Jones-Lamb Insurance in Cedar Rapids, Iowa.

The road to life insurance sales is strewn with hazards, agents say. Successful agencies stress the importance of finding and hiring—or contracting with—an experienced life producer to launch the department (see story, page 32B).

This can even be done by small agencies if they work closely with insurers or become educated life producers themselves, said Patricia A. Borowski, vp of government and industry affairs for the PIA.

And the efforts can pay off handsomely.

Most agents cite "account rounding"—filling all of an

Continued on next page



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Continued from page 32C

principal because "it becomes difficult to determine who owns the business and who services the customers," said Robert S. Hensley, vp of financial services and sales for Travelers Corp. in Hartford, Conn. Travelers suggests agencies hire, rather than contract with, life producers.

When dealing with outside contractors, an agent must also contend with the problem of split commissions, added Mr. Coppock.

Bennett-Elbert Co., an agency in Lake Jackson, Texas, attempted to start a life sales division three times "without much success" because the producers did not work out, said President Doug R. Bennett.

For instance, one life producer, hired on a contractual basis, generated good sales, but "every time he had a good month, he wanted to change his contract" to a more favorable commission split, said Mr. Bennett.

Other agency principals decided to become life experts themselves.

But, before an agency takes this step, "make sure at least one principal has a life education," said Mr. Lubin. This could mean attaining a professional designation such as the Certified Life Underwriter designation, or taking intensive courses.

In addition, Mr. Lubin recommends Insurance Marketing Services' "LifePlus" membership program, which offers property/casualty agents a number life insurance sales services. For instance, "LifePlus" members receive a monthly newsletter and consulting assistance for hiring new life producers.

But even in-house staffing—the method that most agents recommend as the most efficient—can have its problems, the biggest of which is finding and keeping good life producers, said Ms. Paterson.

Arnold K. Davis & Co. in New York has had producer hiring problems, said Vp and Chief Executive Officer Paul S. Wasserman.

When Davis & Co. launched its life division more than a year ago, it hired a life producer through an employment agency who initially seemed to work out well, said Mr. Wasserman. But the relationship soured when the producer began placing business with insurers the agency was not contracted to write business for, he said.

The producer was subsequently dismissed and another producer added, Mr. Wasserman said.

Although most experts recommend hiring a former or current life producer to do the job, there are exceptions to this rule as well.

"Life companies are not necessarily the best place to find producers," said Mr. Haack. Although Mr. Haack's agency has hired its share of experienced life producers for its two separate life insurance and benefits divisions, Mr. Haack noted he is not averse to considering a producer

from outside the insurance industry.

A case in point is Mr. Coppock's agency. Although two of the agency's three life producers were formerly full-time life salesmen, the third had no sales experience when he was hired to replace another life producer who did not work out, he said.

Insurers, anxious to develop more life insurance and financial product volume for themselves, usually are eager to help property/casualty agents learn the business because of the built-in prospecting base they have in their commercial books of business, said Mr. Adler of Meserow.

Both life and multiline insurers offer property/casualty agents a variety of assistance programs, ranging from financial assistance in hiring a producer to supplying agents with printed sales material.

Mr. Coppock's agency used such a program for neophyte producers. A "green" producer was trained for a

year at a Northeastern Life Insurance Co. of Philadelphia branch office before starting at the agency.

Northeastern absorbed training costs as part of its agency assistance program, and the producer came on board at Mr. Coppock's agency after successfully completing the course.

Regardless of how an agency hooks up with a life producer, that producer's progress must be watched closely. How that occurs depends in part on any contractual arrangements the agency has with the producer—such as the type of sales he intends to specialize in and the volume he plans to produce—and on the producer himself.

For instance, Haack & Associates tracks the performance of its life and benefits producers the same way it does its commercial property/casualty salespeople, said Mr. Haack.

The agency and the life producer set specific sales goals when the pro-

ducer is hired, and monitor them "as frequently as possible," he said.

The Davis-Jones-Lamb agency's producer monitoring system is similar, said Mr. Coppock.

All producers are required to file a marketing plan each October for the upcoming year, which includes segments of business on which the producer will be concentrating, said Mr. Coppock.

The producer then sets commission goals in each area, and determines whether he will need agency assistance in attaining them.

The sales manager of each department then establishes a monthly sales progress chart for both the agency and the individual producer, which is used as the springboard for monthly sales meetings with the producer, said Mr. Coppock. This chart tracks how many applications the producer submitted and the commission percentage for each.

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Insurers offer many types of life products

By LAURA MAZZUCA

Independent property/casualty agents and brokers are moving to meet the increasingly complex business and personal needs of their clients by selling today's more sophisticated life insurance and disability products.

Agents and brokers who market life insurance products by cross-selling to affluent executives of their client corporations are using these products not only to provide death benefits, but also to fund future business and personal needs through services like estate, perpetuation and buy-sell agreement planning.

This helps both the agent and the

client because sales of life insurance and other financial services products result in increased revenue, improved relations with insurers and better client retention.

Insurers have responded to the demand for more complex life insurance products by offering their agents other products geared to the specialized needs of today's consumer.

"Everybody out there is trying to sell ordinary life insurance," said L. Keith Holloway, senior vp, chief operating officer of Pekin Life Insurance Co. in Pekin, Ill. But to remain competitive, an insurer must offer its agency force a variety of products for agents to sell to their clients, such as the long-term

health care coverage, individual retirement accounts and Keogh plans, and Medicare supplement insurance that Pekin offers, he said.

Most independent property/casualty agents who cross-sell life insurance and other financial products to their corporate clients report that clients are primarily interested in whole and universal life coverages.

For instance, most of Wolff, Zackin & Associates' corporate property/casualty clients are interested in variable and universal life, whole life and disability insurance, said Gregory S. Wolff, vp of the Vernon, Conn., agency.

Universal life hinges on the

"cash value," or the build-up of dollars in the fund beyond the cost of the policy, he explained.

Under both whole and universal life, the policyholder can receive the policy's cash value in a lump sum if the policy is surrendered.

Because of this cash availability, universal and whole life coverages are popular with buyers doing both personal and professional long-term planning, whether they are funding a retirement, a child's college education or a business acquisition, said Mr. Wolff.

These more sophisticated buyers prefer universal life rather than term coverage because of the tax-deferred accumulation account, he added. Interest rates payable on

universal life policies now are closer to 9% compared with the 3% to 4% payable many years ago, noted Mr. Wolff.

The latest quarterly report compiled by A.M. Best Co. on universal life policies bears this out. Current returns on such policies can run as high as 11%, with a median of 9% and a low of 7.75%.

Best's bases its statistics on 176 universal life contracts of more than 100 insurers, using a \$100,000 policy for a 45-year-old male non-smoker as an illustration.

These generous interest rates allow creative agents to "help clients understand both the issue they need to address and the alternatives, and to help explain the role life insurance can play" in achieving their goals, said William Haack, president of Frank F. Haack & Associates Inc. of Milwaukee.

For example, many of Haack & Associates' executive clients are covered under group term life insurance plans through their corporations, said Mr. Haack.

However, term life—with its limited coverage period and lack of cash value—is not always a good benefit for executives, he said.

The agent's job is to help the client compare his current coverage with alternative "regular or specialized insurance policies" that will meet both the executive's immediate and future needs, said Mr. Haack.

Mesirow Finances, a division of Mesirow Insurance Services Inc. in Chicago, frequently recommends a blend of whole, term, universal life and variable life—in which the policyholder's funds are invested in various investment portfolios—to suit the client's unique needs, said Vp Jeffrey S. Adler.

For example, Mr. Adler recently was referred to one of Mesirow's property/casualty division manufacturing clients who needed some financial planning for both his business and personal life.

He learned that the businessman's long-term plans included perpetuating the business to his only child.

More immediately, however, the client wanted to develop a strategy that would create an incentive for independent manufacturing representatives to carry and sell his company's products.

To satisfy the first need, Mr. Adler developed a buy-sell agreement that will enable the son to purchase the business through funds generated by a life insurance policy purchased by his father, Mr. Adler explained.

And, to offer the client's manufacturing representatives some incentive, Mr. Adler created a plan that would offer the salespeople a tax-deferred bonus for achieving and sustaining production goals.

To do this, the employer purchased a life insurance policy on each salesperson. If the salesperson maintains the specified production level for seven years, he or she can surrender the policy and collect the cash that has accrued, said Mr. Adler.

In this instance, Mr. Adler used a combination of whole life insurance and an "additions rider," which allowed the manufacturer to put extra money into the policy's cash value to increase the incentive to the manufacturer's rep.

To fund such programs, Mesirow generally uses either universal or whole life policies, said Mr. Adler.

However, agents or brokers must study many variables before determining a strategy for a client, such as the client's cash flow, health

Continued on next page

January

Consumer Relations

Agents and brokers are trying to improve their image. This issue will explore consumer relations in an industry confronted by new legislation, regulation and consumer activism.

Issue: January 1, 1990
Ad Closing: December 18

February

Franchising/Clustering

Only a few franchises exist in today's market. BI will report on why franchising has faded and examine the growth in clustering — agents pooling resources for administrative and clerical services while remaining autonomous.

Issue: February 5, 1990
Ad Closing: January 24

March

Agency-Insurer Relations/Errors & Omissions

Agents are looking for help from their insurers, and insurers are willing to give agents financial, marketing, training and other advice. But, is the price agents must pay for this help too high? In addition, this issue will examine how agents can prevent errors and omissions claims and how they can best finance the risk.

Issue: March 5, 1990
Ad Closing: February 20

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Agent/Broker Topics

New products

Continued from previous page condition and age, he said.

Whole life insurance often makes more sense for younger clients, since they have a longer period in which to pay into the policy, and the cost per \$1,000 over that time is considerably less expensive than term or universal life, Mr. Adler said.

But there was a time not so long ago when policyholders would have been content with an inflexible term insurance policy, said Mr. Holloway of Pekin Life, a subsidiary of property/casualty insurer Pekin Insurance Co.

The life division has been marketing life coverage solely through Pekin's independent property/casualty agent force for more than 25 years.

The life insurance market changed drastically from the mid-1970s, when term life was still popular, to the early 1980s, when the "universal life revolution" occurred, said Mr. Holloway.

In the early 1980s, fluctuations took place in the three areas that affect life insurance pricing: mortality, investment experience and expenses like commissions, said Mr. Haack.

Over time, as expenses and mortality rates dropped and as insurers' rate of return on invested premiums rose, insurers were able to offer their clients higher yields and more competitive products, he said.

While interest rates payable on all types of life insurance rose, universal life sales benefited the most, said Mr. Haack.

This is attributable to the fact that the interest rates on the more traditional whole life policies reflect the performance of a complete portfolio of the insurer's other products, while universal life interest rates are based on just that product's performance, he said.

Today, although universal life is still popular, it is losing ground to other coverages because buyers recognize that short-term guaranteed interest rates offered under universal life policies do not necessarily offer the best results over the long run, he said.

In fact, with his clients and the industry in general, whole life policies "have experienced a resurgence in popularity," noted Mr. Haack.

This change in trend is borne out by statistics provided by the Life Insurance Marketing and Research Assn. Inc. International in Hartford, Conn.

Whole life, which traditionally held the lion's share of the life insurance market with as much as 71% in 1982, dropped to a 47% share of the market in 1985 and 1986—universal life's peak years.

But whole life began making a comeback in 1987, garnering 51% of the life insurance market. In 1988, whole life climbed to 53% of the market.

In comparison, term life insurance comprised only 13% of the life marketplace in 1988, compared with 18% in 1982. However, this is up from 12% in 1987 and 1986 and 11% in 1985.

Universal life, which grew from only 9% of the market in 1982 to a peak of 38% in 1985, fell to 35% of the market in 1986, 27% in 1987 and 26% in 1988.

Besides traditional universal, term and whole life, most insurers offer their independent agents and brokers other specialized products.

For instance, SAFECO Life Insurance Co., a division of SAFECO Corp. of Seattle, offers both improved life coverages and specialty coverages that can be packaged specifically to suit the client's needs, said Michael M. Pennington, vp of SAFECO Life.

SAFECO Life has improved its term life policies by lowering the mortality charges, or monthly premium charges, said Mr. Pennington.

Additionally, SAFECO offers a mortgage protection term life policy, the face amount of which drops as the policyholder pays off his mortgage balance, he said.

And SAFECO Life's newest product, "Valuespan," is a new type of universal life coverage that is "off to a strong start," he added.

Unlike regular universal life, Valuespan, which is predominantly aimed at business clients seeking to set up buy-sell plans, is a "front-loaded product," in which the policy's cash value and "surrender value" are the same after the first year, said Mr. Pennington.

CNA Financial Corp.'s third-generation universal life program, UL500, was launched about a year

ago.

The policies carry a minimum face value of \$500,000 and are aimed at older, affluent buyers, said James G. Pettorini, assistant vp of life, health and pension dis-

Whole life has 'experienced a resurgence in popularity,' says William Haack.

tribution for the Chicago-based insurer.

However, although CNA's independent property/casualty agents are primarily selling the insurer's whole life and universal coverage to their clients, CNA also markets

financial products like annuities, health insurance, business overhead and disability coverage, according to John R. Lusk, vp of CNA's property/liability distribution division.

Business overhead expense insurance is a form of disability income insurance designed to protect the business owner from revenue losses resulting from a partner's permanent disability, explained Mr. Lusk.

CNA also has recently introduced the Total Protection Plan, an individual long-term care insurance product, for its independent property/casualty agents to market to their clients, he added.

Total Protection Plan is a combination universal life and long-term health care policy. The plan, which provides two separate benefit packages—a life benefit and a long-term care benefit—is cheaper

than buying two policies because CNA administers the two coverages in tandem.

CNA's property/casualty agency force has been "enthusiastic" about the insurer's expansion of this product from group to individual application, said Mr. Lusk.

Most insurers work closely with their agents to help them market and customize these products for their clients.

For instance, Travelers Equities Sales Inc., a division of Travelers Corp. in Hartford, Conn., works closely with agents to create specialized packages for clients, said Robert S. Hensley, vp of financial services and sales for Travelers.

Travelers' field staff is available to assist agents with matching the right individual life, health and disability insurance, annuity and estate planning products to a particular client, Mr. Hensley said. ■

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Agents object to quotas for life products

By LAURA MAZZUCA

Property/casualty agents may want to complement their business by offering life insurance, but many independent agents balk at volume commitment requirements by some national multiline insurers.

Agents complain about insurers' high prices, average or inferior products and the "coercive" nature of the arrangements. In fact, some agents reportedly are buying policies for themselves or their families just to meet quotas.

Many multiline insurers, which say they have adopted the quotas in the last 10 years to penetrate lucrative life markets, stress their extensive assistance plans and programs they offer agents. And, recognizing the burden placed on agents, some multiline companies say they now require life volume commitments only from preferred agents.

"Almost every property/casualty insurer has been in here trying to sell his (life insurance) products, which are very average," said Loren L. Coppock, president of Davis-Jones-Lamb Insurance in Cedar Rapids, Iowa. "They feel like they don't have to be good, because they're just dabbling in life, just like many agents."

"Some companies have not adapted their products to make them more competitive," observed Richard J. Kasyjanski, vp of agency services for the Independent Insurance Agents of America Inc. in Alexandria, Va.

Mr. Kasyjanski said many IIAA members complain about high prices, excessive limitations and exclusions, and low rates of return on the life insurance products some property/casualty insurers require them to sell.

The requirements leave agents between a rock and a hard place, he said: If they do not market the products, they fear insurers will cancel agency contracts; and, if they do, they may jeopardize relationship with existing property/casualty clients, who are the primary target market for these products.

Many agents feel so pressed by these requirements that they purchase life insurance for themselves or family members simply to meet the volume requirements.

"It's fairly common. A lot of agents do it," said one agent who asked not to be named. "But there's a certain amount of coercion to it."

The agent said he had just tried to placate a major property/casualty insurer by purchasing several life policies for himself.

It was a "a reasonable deal. I don't feel like I was ripped off," he said. But the commissions he earned on the life product are low and he feels he probably could have found a better product at a lower price.

Although life insurance volume requirements are a fact of life in the industry, other observers say excessive volume commitments and threats of cancellation are the exception rather than the rule.

"That kind of hard-line attitude on the part of an insurer is really rare," said Patricia A. Borowski, vp of government affairs for the National Assn. of Professional Insurance Agents of Alexandria, Va.

Rather than simply making unreasonable demands on their agents, she said, most multiline insurers concern themselves with *why* agents have trouble marketing life products: Can an agent devote enough time to life sales? Does he target the correct market? Is the product itself flawed?

And insurers, who are also anxious to see volume grow, are willing to help agents, she said.

In fact, agents should take full advantage of assistance plans offered by virtually all insurers, said Mark Lefenfeld, a consultant with Russell

Miller Inc. in San Francisco.

"Multiline insurers can fill a real need for the property/casualty agent if he recognizes the ways to use that insurer most effectively," he said.

Multiline companies have had life insurance volume requirements for at least 10 years—dating back to the time when most of them established separate life insurance divisions—but these commitments were initially "minimal," said Steve Brill, director of member insurance programs for the IIAA.

However, as life sales have grown more profitable over the last four or five years, volume demands have increased and are now built into insurers' profit-sharing or preferred agent programs, he said.

Commission requirements vary, with "one of the worst" insurers requiring between \$5,000 and \$10,000 commission in life sales from its contracted property/casualty agencies, said Mr. Kasyjanski.

Small agents are hit especially hard, since they generally cannot spread out the required sales over a large commercial book of business.

However, the magnitude of these commission requirements is in the eye of the beholder, said Mr. Lefenfeld.

Insurers generally require a small volume commitment, a "warm-up" to help an agent feel comfortable with a new product, he said.

For instance, Mr. Coppock noted that one of his agency's multiline insurers required \$6,000 in annual life commissions. Since the agency generates more than \$500,000 in first-year life commissions, this is no hardship, he said.

"If the product is really bad, I'd object (to volume commitment), but if one or two are buried in the portfolio, that's not bad," said Mr. Coppock.

"Anyway, usually the volume requirements are so small and mediocre that it doesn't matter much."

Some property/casualty insurers only set life volume requirements for their preferred agents.

"Most of the agents we deal with are independent, entrepreneurial types who represent many companies," said Robert S. Hensley, vp of financial service sales for Travelers Corp. in Hartford, Conn.

Because of this, Travelers believes that volume quotas would make the insurer less competitive against the other companies, so it limits quotas to its "Tower" and "Key" preferred agency programs, offering increased commissions and profit-sharing payments to those agents with sizeable growth.

CNA Financial Corp. also requires life volume commitment from its preferred "High Performance" agencies, which comprise about 20% of its total agency force, said James Pettorini, assistant vp of life/health pension distribution for the Chicago-based insurer.

However, many agents say they are more concerned about the quality of life insurance products than about meeting life sales quotas.

"Morally and professionally as an insurance person, I have a totally different responsibility to the insured and the handling of a life product vs. property and casualty," said Willis Hargrave Jr., president of Harco Insurance Services agency in Houston and former national president of the PIA. "The companies basically don't understand that."

Because a life insurance contract is so different from a property/casualty policy, some agents worry that mandating coverage from a single insurer would not best serve their multiline clients.

"The problem isn't volume commitment, but product," said Paul S. Wasserman, vp and chief operating officer of Arnold K. Davis & Co., a

New York agency. "We're just not comfortable with the product they have," he said, referring to the "really inferior" life product of a national multiline insurer.

While his agency has had a preferred agent contract with the insurer for 20 years, Davis & Co. refuses to sell the life product because of its poor quality, he said. The agency has already discussed splitting up the insurer's book of business with other insurers in anticipation of having its contract canceled, he added.

Other agents are concerned about the stability of many of the property/casualty insurers' relatively new life insurance divisions and prefer to deal only with old, established life insurers.

"You've got to be able to transfer risk to a carrier which is financially stronger than your clients," which is not always simple to do if the agency's clients are large and upscale, said Jeffrey S. Adler, vp of Mesirow Finances, part of Mesirow Insurance Services Inc. in Chicago.

Mesirow goes through a rigorous due-diligence process when choosing life insurers it represents, though it generally chooses "very large, old-line insurers," such as Guardian Life Insurance Co. in New York, said Mr. Adler.

Since 300 of the nation's 1,800 life

insurance companies are rated A-plus by A.M. Best Co., "it would seem to me you should find exactly what you want from those 300," he added.

William Haack, president of Frank F. Haack & Associates in Milwaukee, agrees, noting that his agency deals only with life insurance companies, not life insurance divisions of multiline insurers.

"I'm a firm believer in representing excellent companies, especially in the life insurance business, because people will own the product for a very long time," he said.

However, a multiline insurer can offer the same stability because of its commitment to the market and product line, said John W. Bingham, director of producer development and marketing training of the Personal Financial Security Division of Aetna Life & Casualty Co. in Hartford, Conn.

"We are interested in long-term relationships and products that are fairly priced, rather than the short return," he said.

In fact, although Aetna's personal financial division was established as a separate unit only in 1982, the insurer has offered life products to independent agents since before the turn of the century, Mr. Bingham added.

Aetna's life insurance commissions

are typical of the industry, he said, usually between 45% and 55% of the first year premium.


Mr. Bingham also disputed the charge that major multiline firms offer over-priced products.

Agents who say monoline life insurers beat Aetna products on price "may be correct" if they compare current interest rates, said Mr. Bingham. However, products such as universal life typically are sold under both current interest rates—or what percentage the company pays on the investment portion of the policyholder's premium—and guaranteed interest rate—or what percentage the company guarantees as a return to policyholder—and in this area Aetna is "very competitive," he said.

In fact, Mr. Bingham believes that many producers may be disgruntled because Aetna and other multiline insurers have reduced auto insurance commissions in California following passage of Proposition 103.

Aetna requests life commission volume from all its property/casualty agents, but only requires it from its preferred or PRIME agents, he said.

And an agency will not have its contract cancelled solely because of a failure to meet these requirements, he said. "We cancel contracts very carefully because we look at other profit areas as well as life."



READER SERVICE

Advertiser

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Issue of December 4

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Continued from page 32

Group life insurance

Older workers who receive company-paid term life insurance coverage exceeding \$50,000 face higher federal taxes under new Internal Revenue Service tax tables released last month.

The old tax tables, which establish how taxes are to be computed on employer-paid premiums for group term life insurance coverage exceeding \$50,000 in benefits, stopped at age 64.

As a result, a 70-year-old employee was taxed at the same rate as a 64-year-old, even though the employer paid a much higher premium for coverage.

Under the new IRS tables, which are retroactive to Jan. 1, two new age brackets—one for workers age 65 through 69 and the other for workers older than 69—will be used to determine the cost of coverage on which employees are taxed.

For workers age 65 through 69, the cost—for tax purposes—of an employer-paid premium is \$2.10 per month per \$1,000 of coverage exceeding \$50,000.

For workers age 70 and older, the cost of coverage is set at \$3.76 per month per \$1,000 of coverage exceeding \$50,000.

Under the old tables, the cost—for tax purposes—for workers older than age 65 was \$1.17 per month per \$1,000 of coverage exceeding \$50,000.

The new tax tables for older workers, mandated by the 1988 Technical Corrections Act, will result in hefty tax hikes for some older workers, notes Henry Saveth, a principal with A. Foster Higgins & Co. Inc. in New York.

For example, a 69-year-old whose employer pays the annual premium for \$100,000 of term life insurance will have \$1,260 in additional taxable income this year. Under the old tax tables, the 69-year-old receiving \$100,000 of coverage would have had \$702 in additional taxable income.

OSHA fines

The Labor Department has proposed \$241,300 in fines against Hercules Inc., a Wilmington, Del.-based chemical company for 71 alleged violations of Occupational Safety and Health Administration safety standards.

The department has also proposed fines totaling \$377,240 against New York Telephone Co. in New York for 80 alleged health and safety violations as a result of inspections at 26 worksites.

Hercules' fines stem from an investigation into an explosion at a Kenil, N.J., plant last June that injured 12 workers and caused an estimated \$5 million in damage.

These standards, part of the Occupational Health and Safety Act's general duty clause, make an employer responsible for maintaining a workplace free from recognized hazards that are causing, or are likely to cause, serious injury or death.

The department charges Hercules with multiple willful violations of the act, including unsafe handling of explosives; failure to provide protective equipment for firefighting employees; allowing employees to work in confined spaces without proper safety procedures; and failure to conform to the table of distances for explosives operations.

In addition, the department charges Hercules with failure to implement proper storage plans for explosives; insufficient employee safety orientation; and various machine guarding failures.

Other alleged violations include: failure to ensure proper grounding and bonding of equipment used to make explosives; not running electrical power lines underground the required distance from explosives magazines and buildings; not providing employees with remote operation protection; and not cleaning equipment on a regular basis.

Most of New York Telephone's alleged violations involve breaches of responsibility under OSHA's hazard communication standard, the administration said.

Alleged willful violations include: failure to implement and maintain written hazard communication programs at worksites; failure to maintain material safety data sheets for hazardous chemicals used at each worksite; and failure to provide employees with information and training on the proper handling of hazardous chemicals.

Alleged serious violations include: failure to properly test employees for lead exposure; failure to ensure that hazardous chemicals are labeled, tagged or marked with the appropriate hazard warnings; and failure to properly store nitrogen compressed gas cylinders and oxygen cylinders.

Both Hercules and New York Telephone have until Dec. 13 to contest the proposed fines before the independent Occupational Safety and Health Review Commission. ■

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Grange Mutual

Continued from page 2

erage. The company paid out about \$3 million to resolve more than 1,000 claims before its financial troubles surfaced, prompting Mr. Richards to seek court approval for liquidation.

The Insurance Department projected that Grange Mutual would be unable to pay about \$2.5 million in claims, despite a \$625,000 pre-storm surplus and reinsurance recoverables from an excess-of-loss policy, a stop-loss policy and a 50% quota-share policy, according to the spokesman.

However, an agreement between the state's guaranty fund and the Seibels Bruce Insurance Cos. not only will guarantee Grange Mutual policyholders coverage for the remainder of their policies but also reduce their costs.

The Columbia-based insurance group will serve as the servicing carrier for Grange Mutual and

manage the claims, which will be paid by the South Carolina Property & Casualty Insurance Guaranty Assn.

Seibels Bruce was scheduled to assume Grange Mutual's runoff business last Friday, four days after liquidation.

As a result, coverage written by Grange Mutual prior to the storm will remain in force until the end of each policy's term.

While Seibels Bruce will make individual underwriting decisions about renewing policies that expire in 1990, it plans to offer contracts to "a substantial portion" of policyholders, according to Tom Reichard, executive vp at Seibels Bruce.

Without such a plan, policies would have been canceled within 30 days of liquidation.

Policyholders also would have faced a \$250 deductible on subsequent claims filed against the guaranty fund and a \$100 deductible to obtain the return of their unearned premium.

The \$250 guaranty fund deductible is being paid by Seibels Bruce, which is being paid an administrative servicing fee by the guaranty fund.

The policyholder servicing arrangements are similar to those made a month ago to cope with the insolvency of the Charleston-based Hibernian Mutual Insurance Co. (BI, Nov. 6).

However, the assuming company in the Hibernian liquidation, The American Mutual Fire Insurance Co., managed Hibernian before storm-related losses caused the insolvency.

Mr. Richards said he "couldn't be more appreciative" of the two insurance companies that stepped

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'This whole system is being tested,' says Lanville Mengedoht of South Carolina's guaranty fund.

in to run off the insolvent insurers' policies and act as servicing carriers, because each has made "a financial sacrifice" to do so.

In addition, Seibels Bruce is loaning the guaranty fund money as needed at a favorable 8.2% interest rate until the fund obtains a bank loan to help it pay claims, said Lanville Mengedoht, vice chairman of the fund.

The loan is needed to bridge the gap between guaranty fund payments to policyholders and revenue it will collect from insurer assessments.

The fund annually can assess a maximum of 1% of net premium written by insurers in identical lines during the calendar year preceding the insolvency.

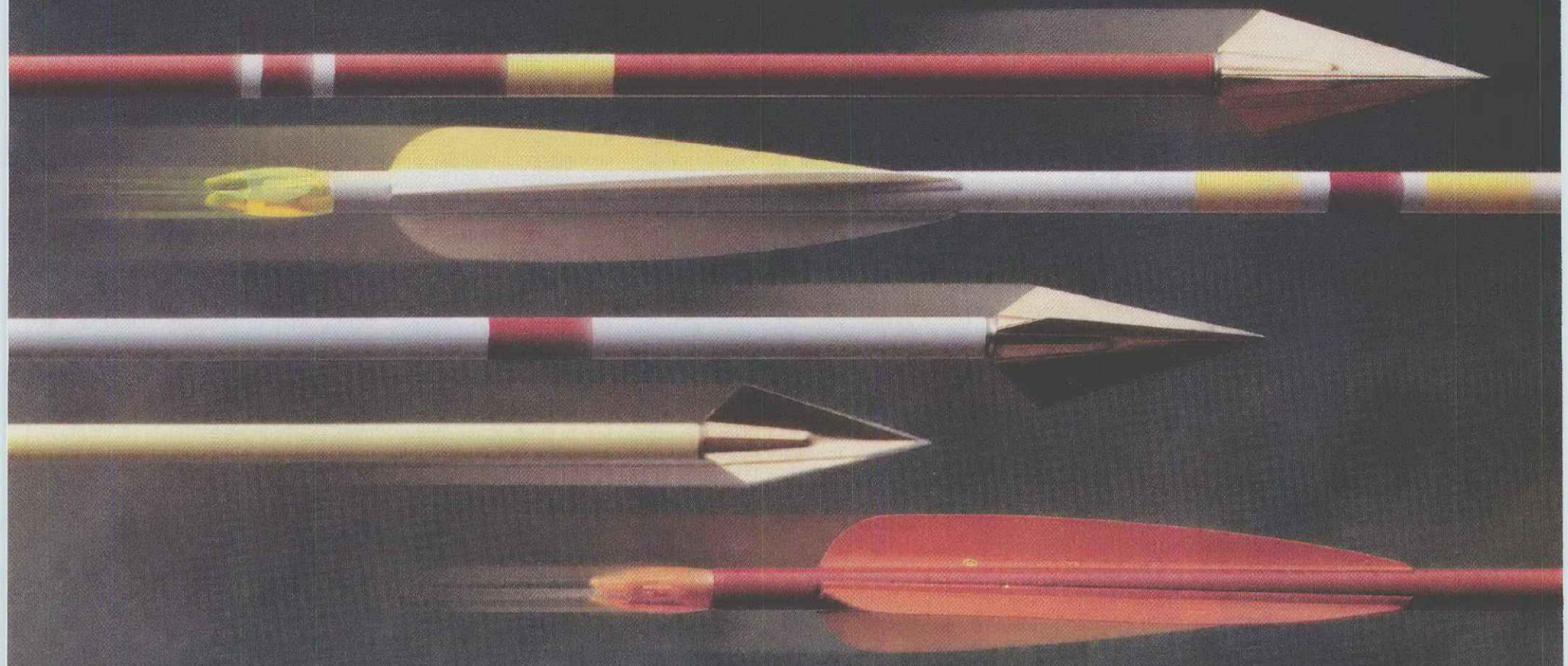
The guaranty fund plans to assess the full 1% by the end of the year and again early next year, Mr. Mengedoht said.

The 1989 and 1990 assessments will generate \$6.8 million, requiring the guaranty fund to borrow between \$2 million and \$3 million to cover the estimated \$7.5 million to \$9.5 million in potential claims against the guaranty fund from the two Hugo-created insolvencies, said Gerald Garnett, chairman of the guaranty fund.

Mr. Garnett projects Grange Mutual's insolvency could reach \$3.5 million while Hibernian's insolvency is now projected to be \$4 million to \$6 million.

Mr. Mengedoht said he expects the guaranty fund to ask legislators in January to increase the annual cap on the amount of the assessment or broaden the base of insurers that can be assessed to raise additional funds.

"This whole system is being tested," he said.



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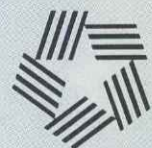
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Gillespie asks judge to reconsider ruling

SAN FRANCISCO—Insurance Commissioner Roxani Gillespie is asking a California judge to reconsider his ruling that Ms. Gillespie violated the state Insurance Code by not holding show-cause hearings against an insurer "whenever she has reason to believe" that an insurer had used unfair practices.

State Superior Court Judge John Dearman also ordered the Insurance Department to release investigatory files of consumer complaints concerning insurers to Ray Bourhis, a San Francisco attorney and Democratic candidate for insurance commissioner who sued Ms. Gillespie and the department.

The rehearing is set for Dec. 13.

"Over the past five years literally thousands of consumer complaints revealing statutory violations... have

Around the states

been made to the commissioner," Judge Dearman said. "Yet in the past five years, the commissioner has issued only three orders to show cause... and not one of these was against a major insurance company."

If upheld, the ruling would require the Insurance Department to hold formal hearings "in sufficient numbers to effectively deter wrongful conduct" and levy fines "to deter unprofitable misconduct," Mr. Bourhis said last week.

"That action should be cheered by all insurance companies that want to do business in California fairly," he said.

In a statement, the department

noted, however, that "both the insurance code and case law clearly give the commissioner power to use other means such as informal conciliation to expedite resolution of consumer complaints."

"In fact, the department has established an excellent record using such means, successfully resolving complaints and recovering more than \$55 million for consumers during the three years of (Ms. Gillespie's) tenure," the statement said.

"If formal hearings are required on routine complaints, the Department is concerned that years could elapse before the cases are resolved," the statement said.

Ms. Gillespie has not yet announced whether she will seek the Republican nomination for insurance commissioner, which will become an elected office next year under a provision in Proposition 103.

—By Louise Kertesz

Work comp rate hike

RALEIGH, N.C.—The North Carolina Rate Bureau and the state Department of Insurance have agreed to a 9% average increase in workers' compensation insurance rates for 1990.

The approved increase is slightly more than half the original request of 16.8% that the bureau filed in September. Regulators had found that request exorbitant.

The revised rates will become effective Jan. 1.

The bureau, which represents all licensed workers compensation insurers in the state, agreed to the 9% increase Nov. 17, thereby avoiding a rate hearing that had been scheduled for Nov. 20 by Insurance Commissioner James Long.

Mr. Long had said in announcing the hearing that the bureau's original filing was too high and did not fairly reflect the excessive profits and investment return insurers would derive from the rate increase.

In requesting the rate hike, insur-

ers did not duly consider their actual losses and expenses, appear to have inflated loss and expense estimates and provided excessive cost estimates for underwriting, issuing and processing policies, Mr. Long charged in the hearing order.

"The Bureau's governing committee considered the proposal very carefully," said Jerry Hamrick, workers compensation manager with the bureau.

"Although this rate change is less than we requested, we believe the settlement is in the best interest of employers and the insurance industry," he said.

Roger Langley, senior deputy commissioner with the Insurance Department, said: "We believe the order reflects a continuing commitment by the commissioner of insurance to hold the line on increasing insurance costs. We are pleased with the agreement."

Mr. Long in 1987 scaled back another request for a 16.8% workers comp rate hike to 4.2%.

—By Michael Schachner

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Bermuda insurers increase net premium volume by 4.8%

HAMILTON, Bermuda—Net premiums written by Bermuda-based insurers and reinsurers increased 4.8% last year to \$8.4 billion from \$8 billion in 1987, according to Registrar of Companies Verbena Daniels.

Total capital and surplus of the Bermuda insurance and reinsurance industry fell 3.4% to \$14.5 billion in

Bermuda

1988 from nearly \$15 billion in 1987, though insurers and reinsurers' total assets rose 11% to \$38.7 billion in 1988 from \$34.9 billion in 1987.

Gross premiums written by the Bermuda market rose 8.1% to \$11.1 billion last year from \$10.3 billion in 1987.

According to Ms. Daniels' report, 33 new insurers were incorporated in the first 10 months of 1989, while 59 insurers were removed from the register of companies during the same period, leaving Bermuda with 1,316 insurers as of Oct. 31, down 1.9% from 1,342 at year-end 1988.

Despite fewer Bermuda-based insurers this year, Ms. Daniels said the performance of Bermuda's captive insurance market was "encouraging" in light of the soft property/casualty insurance market worldwide.

"Asset strengthening and the preservation of capital and surplus base figures is indicative of Bermuda companies positioning themselves for the market hardening," she said.

Ms. Daniels added that the market's net premium-to-surplus ratio, which was less than 1-to-1 in 1988, "demonstrates the continued conservatism of this insurance center."

Belvedere sale

New York-based Belvedere Corp. has reached what it describes as a "definitive agreement" to sell its Bermuda reinsurance unit to a group including the local management and Citicorp.

Belvedere Holdings Ltd.'s subsidiary, Belvedere Insurance Co. Ltd., last year wrote net premiums of \$25.3 million and reported a net profit of \$3.4 million (BI, April 10).

The group has agreed to a purchase price equivalent to about \$17.5 million, including \$13 million in cash, \$3 million in preferred Belvedere Holdings stock and a warrant to acquire 5% of the common stock of a new Bermuda holding company, Caliban Holdings Ltd., that is being incorporated to handle the acquisition.

According to Belvedere Corp., the warrant may be resold at the option of Belvedere to the new company for up to \$1.5 million "under certain circumstances."

The acquisition, still subject to regulatory approval, is expected to be completed within six weeks. Its an-

nouncement signals the defeat of a competing bidders group headed by Peter Wilson, the former president of Forum Reinsurance Co., and Francis Carter, president of Belvedere Insurance until July 1986 (BI, Oct. 30).

Colin O'Connor, who succeeded Mr. Carter at Belvedere Insurance, says he was "relieved" that the Citicorp-backed management buyout was successful. "I don't know all the details of the other offer, but I do know it was pretty much down to the wire for us," he said.

Mr. O'Connor described the purchase as an opportunity that was too good to pass up. "We felt it was the kind of chance that might not have come our way again," he said.

The "we" is almost the company's entire top management in Bermuda. It includes Mr. O'Connor, underwriters Tom Hamill, Robert Power and Derek Ratteray, financial controller Paul O'Shea, treasurer Vanessa Johnson and managers Pamela Martin and Patricia Hawke.

Mr. O'Connor would not discuss shareholder details, other than to say that the banking giant would have a "considerable" controlling stake.

But he added: "I don't think we are going to see Citicorp adopting an intrusive approach to management."

No changes are likely once the takeover is completed, Mr. O'Connor said.

Belvedere writes conventional treaty reinsurance, financial reinsurance and captive reinsurance.

The sale of the Bermuda operation is conditional on the sale of a 49.9% stake in the parent Belvedere Corp. to Christiana Holding Co. Inc., a U.S. subsidiary of Storebrand International A.S. of Oslo, Norway. Should that sale fall through, a Belvedere Corp. statement hints that the Bermuda sale could proceed "at the option of Belvedere."

The purchase agreement was announced after Belvedere Corp. posted a third-quarter net loss of \$702,000—a result it blamed on Hurricane Hugo, which it said cut net income by \$1.2 million. Net premiums written during the three months ended Sept. 30 were \$12.2 million, up from \$8.3 million in 1988. Net premiums written in the first nine months rose to \$41.2 million from \$31.1 million in 1988.



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Cubs decision

Continued from page 3

the boy from the foul ball, the screen was inadequate, he argued.

"The Cubs failed to adequately protect the area behind home plate," Mr. Cirignani said.

He said this situation is analogous to the owner of parking lot. "While the owner does not have a legal duty to put in lights, once the owner puts in lights, they must be maintained," he explained. The owner of such a parking lot would become liable for injury caused by the failure of the lights, he said.

Mr. Cirignani's extension of this theory to the Wrigley Field screen persuaded the judge to allow the case to be heard by the jury, which awarded the injured boy \$67,500 in compensatory damages.

"The Cubs organization believes the decision in the Yates case is incorrect and not in line with the settled law in this area," a Cubs spokes-

man said. "The Cubs will appeal this decision, and we expect to prevail in the appellate court."

Club attorneys and other officials would not comment further.

If the award is upheld on appeal, Chicago-based Tribune Co., which owns the Cubs, would probably tap its liability insurance to cover part of the award. The award would most likely be a covered loss under the team's comprehensive general liability policy, said Doug Williams, vp-sports division at K&K Insurance Group Inc. in Fort Wayne, Ind.

Baseball teams typically have very low deductibles ranging from \$2,500 to \$10,000, he said. Primary policy limits are usually \$1 million, while excess limits range from \$25 million to \$100 million.

The Tribune Co. would not comment on the Cubs' liability coverage. Attorneys criticized the decision.

It "is contrary to decisions in many courts in many states," said Louis Hoynes of Willkie, Farr & Gallagher

in New York.

"It is a well-recognized and well-established principle that as long as the ball club offers protected seats—and every club does—there is no liability for injuries," said Mr. Hoynes, who represents the National League of Professional Baseball Clubs.

He said patrons who choose to sit outside the area protected by the foul ball screen must assume the risk for their decision.

The Yates decision is an "aberration," Mr. Hoynes said. "I expect it will be overturned on appeal."

However, even if the decision is upheld, it would not be troublesome for other ball clubs because "decades" of law hold to the contrary, Mr. Hoynes predicted. "One snowflake does not make a snowstorm."

White Sox attorney Jeff Izeman of Katten, Muchin & Zavis in Chicago also criticized the decision.

"My understanding of the law in Illinois is that the fan assumes the risk when he attends a game," he

said. "It has always been recognized that these are things that happen at sporting events and that there is no liability."

Mr. Izeman predicted the decision would be reversed on appeal, but he said it would create "an unfortunate precedent" if upheld.

Plaintiffs' attorney Mr. Cirignani labeled the verdict in the Yates case the first of its kind.

"This is the first time a jury has found a ball club liable for injury caused by a ball in play," he said.

In 1957, the Cubs were held liable when a pitcher warming up near the dugout accidentally threw a ball into the stands. Mr. Cirignani says that case is distinguishable from the Yates case because the injury was caused by a ball not in play and courts have held that spectators assume risk for injuries that occur only as a result of the actual game.

And in 1983, the Houston Astros were held liable by a trial court jury when a foul ball hit a spectator. But

that decision was overturned on appeal. Mr. Cirignani also distinguished the Houston Astros case from the Yates case because the former involved punitive damages.

Tickets to almost all sporting events specifically attempt to relieve the owners of the stadium and the team for liability for injuries to spectators.

In the Cubs case, the ticket said: "Holder of this ticket voluntarily assumes all risks and dangers incidental to the game or event for which this ticket is issued whether occurring prior to or after same and agrees that the organization, agents, participants, players or Ticketmaster are not responsible or liable for any injuries resulting from such causes."

Ticketmaster is the ticket agency that contracts with the Cubs.

Mr. Cirignani argues that "there are 20 reasons why (the ticket) does not create a binding contract." For example, minors cannot enter into legally binding contracts. ■

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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 10,719
Sub-total **24,021**

Associations 554
Government, Unions and Educational Institutions 1,417
Commercial Consumers
Sub-total **25,992**

Insurance Agents and Brokers 10,515
Insurance Companies 7,673
Actuaries, Consultants, Attorneys, Adjusters, Appraisers and Third Party Administrators 3,800
Others Allied to the Field 2,771
TOTAL **50,751**

* Source Business/Occupational breakdown of qualified circulation, May 29, 1989 issue, as submitted to BPA for June 1989 BPA Publisher's Statement.

Mine loss

Continued from page 3
Islands.

BCL also contends that the company's deductible should apply only once because the attacks are all part of one event.

The company would not disclose its deductible.

Underwriters, though, refuse to pay the claim, arguing that the property policy specifically excludes losses from "insurrection, rebellion, revolution, civil war, usurped power" or government action designed to prevent such occurrences, sources say.

But, underwriters contend that if a court rules the policy covers the losses, then BCL's deductible should be applied to the losses from each of several rebel attacks on the mine, according to sources.

Underwriters also say that BCL did not do all it could to mitigate losses, sources say.

And, insurers argue that fear of further violence is an insufficient reason to close the mine and seek business interruption coverage, sources say.

The litigation, originally scheduled to start last month, was postponed and is now set for Feb. 12 in the Victorian Supreme Court in Melbourne, Australia, Mr. Mutch said.

Mr. Mutch would not comment on the details of BCL's property policy, but he said it is "normal in Australia for such a policy to be written to the full value of assets and one year's loss of profits."

In its latest financial report, the company values its property on Bougainville at 971 million kina (\$839.2 million).

The mine is the world's sixth-lar-

gest copper producer and the 18th-largest producer of gold. Before shutdown, it generated about 3% of the world's total copper production and was a significant source of gold for world metals markets.

Mr. Mutch said the policy is renewed annually, but he would not identify the company's broker.

BCL is insured by CRA's Singapore-based captive, Metals & Minerals Insurance Pte. Ltd., which writes 90% of the coverage.

The coverage is reinsured with between 40 and 50 London, European and Australian reinsurers, according to Ross Bovill, chief executive and a director of the captive.

Mr. Mutch, also a director of the captive, acknowledged that it is rare for a company to sue its own captive insurer.

But, both he and Mr. Bovill denied that BCL is seeking a court victory to make it difficult for the captive's reinsurers to deny the captive's reinsurance claims.

Mr. Mutch said Metals & Minerals would not need a court decision to receive support from its reinsurers.

He said the case is being litigated because BCL and the captive cannot agree on the size of the claims and "there has not been a court precedent set on some of the issues in this case."

Three insurers wrote the remaining 10% of the coverage: Taisho Marine & Fire Insurance Co. Ltd. of Tokyo; GRE Pacific Insurance Ltd. of Lae, Papua New Guinea, a unit of GRE Insurance Ltd. in Sydney; and American Home Assurance Co. of New York, a unit of American International Group Inc., according to Mr. Mutch.

The insurance companies and their attorney, the Melbourne firm Ebs-

worth & Ebsworth, would not comment on the litigation.

BCL claims that it has done everything possible to keep the mine open, closing it only when forced to do so to protect employees' lives.

Property losses and BCL's decision to close the mine stem from uprisings

BCL says it has done everything possible to keep the mine open, closing it only to protect employees.

by Bougainville natives who want the island to secede from Papua New Guinea.

The mine is 19.1% owned by the Papua New Guinea government and produces 17% of the country's revenue.

Bougainville rebels also demand that Papua New Guinea give them the 14 billion kina (\$12.1 billion) in royalties it has received since the mine was opened in 1972, plus an additional 6.4 billion kina (\$5.5 billion), according to Mr. Mutch.

Bougainville's natives receive a much smaller royalty than does the Papua New Guinea government. Since 1972, local owners of the land where the mine is situated have received \$34 million Australian (\$26.7 million), or 2.4% of the revenues the government has received, Mr. Mutch said.

Rebels first attacked BCL property in late 1988 after the Papua New Guinea government said it would not accede to a rebel request to close the mine. However, the gov-

ernment said it would give natives a portion of mine revenues if the natives agreed not to attack the mine.

In November 1988, though, rebels bombed a guest house, mine equipment and a supermarket, all owned by BCL, and, a month later, blew up a transmission tower carrying power to the mine. Power was restored in two days and the mine resumed operation.

But three days after power was restored, the mine was shut down for four more days when rebels damaged another transmission tower and a mine-owned maintenance building.

In March, the island's BCL-owned airport terminal was burned down, damaging company property, including aircraft.

Another transmission tower was toppled April 15, halting mine operations for several days.

On May 15, miners were attacked and the Bougainville Mine Workers' Union advised employees to with-

draw their labor until safe conditions could be guaranteed, Mr. Mutch said.

Another transmission tower was toppled May 21 and the mine has been closed since. BCL attempted to restart operations the next day, workers in buses were shot at and a second power pylon was toppled, Mr. Mutch said.

Rebel attacks in September frustrated another attempt to reopen the mine.

The mine will remain closed until worker safety can be guaranteed, Mr. Mutch said.

Sources expect insurer attorneys to file an amended defense in the Victorian Supreme Court early this week.

BCL's experience has prompted the large Australian mining group MIM Holdings Ltd. to insure its loans for its new gold mine subsidiary in the Papua New Guinea Highlands on island of New Guinea against "warlike activities." The insurance was required by an international banking syndicate that is partially financing the new gold mine.

Constellation Re

Continued from page 3
refused to consider the idea.

Great American asked Judge Schackman to reject the Insurance Department's liquidation plan, find that the liquidator behaved arbitrarily, capriciously and unreasonably in refusing to consider the alternative plan and to order the liquidator to solicit proposals from companies willing to assume Constellation Re's assets and liabilities (BI, May 1).

In an Aug. 7 ruling, Judge Schackman refused to approve the New York department's liquidation plan because an audit of Constellation Re had not been performed to support the plan (BI, Aug. 28).

But, the judge also refused to rule that the liquidator had acted arbitrarily. He further concluded that the court had no authority to compel the Insurance Department to solicit alternative plans, noting that this was a matter of department discretion and that the court could only approve or reject plans submitted by the department.

At the same time, however, the judge rebuked the liquidation bureau for its "unreasonable" refusal to consider buyout proposals and strongly suggested that it discuss such options with creditors.

Representatives of the Insurance Department and Constellation Re creditors met in late August and again in mid-September, though the New York department maintained its hard-line stand against any buyout proposals, lawyers for Constellation Re creditors say.

However, Mathias E. Mone, a lawyer for the liquidator, denies that the Insurance Department adopted a hard-line position. "We were not taking a steadfast position that we would never consider a creditor plan," said Mr. Mone, a partner with Cahill, Gordon & Reindel in New York.

Two creditors—H.S. Weavers (Underwriting) Agencies Ltd. and Gibraltar Casualty Co., a unit of Prudential Reinsurance Co.—subsequently asked Judge Schackman's permission to file an action

against the liquidator for allegedly refusing to discuss alternative proposals, charging the liquidator with bad faith and breaching its fiduciary duties to creditors.

Weavers and Gibraltar also sought a court order directing liquidators to seek proposals from insurers qualified to assume Constellation Re's assets and liabilities.

The creditors also sought an order enjoining the liquidator from depleting Constellation Re's assets, including by proceeding with its audit of the defunct reinsurer.

Great American filed a similar motion.

On Nov. 14—six days before

The judge rebuked the liquidation bureau for its 'unreasonable' refusal to consider buyout proposals.

Judge Shackman ruled on these motions—Mr. Mone told Great American's lawyers that the liquidator would give "due consideration to any proposal submitted by Great American or any other creditor" relating to the assumption of Constellation Re's assets and liabilities "or any other plan for an orderly and equitable termination of the liquidation proceeding."

Citing this letter, the judge ruled Nov. 20 that the liquidator has not breached its duties to creditors.

The judge also affirmed his Aug. 7 ruling that the court has no authority to order the liquidator to seek such proposals.

However, the judge suggested resolving the stalemate between the Insurance Department and the creditors with an "unofficial request for proposals" to insurers by a committee of creditors.

Proposals for assumption of Constellation Re's assets and liabilities could then be forwarded to the liquidator for the promised review, the ruling said.

Judge Schackman wrote that Insurance Department rejection of any proposal should be in writing and should explain the reasons for the rejection "so that the court may evaluate whether the liquidator is fulfilling his fiduciary duty to the creditors by exercising his discretion in a financially sound, responsible and responsive manner."

Meanwhile, the judge denied the creditors' motions to freeze Constellation Re assets and ordered the liquidation bureau to continue its audit of the reinsurer.

If the creditors proceed—at their own expense—to unofficially seek buyout proposals, a copy of the request for proposals should be sent to the liquidator for comments before publication, the judge ruled.

Lawyers for the creditors say they hope the ruling will resolve the standoff between the liquidator and the creditors.

"Hopefully, now the department is realizing that it has to listen to the input of the creditors as to what they would consider an appropriate resolution to the estate," said Peter Bickford, a partner with Bickford, Hahn & Hayes in New York, representing Gibraltar.

"The longer these proceedings drag on, the harder it is to do anything meaningful with the estate," he added.

"It's our money that's being used to finance this jurisdictional fight," observed James Veach, a lawyer with Mound, Cotton & Wollan in New York, representing several creditors.

However, one lawyer involved in the proceedings noted that the latest ruling still leaves the fate of any buyout proposal in the hands of the New York department.

"It's nothing, really," the lawyer said of the ruling, "unless (the liquidator) is really serious about examining our proposal."

Constellation Re, a former unit of Santa Fe Southern Pacific Corp., was ordered liquidated in February 1987 and has been estimated to be insolvent by \$39 million.

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MARKET REPORT: EMPLOYEE BENEFITS

December 18, 1989

BI editors will evaluate market conditions affecting group health and managed care, forecast how much group health care costs will rise, and examine other benefits including dental plans and long-term disability plans. Plus editors will rank and profile the 10 largest consulting firms in our annual Directory of Benefit Consultants. This issue will provide executives with a clear picture of how to plan and implement their strategies for the coming year.

THE YEAR IN REVIEW

December 25, 1989

BI editors will recap the events of the past 12 months — how these events have shaped the commercial insurance industry at home and abroad. The Year In Review serves as a barometer tracking news and trends: legislation and regulation; tort reform; section 89; prop 103; pollution liability; and the dramatic impact of the Valdez oil spill, hurricane Hugo and the San Francisco earthquake. This recap issue will provide readers with details of events and trends that will help shape the future.

AD CLOSING: DECEMBER 12

MARKET REPORT: RISK MANAGEMENT

January 1, 1990

BI editors will look at where property/casualty insurance rates are heading during year-end renewals. Will the spate of disasters that occurred in 1989 mean higher insurance prices as we enter the '90's? Editors will talk to insurers, brokers, reinsurers, surplus lines market executives, London market officials and risk managers for their views. To take the pulse of the property/casualty insurance marketplace readers turn to BI.

AD CLOSING: DECEMBER 18

Aviation market

Continued from page 3

"We think that most people writing treaties are on our side."

As a result of the reinsurers' action, "the aviation insurance market is no longer providing policies for longer than 12 months as of Jan. 1," with the option of a three-month extension, said Iain Nurse, director of Lloyd's brokerage Bowring Aviation Ltd.

"We are required by reinsurers to impose 12-month policies with three-month extensions, but the extensions must be negotiated not earlier than 90 days" before the coverage is due to expire, said a London aviation insurer.

However, this insurer, along with others, said that although he welcomed the restriction because it brings discipline back to the aviation insurance market, he believes the restriction should apply only to policies written after April 1. Eighteen-month policies were first

written in April 1989, he said, noting that not all airlines have yet had the opportunity to buy an 18-month policy.

For instance, Pan American World Airways last year renewed its aviation insurance on Jan. 1 for a 12-month term.

But Mrs. Franklin-Engler said, "That's tough." Besides, there are not many airlines that renew on Jan. 1, she noted.

Brokers say that at least two airlines already have renewed coverage that expires Jan. 1 for 18-month policy periods, but only because they completed their renewals in October.

No one is certain whether limiting policy periods will increase airline hull and liability rates. But many underwriters hope this move will end the severe slide in rates.

Airline hull rates have continued to drop by at least 60% since the 18-month policies came into vogue in April, while liability rates have slid by about 55% (BI, Sept. 18; Feb. 13).

Total worldwide airline premium income this year will total only about \$350 million, while total worldwide insured hull and liability losses from airline disasters will amount to about \$1 billion, predicts Bowring's Mr. Nurse.

"There is no doubt that the market can, if it wants, correct rates at the end of the current policies," said a Lloyd's aviation underwriter. "And there is no doubt that the proportional reinsurers have reacted (to the length of the policies). But it's extremely difficult to read more into it at this stage."

"There are indications of hardening, though the initial (Jan. 1)

'The market can, if it wants, correct rates at the end of the current policies,' says an aviation underwriter.

1989 INTO 1990

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renewals are being reduced" because the airlines now renewing their coverage have not benefited from the last round of rate cuts, which began last April, added the London aviation underwriter.

"I doubt whether rates will increase before the middle of next year," he said.

"Rates may be on the move next year," said another London aviation underwriter.

Among the 1989 aviation disasters is last week's crash of an Avianca Air Boeing 727 just outside Bogota, which killed all 107 people on board. Officials suspect drug traffickers planted a bomb on the plane.

All-risk and war risk hull coverage for the aircraft, valued at \$3.5 million, and \$600 million of liability insurance is placed with Colombian insurer La Nacional de Seguros and is partially reinsured in London by Bowring Aviation.

The London reinsurance of the hull all-risk and liability coverage is led by British Aviation Insurance Co. Ltd. The lead hull war-risk reinsurer was not known.

Also last week, a Korean Air Fokker F-28 crashed just after takeoff, injuring 40 people.

Coverage for the \$15.3 million hull and liability insurance with limits of possibly up to \$1 billion is underwritten by Seoul-based Oriental Fire & Marine Insurance Co.

The coverage is 44% reinsured in the London market through brokerage Nicholson Chamberlain Colls Ltd. The London reinsurance is led by The Orion Insurance Co. P.L.C. and by Lloyd's underwriter Barry Coleman. ■

Line slip rules

Continued from page 1
bind a risk," said Alan Hiscock, deputy chairman of Sedgwick Energy Ltd.

Therefore, the current renewal season likely will be particularly hectic, and underwriters will have to man their underwriting rooms and boxes for longer hours to see more brokers, said Mr. Hiscock.

The rules could have been even stricter, but brokers successfully fought off initial proposals by underwriters that would have forced brokers to seek the approval of every underwriter on a line slip for business written exceeding specified limits.

The Lloyd's Insurance Brokers Committee, which represents the most influential brokers in London, agreed with the LUA and the ILU to the new restrictions on brokers' line slips.

Brokers' line slips—and other facilities such as binding authority covers and automatic treaties—have allowed brokers to place risks in the London market quickly and cost effectively. Both underwriters at Lloyd's and in the company market participate on the same brokers' line slips.

During the last decade, the number of brokers' facilities in London's marine market has increased dramatically. Underwriters estimate that between 50% and 75% of all premium income now written by marine underwriters in the London market is written via such facilities.

A 25% reduction in capacity available through the line slips could be very significant.

Large brokers have dozens of facilities covering property, liability, business interruption and energy related risks. Line slips and other binding facilities offer limits from less than \$500,000 to several hundreds of millions of dollars.

For example, the London Master Energy Lineslip and the Excess Energy Lineslip currently have limits of \$725 million and about \$434 million, respectively. Thus, the proposed capacity reductions will automatically cut nearly \$290 million in broker facility capacity for major energy companies.

Meanwhile, there are several other energy liability line slips with limits in excess of \$100 million held by major Lloyd's brokers that will have their limits slashed by tens of millions of dollars.

While most of the huge line slips in the marine market are for energy-related risks, and every major broker has at least one big energy line slip, line slips are used for the whole range of business written in the market, including small fishing vessels and cargo risks.

But the reduction in capacity under the line slips is designed to give underwriters more control over their business, not to necessarily cut

available capacity. Brokers can replace the capacity cut from their line slips by directly placing the needed limits with underwriters.

Furthermore, by increasing the number of underwriters establishing the terms and conditions of insuring risks through a line slip and making all underwriters on the slips more aware of what they are writing, the underwriters hope to "strengthen the market and strengthen rates," said Mr. Jackson, who also is an underwriter for syndicate 735, managed by Wren Underwriting Agencies Ltd.

To the consternation of the underwriters, in many cases the following underwriters on the line slip had not been informed when risks were placed with the facilities.

The proposed measures are designed to "strengthen the resolve" of London's marine underwriters who are currently facing claims from a series of unprecedented and massive losses, said Mr. Parton of the ILU.

"Because of the losses we have incurred and the general adverse figures, the market now is digging its toes in," Mr. Jackson said.

Losses that have pounded the marine market in the last few years include the \$1.4 billion loss of the Piper Alpha oil platform in July 1988, the \$300 million loss of a Petrobras S.A. platform off Brazil in April 1988, the estimated \$400 million insured cost of the oil spill from the Exxon Valdez tanker off the coast of Alaska in March, and the October Phillips Petroleum plant explosion in Texas, which could cost underwriters more than \$1 billion.

In addition, windstorms and hurricanes also have wreaked havoc in London's marine market, including Hurricane Alicia in 1983, the European October 1987 windstorm and Hurricane Hugo, whose cost has been estimated to be as much as \$9 billion.

Indeed, many see the moves to strengthen underwriting in the marine market necessary for survival.

"It is in the interest of assureds to have a viable long-term market. Certain steps had to be taken as a result of the recent loss history," said Donald Payne, chairman of the oil and gas division of Lloyd's broker Willis Faber & Dumas Ltd.

"There are substantial concerns about the way different risks are aggregating following several catastrophic claims," said Lloyd's underwriter Stephen Merrett, chairman of Merrett Holdings P.L.C.

"Some of the underwriters who are following contracts are concerned at the quantity of business to which they may be committed without prior specific knowledge. The market is trying to come to terms with that issue," Mr. Merrett said.

"The more following underwriters know about what they're underwriting, the more they can control their own destiny," said Lloyd's underwriter Richard Outhwaite, a director of R.H.M. Outhwaite (Underwriting Agencies) Ltd.

In recent years, up to 75% of all business written in the London market has been coming through brokers' facilities, estimated Declan McMahon, deputy chairman of the ILU and managing director of insurance company Hansa (UK) Ltd.

Such facilities "restrict the knowledge of the following underwriter and impinge on underwriters' ability to know their exposures," he said.

"The steps we are taking in the market are only a re-establishment of disciplines that we had in the past," said Mr. Parton.

In addition, reductions in capacity and tightening rates in London's marine excess-of-loss market also are forcing following underwriters to more closely monitor their exposure levels, underwriters point out.

"Underwriters are concerned about the ability to get their own protections (reinsurance) in place and whether they will be able to afford them. It is the first manifestation of a tightening market," Mr. Parton noted.

'Because of the losses we have incurred. . . the market now is digging its toes in,' Mr. Jackson says.

The proposals are "a pragmatic solution to the problems of dissemination of information to underwriters and a reduction in the amount of coverage that can be bound automatically," said Mr. Payne of Willis Faber.

But, "it's not a full answer in itself. Proper analysis of risk comes from the underwriting side," he added.

Some brokers fear that the new restrictions could drive policyholders and brokers to use other markets outside of London.

Brokers "have to have the ability to bind business quickly, otherwise we will lose business and there is plenty of competition outside of London," said one broker.

"If we have more legs going round the London market to place risks, it will reduce our efficiency at a time when we're trying to increase the market's efficiency," said Ian Waite, deputy chairman of Alexander Howden Ltd.

If London underwriters are "concerned over accumulation of lines, its for themselves to be more disciplined in their own underwriting" rather than laying down market regulations, he added.

Mr. Parton contends that with the increasing use of computer technology the new rules should not handicap the London market.

However, the London Insurance Market Computer Network isn't fully functional yet, and with or without technology, the broker will still have

to negotiate with more underwriters under the new rules.

The new rules as approved are much less severe than underwriters' original proposals, released Nov. 7.

These would have required all risks above certain limits to be agreed to by every underwriter subscribing to a broker's line slip.

The earlier proposal called for every underwriter subscribing to a facility to see and agree to all package property/liability programs with limits exceeding \$50 million; liability business with limits exceeding \$25 million; hull business with limits exceeding \$5 million; and rig and energy business with limits exceeding \$50 million.

"The limits originally proposed would have been totally impracticable to work. Brokers would have needed to quadruple their broking staff to walk the risks around the market," Mr. Hiscock said.

Moreover, "it would have chased business away from the market and would have meant a lot of small underwriters would not have been shown business," he added.

However, after a series of meetings between brokers and underwriters, the market has come up with something "sensible and workable," Mr. Hiscock said.

In a market circular dated Nov. 28, Derek Wills, chairman of the LUA, pointed out that "an overwhelming majority" of LUA and ILU members supported the original recommendations.

However, "to ensure that the operation of these recommendations should be entirely practicable, extensive discussions have taken place with representatives of the Lloyd's Insurance Brokers Council, who have agreed to support an alternative set of proposals which they believe would broadly achieve the original purpose," Mr. Wills wrote.

A memorandum accompanying the letter stated that "the ILU and LUA committees recommend that the following shall apply in respect of covers and/or line slips and/or facilities and/or treaties which provide for risks to be accepted by only the leading underwriter:

- That acceptances on line slips, facilities etc. will be agreed by six leaders (three Lloyd's and three ILU) or four leaders if only one market is involved.

- Brokers should reduce the capacity of all brokers' facilities by 25%, unless all subscribing underwriters agree otherwise.

- Brokers should "amalgamate facilities into one cover per discipline." Currently, brokers may have several line slips relating to specific lines of business, like liability or warehouse storage, and underwriters contend that some brokers use their range of line slips competitively to drive down rates.

Brokers, though, say they need different line slips because some underwriters wish to exclude certain

risks or support different levels of limits.

"How do we combine a facility offering limits of less than \$1 million with a facility offering limits in excess of \$50 million?" asked one broker.

Or, he asked, if leaders on a line slip for fishing vessels wish to exclude, say, U.S. fishing vessels, can the broker no longer have a separate line slip specifically for U.S. fishing vessels?

- Lists of all declarations (of new risks/renewals) will be issued to all underwriters within five working days of acceptance by leaders, in a format set by the leading underwriter.

Meanwhile, the Joint ILU/LUA Cargo Committee issued a similar memo on Nov. 20 outlining guidelines for cargo business.

Cargo underwriters have been less heavily hit by recent disasters, particularly compared with energy underwriters facing claims from the Piper Alpha oil rig in July 1988 and the October blast at the Phillips Petroleum plant in Texas.

However, "the cargo premium income will be required to play its part in replenishing the London marine market's funds," said Leslie Maton, a director of Andrew Weir Insurance Company Ltd. and chairman of the ILU cargo committee.

Although many of the big losses will not directly hit the cargo underwriters, they will be charged higher reinsurance rates by their reinsurers.

"The whole market will be required to make a contribution to the losses," Mr. Maton said.

As a result, the cargo underwriters and the LIBC have agreed that:

- Cargo business written through brokers' facilities "requires the approval of two leading Lloyd's and two leading company underwriters—or the three leading underwriters should only one market subscribe to the risk."

- Copies of attachments should be listed to all participating underwriters within seven days.

- "No increase in limits on (facilities, line slips, etc.) should be allowed for at least the next 12 months."

- Only one facility "should be utilized for each named assured unless specifically agreed by all leaders concerned."

- No increase in brokers' and cedants' commissions should be agreed for at least the next 12 months.

- "Leaders should review facilities granted to overseas markets both as to the limits and coverage, deductions and overrides so granted."

- Leaders should review the wording of "all embracing covers" and following underwriters must be aware that such covers may, for example, include business interruption, long-term storage and other risks that generally are not insured by cargo underwriters. ■

Acquisition to boost revenues 25%: Poe

Poe & Associates Inc. has reached an agreement in principle to acquire broker Arthur A. Watson & Co. Inc. of Hartford, Conn.

"We are extremely pleased at the prospect of having . . . Watson's staff of 150 insurance professionals join the Poe family," said William F. Poe, chairman of the Tampa, Fla.-based brokerage.

Watson's "strong involvement in the medical malpractice and lawyers malpractice insurance fields will further enhance our current presence in these, as well as other, markets," he said.

Terms of the agreement were not disclosed, but Poe expects to close the deal by year end.

Mr. Poe said he expects the acquisition to increase Poe & Associates' revenues by more than 25%. Poe ranked as the 15th-largest U.S. broker in 1988 based on gross reve-

Markets

nues of \$35.1 million (BI, June 26). Watson generated more than \$80 million in premiums and \$11.2 million in gross revenues in 1988, making it the 57th-largest U.S. broker.

Its Connecticut offices, including Hampden, Waterbury and Wethersfield, will retain the Watson name and operate as wholly owned subsidiaries of Poe.

Japanese life venture

The Mutual of Omaha Cos. has entered into a formal arrangement with Sumitomo Life Insurance Co. of Tokyo to market Mutual of Omaha's group life products to Japanese-owned businesses lo-

cated in the United States.

The arrangement has created more than the opportunity of new markets, says Tom Skutt, chairman and chief executive officer of Omaha, Neb.-based Mutual of Omaha. Because of "Sumitomo's position among the biggest and best of insurance companies, the agreement will promote a long and a successful business arrangement," he said.

Under the agreement, Mutual of Omaha's New York group office will write group life, health, dental and long-term disability insurance for Japanese businesses. Sumitomo Life will reinsure a portion of the business generated by the agreement.

Mutual of Omaha expects to insure approximately 150 Japanese groups by year end, said a spokeswoman. Sumitomo Life, through several of its affiliates, has an investment interest in many of these Japanese businesses.

For more information about the new venture, contact Lynne Keller, Mutual of Omaha Cos., Mutual of Omaha Plaza, Omaha, Neb. 68175; 402-978-2944.

New benefit consultant

A new employee benefits consulting and brokerage firm has been formed to manage all aspects of clients' employee benefit programs.

Greenwood, Ind.-based W.B. Davenport & Associates Inc. will also provide services to insurers, utilization review firms, third-

party administrators and employee assistance programs.

W.B. Davenport, who has spent the past 30 years as an employee benefits economist and benefits manager, is the former president of Independent Benefit Plans Inc. In addition, he has served as president and chairman of the Self-Insurance Institute of America.

For more information on the new firm, contact W.B. Davenport, W.B. Davenport & Associates Inc., 494 S. Emerson Ave., Suite I, Greenwood, Ind. 46143; 317-885-9161.

New offices

William M. Mercer Meidinger Hansen Inc. has moved its New York City headquarters to 1166 Ave. of the Americas, New York, N.Y. 10036; 212-345-7000. ■

American Airlines

Continued from page 1

ployee will fund just under 30% of retirement medical costs," Ms. Jordan estimated.

American developed the plan partially in response to proposed Financial Accounting Standards Board rules requiring employers to account for future retiree health care liabilities on their financial statements as those liabilities are accrued.

The proposed accounting rules will wallop employers' earnings and deflate net worth, according to a new study (see story, page 1).

Another consideration was the fact that American's workforce has doubled since 1983, Ms. Jordan explained.

While American's ratio of retirees to active employees is currently "very low," that ratio "will change dramatically," Ms. Jordan said. American currently has 9,000 retirees.

And, assuming that all 80,000 American employees become eligible for retirement benefits, the company estimates its retiree health care liabilities would be nearly \$800 million, Ms. Jordan said.

Because medical care costs are rising so rapidly, "things can't continue as they are," she said, noting that retiree and employee health care costs have increased 12% annually over the past three years.

"Other companies have eliminated benefits. We have told our employees that we cannot guarantee fixed benefits and that prefunding was the best alternative" to reducing the "rich benefits" to which airline industry workers have become accustomed, she said.

However, American is reducing some benefits under its self-insured retiree medical indemnity plan for TWU workers beginning in 1990. For example, American is increasing the annual deductible to \$150 from \$100 for individuals and to \$400 from \$300 for families.

Other American retirees already are subject to these deductibles.

American is now requiring workers to pay a 20% hospitalization copayment above the deductible for the first \$5,000 of covered charges, Ms. Jordan said. The retiree plan will continue to pay 100% of covered charges above that amount.

The maximum lifetime benefit under the retiree plan is \$50,000 per family member for retirees who are 65 or older. The maximum lifetime benefit is \$300,000 per family member for retirees younger than 65.

Other covered expenses include:

- Prescription drugs, paid at 80% after the deductible. Employees also can purchase a 90-day supply of maintenance drugs for \$4 per prescription.

- Outpatient care for mental and nervous conditions, paid at 50%.

- Physical occupational therapy.

Coordination of benefits proce-

dures also will be revised to prevent duplication of benefits, she said.

To participate in the retiree benefit prefunding plan, an employee must be at least 30 years old and have one year of service with the company.

Employees will be eligible for retiree health benefits only if they have paid into the fund for 10 consecutive years immediately prior to their retirement. Workers at American are eligible to retire at age 55.

However, employees who retire before Jan. 1, 2000, and have been covered under the active employee health care plan for 10 years or more will be eligible for retiree medical benefits if they prefund continuously from Jan. 1, 1990.

Active employees covered by one of the health maintenance organizations with which American Airlines contracts also will be required to pay the prefunding charge to be eligible for retiree medical benefits.

Workers currently eligible to participate in the prefunding plan who decide not to contribute beginning in January may join the plan at subsequent annual enrollment periods, but they will pay a higher rate based on age. These employees also will be charged a \$250 late enrollment fee.

While current American employees initially will be required to pay \$10 per month to prefund their retiree health benefits, the charge will rise to \$12 a month if American's retiree health care costs increase by more than 5% between 1991 and 1990.

Employees will be charged an additional \$2 if retiree health care costs increase by more than 5% in 1992, bringing the charge to \$14.

Charges have not been calculated beyond that time, Ms. Jordan said.

The \$14 cap was negotiated this fall in a TWU contract that expires in March 1993, said Edward Koziatek, international vp for TWU in its southwest regional office in Dallas.

The \$10 flat rate for all current employees is a concession to workers with seniority, Ms. Jordan explained. Workers hired after Jan. 1, 1990, will be charged a higher monthly fee based on their age, and the fee will be increased as retiree health care costs rise.

For instance, a 40-year-old worker hired after Jan. 1, 1990, will pay \$31.20 a month, while workers hired in January aged 49 years and older will pay \$91.50 a month.

If workers pull out of the prefunding plan for a year or more and then wish to re-enroll, their contributions will be calculated as though they were new employees, American told its active employees. These workers also would be required to pay an additional \$250 late fee.

The employees' contributions will be placed in trusts, called Voluntary Employee Beneficiary Assns. or 501(c)(9) trusts.

Earnings on employees' contribu-

tions are taxable to the trust.

Funds will be returned with interest to those workers who terminate their employment or to the beneficiaries of active workers who die.

American employees view the plan "as a takeaway, definitely," Ms. Jordan said. But what made the plan "a little more palatable" to employees is that monthly payments cease upon retirement, she said.

In contrast, some companies are now charging retirees for their medical plan, she observed.

The TWU's Mr. Koziatek said that in negotiations with American, "FASB drove the issue" of employee prefunding. If the requirement to account for benefits as they are accrued "doesn't come to pass," the union may again hold out for complete company funding of retiree health benefits, he said.

But, benefit experts say it is very unlikely that FASB will withdraw its proposed retiree health care accounting rules.

Benefit consultants generally endorse American's prefunding plan.

"The plan makes a heck of a lot of sense for American. They have a fairly young workforce," said Perry Brandorf, a consultant in the Dallas office of Hewitt Associates.

Over the long term, even flat-rate contributions in the \$10- to \$15-a-month range will add up to a significant amount, he said.

"Going from the company paying for all medical coverage at retirement to an eventual employee contribution of 30% is a very dramatic step," Mr. Brandorf said.

Other benefit consultants agree that the plan makes sense, particularly since the retiree health care liabilities of workers who opt out of the monthly charge will not have to be reflected on the company's financial statements under the proposed FASB rules.

American's plan "is consistent with the FASB proposal to fund benefits over the working lifetime of the employee," said Glenn Meister, a managing consultant in the Los Angeles office of A. Foster Higgins & Co. Inc.

But John Hickey, a partner at Kwasha Lipton in Fort Lee, N.J., said he wonders how a company could "avoid painting itself into a corner" by requiring employee contributions to fund retiree health benefits. Mr. Hickey said the plan might limit American's flexibility to change its retiree health plan.

"You're sort of entering into a contract" with employees who contribute to the plan, Mr. Hickey said. "As long as you haven't asked for a contribution, you have a much better case for amending or terminating a benefit," he said. "A number of my clients wanted to explore this option, but we always bumped into this obstacle. What do you promise? an employee in his 30s who begins to contribute to a retirement fund? Mr. Hickey asked. ■

Update

Insurance sales by bank OK'd

NEW YORK—An agency advocacy group plans to appeal a U.S. appellate court ruling that allows subsidiaries of an Indiana bank holding company to continue to sell insurance under a Federal Reserve Board waiver of federal banking law.

The agency group, Alliance for Separation of Banking & Insurance, plans to argue that last week's ruling by a 2nd U.S. Court of Appeals panel undermines federal regulatory authority.

The Nov. 29 appellate court ruling is the latest in a two-year fight between insurance agents and banks that began when the Fed allowed the Indiana bank holding company, Merchants National Corp., to continue to sell insurance through two state-chartered bank units.

While U.S. law prohibits bank holding companies from selling insurance, nine states permit state-chartered banks to sell insurance.

The ruling will encourage bank holding companies to acquire state-chartered banks as "Trojan horses" to sell insurance, said Robert A. Rusbult, director of federal affairs for the Independent Insurance Agents of America, an ASBI participant.

Champion drops suits

BATON ROUGE, La.—The liquidator of Champion Insurance Co. will not pursue suits against former Louisiana Insurance Commissioner Sherman Bernard, other state regulators and A.M. Best Co.

Frederick S. Ellis, a retired judge who is liquidating the failed insurer, said lawyers consider the suits "not worth pursuing."

When the Baton Rouge-based insurer was ordered into liquidation, the 1987 suit was considered a potential asset (BI, June 12).

Champion sought \$55 million from Mr. Bernard, charging he and the department tried to damage the insurer through unnecessary examination of Champion's books and records.

In a supplemental suit last year, Champion sought \$35 million from A.M. Best, charging it damaged Champion's reputation by putting it on a "watch list" based on incorrect information from regulators.

Soccer match settlement set

LONDON—Most of the 1,000 claimants from Europe's deadliest sports disaster will be compensated under a settlement with the South Yorkshire Police Authority.

In agreeing to settle the claims, the police did not admit liability in the April 15 incident, said Peter Metcalf, attorney for the police.

A public inquiry last summer criticized police actions at an overcrowded soccer match at Hillsborough Stadium in Sheffield, England, where a crush of people killed 95 fans and injured 170.

The authority has an undisclosed amount of liability coverage through Municipal Mutual Insurance Ltd. in London (BI, April 24).

Negotiations will now begin with police to set damage awards, added Blaise Smith, an attorney for the Hillsborough Steering Committee representing the claimants. Once settlements are set, claimants will consider dropping litigation against the police authority, Sheffield Wednesday Football Club, Sheffield City Council and stadium consulting engineers Eastwood & Partners.

The police authority's insurer will seek subrogation against the other defendants, Mr. Metcalf confirmed.

Briefly noted

CIGNA Corp. has confirmed that it is negotiating to purchase EQUICOR Inc., the 3-year-old Nashville, Tenn.-based joint health care venture of Equitable Life Assurance Society of the United States and Hospital Corp. of America (BI, Nov. 20). . . . A federal judge in New York has sentenced former American Centennial Insurance Co. managing general agent **John A. Kraeutler** to three years probation, fined him \$15,000 and ordered him to perform 600 hours of community service. Mr. Kraeutler pleaded guilty in September to one count of tax evasion contained in a wire fraud and conspiracy indictment charging him with scheming to divert reinsurance premiums paid by utility industry captive Associated Electric & Gas Insurance Services Ltd. (BI, Oct. 9). . . . The California Supreme Court has agreed to rule on the insurability of **government-mandated hazardous waste cleanup costs** in litigation between Chicago-based FMC Corp. and 174 of its liability insurers (BI, Sept. 18). . . . A New Jersey state judge will allow Ingersoll-Rand Financial Corp. to collect more than \$10 million in surety bond claims directly from reinsurers of the defunct **Integrity Insurance Co.** The decision affirms the ruling of a court-appointed special master denying a New Jersey Insurance Department motion that would have barred direct recovery from the reinsurers (BI, Oct. 9). . . . A U.S. District judge in Aberdeen, Miss., has overturned a \$925,000 jury verdict against Hoffmann-La Roche Inc. for injuries allegedly caused by **Accutane**, a drug used to treat severe acne. The verdict was the only one that found the Nutley, N.J.-based drug company liable for injuries attributed to Accutane (BI, July 10, 1989). . . . An Albany County Supreme Court judge last week dismissed a suit by the **New York State School Board Assn. Inc.** charging the New York Insurance Department failed to properly investigate allegations that certain insurers colluded in 1987 to thwart the association's efforts to establish a reciprocal insurer (BI, June 12). . . . Wind, hail, tornadoes and flooding that struck Huntsville, Ala., and at least 15 other states Nov. 15-16 caused about **\$225 million in insured damage**, says the Property Claims Services division of the American Insurance Services Group, which assigned the storm Catastrophe No. 22. Also, a series of wind storms dubbed Catastrophe No. 23 caused about \$55 million in insured property damage primarily in the Mid-Atlantic region Nov. 20-21. . . . **Shell Oil Co.** says its pollution liability insurers will cover a major portion of a \$20 million settlement it has reached with various California and federal agencies to cover claims from a 1988 oil spill at a refinery near San Francisco Bay.

New political risk facility formed for Eastern Bloc

Products & services

SAN FRANCISCO—Responding to recent political and economic changes, Frank B. Hall & Co. Inc. and Lloyd's of London today are launching a \$400 million political risk facility for Western firms investing in Eastern Europe or the Soviet Union.

The Soviet & Eastern European Risk Insurance Facility will provide comprehensive political risk insurance protection for U.S. and Western European companies' investments, including coverage against expropriation by the Soviet Union and U.S. trade restrictions.

Since "most U.S. companies are

as concerned with U.S. government risks as they are with Soviet government risks, it was important to design a program that covered both sides," said Price G. Lowenstein, director of international political risk services for Frank B. Hall & Co. of California in San Francisco.

Within the aggregate limit of \$400 million, the line slip offers up to \$100 million in claims-made per-risk coverage, with no deductible, exclusively through Hall's San Francisco office or SBJ North America Ltd., a London-based unit of Lloyd's broker Steel Burrill Jones Ltd.

Excess market placements can also be arranged for clients with exposures greater than \$100 million.

"We tried to bring together two Lloyd's markets under one comprehensive program: the assets market, which covers confiscation, expropriation and nationalization; and the contracts market, which covers license cancellations, forced withdrawal orders or any other governmental actions that make it impossible to continue doing business, or to import or export goods or technology," Mr. Lowenstein explained.

—By Linda J. Collins

Straight talk could start needed image turnabout

By MYRON M. PICOULT
Special to Business Insurance

OVER THE PAST YEAR, we have heard observers both inside and outside the property/casualty insurance industry comment on the industry's lowly image. There is general agreement that it must be spruced up, but there are clear differences of opinion about how to accomplish the task.

We believe that it is time for the industry to take off its kid gloves and tell it like it is. Some people disagree, arguing that such an approach would only further exacerbate the problem. We disagree. We do not believe that the industry's image can get worse. Put another way, you can't fall off the floor.

The industry clearly brought this grief upon itself, although regulators and politicians have a clear share of the blame and this must be succinctly pointed out.

On the industry's side of the page, a concerted effort must be made to produce insurance policies that are "user friendly." If insurers cannot break with the tradition of sending out difficult-to-understand legalistic documents, then they should be accompanied by booklets that simply state the responsibilities of both parties and provide straightforward guidance on what to do if a claim is involved.

This would be applicable to both personal lines and even "mom and pop" commercial coverages. To their credit, some insurers have either reformatted their policies to be user friendly or have supplemented the policies with short, concise and readable book-

lets. There is general agreement that the industry must do a more efficient job of issuing policies and servicing its policyholders. To be sure, there will be and should be instances where a higher cost factor will relate to a higher level of service. Regulators should not try to bring all insurers down to a common denominator. The free market system will ferret out the inefficient players unless the regulators interfere via guaranty fund bailouts. Those individuals and companies that require and want a higher level of service from an insurance company should have the opportunity to seek it out.

Finally, the insurance industry is entitled to a "fair and reasonable return." This is not something to be ashamed of since the property/casualty industry is not an eleemosy-

On the industry's side of the page, a concerted effort must be made to produce insurance policies that are 'user friendly.'

nary institution. Capital will and should leave the industry if returns commensurate with the risk factor are not achieved. This must be brought home to managements. As we have noted many times in this column, in too many instances management ownership in the companies they manage is woefully low. Bonuses should be paid out in stock at current price levels.

Let us now turn to both the regulators and the politicians.

It is appropriate to say that people who live in glass houses should not throw stones. It is interesting to hear regulators harp on industry inefficiency when, in fact, the patchwork quilt of regulation facing the industry adds billions of dollars to operating costs. Much could also be done to improve regulators' efficiency. In fact, in many instances there is a wide disparity between

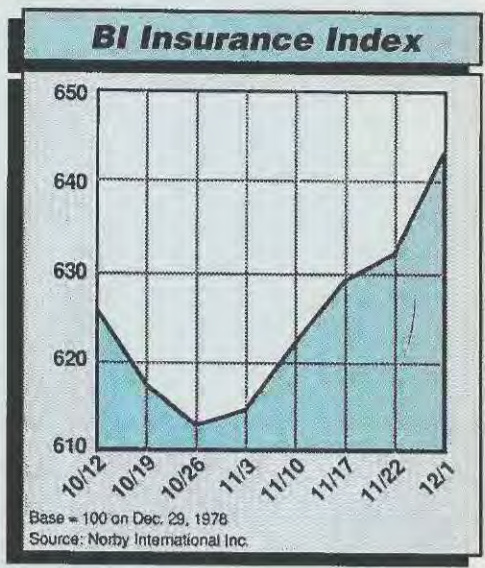
what is spent by insurance departments vis-a-vis what is collected in premium taxes.

We find it interesting that regulators are reticent to permit insurers to provide policyholders with specific insights into the costs of involuntary and residual markets. We think that both individuals and corporate accounts would be very interested in seeing what portion of their annual premiums are used to subsidize these facilities. Perhaps regulators would be more inclined to permit more appropriate rate adjustments if these costs were simplistically apportioned.

Last but not least are the horrendous problems with the industry's guaranty pools. It is obvious to all that the number of insurers that have been hitting the wall has been increasing and that the costs of relatively recent insolvencies have increased sharply, given the broader geographic and business mix of those ill-managed entities. Why should well-run companies have to pay for the ineptness and inefficiencies of less-well-run entities?

The original concept of the pools—to protect the little guys—was and remains valid. However, the interpretation of the scope of the coverage has simply gotten out of hand. There must be reforms to the guaranty pools in terms of what kinds of insurers are covered and the limits that should be involved. Perhaps one way to start is to eliminate all commercial covers—except for specific and well-defined "mom and pop" situations—from the pools. Caveat emptor should be the cry to corporate insurance buyers, as well as individuals who seek low-ball covers.

We are a very litigious society. If this is what we want, then we should have to pay for the consequences. Legislators should take hold of their responsibilities and develop meaningful no-fault laws, or at least provide insurance buyers with such options. Furthermore, the deep pocket theory has to stop and the buck stops at the legislator's desk. The circus atmosphere that prevails in many states is directly related to the actions of both the insurance regulators and the legislators. Given the results to date, federal regulation of the business is beginning to look better.



Insurance industry stocks climbed last week as the Business Insurance Index rose 11 points to 643.1 on Dec. 1, from 632.1 on Nov. 22. Advancing issues were led by Sierra Health Services, up 15.9%; Belvedere Corp., up 15.8%; and NWNL Cos., up 12.3%. Declining issues followed Statesman Group Inc., down 6.0%; Durham Corp., down 4.4%; and FHP International, down 3.1%. The most active issue during the period was Sears, Roebuck & Co. (Allstate), 2.6 million shares traded. The BI Index gained 1.8% for the period; the Dow Jones 30 Industrials rose 3.4%; the Standard & Poor's 500 gained 2.6%; and the New York Stock Exchange Composite was up 2.4%.

Nov. 30 Companies	Price	P/E	Div. pence	Yield %	1 Week High-Low pence
Comml Union	474	26.3	29.3	6.2	—
Genl Accident	1145	16.4	68.0	6.2	—
Gdn Royal Exch	248	19.5	15.7	6.2	—
Royal	497	23.9	34.0	6.8	—
Sun Alliance	321	11.1	17.0	5.3	—

Brokers	Price	P/E	Div. pence	Yield %	1 Week High-Low pence
Bradstock	220	15.1	10.0	4.5	—
CE Heath	511	14.4	34.5	6.8	—
Hogg Robinson	168	11.7	9.7	5.7	—
Lloyd Thompson	269	17.9	9.3	3.5	—
PWS Holdings	48	13.0	2.7	5.6	—
Sedgwick Grp	300	22.2	16.0	5.3	—
Steel Bri Jones	259	16.2	15.3	5.9	—
Willis Faber	269	18.9	15.3	5.7	—

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitecat & Aitken Stockbrokers, London

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BI Industry Stock Report

DEC. 1, 1989

11/23/89 THROUGH 12/1/89

		Weekly		Year to Date		Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value			Weekly		Year to Date		Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value		
		Price	% change	% change	% change	High	Low									High	Low	High	Low	High	Low								
BROKERS																													
Alexander & Alexander	NYS	33.38	1.52	43.55	34.00	22.63	330	1.00	3.00	21	9.18	3.64	Kemper Corp.	NYS	46.50	-2.87	97.87	51.88	22.75	175	0.84	1.81	10	29.97	1.55				
Corroon & Black	NYS	39.38	-0.63	24.02	41.00	29.13	227	1.24	3.15	18	12.73	3.09	Lawrence Insurance Group	ASE	7.25	0.00	-9.38	9.63	6.63	0	0.28	3.86	15	3.29	2.20				
Gallagher Arthur J. & Co.	NYS	25.63	0.49	50.74	26.50	15.88	22	0.52	2.03	18	5.33	4.81	Liberty Corp.	NYS	37.63	4.15	3.44	39.25	32.50	35	0.80	2.13	16	31.82	1.18				
Frank B. Hall	NYS	3.13	8.70	4.17	4.63	2.50	118	0.00	0.00	-1	-2.80	-1.12	Lincoln National	NYS	62.63	2.24	44.80	62.63	42.75	157	2.60	4.15	11	49.19	1.27				
Hilt, Rogal & Hamilton	OTC	25.00	-2.91	80.35	25.75	13.00	22	0.32	1.28	22	4.60	5.43	NAC Re Corp.	OTC	39.00	-1.27	88.72	41.00	20.00	281	0.20	0.51	17	22.81	1.71				
Marsh & McLennan	NYS	86.63	2.51	56.08	89.75	55.00	613	2.48	2.86	21	10.56	8.20	Navigators Group	OTC	27.88	-0.45	35.98	28.25	19.25	20	0.00	0.00	11	15.22	1.83				
Poe & Associates	OTC	11.00	10.00	25.71	11.00	8.00	7	0.40	3.64	11	1.89	7.69	Nobel Insurance LTD	OTC	2.25	0.00	-51.35	5.38	1.50	61	0.00	0.00	0	7.76	0.29				
BROKERS AVERAGE																													
2.8 40.7 2.3 16																													
CONGLOMERATES & HOLDING COMPANIES																													
Berkley W.R. Corp.	OTC	45.88	-0.54	54.85	46.50	29.25	270	0.40	0.87	10	25.06	1.83	Oron Capital Corp.	NYS	24.13	-1.53	50.78	28.50	13.88	25	0.84	3.48	7	19.72	1.22				
Berkshire Hathaway Inc.	NYS	8325.00											Phoenix RE Corp.	OTC	15.13	-0.82	55.13	15.50	8.75	213	0.20	1.32	12	12.99	1.98				
ITT (Hartford Group)	NYS	60.75	4.74	79.03	8900.00	4625.00	1	0.00	0.00	27	2669.00	2.90	Protective Life Corp.	OTC	14.25	-0.87	7.55	16.25	12.88	33	0.68	4.77	27	14.54	0.96				
Sears (Allstate)	NYS	38.75	2.31	-4.02	48.13	37.25	2612	2.00	5.16	13	37.75	1.03	Provident Life	OTC	29.88	10.65	54.19	29.88	17.75	646	0.80	2.68	10	23.24	1.29				
CONGLOMERATES AVERAGE																													
1.7 37.8 2.2 15																													
INSURERS/REINSURERS																													
Aetna Life & Casualty	NYS	61.50	1.65	31.20	62.50	46.00	1451	2.76	4.49	10	58.11	1.06	Re Capital Corp.	ASE	14.63	5.41	58.11	14.88	8.88	29	0.00	0.00	13	12.60	1.16				
Ambase Corp.	NYS	13.75	0.92	23.60	16.38	10.50	376	0.20	1.45	5	29.08	0.47	RLJ Insurance Corp.	NYS	9.25	5.71	21.31	9.38	6.88	38	0.40	4.32	9	10.71	0.86				
American General	NYS	33.63	-0.74	12.06	38.50	29.50	1565	1.48	4.40	10	34.68	0.97	St. Paul Companies	OTC	63.00	0.80	46.51	63.50	41.50	1592	2.20	3.49	9	43.47	1.45				
American Heritage	NYS	29.00	2.20	13.73	29.00	25.00	3	1.20	4.14	11	22.60	1.28	SAFECO Corp.	OTC	36.75	-1.67	57.22	38.63	23.13	713	2.20	3.27	9	24.87	1.48				
American Indemnity/Fin'l	OTC	8.25	3.13	-21.43	13.00	8.00	6	0.56	6.79	-6	17.38	0.47	SCOR U.S. Corp.	NYS	13.63	4.81	57.97	13.75	6.88	31	0.40	2.94	14	10.61	1.28				
American International	NYS	111.38	3.48	67.17	111.38	64.38	1137	0.48	0.43	14	41.92	2.46	Seibels Bruce Group	OTC	10.75	3.61	-4.44	13.63	10.25	162	0.80	7.44	-51	13.75	0.78				
Aon Corp.	NYS	39.63	2.59	43.44	39.63	26.00	653	1.40	3.53	11	19.62	2.02	Selective Ins. Group	OTC	18.75	5.63	-18.48	19.50	14.50	84	0.96	5.12	6	15.72	1.19				
Argonaut Group	OTC	68.25	0.37	56.90	69.50	43.25	8	1.00	1.47	8	38.83	1.85	Statesman Group Inc.	OTC	2.94	-5.98	2.19	3.63	1.88	130	0.16	5.45	8	4.19	0.70				
AVEMCO Corp.	NYS	24.63	6.49	-3.90	27.50	20.38	34	0.40	1.62	14	9.52	2.59	Tokio Marine & Fire	OTC	81.88	5.65	-10.76	95.50	66.00	16	0.92	1.12	35	70.93	1.15				
Baldwin & Lyons Inc.	OTC	21.63	7.45	49.14	21.63	14.38	78	0.28	1.29	7	20.80	1.04	Torchmark Corp.	NYS	55.38	5.23	81.56	55.38	30.00	252	1.40	2.53	15	13.23	4.19				
Belvedere Corp.	ASE	5.50	15.79	22.22	6.50	4.25	19	0.04	0.73	17	8.03	0.68	Transamerica	NYS	45.00	0.28	34.83	48.00	32.75	414	1.92	4.27	11	34.63	1.30				
Chandler Insurance	OTC	12.50	7.53	66.67	12.50	6.88	97	0.00	0.00	7	9.53	1.31	Trenwick Group Inc.	OTC	25.75	-1.90	80.70	26.88	13.50	180	0.36	1.40	13	16.91	1.52				
Chubb Corp.	NYS	93.75	2.04	62.34	94.63	55.88	532	2.32	2.47	10	55.49	1.69	United Fire & Casualty	OTC	33.00	0.76	8.20	34.50	28.75	1	1.20	3.64	9	22.56	1.46				
CIGNA Corp.	NYS	64.88	0.39	40.27	66.75	45.75	579	2.96	4.56	11	66.64	0.97	USF&G Corp.	NYS	30.25	0.83	4.31	34.00	28.25	1381	2.80	9.26	47	22.87	1.32				
CNA Financial Corp.	NYS	105.25	7.95	79.15	105.25	57.63	123	0.00	0.00	10	54.87	1.92	UNUM Corp.	NYS	47.00	2.17	75.70	47.75	26.38	479	0.60	1.28	13	31.20	1.51				
Continental Corp.	NYS	33.88	0.74	5.86	38.63	31.50	621	2.60	7.68	69	41.36	0.82	USLIFE Corp.	NYS	46.50	4.49	35.27	48.13	32.88	194	1.48	3.18	10	54.34	0.86				
Durham Corp.	OTC	32.75	-4.38	2.34	34.75	30.00	5	0.92	2.81	21	26.32	1.24	Washington National	NYS	26.75	1.90	0.47	29.13	24.00	45	1.08	4.04	-	32.90	0.81				
Fireman's Fund	NYS	34.50	0.36	18.45	40.75	28.63	1005	0.60	1.74	12	32.74	1.05	Zenith National Ins	NYS	18.88	2.03	7.09	21.50	15.75	150	0.84	4.45	9	13.81	1.37				
Fremont General Corp.	OTC	19.38	0.00	55.00	19.63	12.13	278	0.80	4.13	18	19.09	1.01	INSURERS/REINSURERS AVERAGE																
Frontier Insurance Group	NYS	19.25	-2.53	72.88	21.75	10.00	6	0.00	0.00	9	7.29	2.64	2.1 33.6 2.9 11.9																
General RE Corp.	NYS	94.00	1.08	70.91	96.25	54.38	1056	1.36	1.45	15	29.04	3.24	HEALTH MAINTENANCE ORGANIZATIONS																
Hanover Insurance Co	OTC	31.75																											



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